SATISFACTION OF STAKEHOLDERS WITH THE IMPLEMENTATION OF THE TERTIARY INSTITUTIONS SOCIAL HEALTH INSURANCE PROGRAMME IN JOS: A QUALITATIVE STUDY

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ABSTRACT

Background:The tertiary Institutions Social Health Insurance programme was developed to provide access to quality health care services to students in institutions of higher learning in Nigeria but several authors have reported underutilization by students. The purpose of the study was to determine how the programme is implemented in tertiary institutions in Jos.

Methodology: A two-stage sampling technique was used to select respondents for the study. Data was collected using key informant interviews and focus group discussions with important stakeholders of the programme. The recorded interviews were transcribed and analysed using NVivo 12.

Results :Enrolment fees is compulsorily collected from students but most of them are not aware of the other steps they need to take to access services under the scheme. An initial medical examination is performed as part of the enrolment process in some schools but not in others. The school management collect premium on behalf of the health maintenance organizations but often delay remittance, in some cases, up to two consecutive sessions. There is also the strong belief among school clinic heads that the proportion of premium meant for provision of primary care services in often misappropriated. The Tertiary institution social health insurance programme management committees are non-functional in all the schools studied. Quality of primary care services provided by the school clinic is sub-optimal because of frequent drug stock out and lack of equipment and supplies. Most respondents were not satisfied with the implementation of the programme in their school.

Conclusion:Key stakeholders are dissatisfied with the implementation of TISHIP. The NHIA needs to supervise the implementation of the programme to ensure that the good intentions of the programme are not jeopardized.

***Key words**:* Satisfaction, Implementation, Stakeholders, TISHIP, Nigeria

Background

Tertiary Institution Social Health Insurance Programme (TISHIP) is one of the formal sector programs of the National Health Insurance Authority (NHIA) that is designed to cater for the health needs of students of higher institutions, who lose coverage in their parents' insurance when they turn 18 years.1 Enrolment is compulsory for all students and each student is required to pay a minimum premium of two thousand naira per session although the actual premium paid is determined actuarially. Payment is made at the time of school fees payment before school registration for the academic session. Enrolled students are registered with a Health Maintenance Organisation (HMO) at the beginning of the session. The HMO is

responsible for providing secondary and tertiary care for enrolled students and receives about thirty percent (30%) of the total premium while the school, responsible for primary care of enrollees through the school clinic, receives about 70 %.1,2

Like in every health insurance programme, successful implementation of the TISHIP requires the participation of several organisations and groups including the NHIA, tertiary institutions, HMOS, Health care leaders and workers, the students' union executives and students. These stakeholders need to be satisfied with the operations of the programme to be committed to the attainment of its goals and objectives.

The TISHIP programme has been in operation for several years and authors in different parts of the country have reported low level of awareness of its existence, its operational guidelines and utilization by students in several institutions among other challenges.3-6 The purpose of this study is to explore how TISHIP is implemented by tertiary institutions in Jos and the satisfaction of key stakeholders with the implementation.

Methodology

Study setting

The study was conducted in Jos Metropolis, Plateau State. Jos Metropolis is made up of Jos North and Jos South local government areas (LGAs). Plateau State is located in the North-Central Nigeria with a 2023 projected population of 4,830,515. Jos North has a population of about 429,300, and is headquartered in Jos; while Jos south has a population of about 407,900 with headquarters in Bukuru. Both LGAs are predominantly urban.7

Sampling technique

Respondents were selected using a two-stage sampling technique. The first stage involved the selection of institutions from a sampling frame of six largest tertiary institutions in Jos metropolis; and three tertiary institutions in the metropolis were selected using simple random sampling technique by balloting. In the second stage, participants for the key informant interview and the focus group discussion were purposively selected from each of the schools.

