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Implementation of Tertiary Institution Social Health Insurance Programme in Two Federal Universities in Southwestern Nigeria

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Abstract

This study assessed the implementation of Tertiary Institution Social Health Insurance Programme (TISHIP) in University of Ibadan (UI), Ibadan and Obafemi Awolowo University (OAU), Ile-Ife in Southwestern Nigeria. Based on the objective of United Nations' Universal Health Coverage (UHC), the study provided an empirical evidence of the implementation of Social Health Insurance (SHI) in two Federal Universities in Southwestern Nigeria in form of TISHIP. The study utilised sequential explanatory mixed method—a combination of quantity/qualitative data analysis. Hence, 447 copies of questionnaire were administered to respondents in the two Federal Universities. In addition, 16 key informants in the implementation of TISHIP were interviewed to complement information gathered through the administration of questionnaire. The study thus concluded that the implementation of TISHIP in the study area had positive effect on students' health care, as it has increased health care utilisation among the students ($\chi^2 = 43.6$; $p < 0.05$). The study further reduced the dearth of research on existing policy on SHI vis-à-vis students' health care in Tertiary Institutions in resource-constrained countries like Nigeria.

Key words: Social health insurance; Tertiary institution; Health care facility; Universal; Health care

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1. INTRODUCTION

The implementation of Social Health Insurance (SHI) has practically become a global best practice in health care management and financing (Aniwada et al., 2019; Ridic et al., 2012). SHI is, inevitably, a strategic shift toward providing affordable health care for a considerable number of people in many countries (Choi et al., 2020). Basically, through a co-payment system, SHI allows universal access to health care. While in addition to universal access to health care, SHI protects patients from the depressing effect of Out-Of-Pocket Spending (OOPS). In line with the objectives of access and financial protection by SHI, the Federal Government of Nigeria (FGN) officially initiated the expansion of health care utilisation among Nigerians by reforming its defective Primary Health Care (PHC) system (International Social Security Account (ISSA), 2014; Omoruan et al., 2009; Omotai & Nwakwo, 2012; Usoroh, 2012). The determination by FGN to implement SHI in Nigeria was, perhaps, sequel to the cumulative global acceptance of Universal Health Coverage (UHC)—a universal consensus for achieving the Millennium Development Goal (MDG).

The sequencing of the goals of UHC and MDG in Nigeria by FGN manifested in the implementation of National Health Insurance Scheme (NHIS) in 2005 (Adefolaju, 2014). The implementation of NHIS in Nigeria was envisaged at strengthening previous reforms in health sector, and to correspondingly improve the overall health status of Nigerians (Vambe et al., 2019). All these reforms were thus reflected in some of the legislative frameworks that seek to address some of the challenges confronting Nigeria's health sector, and also contribute to the realisation of the right to health, and by extension, the right to life for every citizen as codified in Section 17(3)(c), 17(3)(d) and 33 of 1999 Constitution (Ofoegbu, 2015). Implementing SHI in Nigeria presupposes a novel mechanism for protecting many poor patients against the risk of incurring unbearable medical expenses (National Health Insurance Scheme (NHIS), 2005; Obikeze, 2013;

Odeyemi, 2014). As part of Nigerian health care policy outline, which, of course, represents the desires to provide affordable health care for the mass of the people, the Tertiary Institution Social Health Insurance Programme (TISHIP) was then introduced in 2007 as a students' account of the Social Health Insurance (SHI) in Nigeria—a sub-scheme of NHIS (NHIS, 2012).

The implementation of TISHIP in Tertiary Institutions in Nigeria was officially planned to provide health care coverage for all students in Universities, College of Education, Polytechnics, specialized Colleges of Agriculture and Monotechnics, Schools of Nursing, Midwifery, and Health Technology (Agbo & Okoh, 2014, NHIS, 2005). In view of the implementation of TISHIP in Nigeria, there have been widespread complaints about the quality of health care at the Health Centres of various Tertiary Institutions. Reports have further shown that students of these Tertiary Institutions in Nigeria have frequently expressed dissatisfaction with their clinical experience at different Health Centres. These complaints include unsatisfactory hospitalisation, poor medical attention, long waiting time, and poor emergency response. In an article published by The Nation, entitled "In pursuit of better health for student," Dikehowa (2016) noted that students' health issues have steadily caused crises in many Tertiary Institutions in Nigeria and the crises usually follow unfortunate deaths of students in ill-equipped medical centres, or poor response time at health care institutions." The recent protest by students of the Obafemi Awolowo University (OAU), Ile-Ife on October 1, 2021 exemplifies the crises in medical centres of Tertiary Institutions in Nigeria. The protest in OAU manifested from the death of a Part-four student of Department of Foreign Languages, Ms Adesina Omowunmi Aisha, as the protesting students accused the health workers of the University's Health Centre of "poor service delivery," which they perceived as, essentially, responsible for the death of their fellow student (Dokubo, 2021).

