

## Challenges of Implementing Tertiary Institution Social Health Insurance Programme: Empirical Evidence From Southwest Nigeria

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### Abstract

Managed care is still prematurely implemented in tertiary institutions in Nigeria. This study then examined the challenges of implementing Tertiary Institution Social Health Insurance Programme (TISHIP) in federal universities in southwest Nigeria between 2005 and 2019. Primary and secondary data were used for this study, while University of Ibadan (U.I.) and Obafemi Awolowo University (O.A.U.) were purposively selected from the study population. The study concluded that the following challenges confront the implementation of TISHIP in southwest Nigeria, and these include: irregular feedback in the implementation of TISHIP (RII=3.52), failure to educate students about the benefits of implementing TISHIP (RII=3.50), lack of public advocacy to generate support for the objectives of TISHIP (RII=3.45), lack of transparency in the collection and remittance of the sickness fund (RII=3.01), and poorly constituted TISHIP management committee. The recommendations of the study suggest a robust funding for implementing TISHIP to enhance the capacity of the Scheme to provide accessible and affordable health care services for students of federal universities in southwest Nigeria.

**Key words:** Social health insurance; Health maintenance organization; Capitation payment; Health care utilization; Health centre

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### 1. INTRODUCTION

Health care utilization in Nigeria's health care facilities (HCFs) is considerably low due to high cost of medical services (Omotai & Nwakwo, 2012; Usoroh, 2012; Hadiza & Elizabeth, 2014). Unfortunately, the cost of medical services in both the cash and carry private HCFs and the underfunded public HCFs is essentially beyond the reach of many Nigerians. Attempt by some Nigerians to avoid paying for this high cost of medical services has thus amplified the phenomenon of substituting orthodox medication for primitive curative techniques (self-medication or the use of herbal drugs) during ill health, which has, undoubtedly, increased cases of premature deaths of sick individuals.

In view of these intricate health care challenges, Section C and E of Part 1 of National Health Bill was signed into law by President Goodluck Jonathan in December, 2014, to provide for citizens living in the country with the best possible health care services within the limits of the available resources, and promote and fulfil the rights of the people of Nigeria to have access to health care services, respectively (National Health Act, 2014). The provision of the Act is, therefore, expected to reduce the hitherto culture of out-of-pocket expenditure for health care services in Nigeria's HCFs (Osuchukwu et al., 2013).

In addition to the provision of the Act, the affordable students' health care delivery mechanism in Nigeria's tertiary institutions, known as the Tertiary Institution Social Health Insurance Programme (TISHIP)—a managed health care, which was inaugurated in 2007 as a sub-scheme of the National Health Insurance Scheme (NHIS). The inauguration of TISHIP by the government was predicated on a Social Health Insurance (SHI) system that focuses on the provision of affordable and quality health care delivery for students of tertiary institutions, enhance health care utilization among students, and create conducive learning environments with less worries in the event of unforeseen ill health.

However, the adoption and the implementation of the Scheme by federal, state, and private tertiary institutions have been confronted with challenge of take-off, as some of the institutions where the Scheme was adopted are yet to implement it. The implementation of TISHIP in tertiary institution are therefore reflected in the manner in which students' health care delivery is coping with the problem of students' registration under the Scheme, and other complexities arising from the process of developing health plans for student beneficiaries, which have, unfortunately, resulted in deaths of students in health centres of some of these tertiary institutions in Nigeria.

In a report by Awodipe (2015, September 19) titled "University of Ibadan Clinic Not Living Up to Expectation, Say Students" published in Guardian Newspaper, reminded us of the ill-fated death of Mayowa Alaran, a 200 Level student of Human Kinetic, University of Ibadan in May 2015. In addition to the report of increasing mortality rate in Nigeria's universities' health centers, the death of another student, Sukanmi Ogunleye occurred in October, 2015—a part one student of International Relations, Obafemi Awolowo University—who died of internal bleeding after he was rushed to the university's health centre and later to the Obafemi Awolowo University Teaching Hospital, Ile-Ife (Agbor, 2015, October 21).

The reports of students' mortality and the aforementioned challenge of take-off of the Scheme suggest the need to evaluate the degree of the implementation of TISHIP in tertiary institutions in Nigeria. To be sure, problems that are associated with students' health care delivery in Nigeria's tertiary institutions needed to be clearly understood by critically evaluating the amount of the challenges of implementing TISHIP in Nigeria. Nevertheless, useful recommendations for future implementation strategies of the Scheme, the identification of what has happened, and how to progress would make the Scheme better for all. This paper, therefore, investigated the challenges and prospects of implementing TISHIP, using federal universities in southwest Nigeria as a case study between 2007 and 2019.

