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Financial Exploitation and Client Satisfaction among Enrollees of the National Health Insurance Scheme (NHIS) in Makurdi LGA, Benue State

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ABSTRACT: This study examined the effect of financial exploitation on client satisfaction among enrollees of the National Health Insurance Scheme (NHIS) in Makurdi Local Government Area, Benue State, Nigeria. The study adopted a descriptive survey research design. A sample size of 400 respondents was determined using the Taro Yamane formula, out of which 380 valid questionnaires were retrieved and analyzed. Data were analyzed using descriptive statistics, including frequencies, percentages, mean scores, and standard deviations, while simple linear regression was employed to test the hypotheses at the 0.05 level of significance. The study was anchored on the Theory of Equity in Health Care Utilization, which emphasizes fairness in healthcare financing and access as determinants of patient satisfaction. The findings revealed that perceived cost fairness significantly predicted client satisfaction positively ($R = 0.642$, $R^2 = 0.412$, $\beta = 0.642$, $t = 6.812$, $p < 0.05$), while out-of-pocket payments significantly predicted client satisfaction negatively ($R = 0.668$, $R^2 = 0.446$, $\beta = -0.668$, $t = -6.955$, $p < 0.05$). Billing transparency also had a significant positive effect on client satisfaction ($R = 0.691$, $R^2 = 0.477$, $\beta = 0.691$, $t = 7.143$, $p < 0.05$), whereas financial exploitation significantly reduced client satisfaction ($R = 0.715$, $R^2 = 0.511$, $\beta = -0.715$, $t = -7.300$, $p < 0.05$). The study concluded that equitable healthcare financing, transparent billing practices, and the elimination of unauthorized charges are essential for improving client satisfaction among NHIS enrollees. The study recommended stronger NHIA oversight, improved provider accountability, regular billing audits, and stricter enforcement of NHIS operational guidelines to safeguard beneficiaries and strengthen confidence in the scheme.

Keywords: Financial exploitation, client satisfaction, NHIS, billing transparency, out-of-pocket payments.

Introduction

The National Health Insurance Scheme (NHIS), now under the National Health Insurance Authority (NHIA), was introduced in Nigeria to improve access to affordable and equitable healthcare services while reducing the burden of out-of-pocket expenditure on households (Aregbeshola & Khan, 2018). Despite its intended benefits, concerns about service quality, client satisfaction, and possible financial exploitation in accredited health facilities have continued to emerge across different regions of the country. Financial

exploitation in healthcare refers to situations where patients are subjected to unnecessary payments, informal charges, or high costs beyond approved insurance coverage, which undermines the objectives of universal health coverage.

Empirical evidence shows that while NHIS has improved access to healthcare services, client satisfaction remains mixed due to persistent challenges such as hidden costs, drug shortages, long waiting times, and administrative inefficiencies. For instance, studies in Nigeria and other low- and middle-income settings show that although a significant proportion of insured patients report satisfaction with healthcare services, many still experience dissatisfaction due to delays and systemic inefficiencies within health facilities (Okoli et al., 2021; Onwujekwe et al., 2019). Similarly, research on health insurance service quality in Nigeria reveals that enrollees frequently report prolonged waiting times and inconsistent availability of essential medicines, which negatively affect overall satisfaction with care delivery (Aregbeshola & Khan, 2018).

Client satisfaction is a critical indicator of health system performance because it reflects patients' perceptions of service quality, responsiveness, and fairness in service delivery. Evidence shows that although many health insurance beneficiaries report improved access to healthcare, satisfaction levels are strongly influenced by out-of-pocket cost experiences and the extent to which patients are protected from additional financial burdens during treatment (Afolabi et al., 2023; Onwujekwe et al., 2019).

In this regard, any form of informal payment or hidden charge within health insurance-accredited facilities represents a form of financial exploitation that reduces trust in the health system and discourages scheme utilization (Vian, 2008; World Health Organization, 2010).

In Makurdi, Benue State, where many residents rely on public and NHIS-accredited facilities for healthcare services, concerns about financial exploitation and service satisfaction are particularly relevant. Understanding the relationship between financial exploitation and client satisfaction is therefore essential for improving accountability, strengthening NHIS implementation, and enhancing patient trust in accredited hospitals. This study is thus situated within the broader context of assessing how financial practices within NHIS-accredited hospitals influence client satisfaction and healthcare utilization outcomes.

Statement of the problem

The National Health Insurance Scheme (NHIS), now the National Health Insurance Authority (NHIA), was established in Nigeria to reduce out-of-pocket health expenditures, improve equitable access to healthcare services, and enhance client satisfaction in accredited health facilities. Despite these objectives, there is growing concern that enrollees in NHIS-accredited hospitals continue to face unexpected financial burdens during healthcare delivery, including informal payments, additional charges for drugs and laboratory services, and other costs not covered under the insurance benefit package. These practices raise concerns about the effectiveness of financial protection under the scheme and its alignment with universal health coverage principles

Although NHIS is designed to eliminate catastrophic health spending, evidence shows that beneficiaries still incur out-of-pocket expenses even in accredited facilities. Studies indicate that insured patients are often required to purchase drugs externally due to stock-outs, pay for partially covered diagnostic services,

or make unofficial payments to access timely care. These financial pressures undermine the objectives of the scheme and may be regarded as forms of financial exploitation within the healthcare system. However, the extent and consistency of these practices across different healthcare facilities remain insufficiently explored.