In addition to these reported cases of poor health care in various Health Centres of Tertiary Institutions in Nigeria, extant studies have mostly provided analyses of the policy objectives and structures of TISHIP, students' level of awareness of TISHIP (Vambe et al., 2019), and utilisation level of TISHIP among students (Aniwada et al., 2019). Based on this limited scope in knowledge on TISHIP, this study therefore provided empirical reassessment of the implementation of TISHIP vis-à-vis its relationship with students' health care in two Federal Universities in Southwestern Nigeria, as a reference point.

2. EMPIRICAL REVIEW

2.1 Social Health Insurance (SHI): Evidence From Nigeria

Nigeria is a country with low Gross National Income (GNI) and inadequate health care financing (Okpani & Abimbola, 2015). The characterisation of Nigeria's health sector as distressed is reflected in the dwarfing of health expenditure by FGN (Ejughemre et al., 2014; Omoruan et al., 2009). For instance, the budgetary allocation to Nigeria's health sector has been inconsiderable, hovering between 6% and 8% of national budget in the last two decades, as against the prescribed minimum of 15% of its GNI (Odo, 2021). The steady low budgetary allocation to health sector has significantly made it difficult for the FGN to comprehensively attain the goal of Universal Health Coverage (UHC) in Nigeria. But, supporting basic Primary Health Care (PHC) in Nigeria is important to realising a sustainable UHC. Based on universal desire for UHC, many political leaders of member states of World Health Organization (WHO), at a Global Conference on Primary Health (PHC) in Astana on October 25-26, 2018, renewed their commitment to PHC at the event to mark the 40th anniversary of the Alma-Ata Declaration of 1978— "which enshrined health as a basic human right and understood the potential of equitable, high quality PHC to deliver 'health for all." (Glassman et al., 2018, p.2). This Declaration was later reinforced by the World Health Assembly (WHA 58.33) in 2005, stressing that member states should adopt a method of prepayment for health care to share the risks among their population and avoid catastrophic health care expenditure (Omotai & Nwakwo, 2012; WHO, 2005).

In addition, the Alma-Ata Declaration was a reaction to the various challenges confronting the actualisation of UHC in many developing countries on the ambitious goals of health for all (Lawn et al., 2008). Poor health care financing, uncoordinated health care outcome measurement, and inadequate utilisation of health service facilities have been identified as some of the factors influencing the realisation of UHC (Ejughemre et al., 2014; Odo, 2021). Indeed, the mechanism for financing primary health care in Nigeria has, for too long, been based on OOPS, which seems to have consequently affected the realisation of UHC (Agbo & Okoh, 2014; ISSA, 2014). There is no doubt that OOPS in health care is "catastrophic," as this can lead to the crowding out of other important necessary goods such as clothes, diet, education and housing (Ejughemre et al., 2014).

The attempt by FGN to address the catastrophic nature of OOPS was seen in its efforts at resuscitating the Federal Primary Health Care Development Agency (PHCDA) to cater for SHI paradigm. Promoting SHI by FGN became a health policy focus in Nigeria in terms of national primary health care strategy for providing alternative means of delivering health care, improving the roles and responsibilities of the various tiers of government, and providing better health care for Nigerians (Adefolaju, 2014, p.155). In view of this health policy focus, the Nigerian National Assembly Act 38, 1999 established the National Health Insurance Scheme (NHIS) to provide affordable and quality health care for Nigerians. This

Act was apparently implemented on June 6, 2005 (NHIS, 2005). Since its implementation, other NHIS sub-schemes have also been established by FGN to silhouette the archaicness of OOPS. These NHIS sub-schemes include the Formal Sector Social Health Insurance Programme (FSSHIP), Community Based Health Insurance Scheme (CBHIS), Children Under 5 Social Health Insurance Programme (CUSHIP), Urban Self-Employed Social Health Insurance Programme (USESHIP), Prison Inmates Social Health Insurance Programme (PISHIP), Armed Forces/Police and other Uniformed Forces Social Health Insurance Programme (AFSHIP), Rural Community Social Health Insurance Programme (RCSHIP), Permanently Disabled Persons Social Health Insurance Programme (PDPSHIP), and the Tertiary Institution Social Health Insurance Programme (TISHIP).

Despite the implementation of these NHIS sub-schemes in Nigeria, there are still system-wide inequities in the provision of prepaid health care benefits for many Nigerians vis-à-vis the actualisation of UHC (Okpani & Abimbola, 2015). In line with the objectives of this study, focus was therefore devoted to reassessing the implementation of TISHIP as a financial risk protection mechanism set up by FGN in 2007 to mobilize resources for the health care needs of students of Tertiary Institutions, using Southwestern Nigeria as reference point.