Data collection

Data was collected using focus group discussions and key informant interviews. The interview guides were informed by previous research and the designated roles of the stakeholders in the TISHIP programme. One focus group discussion with ten participants was held in each of the schools. Each focus group discussion was held within the school in a suitable venue selected by the participants and lasted 45-60 minutes. The discussions were used to explore the views and satisfaction of the students, who are the intended beneficiaries, with the implementation/operation of the programme and the services received through the scheme. Semi structured interviews were conducted with one male and one female member of the student union executives, the health worker in-charge of the school health service (school nurse or chief medical officer), and a representative of the HMO responsible for services in the school. Each interview was conducted in the interviewee's office by two authors and lasted 30-45 minutes. The interviews and FGDs were digitally recorded and transcribed verbatim. Both the interview and the focus group discussions were continued until data saturation was reached.

Data analysis

Transcripts were imported into NVivo 12 where participants' characteristics for each of the respondents were created. A thematic framework approach was used to analyse the data, an initial coding framework was developed inductively based on the issues found. Further coding was now done using the coding framework. A framework matrix was developed as an output which was used for the narrative analysis.

Ethics

Ethical approval was obtained from the Jos University Teaching Hospital Human and Research Ethics Committee (JUTH/DCS/IREC/127/XXXI/2552) before the commencement of the study. Anonymity, confidentiality and autonomy of research participants were ensured throughout and after the research process.

Results

Eleven of the twelve major stakeholders identified for key informant interviews were interviewed. The twelfth, a representative of one of the HMOs cancelled appointments for the interview repeatedly and could not be interviewed. Three Focused Group Discussions were also held with students of the three institutions studied (Table 1).

Table 1: description of study participants

INTERVIEW TYPE	RESPONDENT	No PER INSTITUTION	TOTAL
Key Informant Interviews	School clinic Head	1	3
Key Informant Interviews	Male SUG member	1	3
Key Informant Interviews	Female SUG member	1	3
Key informant interview	HMO Representative	1	2
Focused Group Discussions	Students	1	3
TOTAL		**5**	**14**

Enrolment:
All the respondents maintained that enrolment was nonvoluntary for all full-time students and the enrolment fee was collected as part of the school fees. The actual enrolment fees charged varied per school and ranged between two thousand naira and three thousand naira. Students are required to go to the school's health facility with their receipt of payment for enrolment, after which they are given an enrolment identification card.

> "Students are enrolled into the program when they register as incoming students when they complete their school fees payment and have an Identity card with the HMO. Without which, they would not be able to access the health services of the University." - (58-year-old Health Director)

Although students are required to go to the school health service for enrolment many students don't do this because of lack of awareness as stated by one FGD participant:

> "We do not know about it because we have not been informed" (22-year FGD participant)

In two of the schools, students undergo a medical examination before or at enrolment but this was not the case in the third school.

Health services covered:
Nearly all the respondents said that TISHIP covers primary care services which are provided by the school's health clinic, while secondary and tertiary services are provided through referrals and include admission (in-patient services) for a maximum of twelve days. Unlike in other programmes of the NHIA, special investigations like MRI are also covered fully and enrollees are not required to make any co-payment.
Pharmaceuticals and laboratory services are also covered but common drugs which are on the NHIA list are often out of stock in the school clinics responsible for providing primary care services to the students' enrollees. A focus group discussion participant has this to say.

> "There is no drug only paracetamol." (25-year-old focus group discussion participant).

Funding/Premium management:
Students pay their premium to the school at the time of school fees payment. The schools are meant to remit the funds to the HMO after collection but this happens irregularly and sometimes does not happen for two consecutive sessions. The HMO responsible for services in one of the schools has this to say:

> "When the students pay to the institution, in some cases, the institution remits to the HMO 100% then the HMO remits back to the school Clinic 65% as part of the capitation which is what cater for the Primary care…."
> "I can say that the last time they remitted was in 2017 I cannot say precisely but I think the last time they remitted was in 2017/2018. But from 2019 till date, they have not remitted a Kobo."

The HMO share the collected premium with the school for the primary care services which are provided by the school clinic.

> "We pay 65% back to the school, that 5% is for administrative fee and improvement fee while 60% is for capitation for primary care to furnish their facility with drugs…". (38-year-old HMO personnel).