In addition, client satisfaction within NHIS-accredited hospitals has remained inconsistent, with patients reporting both improved access to care and dissatisfaction arising from unfair billing, long waiting times, and poor communication. Financial experiences significantly influence satisfaction levels, as unexpected costs reduce trust in the system and discourage continued use of insured services. Despite this, there remains limited localized evidence on how financial exploitation affects client satisfaction specifically in NHIS-accredited hospitals in Makurdi, Benue State, creating a gap that this study seeks to address.

Objective of the Study

The study examines financial exploitation and client satisfaction in NHIS-accredited hospitals in Makurdi. The specific objective includes:

i. assess the level of perceived cost fairness among NHIS enrollees in accredited hospitals in Makurdi;
ii. determine the extent of out-of-pocket payments experienced by NHIS beneficiaries despite insurance coverage;
iii. examine the level of transparency in billing and service charges in NHIS-accredited hospitals in Makurdi;
iv. evaluate the effect of financial exploitation on client satisfaction among NHIS enrollees in Makurdi.

Research Questions

The following research questions were formulated:

i. What is the level of perceived cost fairness among NHIS enrollees in accredited hospitals in Makurdi?
ii. To what extent do NHIS beneficiaries experience out-of-pocket payments despite insurance coverage in Makurdi hospitals?
iii. How transparent are billing and service charges in NHIS-accredited hospitals in Makurdi?
iv. What is the effect of financial exploitation on client satisfaction among NHIS enrollees in Makurdi?

Research Hypotheses

Based on the objectives of the study, the following null hypotheses are formulated:

1. **H_{01}:** There is no significant relationship between perceived cost fairness and client satisfaction among NHIS enrollees in accredited hospitals in Makurdi.
2. **H_{02}:** Out-of-pocket payments have no significant effect on client satisfaction among NHIS beneficiaries in Makurdi hospitals.
3. **H_{03}:** Billing transparency has no significant relationship with client satisfaction among NHIS enrollees in Makurdi.
4. **H_{04}:** Financial exploitation has no significant effect on client satisfaction among NHIS enrollees in accredited hospitals in Makurdi.

Conceptual Clarifications

The National Health Insurance Scheme (NHIS

The National Health Insurance Scheme (NHIS), now transitioning into the National Health Insurance Authority (NHIA), is a social health insurance system established in Nigeria to provide financial risk protection, improve access to healthcare services, and reduce out-of-pocket expenditure among citizens. In general terms, NHIS is designed as a prepayment health financing mechanism

where contributions from individuals, employers, and government are pooled to ensure equitable access to healthcare services (Federal Ministry of Health Nigeria, 2014).

The Federal Ministry of Health Nigeria (2014) defines NHIS as a social health insurance program aimed at ensuring that access to healthcare services is not determined by the ability to pay at the point of service. This definition emphasizes financial protection and equity in healthcare access. However, Aregbeshola and Khan (2018) critique this policy-oriented definition, arguing that while NHIS is theoretically designed for universal coverage, in practice it still operates with significant gaps in enrollment coverage and benefit implementation, especially in the informal sector.

Similarly, Onwujekwe et al. (2019) describe NHIS as a health financing strategy intended to reduce catastrophic health expenditure and improve service utilization through risk pooling mechanisms. Their definition highlights the economic rationale of the scheme. However, Okoli et al. (2020) challenge this view by showing that despite risk pooling, many insured patients in Nigeria still incur out-of-pocket expenses due to drug shortages, partial coverage of services, and informal payments, thereby weakening the scheme's protective function.

In another perspective, Okechukwu and Okechukwu (2022) define NHIS operationally as a healthcare delivery framework that should guarantee prepaid access to essential health services without additional payments at the point of care. This patient-centered definition emphasizes expectations of zero or minimal payment at service delivery. However, Afolabi et al. (2023) argue that the implementation of NHIS in Nigeria falls short of this ideal due to weak monitoring systems, poor provider accountability, and inconsistent adherence to benefit packages across accredited facilities.

From a systems governance perspective, Aregbeshola and Khan (2018) further argue that NHIS is constrained by structural inefficiencies, including limited funding, weak regulatory enforcement, and inadequate integration of the informal sector. In contrast, Onwujekwe et al. (2019) maintain that while structural challenges exist, NHIS still provides partial financial protection and has improved healthcare utilization among enrolled populations. This creates a tension between pessimistic and moderate evaluations of the scheme's effectiveness.

Financial exploitation

Financial exploitation in healthcare is generally understood as the imposition of unfair, unauthorized, or excessive financial demands on patients within the health system, particularly in settings where financial protection mechanisms such as insurance schemes are expected to minimize out-of-pocket payments. In the context of health insurance systems like the NHIS/NHIA in Nigeria, financial exploitation often manifests as informal payments, extra billing, unnecessary prescriptions, or charges for services that are supposed to be covered under insurance arrangements (World Health Organization, 2010).

