ASSESSMENT OF AWARENESS, UTILIZATION AND SATISFACTION WITH TERTIARY INSTITUTION SOCIAL HEALTH INSURANCE PROGRAMME AMONG STUDENTS OF TERTIARY INSTITUTIONS IN KADUNA STATE, NIGERIA

BY

Abdullateef Gbenga SULE

MEd Health Education (ABU, 2021)
(P15EDPE8014)

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION,
FACULTY OF EDUCATION,
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A THESIS SUBMITTED TO THE SCHOOL OF POSTGRADUATE STUDIES, AHMADU BELLO UNIVERSITY ZARIA, NIGERIA. IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER DEGREE IN HEALTH EDUCATION

DEPARTMENT OF HUMAN KINETICS AND HEALTH EDUCATION,
FACULTY OF EDUCATION,
AHMADU BELLO UNIVERSITY,
ZARIA

JUNE, 2021

DECLARATION

I hereby declare that this dissertation entitled "**Assessment of the Awareness, Utilization and Satisfaction with Tertiary Institution Social Health Insurance Programme among Students of Tertiary Institutions in Kaduna State, Nigeria.**" has been written by the researcher in the Department of Human Kinetics and Health Education under the supervision Prof. M.A Suleiman and Dr.S.N.Akorede. The information gathered from literature has been duly acknowledged in the text and list of references provided. No part of this dissertation was previously presented for another degree or diploma at any university.

___________________________ ___________________

AbdullateefGbenga SULE Date

CERTIFICATION

This thesis entitled "**Assessment of awareness, utilization and satisfaction with Tertiary Institution Social Health Insurance Programme among students of tertiary institutions in Kaduna State, Nigeria**" by AbdullateefGbenga SULE, meets the requirement governing the award of Master degree in Human Kinetics and Health Education of the Ahmadu Bello University, Zaria, Nigeria and it is approved for its contribution to knowledge and literary presentation.

____________________________ ______________________
Prof. M. A. Suleiman Date
Chairman Supervisory Committee

____________________________ ______________________
Dr S.N. Akorede Date
Member, Supervisory Committee

____________________________ ______________________
Prof. Umar Musa Date
Head of Department

____________________________ ______________________
Prof. S. Abdullahi Date
Dean, School of Post Graduate Studies

DEDICATION

This research work is dedicated first to Almighty Allah for his grace and enabling strength he bestowed on me to complete this work. Then to my beloved late mother 'RemilekunSule' and my supportive Father 'Alhaji Idris Sule'.

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ABSTRACT

The Tertiary Institutions Social Health Insurance Programme (TISHIP) is a healthcare delivery scheme that is targeted for students of tertiary institutions such as universities, polytechnics and colleges of education to ensure that every student in tertiary institution have access to quality healthcare. The awareness, utilization and satisfaction among students are very crucial to realization of objectives of the programme. It was against this backdrop that this study assessed the levels of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State. The study was carried out using descriptive study design to assessed 400 students in a proportionately sampled from Ahmadu Bello University Zaria, Federal College of Education Zaria and Kaduna Polytecnic, Kaduna. Patient Satisfaction Questionnaire short form (PSQ-Short form) was used to assess satisfaction among the students while questionnaires on awareness and utilization were adapted from the National blueprint for TISHIP. One sample t test, ANOVA and paired t test were used to analysed the hypotheses with level of significant set at (P-value 0.05). The data analysis revealed that awareness is about forty seven percent (47.2%) with (m=2.36; SD=0.92), Utilization was about forty two percent (42.5%) with (m=2.26; SD=1.08) and satisfaction fifty seven percent (57%) with (m=2.85; SD=1.14). Awareness was significantly different from utilization (t=12.456; p=0.000) and Utilization was also significantly different from satisfaction (7.395; p=0.000). However, the levelsof awareness, utilization and satisfaction were not significantly different among students of the various tertiary institutions. The levels of awareness, utilization and satisfaction were similar in all the tertiary institutions but were generally low and have no practical significance.

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LIST OF ABBREVIATIONS

ABU:	Ahmadu Bello University
ASUU:	Academic Staff Union of Universities
CU5:	Children Under 5 years
FCE:	Federal College of Education
FMOH:	Federal Ministry of Health
HIV/AIDS:	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
HMIS:	National Health Management Information System
HMO:	Health Management Organization
HSRPP:	Health Services Research and Pharmacy Practice
KADPOLY:	Federal Polytechnic Kaduna
LGDH:	Local Government Department of Health
MCH:	Maternal and Child Health
MDGs:	Millennium Development Goals
NEEDS:	New Economic Empowerment and Development Strategy
NGN:	Nigerian Naira
NHB:	National Health Bill
NHIS:	National Health Insurance Scheme
NPHDF:	National Primary Healthcare Development Fund
NSHDP:	National Strategic Health Development Plan
NUC:	National Universities Commission
PIN:	Personal Identification Number
PPP:	Public Private Partnership
SDGs:	Sustainable Development Goals
SHI:	Social Health Insurance
SMOH:	Ministry of Health

TISHIP: Tertiary Institutions Social Health Insurance Programme

UHC: Universal Health Coverage

UN: United Nations

US$: United State Dollars

WB: World Bank

OPERATIONAL DEFINITION OF TERMS

Tertiary Institutions Social Health Insurance Programme: This refers to the contributory scheme that enables students, and their less than 3-months old babies where the student is female, to enjoy free medical services within the coverage for a period of their course of study in the institution.

Awareness: This refers to the knowledge the students of tertiary institutions acquired about the existing benefit packages which are various healthcare services that an enrollee of TISHIP is entitle to access according to NHIS operational guidelines.

Utilization: This refers to the effective and profitable usage of the health care services provided by the TISHIP to the students of tertiary institutions as provided in the NHIS guidelines.

Satisfaction: This refers to the fulfilled desire of the students of tertiary institutions as a result of the healthcare services received through TISHIP

Benefit Packages: This refers to all healthcare services that students of tertiary institutions are entitled to access from their healthcare providers based on their enrolment to TISHIP.

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

Health is wealth, and to create wealth at the individual, family, community or national level, people must be healthy; to enjoy wealth that is created, an individual, family, community or nation must be healthy. Health is the good entry point for breaking the vicious circle of illhealth, poverty and underdevelopment and for converting it to the circle of improved health status, prosperity and sustainable development (Saka, Isiaka, Agbana, &Bako 2012).

Health care financing has gained prominence on the global health policy agenda. Low-and middle-income countries face the problem of providing for the health care needs of their population. Shrinking budgetary support for health care services, inefficiency in public health provision, an unacceptable low quality of public health services and the resultant imposition of user charges are reflective of our nation's inability to meet health care needs of the poor (World Bank, 2008). Meanwhile, focus on poverty reduction as reflected in the Millennium Development Goals (MDGs) and currently Sustainable Development Goals (SDGs) has generated a growing emphasis on the need for health care financing mechanisms that protect the citizens of developing countries from the potentially impoverishing effects of health care costs. While the objective of improved standard of living remains a central concern, there has been a shift of focus away from poverty reduction to social risk management. Such is the case because of the growing appreciation of the role health financing in the lives of the poor. Of all the risks facing poor households,

health risks probably pose the greatest threat to their lives and livelihoods. A health shock leads to direct expenditures for medications, transport and treatment but also to indirect costs related to a reduction in labour supply, academic performance and productivity (Asfaw, 2003).

The World Bank (2013) introduces the idea of Universal Health Coverage (UHC) as very important in achieving the health development goals of a country. The institution further explains that out-of-pocket expenditures constitute a major barrier to accessibility of healthcare services. Universal Health Coverage is therefore enhanced in situations where there is pre-payment and risk pooling. It can be deduced that health insurance is a policy that encourages pre-payment and risk pooling and the corollary is enhanced Universal Health Coverage (Prasad, 2013).

Hence, countries across the world presently consider health insurance as a means of ensuring access to health care and protecting patients from financial risks (Yang, 2013). Expectedly, many African countries have established health insurance schemes due to the need for improvements in healthcare service provision and the promotion of healthcare utilization (Mohammed, Sambo& Dongs 2011).

The introduction of National Health Insurance Scheme (NHIS) by countries in the developing world is expected to improve the quality and accessibility of healthcare services to the poor and the general public. However, it must be emphasized that sustainability of the financing and maintaining of service provision should be given the deserved attention. Improved health condition leads to an increase in productivity, educational performance, higher life expectancy, saving, investment, decreased debt and expenditure on health care.

This would result to greater equity, economic return, social and political stability (Kaseje 2006).

The need for the establishment of health insurance scheme which was informed by the general poor state of the nation's healthcare services, the excessive dependence and pressure on government provided health facilities, dwindling funding of healthcare in the face of rising costs, poor integration of private health facilities in the nation's healthcare delivery system and overwhelming dependence on out-of-pocket expenses to purchase healthcare services before its inception in Nigeria (Olanrewaju, 2011).This situation, according to National Health Insurance Operational Guidelines (2005) prompted the Federal Government of Nigeria to join the League of Nations to initiate the search for other means of funding health care that had been neglected in the past. Health insurance is an alternative source of health care financing that has become important in the developing world (Ibiwoye&Adeleke 2009). It has been implemented as part of health reform programs and strategies aimed towards providing effective and efficient health care for citizens, most especially for the poor and vulnerable (Yahaya, 2015). The National Health Insurance Scheme (NHIS) in Nigeria was established in 2005 as a social security system based on social health insurance to ensure that enrollees have access to quality and effective healthcare.

The Federal Government of Nigeria through the National Health Insurance Scheme (NHIS) has implemented the Tertiary Institutions Social Health Insurance Programme (TISHIP) with the hope to achieve a more flexible, more innovative and more competitive response to the health need students in tertiary institution in the Nigeria (Ibiwoye&Adeleke, 2009). The TISHIP is a healthcare delivery scheme that is targeted for only students of tertiary

institutions such as universities, polytechnics and colleges of education. This will ensure that every students in tertiary institution has access to quality healthcare while schooling, that parents and guardians are protected from the financial hardship of huge medical bills, ensure equitable distribution of healthcare costs among different students, ensure equitable distribution of healthcare facilities within the nation's tertiary institutions of learning and to ensure the availability of funds to the health sector for improved service delivery (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme 2014).

The Tertiary Institutions Social Health Insurance Programme (TISHIP) is a scheme where the healthcare of students in tertiary institutions is paid for from funds created by pooling the contributions of students and Government. The programme according to Precious Healthcare (2012) is committed to ensuring access to qualitative healthcare service for students of tertiary institutions, thereby promoting the health of students with a view to creating conducive learning environment. Extensive evidence is now available to demonstrate the link between health, as well as school health programmes to academic performance and achievement. Some tertiary institutions have existing network of quality in-house health schemes. Such commendable in-house arrangement is fully integrated into TISHIP scheme.

An actuarial review has been carried out by National Health Insurance Scheme (NHIS) and ₦2,000:00 per annum was recommended as minimum premium to be paid by every student in tertiary institution (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The adequacy of the information available to the students determines the popularity and acceptance or otherwise of the scheme among students. Since the scheme is meant to take care of the health care service delivery of students; for the scheme to be successful, there is need for the students to have adequate information that will enable them to utilize and participate in the scheme as stakeholders and as beneficiary. The utilization of the healthcare delivery services of the scheme by the students is very paramount, as they serve as the beneficiary of the scheme.

A concern for patients' satisfaction have been taken up by many health care authorities worldwide with the aim of responding to the clients' needs when addressing the issue of quality improvements in healthcare services. It is easier to evaluate the patients' satisfaction towards the service than evaluate the quality of medical services that they receive. Information about client perception with a thorough understanding of the needs and expectations of the client about the healthcare services can help in higher utilization and better service delivery. Therefore, a research on patients' awareness, utilization and satisfaction may be an important tool to improve the quality of services.

1.2 Statement of the Problem

Healthy students and indeed youth are indispensable tools for rapid socio-economic and sustainable development the world over. Despite this undisputable fact, most African countries including Nigeria, always have serious problem with the provision of quality, accessible and affordable healthcare service delivery. This is because the health sector is perennially faced with gross shortage of personnel, inadequate and outdated medical equipment, poor funding, policies inconsistence and corruption (Yahaya, 2015). Other

factors that impede quality health care delivery in Nigeria include inability of the consumer to pay for healthcare services. Many Nigerians have lost their lives due to inability to meet their healthcare need.

However, with the high demand from students for health care services of good quality and the extreme under-utilization of healthcare services in Nigeria, it has been argued that social health insurance may improve the utilization of health care of acceptable quality. Students of tertiary institutions who are the beneficiary of TISHIP need to have adequate and sufficient information and awareness about the scheme. Generally, the underutilization of available facilities is of significant concern. The lack of drugs, unavailability of doctors and nurses, as well as their negative attitudes and behaviours, are major hindrances to the utilization of healthcare services. The situation is further compounded by lack of information about available services and long waiting times. These factors could play a powerful role in shaping patients' negative attitudes and dissatisfaction with healthcare service providers and their services (Ortola, 2003).

Health care services are amongst the most basic of all essential services, and their significance cannot be over emphasized. However, health care delivery in Nigeria is bedeviled with the problem of health information, awareness, quality of care and accessibility to care. Students' awareness and utilization have emerged as increasingly important parameters in the assessment of the quality of health care and satisfaction of any health care scheme in tertiary institutions. Hence, health care insurance scheme performance can be best assessed by measuring the patient's level of awareness, utilization and satisfaction.

Tertiary institutions social health programme was designed to ameliorate the health burden of students to improve their academic performances. It is believed that the National Health Insurance Scheme will considerably improve utilization and access to health services and facilities through decrease in physical distance to health amenities, enhancement of quality and increase the rate of affordability of healthcare. Complaints have arisen where providers denied enrollees their full entitlements and some providers have charged additional fees on the pretext of non-inclusion of the service in the benefit package. Clients may also have complained of poor attitude and behaviour of service providers operating in the health insurance scheme leading to high level of dissatisfaction.

Assessing the awareness and utilization of TISHIP services of the enrollees and consequently their satisfaction is crucial to assure the continuous attractiveness of the scheme and active participation of students. It is against this backdrop that this research seeks to look at some pertinent issues relating to the awareness, utilization and satisfaction of students with regard to TISHIP services.

1.3 Purpose of the Study

This research assesses the level of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State. More specifically, the research assessed:

i. The level of awareness of TISHIP among students of tertiary institutions in Kaduna State, Nigeria.

ii. The level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria.

iii. The level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria.

iv. Whether the level of awareness of TISHIP differ among students of different tertiary institutions in Kaduna State, Nigeria.

v. Whether the level of utilization of TISHIP differ among students of different tertiary institutions in Kaduna State, Nigeria.

vi. Whether the level of satisfaction with TISHIP differ among students of different tertiary institutions in Kaduna State, Nigeria.

vii. Whether the level of awareness of TISHIP differ with the level of utilization among students of tertiary institutions in Kaduna State, Nigeria.

viii. Whether the level of utilization of TISHIP differ with the level of satisfaction among students of tertiary institutions in Kaduna State, Nigeria.

1.4 Research Questions

This study will be guided by the following research questions;

i. What is the level of awareness of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

ii. What is the level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

iii. What is the level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

iv. Does the level of awareness of TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

v. Does the level of utilization of TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

vi. Does the level of satisfaction with TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

vii. Does the level of awareness of TISHIP differ from the level of utilization among students of tertiary institutions in Kaduna State, Nigeria?

viii. Does the level of utilization of TISHIP differ from the level of satisfaction among students of tertiary institutions in Kaduna State, Nigeria?

1.5 Basic Assumptions

The following assumptions were made for the purpose of this study:

i. The federal tertiary institutions under consideration (Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria) have implemented the Tertiary Institution of Social Health Insurance Programme.

ii. It is also assumed that the students of the tertiary institutions seek for medical care within the institutions.

iii. It is assumed that the level of awareness, utilization and satisfaction of the services of the Tertiary Institution of Social Health Insurance Programme can be measured.

1.6 Hypotheses

The following assumptions were formulated for the purpose of this study:

i. There is no significant difference between the level of awareness of TISHIP among students of tertiary institutions in Kaduna State and the proposedlevel of awareness.

ii. There is no significant difference between the level of utilization of TISHIP among students of tertiary institutions in Kaduna State and the proposed level of utilization.

iii. There is no significant difference between the level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State and the proposedlevel of `satisfaction.

iv. There is no significant difference between the levels of awareness among students of tertiary institutions in Kaduna State based on school types.

v. There is no significant difference between the levels of utilization among students of tertiary institutions in Kaduna State based on school types.

vi. There is no significant difference between the levels of satisfaction among students of tertiary institutions in Kaduna State based on school types.

vii. There is no significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria

viii. There is no significant difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria

1.7 Significance of the Study

The study assessed the awareness, utilization and satisfaction with TISHIP of National Health Insurance Scheme among students of tertiary institutions in Kaduna State. This study has significance to the following:

i. Students
ii. Health workers
iii. Health educators
iv. Tertiary institutions
v. Health Management Organizations and
vi. Policy makers.

This study will create awareness and promote utilization of TISHIP benefit package among the students as well as challenged the students' unions to pay more attention to their responsibilities as an important stakeholder in the TISHIP. It will also serves as an important resources for clinical audit for the healthcare workers and the healthcare facilities on their general service delivery and TISHIP in particular.

The study will serve as an important resources for health educators to determine the health education and health promotion needs of the students. Therefore, enable the health educators to design an appropriate strategies, interventions and programmes for health education and health promotion needs of the school community and the students in particular.

It will enable the authorities in the tertiary institutions to assess their performance in the discharge of their roles and responsilities in the implementation of TISHIP to their students.

It also serves as an important feedback from the end users (students) for the authorities to act on. The health Maintenance Organizations (HMOs) whose role and responsilities in TISHIP among others are to ensure quality assurance of the healthcare services, carry out sensitization programmes as well as giving feedback to the regulatory body (NHIS) will find this study as an important resources in discharging their responsibilities.

This study also will serves as vital resources for policymakers to evaluate and fine tune the TISHIP blueprint as well as to generally improve the National Health Insurance Scheme services. This study will serve as a resource material for further researches in the field of healthcare finance, implementation of public policies for students and more importantly health education and health promotion.

Finally, this study will contribute to the body of knowledge on Social health insurance scheme services as well as Universal Health Coverage (UHC) not only Nigeria but also subSaharan Africa.

1.8 Delimitation of the Study

This study is delimited to awareness, utilization and satisfaction with Tertiary Institution Social Health Insurance Programme among students of tertiary institutions in Kaduna State.

This study covers only full-time students of the Federal Tertiary Institutions in Kaduna State: Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. The choice of regular students is informed by the fact that all the regular students remain in session for long period and therefore access the institutions' base healthcare services. The choice of the institutions is as a result of the fact the TISHIP are

made compulsory for all students of Federal Institutions and the three institutions are the most commonly accessed Federal Institutions in Kaduna State.

This study will also be beneficiary to specific categories of people and stakeholders in both education and health sector. These beneficiaries include students of the tertiary institutions, health workers in the tertiary institutions, the tertiary institutions and their management,

Health Management Organizations and the policy makers in the Ministries of Health and Education.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.0 Introduction

This chapter will discuss the concept of health insurance, history and evolution of national health insurance scheme and Tertiary Institutions Social Health Insurance Programme in Nigeria. This chapter will provide an overview of National Health Insurance Scheme and Tertiary Institutions Social Health Insurance Programme, its historical background, objectives, functions, purposes, guiding principles, operational strategies and the stakeholders. It will also discuss the empirical reviews of studies on related healthcare delivery services and the theoretical framework upon which this study will be built.