2.2 Implementing TISHIP in Nigeria's Tertiary Institutions: An Outline

With respect to significant number of literature, TISHIP presupposes a novel policy of financing the health care needs of students of Tertiary Institutions in Nigeria (Agbo & Okoh, 2014; ISSA, 2014; NHIS, 2005; Shagaya, 2015). Since students are categorised as dependent population, payment for their health care needs, through OOPS, may constitute a financial burden that could affect their academic performance. TISHIP was therefore implemented by FGN as a social security system for addressing the health care needs of students of Tertiary Institutions in Nigeria. Payment for students' health care needs under TISHIP are recompensed from the "sickness fund" that must have been pooled through the contribution of students, international donor agencies, philanthropic organizations, and government subsidies. TISHIP is a sub-scheme of NHIS devoted to providing access to affordable and quality health care for all students of Tertiary Institutions in Nigeria (NHIS, 2005).

Fundamentally, TISHIP is projected to enhance access to affordable and quality health care for students, using a treatment code or TISHIP identity card, which allows registered students to access health care at an affordable cost at any designated NHIS centres across the nation (Agbo & Okoh, 2014). In view of the importance of health, health care is a "basic right" as enshrined in the Alma Ata Declaration for achieving UHC, which should not be based on the ability to pay. In line with the objective of providing affordable health care for all, FGN officially implemented TISHIP to achieve a more flexible, more innovative, and more competitive response to the health care need of students of Tertiary Institutions in Nigeria. This is with a view to provide access to affordable and quality health care during college education. With the implementation of TISHIP in Tertiary Institutions in Nigeria, students are officially protected against the financial hardship of huge medical bills, including equitable distribution of health care costs among students, equitable distribution of health care facilities within the nation's Tertiary Institutions, and ensuring the availability of funds to health sector for improved services (NHIS, 2005).

Structurally, as outlined by NHIS (2005), TISHIP is piloted through a private insurance model, for which Health Management Organizations (HMOs) develop and sell health plans to Tertiary Institutions. The outline of NHIS (2005) provided for all Tertiary Institutions in Nigeria to set up TISHIP Management Committee that will be made up of all-inclusive representatives of the Institution, students, Health Centre, HMOs, and NHIS within a central administrative unit. The national steering committee of NHIS and representatives of regulatory bodies must oversee the implementation of the Programme in all Tertiary Institutions across the country. Fund generated for implementing TISHIP must be domiciled in account that is managed by TISHIP Management Committee, where capitation payments would be made available for primary health care facilities, while fee for service will be remitted to HMOs that carry out the secondary care purchasing (ISSA, 2014). An actuarial review by NHIS showed that ₦1,600, which is approximately $3 (USD) per annum was recommended as the premium paid by every student in all Tertiary Institutions in Nigeria before the 2016 upward review (Shagaya, 2015). However, the current payable premium is ₦2,000, which is approximately $4 (USD) per annum, while an actuarial review is carried out annually by NHIS to ensure the continuing adequacy of contribution rates and amount paid to health care service providers.

However, some Tertiary Institutions in Nigeria have an existing network of in-house health Programmes, and such in-house arrangement are to be fully integrated with TISHIP. Many Tertiary Institutions in Nigeria have adopted TISHIP, but, as at 2016, not all of them have successfully implemented the Programme due to challenges of take-off. For instance, in Rivers State, only four out of the six Tertiary Institutions in the State have so far implemented TISHIP (Dikewoha, 2016). This report identified University of Port Harcourt (UNIPORT), Rivers State University of Science and Technology (RSUST), Ignatius Ajuru University of Education (IAUE), and Rivers State College of Health Technology (RSCHT) as the four Tertiary Institutions that have implemented

TISHIP in the State, while the two that were yet to implement the Programme include the Federal College of Education Technology (FCET), Omoku and Ken Saro Wiwa Polytechnic, Bori.