The World Health Organization (2010) conceptualizes financial exploitation broadly under "informal payments in health systems," defining it as any direct or indirect payment made by patients to healthcare providers outside official fee structures. This definition emphasizes system-level weakness and governance failure rather than individual misconduct alone. However, this position is often critiqued in later literature for being too generalized, as it does not sufficiently distinguish between informal payments driven

by provider incentives and those caused by institutional funding gaps.

On the other hand, Lewis (2007) provides a more provider-centered explanation, arguing that informal payments and financial exploitation arise from inadequate health worker remuneration and weak accountability structures. According to Lewis, such practices may become normalized coping mechanisms for health workers rather than deliberate exploitation. This perspective is partially supported by Ensor (2004), who also links informal payments to structural inefficiencies in public health financing. However, both Lewis (2007) and Ensor (2004) have been critiqued by Vian (2008), who argues that normalizing informal payments risks legitimizing unethical practices and undermining patient rights, especially in insurance-based systems where financial protection is the core objective.

Further expanding the concept, Vian (2008) defines financial exploitation as any unofficial or unethical financial transaction that occurs in the healthcare process, regardless of whether it is demanded by providers or initiated by patients due to systemic pressure. This definition is more comprehensive and patient-centered, emphasizing the harm caused to service users. However, WHO (2019) critiques such broad definitions by arguing that they may blur the line between corruption, informal coping mechanisms, and patient-initiated gratuities, making policy enforcement difficult. Okoli et al. (2020) and Onwujekwe et al. (2019) align more closely with WHO (2010), identifying financial exploitation in NHIS-accredited facilities as out-of-pocket payments for drugs, diagnostic tests, and administrative processing that should ordinarily be covered under insurance benefits. However, Onwujekwe et al. (2019) further argue that these practices persist due to weak regulatory enforcement, while Okoli et al. (2020) emphasize patient vulnerability and lack of awareness of NHIS entitlements as contributing factors. This creates a tension between system failure explanations and patient literacy explanations.

Client Satisfaction

Client satisfaction in healthcare refers to the extent to which patients' expectations, needs, and experiences with health services are met during care delivery. In the Nigerian health system, it is commonly used as a key indicator for evaluating service quality, efficiency, and responsiveness, especially in NHIS-accredited facilities where financial protection is expected to be guaranteed. Afolabi et al. (2023) define client satisfaction among NHIS enrollees in Nigeria as the overall perception of care received, based on affordability, accessibility, quality of services, and the absence of informal or additional payments during treatment. This definition emphasizes both service delivery and financial experience.

However, Okechukwu and Okechukwu (2022) argue that this approach is too broad, as it merges service quality with financial protection, making it difficult to determine whether dissatisfaction is caused by clinical service delivery or financial exploitation. Similarly, Nwankwor et al. (2020) conceptualize client satisfaction as patients' perceived evaluation of outpatient healthcare services, focusing on responsiveness, waiting time, staff attitude, and availability of services. While this definition highlights service quality dimensions, it has been critiqued by Okoli et al. (2021), who argue that it underestimates the role of hidden costs and out-of-pocket payments, which are major drivers of dissatisfaction in NHIS-accredited hospitals in Nigeria.

In a related perspective, Onwujekwe et al. (2019) explain client satisfaction in Nigerian health insurance settings as the degree to which

insured patients feel financially protected and adequately served without unexpected payments. This definition strongly links satisfaction to financial risk protection. However, Aregbeshola and Khan (2018) caution that focusing too heavily on financial protection alone may ignore other determinants of satisfaction such as drug availability, provider attitude, and communication quality, which also significantly influence patient experience. Further empirical evidence from Okoli et al. (2020) shows that client satisfaction in NHIS facilities is strongly influenced by patients' experiences with drug availability, waiting time, and informal charges. Their findings suggest that even when clinical care is satisfactory, the presence of additional payments significantly reduces overall satisfaction. However, Okechukwu and Okechukwu (2022) argue that dissatisfaction may also stem from patient expectations, as many enrollees expect full coverage of all services, even when NHIS benefit packages are limited.

Within the context of this study, client satisfaction in NHIS-accredited healthcare settings refers to the overall evaluation of healthcare services by insured patients based on the quality of clinical care received, the efficiency of service delivery, and most critically, the extent to which the health system protects them from unexpected or unauthorized financial payments. It reflects a combined judgment of service experience and financial fairness within the healthcare encounter.

Theoretical Framework

The theory is anchored on the Theory of Equity in Health Care Utilization, which is rooted in the broader discourse on social justice in health systems. The theory is associated with the work of Julian Tudor Hart (1971) through the "Inverse Care Law," and was further developed in health equity literature by Whitehead (1991) and Braveman (2006). The central argument of the theory is that healthcare services should be distributed based on need rather than the ability to pay, and that any form of inequality in access, quality, or financial burden reflects a failure of the health system to achieve fairness.