The reviews of the related literature will be made under the following sub-headings:

2.1 Health Insurance Scheme

2.1.1 National Health Insurance Scheme (NHIS) in Nigeria

2.1.2 Overview of National Health Insurance Scheme (NHIS) in Nigeria

2.1.3 Tertiary Institutions Social Health Insurance Programme in Nigeria

2.2 The Purpose of Tertiary Institutions Social Health Insurance Programme

2.2.1 Guiding Principles of Tertiary Institutions Social Health Insurance Programme

2.2.2 Objectives of Tertiary Institutions Social Health Insurance Programme

2.2.3 Operational Strategies of Tertiary Institutions Social Health Insurance Programme

2.2.4 Stakeholders of Tertiary Institutions Social Health Insurance Programme

2.2.3 Challenges of Tertiary Institutions Social Health Insurance Programme

2.3 Review of Related Empirical Studies

2.3.1 Awareness of National Health Insurance Scheme – TISHIP

2.3.2 Utilization of National Health Insurance Scheme – TISHIP

2.3.3 Satisfaction of National Health Insurance Scheme – TISHIP

2.4 Theoretical Framework

2.5 Summary

2.1 Health Insurance Scheme

Compulsory Health Insurance Scheme took shape in developing countries which reflected the social policies which had gained acceptance in Europe (Aviva, Fishbein, Ajzen&Tizeni 2000). Aviva, *et al.*, (2000) noted that since the social and economic context was different from the European one, developing countries had to adapt the approach to Health Insurance to their own situation, in particular with regard to coverage and the methods of delivering health care as benefits mandated by law.

In Nigeria the National Health Insurance Scheme was launched formally as a public health policy in 1999. But the Formal Sector programme, one of the programmes under the scheme designed to cover employees in both the public and the private sector was only flagged off in 2005 (NHIS, 2006). This marked the commencement of access to the health care by enrollees in Nigeria. The launching of the Formal Sector Social Health Insurance Scheme sprung up series of activities under the scheme ranging from registration of enrollees, issuance of identity cards, registration of hospitals, banks and registration of Health Maintenance Organizations (HMOs) to serve as the managers of the NHIS funds.

They are expected to collect contributions from employers, employees, and voluntary contributors, pay health care providers for the services they render and ensure the maintenance of quality assurance in health care delivery under the Formal Sector Social Health Insurance programme (NHIS Annual Report, 2006).

The National Health Insurance Scheme (NHIS) is a corporate body established under Act 35 of 1999 by the Federal Government of Nigeria to ensure access to health care by all Nigerians at an affordable cost. James (2003) defined the National Health Insurance Scheme as a social health insurance programme designed by the Federal Government of Nigeria to complement sources of financing the health sector and to improve access to health care by the majority of Nigerians. It is a form of social health insurance which pays for health care services through contributions to a health fund. Contributions, which are usually from both employers and employees, are based on payroll and ability to pay while access to services is based on need. The fundamental rationale for health insurance is risk sharing. According to James (2003), the programme aims at: ensuring that every Nigerian has access to good health care services; protecting families from the financial hardship of huge medical bills; limiting the rise in the cost of health care services; maintaining high standard of health care delivery services within the system; ensuring efficiency in health care services; ensuring the availability of funds to the health sector for improved services and; ensuring equitable patronage of all of health care.

According to James (2003), the National Health Insurance Scheme was launched formally as a Public Health policy in 1997. The government recognizing the importance of the scheme as a good opportunity for mobilizing additional resources towards financing the

health, and therefore decided to introduce a health insurance scheme that will take care of that. According to Okonkwo (2001), National Health Insurance Scheme (NHIS) has been introduced in Nigeria in response to inadequate provision of health facilities. The general poor state of the nation's health care services and the excessive dependence and pressure on government provided health facilities the inadequate participation of private health services. The scheme is at the initial phase of transition to universal coverage in Nigeria. The first phase is the implementation of the Formal-Sector programme that began five years ago. As a complementary or alternative source of health care financing, Mohammed (2008) reported that National Health Insurance Scheme has become important in developing countries. According to him it is implemented as part of health reform programmes and strategies towards providing effective and efficient health care for all citizens, most especially the poor and the vulnerable populace. Mohammed (2008) further reported that the scheme (NHIS) which aims at providing risk sharing in health expenditures through the contribution of enrolled members is at the tail-end of its first-phase in Nigeria. As part of the health sector reform, the scheme's vision is "a strong, dynamic and responsive government parastatal that is totally committed to securing universal coverage and access to adequate and affordable health care in order to improve the health status of Nigerians (NHIS 2006).

As a complementary or alternative source of health care financing, National Health Insurances is seen as a key to attaining one main target of government, international organization and the whole community which is the attainment by all people of the world of a level of health that will permit them to lead a socially and economically productive life (Hamza, 2006). Hamza (2006) noted that the need for good health care delivery system as

part of an enlarged poverty alleviation programme makes National Health Insurance Scheme essential to all. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life.

According to NHIS (2006), the benefits of implementing the Compulsory Health Insurance Scheme include:

i. The scheme provides the pooling of resources for cross subsidization of health costs where those in high-income bracket subsidize those in low income bracket the healthy subsidize the sick while the young subsidize the old.

ii. The burden of funding health care services is shared between government private employers and enrollees.

iii. Quackery is minimized due to standards for personnel and equipment set for providers by the scheme.

iv. Competition among health care providers to attract and retain clients leads to improvement in the quality of services.

v. The scheme provides employment opportunities for health professionals in the health care delivery system and thereby reduces brain drain.

vi. Donor Agencies/Government will have the confidence to donate to rural communities or less privileged through the proposed vulnerable group fund.

vii. Improved services resulting from improved income reduces the need for overseas treatment, thereby conserving the country's foreign reserve.

viii. Improved access to health care services creates a healthier work force for increased economic activities and national prosperity.

ix. Communities and associations contribute for their health care services without viewing it as tax or levy, as they are the financial managers and administrators of their programme and reap the benefits from there.

Like all other types of health insurance, there are several issues in the National Health Insurance Scheme. These include inefficiency, high cost, adverse selection, moral hazard and fraud. In developing countries, other issues which can add up to the foregoing include underestimation of costs, revenue mobilization from the informal sector, free rider dilemma, social factor, poverty and political (Mohammed, 2008).

NHIS in Nigeria, from the policy point of view, could also stand as the regulatory body of the health insurance with a corporate headquarters at the country capital. Abuja which provides oversight functions to organs (Health maintenance organizations and participating providers) that are involved in direct delivery of services to members. The health insurance is a single fund like that of France and Tanzania. The essence of the single fund is to enhance easy implementation and coordination of the scheme through the Health Maintenance Organizations (HMOs). It also provides easy planning for distribution of health services and at the same time reduces the chance of moral hazard**,** (Mohammed. 2008).

The preceding paragraphs demonstrate that the Nigerian health system has been chronically underfunded since independence. The health system competes with other social service systems like power, education, transportation, security, the environment and servicing of external debts. Public financing of healthcare in Nigeria has faced several challenges including lack of political will, corruption, poor institutional capacity, lack of data on health status and utilization. Other challenges include unstable political and economic climates (Soyibo, 2005 &Soyibo, 2009). The beginning of the 21st century witnessed several renewed attempts of successive governments at health sector and health financing policy reforms.

The Federal Government in 2004 committed to a sustained process of health system strengthening, focusing on policies, regulation, improved financing, re-organization of management and institutional arrangements. The framework was encapsulated in the new economic empowerment and development strategy (NEEDS) and the Health Services Research and Pharmacy Practice (HSRPP) include goals, targets and priorities to guide the activities of the Federal Ministry of Health (FMOH) between 2004 and 2007 (FMOH, 2004).

The action points of the programme were:

i. Improving the stewardship role of government;
ii. Strengthening the national health system and its management;
iii. Reducing the burden of disease;
iv. Improving the availability of health resources and their management;
v. Improving access to quality health services;

vi. Improving consumers' awareness and community involvement;

vii. Promoting effective partnership, collaboration and coordination.

Measurable results of the HSRPP were expected by the end of 2007. Of importance was the development of policy documents to guide and sustain the reforms into the future. The key results pertaining to health financing reforms were:

a. **A 5-Year strategic plan** of action developed by departments of FMOH, SMOH, LGDH and other federal health institutions.
b. The NSHDP reviewed, updated and harmonized into a **National Health Bill** that described the re-defined national health system and the functions of each level of government.

- **National Strategic Health Development Plan (NSHDP 2010-2015)**

The renewed effort to reform the Nigerian health system birthed a 5 year National Strategic Health Development Plan (NSHDP) 2010-2015 with 8 strategic priority areas. It was developed as the health component of the government's poverty reduction policy (Nigeria Vision 20:20, 2010). The areas are (NSHDP, 2010):

i. Leadership and governance for health
ii. Financing for health
iii. Health service delivery
iv. Human resources for health
v. National health management information system (HMIS)
vi. Partnerships for health
vii. Community participation and ownership viii.Research

-National Health Bill (2011) and the National Primary Healthcare Development Fund (NPHDF)

Financing for healthcare delivery is a key focus of the 2011 National Health Bill (NHB). The NHB is “an act to provide a framework for the regulation, development and management of a national health system and set standards for rendering health services in the Federation, and other matters connected therewith” (NHB 2011). It proposes a radical shift in health financing in Nigeria through the establishment of a fund – National Primary Healthcare Development Fund (NPHDF). This fund (separate from the budgetary allocation for health) will be financed from the federal government (with an amount not less than 2% of the consolidated fund of the federation); international donor partners; and funds from any other innovative sources. The fund is intended to boost delivery of primary health care and its proposed allocation. The NHB passed in 2011 by the executive arm of government lists a fully functional National Health Insurance Scheme (NHIS) as one of its provisions and is the key resource platform for funding the NPHDF.

Implementation of the NHB has been stalled as the current president failed to assent to it within the legally stipulated time. According to Shokunbi, (2012), a major reason cited for this is the lack of political will to raise the funds required to establish the NPHDF. This means the NHB has to be re-presented by the executive arm of government for another attempt to have it ratified and passed into law. This also means that the establishment and funding of the NPHDF has been placed on hold (Shokunbi, 2012).

2.1.1 National Health Insurance Scheme (NHIS) in Nigeria

National Health Insurance Scheme (NHIS) is a compulsory universal or employment grouptargeted insurance system financed by employee-employer payroll deductions. It is a social security programme which is designed to pool funds into several not-for-profit insurance funds or a single pool of funds which may be centrally administered. An equity fund from the government can also be created to supplement contributions for those not formally employed. Over 60 high to middle-income countries use this method including the old Dutch Ziekenfonds, Colombia, Philippines (recently) and most famously, Germany. It is a useful method for funding the health system where there is a large payroll contribution to protect purchasing of health care services, and efficiency can be improved through competition in purchasing services. The drawbacks of this method are the need for a large enrollee base as well as efficient supervision and administration of the funds. Only 27 of the 60 countries have achieved universal coverage (Rijneveld, 2006).

Social Health Insurance (SHI) as a category of health insurance to which NHIS falls, is a form of financing that pays for health services through contributions to a health fund. The most common basis for contribution is the payroll, with contributors from both employer and employees. The contributions are based on ability to pay, and access to services depends on need (Hamza, 2007). The health fund is usually independent of government, but works within a tight framework of regulations. Social health insurance is based on mutual support and involves a transfer of resources from the relatively richer and healthier people to the relatively poor and sickly people. It is pertinent to note, asserted Hamza

(2007) that there is no stereo typed or standard design for a national health insurance scheme. Individual countries design their own insurance systems that suit their socio-economic, cultural and political backgrounds.

National Health Insurance Scheme (NHIS) is a body corporate established under the Act number 35 of1999 by the Federal Government of Nigeria to improve the healthcare for all Nigerians at a cost the government and the citizens can afford, (Mohammed, 2008). NHIS, according to Dogo (2007) is a social security system adopted by Nigerian Government to guarantee the provision of needed health services to persons on the payment of token contribution to the common pool at regular interval. The fundamental rationale for social (national) health insurance is risk sharing. In the present study, NHIS refers to a system of health care financing introduced by Federal Government of Nigeria for addressing the problems of the nation's healthcare delivery which has been affected by challenges. It is nonprofit in concept and contribution is based on the ability to pay. As a social health insurance, the NHIS's main thrust is easy and equitable access to health care of adequate quality and affordable type. The system is financed by compulsory contribution, mandated by law, and by taxes and the systems provision is specified by legal statute (Adeoye, 2004). The Scheme is comprised of four main components namely: formal sector group, informal sector group, vulnerable group and others (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

This formal sector group which consists; of public sector (Federal, State, Local Government, Armed Forces, Police and other Uniformed Services, Organized Private Sector, Students of Tertiary Institutions and Voluntary Participants). Since the operations

and coverage of the Scheme is carried out in phases, formal sector is where the efforts of NHIS is focused the most for now, public servants in Kaduna State fall under this sector (Precious Healthcare, 2012).

It is mandatory for every organization with ten (10) or more employees. Informal sector group comprises of Rural Community Social Health Insurance Programme. This is a nonprofit health insurance programme for a cohesive group of household or individuals (i.e. community) who are run by its members; and the Urban Self Employed Social Health Insurance Programme, covering groups of individuals with common economic activities run by their members. Vulnerable group: – This group comprises Permanently Disabled Persons Social Health Insurance Programme, This is a programmed designed to provide health security for permanently disabled persons in Nigerian society, who due to their disability cannot engage in any economically productive activity; Children Under Five Social Health Insurance Programme – this programme is designed for children under the age of five years nationwide. The contribution will be fully paid by the Federal Government; Prison Inmate Social Health Insurance Programme – this programme is designed for convicted persons in prisons and borstal homes nationwide. Contributions for this category of persons (vulnerable groups) will be fully paid by the Federal Government. Others: – Programmes under this category include: International Travel Health Insurance, Pregnant Women and Orphans, and Retirees and Unemployed (Yahaya, 2015).

Issue in the component of NHIS include: how the formal sector programme works – an employer registers itself and employee with the Scheme. Thereafter, the employer affiliates itself with an NHIS approved Health Maintenance Organization (HMO) who now

provide(s) the employee with a list of NHIS approved health care providers (public or private). The employee registers himself/herself and dependants with such provider of his/her choice. Upon registration, a contributor will be issued an identity card with a personal identification number (PIN). In the event of sickness, the contributor presents his/her identity card to his/her chosen primary health care provider for treatment. The contributor will be able to access care after a waiting period of thirty (30) days. This will enable the completion of all administrative process (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

A contributor has the right to change his/her primary provider after a minimum period of three (3) months, if he/she is not satisfied with the services being given. The HMO will make payment for services rendered to a contributor to the health care provider. A contributor may, however, be asked to make a small co-payment (where applicable) at the point of service. Contributions are earnings-related and currently represent15% of basic salary. The employer will pay 10% while the employee will only contribute 5% of the basic salary to enjoy health benefits. The contributions made by/for an insure person entitles himself/herself, a spouse and four (4) children under 18 years of age, to full health benefits. Extra contribution will be required for additional dependants. The contributions of two working spouse cover the spouse and four (4) children for each of them (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The objectives of NHIS include, among others, to ensure that every Nigerian has access to good healthcare services; protect families from the financial hardship of huge medical bills;

limit the rise in the cost of health care services; The goal of the Scheme is to enhance the health status of citizens through the provision of financial protection and customer satisfaction. The Role of NHIS is to maintain and operate a Health Insurance Fund; develop, promote and ensure the quality of health insurance scheme under the Act, issue guidelines and set standards for providers and health insurance programmes and regulate the activities of insurance actors. It is the responsibility of NHIS to register employers and employees under the Scheme, registration and accreditation of health care providers, Health Maintenance Organizations, (HMOs) Banks, insurance brokers and liaising with organizations on issues relating to the improvement of the Scheme (Yahaya, 2015).

NHIS is also responsible for the general administration and appropriate running of the Scheme. The benefit package or advantages derivable from NHIS covers Primary Healthcare Services, consisting of curative services for common ailments and injuries, Maternal and Child Health services and Health Education; Secondary healthcare such as surgical procedures, Internal Medicine service; Tertiary Healthcare Services provided in Teaching hospitals, Specialist/Specialized hospitals Federal Medical Centers and Military Reference hospitals In all the health care services, only ten per cent (10%) of the cost drugs prescribed is paid by the enrollee except on cases (partial or total exclusion) where the recipient pays part or all the cost of treatment, depending on the kind of illness (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The core functions of the Scheme include, among others: maintenance and operation of health insurance fund; developing, promoting and ensuring the quality of health insurance

scheme under the act. Issuing guidelines and setting standard for providers and health insurance actors, mobilizing additional resources (domestic and external) to fund the health sector defining benefit packages and to introduce and market health insurance products registration of Health Maintenance Organizations and HealthCare Providers and approval of contracts between various actors etc. For the smooth running of the Scheme, the stakeholders, according to Dogo-Mohammed (2006) are expected to play their roles and accept and carry out their responsibilities when and/as due. The main stake holders in the Scheme and their roles and responsibilities are discussed below.

The government through the NHIS, sets standards and guidelines while protecting the rights and enforcing the obligations of all the stakeholders; approving format of contracts proposed by the health maintenance organizations (HMOs) for all health care providers and maintaining quality assurance and monitoring of facilities for continuous improvement service delivery (Dogo-Mohammed, 2006).

Health Maintenance Organizations are limited liability companies under the Scheme, responsible for receiving/collecting contributions from eligible employers and employees, payment of health care providers for services rendered and maintenance of quality assurance in the delivery of health care benefits in the formal sector social health insurance programme. The providers are licensed government or private health care practitioners or facilities registered under the Scheme with the responsibility of providing prescribed health benefits to contributors and their dependants. Employees are the contributors in formal sector social health insurance programme. Their contributions (5% of the basic salary) paid regularly in advance into the common pool as premium (Dogo-Mohammed, 2006).

The overall benefits of the NHIS, as enshrined in the Federal Republic of Nigeria Official Gazette of May 1999, include: Easy access to vast variety of good and efficient health care services at all times; protection from financial hardship of huge medical bills; improved private participation in the provision of health care services and affordable health care services for all income groups (Yahaya, 2015).

Despite all the short-comings in health sector and health financing reforms, the NHIS received a push and was launched in 2005. Operational guide-line and current implementation are as follows:

a. **Operational Guide-Line**

In order to ensure that every Nigerian has access to health care services, the Nigerian government deemed it necessary to commence a NHIS. The NHIS was established under decree no. 35 of 1999. The NHIS is designed as a SHI programme; its aim is to provide easy access to healthcare for all Nigerians at an affordable cost through various pre-payment systems. The strategy of the NHIS segments the entire population into formal and informal sectors, vulnerable groups and others. The scheme is expected to provide financial access to good quality health care via multiple programmes. The scheme is a Public Private Partnership (PPP) and the NHIS accredits privately owned HMOs to operate nationally and also regionally (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The NHIS also accredits a mix of public and private health care providers to provide health care at primary, secondary and tertiary levels. Enrollees are free to choose any accredited

primary provider as first contact for obtaining care. Secondary and tertiary levels of care are only accessed via referrals from the primary level (NHIS decree no. 35 of 1999). There are presently 62 accredited national and regional HMOs and 5,949 accredited providers (public and private) (NHIS, 2012a). The HMOs deal directly with the health care providers as fund and quality assurance managers for enrollees; the government regulates all activities of the scheme (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

b. **Current Implementation**

In 2005, the NHIS was officially flagged off with the formal sector programme which aims to provide SHI coverage to all workers in the civil service (public sector, armed forces, police and other uniformed services) and the organized private sector. The states (except Bauchi,

Rivers and Cross-Rivers) however did not immediately embrace the scheme (Asoka, 2011).