TISHIP is seen, if fully implemented, as a promising and a sustainable health care financing mechanism for students' health care needs in various Tertiary Institutions in Nigeria, through a coordinated collaboration with HMOs. HMOs serve as intermediaries between NHIS and Tertiary Institutions' Health Centres (Obikeze & Onwujekwe, 2020). HMOs are also limited liability companies that are privately or publicly owned for the purpose of economic participation in the implementation of NHIS-TISHIP in Nigeria (Agbo & Okoh, 2014; Shagaya, 2015). However, implementing TISHIP has not really been easy for many Tertiary Institutions in Nigeria, as reports of unfortunate deaths still emanate from different Tertiary Institutions' Health Centres. Empirical review of mortality of student beneficiaries, even after implementing TISHIP in these Tertiary Institutions in Nigeria, continues unabated with report of the death of Ms Kelechi Precious, a Part-two student of Theatre Art and Film Study in University of Port-Harcourt (UNIPORT). The death of the student occurred in August, 2014 after she had collapsed in the bathroom, regardless of the adoption and implementation of TISHIP by the institution (Dikewoha, 2016). Incidentally, the student, who was a beneficiary of TISHIP, died at the University of Port-Harcourt Teaching Hospital (UPTH) due to the failure of emergency response to the dying student, according to the report. Unfortunately, the report also noted that most of the University's hospital health care workers were unaware of the implementation of the TISHIP in UNIPORT since 2014. In relation to poor advocacy for TISHIP, many students are still unaware of its implementation in their Tertiary Institutions, while the other students who were aware have reservations about the effective implementation of the Programme, which tends to limit their participation in the implementation of TISHIP (Aniwada, 2019, p.414).

Moreover, implementing TISHIP in Nigerian Tertiary Institutions has been a reflection of the ways health policies have been handled in the country. This is mostly associated with poor implementation mechanism, policy inconsistency, lack of political will, corruption, and lack of administrative direction. Indeed, the incessant politicisation of public policies by over ambitious governments of many African countries has been related to the prevalent excessive bureaucratic procedure to defraud the people without positive results (Imurana et al., 2014). One such ambitious government policy agenda was the "free education for all" in Nigeria, for which public education system is considerably weak, putting many Nigerians on the path of seeking alternative private education (Makinde, 2005).

Furthermore, the study conducted by Vambe et al. (2019) in University of Abuja, Nigeria, showed that students were not satisfied with the level of the implementation of TISHIP in their institution. The study further confirmed that half of the students were generally unaware of the implementation of Programme in their institution, and those who were aware of the Programme occasionally visit the institution's Health Centre. The reason given for students' apathy toward the Programme in the institution was based on the general perception that the University's health facilities were under equipped. The study by Aniwada et al. (2019) on the utilisation of TISHIP among undergraduate students in Enugu State, Nigeria reported that half of the respondents became aware of the implementation of TISHIP through friends and relatives. But they concluded that majority of the respondents in the study area had positive perception about the activities of TISHIP, such as the benefits of reducing cost of medical bills and efficiency of health care, with a cautious need for improvement, especially in the areas of awareness and utilisation.

3. METHODS

This study utilised sequential explanatory mixed-method—a combination of quantitative and qualitative data. The quantitative phase (survey) preceded the qualitative phase (interviews). For the quantitative phase, students in University of Ibadan (UI), Ibadan and Obafemi Awolowo University (OAU), Ile-Ife responded to 447 questionnaires. But for the qualitative phase, 16 key informants in the study area responded to a few interview questions to complement information gathered through the administration of questionnaire. Furthermore, the key informants in the study area provided information on behalf of TISHIP Management Committee, students, HMOs, and the Health Centres. Secondary data on the implementation of TISHIP in UI, Ibadan and OAU, Ile-Ife were obtained from NHIS Bulletin, TISHIP Operational Guidelines, textbooks, journals on SHI, and newspaper publications. The data collected were analysed using appropriate descriptive and inferential statistics.

4. FINDINGS AND DISCUSSION

4.1 Results

The success or failure of implementing TISHIP in University of Ibadan (UI), Ibadan and Obafemi Awolowo University (OAU), Ile-Ife in Southwestern Nigeria represents the views of respondents who either agreed or disagreed with the roles/activities of TISHIP in the study area. Table 2 showed frequency and percentage distribution of respondents on each of the descriptive assertions set out to measure the association between the implementation of

TISHIP and students' health care. The values/responses were organised with Likert scale measurements, such as: Strongly Agree (4), Agree (3), Disagree (2) and Strongly Disagree (1). In addition, the mean value ($\bar{\chi}$) summarised the strength of the respondents for each of the assertions set out to achieve this objective, using a decision rule as thus: where ($\bar{\chi} > 2.5$), more respondents agreed, and where ($\bar{\chi} < 2.5$), more respondents disagreed.