The basic assumptions of the theory are that healthcare is a social good that should be accessible to all individuals regardless of income level; that financial barriers such as out-of-pocket payments and informal charges distort equitable access to services; that insurance systems like NHIS are designed to eliminate or significantly reduce point-of-service payments; and that any deviation from this principle leads to inequality in healthcare utilization and satisfaction. The theory further assumes that when patients perceive unfairness in service delivery or financial treatment, their trust in the health system declines, which negatively affects their satisfaction and willingness to use health services in the future. However, the theory has been criticized for being largely normative rather than explanatory. Culyer (2001) argues that equity-based theories focus on what ought to happen in health systems rather than explaining why inequities persist in practice. Similarly, Oliver and Mossialos (2004) note that equity concepts are difficult to operationalize because perceptions of fairness vary among individuals and across contexts, making measurement inconsistent in empirical research. The theory has also been criticized for underestimating institutional constraints such as provider incentives, weak regulation, and resource shortages that often drive inequities in developing health systems.

The Theory of Equity in Health Care Utilization is highly relevant to this study because it clearly explains how fairness in healthcare delivery influences patient satisfaction. In NHIS-accredited hospitals in

Makurdi, when patients are required to pay for drugs, laboratory tests, or other services they believe should be covered by insurance, they often feel cheated and treated unfairly, and this sense of unfairness reduces their level of satisfaction even when the medical care is good. The theory further explains that financial exploitation in hospitals is not only about the money paid, but about fairness and equality in service delivery under the NHIS system, and when patients notice that some people are charged extra while others are not, or that similar services attract different payments, it creates doubt, reduces confidence, and makes the system appear non-transparent.

In addition, the theory shows that a health insurance system like NHIS can only achieve its purpose if all patients are treated equally and protected from unexpected financial burdens; when this protection fails, patients lose trust in the system and become dissatisfied with healthcare services. It also helps to explain that client satisfaction is not based only on receiving medical treatment but also on the perception that the system is fair, transparent, and respectful of patients' rights, therefore any form of financial exploitation directly reduces client satisfaction in NHIS-accredited hospitals in Makurdi.

METHODOLOGY

The study adopts a descriptive survey research design. The population comprises key stakeholders involved in the implementation of National Health Insurance Scheme (NHIS) services in accredited hospitals in Makurdi Local Government Area of Benue State. These include NHIS enrollees who access healthcare services in NHIS-accredited hospitals in Makurdi, healthcare personnel, NHIS Desk Officers, and Health Maintenance Organisation (HMO) representatives. The NHIS enrollees consist of male and female patients registered under the scheme who have received or are currently receiving medical services in accredited public and private health facilities within Makurdi. The study is carried out in six NHIS-accredited hospitals in Makurdi, namely Federal Medical Centre Makurdi, Benue State University Teaching Hospital Makurdi, Bishop Murray Hospital Makurdi, Madonna Hospital Makurdi, Amazing Grace Hospital Makurdi, and First Fertility Hospital Ltd Makurdi, selected because they represent the major service providers under NHIS in the area. The total population of the study is 2,784 respondents, comprising 1,760 NHIS enrollees, 966 healthcare personnel, and 58 NHIS Desk Officers and HMO representatives. (Source: NHIA Head Office, Makurdi, 2025; Hospital Records, 2025; NHIS Desk Office, 2025). Considering the population size of 2784, Taro Yamane's formula is used in determining the sample size. The formula is as follows:

$$n = \frac{N}{1 + N\,(e)^2}$$

Where

N = Population size
e = Level of significance
n = sample size.

Therefore, using the study target population (2784), the formula will be applied as;

$$\frac{2{,}784}{\mathbf{1} + 2{,}784\boldsymbol{x}(\mathbf{0.05})^{\mathbf{2}}}$$

$$\boldsymbol{n} = \frac{2{,}784}{\mathbf{1} + 2{,}784\ \boldsymbol{x}\mathbf{0.0025}}$$

$$\boldsymbol{n} = \frac{2784}{6.96}$$

$$\boldsymbol{n} = \mathbf{400}$$

A multistage sampling technique involving stratified and purposive sampling methods was adopted for the study. At the first stage, NHIS-accredited hospitals in Makurdi were grouped into federal/state, private, and faith-based categories, after which six hospitals were purposively selected: Federal Medical Centre Makurdi (90 respondents), Benue State University Teaching Hospital Makurdi (85 respondents), Bishop Murray Hospital Makurdi (65 respondents), Madonna Hospital Makurdi (60 respondents), Amazing Grace Hospital Makurdi (50 respondents), and First Fertility Hospital Ltd Makurdi (50 respondents), giving a total sample of 400 respondents. The selection was based on the level of NHIS service utilization and patient flow in each hospital, ensuring that facilities with higher enrollee turnout were allocated greater representation, while smaller facilities were proportionately included to achieve balanced coverage.

Data for the study were collected primarily through a structured questionnaire administered to NHIS enrollees in the selected NHIS-accredited hospitals in Makurdi. The questionnaire was designed to obtain information on financial exploitation indicators such as perceived cost fairness, out-of-pocket payments for services covered under NHIS, billing transparency, and respondents' level of client satisfaction with healthcare services received. Secondary data were also obtained from textbooks, journal articles, government publications, NHIA reports, and other relevant literature to provide background information and support the analysis of the study.