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## 2. LITERATURE REVIEW

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### 2.1 Efficiency in Health Care

Efficiency in health care can be viewed from the perspective of proper use of resources for a given medical task. Perhaps, efficiency in health care tends to focus on prudent use of existing funds (Brinkerhoff, 2003), either as allocative efficiency or technical efficiency (Poterba, 1996), while Poterba technically identified the difference between the two concepts in this way:

Allocative efficiency is achieved when the right level and mix of goods and services is produced in the economy. This occurs when the marginal benefit equals the marginal cost, i.e. when

the last pound spent on providing a service brings one pound's worth of benefit. Technical efficiency (sometimes termed production efficiency) is achieved when health care outputs (in the form of goods and services) of a given quality are produced at a least cost. (p.9)

In order to achieve a better health care outcome, efficiency in both allocative and technical standpoints may represent a prudent process of resource deployment for improving the quality of health care. The distinction between health care output and outcome seemed to be tied to both allocative and technical efficiency. In fact, health care output is, particularly, an intervention intended for curative objectives, while efficiency of outputs can be determined by the quality of health care outcome in term of service improvements (or the prevention of deterioration or adverse events) in health status of a patient (Poterba, 1996).

In order to minimize wastage in the provision of health care, there is now more emphasis on information sharing among health sector actors, which tends to prevent abuse during treatment, ensure compliance with treatment procedures and standards, and improve performance/learning (Brinkerhoff, 2003). Policy makers in health sector therefore expect government to justify health care expenditure in terms of its efficiency and in relation to health care outputs and outcomes. Finally, regulating the provision of health care through government intervention in both private and public HCFs is important for ensuring minimum standard of efficiency in health care delivery (Scott, 2001; Poterba, 1996; Zweifel, 2015).

### 2.2 Accountability in Health Care

Accountability system emphasizes the establishment of process of observing, monitoring, analyzing certain individuals and institutions in terms of improving their performance as a key mechanism for good governance outcomes (Health Policy Project, 2004, Capacity Development Resource Guide). Good governance outcome is, however, meaningful when systems and the stakeholders operate in a network that strive to achieve efficiency, effectiveness, openness, transparency, accountability, responsiveness, and inclusiveness (Brinkerhoff, 2003, as cited in Health Policy Project, 2004, Capacity Development Resource Guide), which Reginato et al. (2007) described as 'a complex reciprocating matrix of accountability' (p.382). Extending accountability to achieving good governance outcome in health care may significantly involve relying on performance management system and quality improvement strategies, which requires health care providers to improve quality, effectiveness, and efficiency (O'Hagan & Persaud, 2009) Good governance system in the provision of health care further suggests that hospitals need to provide necessary information on cost, quality, effectiveness, efficiency, and appropriateness of service delivered, and protecting hospital assets (Reginato et al., 2011).

In all of these assertions, there seem to be the need for a process of deploying internal control system in reducing the negative effects of information asymmetry that is associated with the provision of care (i.e. health care professionals know more about treatment procedure than patients) by disclosing relevant information to consumers of health care about the benefits of treatment. Information asymmetry creates a difficult condition for patients in determining the quality of care (Dulleck & Kerschbamer, 2006, as cited in Das et al., 2016). A general reflection of the benefits of treatment may also takes our minds to the recurrent disputes between health care professionals and patient care goals and treatment (Sorensen & Iedema, 2007), which constitute a significant challenge to improving patients' experience of clinical care. It is even worse in low income settings where patients have few options for health care in both public and private HCFs (Das et al., 2016). And one of the challenges of improving patients' experience of clinical care in high income settings is the practice of defensive medicine, which occurs when health care professionals refuse to give in their best medical knowledge during medical care resulting from the burden of medical malpractice lawsuits (Catino, 2009; Barber, 1991). This observation therefore suggests restructuring of communication and decision-making process as a sine qua non for achieving clinical accountability in any health care facility (Sorensen and Iedema, 2007), which acts as a way to overcome the challenge of defensive medicine, which Barber sees as demoralizing the willingness of physicians to commit their best to patient care or Catino's (2009) view of defensive medicine as responsible for the high cost of health care and patients' exposure to unnecessary risks.

Indeed, the growing complexities of health care arrangements in both the public and private health care facilities (HCFs) may represent the need for a greater attention in performance evaluation and monitoring of health care operations through proper accountability framework (Scott, 2001). Health sector actors must also be accountable for their various roles in health care management. Accountability in health care system tends to bring effectiveness to health care delivery, while extrapolating the relationship between accountability and effective health care delivery leads to soundness of health care systems. This assertion can also be inferred from a quality perspective in relation to improving patients' experience of care, and also ensure what Burt (2006, as cited in O'Hagan & Persaud, 2009) described as 'more satisfied staff, fewer preventable medical errors, fewer malpractice lawsuits, and improved revenues—therefore helping to reinforce a couturier accountability' (p.129).