Table 1
Implementation of TISHIP in Two Federal Universities in Southwestern Nigeria

Variables	Strongly agree		Agree		Disagree		Strongly disagree		N = 407	
	F	%	*F*	%	*F*	%	*F*	%	$\bar{\chi}$	Remark
The implementation of TISHIP in the University ensured students' access to affordable health care	163	40.0	168	41.3	51	12.5	25	6.1	3.15	Agreed
TISHIP protects students from financial hardships of huge medical bills	188	46.2	171	42.0	31	7.6	17	4.2	3.30	Agreed
TISHIP maintains high standard of health care within the University	70	17.2	254	62.4	61	15.0	22	5.4	2.91	Agreed
TISHIP ensures availability of fund to the University's Health Centre for improved services	40	9.8	262	64.4	85	20.9	20	4.9	2.79	Agreed
TISHIP takes cognisance of the peculiar health care needs of students in designing the Programme, including access to periodic health education and outreaches	25	6.1	178	43.7	165	40.5	39	9.6	2.46	Disagreed
Co-payment that are pooled for the implementation of TISHIP are efficiently utilised in achieving the objectives of the Programme	91	22.4	170	41.8	112	27.5	34	8.4	2.78	Agreed
The implementation of TISHIP in the University allows registered students to enjoy unhindered access to health care	110	27.0	206	50.6	71	17.4	20	4.9	3.46	Agreed
Treatment for registered beneficiaries of TISHIP are provided without difficulties	87	21.4	211	51.8	83	20.4	26	6.4	2.88	Agreed
The implementation of TISHIP has engendered availability of funds to the University's Health Centre for improved services	56	13.8	234	57.5	105	25.8	12	2.9	2.82	Agreed
The implementation of TISHIP does not allow registered students to pay extra fees for medical services covered by the Programme	137	33.7	194	47.7	58	14.3	18	4.4	3.11	Agreed

Source: Field Survey by Researcher, 2021
NB: *f* = Frequency % = Percentage $\bar{\chi}$ = Mean value N = Total Number of Respondents

As shown in Table 2, 331 (81.3%) of the respondents were in agreement with item (1) that says: implementation of TISHIP in the university ensured students' access to affordable and quality health care through premium contributed by students in line with the benefit package of TISHIP. This means that the provision of affordable and quality health care is a cardinal objective of the implementation of TISHIP. It was also expected of the respondents to either agree or disagree on the statement that TISHIP protects students from the financial hardships of huge medical bills. In their responses, 359 (88.2%) of the respondents were in agreement with this assertion. This indeed implies that protecting students from huge medical bills is one of the essentialities of the implementation of TISHIP that intends to eliminate OOPS.

Also, there was an ordinary agreement level of 254 representing 62.4% of the respondents' views on the assertion that the implementation of TISHIP maintained high standard of health care within the university (χ =2.91). The percentage of agreement indicated that NHIS ensured accreditation of health care facilities (HCFs) periodically. It was further found that improved services in the Universities' Health Centres manifested from the extra finances made available to HCFs from the sickness fund by the Universities' managements. This result was deduced from 264 (64.4%) agreement level with the assertion that the implementation of TISHIP ensured availability of funds to the Universities' Health Centres for improved services ($\bar{\chi}$ =2.79). This agreement level from respondents tends to be associated with the fact that the sickness fund for implementing TISHIP was generated from co-payments, such as students' premiums, parents, philanthropic donation, support from international agencies, and government subsidies.

Also, respondents were asked to either agree or disagree with the statement on whether the implementation of TISHIP takes cognisance of the peculiar health care needs of students in the design of the Programme, including access to periodic health education and outreaches. To this assertion, the descriptive statistics showed 204 (50.1%) of respondents in disagreement (χ =2.46). This implies that the implementation of TISHIP should be reviewed to ensure adequate provision of students' health care needs in the Universities. However, 261 (64.1%) of the respondents agreed that co-payment

that were pooled for implementing TISHIP could have been efficiently utilised to achieve the objective of the Programme ($\bar{\chi}$ =2.78). This respondents' agreement may be summed up from consistent provision of free drugs for student beneficiaries during ill health. Furthermore, 206 (50.6%) of the respondents agreed that the implementation of TISHIP allowed registered students to enjoy unhindered access to health care, while 110 (27%) respondents affirmed this statement by choosing "strongly agree." In total, more respondents tended toward agreement than disagreement level ($\bar{\chi}$ =3.46).

Another significant concern is access to affordable health care by registered beneficiaries. The descriptive statistics showed 211 (51.8%) of the respondents who merely agreed, and 87 (21.4%) strongly agreed that treatment under the implementation of TISHIP were provided without difficulties for registered beneficiaries ($\bar{\chi}$ =2.88). This was further reiterated by the level of availability of fund, for which there was a remarkable agreement level of about 71.3% on how availability of fund has impacted positively on the health care needs of students at the Universities' Health Centres ($\bar{\chi}$ =2.82.). In addition, there was an attempt to clarify whether beneficiaries do not pay extra fees for medical services. In their response, 331 (81.4%) of the respondents were in agreement with the statement that the implementation of TISHIP does not involve additional pay from its beneficiaries ($\bar{\chi}$ =3.40). This serves as a distinctive feature of TISHIP, which makes it different from other sub-schemes of NHIS, which allow beneficiaries to pay certain percentage of the cost of treatment.