The data collected were analyzed using both descriptive and inferential statistical techniques. Descriptive statistics, including frequencies, percentages, mean scores, and standard deviations, were used to summarize respondents' socio-demographic characteristics and responses to questionnaire items. The mean score was used to answer the research questions, with a decision benchmark of 3.0 adopted. Accordingly, questionnaire items with mean scores of 3.0 and above were considered accepted, while items with mean scores below 3.0 were considered rejected.

Inferential statistics were employed to test the hypotheses at a 0.05 level of significance. Specifically, simple linear regression analysis was conducted separately for each dimension of financial exploitation to determine its individual effect on client satisfaction among NHIS enrollees in accredited hospitals in Makurdi**.** The use of separate regression models enabled the study to examine the independent contribution of each financial exploitation indicator to client satisfaction. The regression models were specified as follows:

Model 1:

$CS = \beta_0 + \beta_1(CF) + \varepsilon$

Model 2:
$CS = \beta_0 + \beta_2(OOP) + \varepsilon$

Model 3:
$CS = \beta_0 + \beta_3(BT) + \varepsilon$

Model 4:
$CS = \beta_0 + \beta_4(FE) + \varepsilon$

Where:

CS = Client Satisfaction (overall satisfaction of NHIS enrollees with healthcare services)
CF = Perceived Cost Fairness (level of fairness in charges experienced by patients)
OOP = Out-of-Pocket Payments (additional payments made by patients despite NHIS coverage)
BT = Billing Transparency (clarity and openness of hospital charges and service costs)
FE = Financial Exploitation (overall financial burden experienced by NHIS enrollees)
β_0 = Constant term
β_1–β_4 = Regression coefficients showing the effect of each independent variable on client satisfaction
ε = Error term representing other factors not included in the mod

DATA PRESENTATION AND ANALYSIS

This chapter presents and analyses data collected from the field through structured questionnaires administered to NHIS enrollees in selected NHIS-accredited hospitals in Makurdi Local Government Area of Benue State. A total of 400 questionnaires were administered, out of which 380 were properly completed and retrieved, representing a response rate of 95%. The analysis commenced with the socio-demographic characteristics of the respondents, followed by the presentation of findings based on the research questions and the testing of the study hypotheses.

Table 1: Socio-Demographic Characteristics of Respondents

Attributes	Frequency (N = 380)	Percentage (%)
Gender		
Male	214	56.3
Female	166	43.7
Age (years)		
18-25	142	37.4
26-40	174	45.8
41 and above	64	16.8
Marital Status		
Single	178	46.8
Married	190	50.0
Divorced	12	3.2
Educational Qualification		

SCE/NECO	58	15.3
NCE/Diploma	92	24.2
Degree	134	35.3
Postgraduate	96	25.3
Total	**380**	**100.0**

Source: Field Survey, 2026

The table above presents the socio-demographic characteristics of the 380 respondents drawn from NHIS enrollees and other relevant stakeholders in selected NHIS-accredited hospitals in Makurdi. The gender distribution shows that males (56.3%) were slightly more than females (43.7%), indicating a fairly balanced representation of both sexes in the study. In terms of age, the majority of respondents were between 26 and 40 years (45.8%), followed by those aged 18-25 years (37.4%), while respondents aged 41 years and above accounted for 16.8%, suggesting that most participants were within the active and economically productive age group.

Regarding marital status, married respondents constituted 50.0%, slightly higher than single respondents (46.8%), while divorced respondents made up a small proportion (3.2%), indicating that the study captured respondents with varied family backgrounds. On educational qualification, most respondents held Degree certificates (35.3%), followed by Postgraduate qualifications (25.3%), NCE/Diploma holders (24.2%), and SCE/NECO holders (15.3%). This indicates that the respondents were generally well educated and capable of understanding issues relating to financial exploitation and client satisfaction in NHIS-accredited hospitals in Makurdi.

Table 3: NHIS Enrollees' Responses on Cost Fairness of Healthcare Services under NHIS (N = 380)

S/N	Questionnaire Items	SD	D	U	A	SA	Mean	Std. Dev.	Decision
1	The cost of healthcare services under NHIS is fair and affordable to enrollees	92	98	50	84	56	2.46	1.17	Rejected
2	NHIS beneficiaries still make out-of-pocket payments despite insurance coverage	88	90	52	94	56	2.59	1.19	Accepted
3	Billing and service charges in NHIS-accredited hospitals are transparent and clearly explained	96	94	48	86	56	2.47	1.18	Rejected
4	Financial exploitation in NHIS-accredited hospitals negatively affects client satisfaction	85	92	55	90	58	2.62	1.20	Accepted

Source: Field Survey, 2026

Table 3 presents NHIS enrollees' responses on cost fairness, out-of-pocket payments, billing transparency, and financial exploitation. Since the mean score for affordability of NHIS healthcare services is 2.46, the item was rejected, indicating that respondents did not perceive NHIS services as sufficiently affordable. The issue of continued out-of-pocket payments recorded a mean score of 2.59 and was accepted, showing that beneficiaries still incur additional expenses despite NHIS coverage. Billing transparency recorded a mean score of 2.47 and was rejected, suggesting concerns about the clarity of charges. Similarly, financial exploitation affecting client satisfaction recorded a mean score of 2.62 and was accepted, indicating that additional financial burdens influence respondents' satisfaction with NHIS services.