Health Policy Project (2004, Capacity Development Resource Guide, p.1) further showed the need for governments and policy makers to focus on key roles in fostering good governance and accountability in health care system by engaging in the following: (a) determining

the rules and regulations that govern health care system; (b) providing policy leadership and oversight; (c) guiding policy and program implementation; (d) harnessing resources; (e) creating mechanisms for social participation; and (f) answering to their citizens for pledged commitments.

Perhaps, accountability in health care has become an important reference point for measuring the level of health care system performance. The measurement of performance of health care system is related to the definition of accountability of health care organization (HCO) which takes into account and/or responding to political, commercial, community, clinical/patient interest and expectations (American Hospital Association, 1999, *Accountability: The Pathway to Restoring Public Trust for Hospitals and other Health Care Organizations*). The complexity of health systems means that inevitably, and, particularly, there are diverse expectations among stakeholders, which include the public, patients, health care professionals, politicians, managers, and public sector agencies (Scott, 2001).

Definitely, accountability seems to be confronted with challenges of enforcements in the course of monitoring health care system operation as Brinkerhoff (2003) clearly noted:

Achieving these accountability purposes face numerous challenges. First, health services are characterized by strong asymmetries among providers, users, and oversight bodies in terms of information, expertise, and access. Second, public and private interests and incentives often diverge, which can limit efforts to increase accountability. Third, institutional capacity gaps often undermine efforts to enhance accountability for all three purposes. (p. xii)

Given these challenges, all health care systems must develop and incorporate different types of accountability relationships, which tend to function with varying degree of success (Brinkerhoff, 2003).

### 2.3 Students' Health Care Delivery

A well-intentioned state of health care facility (HCF) in learning environments is important to the pursuance of academic excellence (Shagaya, 2015). Psychologically, students tend to be less distracted during academic session when a health care structure is capable of providing quick medical attention to them in situations of ill health. According to Poterba (1996) "education and health care are two important elements of national development and they are the two largest government expenditure items in most developed countries" (p. 10). Education and health tend to be given significant priority in the budgetary allocation of many advanced countries (James & Savedoff, 2010). In view of this observation, study by Poterba (1996) had previously shown statistics that revealed that in 1991, \$96 billion was spent on public colleges and universities in the United States and the general educational outlays represent nearly 30% of government purchase of goods

and services. Comparatively in low income countries, allocation to education is significantly low and the United Nation Development Programme (UNDP) recommends 26% of national budget of any country to be allocated to education alone.

Importantly, a functioning health care system is imperative to the academic performance of students of higher learning (Shagaya, 2015; LiveWellNYU, 2012). A Comprehensive Public Health Framework to Improve Student's Health throughout the Global Network Community). In line with this argument, there is an externality proposition that, there is a negative relationship between education and crime, so that widespread education will reduce crime and associated social disruption (Shagaya, 2015; Poterba, 1996, p.280). Securing students' health care through financial protection from multiple contributions and government subsidies may create a sense of equality in health care accessibility. Financially weaker students, who could not easily access health care, can now otherwise be enlisted under a Social Health Insurance (SHI) scheme.

Undoubtedly, there are growing concerns on students' health care in relation to the dynamics of national development. These concerns have led to policy plan by government of several countries, as reflected in their determination to achieve Universal Health Coverage (UHC) at all levels. Interestingly, Social Health Insurance (SHI) has now become a strategic framework for achieving UHC in Nigeria, and this has also been adopted in Nigeria's government as a way of providing access to affordable and quality health care for students of tertiary institutions. The Nigeria's version of SHI for student is the implementation of TISHIP, which may be seen as government efforts in achieving the goal of universal health coverage for all students of tertiary institutions in Nigeria.

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### **3. EMPIRICAL REVIEW OF STUDENT'S HEALTH INSURANCE PLANS (SHIPS) IN DEVELOPED COUNTRIES**

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#### **3.1 Students' Health Insurance Plans (SHIPs) in American Universities**

A fifth of college students ages 18 to 23 lack health insurance in the US (United States Government Accountability Office, 2008, as cited in Orozco & Mayo, 2010). It was further stated that young people without health insurance are twice as likely not to see a health care provider when they are sick, a specialist when needed, fill a prescription, or get a medical test or treatment (Holahan & Kenney, 2008, as cited in Orozco & Mayo, 2010). Studies have also shown that there are several young people in the United States who are undergoing tertiary education without health insurance, and these young

people are more likely to experience financial burdens from health care needs, making it more difficult to finance their education and possibly face long-term and unsafe debt (Orozco & Mayo, 2010; Balise & Devine, 2011).

In view of this limited coverage for college students in the US, the enforcement of the Affordable Care Act (ACA), Patients Protection and Affordable Care Act (PPACA), and the Healthcare and Education Affordability Act (HEAA), which were signed by President Barack Obama in March 2010, have expanded affordability, quality, accessibility of private and public health insurance to all American students through consumer protection, regulations, subsidies, taxes, insurance exchanges, and other reforms (Obama Care and its Mandates Fact Sheet, 2010, Affordable Care Act; Orozco & Mayo, 2010).