The formal sector SHI scheme being implemented is funded by pay-roll deductions, and the NHIS is currently responsible for collection of funds. The payroll deductions are proportional and theoretically comprise employer = 10% of basic salary; employee = 5% of basic salary. Notably, at the roll-out stage, the government waived the initial 5% which was to be contributed by the employee, and the NHIS commenced the programme with the 10% of basic salary provided by the federal government i.e the employer (NHIS, 2012a). Till date, this is how the scheme is being funded due to widespread resistance from the National

Labour Congress (NLC) to have the 5% employee contribution deducted for the scheme, citing widespread poor salaries and non-inclusion in decision-making (Asoka, 2011).

In addition, the joint NHIS/MGD- maternal and child health (MCH) project was piloted in phases over 3 years (2008 – 2010) in 12 states. It is being expanded nationwide to provide care for pregnant women and children under 5 years (CU5) only up till 2015 and is presently funded by the MDG debt relief funds. Beyond 2015, the state governments are required to incorporate the project into state funded SHI programmes (Briscombe&McGreevey, 2010). Other methods of revenue collection are yet to be designed to fund the scheme for the informal sector, vulnerable and other groups (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

In 2011, blueprints for the Tertiary Institutions Social Health Insurance Programme (TISHIP) and voluntary participants SHI schemes were launched to complete commencement of the formal sector programmes. The target populations are students of higher schools, the urban self-employed sector and any interested individuals, including those in the formal sector contributing on behalf of their dependants in the informal sector. Some tertiary institutions have commenced the TISHIP but the voluntary participants' scheme has not progressed beyond the blueprint phase (NHIS, 2012). Some states have initiated donor and state-funded community health insurance pilot schemes (Uzochukwu*et al.*, 2009). In addition, fractions of the organized private sector subscribe for direct premium-based voluntary private health insurance schemes with the HMOs (Asoka, 2011).

2.1.2Overview of Health Insurance Scheme

Andersen, (2005) the practice of pooling resources to ensure protection against the risks of ill-health grew mainly out of labour developments, in Mediaeval Europe, craftsmen formed societies “guilds” which in turn created funds to help members in times of distress, due to sickness. Each member contributed to the fund on a regular basis. The threat to the individual worker's earnings because of illness was seen as a risk to be shared, and from the late eighteenth and early nineteenth century’s groups of workers and small farmers in the same industry or location formed sickness funds as mutual benefit societies to serve this purpose. First cash benefits were provided, and then the guilds asked doctors to certify sickness. To ensure services for their members, some guilds then began to contract with providers on a regular basis, and later to develop their own medical services, particularly in countries with a low supply of doctors and hospital beds (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

New initiative came from employers: the schemes often becoming compulsory as employers in specific high-risk industries, such as mining made employment conditional upon regular contributions to a fund to cover health care. With these developments**,** the concept of contributions related to earnings rather than to individual risk became firmly established in some countries (International Labour Organization and Pan-American Health Organization, 2000). The term health insurance is basically used to describe that form of insurance which pays for almost all medical expenses. It is many times used much more broadly to include insurance covering long term nursing or disability care needs. It is technically defined as a mechanism in which the risks of incurring health care costs are spread over a group of individuals or households (Arhin – Tenkorang, 2001). It may be provided through a private insurance company, agency or provider or from a government –

sponsored social insurance program. It may also be on a group basis (e.g by a company to cover its employees) or bought by individual consumers.

In each of the above cases, the covered individuals or groups pay taxes or premiums to help protect them from an unexpected or a very high healthcare expense. Similar benefits paying for healthcare expenses may also be provided through social welfare programs that are generally funded by the government. By calculating the total risk of the expenses of healthcare, a structure of routine finance (like annual tax or a monthly premium) can be made, ensuring that money is really available to pay for the benefits of healthcare specified in the agreement of the insurance. The benefit is administered by a central organization, most often either by a private or government agency or non-profit organization that operates a health plan (Omoruan, Bamidele& Phillips, 2009).

The first Nigerian colonial development plan in 1946 regionalized the health system and lasted into the 1950s (Asuzu, 2005). Most public hospitals provided cost-free care for civil servants and their dependants while parallel church-owned hospitals provided care for the most needy in this period. Immediately post-independence in 1960, the 2nd and 3rd national development plans (by the 1970s) focused on building and expanding modern health facilities. No defined policy framework designated responsibilities including resource generation, development of human resources for health and service delivery between the 3 levels of government. Cost-free, tax-based care continued for all Nigerians under 18 years, civil servants and their dependants with subsidized services for the rest of the population till 1984 (Asuzu, 2005). Continuing attempts at improvement include the United Nations (UN) sponsored Bamako initiative of 1987 (Hardon, 1990), and

introduction of the drug-revolving fund in 1988 (Uzochukwu, 2005). These two schemes achieved little success and government allocation of resources to the health sector dwindled in this period, ranging between USD 42-62 cents per capita or 1.6 – 1.9% of the GGE (Orubuloye, 1996). This led to a rise in the general cost of health care and a decline in the quality of care offered by public hospitals. The private sector responded with a proliferation of hospitals and clinics and their charges were mostly exorbitant and out of reach of the poor and low income earners (Abdulraheem, 2012).

The rationale for adopting the National Health Insurance policy in Nigeria was based on the huge cost involved in the provision of health care services. Carrin (2004), carried out a research on the evolution of health care financing in Ghana and the finding review that financing of health care was mainly done through tax revenue and donors support. However, with the decline in the economy in the 1960s and 1970s sustaining free health care become a problem, as a result, in 1969 user fees was introduced at the public health facilities in the country (Omoruan, Bamidele& Phillips, 2009).

2.1.3 Tertiary Institutions Social Health Insurance Programme

The Federal Government controls universities and other higher education institutions through the following organs: the Federal Ministry of Education; the National Universities Commission, which among other things allocates funds to federal universities and also prescribes the spending formula, and the Committee of Vice Chancellors of Nigerian Federal Universities, which acts as a coordinating body and offers advice to government and universities governing councils on matters of general and specific concern to higher

education. Each university is administered by a Council and a Senate, and is headed by an appointed Vice Chancellor as CEO. Within universities and colleges, the institutes and centers are more autonomous. The Academic Staff Union of Universities (ASUU) safeguards the interests of the academicians in the Nigerian university system (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The Federal Government maintains a policy of no tuition fees in federal universities while at the same time allowing students enrolled in state universities to pay tuition fees in addition to room and board. In May 2002, the Federal Government issued an order "*forbidding*" the charging of tuition fees at all 24 federal universities as these universities were contemplating charging tuition fees as a cost recovery strategy. The Government believes that it has a duty to provide qualified Nigerians with free university education. Before this presidential decree, federal universities intended to charge a tuition fee ranging from US$ 200-400 per semester.

(The Higher Education Chronicle, Tuesday May 28, 2002). The Government through the National Universities Commission makes it mandatory for all federal universities to generate 10 percent of their total yearly funds internally through various revenue diversification means (Odebiyi&Aina 1999).

The Education Tax Decree No. 7 of 1993 enforces the payment of 2 percent of profits of limited liability companies registered in Nigeria as an education tax to be disbursed according to the ratio of 50:40:10 to higher, primary, and secondary education respectively. The share of higher education is further allocated to the universities, polytechnics, and

colleges of education according to the ratio of 2:1:1 respectively (Ajayi& Alani 2002). As of Summer 2002, no information was available to show the amount of funds collected and disbursed since the promulgation of the education tax decree. It is known that the Education Bank was supposed to be a depository of the funds collected through the decree. All federal universities receive the bulk of their financing (almost 95 percent) from the Federal Government through the National Universities Commission (Hartnett, 2000).

Furthermore, the federal universities' budgeting processes and expenditures have to adhere to budgeting and expenditure formula stipulated by National Universities Commission (NUC) as follows: 60 percent total academic expenditure; 39 percent for administrative support; and 1 percent for pension and benefits (Hartnett, 2009). At the general level, four sources finance university education in Nigeria (Ogunlade, 1989):

(a) support from federal and state governments constituting more than 98 percent of the recurrent costs and 100 percent of capital costs,

(b) Student contributions towards living expenses on campuses constituting less than 1 percent of the total operating costs of institutions. While there is no evidence to suggest this percentage of students contribution is capped by the government, anecdotal evidence suggest that successive administrations in Nigeria (civilian and military) have been reluctant to charge more than nominal fees probably to obtain and maintain public support. Charging realistic fees has been unpopular among policy makers (Ogunlade, 2009),

(c) private contributions by commercial organizations in the form of occasional grants for specific purposes, and,

(d) interest earnings on short-term bank deposits and rents of university properties. Other sources of finance to higher education in Nigeria include endowments, fees/levies, gifts, and international aid from international organizations. For example, the World Bank has financed a US$ 120 million project titled: Federal Universities Development Sector Operation (Odebiyi&Aina 1999: Babalola, Sikwibele& Suleiman, 2000).

To respond to the problem of chronic under-funding, Nigerian public universities adopted an array of cost sharing measures, notable among them being the following:

a. Student Contributions

Student contributions are made through a multitude of fees: tuition in state and private institutions, acceptance, registration and certification, caution (equivalent to security deposit in US), sports, identity cards, late registration, examination, laboratory, transcript, and medical center registration fees. These fees vary in amount paid from one university to another (Ajayi& Alani 2012). In all federal universities, undergraduates pay the following fees: examination NGN 200 (US$ 3.7); registration NGN 150 (US$ 2.77); Students Handbook for new students NGN 200 (US$ 3.7); accommodation (excluding food) NGN 90 (US$ 1.66); hostel maintenance NGN 200 (US$ 3.7); sports NGN 150 (US$ 2.77); and acceptance fees for new students NGN 300 (US$ 5.55). Other amount of fees charged include: caution NGN 100 (US$ 1.85) for science students and NGN 150 (US$ 2.77) for arts students; students union fees NGN 60 (US1.11); medical registration NGN 100 (US$ 1.85), identity card NGN 400 (US$ 7.40); departmental registration NGN 50 (US$ 0.92) for parent department and other departments NGN 25 (US$ 0.46), and library fees NGN 50 (US$ 0.92).

Students also are required to pay NGN 300 (US$ 5.55) for management information system; NGN 200 (US$ 3.70) for examination results verification for new students; and late registration NGN 1000 (US$ 18.51) (Amin, 2002).Students' contribution to university financing for the period 1988-1994 ranged from 0.28 percent to 3.89 percent (Ajayi& Alani 2012).

b. **Private Sector Contributions**

Contributions from the private sector to education in Nigeria are limited to the endowment of prizes and professorial chairs, and voluntary donations. Campaigns to raise endowment funds in Nigerian universities dates as far back as the 1950's when the University College, Ibadan started an endowment drive. From 1988-1994, the University of Ibadan generated approximately NGN 22.02 million from endowments and grants, which was the highest during the period (Ajayi& Alan, 2012). Decree No. 9 of 1993 authorizing individuals and private organizations to establish private higher education institutions has also enhanced the private sector contribution to financing of higher education (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

Tertiary institutions are categorized as Universities, Colleges of Education, Polytechnics, Colleges of Agriculture, Monotechnics, Schools of Nursing, Midwifery, Health Technology and other Specialized Institutions. Major health problems faced by students of tertiary institutions include illnesses and diseases like malaria, typhoid, respiratory tract infection, anxiety disorders, sexually transmitted infections (including HIV/AIDS), physical injuries (including domestic accidents, road accidents, and sports injuries), dental problems, visual disorders, skin problems, gastroenteritis, hernias, surgical emergencies, drug and alcohol

abuse, hypertension and so on. Health education and literacy is also a major health issue among this population (Operational Guidelines of TISHIP, 2015).

The current health-seeking behaviours of students in tertiary institutions comprises selfmedication and accompanying drug misuse/abuse, patronage of patent medicine stores, traditional medicine practitioners, spiritual healers, quacks and non-orthodox practices. Payments for these practices are out-of-pocket. Some students also access private medical insurance, particularly during out-of-session periods. Within the tertiary institutions, there is an institutional medical fee, charged with tuition expenses which cover access to the available health services in the institutions. However, there is low utilization of these services amongst students - dependent on the availability of qualified personnel, hours of operation of these health facilities, availability of drugs and equipment. There are also issues related to the lack of confidence in personnel by students and staff, perceived lack of confidentiality and inefficiency in service delivery (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The health and wellbeing of students of the tertiary institutions are essential to bringing about good quality, equitable, efficient tertiary education and research. These are critical determinants of a country’s economic growth and standard of living as learning outcomes are transformed into goods and services, greater institutional capacity, a more effective public sector, a stronger civil society, and a better investment climate (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The Tertiary Institutions Social Health Insurance Programme (TISHIP) is a social security system whereby the health care of students in tertiary institutions is paid for from funds pooled through the contributions of students. It is a programme committed to ensuring access to qualitative healthcare service for students of tertiary institutions thereby promoting the health of students with a view to creating conducive learning environment. It takes cognizance of the current practices and challenges faced by students in accessing care both during and out of session, as well as the potential of the current tertiary health facilities to maximize access to quality health care (Operational Guidelines of TISHIP, 2015).

2.2 The Purpose of Tertiary Institutions Social Health Insurance Programme

The purpose of TISHIP is to cater for the health care needs of Nigerian students in tertiary institutions who due to their studentship status cannot benefit under other health insurance programmes. This population constitutes a very large percentage of the country's population. By virtue of their age and their status as students, most of them cannot benefit from the public sector programme as enrollees or dependants of enrollees. This necessitates a programme designed to meet their needs (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

Providing students access to qualitative and affordable healthcare is not only imperative to the achievement of the presidential mandate which is to achieve universal coverage and access to healthcare services for all Nigerians and legal residents but also to the overall development of our nation. The ultimate goal is to ensure the health and well-being of this critical population with a view to creating a conducive learning environment and contributing to the overall development of the country (Operational Guidelines of TISHIP, 2015).

However, the specific purpose of the Tertiary Institutions Social Health Insurance Programme to the society at large can be highlighted as below:

i. **To Protect Families from the Financial Hardship of Huge Students' Medical Bills**

The scheme is targeted at reducing and deferring the burden of health care services from the direct beneficiaries. The primary purpose of the Tertiary Institutions Social Health Insurance Programme is to reduce the financial burden of the ever increasing financial burden of helpless students' medical bills which more often falls on their parents who are often peasants and low income earners. The students also do not have to set aside money for the purpose of health conditions as their health challenges would be taken care of by the scheme except otherwise when it is outside the coverage. Where such is the case, certain measures are put in place to ensure that the conditions are stable and the patients are out of immediate danger before referrals are made (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

Since it provides cost-burden, sharing for people as against high cost of health care through various pre-payment prior to their falling ill, sick or as the case may be that requires medical attention. This also eliminates the possibility of being taken unaware of the medical conditions or bills as the payment is made at specific points in time during the course of the study. In such cases therefore, there is less financial difficulty because they end up paying almost nothing as medical bills except where situation outside the scheme's coverage is involved. By this, the families are also immune from the sudden needs for the payment of medical bills. Finally, the cost of medical bills are however reduced drastically and kept within the reach of many (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

ii.**To Limit the Rise in the Cost of Health Care Services**

The scheme is meant to ensure a fixed pre-payment and to this extent therefore, there is no need whether necessary or unnecessary for increment in the amount paid for medical bills because the payment has been made prior to the period of illness. This prepaid method of medical bills allows the students and their families to plan within the limit of their budget on how much to be spent on medical bills within the year (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

This guarantees high health care services, rise in cost of health care services is limited even when the price of other services (substitutes or complementary) are on the increase.This means that health services and sector at large would be shielded from the unnecessary dynamics of market forces of inflation, supply and demand of goods and services which

can affect health services. It also serves as a source of confidence for the in-patients, that there health provision is guaranteed within certain operational limit and there is no change in the economic conditions can immediately affect the quality and quantity of health care services there get from the health care providers (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

iii. **To ensure Equitable Distribution of Healthcare Cost among different Categories of Students**

The scheme is meant to provide a means of equal distribution of health care services and cost to all categories of the students. There is also this fear of favouritism in the provision of services to pool of people requesting for such services especially in line of economic, gender, academic, social affiliation differences. The elimination of this differences which is due to the fact that all the students of the institutions makes equal contributions to earn such health services ensures equal distribution of the services without any preference.

As there is no discrimination in the line of the social background, class or nature of degree programme or the level of study, and therefore guarantee equitable services. Every student irrespective of their faculties and departments are provided such services on equal bases; all students irrespective of their year of entry into the tertiary institutions are served in the same way without any form of differences and; to all students without regards to the socioeconomic backgrounds are given even distribution of the health services available to them

(Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

iv. **To ensure High Standard of Health Care Services Delivery to Students**

The scheme represents the government essence of delivery of welfare services to all irrespective of one's' political, social or economic affiliation, this is because it discourages the delivery of high standard of health care services to a selected few. It also encourages sharing cost of health care services among all students so that high standard health care services of TISHIP will cover all participants irrespective of one's affiliation (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

v. **To ensure Efficiency in Tertiary Institution Health Care Services**

In as much as Tertiary Institutions Social Health Insurance Programme covers the services required by a student, that student will receive efficient health services that will not cost much whereas, a student who is not involved in TISHIP (students of private or States' tertiary institutions) in need of same health services with little money will have to go for a less efficient or in some cases incomplete services because of the huge amount that will be required (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

Another important benefit of Tertiary Institutions Social Health Insurance Programme, is to ensure that the state of health care provision and services at the tertiary institutions are not at the deplorable states. So it is the aim of the scheme to guarantee efficient and effective health care services in terms of provision of drugs, diagnosis, treatments etc (Operational

Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

vi. **To ensure Equitable Distribution of Health Facilities among the Federal Institutions**

The scheme is meant to allow cost-burden to be shared which allows equal right to health services to all the students of the tertiary institutions. Every student is entitled to equal access to health facilities when he/she is in need of such services. In addition, the Federal institutions have the possibilities of being at par if there are no standardize way of checkmating and regulating the health care scheme to this extent therefore, the Tertiary Institutions Social Health Insurance Programme is meant to ensure equitable distribution of health facilities among the federal institutions (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The Health Maintenance Organizations are common among the federal institutions and therefore ensures that there service provision are uniform among the institutions which they provide health services for.

vii. **To ensure Availability of Funds for Health Care Services Provision**

This scheme is meant to pull resources from vary stakeholders in the health sector such as government, private health maintenance organizations, students etc so that there will be consistent and adequate supply of funds for the purpose of health care services to the

students of tertiary institutions in Nigeria (Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

There are several stakeholders such as government, tertiary institutions, health maintenance, students, private etc who have dormant resources that can be pulled together for the purpose of health provision for those who are in need of the health services at a point in time.