4.2 Test of Hypothesis

This section showed the analysis/interpretation of hypothesis in this study. The statistical tool used in the analysis of the data is Chi-square. Chi-Square is appropriate because it was used to measure the degree of association between two categorical variables and evaluate the strength of the association between two nominal variables. The level of significance used in this analysis is 5% (i.e. 0.05).

Table 2
Chi-square Table

Hypothesis Statement	Chi-square χ^2	Df	p-value	Chi-square Table Value χ^2_{tab} at 5%
H_o—Implementation of TISHIP has no positive association with students' health care in Federal Universities in Southwestern Nigeria	43.6	1	0.000	7.815

Source: Field Survey by Researcher, 2021

Table 2 presents the association between the implementation of TISHIP and students' health care in Federal Universities in Southwestern Nigeria. Since p-value (0.000) is less than significant level (0.05) and the $\chi^2_{calculated}$ = 43.6 is greater than $\chi^2_{tabulated}$ at 5% level of significance =7.815, this study rejected H_o and accepted H_i. The result showed that the implementation of TISHIP has no positive association with students' health care delivery in Federal Universities in Southwestern Nigeria (χ^2 = 43.6; $p < 0.05$). This implies that the implementation of TISHIP has positive association with students' health care delivery in Federal Universities in Southwestern Nigeria.

4.3 Key Informant Interviews (KIIs)

To complement data gathered through the administration of questionnaire, key informant interviews (KIIs) were conducted with several key informants in the implementation of TISHIP in the study area. The key informants in the implementation of TISHIP in the study area were Medical Directors of the Health Centres; representatives of the HMOs, doctors; nurses, pharmacists, and representatives of SUGs.

Proceeding with responses from key informants, some doctors at the Health Centre of OAU, Ile-Ife posited that implementing TISHIP in the University has enhanced the provision of affordable and quality health care for students through the provision of adequate wellness package. This wellness package includes ambulatory patient services, medical consultations, hospitalisation care, surgical and accidental care, emergency services, maternity treatment, and the provision of free prescription drugs for registered beneficiaries. Some nurses at the Health Centre of OAU, Ile-Ife noted that students receive treatment at any time of the day, without the exception of holidays and period of industrial strike.

One doctor working at the Health Centre of UI, Ibadan noted that students enjoy 100% access to free drugs, free surgery through referral to the University's tertiary health care facility (i.e. University College Hospital (UCH), Ibadan), and free emergency treatment through the integrated health service of the University. The nurses at the Health Centres of both UI and OAU, where TISHIP is currently implemented, acknowledged the efforts of social workers in distributing relief materials, money, and food to indigent students/patients during treatment. Although, the nurses admitted that some of the relief materials were donated by international donor agencies that were supporting the implementation of TISHIP in the Universities in the study area.

Furthermore, official of one of the HMOs at the Health Centre of OAU noted that "health care provided by the University's tertiary health care facility (i.e. Obafemi Awolowo University Teaching Hospital's Complex (OAUTHC), Ile-Ife) during referrals were promptly paid for, using the NHIS approved drug list." Another doctor at the Health Centre of OAU noted that "students who are sincere would confirm that the implementation of TISHIP has helped many of them to access affordable and quality health care. He further noted that students who have benefited from TISHIP would prefer the

maintenance of the Programme." A pharmacist, who was interviewed, compared both pre-TISHIP and TISHIP periods. The pharmacist enumerated the positive side of the Programme, which includes the possibility of treatment with free drugs in TISHIP period compared to the pre-TISHIP period when students can only enjoy free drugs at a rate less than ₦500, which is approximately $1 (USD). Another doctor at the Health Centre of UI, when interviewed, noted a substantial improvement in the availability of drugs for students' health care needs.

At the highest administrative level of implementing TISHIP in Federal Universities in Southwestern Nigeria, the Medical Director (MD) of Health Centre of OAU, Ile-Ife acknowledged that students' health care needs have been sufficiently covered under the Programme, such as primary, secondary, and tertiary health care. The MD also disclosed that HMOs in the University have always fulfilled their obligation to students' health care needs, and if the HMOs do not fulfil their statutory obligation to student's health care needs, they will be delisted from operating at the Health Centre of the University. The MD further noted that "more efforts toward providing adequate coverage for students' health care needs could have been achieved if the sickness fund is sufficient for proper implementation of the Programme." He, thus, concluded that the quality of health care provided for students in the course of implementing TISHIP in the University has gone up tremendously.