Students in the US can therefore seek university health care coverage, which is likely cheaper and sometimes included in tuition fees or paid through student loans or grants in which this coverage allows students to visit a preferred provider in the area and carrying out doctor visit and prescription needs through campus facilities (American Safety & Health Institute, 2016, Health Counselling and Training). Whichever route a student may take, health insurance is seen as a priority for containing unforeseen ill health.

Prior to President Donald Trump's executive order to repeal the Obamacare, the PPACA and HEAA provides coverage for college students (Obama Care and its Mandates Fact Sheet, 2010, Affordable Care Act), and students will be eligible for the following health insurance options and these may include coverage as a dependent on parents' health insurance plan at the age of 26; coverage through medicaid based on expanded eligibility requirements as recognized in some states; coverage through a marketplace with premium tax credit, or subsidy, if income requirements are met; catastrophic plan offered through a marketplace; school-sponsored Student Health Insurance Plan (SHIP); and coverage through Individual Health Plan (IHP) offered outside of marketplace (Gallagher, 2014).

However, most universities in the United States of American require students to have health insurance as a way of protecting students' academic investment and progress. Although most undergraduate students have health insurance through their parents plan or have their own individual health plan (IHP) which makes it possible for them to waive the Social Health Insurance plan through a simple waiver process (Colorado State University Health Network, 2013). For students who cannot access health insurance through their parents or employer, including the cost of health insurance in their total budget, more accurately represents the costs that they face as students (Orozco & Mayo, 2010). If schools do not provide health insurance coverage to their students, those students who are not covered under a parent's, spouse's, or employer's plan will have to purchase individual

policy or risk going without insurance coverage and SHPs are typically much less expensive than other individual insurance plans that are marketed to the general public (Balise & Devine, 2011). This however indicates that many students would thus be put at financial risk if their schools stopped offering SHIPs.

In Princeton University, access to a Preferred Provider Organization (PPO) is available to SHP covered person(s) through the claims administrator and is identified on the back of the SHP ID card (Princeton University Student Health Plan Document, 2015). It was further stated in the report that Colorado State University undergraduate and postgraduate students are required to have health insurance or eligible to enroll in the Colorado State University Student Health Insurance Plan (SHIP) or show proof of private health insurance coverage (Colorado State University Health Network, 2013). The Colorado State University Health Network believes that a relatively minor health adverse event such as knee injury could put students in a situation where medical debt may preclude their ability to continue in school.

Furthermore, John Hopkins University (JHU) requires that all full-time domestic students purchase health plan unless proof of comparable coverage is provided and international students on F1/J1 visa status are required to enroll in the Student Health Benefit Plan (SHBP) (John Hopkins University, 2015). The benefits under the SHBP includes coverage while at school and at home and comprehensive coverage both for emergency and non-emergency situations (John Hopkins University, 2015). The New York University Health care plan seems unique because of its innovative strategies in ensuring student wellness on campus. According to LiveWellNYU (2012, A Comprehensive Public Health Framework to Improve Student's Health Throughout the Global Network Community), New York University clearly establishes recommendations for each priority areas which seek to improve health and wellness through three distinct types of interventions: (1) Prevention, Access and Quality: Advancing evidence-based preventive practices, enriching healthcare services that are of highest quality, and assuring that each NYU student has access to the means to live a healthy life; (2) Health Promotion: Empowering NYU students with the education, tools, and resources to achieve their best possible health and improve the overall health; (3) Policies and Guidelines: Enhancing existing and developing new NYU policies guidelines, and protocols to facilitate change in the environmental and social conditions that affect student health.

Finally, the Obama universal health care coverage for college students, which was implemented in 2010 through the PPACA and HEAA in the US comes at huge budgetary allocation for university administrators. Study revealed that college administrators were reluctant to incorporate health care costs into student budgets because they fear that this would increase the total cost of attendance, which

may discourage students from attending their institutions (United States Government Accountability Office, 2008, as cited in Orozco & Mayo, 2010). To reduce cost, higher education institutions jointly purchased health insurance through consortiums and in fact, the majority of the community colleges nationwide that offer student health insurance plans purchased them through a consortium (Orozco & Mayo, 2010).

### **3.2 Students' Health Insurance Plans (SHIPs) in European Universities**

In several European universities, health care insurance plan is compulsory for resident and exchange students who are undergoing learning, as this insurance signifies a way of integrating health into the culture, processes and policies of universities (Tsouros, 1998). Health is seen as everybody's business in Europe and it is expected that students should be able to purchase health insurance policy so as not to become financially overburdened with expenses when the need arises. In Europe, students may be eligible for coverage under their parents' health insurance, depending on the extent of coverage allowed by the university. Basic health insurance for students of European universities covers essential health care needs which include general practitioner visits and treatment, medicine and hospital treatment (Dutch Social Security Institute, 2016, Social Security System in the Netherlands). Many of these European universities seem to offer compulsory coverage for students based on the notion that investing in health promoting university is above all an investment in the future. However, health insurance guidelines for students in Europe depend on one's country of citizenship (German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience). Study by German Academic Exchange Service further shows that citizens of European Union (EU)/European Economic Area (EEA) countries can register for European Health Insurance Card (EHIC) in his/her home country before travelling to study in any European country.