2.2.1 Guiding Principles of Tertiary Institutions Social Health Insurance Programme

The design and implementation of the Tertiary Institutions Social Health Insurance Programme are based on the following guiding principles according to (Operational

Guidelines of TISHIP, 2015):

i. Universality - the right of the citizenry to access health services based on the principles of universal coverage irrespective of their geographical locations. This implies that the provision of health care services must be provided for every student that has completed the registration for a particular academic session. This principle therefore does not cover the alumnus of the tertiary institutions or students that are considered to be out-of-school either inform of rustication or expulsion.

ii. Equity - the right of students to receive healthcare in equivalent balances, drives the fact that "*unnecessary*" or "*avoidable*" gaps in health and health care service delivery between groups with different levels of social privilege should be

eliminated. This is to say that all the students shall be treated equally and fairly without any favour in terms social class, department section or as the case may be. This is because all the students make equal contributions to scheme and therefore have equal standing before another student.

iii. Social solidarity - the broader risk pooling and equitable benefits in exchange for contributions from those able to make payment. The scheme establish some sense of solidarity among the students as many of the students may not have to seek medical attention from the scheme while others who will have need for the scheme would be taken care of from the contribution of others.

iv. Responsiveness -the thrust of qualitative service delivery for every student regardless of age or social class reflected through prompt delivery of healthcare services, reduced waiting time, and service value for premiums paid and so on. The scheme ensures that the traditional waiting time, low quality of services provision and other avoidable anomalies are eliminated so that students health that will enhanced improved academic performances are provided. Most literature suggest that students would like to have increase access to health workers who are willing to serve promptly and warmly.

v. Fiduciary responsibility - these are important responsibilities and are subject to standards of conduct because they act on behalf of participants in a group health plan and their beneficiaries. It is the obligation for people entrusted with financial affairs to act in their client’s best interest, theoretically being both transparent in their dealings and accountable for them.

vi. Innovation – to reflect students' friendly changes in actuarial and service delivery policy and progressive dynamics from the private sector that have helped to moderate the rise in health insurance cost, create new models for care delivery and financing, and support the movement toward patient-centered health care.

2.2.2. Objectives of Tertiary Institutions Social Health Insurance Programme

The objectives of this Tertiary Institutions Social Health Insurance programme according to Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, (2014) are:

i. To ensure that every student in tertiary institutions has access to good health services. By this it means the health care services providers should; have a willingness to serve the students at any time of the day or night; a large numbers of providers (like doctors, nurses, attendants etc) should be available, short waiting time before attention is given, punctuality among others.

ii. To protect students and families from the financial hardships of huge medical bills. The financial burden of health care service sometimes comes very handy such that immediate response to such situation, which is usually emergency cases, may not be available. It is to this regard, that TISHIP help to cushion the effect of this burden on the parents and students by making them to pre-paid certain contribution that will make them enjoy what might may seems like free health care services throughout their stay in the tertiary institution.

iii. To maintain high standard of health care delivery services within tertiary institutions. In this regard, a qualitative health care service is provide to meet the medical needs and challenges of the students at the appropriate point in time. TISHIP is established to ensure this provision of effective and efficient health care service delivery to the students of tertiary institutions.

iv. To ensure availability of funds to the tertiary institution health centres for improved services. Fund has being one of the major bane to effective and efficient health care service delivery not just in the tertiary institutions but in the country at large. It is to this extent that the scheme was established to ensure that resources are pulled together by the stakeholders such as government, students, health maintenance organizations etc, to ensure that is sufficient and constant supply of fund for the purpose of effective and efficient health care services delivery in the tertiary institutions.

v. To take cognizance of the peculiar health needs of students in the design of the programme, including access to periodic health education and outreaches. This means that the scheme goes beyond health care service provision to other health care programmes such as awareness, sensitization, conscientization and monitoring of students health programme.

2.2.3. Operational Strategies of Tertiary Institutions Social Health Insurance Programme

The strategy of Tertiary Institutions Social Health Insurance programme is to operate the TISHIP as a sickness fund with a Committee responsible for its administration. This committee would consist of all the stakeholders of TISHIP which are National Health

Insurance Scheme, Tertiary Institutions, Students Union, Health Maintenance Organizations (HMOs), Health Care Facilities, Regulatory bodies of Tertiary institutions. The committee will operate with maximum pooling, strategic purchasing by the Committee and HMOs at the core of its operation, with high level monitoring by the regulatory bodies of tertiary institutions to ensure transparency, accountability and value addition in the whole process

(Operational Guidelines for Implementation of Tertiary Institutions Social Health Insurance Programme, 2014).

The programme will include a sustainable system of funds mobilization, collection, management and disbursement for financing a defined standard TISHIP benefit package. It will also provide the platform for the implementation of supplementary packages as demanded by students, but at an additional cost to them. Scope of cover is for the contributing student, and baby delivered by a married female student is entitled to care for 12 weeks postnatal for a maximun of two (2) live births.

2.2.4 Stakeholders of Tertiary Institutions Social Health Insurance Programme

Several stakeholders are crucial to the successful implementation of the TISHIP. The following key stakeholders and their roles according TISHIP operational guideline (2015) are as follows:

a.National Health Insurance Scheme

i. Provide guidance through the development and enforcement of the Blueprint and Operational guidelines for implementation.

ii. Grant approvals for supplementary benefit packages as requested by the students, which must be forwarded to NHIS with an accompanying actuarial report.

iii. Accredit health care facilities.

iv. Set quality standards for health care providers.

v. High level advocacy to generate support from tertiary institutions and other stakeholders.

vi. Supervise quality as well as the monitoring and evaluation of the programme. vii.Participate in the TISHIP Management Committee.

viii. Coordinate the activities of the National TISHIP Steering Committee.

b.Tertiary Institutions

i. Select/change HMO that will purchase secondary healthcare for the students. ii.Enter into a Memonrandum of Understanding (MoU) with the HMO and notify the NHIS of same.

iii. Oversee the collection and remittance of contributions to the TISHIP Fund. iv. Participate in mobilizing students for the programme.

v. Ensure that the HMO meets its obligations to students.

vi. Ensure that the health care facilities of the institution meet the NHIS accreditation requirements.

vii. Provide accurate record of registered students at the beginning of each academic session to the selected HMO, NHIS and Health Care Facility through the TISHIP Management Committee. viii.Ensure that every student pays his/her contribution at the commencement of each academic session.

ix. Provide identification cards with students' identification numbers as TISHIP numbers.

x. Participate in the activities of the TISHIP Management Committee.

c.Students Union

ii. Educate its members on the benefits and operational modalities of the programme. Ensure that all students register for TISHIP in the school.

iii. Ensure that all students pay for TISHIP on resumption of each academic session

iv. Encourage students to register at the Health Care Facility.

v. Participate to ensure that quality services are provided by reporting complaints to the TISHIP Management Committee.

vi. Participate in the activities of the TISHIP Management Committee.

d.***Health Maintenance Organizations***

i. Approve referrals by Primary Provider.

ii. Ensure proper adherence to and completion of referral procedures Make fee-for service payments for secondary care.

iii. Develop supplementary benefit package, as demanded by the students.

iv. Market approved supplementary package (with ethical standards) to the tertiary institutions

v. Establish quality assurance mechanisms.

vi. Conduct periodic sensitization and enlightenment on the programme to the students

vii. Generate primary and secondary data for the purpose of programme improvement and monitoring viii.Participate in the activities of the TISHIP Management Committee.

ix. Send quarterly reports to the tertiary institutions and NHIS through the TISHIP committee.

e.Health Care Facilities

i. Enter into contracts with the HMOs for secondary services.

ii. Provide quality services to registered beneficiaries as contained in the benefit package.

iii. Maintain records of all TISHIP activities within the facility

iv. Submit quarterly reports to the TISHIP Committee and the institution.

v. Participate in the activities of the TISHIP Management Committee.

f.Regulatory bodies of Tertiary institutions

i. Ensure that all institutions under their control join the TISHIP.

ii. Assist the NHIS to ensure that all institutions abide by the contents of the Blueprint/Operational Guidelines.

iii. Join the NHIS in sensitization activities for the TISHIP programme.

iv. Participate in the activities of the National Steering Committee for TISHIP Other Stakeholders include; State Governments, Federal Ministry of Education, Federal Ministry of Health, Development Partners etc.

2.3 Theoretical Framework on Health Insurance

2.3.1 The Theory of Reasoned Action

Theory of reasoned action (TRA) developed by Martin Fishbein and IcekAjzen (1980) as obtained from other research that started out as the theory of attitude which led to the study of attitude, behaviour and satisfaction. The components of the TRA were three general constructs: Behavioural intention (BI), attitude (A), and subjective norm (SN). TRA suggests that a person's behavioural intention depends on the person's attitude about the behaviour and the subjective norms (BI=A+SN). The theory identifies intention as the most immediate determinant of behaviour (Ajzen, 1991). According to this theory, the intention to carry out a given health behaviour is often a function of privately held attitude towards the particular behaviour and socially determined subjective norms that represent a person's belief that others think he or she should behave in a certain way.

This theory links health attitude directly to behaviour, a health behavior is the direct result of behavioural intention. An intention is a plan or likelihood that someone will behave in a particular way in specific situations. Attitude towards the action are based on belief about the likely outcome of the action and evaluation of those outcomes (Taylor, 2003). Relating Fishbein attitude theory (TRA) to the attitude of students towards NHIS-TISHIP, it follows that through psychological process of mediated generalization (and classical conditioning) the effect associated with previous government Schemes that involves out-of-pocket means of payment. This theory therefore captures how belief attributes of a certain object (Health Insurance Scheme in tertiary institutions in Nigeria) leads to the attitude towards that object, in this case, any government Scheme such as NHIS- TISHIP.

This theory, on the other hand, can be used to analyze the utilization of students of tertiary institutions towards NHIS-TISHIP. It then follows that if the students believe that poor health or illness expenses will have adverse consequences on them or their academic performance; and believe that NHIS-TISHIP would be able to address the above problems, they will be motivated, through the Schemes education and enlightenment campaigns, to embrace positive attitude towards NHIS-TISHIP. This positive attitude will in turn compel them to participate and utilize (choose and adopt) in the operations of the Scheme. On the basis of this, these students that utilize NHIS-TISHIP will be anchored on the theory of reasoned action (TRA).

2.3.2 Theory of Satisfaction

People often express judgments of satisfaction or dissatisfaction towards their own past experience of a brand, a treatment, their job, the incumbent government, and even their whole life. These judgments, which are often much easier to collect than objective data,

have been widely used by psychologists, political scientists, and consumer studies for predicting repeat purchases of a brand or electoral outcomes, repeat action, and for describing the happiness or "subjective well-being" (SWB) of various segments of the population. However, the bulk of satisfaction and happiness research emphasizes the *reference dependence* of the satisfaction variable (for a recent survey of the psychological literature on SWB, a result which stands in sharp contradiction with the conventional economic analysis of utility as a preference index (Diener*et al.* 1999).

Kahneman*et al.* (1997) solve this theoretical puzzle by making a distinction between decision-utility and experienced utility. They refer to decision-utility as a preference index describing how choices are made and to experienced utility as the measure of pleasure and pain suggested by (Bentham, 1789). Consequently, they postulate the existence of two very different meanings for "utility" and show experimentally that experienced utility, unlike decision-utility, is not being maximized. However, the conceptual meaning of experienced utility, or pleasure and pain, remains unclear in their approach.

The contribution of this theory is it proposes a more complete, yet more parsimonious, solution to the satisfaction puzzle. The latter is consistent with Kahneman*et al.*,(1997) contention that experienced utility should not be confused with decision-utility but it strictly follows the economic usage of defining "utility" as a preference index. Since preferences involve comparisons, satisfaction judgments and feelings which reflect this experienced preference must be relative. Thus the reference-dependence of satisfaction judgments and feelings does not require that an individual's *utility function* be reference-dependent as well. The findings and discourse of psychologists about the reference-

dependence of satisfaction judgments and feelings may be reconciled with the conventional economic analysis of utility as a preference index. This has the further consequence that human feelings and subjective well-being should be measured on ordinal scales.

There is an "obvious" theory of satisfaction judgments and feelings, which simply identifies the latter (SWB) with "utility" (U): $SWB = U$.

This theory is seldom taken literally. For instance, Clark and Oswald (1996) refer to a social utility, Frey and Stutzer (2002) to a procedural utility, and Kahneman*et al.*,(1997) to a hedonic notion of utility suggested by Bentham (1789) and later discarded by economists. It is not very clear whether these utility functions should be the same and how they relate to actual decisions. However, in order to demonstrate that SWB is an economic variable, it is necessary to relate the latter to decision utility.

In marketing research, consumers' satisfaction is taken as a good predictor of repeat purchases of the experienced product. To this extent therefore, the students would repeat the patronage of NHIS-TISHIP services in the tertiary institution if they are satisfied. The problem is that none of these contentions, which have received extensive empirical confirmation, can be seen as a straightforward prediction of the simple theory of satisfactionas-utility. Although a satisfying experience may often yield high utility, a high-utility good would only be chosen if it yielded more utility than available alternatives. Moreover, competition normally entails the availability of alternative goods yielding high utility as well, so that high utility *per se* cannot explain the positive correlation between consumers' satisfaction and repeat purchases of an experienced good. An experienced good

will be repeatedly purchased by rational consumers only as long as it is experience-preferred to the best opportunity.

The operational function of the above theories cannot be over-emphasized in this study. The theory has provided coherent mental construct to account for and predict hypotheses which can be tested and confirmed or falsified or shown weaknesses so that improvement can be made. The theory sort to explain why people (students) think, feel and act the way they do with respect to NHIS-TISHIP. And the students will behave in particular way based on the information they have about the programmes, the level to which they can access the facilities of the programme and the satisfaction they derive from the facilities.

2.4 Empirical Studies

Naseem, Muzamil, Talal and Jacob, (2013) in their study on Strategies for Enhancing the Use of Health Care Services by Nomads and Rural Communities, they observed that the implementation of NHIS in Ghana has a coverage of about 60% within 10 years of the patients awareness about the scheme and have move away from out-of-pocket financing mechanism to incorporate those in the formal and informal sectors in a single insurance system. This study agrees with Chikwe (2011) who stated that about 60 percent awareness level is attained in Imo state of Nigeria and has improved the standard of living. With regards to implementation of the health care programmes and the benefits that the law entrusts to the sub-system.

Sanusi, (2009) examined the level of awareness on NHIS in Oyo state, Nigeria; His results showed that 87.4 percent of the people were aware of the programme and 83.2 percent were registered under the programme and the people who enjoys the programme is just

58.9percent a similar study was conducted in Andrew et al (2007) on awareness of NHIS in Asaba Delta state, 92 percent of the awareness and utilization was related to education, media and campaign and concluded that more people are becoming more exposed to the NHIS issue in the study area. However, the study was conducted among the employees of both formal and informal sectors and not among students of tertiary institutions.

Jibo (2011) used across sectional descriptive study with 152 respondents drawn from the public sector to examine the awareness and utilization of NHIS among public servants in Kano, his findings showed that more than half of the respondents were males 88 (62.99 percent) married (80 percent) had tertiary education (93.6 percent) and that awareness is high among male compared to females. Jibo further noted that there are obvious reasons for under awareness of the scheme in some rural areas because of low educational level, access to good health care and lack of information on the scheme. However, Jibo (2011) did not highlight reasons why the male respondents have high level of awareness than the female.

Ndie (2013) assessed the awareness of National Health Insurance Scheme (NHIS) by civil servants in Enugu and Abakaliki. Using descriptive statistics to analyze responses from the administered questionnaires, the results showed that 64 percent of the nurses 20 percent of artisan, 28.1 percent of clerical officers and 20 percent of the teachers only 1 percent are registered members of NHIS. Nurses that know the health care facilities accredited for NHIS is 56.1 percent while 12.5 percent, 20.88 percent and 8.5 percent of artisans, clerical

officer and teachers respectively know health care facility accredited for NHIS. Ndie concluded that the result indicates that civil servants working with Ebonyi and Enugu state governments do not know much about the NHIS. Nurses have the greatest knowledge about NHIS when compared to artisans, clerical officers and teachers. This study did look at the students who have their own special NHIS scheme which is referred to as TISHIP.

Jolie and Robert (2009) in Quality of healthcare and patient satisfaction using survey method to determine difference in the access to rural and urban health care reported that though differences in access to rural and urban health care units also account for differences in awareness, tendencies towards higher knowledge of the health care services emerge, first of all from education which is described as a major force in breaking down reliance upon traditionalistic worldviews and folk practices, or as instrument in helping individuals cope with their needs by making intelligent use of available social and health care services. They concluded that maternal education was identified as an important factor affecting awareness of the health care services, as higher educational levels have been associated with an increased self-perception of health status and influence the use of both curative and preventive health care services.

According to Odebiyi, Aiyejunsunle, Ojo and Tella (2009) in the study comparison of patient satisfaction with physio-therapy care in private and public hospitals using survey method. The data obtained from the questionnaire were analyzed using correlation and ANOVA which reveals that sex is one of the most influential variables affecting the awareness of the National Health Insurance Scheme services. Sex has influence on awareness of the health care services through its association with other predictors of

informed such as tendency to use services anxiety and skepticism. They concluded that levels of personal distress are an important trigger in the use of health care services; since women have higher levels of distress, they make more use of the health care services.

According to Olatunji, Ogunlana, Bello and Omobaanu (2008) in Assessment of patient's satisfaction with physiotherapy care, the health status of members of a society is positively correlated to their cultural practices. Culture determines what symptoms signs are recognized as illness, the cause to be associated with them, who has authority to assess and diagnose them and most importantly who should be consulted for treatment. Mohammed (2008) in his study on Perceptions of Formal-Sector Employees on the Health Insurance Scheme in Nigeria: The Case of Ahmadu Bello University Staff, Zaria-Nigeria using simple regression analysis on the data obtained from the primary source (questionnaire) reported that cultural perception of ill health has been identified as a hindrance to awareness and knowledge of health insurance. Cultural problems evolve with the belief of illness and risk which may be affiliated to religion or traditional norms. He concluded that illnesses are perceived ethnically or religiously by the society as punishment for certain misdeeds, it affects the rate of enrollment in health insurance; in the end, acceptance and participation in the health insurance is jeopardized.

According to Jane, Obinna, Benjamin and Ogochukwu (2014) in their study on Patients' Satisfaction and Quality of Care in a Tertiary Institution in Southeast Nigeria using survey method. The data obtained from the questionnaire were analyzed using correlation which reveals that gender is one of the most influential variables affecting the awareness of the National Health Insurance Scheme services. Gender has affected the awareness of the

health care services through its association with other predictors of informed such as tendency to use services. They conclude that there is no significant difference between the awareness among the gender.

Andersen's behavioural model of health services utilization proposes that people's use of health care services is a function of their predisposition to use services, the factors enabling or impeding use, their need for care, and their satisfaction with services (Andersen.1995). The utilization of National Health Insurance Scheme services varies across different cultures for a variety of reasons. But it appears, according to Nora (2005), that the determining factors are universal. Nora noted that utilization of National Health Insurance Scheme services is determined not only by its availability but by a number of other factors such as location, distance, accessibility, perception etc.

Nora (2005) in his study on Factors Affecting the Choice of Material and Child Health Services in Rural Area in Saudi Arabia using content analysis reported that place of residence has been an important factor in the utilization of the services. He posits that urban population make greater use of services than those in rural areas. Nora (2005) further noted that distance from the health care service centre, education of the participants, as well as their age are the strongest determinants of service utilization among participants in developing countries. And therefore conclude that there would always be disparity in the utilization of the health services. In this study, emphasis is laid on the maternal and child health services which are just aspects of the insurance scheme.

In the explanations of Fiedler (2003), access to health care services is considered as the link between the health care system and the population it serves; the volume and type of

services, whether or not the service can be reached, the client's perceptions of the relative worth of the service and acceptability of services provided, all influence access and the utilization of services. In line with the postulates of the central place theory, health care facilities in Nigeria constitute a hierarchical system which is reflected in space by the geographical arrangements of service outlets in which a particular area tend to have numerous primary health facilities, much fewer secondary facilities and very few tertiary facilities if at all. Consequently, the findings of studies conducted by Okafor (2007) on the petroleum - producing region of Nigeria (the Niger Delta) revealed that inaccessibility of the available health care facilities in the region has obviously affected the utilization of health care services by a vast proportion of the beneficiaries who still depend on traditional medical care and self medication.