However, the Medical Director (MD) of the Health Centre of UI, Ibadan, which is also known as Jaja Clinic, decried the implementation of TISHIP in Nigeria. This is based on the inability of the Programme to provide a comprehensive coverage for students' health care needs. The MD was critical of the exclusion list in the treatment guidelines of TISHIP and stated that coverage of the Programme is narrow and apparently unable to meet the health care needs of all students of Tertiary Institutions in Nigeria. The MD summarised his doubt about the implementation of TISHIP in Nigeria, which includes the inability of HMOs to provide full medical coverage for students during ill health, such as in the eventuality of accident during sporting events or protests; and its inability to manage six hospital visits per student in a month. In addition, the MD queried the intention of HMOs to collect 40% of the sickness fund available for implementing TISHIP. For him, Health Centres would have been more efficient in providing quality health care for students in various Tertiary Institutions in Nigeria if they are provided with 100% access to the sickness fund. The MD then suggested the review of the implementation of TISHIP in Nigeria's Tertiary Institutions by the Minister of Health, Dr. Osagie Ehanire, to make the Programme more implementation friendly.

From the general interview responses, there were much emphases on the paucity of the sickness fund that is available for achieving the implementation of TISHIP. TISHIP sickness fund has always been reduced to about 60%-70% of the total budget, considering the deduction of about 30%-40% fee-for-service paid to HMOs. It was also noted from the interview responses that the level of students' awareness of the Programme is substantially low compared to the importance of students' well-being on campus. Imagine a situation, from an interview subject, where a top official of SUG in OAU does not simply understand the implementation of TISHIP. How would such SUG official ensure that students in the University enjoy affordable and quality health care? The interpretation is that the role of the SUG, as a significant stakeholder in the implementation of TISHIP, is apparently weak in this important area of ensuring students' academic performance and success.

5. CONCLUSION

The co-payment of students to TISHIP's sickness fund at the beginning of every academic session justifies their financial protection during ill-health in Tertiary Institutions. This co-payment is important in providing conducive learning environment for students of Tertiary Institutions in Nigeria. This observation is coterminous with the submission of Shagaya (2015) and Aniwada (2019) on the connection between students' health care and academic performance. The various roles of HMOs in providing the necessary support for student enrollees in accessing affordable and quality health care at the Health Centres of Nigeria's Tertiary Institutions further cemented the position of Onoka (20I4) on the collaboration between HMOs and NHIS/TISHIP. The study therefore concluded that the implementation of TISHIP had positive effect on students' health care, in terms of increased health care access and utilisation among students in the study area.

Finally, the most serious goal of this study has been to provoke further reflection and discussion on the factors influencing the implementation of TISHIP in Tertiary Institutions in Nigeria. More could have been achieved by implementing TISHIP upon the basis of sufficient commitment of all stakeholders towards providing feedback on certain challenges that could help understand the shortcomings of the Programme.

REFERENCES

Adefolaju, T. (2014). Repositioning health insurance in Nigeria: Prospects and challenges. *International Journal of Health Sciences*, *2*(2), 151-162, 2372-5079. http://www.ijhsnet.com.

Agbo, H. A., & Okoh, E. O. (2014). Assessment of tertiary institution social health insurance programme at the University of Jos Health Centre. *Journal of Biological and Chemical Research, 31*(1), 253-259. ISSN2319-3077.

Aniwada, E. C., Ndu, A. C., Okoye, C. J., Okoye, p.C., Okpala, A. C., & Okpala, C. V. (2019). Utilisation of Tertiary Institution

Social Health Insurance Programme (TISHIP) among undergraduate students in Enugu State. *Nigerian Journal of Medicine, 28*(4), 413-422, ISSBN 1115-2613.

Choi, S., Sohn, M., Jeong, H., & Kim, S. (2020). Determinants of legislation on social health insurance in transition countries. *International Journal of Health Services, 0*(0)1-10. http://www.doi.10.1177/00207314220731420952013.

Dikewoha, P. (2016, August, 25). In pursuit of better health for students. *The nation.* http://www. the nationonlineng.net-Education.

Dokubo, B. (2021, October 2). OAU shut down: What led to the death of Adesina Aishat, an undergraduate students on campus. *QEDaily.* http://www.qedaily.com.

Ejughemre, U. J., Agada-Amadi, Y. A., Oyibo, P. G., & Ugwu, I. C. (2014). Healthcare financing in Nigeria: A systematic review assessing the evidence of the impact of health insurance on primary health care delivery. *Journal of Hospital Administration, 4*(1). http://www. sciedu.ca/jha.

Glassman, A., Keller, J. M., & Lu, J. (2018). The declaration of Alma Ata at 40: Realising the promise of primary health care and avoiding the pitfalls of making vision reality. *Centre for Global Development*. http://www.jstor.org/stable/resrep29646.