In addition, Swerge (2016) amplified this reciprocal agreement between Sweden and a number of countries for medical benefit for students while students who are not covered by these agreements must arrange their own insurance plans with Swedish universities. Swerge's study also indicated that non EU/EEA citizens with a degree programme longer than one year are entitled to the same health insurance as Sweden citizens after registering with the Swedish Tax Agency to receive permanent identity number and once a student receives this number, the student will be entitled to all health care benefits and pay the Swedish patients' fees. Similarly in Lund University, degree students are covered by special insurance scheme provided by the Swedish government, known as the Student IN (Lund University's Student Health Centre & General Medical Services, 2016).

In the case of Germany, all students are mandated to have health insurance i.e. you must have proof of sufficient insurance cover in order to be eligible to enroll at German universities (German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience). This implies that anyone desiring to study in Germany requires health insurance to enroll in a German university. Is thus technically important for foreign student to obtain proof of medical coverage before admission is granted in a university like Technische Universität München (TUM), 2016, TUM Mandatory Health, Germany). For any one intending to study in a German university, it is not sufficient to present proof of insurance from your home country, such as insurance card or insurance policy, except students who are from countries in the European Union (EU) (German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience)).

Interestingly, there are social security agreements between Germany and other EU/EEA countries (Technische Universität München, 2016, TUM Mandatory Health Instance, Germany; German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience). This means that anyone who has statutory health insurance in their home country can register this insurance coverage with a statutory health insurer in Germany (German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience). Students who are not from EU countries, and who are insured in their home country with a social insurance treaty with Germany (former Yugoslavian states, Switzerland, Turkey, and Tunisia) must also present a certificate of their health insurance to one of the social health insurers in Germany (Technische Universität München, 2016, TUM Mandatory Health Insurance, Germany). Students who are not insured in their home country, who intend to study in German universities, must also obtain German insurance through a registered health insurer of their choice (German Academic Exchange Service, 2015, Organizing Health Insurance: The German Experience).

In addition, social security coverage is compulsory in France and coverage is extended to students of EU nationals under the university's health care system once the student is registered with EHIC in their home country (Université de Nantes, 2016, Health Care and Health Coverage). The University de Nantes also stated that for non EU nationals, students must pay and register for the social security scheme or French university health coverage, even if they are covered by their home country insurance (Université de Nantes, 2016, Health Care and Health Coverage).

The report by Dutch Social Security Institute (2016) showed that health care insurance for students is mandatory in Dutch universities, and that EU/

EEA countries and Switzerland have agreements and treaties with the Netherlands about medical coverage for students where it is allowed for student to keep his/her home country insurance through the use of European Health Insurance Card (EHIC). The EHIC tends to give students of EU nationals same right to medical care as Dutch residents who have basic Dutch health insurance for students as a demonstration of a culture of health promoting university—a new public health movement in European universities (Dutch Social Security Institute, 2016, Social Security System in the Netherlands). This movement seems to be inspired by the strategy of health care for all through health-promoting settings such as the healthy city and the health-promoting school and hospital that have generated a climate that is much more favourable to change than the climate in the past (Tsouros, 1998).

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#### 4. AREA OF THE STUDY

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The study was conducted in University of Ibadan and Obafemi Awolowo University as the first two universities to adopt TISHIP in 2007 out of the six (6) federal universities in southwest Nigeria. University of Ibadan is located in Ibadan, Oyo State with an estimated student population of 33,481 and it is established in 1948. It has University Health Services called Jaja Clinic which caters for the health needs of the university community (students, staff and dependents) through health promotion, disease prevention, prompt curative and rehabilitative services (backed by adequate referral support services) and provides 24 hours services. The university health services has 11 board certified medical officers, 25 registered nurses (general nursing and midwifery), 6 laboratory technologists, 4 council registered pharmacists, 2 board registered physical therapists and 2 qualified optometrists. The back-up team consisted of 2 registered medical social workers, 4 health education officers and public health educators and assistant chief officers that oversee the environment health unit and health services. Other auxiliary staff includes administrative officers, orderlies, porters and ambulance drivers. The implementation of TISHIP in UI was integrated into the University Health Services and covers health care services for students such as general out-patient, emergency/urgent care, mental health care, surgical out-patient care, in-patient care, public health services, visual care, pharmaceutical services, and ambulance services.