Jibo (2011) used across sectional descriptive study with 152 respondents drawn from the public sector to examine the awareness and utilization of NHIS among public servants in Kano, his findings showed that more than half of the respondents were males 88 (62.99 percent) married (80 percent) had tertiary education (93.6 percent) and that utilization is high among male compared to females. Jibo further noted that there are obvious reasons for under utilization of the scheme in some rural areas because of low educational level, funding, access to good health care and lack of information on the scheme. However, Jibo (2011) did not highlight reasons why the male respondents have high level of utilization than the female.

There is no doubt as reported by Okafor (2007), that many other factors influence the utilization pattern of health care services among beneficiaries in the Niger Delta region including the level of formal education, facilities available in the health establishments,

availability of alternative medical attention in the locality, perception of the attention received in the health care centre and the distance to the centres in terms of travel cost and time of reaching the health centre. According to Dibley, Luu, Vinh, Hong, Loan, and Tuan, (2003) in their study on Vietnam Australia Primary Health Care for Women and Children Project using survey analysis posit that the most common reason for not seeking care is the expectation that the individual would recover. Other reasons include distance to provider or facility and lack of satisfaction with services.

Sule, Ijadunola, Onayade, Fatusi, Soetan and Connel, (2008) in the study on Utilization of Primary Health Care Facilities: Lesson from a Rural Community in Southwest Nigeria using secondary data and content analysis reported that implementation of a National Health Insurance Scheme alone cannot guarantee improvement in the health status of people, it is their effective utilization of the health care services that can contribute to the health of the people. Utilization of the health care services is affected by a variety of constraints like availability, acceptability, accessibility and affordability. They noted that first and foremost, for people to utilize the health care services they should be available. Even if they are available they should be acceptable to the people because utilization of any health care service depends, to a great extent, on cultural preferences. Factors of awareness, availability act as the main barriers to initial utilization. Once these have been achieved people may then begin to find the intensity and frequency of the utilization limited by accessibility and acceptability.

The need for health care varies in space and so the organization of provision necessarily has a spatial component. Neither population totals nor population characteristics such as age, sex, occupation is uniform in space. In a like manner, the physical environment varies in

characteristics from place to place and this invariably has implication for the pattern of demand for health care. The spatial dimension is also important in utilization behaviour since accessibility is a major determinant of the use of health care service (Okafor, 2007). The spatial pattern of utilization of service of the various categories of health establishments by the beneficiaries show marked differences between local governments where tertiary and secondary health establishments are accessible and those where such facilities are not accessible.

Geitona, Zavaras and Kyriopoulos (2007) in the Determinants of Health Care Utilization in Greece using regression analyses on the instrument of questionnaire returned from the field revealed that the utilization of National Health Insurance services among participants depends on self-rated health status, age, gender, and region individuals with moderate and poor self-rated health, older people, and women showed increased utilization of health care services in Epirus while individuals with better self-rated health status showed decreased utilization of health care services. They conclude that the frequency of utilization of services depends on region and lower evaluations of health status among participants.

Charles (2001) in the study Health Services Utilization in Central Virginia: A Comparison of Estimated and Observed Rates using analysis of variance on data obtained from the administration of questionnaire to respondent stated that a possible explanation for the higher rate of utilization among women is that they are more dependent and affiliated and thus seek interpersonal solutions to feelings of distress more than the men. To this study, such reasons for utilization are not directly due to higher presence of health conditions.

Most often emphasis is placed on socio-economic conditions as the main determinants of people's willingness to enroll in a health insurance scheme, neglecting culture which also has much impact. Helman (2001) further reported that it is of paramount importance to note that illness and choice of health care services is shaped by cultural factors governing perception in the sense that how we perceive and cope with disease is based on our explanations of sickness, explanation specific to the systems of meaning we employ. It is not surprising then that there can be marked cross-cultural variation in how diseases are defined and coped with in our societies. Helman (2001) concluded by saying that it is obvious that culture and ethnicity are influential social determinants of willingness to enroll or use a health insurance scheme.

The findings of a study conducted by Naseem*et al.,* (2002) on the use of National Health Insurance services by participants in rural communities in Saudi revealed that despite the availability of services, these groups tend to under use the services due to traditional conservatism and resistance to ideas from outside; deep rooted traditions and customs, including health beliefs and practices, which create a tendency to over utilize the services of traditional healers.

Oche (2011) in the study patient waiting time in a tertiary health institution in Northern Nigeria try to determine the waiting time of patients and how it affects their level of satisfaction using survey method by administering questionnaires to the respondents. The study asserts that, it is difficult to sell services if individuals are dissatisfied; with waiting time, which is the length of time from when the patient entered the waiting room to the time the patient actually left the hospital. In a competitively managed health care environment, patient waiting time play an increasingly important role in a clinic's ability to

attract new business. Oche fails to establish whether the patients' waiting time in tertiary health institutions are satisfactory or not but went ahead to state the role of waiting time in a clinic's ability to attract new patients.

Ofili and Ofovwe (2005) in the study 'patients' assessment of efficiency of services at a teaching hospital in a developing country patients' satisfaction through enhance medical care' try to assess the role of efficiency of services on patients' satisfaction using survey method. The data obtained from the questionnaires administered were analyzed using simple descriptive statistics and reveals that long waiting time has frequently been mentioned as one factor which may limit health service utilization by any given community. Ofili and Ofovwe (2005) assert in their studies that, of the 250 patients enrolled for the study, 140 patients were satisfied with the service sat the pharmacy which is (56.0%) patients, while 108 patients (43.3%) were not satisfied. Reasons given for the dissatisfaction were long delay in serving patients (73.1%), unavailability of certain drugs (13.8%), high cost of drugs (11.1%), and rudeness of staff (1.8%).The studies further revealed that 183 patients (73.2%) were satisfied with services in the laboratories, while 25.6% were dissatisfied and the reasons for the dissatisfaction were mostly delayed results (48.4%) and expensive tests (23.4%). 115 patients (46.0%) thought the bathrooms and toilet facilities were dirty, while 135 patients (54.0%) thought they were clean enough. They therefore conclude that consumer factors have an influence on patient's satisfaction with the healthcare deliver.

Onwudiegwu (1999) identify some of these factors to include; distance, waiting time, communication, cleanliness and level of education, as well as the general attitude of the

healthcare providers. These factors are found to be significant predictors of healthcare satisfaction. However, this study is not concerned about the health services under an insurance scheme but just looking at health care provision.

Iloh, Ofoedu, Njoku, Okafor, Amadi and Godswill (2013) in the evaluation of patient satisfaction with quality of care provided at the national health insurance scheme clinic of a tertiary hospital in south-eastern Nigeria using content analyses revealed in their studies that, satisfaction with patients waiting time (service delay) is ranked the least with an average score of 2.4. Duration of consultation can also affect patient satisfaction. Ofili and Ofovwe (2005) found out that, the duration of examination to be three minutes and 47% of the patients from this study expressed dissatisfaction over that. Prolong waiting time before consultation and average duration of examination was found to be the greatest source of discontent among patients.

Prasad, (2013) in the study on Level of satisfaction in patients/attendants admitted with traumatic brain injury at an advanced ER/Casualty in a Tertiary Care Teaching Hospital using a survey method. The returned questionnaires were analyzed using chi-square asserts the non-availability and prices of drugs, to be a major hindrance towards patient satisfaction and quality of care through enhanced medical care, the studies asserts that, (57.7%) of the patients were of the level of dissatisfaction on the length of waiting time for drugs.

The area of dissatisfaction as asserted in Fekadu*et al*., (2010) are Lack of drugs and supplies, poor information provision, long waiting time, poor cleanliness, lack of privacy

and inadequate visiting hours, were found to be the major causes of dissatisfaction in these studies. However, Ibrahim (2009) indicate that there are documentary evidence which has shown that health service delivery in Nigeria is as low as 30% and other indicators such as waiting times, staff attitude to work and public confidence in the health sector has declined significantly over the years. The study further Identify the following hindrances to care/service delivery; Shortage of human resources, lack of equipment and inadequate drugs, lack of training and re-orientation of staff, lack of staff commitment e.g. nurses, midwives, laboratory technicians and doctors, brain-drain resulting from lack of motivation, inter/intra professional rivalry among health professionals, poor budget allocation, weak health information system. In this study, the extent of the satisfaction was not given adequate concern but instead the factors responsible for the dissatisfaction.

There are a number of challenges facing the actualization of Tertiary Institutions Social Health Insurance Programme of NHIS in Nigeria. Funding remains a critical issue to the scheme. The percentage of government allocation to the health sector has always been abysmally low, about 2% to 3.5% of the national budget. For example, in 1996, only 2.55% of the total national budget was spent on health; 2.99% in 1998; 1.95% in 2005; 2.01% in 2010 and a marginal increase to 2.1% in 2016 (WHO, 2013, NBS, 2017). Consequently, per capita public spending for health in the country is less than US$4; which is far below the US$34 recommended by WHO for low-income nations (WHO, 2013). While the Nigerian per capita health expenditure dwindles, the South African per capita health expenditure for example is US$22 in 2011 (The Vanguard Editorial, 2015).

Tertiary Institutions Social Health Insurance Programme of NHIS is also impeded by obsolete and inadequate medical equipment used by health services providers and sickbays in the institutions. The tertiary institutions suffer from perennial shortage of modern medical equipment such as radiologic and radiographic testing equipment and diagnostic scanners (Johnson &Stoskopt, 2009). And where these equipments are available, their repairs/servicing are always a problem. According to Oba (2009), this situation is not unconnected with corruption. Money meant to boost the health sector and health facilities in the institutions ends up in private pockets.

Again, lack of adequate personnel in the healthcare section of the institutions is another impediment to the scheme. The country for instance had 19 physicians per 100,000 people between 1990 and 1999 (The Vanguard Editorial, 2005). In 2003, there were 34,923 physicians in Nigeria, giving a doctor-patient ratio of 0.28 physician per 1000 patients and 127,580 nurses or 1.03 nurses per 1000 patients as compared to 730,801 physicians or 2.5 per 1000 population in 2000 in the United States of America; and 2,669,603 nurses or 9.37 per 1000 patients. Out-migration of health personnel to the US, UK, Europe and other western/eastern countries is significantly responsible for the personnel situation in the health sector in Nigeria. For instance, in 2005 alone, there were 2,393 Nigerian doctors practicing in the US and 1,529 in the UK. Attributing factors include poor remunerations, limited postgraduate medical programs and poor conditions of service in Nigeria (WHO, 2007). According to the World Bank Development Indicators (2005), the personnel situation in the healthcare sector influenced birth attendance in Nigeria.

Another striking challenge to the success of Tertiary Institutions Social Health Insurance Programme of NHIS is the epileptic and sometimes lack of electricity in most parts of

Nigeria which hampers the smooth operation of TISHIP. For instance, a physician is carrying out a major operation on a patient and there is power disruption. This will threaten the success of that surgical procedure and endanger the life of the patient.

In addition, Student's satisfaction is a fundamental indicator of success in this form of service delivery and is therefore a key component of quality of healthcare in Nigerian tertiary institutions of learning. The idea of satisfaction is fundamental to the delivery of the service. The health sector is aimed at ensuring effective health service provision whereby care is demand-driven, performance-driven, and consumer driven and evidence based. Such care is expected to increase consumer satisfaction and improve the confidence of the public in the health care delivery system in the country. Another important issue is the nature of students' assessment of care. Also, one needs to know the basis of expressions of success of otherwise of the scheme.

Agba, Ushie and Osuchukwu, (2010) demonstrates that a relationship between satisfaction and expectation is not necessarily direct but contend that, it then seems reasonable to suggest that expression of satisfaction are the end-product of a process of evaluation in which expectations figure to some extent. Mackey and Cole, as cited in Oche*et al*., (2011) assert that, it is difficult to sell services if individuals are dissatisfied; with waiting time, which is the length of time from when the patient entered the waiting room to the time the patient actually left the hospital. In a competitively managed health care environment, patient waiting time play an increasingly important role in a clinic's ability to attract new business.

Cunningham in Ofili and Ofovwe (2005) patients' satisfaction through enhance medical care, long waiting time has frequently been mentioned as one of the challenges which may limit health service utilization by any given tertiary institutions. Students' factors have an influence on the success with the healthcare deliver. Onwudiegwu (1999) identify some of these challenges of health care schemes to include; distance, waiting time, communication, cleanliness and level of education, as well as the general attitude of the healthcare providers. These factors are found to be significant predictors of healthcare satisfaction.

Duration of consultation is also other challenge as it affects patient satisfaction. Singh and his co-workers in Ofili and Ofovwe (2005) found out that, the duration of examination to be three minutes and 47% of the patients from this study expressed dissatisfaction over that. Prolong waiting time before consultation and average duration of examination was found to be the greatest source of discontent among patients and hug challenge for any health insurance scheme including TISHIP. The finding from Ofili and Ofovwe studies (2005) is in consonance with the Trinidad and Tobago studies of Singh *et al*., (1999).

Shortage or lack of drugs and essential pharmaceuticals in health care is indicative of a serious failure in the system. Drug shortages have been a recurring phenomenon particularly in the public health sector. Even when drugs are available it does not translate to accessibility. Availability is not synonymous to accessibility because of the huge impact of prices in the determination of accessibility to essential medicines. Access to essential drugs has assumed significance over the years because of increasing difficulty experienced by people in obtaining their medication both within and outside the regular health care structures.

Availability is the first step in ensuring access and affordability is the second step in ensuring access. Akande, Salaudeen and Babatunde (2011) asserts that the availability of drugs, to be a major hindrance towards effective implementation of health insurance scheme, patient satisfaction and quality of care through enhanced medical care.

Adagadzu (2009) asserts that, the procurement process of drugs often lacks transparency and contributes significantly to the high prices and by extension, affordability and quality of the medicines procured which is another problem faced by the health insurance scheme. Medicines and pharmaceuticals available have a high cost process and therefore access to them is denied and when quality is compromised, safety cannot be guaranteed. The studies further assert that, Baseline assessment of the Nigerian pharmaceutical sector in 2002showed that only 46% of essential medicines were available in public health facilities. A national survey in Nigeria in 2004 – 2006 as contain in Adagadzu (2009), showed that the drugs were neither sufficiently available nor were they affordable.

According to Oche*et al*., (2011), lack of drugs and supplies, poor information provision, long waiting time, poor cleanliness, lack of privacy and inadequate visiting hours, were found to be the major challenges of TISHIP and therefore causes high level of dissatisfaction. However, Ibrahim (2009) indicate that there are documentary evidence which has shown that health service delivery in Nigeria is as low as 30% and other indicators such as waiting times, staff attitude to work and public confidence in the health sector has declined significantly over the years. The study further identify the following as the challenges faced by any health insurance scheme which intend to provide care/service delivery; shortage of human resources, lack of equipment and inadequate drugs, lack of

training and re-orientation of staff, lack of staff commitment e.g. nurses, midwives, laboratory technicians and doctors, brain-drain resulting from lack of motivation, Inter/ intra professional rivalry among health professionals, Poor budget allocation, Weak health information system.

Finally, the commodification of health services could mar the objectives of Tertiary Institutions Social Health Insurance Programme of NHIS. This is because healthcare providers see their services as economic commodity which they sell at a bargained and exorbitant cost to those who could afford it. This negates one of the objectives of Tertiary Institutions Social Health Insurance Programme of NHIS aimed at giving UHC to all students of tertiary institutions.

2.5 Summary

This chapter reviewed concepts such as Social Health Insurance which is a form of insurance which pays for health care services through contributions to a health fund. Contributions; National Health Insurance Scheme which is a compulsory universal or employment grouptargeted insurance system financed by employee-employer payroll deductions and; Tertiary Institution Social Health Insurance Programme which is respond to the problem of chronic under-funding in the Nigerian public universities adopted an array of cost sharing measures, notable among stakeholders in the universities such as students, the universities, government, health maintenance organization etc.

The purpose of TISHIP were reviewed which are to protect families from the financial hardship of huge students' medical bills, to limit the rise in the cost of health care services,

to ensure equitable distribution of healthcare cost among different categories of students, to ensure high standard of health care services delivery to students among others. The strategy is to operate the TISHIP as a sickness fund with a Committee responsible for its administration. This committee would consist of all the stakeholders of TISHIP which are

National Health Insurance Scheme, Tertiary Institutions, Students Union, Health Maintenance Organizations (HMOs), Health Care Facilities, Regulatory bodies of Tertiary institutions. The challenges of TISHIP were also explored which include inadequate funding, obsolete and inadequate medical equipment used by health services providers, lack of adequate personnel and epileptic and sometimes lack of electricity which affects the satisfaction of the beneficiaries.

In addition, several literatures on the awareness, utilization and satisfaction of National Health Insurance Scheme - TISHIP by the students were reviewed which include Naseem, Muzamil, Talal and Jacob, (2013) in their study on Strategies for Enhancing the Use of Health Care Services by Nomads and Rural Communities which evaluate the awareness level of health schemes among rural communities; Jibo (2011) who examine the awareness and utilization of health insurance among public servants in Kano and; Oche (2011) in the study patient waiting time in a tertiary health institution in Northern Nigeria. Also, literatures on the effect of the socio-demographic profile and socio-economic conditions on the awareness, utilization and satisfaction of the scheme were also reviewed which leave out the gap in which this study wish to cover.

The theoretical framework adopts by this study are the theory of reasoned action and theory of satisfaction. These approaches suggest the ways in which individuals perceive both their internal and external environment (National Health Insurance Scheme - TISHIP) which in

turn may influence the nature and level of taking action (awareness, utilization and satisfaction).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The study assesses awareness, utilization and satisfaction of Tertiary Institution Social Health Insurance Programme among students of tertiary institutions in Kaduna State. This chapter discusses research design; population of the study; sample and sampling techniques; instrument for data collection; validity of the instrument; data collection procedure and procedures for data analysis.

3.2 Research Design

Descriptive research design was employed in this study. Descriptive research aims to accurately and systematically describe a population, situation or phenomenon. A descriptive research design can use a wide variety of research methods to investigate one or more variables. Unlike in experimental research, the researcher does not control or manipulate any of the variables, but only observes and measures them.The research design was conducted to estimate the prevalence of the outcome of interest for a given population, commonly for the purposes of public health planning (Babbie, 2003).

3.3 Population of the Study

Population of this study was made up of all full-time students who had accessed healthcare services in the school clinics in the last six (6) months from Ahmadu Bello University Zaria, Federal Polytechnic Kaduna and Federal College of Education Zaria in Kaduna State. In the case of the university, the students considered were undergraduates and postgraduates;

For polytechnics, it was the National Diploma and Higher National Diploma students while; for the Federal Colleges of Education, it was the students of Nigerian Certificate in Education. The population of the study 123,651 comprising the total number of students from the three tertiary institutions as shown in table 3.1 (Management and Information System office, ABU, 2019; Academic Planning Office, KADPOLY, 2019; Academic Office, FCE, 2019).

3.4 Sample and Sampling Techniques

In determining the number of respondents that were included in the study, the Yamane's equation was used to determine the sample size. In using this formular, the study used significance level of 5% (i.e. e = 0.05).

According to Yamane, (1967) the formula for calculating sample size is as follows;

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

Where; n =

sample size

N = population size = (123,651) e = level of precision which is

constant with a value of 0.05 or 5%.