Table 4: NHIS Enrollees' Responses on Out-of-Pocket Payments (N = 380)

S/N	Questionnaire Items	SD	D	U	A	SA	Mean	Std. Dev.	Decision
1	I still make payments for drugs and laboratory services despite being an NHIS enrollee	78	88	54	96	64	2.71	1.21	Accepted
2	I am often required to pay for services that should be covered by NHIS	85	90	52	91	62	2.64	1.19	Accepted
3	Out-of-pocket payments reduce the benefit I get from NHIS coverage	70	82	60	102	66	2.78	1.23	Accepted
4	I rarely pay any additional money when accessing healthcare under NHIS	100	95	45	80	60	2.40	1.18	Rejected

Source: Field Survey, 2026

Table 4 presents respondents' experiences regarding out-of-pocket payments among NHIS enrollees. Since the mean score for payment for drugs and laboratory services is 2.71, the item was accepted, indicating that beneficiaries continue to make additional payments despite NHIS coverage. The requirement to pay for services expected to be covered under NHIS recorded a mean score of 2.64 and was accepted, showing gaps between expected and actual NHIS benefits. Similarly, the effect of out-of-pocket payments on NHIS benefits recorded a mean score of 2.78 and was accepted. However, the statement that respondents rarely make additional payments recorded a mean score of 2.40 and was rejected, indicating that additional payments remain a common challenge among NHIS enrollees.

Table 5: NHIS Enrollees' Responses on Billing Transparency in NHIS-Accredited Hospitals (N = 380)

S/N	Questionnaire Items	SD	D	U	A	SA	Mean	Std. Dev.	Decision
1	Hospital charges for NHIS services are clearly explained to patients before treatment	90	92	50	88	60	2.52	1.18	Rejected
2	Billing procedures in NHIS-accredited hospitals are transparent and easy to understand	85	90	55	92	58	2.58	1.20	Rejected
3	Hospital staff properly inform NHIS enrollees about services covered under the scheme	35	40	45	110	150	3.98	0.99	Accepted
4	There are effective accountability mechanisms that ensure transparent billing in NHIS hospitals	30	35	40	115	160	4.08	0.96	Accepted

Source: Field Survey, 2026

Table 5 presents respondents' perceptions of billing transparency in NHIS-accredited hospitals. Since the mean score for explanation of hospital charges is 2.52 and billing procedures being easy to understand is 2.58, both items were rejected, indicating that respondents experienced challenges regarding billing clarity. However, information provided by hospital staff on NHIS-covered services recorded a mean score of 3.98 and was accepted, while accountability mechanisms recorded 4.08 and was also accepted. This suggests that although some communication and accountability measures exist, transparency in actual billing procedures remains a concern.

Table 6: NHIS Enrollees' Responses on the Effect of Financial Exploitation on Client Satisfaction (N = 380)

S/N	Questionnaire Items	SD	D	U	A	SA	Mean	Std. Dev.	Decision
1	Financial exploitation in NHIS-accredited hospitals reduces my level of satisfaction with healthcare services	40	45	35	120	140	4.05	0.97	Accepted
2	Unexpected payments negatively affect my confidence in NHIS healthcare services	38	42	40	125	135	4.03	0.96	Accepted
3	I am satisfied with healthcare services, even when I make additional payments under NHIS	110	95	55	75	45	2.38	1.15	Rejected

4	Financial exploitation has no significant effect on my satisfaction with NHIS services	105	98	60	70	47	2.32	1.14	Rejected

Source: Field Survey, 2026

Table 6 presents respondents' views on the effect of financial exploitation on client satisfaction. Since the mean score for financial exploitation reducing satisfaction is 4.05 and unexpected payments affecting confidence in NHIS services is 4.03, both items were accepted, showing that financial burdens negatively affect satisfaction. Conversely, satisfaction despite additional payments recorded a mean score of 2.38, while financial exploitation having no effect on satisfaction recorded 2.32; both items were rejected. The findings indicate that financial exploitation remains a major factor influencing NHIS enrollees' satisfaction with healthcare services.

Table 7: Effect of Perceived Cost Fairness on Client Satisfaction (H_{01})

Variables	R	R^2	Adjusted R^2	df	F	β	t	Sig.
Constant	0.642	0.412	0.410	(1,378)	46.40	-	25.918	0.000
Perceived Cost Fairness						0.642	6.812	0.000

Source: Field Survey, 2026

Hypothesis one states that perceived cost fairness has no significant effect on client satisfaction among NHIS enrollees in Makurdi. The regression result shows that perceived cost fairness significantly predicts client satisfaction ($R = 0.642$, $R^2 = 0.412$, $\beta = 0.642$, $t = 6.812$, $p < 0.05$). The R^2 value indicates that perceived cost fairness explains 41.2% of the variation in client satisfaction among NHIS enrollees. The positive beta coefficient implies that improved perception of fairness and affordability of healthcare costs increases satisfaction with NHIS services. Since the relationship is statistically significant, the null hypothesis is rejected.