The Obafemi Awolowo University is located in Ile-Ife, Osun State with an estimated student population of 31,058 and it is founded in 1961. It has Health Services known as OAU Health Centre which caters for the health care needs of the university community (students, staff and dependents). It provides 24 hours services and has 16 bed spaces for admitting patients. The Health Centre is divided

into nine functional units, namely, Medical Consultation Unit, Nursing Unit, Maternity Unit, Pharmacy Unit, Environmental Health Unit, Laboratory Unit, Radiology Unit, Records Unit, Central Administration Unit and Driving Unit. The Health Centre has contract with two Health Maintenance Organizations (International Health Management Services and Wise Health Services Ltd) in providing the following medical services for student beneficiaries such as diagnostic services, radiological services, ambulatory services, eye care, dental care, hospitalization care, and health education.

## 5. METHODS

Primary and secondary data were used for this study. Primary data were collected through administration of questionnaire and conduct of interviews with key officials of the administrative structure for implementing TISHIP in the two universities. The administrative structure includes TISHIP Management Committee in both universities, Health Management Organizations (HMOs) for both universities, Health Centres in both universities, and Student Union Governments (SUGs) in both universities. Proportionate sampling technique was adopted in which each administrative structure had a proportion corresponding to its size within the study population using a sample fraction of 10% for staff and 5% for students. In addition, interviews were conducted with key TISHIP officials in order to elicit information on variables, such as the challenges of implementing TISHIP and students' health care delivery from two (2) Chairmen of TISHIP Management Committee in U.I. and O.A.U., two (2) Presidents of Students' Union Governments in U.I. and O.A.U., and two (2) the unit heads of HMOs in U.I. and O.A.U, including doctors, nurses, and pharmacists in order to complement information gathered through questionnaire administration. Secondary data on the implementation of TISHIP were also obtained from NHIS bulletin, TISHIP operational guidelines, books on the management of primary health care delivery in Nigeria, journals on the adoption of Social Health Insurance (SHI) policy, and newspaper publications on the challenges of implementing TISHIP in tertiary institutions in Nigeria. Data collected were analysed using appropriate descriptive and inferential statistics and content analysis. Analysis of data was carried out after field work by which questionnaire underwent editing while open ended variables were among those coded.

## 6. DISCUSSION AND FINDINGS

This study covers the analysis of the challenges of implementing TISHIP in federal universities in the study area between 2005 and 2019 using Likert-scale ratings. Respondents were asked to agree or disagree

with 12 assertions on the challenges confronting the Scheme. Table 1 revealed the frequency and percentage distribution of respondents on each of the statements in the questionnaire while values/responses were organized, ranging from 1 to 5 (RII=1-5). In addition, the Sum Score and Relative Impact Index (RII) were adopted to examine and rate these challenges using mean value statistics.

Most remarkably, majority of the statements were relatively acknowledged by the respondents since eleven (11) out of the twelve (12) of the weighted average scores were above 2.50 mid-points. In addition, the rating was further shown so as to identify the most and least challenging ones. As presented in Table 1 inability to provide regular feedback to the management of the university on the quality of health care provided at the health centre (item 8) was highly rated as the leading challenge confronting the implementation of TISHIP in federal universities in the study area with sum score (1433) and RII (3.52). The former was followed by failure of student union governments to educate their members on the benefits and modalities of the Scheme, since the sum score (1424) and RII (3.50) of item nine (9) was second on the list. It was also noted that low level participation of the universities in mobilizing students for TISHIP had the same sum score (1412) and RII (3.47), thus placing the item 5 as the third-rated challenge confronting the implementation of TISHIP in federal universities in the study area.

Also, poor level of public advocacy to generate support from tertiary institutions and students (item 2) was rated to be the fourth challenge confronting the implementation of TISHIP in the study area with sum score (1403) and RII (3.45). Poor level of students union participation in ensuring that quality services are provided by reporting complaints to HMOs in the first instance and NHIS if unsatisfied (item 11) was placed on the fifth position with the sum score (1396) and RII (3.43) as among the challenges facing the implementation of TISHIP in the study area. While, item twelve (12), which states that registered beneficiaries of TISHIP experience long waiting time before receiving treatment, was also ranked at the sixth position of the challenges facing the implementation of TISHIP with sum score (1341) and RII (3.29).

In addition, poor communication network between TISHIP Management Committee and student population in ensuring that their health care needs are being met (item 7) was also numerically rated to be the seventh challenge confronting the implementation of TISHIP in the study area with sum score (1331) and RII (3.27). The eighth position was occupied by item 3, the challenge of selecting the best suitable HMOs that will purchase health care for students in collaboration with the students' union governments, with the sum score (1280) and RII (3.14). Also, lack of transparency in the collection and remittance of contributions to HMOs (item 4) was ranked to the ninth position among the listed challenges facing the

implementation of TISHIP in selected federal universities with sum score (1224) and RII (3.01). The tenth rated challenge facing the implementation of TISHIP was the first item which states that poor supervision of service provided at the health centre as well as weak monitoring and evaluation of implementing TISHIP having its sum score at 1104 and RII at 2.80.