Therefore,

$$n = \frac{123,651}{1 + 123651(0.05)^2}$$

$$n = \frac{123,651}{1 + 123651(0.0025)}$$

$$n = \frac{123,651}{1 + 309.1275}$$

$$n = 399.37$$

The sample size of approximately 399, however, the researcher increased it to 560 by adding about 40% based on the submission of Bartlett, Kotlik and Higgins (2001), that 40% to 50% could be added as additional sample to make up for those that may not be returned or would be invalid. Hence, the sample was proportionate allocated to the three (3) types of tertiary institutions Kaduna State i.eAhmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria where TISHIP is operational as shown in table 3.1 below:

Table 3.1 Distribution of the Sample Size of the Study

S/N	Types of Institution	Population	Sample
1.	Ahmadu Bello University, Zaria	51,493	235
2.	Federal Polytechnic, Kaduna	39,786	179
3.	Federal College of Education, Zaria	32,372	146
Total		**123,651**	**560**

Source: Management and Information System office ABU, (2019); Academic Planning Office KADPOLY, (2019); Academic Office FCE, (2019) Researcher's Computation (2019)

In this study, purposive sampling technique was used in all the Federal tertiary institutions that are selected, that is, Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. This is because only federal tertiary institutions have enrollees in the scheme (TISHIP) as at the period of this study.

3.5 Instrumentation

The instrument for data collection in this study was adopted questionnaire based on awareness on TISHIP scheme and utilization of TISHIP benefit packages as outlined in the TISHIP operational guideline. The Patient Satisfaction Questionnaire Short-Form (PSQ 18) which is an 18-items questionnaire was used to assess the level of satisfaction of the respondents. PSQ-18 which is a short version of PSQ III tapped the Global satisfaction with medical care as well as the satisfaction with six dimensions of care; technical quality, interpersonal manner, communication, financial aspect of care, time spent with doctor and accessibility of care. The subscales showed acceptable internal consistency and reliability and corresponding PSQ-18 and PSQ III subscales are substantially correlated with one another, except for one, correlation exceed 0.90 (Marshall *et al*., 1993).

The Patient Satisfaction Questionnaire Short-Form (PSQ-18) yields separate scores for each of the seven subscales: General Satisfaction (Items 3 and 17); Technical Quality (Items 2, 4, 6 and 14); Interpersonal Manner (Items 10 and 11); Communication (Items 1 and 13); Financial Aspect (Items 5 and 7); Time Spend with Doctor (Items 12 and 15); Accessibility and Convenience of Care (Items 8, 9, 16 and 18). Some of the questions were worded so that agreement reflects satisfaction with medical care while others reflects dissatisfaction with medical care. After items scoring, items within the same subscale would be averaged together to create the seven (7) subscale scores. The responses are in five (5) points Likert format to show degree of agreement or disagreement with the items as follows; Strongly Agree, Agree, Uncertain, Disagree and Strongly Disagree

3.6 Validity of the Instrument

The draft questionnaire was submitted to experts in the Department of Human Kinetics and Health Education and the Faculty of Medicine of Ahmadu Bello University, Zaria, Nigeria for vetting. This was aimed at meeting the face and content validity of the instrument. It was aimed at ensuring that questions can elicit the information required to answer the research questions and satisfy the objectives of the study. All the corrections and observation made were incorporated in the final copy of the questionnaire for the study.

3.7 Procedure for Data Collection

The researcher obtained a letter of introduction from the Head, Department of Human Kinetic and Health Education, Ahmadu Bello University, Zaria, Kaduna State, introducing the researcher and also stating the purpose and benefits of the research. In conducting this study, five (5) research assistants were involved in the administration of questionnaire in obtaining data for the study. These research assistants were trained by the researcher on how to administer the questionnaire to respondents in their school or at their institution health facilities.

The questionnaires were given to the research assistants who were made to visit the students in their faculties and departments to administer the instrument. The research assistants guided the students where necessary on how to respond to the questions without influencing their decision. The field work was done simultaneously across the faculties within five (5) working days of a week (i.e 31st July – 6th August, 2019).

3.8 Procedure for Data Analysis

The data obtained from the field were analysed using both descriptive and inferential statistical tools. The descriptive statistics that were used are means, percentage, standard deviations and standard error of means, and the essence is to summarize the data/results for easy comprehension. The inferential statistical analysis used was one sample t test for hypotheses i, ii and iii to determine significant awareness, utilization and satisfaction among students of tertiary institution in Kaduna State while analysis of variance (ANOVA) was used to analyze and test hypotheses iv, v and vi to determine whether there are significant differences in the level of awareness, utilization and satisfaction among students of different tertiary institutions in Kaduna State while t-test was used to determine whether there are significant differences between the level of awareness and level of utilization in hypothesis vii and the level of utilization and level of satisfaction in hypothesis viii respectively. In this study, ANOVA and t test values were determined using the Statistical Package for Social Scientist (SPSS version 22) software. The decision rule to test the hypotheses in this research was to accept the hypothesis if asymptotic significance is less than 0.05 (i.e $p\text{-value} < 0.05$) at 5% level of significance and reject the hypothesis if asymptotic significance is greater than 0.05 (i.e $p\text{-value} > 0.05$) at 5% level of significance.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION

4.1 Introduction

The chapter is discussed under the following sub-heading:

4.2 Data analysis and results presentation

4.3 Summary of findings

4.4 Discussion of results

4.2 Data Analysis and Results Presentation

Data was collected using, The Patient Satisfaction Questionnaire Short-Form (PSQ 18) which is an 18-items questionnaire was used to assess the level of satisfaction of the respondents. PSQ-18 which is a short version of PSQ III tapped the Global satisfaction with medical care as well as the satisfaction with six dimensions of care; technical quality, interpersonal manner, communication, financial aspect of care, time spent with doctor and accessibility of care were used to measured students' satisfaction with TISHIP while adopted questionnaires based on awareness and utilization of TISHIP benefit packages as outlined in the TISHIP operational guideline were used to assessed the students' awareness and utilization of TISHIP in their institutions.

During the course of the field survey, in order to ensure that the total number of questionnaire returned is not less than the sample size, a total of five hundred and sixty (560) questionnaire were administered to the students across the three institutions (Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria) based on their populations' proportion. Four hundred and sixty (462) questionnaire

were returned out of which four hundred (400) were validly filled and completed. The study's data analysis and presentation were based on the 400 respondents that completed and validly filled the questionnaires and this is above the calculated sample size of 399.

4.2.1 Answer to Research Questions

In this section the data collected was analyzed using some statistical tools depending on the type of data collected. Means, percentages and standard deviations were used to answer research questions 1 to 8.

Research Question One

What is the level of awareness of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale, percentage, standard deviation and Standard error of mean. The summary of the computation is presented in Table 4.1.

Table 4.1: Descriptive Statistics Test for Hypothesis one

	N	Mean	Percentage (%)	Std. Deviation	Std. Error Mean
AWARENESS	400	2.36	47.2	0.92	0.046

Table 4.1 shows the mean score of level of awareness of TISHIP among students of tertiary institutions in Kaduna State (M=2.36, SD=0.92).

In summary, the level of awareness of TISHIP among students of tertiary institutions in Kaduna State is 47.2%.

Research Question Two

What is the level of Utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale, percentage, standard deviation and Standard error of mean. The summary of the computation is presented in Table 4.2.

Table 4.2: Descriptive Statistics Test for Hypothesis Two

	N	Mean	Percentage (%)	Std. Deviation	Std. Error Mean
UTILIZATION	400	2.26	45.2	1.08	0.054

Table 4.2 shows the mean score for level of Utilization of TISHIP among students of tertiary institutions in Kaduna State (M=2.26, SD=1.08).

In summary, the level of utilization of TISHIP among students of tertiary institutions in Kaduna State is 45.2%.

Research Question Three

What is the level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale, percentage, standard deviation and Standard error of mean. The summary of the computation is presented in Table 4.3.

Table 4.3: Descriptive Statistics Test for Hypothesis Three

	N	Mean	Percentage (%)	Std. Deviation	Std. Error Mean
SATISFACTION	400	2.85	57.0	1.14	0.057

Table 4.3 shows the mean score of level of satisfaction with TISHIP among students of tertiary institutions in Kaduna State (M=2.85, SD=1.14)

In summary, the level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State is 57.0%.

Research Question Four

Does the level of awareness of TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale and standard deviations. The summary of the computation is presented in Table 4.4.

Table 4.4: Mean scores, percentages and standard deviations of level of awareness of TISHIP among students

	Mean score	Percentage (%)	Std. Deviation	N
Ahmadu Bello University, Zaria	2.39	47.8	0.91	203
Federal Polytechnic, Kaduna	2.38	47.6	1.05	74
Federal College of Education, Zaria	2.30	46.0	0.81	123
Aggregate scores	2.36	47.2	0.92	400

Table 4.4 shows the mean of the level of awareness of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. The mean level of awareness of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are (M=2.39, SD=0.91), (M=2.38, SD=1.05) and (M=2.30, SD=0.81) respectively. The close value of the mean scores for the institutions indicate that the level of awareness of TISHIP does not differ significantly with the types of school among students of tertiary institutions in Kaduna State, Nigeria. However, from the mean scores, students of Ahmadu Bello University, Zaria, have the highest level of awareness of TISHIP while the students of Federal College of Education, Zaria have the least level of awareness of TISHIP.

Research Question Five

Does the level of utilization of TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale and standard deviations. The summary of the computation is presented in Table 4.5.

Table 4.5: Mean scores, percentages and standard deviations of level of utilization of TISHIP among students

	Mean Score	Percentage (%)	Std. Deviation	N
Ahmadu Bello University, Zaria	2.27	45.4	1.09	203
Federal Polytechnic, Kaduna	2.31	46.2	1.11	74
Federal College of Education, Zaria	2.19	43.8	1.03	123
Aggregate scores	2.26	45.2	1.08	400

Table 4.5 shows the mean of the level of utilization of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. The mean level of utilization of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are (M=2.27, SD=1.09), (M=2.31, SD=1.11) and (M=2.19, SD=1.03) respectively. The close value of the mean scores for the institutions indicate that the level of utilization of TISHIP does not differ significantly with the types of school among students of tertiary institutions in Kaduna State, Nigeria. However, from the mean scores, students of Federal Polytechnic,

Kaduna, have the highest level of utilization of TISHIP while the students of Federal College of Education, Zaria have the least level of utilization of TISHIP.

Research Question Six

Does the level of satisfaction with TISHIP differ with the types of school among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale and standard deviations. The summary of the computation is presented in Table 4.6.

Table 4.6: Mean scores, percentages and standard deviations of level of satisfaction of TISHIP among students

	Mean score	Percentage (%)	Std. Deviation	N
Ahmadu Bello University, Zaria	2.89	57.8	1.10	203
Federal Polytechnic, Kaduna	2.87	57.4	1.22	74
Federal College of Education, Zaria	2.80	56.0	1.09	123
Aggregate score	2.85	57.0	1.14	400

Table 4.6 shows the mean of the level of satisfaction of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education,

Zaria. The mean level of satisfaction of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are (M=2.89, SD=1.10), (M=2.87, SD=1.22) and (M=2.80, SD=1.03) respectively. The close

value of the mean scores for the institutions indicate that the level of satisfaction of TISHIP does not differ significantly with the types of school among students of tertiary institutions in Kaduna State, Nigeria. However, from the mean scores, students of Ahmadu Bello University, Zaria, have the highest level of satisfaction of TISHIP while the students of Federal College of

Education, Zaria have the least level of satisfaction of TISHIP.

Research Question Seven

Does the level of awareness of TISHIP differ from the level of utilization among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale and standard deviations. The summary of the computation is presented in Table 4.7.

Table 4.7: Means and standard deviations of level of awareness and utilization of TISHIP among students

	Awareness		**Utilization**	
	Mean score (n)	**Percentage n(%)**	**Mean score (n)**	**Percentage n(%)**
Ahmadu Bello University, Zaria,	2.39	47.8	2.27	45.4
Federal Polytechnic, Kaduna	2.38	47.6	2.31	46.2
Federal College of Education, Zaria	2.30	46.0	2.19	43.8
Aggregate scores	2.36	47.2	2.26	45.2

Table 4.7 shows the mean of the level of awareness and utilization of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of

Education, Zaria. The mean level of awareness and utilization of TISHIP among students of Ahmadu Bello University, Zaria, shows that the level of awareness is higher than the level of utilization (by -0.12 in favour of awareness). The mean level of awareness and utilization of TISHIP among students of Federal Polytechnic, Kaduna, shows that the level of awareness is higher than the level of utilization (by -0.07 in favour of awareness). The mean level of awareness and utilization of TISHIP among students of Federal College of Education, Zaria, shows that the level of awareness is higher than the level of utilization (by -0.11 in favour of awareness).

Research Question Eight

Does the level of utilization of TISHIP differ from the level of satisfaction among students of tertiary institutions in Kaduna State, Nigeria?

This research question was answered using descriptive statistics of means on a 5 – point scale and standard deviations. The summary of the computation is presented in Table 4.8.

Table 4.8: Means and standard deviations of level of utilization and satisfaction of TISHIP among students

	Utilization		**Satisfaction**	
	Mean score (n)	**Percentage n(%)**	**Mean score (n)**	**Percentage n(%)**
Ahmadu Bello University, Zaria,	2.27	45.4	2.89	57.8
Federal Polytechnic, Kaduna	2.31	46.2	2.87	57.4
Federal College of Education, Zaria	2.19	43.8	2.80	56.0
Aggregate scores	2.26	45.2	2.85	57.0

Table 4.8 shows the mean of the level of utilization and satisfaction of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal

College of Education, Zaria. The mean level of utilization and satisfaction of TISHIP among students of Ahmadu Bello University, Zaria, shows that the level of satisfaction is higher than the level of utilization (by -0.72 in favour of satisfaction). The mean level of utilization and satisfaction of TISHIP among students of Federal Polytechnic, Kaduna, shows that the level of satisfaction is higher than the level of utilization (by -0.56 in favour of satisfaction). The mean level of utilization and satisfaction of TISHIP among students of Federal College of Education, Zaria, shows that the level of satisfaction is higher than the level of utilization (by -0.61 in favour of satisfaction).

4.2.2 Null Hypotheses Testing

The variables of awareness, utilization and satisfaction were analyzed using one Sample t test to determine practical significant level of awareness, utilization and satisfaction of TISHIP among student of tertiary institutions in Kaduna State. The three null hypotheses formulated were tested at $p \leq 0.05$.

Null Hypothesis One

There is no significant difference between the level of awareness and expected level of awareness of TISHIP among students of tertiary institutions in Kaduna State.

To test this null hypothesis, an inferential statistic of One Sample t Test was used with expected mean score of 3 as the Test value for level of awareness. The summary of the computation is presented in Table 4.9.

Table 4.9: Summary of One Sample t test on the Level of Awareness of TISHIP

	Test Value 3						
	t	df	Sig (2-tailed)	Mean diff	SEM	95% Confidence interval Of Difference	
						Lower	Upper
AWARENESS	13.9130	399	.0001	-0.740	0.046	-0.7304	-0.5496

**t-test is significant at the 0.05 level (2-tailed).

Table 4.9 shows one sample t test to assess the hypothesis that there is no significant difference between the level of awareness and the expected level of awareness of TISHIP among students of tertiary in institutions in Kaduna State. The analysis is statistically significant (t=13.9130, p= .0001), hence there is no enough evidence to accept the null hypothesis therefore it's rejected. That means there is a significant difference between the level of awareness and the expected level of awareness of TISHIP among students of tertiary in institutions in Kaduna State.

Null Hypothesis Two

There is no significant difference between the level of utilization and expected level of utilization of TISHIP among students of tertiary institutions in Kaduna State.

To test this null hypothesis, an inferential statistic of One Sample t Test was used with expected mean score of 3 signifying the Test Value. The summary of the computation is presented in Table 4.10.

Table 4.10: Summary of One Sample t test on the Level of Utilization of TISHIP

	TestValue 3						
	t	df	Sig (2-tailed)	Mean diff	SEM	95% Confidence interval Of Difference	
						Lower	Upper
UTILIZATION	13.7037	399	.0001	-0.7304	0.054	-0.8462	-0.6338

**t-test is significant at the 0.05 level (2-tailed).

Table 4.9 shows one sample t test to assess the hypothesis that there is no significant difference between the level of utilization and expected level of utilization of TISHIP among student of tertiary in institution in Kaduna State. The analysis is statistically significant (t=13.7037, p= .0001), hence there is no enough evidence to accept the null hypothesis therefore it's rejected. That meansthere is a significant difference between the level of utilization and expected level of utilization of TISHIP among student of tertiary in institution in Kaduna State.

Null Hypothesis Three

There is no significant difference between the level of satisfaction and expected level of satisfaction with TISHIP among students of tertiary institutions in Kaduna State.

To test this null hypothesis, an inferential statistic of One Sample t Test was used with expected mean score of 3 signifying Test Value. The summary of the computation is presented in Table 4.11.

Table 4.11: Summary of One Sample t test on the Level of Satisfaction with TISHIP

	Test Value 3						
	t	Df	Sig (2-tailed)	Mean diff	SEM	95% Confidence interval Of Difference	
						Lower	Upper
SATISFACTION	2.6316	399	.0088	-0.150	.057	-0.2621	-0.0379

**t-test is significant at the 0.05 level (2-tailed).

Table 4.11 shows one sample t test to assess the hypothesis that there is no significant difference between level of satisfaction and expected level of satisfaction with TISHIP among student of tertiary in institution in Kaduna State. The analysis is statistically significant (t=2.6316, p= .0088), hence there is no enough evidence to accept the null hypothesis therefore it's rejected. That meansthere is a significant difference between level of satisfaction and expected level of satisfaction with TISHIP among student of tertiary in institution in Kaduna State.

Null Hypothesis Four

There is no significant difference between the levels of awareness among students of tertiary institutions in Kaduna State based on school type.

To test this null hypothesis, an inferential statistic of analysis of variance was used. The summary of the computation is presented in Table 4.12.

Table 4.12: Summary of analysis of variance on levels of awareness among students based on school type

Statistics	Sum of Squares	F	Df	P
Tukey's test	17.234	0.061[a]	35	0.941
Ahmadu Bello University, Zaria,				
Federal Polytechnic, Kaduna				
Federal College of Education, Zaria				

a. Exact statistic

A one-way ANOVA was calculated to examine the significance difference between the levels of awareness among students of tertiary institutions in Kaduna State based on school type. No significant difference was found (F = 0.061; p=0.941) between the level of awareness among students of tertiary institutions in Kaduna State. The null hypothesis which stated no significant difference was retained. This indicates that there is no significant difference between the level of awareness among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

Null Hypothesis Five

There is no significant difference between the levels of utilization among students of tertiary institutions in Kaduna State based on school type.

To test this null hypothesis, an inferential statistic of analysis of variance was used. The summary of the computation is presented in Table 4.13.

Table 4.13: Summary of analysis of variance on levels of utilization among students based on school type

Statistics	Sum of Squares	F	Df	P
Tukey's test	12.401	0.078[a]	29	0.925
Ahmadu Bello University, Zaria,				
Federal Polytechnic, Kaduna				
Federal College of Education, Zaria				

a. Exact statistic

A one-way ANOVA was calculated to examine the significance difference between the levels of utilization among students of tertiary institutions in Kaduna State based on school type. No significant difference was found (F = 0.078; p=0.925) between the level of utilization among students of tertiary institutions in Kaduna State. The null hypothesis which stated no significant difference was retained. This indicates that there is no significant difference between the level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

Null Hypothesis Six

There is no significant difference between the levels of satisfaction among students of tertiary institutions in Kaduna State based on school type.

To test this null hypothesis, an inferential statistic of analysis of variance was used. The summary of the computation is presented in Table 4.14.