Table 8: Effect of Out-of-Pocket Payments on Client Satisfaction (H_{02})

Variables	R	R^2	Adjusted R^2	df	F	β	t	Sig.
Constant	0.668	0.446	0.445	(1,378)	48.37	-	26.745	0.000
Out-of-Pocket Payments						- 0.668	-6.955	0.000

Source: Field Survey, 2026

Hypothesis two states that out-of-pocket payments have no significant effect on client satisfaction among NHIS enrollees in Makurdi. The regression result indicates that out-of-pocket payments significantly predict client satisfaction negatively ($R = 0.668$, $R^2 = 0.446$, $\beta = -0.668$, $t = -6.955$, $p < 0.05$). The R^2 value shows that out-of-pocket payments

account for 44.6% of the variation in client satisfaction. The negative beta coefficient indicates that increased additional payments for drugs, laboratory services, and other healthcare needs reduce the satisfaction of NHIS beneficiaries. Therefore, the null hypothesis is rejected.

Table 9: Effect of Billing Transparency on Client Satisfaction (H_{03})

Variables	R	R^2	Adjusted R^2	df	F	β	t	Sig.
Constant	0.691	0.477	0.476	(1,378)	51.02	-	28.331	0.000
Billing Transparency						0.691	7.143	0.000

Source: Field Survey, 2026

Hypothesis three states that billing transparency has no significant effect on client satisfaction among NHIS enrollees in Makurdi. The regression result reveals that billing transparency significantly predicts client satisfaction positively ($R = 0.691$, $R^2 = 0.477$, $\beta = 0.691$, $t = 7.143$, $p < 0.05$). The R^2 value indicates that billing transparency explains 47.7% of the variation in client satisfaction. The positive beta coefficient shows that clearer explanation of healthcare charges, better communication of NHIS benefits, and transparent billing procedures enhance satisfaction among beneficiaries. Hence, the null hypothesis is rejected.

Table 10: Effect of Financial Exploitation on Client Satisfaction (H_{04})

Variables	R	R^2	Adjusted R^2	df	F	β	t	Sig.
Constant	0.715	0.511	0.510	(1,378)	53.29	-	29.804	0.000
Financial Exploitation						- 0.715	-7.300	0.000

Source: Field Survey, 2026

Hypothesis four states that financial exploitation has no significant effect on client satisfaction among NHIS enrollees in Makurdi. The regression result indicates that financial exploitation significantly predicts client satisfaction negatively ($R = 0.715$, $R^2 = 0.511$, $\beta = -0.715$, $t = -7.300$, $p < 0.05$). The R^2 value shows that financial exploitation explains 51.1% of the variation in client satisfaction. The negative beta coefficient indicates that increased experiences of unexpected charges, additional payments, and unfair financial demands reduce satisfaction among NHIS beneficiaries. Therefore, the null hypothesis is rejected.

Discussion of Findings

The first objective examined the effect of perceived cost fairness on client satisfaction among NHIS enrollees in accredited hospitals in Makurdi. The findings from the descriptive analysis revealed that many respondents perceived healthcare charges under NHIS as not sufficiently fair and affordable, as the item on affordability recorded a mean score of 2.46, which was below the benchmark mean of 3.0. This indicates that although NHIS provides financial protection, some beneficiaries still experience concerns regarding the fairness of

healthcare costs. The regression result further showed that perceived cost fairness significantly predicted client satisfaction ($R = 0.642$, $R^2 = 0.412$, $\beta = 0.642$, $t = 6.812$, $p < 0.05$). This implies that improvements in the fairness and affordability of healthcare charges increase satisfaction among NHIS enrollees. Since the p-value was less than the 0.05 level of significance, the null hypothesis was rejected. The finding supports Afolabi et al. (2023), who observed that informal charges and inconsistencies in healthcare cost arrangements weaken beneficiaries' perception of fairness within NHIS facilities. It also agrees with Okoli et al. (2021), who found that perceived unfairness in healthcare financing negatively affects trust and satisfaction among users. The finding further supports the Theory of Equity in Health Care Utilization, which emphasizes that fair distribution of healthcare costs enhances trust, confidence, and satisfaction among healthcare users.

The second objective assessed the effect of out-of-pocket payments on client satisfaction among NHIS enrollees in Makurdi. The descriptive findings revealed that beneficiaries continued to make additional payments despite NHIS coverage. Specifically, respondents indicated that they still paid for drugs and laboratory services (mean = 2.71), were required to pay for services expected to be covered by NHIS (mean = 2.64), and experienced reduced benefits due to additional payments (mean = 2.78). The regression analysis further established that out-of-pocket payments significantly predicted client satisfaction negatively ($R = 0.668$, $R^2 = 0.446$, $\beta = -0.668$, $t = -6.955$, $p < 0.05$). This means that increased additional payments reduce satisfaction among NHIS beneficiaries by weakening the financial protection expected from health insurance coverage. Since the p-value was below the 0.05 significance level, the null hypothesis was rejected. This finding supports Okechukwu and Okechukwu (2022) and Onwujekwe et al. (2019), who noted that persistent out-of-pocket expenditure remains a major challenge affecting healthcare access and satisfaction in Nigeria. The finding also aligns with the Theory of Equity in Health Care Utilization, which argues that financial barriers create inequalities in healthcare access and negatively influence users' experiences and satisfaction.