At the bottom line, poor level of record keeping of the activities of the Scheme was rated to be the second to the last among the listed challenges posing threats to universities in the study area within the study period.

**Table 1**  
**Challenges Confronting the Implementation of TISHIP in Federal Universities in the Study Area**

S/N	Statement	Number of respondents	Sum score	Relative impact index	Remarks
i.	Poor supervision of service provided at the health centre as well as weak monitoring and evaluation of TISHIP	407	1140	2.80	10th
ii.	Poor level of public advocacy to generate support from tertiary institutions and students	407	1403	3.45	4th
iii.	The challenge of selecting the best suitable HMOs that will purchase health care services for students in collaboration with the students union government	407	1280	3.14	8th
iv.	Absence of transparency in the collection and remittance of contributions to HMOs	407	1224	3.01	9th
v.	Low level participation of the university in mobilizing students for TISHIP	407	1412	3.47	3rd
vi.	The health centre in the university is unable to meet NHIS accreditation requirement	407	969	2.38	12th
vii.	Poor communication network between TISHIP Management Committee and student population in ensuring that their needs are being met	407	1331	3.27	7th
viii.	Inability to provide regular feedback to the university management on the quality of care provided at the health centre	407	1433	3.52	1st
ix.	Failure of student union government to educate its membership on the benefits and modalities of the Scheme	407	1424	3.50	2nd
x.	Poor level of record keeping of activities of the Scheme	407	985	2.42	11th
xi.	Poor level of students union participation in ensuring that quality services are provided by reporting complaints to HMOs in the first instance and NHIS if unsatisfied	407	1396	3.43	5th
xii.	Registered beneficiaries of TISHIP sometimes experience long waiting time before receiving treatment	407	1341	3.29	6th

Source: Field Survey by Researcher, 2019

### 6.1 Synopsis of Interview Analysis

To complement the data gathered through questionnaire administration, some key officials responsible for implementing TISHIP were interviewed. Most remarkably, the 16 interviewees noted that funding is the number one challenge confronting the implementation of TISHIP and students' health care delivery in federal universities in southwest Nigeria and the country at large. In fact, the medical director of the O.A.U. health centre in the study area noted that the premium of two thousand naira (N2, 000), that is approximately \$6, paid by students at the beginning of every academic session is significantly small compare to the cost of treatment that student beneficiaries get. The acknowledged paucity of fund by the medical director of the O.A.U. health centre for implementing TISHIP is further compounded by system abuse created by dishonest students who collect drugs for other intentions. It was also noted by one interviewee that students collect

the implementation of TISHIP in federal universities in southwest Nigeria with sum score (985) and RII (2.42). However, this inferential value could be interpreted to denote that this factor is not one of the major challenges facing the implementation of TISHIP in university system. Similarly, more respondents tended toward disagreement with the view that health centre in the university is unable to meet NHIS accreditation requirement. This therefore followed that the 12<sup>th</sup> ranked factor is not one of the impeding challenges of implementing TISHIP in federal

drugs for their relatives and friends and this is capable of upsetting the capitation received by the health centres, which is necessarily needed for the provision of affordable and quality health care delivery for student beneficiaries.

Furthermore, an official of one of the HMOs operating in one of the universities, identified lack of monitoring mechanism for preventing students from treatment abuse at the health centre that may consequently result in the difficulty of health centre to adequately account for its capitation. She informed us that the health centre authority complain about shortage of funds in keeping with the objectives of implementing the Scheme. Another doctor that was interviewed at O.A.U health centre did not mince word to say students' misuse of health care facilities is frequent and that non-student sometimes access the facilities under the guise of TISHIP coverage. In addition, the doctor mentioned the possibility of a new system that will prevent non-student from accessing the facilities in the universities through the introduction a proper monitoring mechanism to check misuse of the facilities by



student beneficiaries.

Similar to the previously discussed challenges confronting the implementation of the Scheme is accessing treatments that are contained in the exemption list of TISHIP, as identified by a pharmacist in O.A.U health centre and a medical record officer at Jaja Clinic in U.I who was interviewed. The pharmacist identified situations where people collect drugs for treating terminal illnesses like hypertension and diabetes which are not covered under TISHIP and this according to her could affect the capitation that is allocated for treating student beneficiaries. Terminal illnesses are expensive to treat and are not covered under the implementation of TISHIP or within TISHIP benefit package. The pharmacist in O.A.U health centre noted that “some students that have been diagnosed for such ailments are beginning to visit the health centre to collect free prescription drugs”. This again suggests a review of TISHIP exclusion list in order for the Scheme to be more robust.