Table 4.14: Summary of analysis of variance on levels of satisfaction among students based on school type

Statistics	Sum of Squares	F	Df	P
Tukey's test	35.751	0.063[a]	53	0.939
Ahmadu Bello University, Zaria,				
Federal Polytechnic, Kaduna				
Federal College of Education, Zaria				

a. Exact statistic

A one-way ANOVA was calculated to examine the significance difference between the levels of satisfaction among students of tertiary institutions in Kaduna State based on school type. No significant difference was found (F = 0.063; p=0.939) between the level of satisfaction among students of tertiary institutions in Kaduna State. The null hypothesis which stated no significant difference was retained. This indicates that there is no significant difference between the level of satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

Null Hypothesis Four

There is no significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria.

To test this null hypothesis, an inferential statistic of t-test was used. The summary of the computation is presented in Table 4.15.

Table 4.15: Summary of t-test on difference between the level of awareness and level of utilization

pair 1	Awareness & Utilization	Values
	Mean	2.25
	Standard deviation	1.549
	Standard Error Mean	0.077
	t-stat	-12.456
	P	0.000**
	Df	399
	N	400

**. t-test is significant at the 0.05 level (2-tailed).

The table 4.12 shows the difference between the level of awareness and level of utilization. From the analysis (t= -12.456; p = 0.000), it shows that there is a significant difference between the level of awareness and level of utilization. The calculated probability value is lower than 0.05 level of significance therefore, the null hypothesis which states that "There is no significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria" is rejected. Hence, it indicated that there is a significant difference between level of awareness and level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

Null Hypothesis Eight

There is no significant difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria

To test this null hypothesis, an inferential statistic of t-test was used. The summary of the computation is presented in Table 4.16.

Table 4.16: Summary of t-test on difference between the level of utilization and level of satisfaction

pair 1	Utilization & Satisfaction	values
	Mean	2.28
	Standard deviation	1.758
	Standard Error Mean	0.088
	t-stat	-7.395
	P	0.000**
	Df	399
	N	400

**. t-test is significant at the 0.05 level (2-tailed).

The table 4.16 shows the difference between the level of utilization and level of satisfaction. From the analysis ($t=-7.395$; $p = 0.000$), it shows that there is a significant difference between the level of utilization and level of satisfaction.The calculated probability value is lower than 0.05 level of significance therefore, the null hypothesis which states that "There is no significant difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria" is rejected. Hence, it indicated that there is a significant difference between level of utilization and level of satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

4.3 Summary of Findings

The summary of findings of the study includes the following:

i. There is a significant difference ($p= 0.0001$) between the level of awareness and expected level of awareness. This indicate that there is statistically significant difference between the level of awareness in this study and expected level of awareness of TISHIP among of tertiary institution in Kaduna State.

ii. There is a significant difference (p= 0.0001) between the level of utilization and expected level of utilization. This indicate that there is statistically significant difference between the level of utilization in this study and expected level ofutilization of TISHIP among of tertiary institution in Kaduna State.

iii. There is a significant difference (p= 0.0088) between the level of satisfaction and expected level of satisfaction. This indicate that there is statistically significant difference between the level of satisfaction in this study and expected level of satisfaction with TISHIP among of tertiary institution in Kaduna State.

iv. There was no significant difference (F = 0.061; p=0.941) between the level of awareness among students of tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the level of awareness among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

v. There was no significant difference (F = 0.078; p= 0.925) between the level of utilization among students of tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

vi. There was no significant difference was found (F = 0.063; p= 0.939) between the level of satisfaction among students of tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the level of

satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

vii. There was significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. It indicated that there is a statistically significant difference ($t=-12.456$; $p = 0.000$) between level of awareness and level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

viii. There was significant difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. It indicated that there is a statistically significant difference ($t=-7.395$; $p = 0.000$) between level of utilization and level of satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

4.4 Discussion of Results

The objective was to assess the level of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State. The study focused on students from three federal tertiary institutions from Kaduna State Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria that have commenced the TISHIP.

For the purpose of data collection, this study adopted questionnaires based on awareness and utilization of TISHIP benefit packages as outlined in the TISHIP operational guideline. The Patient Satisfaction Questionnaire Short-Form (PSQ 18) which is an 18-items questionnaire was used to assess the level of satisfaction of the respondents. PSQ-18 which is a short version of PSQ III tapped the Global satisfaction with medical care as well as the satisfaction with six dimensions of care; technical quality, interpersonal manner, communication, financial aspect of care, time spent with doctor and accessibility of care. Based on the three variables, five hypotheses were formulated for testing. The results are discussed as follows:

This study revealed that the level of awareness of TISHIP benefit package among students of tertiary institutions in Kaduna State is below average, that is, 47.2%. This finding is slightly lower than 50% found in the study by Ndie (2013) who assessed the awareness of National Health Insurance Scheme (NHIS) by civil servants in Enugu and Abakaliki and 60% found by Chikwe (2011) in Imo state and in Ghana by Naseem, Muzamil, Talal and Jacob, (2013). The level of awareness in this study is far less than 87.4% found in Oyo State by Sanusi (2009) and 92% by Andrew *et al*. (2007) on awareness of NHIS in Asaba Delta state. However, the finding is higher than less than 40% found by Mohammed (2008) in the same study area from his study on perceptions of formal-sector employees on the health insurance scheme in Nigeria: The Case study of Ahmadu Bello University Staff, ZariaNigeria. Based on the findings of Andrew *et al*. (2007) and Jolie and Robert (2009), it was revealed that the level of exposure, education and media campaign account for the level of awareness. Although the participants in this study are literate and have post-secondary education however, there is far less publicity and public enlightenment

campaigns by all the stakeholders (NHIS, HMO, Media, healthcare workers, student union, school authorities etc) for TISHIP compare to formal sector NHIS programme for civil servants which was the focus of other studies.

This study revealed that the level of utilization of TISHIP among students of tertiary institutions in Kaduna State is below average, that is, 45.2%. This is slightly lower than level of utilization of the health insurance scheme obtained by Sanusi, (2009), which examined the level of utilization of NHIS in Oyo state, Nigeria and showed that 83.2 percent were registered under the programme but the people who utilize the programme was just 58.9 percent.

Andersen (1995) states that the utilization of National Health Insurance Scheme services varies across different cultures, for a variety of reasons and which determine the level of utilization of the programme. Nora (2005), noted that utilization of National Health Insurance Scheme services is determined not only by its availability but by a number of other factors such as location, distance, accessibility and perception. According to Okafor (2007) in a study carried out in Niger Delta region, the level of utilization was similarly low due to inaccessibility, perception of attention received at healthcare facilities and low level of education in the region which has obviously affected the utilization of health care services by a vast proportion of the beneficiaries who still depend on traditional healthcare and self-medication. Sule*et al.*, (2008) state that utilization of the health care services is affected by a variety of constraints like availability, acceptability, accessibility and affordability. Odebiyi, *et al.*, (2009) also revealed that levels of personal distress are an important trigger in the use of health care services.

In this study, the distance of the healthcare facilities from the various students' hostels and the fact that a good number of students are resident off-campus coupled with the low level of awareness campaign for TISHIP by the stakeholders might account for the low level of utilization by the students. And the perceptions of drugs out of stock, delayed in the turn-out of laboratory results and long awaiting time for consultation with doctors that characterized the school healthcare facilities prior to the TISHIP could have a negative influence on the utilization of TISHIP by students of Tertiary institutions in Kaduna State especially with the low level of awareness among the students.

This study revealed that the level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State is slightly above average, fifty seven percent (57.0%). This is similar to fifty six percent (56%) found by Ofili and Ofovwe (2005) in the study of patients' assessment of efficiency of services at a teaching hospital in a developing country; tried to assess the role of efficiency of services on patients' satisfaction. In contrast, Olatunji, *et al.*, (2008) in assessment of patient's satisfaction indicate that the level of satisfaction is low (below 50%) among the patients that assess the health care from the health insurance scheme. The level of satisfaction in this study is comparable to the findings in most of the studies on patients' satisfaction in the country.

This study furtherrevealed that no significant difference between the levels of awareness among students of different tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the level of awareness among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. This may be due to the fact that the participants across all the three institutions have comparably same level of education and other demographic factor. This

also indicate the generally low level of publicity for TISHIP by the stakeholders (Government agencies, media, NGO etc) with slight better focus on civil servants NHIS programme with different structure, premium, scope, coverage and benefit packages from TISHIP. This finding corroborate the low level of awareness found by Mohammed (2008) in his study in the same study area on perceptions of formal-sector employees on the health insurance scheme in Nigeria as well as the findings of Andrew *et al*. (2007) and Jolie and Robert (2009), which revealed that the level of exposure, education and media campaign account for the level of awareness.

There was no significant difference between the levels of utilization among students of different tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the levels of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. This is likely an indication to the effect of low level of awareness across all the schools and the fact that the students of different tertiary institutions in Kaduna state are similarly affected by other factors militating against the utilization of TISHIP. This finding is in conformity with Nora (2005), which noted that utilization of National Health Insurance Scheme services is determined not only by its availability but by a number of other factors such as location, distance, accessibility and perception. However, differs with Okafor (2007) findings in a study in Niger Delta region, which postulated that low level of utilization was due to inaccessibility and low level of education.

There was no significant difference between the levels of satisfaction among students of tertiary institutions in Kaduna State. This indicates that there is no statistically significant difference between the level of satisfaction among students of Ahmadu Bello University,

Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. This study agrees with Jane *et al.*, (2014) in their study on Patients' Satisfaction and Quality of Care in a Tertiary Institution in Southeast Nigeria reveals that there is no significance difference between patients satisfaction with TISHIP.

There was a significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This means there is actual difference between level of awareness and level of utilization of TISHIP benefit package among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. Therefore, the slightly lower level of utilization compare to awareness in this study may be due to the fact that health services are only utilized when the need arise. The negative perceptions towards the school healthcare facilities because of long waiting time, drug out of stock etc, students with mild illnesses may rather resort to self-medication or present to other private healthcare facilities. The distance of the healthcare facilities to the students' place of residence would definitely affect the accessibility and consequently utilization.

This hypothesis is unique in that there is no study in the literature reviewed that considers the difference between the level of awareness and utilization however, some of the studies (Olatunji, *et al.*, 2008; Sanusi, 2009) concluded that there is a direct correlational relationship between awareness and utilization. And that the higher the level of awareness of health insurance scheme, the high the utilization of the health insurance scheme.

There was significant difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This indicate that there is a difference between level of utilization and level of satisfaction with TISHIP

among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. In this study the level of satisfaction (57%) is higher than the level of utilization (45.2%) possibly because of the robust benefit package of the TISHIP which is a tremendous improvement compare to what was obtainable under the previous school health programme. Tertiary Institution Social Health Insurance Programme (TISHIP) offers the students not only primary healthcare services but secondary and tertiary healthcare services in any NHIS-accredited hospital in the country while the Health Management Organizations (HMOs) settle the bills. TISHIP also make pool of fund available to the school healthcare facilities to solve the problems of inadequate staff, lack of laboratory reagents and drugs out of stock (esp essential drugs). These factors are likely to influence students level of satisfactions which is a measure of perceived performance of the TISHIP (services received) against their expectations**.**

This hypothesis is unique in that there is no study in the literature reviewed that considers the difference between the level of utilization and level of satisfaction however, some of the studies (Jane *et al.*, 2014; Iloh*et al.*, 2013) concluded that there is a direct correlational relationship between utilization and satisfaction. And that higher level of utilization of health insurance scheme, indicates higher level of satisfaction of the health insurance scheme.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This study assessed the level of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State. The study focused on students from three federal tertiary institutions from Kaduna State Ahmadu Bello University, Zaria, Federal Polytechnic,Kaduna and Federal College of Education, Zaria that which have implemented the TISHIP. The data collected were analyzed using the following statistical tools: percentage, mean and standard deviation were used to answer research question 1 to 8. This chapter is presented in the following sub-heading:

5.2 Summary of the Study

5.3 Summary of Major Findings

5.4 Conclusion

5.5 Recommendations

5.6 Limitation of the Study

5.7 Implication of the Study

5.8 Contributions to Knowledge

5.9 Suggestion for Further Studies

5.2 Summary of the Study

This research assesses the level of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State. Assessing the awareness and utilization of TISHIP services of the enrollees and consequently their satisfaction is crucial to assure the continuous attractiveness of the scheme and active participation of students. Based on this, the research looked at some pertinent issues relating to the awareness, utilization and satisfaction of students with regard to TISHIP services. This study covers only full-time students of the Federal Tertiary Institutions in Kaduna State Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

This study discussed the concept of health insurance, history and evolution of national health insurance scheme and Tertiary Institutions Social Health Insurance Programme in Nigeria. The historical background, objectives, functions, purposes, guiding principles, operational strategies and the stakeholders of Tertiary Institutions Social Health Insurance Programme were discussed. Several empirical studies on related healthcare delivery services were reviewed which left the gap in literature that this studied covered. The gap in literature is that, this study focused on the relationship among awareness, utilization and satisfaction of TISHIP among Federal tertiary institutions in Kaduna State. The theoretical framework adopts by this study are the theory of reasoned action and theory of satisfaction. These approaches suggest the ways in which individuals perceive both their internal and external environment (National Health Insurance Scheme - TISHIP) which in turn may influence the nature and level of taking action (awareness, utilization and satisfaction).

The research design that was employed in this study is expost-facto research design. The population of the study 80,555 comprising the total number of students from the three tertiary institutions. In using Yamane's equation to determine the sample size at significance level of 5%, the minimum sample size to be used is 399. The instrument for data collection in this study was adapted questionnaire based on awareness on TISHIP scheme and utilization of TISHIP benefit packages as outlined in the TISHIP operational guideline. The Patient Satisfaction Questionnaire Short-Form (PSQ 18) which is an 18-items questionnaire was used to assess the level of satisfaction of the respondents.

The data obtained from the field which were responses from 400 respondents across the tertiary institutions selected were analyzed using both descriptive and inferential statistical tools. The descriptive statistics that were used are mean and standard deviations to answer the research questions. The inferential statistical analysis used is one sample t test to assess if the level of awareness, utilization and satisfaction are practically significant while analysis of variance (ANOVA) was used to analyze and test hypotheses vi, v and iv and paired t-test was used to determine whether there are significant differences between the level of awareness and level of utilization in hypothesis vii and the level of utilization and level of satisfaction in hypothesis viii respectively. In this study, ANOVA and t test values were determined using the Statistical Package for Social Scientist (SPSS version 22) software. The decision rules that were used to test the hypotheses in this research are to accept the hypothesis if significance is less than 0.05 (i.e p-value < 0.05) at 5% level of significance and reject the hypothesis if significance is greater than 0.05 (i.e p-value > 0.05) at 5% level of significance.

Based on the methodology summarized, the study collected the data, analyzed and presented accordingly upon which the research questions were answered and null hypotheses were tested. The summary of findings and discussions were presented upon which conclusion and recommendations of the study were made.

5.3 Summary of Major Findings

i. There is about forty seven percent (47.2%) level of awareness with ($m=2.36$; $SD=0.92$) in this study. There is a statistical significant difference ($t=2.6316$; $p< 0.05$) between the level of awareness in this study and the assumed significant level of awareness. This indicate that there is no practically significant awareness of TISHIP among of tertiary institution in Kaduna State.

ii. There is about forty five percent (45.2%) level of Utilization with ($m=2.26$; $SD=1.08$) in this study. There is a statistical significant difference ($t=2.6316$; $p< 0.05$) between the level of utilization in this study and the assumed significant level of utilization. This indicate that there is no practically significant utilization of TISHIP among of tertiary institution in Kaduna State.

iii. There is fifty seven percent (57%) level of satisfaction with ($m=2.85$; $SD=1.14$) in this study. There is a statistical significant difference ($t=2.6316$; $p< 0.05$) between the level of satisfaction in this study and the assumed significant satisfaction. This indicate that there is no practically significant satisfaction with TISHIP among of tertiary institution in Kaduna State.

iv. There was no significant difference ($F = 0.061$; $p > 0.05$) between the level of awareness among students of tertiary institutions in Kaduna State. This

indicates that the differences observed in the level of awareness among Ahmadu BelloUniversity, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are likely not real but due to chance.

v. There was no significant difference ($F = 0.078$; $p > 0.05$) between the level of utilization among students of tertiary institutions in Kaduna State. This indicates that differences observed in the level of utilization among Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are likely not real but due to chance.

vi. There was no significant difference was found ($F = 0.063$; $p > 0.05$) between the level of satisfaction among students of tertiary institutions in Kaduna State. This indicates that differences observed in the level of satisfaction among Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are likely not real but due to chance.

vii. There was significant difference ($t=-12.456$; $p = 0.000$) between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This indicated that it’s unlikely the differences observed between level of awareness and level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are due to chances.

viii. There was significant difference ($t=-7.395$; $p = 0.000$) between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This indicated that it’s unlikely the

differences between level of utilization and satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and FederalCollege of Education, Zaria are due to chances.

5.4Conclusion

Based on the findings of this study, the following conclusions were drawn:

i. There is a significant difference between the levels of awareness, utilization and satisfaction in this study and the expected level of awareness, utilization and satisfaction. This indicate that the level of awareness, utilization and satisfaction in this study is lower than the expected level of awareness, utilization and satisfaction with TISHIP among of tertiary institution in Kaduna State.

ii. There is no difference between the levels of awareness among students of tertiary institutions in Kaduna State. This indicates that the students of the tertiary institutions, that is, Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are likely exposed to similar environment and circumstances in respect to the health activities within their institutions. And this study posits that such levels of awareness is relatively low as less that 50% of the students are aware of the TISHIP in their institutions.

iii. The levels of utilization among students of tertiary institutions in Kaduna State are similar which means that there is no significant difference between the level of utilization among Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. This study submits that less

than half of the students agree that they utilize the TISHIP as provided by their institutions which could be due to their level of awareness of the programme.

iv. This study revealed that no significant difference was found between the level of satisfaction among students of tertiary institutions in Kaduna State. This indicates that there is no significant difference between the level of satisfaction among Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria. And this study concludes that such level of satisfaction is quite low even among those students who still utilize TISHIP in their institutions.

iv. This study shows that there significant difference between the level of awareness and level of utilization of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This indicate the level of awareness and level of utilization among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are not at per. The level of awareness is lower than the level of utilization which means that some students are aware of TISHIP but don’t utilize the programme for some reasons.

v. The study shows that there difference between the level of utilization and level of satisfaction of TISHIP among students of tertiary institutions in Kaduna State, Nigeria. This affirms that the level of utilization and satisfaction among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria are not the same. Based on this, it can be deduced that some students still utilize the TISHIP even though they are not satisfied.

5.5 Recommendations

This study that assessed the level of awareness, utilization and satisfaction with Tertiary Institutions Social Health Insurance Programme (TISHIP) among students of tertiary institutions in Kaduna State has the following recommendations:

i. School authorities should create health education and health promotion desk office in the central administrative block with officers in all the student hostels to implement health education and health promotion strategies, interventions and programmes on campus.

ii. Government and other stakeholders such as HMOs, and tertiary institutions should sensitize and create awareness about the TISHIP programmes through public programmes such as lectures, symposiums and seminars to increase its awareness level. The institutions should also improve the awareness through school websites, social media and students' portals which they visit regular for registration, and updates.

iii. The HMOs and health care providers in conjunction with the tertiary institutions should enforce compliance of the students to the utilization of the programmes by ensuring that no medical reports or conditions is accepted or treated formal without due recognition or acknowledgement from the TISHIP health care service providers within the institutions. In addition, the students should be

encourage to use the health facilities within their institution by providing easy access to the facilities.

iv. Government through the tertiary institutions health service providers should ensure that the HMOs are providing the required facilities to prompt the satisfactions of the students. Also, the institutions should ensure that the personnel in the facilities that providers the services within the institutions are supervised and motivated to carry out their responsibilities.

v. The difference in the level of awareness and utilization should be closed by the health service providers and HMOs by ensuring that all students who are aware of the TISHIP as provided are guided properly to using the facilities through convictions and persuasion.

vi. The difference in the level of utilization and satisfaction should be closed by the health service providers and HMOs by ensuring that all students treated promptly and effectively by providing quality health service delivery and removing all obstacles to achieving that such delay, lack of hospitality management and conducive facilities.