Imurana, B. A., Haruna, R. K., & Kofi, A. B. N. (2014). The politics of public policy and problems of implementation in Africa: An appraisal of Ghana's national health insurance scheme in Ga East District. *International Journal of Humanities and Social Science, 4*(4). http://www.ijhssnet.com/.../Vol.../23.pdf.

International Social Security Account (ISSA) (2014). *Implementation of tertiary institution social health insurance programme: A case of the national health insurance scheme in Nigeria.* http://www.issa.int/observatory/country/profiles/regions/Africa/Nigeria/A-National-Health-Insurance-Scheme-for-Nigeria.

Lawn, J. E., Rohde, J., Rifkin, S., Were, M., Paul, V. K., & Chopra, M. (2008). Alma-Ata 30 years on: Revolutionary, relevant, and time to revitalise: Alma-Ata: *Rebirth and Revision, 1*(372). http://www.thelancet.com.

Makinde, T. (2005). Problems of policy implementation in developing nations: The Nigerian Experience. *Journal of Social Sciences, 11*(1), 63-69, Taylor and Francis.

National Health Insurance Scheme (2012). *Operational guidelines revised edition.*

National Health Insurance Scheme (NHIS). (2005). *Operational guidelines*. http://www.nhisng.org/downloads/fuull%20NHIS520guidelines.pdf.

Obikeze, E. (2013). Benefit incidence of national health insurance scheme in Enugu, Southeast,Nigeria. *African Journal of Health Economics.* http://www.researchgate.net/…/260749853

Obikeze, E., & Onwujekwe, O. (2020). The roles of health maintenance organisation in the implementation of a social health insurance scheme in Enugu, Southeast Nigeria: A mixed method investigation. *International Journal in Equity in Health, 19*(33). https://doi.org/10.1186/s12939-020-1146-4.

Odeyemi, I. A. (2014). Community-based health insurance programmes and the national health insurance scheme of Nigeria: Challenges to uptake and integration. *International Journal for Equity in Health.* http://www.equityhealth.com/content/13/1/20.

Odo, I. (2021, October 19). Nigeria's healthcare in danger. *The Guardian.* www.guradian.ng.

Ofoegbu, D. I. (2015, April 23). Saving mothers and babies. *The Nation.* www.thenationonlineng.net.

Okpani, A. I., & Abimbola, S. (2015). Operationalizing universal health coverage in Nigeria through social health insurance. *Nigeria Medical Journal*, *56*, 305-310. https://doi.org/10.4103/0300-1652.170382.

Omoruan, A. I., Bamidele, A. P., & Phillips, O. F. (2009). Social health insurance and sustainable healthcare reform in Nigeria. *Studies on Ethno-Medicine, 3*(2) 105-110. https://doi.org/10.1080/09735070.2009.11886346.

Omotai, L. O., & Nwakwo, N. C. (2012). A review of the Nigerian health care funding system and how it compares to that of South Africa, Europe and America. *Journal of Medicine and Medical Sciences, 3*(4), 226-231. http://www.interes.journal.org/JMMS.

Onoka, C. A., (2014). *The private sector in national health financing systems: The role of health maintenance organisations and private healthcare providers in Nigeria*. (PhD thesis) London School of Hygiene & Tropical Medicine. http://doi.org/10.17037/PUBS.02089174.

Ridic, G., Gleason, S., & Ridic, O. (2012). Comparisons of health care systems in the United States, Germany and Canada, *Journal of Mat Soc Med, 24*(2), 112-120, Sarajevo, Sarajevo International University, https://doi:10.5455/msm.2012.24-120.

Shagaya, Y. J. (2015). Assessment of students' satisfaction and quality of patient care under the Nigerian Tertiary Institution Social Health Insurance Programme (TISHIP). *European Journal of Business and Management*, Department of Business Administration, Ahmadu Bello University, Zara, *7*(6). http://www.iiste.org. ISSN/2222-1905.

Usoroh, E. E. (2012). *Achieving health coverage in Nigeria: The national health insurance as a tool.* 48th International Course in Human Development (ICHD). Royal Tropical Institute, Amsterdam. http://www.bibalex.org/search4dev/..../455718.

Vambe, T. J., Okafor, I. J., & Nweke, O. I. (2019). Awareness and patronage of the Tertiary Institution Health Insurance Programme (TISHIP) among students of tertiary institutions in Abuja, Nigeria. *Global Journal of Applied, Management and Social Studies (GOJAMSS), 17,* 323-7.

World Health Organization (2005). Sustainable health financing: Universal coverage, and social health insurance. *58th World Health Assembly*, Geneva. http://www.who.int/health/.../cov../e...