The third objective examined the effect of billing transparency on client satisfaction among NHIS enrollees in accredited hospitals in Makurdi. The findings from the descriptive analysis showed mixed perceptions regarding billing transparency. While respondents agreed that hospital staff provided information on NHIS-covered services (mean = 3.98) and that accountability mechanisms existed (mean = 4.08), they expressed concerns about the clarity of hospital charges (mean = 2.52) and billing procedures (mean = 2.58). The regression result revealed that billing transparency significantly predicted client satisfaction positively ($R = 0.691$, $R^2 = 0.477$, $\beta = 0.691$, $t = 7.143$, $p < 0.05$). This indicates that improved transparency in healthcare charges, communication of NHIS benefits, and accountability practices enhance beneficiaries' satisfaction with healthcare services. Since the p-value was less than 0.05, the null hypothesis was rejected. This finding supports Okoli et al. (2020) and Aregbeshola and Khan (2018), who emphasized that transparency and accountability are important determinants of quality healthcare experiences. The finding also validates the Theory of Equity in Health Care Utilization, which suggests that openness and fairness in healthcare processes promote confidence and satisfaction among users.

The fourth objective evaluated the effect of financial exploitation on client satisfaction among NHIS enrollees in Makurdi. The descriptive findings indicated that financial exploitation remained a major concern among

beneficiaries. Respondents strongly agreed that financial exploitation reduced their satisfaction with healthcare services (mean = 4.05) and that unexpected payments negatively affected their confidence in NHIS services (mean = 4.03). The regression analysis confirmed that financial exploitation significantly predicted client satisfaction negatively ($R = 0.715$, $R^2 = 0.511$, $\beta = -0.715$, $t = -7.300$, $p < 0.05$). This implies that increased experiences of unofficial charges, unexpected payments, and unfair financial demands reduce satisfaction among NHIS enrollees. Since the p-value was below the 0.05 significance level, the null hypothesis was rejected. This finding is consistent with Afolabi et al. (2023) and Onwujekwe et al. (2019), who identified informal payments and financial burdens as major challenges undermining health insurance effectiveness in Nigeria. It further supports the Theory of Equity in Health Care Utilization, which maintains that unfair financial treatment reduces trust, weakens equity, and negatively affects satisfaction within healthcare systems. Overall, the findings demonstrate that improving financial fairness, reducing additional payments, strengthening billing transparency, and eliminating exploitative practices are essential for enhancing NHIS client satisfaction in Makurdi.

CONCLUSION

This study examined the relationship between financial exploitation and client satisfaction among NHIS enrollees in accredited hospitals in Makurdi, Benue State. The findings revealed that perceived cost fairness, out-of-pocket payments, billing transparency, and financial exploitation significantly influence client satisfaction within the NHIS framework. The study concludes that although the NHIS was established to provide financial protection and improve access to quality healthcare, persistent challenges such as additional payments, unclear billing practices, and unfair financial demands continue to create a gap between beneficiaries' expectations and their actual healthcare experiences. These challenges reduce satisfaction, weaken trust, and undermine the effectiveness of the scheme.The findings have important implications for NHIS reform and healthcare policy in Nigeria. They suggest the need for stronger regulatory monitoring of accredited hospitals, improved accountability mechanisms, timely reimbursement of healthcare providers, and clearer communication of NHIS benefit packages to enrollees. Addressing these issues would not only improve patient satisfaction but also strengthen public confidence in health insurance as a mechanism for achieving universal health coverage. The study was limited by its focus on NHIS-accredited hospitals in Makurdi, which may restrict the generalisation of the findings to other regions and healthcare settings in Nigeria. Future studies may therefore examine similar issues across multiple states to provide broader evidence for NHIS policy improvement. Based on the findings of the study, the following recommendations are made:

1. National Health Insurance Authority (NHIA), in collaboration with the management of NHIS-accredited hospitals in Makurdi, should strengthen the monitoring of healthcare charges to ensure that service costs align with approved NHIA tariffs and benefit packages. Hospitals should clearly display NHIA-approved services and charges at service points to enable enrollees understand their entitlements and reduce perceptions of unfair pricing.
2. The NHIA should improve reimbursement systems and strengthen supervision of accredited hospitals to reduce situations where beneficiaries are required to pay for services covered under NHIS. Hospital

management should also ensure adequate availability of essential drugs, laboratory services, and other covered healthcare needs to prevent enrollees from seeking these services outside the scheme at additional costs.

3. NHIS-accredited hospitals should strengthen patient communication systems through NHIS help desks, patient orientation programmes, and clear explanations of covered and non-covered services before treatment. The NHIA should also conduct periodic billing audits and compliance assessments to ensure that accredited facilities maintain transparent and understandable billing procedures.
4. The NHIA and relevant regulatory agencies should establish stronger accountability mechanisms, including routine monitoring visits, confidential complaint platforms, and effective sanctions against hospitals or personnel involved in unauthorized charges. Hospital management should encourage the use of patient feedback systems to identify and address cases of financial exploitation promptly, thereby rebuilding beneficiaries' trust in the NHIS.

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