Other challenging situations identified by the pharmacist include post-natal treatment received by student beneficiaries beyond 6 months of birth and the incessant hospital visits by post graduate students who are also university staff. Postgraduate students who are also university staff are covered by the National Health Insurance Scheme (NHIS), and they frequently collect free prescription drugs under the guise of TISHIP in order to avoid the mandated 10% payment for treatment under NHIS coverage. All these situations, in the view of the pharmacist, have tended to affect the provision of quality and affordable health care for students in the universities.

Another major challenge identified during the course of the interview is the problem with student registration at the health centre. Many of the student beneficiaries of TISHIP are yet to register a medical case file at the health centre, and this situation makes it difficult for doctors to perform comprehensive medical function in the absence of patients’ medical history. One doctor working in Jaja Clinic in U.I noted that “it is always difficult for doctors to treat patient without a case file at the record section of the facilities”.

The Chief Record Officer (CRO) of O.A.U health centre, when interviewed, berated students’ ignorance of the benefit of keeping health centre record that tends to be very useful for patients treatment. He identified the benefit of keeping record of medical history of each student with the hospital, in which he lamented that this record serves as an advantage for the provision of quality diagnoses and treatment. Also, keeping record with the health centre can serve as safety net for students whenever they miss test or examinations during ill health, according to the CRO. The CRO further noted that “all students on first year admission during the orientation week, are required to undergo a medical examination at the university health centre and each student is then issued a health centre registration card with his/her photograph on it at the

completion of the medical examination.

Furthermore, one of the interviewees suggested that students should be enlightened more about health care services at the university health centre because of students’ ignorance of the implementation of TISHIP that is widespread. One doctor in Jaja Clinic in U.I. also suggested that officials of student union government in the universities needed to be educated on the idea of Social Health Insurance (SHI) including its benefits, particularly, for students who are medically vulnerable. A staff of a HMO in one of the universities also suggested that seminar should be conducted to mobilise students for health centre registration with serious emphasis on the benefits of the university health services and the implementation of TISHIP.

Another challenge confronting the implementation of TISHIP is referral controversy. A doctor in O.A.U health centre noted that “students bypass the health centre for treatment at the teaching hospital without referral from doctors working at the university health centre. For him, this situation usually occurs as a result of students’ perception that health centres’ doctors are inferior to their counterpart at the teaching hospital. Finally, all the interviewees admitted that the challenges confronting TISHIP can be addressed if the Scheme is reviewed.

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## CONCLUSION

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The study explores the challenges of implementing TISHIP in federal universities in southwest Nigeria between 2007 and 2019. Some of the identified challenges of implementing TISHIP in the tertiary institutions were in furtherance to those found in the work of Odeyemi (2014) titled the “Challenges of Uptake and Integration in NHIS Implementation” and in Omotai and Nwakwo (2012) on the “Review of Nigeria Health Care Funding System.” There are also complaints from students about some health care providers who charge additional fees on the pretext of non-inclusion of the service in the benefit package (Shagaya, 2015), while registered beneficiaries of TISHIP sometimes experience long waiting time before receiving treatment (Hadiza & Elizabeth, 2014).

Other findings that are related to the failure of the Scheme were generated from the interviews granted to stakeholders for implementing TISHIP and these include delay in payment of capitation, inability of the Scheme to prevent system abuse by students who collect drugs for their friends and families, lack of transparency in the collection and remittance of the sickness fund and lack of proper monitoring of the activities of health care providers by the Ministry of Health. Students who are contributors to the Scheme are not properly informed about preventive health in relation to their bad eating habit, which tends to affect their well-being and further strain the sickness fund. Due to lack of preventing health care information, tertiary institutions in Nigeria

should build a wellness model that can help thousands of students to grapple with a wide range of issues that affect their wellbeing through information dissemination. The wellness model will emphasize prevention and promotion of public health strategies that can help students to take care of their health by developing healthy lifestyle and habits, creating an environment that will facilitate healthy lifestyle, provide students with the tools to make their own healthy decisions, and also prepare them to become active participant in their health and wellness.

Based on the findings that identified the exclusions of treatment for certain categories of illnesses in the implementation of TISHIP in federal universities, the Federal Ministry of Health should further review TISHIP exclusion list, which seems to be too narrow and broadens its capacity to cover students' health care needs for treatment that are hitherto excluded in the coverage of the Scheme. In addition to lack of monitoring of the implementation of the Scheme by the Ministry of Health and the university authorities, the implementation of TISHIP should be strengthened to increase stakeholders' engagement in developing communication strategies through interaction that can help improve understanding of the unique health care needs of the target population. Health centres in tertiary institutions should collect data and analyse them in order to know the extent of health care utilization among student beneficiaries and also upgrade their operational capacity with the aid of technological support. The federal government should also draw out a working plan for implementing TISHIP, set a target for 100% implementation, and reconstitute a proper governance framework that is entrusted with achieving the objectives of the Scheme and then apply sanction in the course of its failure.

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