Satisfaction with the Programme:

The Implementation:

Most of the respondents were not satisfied with the implementation of the programme. Dis-satisfaction was nearly universal with the allocation and utilization of funds (premium) paid by the students, the functioning/performance of the T-SHIP management committees at the school level, as well as collaboration with the HMOs.

"The management of funds is not satisfactory as the funds acquired are used in other projects depriving the progress of projects in the Health Center". (54-year-old School clinic Director)

> "In the management of the TISHIP, there is supposed to be a TISHIP management committee to be chaired by the Director and all the departments are supposed to be represented. The Students' Union Government is supposed to be represented, the Provost, the VC and the Registrar are all supposed to be managers of this. In principle that committee exists but in practice, it does not" (54-year-old school clinic Director)

There was also dis-satisfaction with the enrolment process, particularly the lack of information about the process. Un-informed students do not follow the enrolment procedures and are unable to access services at the time of need, resorting to self-medication.

> "Some students do not even collect their receipts from the bursary, talk less of coming here to register with the forms before they get their NHIS Cards. And until in the scenario of a medical emergency when it is discovered that the student has not registered." - (58-year-old Health Director)

Discussion

Analysis of the data revealed that the schools compulsorily collect enrolment fees from students but do not make adequate efforts to enlighten them about the insurance programme and the other steps they need to take before they can access health care services when they need them. As a result, many students do not receive an enrolment identification card which is necessary before they can access services. This may account for the low level of awareness and utilization of services reported in several institutions across the country as shown among similar population in Enugu, Abuja-Nigeria; but contrary among College of Education students from northcentral Nigeria and Awka-Nigeria who were shown to have higher proportion of respondents being aware of TISHIP. Aniwada *et al* reported that the commonest source of awareness on TISHIP are family and friends. However, where there are high level of awareness; there is high level of utilization and consequent satisfaction with TISHIP.

All the schools have a health facility (school clinic) that provides primary care services to TISHIP enrolees. However, the package of services varied depending on the availability of staff and other resources and frequent stock out of drugs and other essential supplies appeared to be a regular occurrence in all the facilities. This is similar to reported experience among similar population at Enugu and Uyo, Nigeria; where respondents complained of non-availability of consumables and supplies. This might have contributed to students' perception of lack of utility from TSHIP in Nigeria.

The TISHIP operational guidelines require schools to remit the collected premium to the HMO after which they receive 65% of the collected sum as capitation for the provision of primary care services in the school clinic but the schools often fail to remit the collected sum in some cases for over two years. This will obviously affect the HMOs ability to pay for the secondary and tertiary services that are provided through referral. There is also a strong belief among school clinic heads that the proportion of the premium paid to the schools for capitation is misappropriated. Their belief stems from the frequent inability of the school management to provide the most basic essential drugs/supplies for the provision of services even after nearly all enrolled students have paid their enrolment fees. Similar perception has been expressed by Nigerian

tertiary students as a result of the challenges discussed above. For example, some students complained of lack of transparency and poor management of TISHIP.

Our results also how that there is widespread dissatisfaction with the way TSHIP is implemented in the institutions studied. While all the stakeholders studied expressed dissatisfaction with the implementation of the programme, the aspect of the implementation with which they were discontented varied. Student beneficiaries were more dissatisfied with information provided to students about the programme, the enrolment process and the quality of services provided under the programme while the health care providers (represented by the school clinic heads) were more dissatisfied with the use of the premium paid by the students which they felt was largely misappropriated. The HMOs were more dissatisfied with the remittance of the collected premium. The reason for this variability in the component of the process the various stakeholders are dissatisfied with could be due to the different roles and interests of the various stakeholders.

Conclusion

Many stakeholders are dissatisfied with the implementation of TISHIP in their Institutions. The NHIA needs to address the concerns of key actors to ensure the programme achieves its noble objectives. There should also be regular monitoring and evaluation of the quality of care so as to improve the level of satisfaction with TSHIP.

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