5.6 Limitation of the Study

Student may have found that the statement on the survey did not resonate with their own perspectives and unique self-beliefs, or students may have found some survey items difficult to interpret. In addition, self-report data entails the risk that students may not have answered items honestly therefore resulting in some of them rating themselves lower than

their utilization and satisfaction while some rating themselves higher that their utilization and satisfaction.

5.7 Implication of the Study

This study has implication for policy formulation, advice and instructions. School may attempt to offer every advantage possible to students; however unless students become fully aware of TISHIP that would foster students utilization of the scheme, these attempt could prove futile. Health maintenance organizations and other stakeholders need to maintain awareness of power of positive emotions that range from high energy, enthusiasm and excitement, to efficiency and effectiveness. These are very important to the education process as the drive attention and consequently learning and memory.

Also, the health care providers should also note that the satisfaction of service delivery by the students is very important not only for performing well in their academics but also to be able to survive and compete. Institutions should make provision for materials that can stimulate students' awareness, utilization and satisfaction of TISHIP within the institutions. Similarly, stakeholders within the institutions need to maintain awareness of the power of understanding for their students. Verbal persuasion, seminars, symposium, lectures among others are important source of awareness of the health insurance scheme.

Policy makers in schools, curriculum planners and parents should also be aware of these findings so that they can advise the students appropriately to utilize this scheme while in schools.

5.8 Contribution to Knowledge

This study has contributed to knowledge in the following ways:

i. It was established that the level of awareness, utilization and satisfaction among students of tertiary institutions in Kaduna State were not practically significant.

ii. It was established that there is no significant difference in the level of awareness of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

iii. The study established that there is no significant difference in the level of utilization of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

iv. It was established that there is no significance difference in level of satisfaction of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

v. The study showed that the level of awareness is higher than the level of utilization of TISHIP among students of Ahmadu Bello University, Zaria, Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

vi. The study established that the level of satisfaction is higher than the level of utilization of TISHIP among students of Ahmadu Bello University, Zaria,Federal Polytechnic, Kaduna and Federal College of Education, Zaria.

vii. It had added to the existing literature.

viii. The other researches on awareness, utilization and satisfaction are mainly on public services and health care centres while this is on tertiary education.

5.9 Suggestions for Further Study

Based on the findings of this research, the following suggestions were offered for further studies;

i. Since the sample respondents were drawn from some selected tertiary institutions in Kaduna State, Nigeria, the effect found may mainly reflect the situation on the state.

   Hence, the findings may not be representative of all tertiary institutions in Nigeria. Thus, this study needs to be replicated in other parts of Nigeria in order to get a better general picture of the whole country. This will facilitate better decision making as regards relationship among awareness, utilization and satisfaction of TISHIP in tertiary institutions in Nigeria.

ii. Similar study in other tertiary institutions that are not federal institutions to be carried out. Institutions such as state government and private tertiary institutions.

iii. Since this study was done using undergraduates and postgraduate students in the university similar studies could be replicated using pre-degree and sub-degree students.

iv. Similar study maybe carried to evaluate for the factors responsible for the differences in the level of awareness and utilization on one side and level of utilization and satisfaction of TISHIP among students of tertiary institutions in Kaduna State.

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APPENDIX I

Questionnaire

Section A: Socio-demographic data of the respondents

Instruction; in this section, you are expected to tick(√) the option that is applicable to you.

1. **Sex:**

a. Male ( )

b. Female ( )

2. Age group

a. Under 16 years ( )

b.16 – 20 years ( )

c.21 – 25 years ( )

d.26 – 30 years ( )

e. 31 years and above ( ) **3.**

Name of your institution

a. Ahmadu Bello University Zaria ( )

b. Kaduna Polytechnics, Kaduna ( )

c. Federal College of Education, Zaria ( )

4. Your level of study

ABU- a. 100L ( ) b. 200L ( ) c. 300L ( ) d. 400L ( ) e. 500L ( ) f. 600l ( ) h. 700L ( ) g. 800L ( )
KADPOLY- a. Introductory level ( ) b. ND1 ( ) c. ND2 ( ) d. HND1 ( ) e. HND2 ( )
FCE- a. Pre-NCE ( ) b. NCE1 ( ) c. NCE2 ( )

5. Types of Accommodation

a. On campus ( )

b. Off Campus ( )

6. Marital Status

a. Married ( )

b. Single ( )

c. Divorced ( )

d. Widow ( )

SECTIONB: Awareness of NHIS-Tertiary Institution Social Health Insurance programme (TISHIP)

Instruction; Please tick (√) as appropriate

7. Are you aware of Tertiary Institution social Health Insurance programme (TISHIP) of NHIS in your institution? Yes ( ) No ( )

8.If you are, what is/are your source(s) of information?

a. Print Media (Newspaper, Magazine) ( )

b. Audio-visual (TV, Radio) ( )

c. Social Media (facebook, twitter, whatsApp, sms) ( )

d. Internet (Your institution website, NHIS website) ( )

e. Seminar/Presentation/awareness programme in your institution ( )

f. Friends/Schoolmates ( )

g. Staff of your institution health centre ( )

NOTE: Strongly Agree = SA
Agree = A
Uncertain = U
Disagree = D
Strongly disagree = SD

S/N	You are aware of availability of the following benefit packages in TISHIP	SA	A	U	D	SD
9.	Consultation, treatment and prescribed drugs by primary care physicians					
10.	Health promotion and prevention services					
11.	Consultation and treatment by various specialists					
12.	Surgical operation					
13.	Treatment for chronic diseases except Cancers and HIV					
14.	Laboratory investigations					
15.	Accident and emergency care in any NHIS accredited centre (even outside your residential area)					

16.	Antenatal and delivery care for pregnant female students					
17.	Twelve (12) weeks of postnatal (Neonatal) care for babies delivered by female students (maximum of two (2) live births)					
18.	Free hospital admission (maximum of 15 days cumulative per year)					
19.	Dental care services					
20.	Blood transfusion services					

Adapted from: Operational Guidelines for implementation of Tertiary Institution Social Health Insurance Programme April 2014.

SECTIONC: Utilization of NHIS-Tertiary Institution Social Health Insurance Programme

Instruction: Please tick (√)as appropriate, your level of utilization of various healthcare services under TISHIP in the last six (6) months.

NOTE: Never = N
Rarely = R
Occasionally = O
Frequently = F
Very Frequently = VF

S/N	Variables	N	R	O	F	VF
21.	Have you accessed healthcare under TISHIP?					
22.	Have you accessed referral for specialist care?					
23.	Have you collected drugs prescribed for you under NHISTISHIP without any payment?					
24.	Have you had hospital admission under NHIS-TISHIP without payment (for maximum of 15 days)?					
25.	Have you complained to appropriate authority when you feel dissatisfied with treatment?					
26.	Have you attended any health-related seminar/enlightenment programme under NHIS-TISHIP?					
27.	Have you accessed dental care services?					
28.	Have you sought for explanation from your health care provider when you don't understand a procedure?					
29.	Have you read NHIS-TISHIP pamphlets (e.g. frequently asked questions on NHIS-TISHIP) to update your knowledge of NHIS-TISHIP					
30.	Have you had investigations done under NHIS-TISHIP without any payment?					

Adapted from: Agu, M.A (2012) Knowledge, Attitude and Practice of National Health Insurance Scheme (NHIS) by Federal Civil Servants (FCSs) in Abuja Municipal Area Council (AMAC) Federal Capital Territory (FCT). SECTION D: Satisfaction with NHIS-TISHIP

Instruction: Please tick (√) as appropriate
NOTE:SA = Strongly Agree

A = Agree

U= Uncertain

D= Disagree

SD = Strongly Disagree

S/N	Variables	SA	A	U	D	SD
31.	Doctors are good at explaining reason for medical tests					
32.	Your doctor office has everything required to provide medical care					
33.	The medical care I have been receiving is just about perfect					
34.	Sometimes doctors make me wonder if their diagnosis is correct					
35.	I feel confident that I can get the medical care I need without been set back financially					
36.	When I go for medical care, they are careful to check everything when treating and examining me					
37.	I have to pay for more of my medical care than I can afford					
38.	I have easy access to the medical specialist I need					
39.	Where I get medical care, people have to wait too long for emergency treatment					
40.	Doctors are too businesslike and impersonal towards me					
41.	My doctors treat me in a very friendly and courteous manner					
42.	Those who provide my medical care often hurry too much when they treat me					
43.	Doctors sometimes ignore what I tell them					
44.	I have some doubts about the ability of doctors who treat me					
45.	Doctors usually spend long time with me					
46.	I find it hard to get medical appointment right away					
47.	I am dissatisfied with somethings about the medical care I receive					
48.	I am able to get medical care whenever I need it					

Adopted from: **Short form of Patient Satisfaction Questionnaire (PSQ-18)**

Appendix II

Names of Institution and Awareness of TISHIP

Names of Institutions

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Ahmadu Bello University, Zaria	203	50.8	50.8	50.8
	Kaduna Polytechnics, Kaduna	74	18.5	18.5	69.3
	Federal College of Education, Zaria	123	30.8	30.8	100.0
	Total	400	100.0	100.0	

Aware of TISHI P

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	133	33.3	33.3	33.3
	no	267	66.8	66.8	100.0
	Total	400	100.0	100.0	

Appendix III

Analysis of Hypothesis One

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT AWARENESS
  /METHOD=ENTER VAR00009 VAR00010 VAR00011 VAR00012 VAR00013 VAR00014
VAR00015 VAR00016 VAR00017 VAR00018 VAR00019 VAR00020.
```

ANOVA

Awareness

	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	.063	2	.032	.061	.941
Within Groups	17.171	33	.520		
Total	17.234	35			

Multiple Comparisons

Dependent Variable: Awareness

Tukey HSD

(I) Variables	(J) Variables	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper B ound
Kadpoly	FCE	.08750	.29448	.953	-.6351	.8101
	ABU	-.00250	.29448	1.000	-.7251	.7201
FCE	Kadpoly	-.08750	.29448	.953	-.8101	.6351
	ABU	-.09000	.29448	.950	-.8126	.6326
ABU	Kadpoly	.00250	.29448	1.000	-.7201	.7251
	FCE	.09000	.29448	.950	-.6326	.8126

Appendix IV

Analysis of Hypothesis Two

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT UTILIZATION
  /METHOD=ENTER VAR00021 VAR00022 VAR00023 VAR00024 VAR00025 VAR00026
VAR00027 VAR00028 VAR00029 VAR00030.
```

ANOVA

Utilization

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.071	2	.036	.078	.925
Within Groups	12.330	27	.457		
Total	12.401	29			

(I) Variables	(J) Variables	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval Lower Bound	Upper Bound
Kadpoly	FCE	.11600	.30222	.922	-.6333	.8653
	ABU	.03400	.30222	.993	-.7153	.7833
FCE	Kadpoly	-.11600	.30222	.922	-.8653	.6333
	ABU	-.08200	.30222	.960	-.8313	.6673
ABU	Kadpoly	-.03400	.30222	.993	-.7833	.7153
	FCE	.08200	.30222	.960	-.6673	.8313

Appendix V

Analysis of Hypothesis Three

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT SATISFACTION
  /METHOD=ENTER VAR00031 VAR00032 VAR00033 VAR00034 VAR00035 VAR00036
VAR00037 VAR00038 VAR00039 VAR00040 VAR00041 VAR00042 VAR00043 VAR00044
VAR00045 VAR00046 VAR00047 VAR00048.
```

ANOVA

Satisfaction

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	.088	2	.044	.063	.939
Within Groups	35.663	51	.699		
Total	35.751	53			

Multiple Comparisons

Dependent Variable: Satisfaction

Tukey HSD

(I) Variables	(J) Variables	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Kadpoly	FCE	.06833	.27874	.967	-.6045	.7412
	ABU	-.02778	.27874	.995	-.7007	.6451
FCE	Kadpoly	-.06833	.27874	.967	-.7412	.6045
	ABU	-.09611	.27874	.937	-.7690	.5768
ABU	Kadpoly	.02778	.27874	.995	-.6451	.7007
	FCE	.09611	.27874	.937	-.5768	.7690

APPENDIX VI

Analysis of Hypothesis Four and Five

```
REGRESSION
  /MISSING LISTWISE
  /STATISTICS COEFF OUTS R ANOVA
  /CRITERIA=PIN(.05) POUT(.10)
  /NOORIGIN
  /DEPENDENT KADPOLY, FCE, ABU
  /METHOD=ENTER AWARENESS,UTILIZATION SATISFACTION ANOVA
```

		Sum of Squares	Df	Mean Square	F	Sig.
KADPOLY	Between Groups	2.679	2	1.340	2.942	.065
	Within Groups	16.847	37	.455		
	Total	19.526	39			
FCE	Between Groups	3.046	2	1.523	2.347	.110
	Within Groups	24.013	37	.649		
	Total	27.059	39			
ABU	Between Groups	3.163	2	1.581	2.407	.104
	Within Groups	24.304	37	.657		
	Total	27.467	39			

Multiple Comp arisons

Tukey HSD

Dependent Variable	(I) Variables	(J) Variables	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
KADPOLY	Awareness	Utilization	.07617	.28893	.962	-.6292	.7816
		Satisfaction	-.48250	.25148	.148	-1.0965	.1315
	utilization	Awareness	-.07617	.28893	.962	-.7816	.6292
		Satisfaction	-.55867	.26614	.104	-1.2084	.0911
	satisfaction	Awareness	.48250	.25148	.148	-.1315	1.0965
		Utilization	.55867	.26614	.104	-.0911	1.2084
FCE	Awareness	Utilization	.10467	.34494	.951	-.7375	.9468
		Satisfaction	-.50167	.30023	.230	-1.2347	.2313

	utilization	Awareness	-.10467	.34494	.951	-.9468	.7375
		Satisfaction	-.60633	.31773	.151	-1.3821	.1694
	satisfaction	Awareness	.50167	.30023	.230	-.2313	1.2347

		Utilization	.60633	.31773	.151	-.1694	1.3821
ABU	Awareness	Utilization	.11267	.34703	.944	-.7346	.9599
		Satisfaction	-.50778	.30205	.226	-1.2452	.2297
	utilization	Awareness	-.11267	.34703	.944	-.9599	.7346
		Satisfaction	-.62044	.31966	.142	-1.4009	.1600
	satisfaction	Awareness	.50778	.30205	.226	-.2297	1.2452
		Utilization	.62044	.31966	.142	-.1600	1.4009

T-Test Analysis for Hypotheses Four and Five

```
T-TEST PAIRS=VAR00009 WITH VAR00021
(PAIRED)    /CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.

[DataSet1]          C:\Users\user\Documents\
TISHIP.sav
```

Paired Samples Statistics

	Mean	N	Std. Deviation			Std. Error Mean
Pair 1		Awareness	1.64	400	.649	.032
	Utilization	2.61	400	1.600		.080

Paired Samples Correlations

	N	Correlation			Sig.
Pair 1		Awareness & Utilization	400	.280	.000

	Paired Differences					t	df	Sig. (2tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair Awareness - 1 Utilization	-.965	1.549	.077	-1.117	-.813	-12.459	399	.000

```
T-TEST PAIRS=VAR00009 WITH VAR00021 (PAIRED)
/CRITERIA=CI(.9500)
  /MISSING=ANALYSIS.
```

[DataSet1] C:\Users\user\Documents\TISHIP.sav

Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Satisfaction	1.96	400	1.213	.061
	Utilization	2.61	400	1.600	.080

Paired Samples Correlations

	N	Correlation	Sig.
Pair 1 Satisfaction & Utilization	400	.243	.000

Paired Samples Test

	Paired Differences					t	df	Sig. (2tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
				Lower	Upper			
Pair 1 Satisfaction - Utilization	-.650	1.758	.088	-.823	-.477	-7.395	399	.000

Appendix VII

Descriptive Statistics of KADPOLY Awareness, Utilization and Satisfaction

Kadpoly Descriptive Statistics (Awareness)

	N	Mean	Std. Deviation
Awareness	74	1.68	.813
Q10	74	2.15	.932
Q11	74	2.23	1.211
Q12	74	2.58	.907
Q13	74	2.57	.742
Q14	74	2.54	1.482
Q15	74	2.01	1.027
Q16	74	1.96	1.254
Q17	74	2.03	1.216
Q18	74	3.47	1.149
Q19	74	1.65	.818
Q20	74	3.74	1.061
Mean		2.384167	1.051
Valid N (listwise)	74		

KADPOLY Descriptive Statistics (Utilization)

	N	Mean	Std. Deviation
Utilization	74	2.73	1.754
Q22	74	1.22	.815
Q23	74	1.57	.795
Q24	74	3.14	1.286
Q25	74	2.15	.989
Q26	74	2.11	1.041
Q27	74	2.73	1.317
Q28	74	2.22	.940
Q29	74	2.05	.920
Q30	74	3.16	1.239
Mean		2.308	1.1096
Valid N	74		

(listwise)

KADPOLY Descriptive Statistics (Satisfaction)

	N	Mean	Std. Deviation
Satisfaction	74	1.88	1.303
Q32	74	3.39	1.226
Q33	74	3.39	1.083
Q34	74	2.19	1.496
Q35	74	2.15	.871
Q36	74	2.26	1.061
Q37	74	3.74	1.086
Q38	74	3.34	1.037
Q39	74	2.49	1.337
Q40	74	2.96	1.379
Q41	74	2.28	1.092
Q42	74	2.38	1.246
Q43	74	2.22	1.397
Q44	74	2.76	1.479
Q45	74	3.80	.979
Q46	74	3.00	1.414
Q47	74	2.88	1.552
Q48	74	4.49	.954
Mean		2.866667	1.221778
Valid N (listwise)	74		

Appendix VIII

Descriptive Statistics of FCE Awareness, Utilization and Satisfaction

FCE Descriptive Statistics (Awareness)

	N	Mean	Std. Deviation
Awareness	123	1.59	.556
Q10	123	1.80	.398
Q11	123	2.14	1.140
Q12	123	2.49	.872
Q13	123	2.50	.549
Q14	123	2.50	1.393
Q15	123	2.22	1.052
Q16	123	1.61	.826
Q17	123	1.80	1.261
Q18	123	4.00	.000
Q19	123	1.44	.629
Q20	123	3.47	1.027
Mean		2.296667	0.808583
Valid N (listwise)	123		

FCE Descriptive Statistics (Utilization)

	N	Mean	Std. Deviation
Utilization	123	2.65	1.547
Q22	123	1.30	.923
Q23	123	1.56	.780
Q24	123	3.10	1.308
Q25	123	2.06	.917
Q26	123	1.70	.932
Q27	123	2.88	1.316
Q28	123	2.04	.900
Q29	123	1.56	.560
Q30	123	3.07	1.095
Mean		2.192	1.0278
Valid N (listwise)	123		

Appendix IX

Descriptive Statistics of ABU Awareness, Utilization and Satisfaction

ABU Descriptive Statistics (Utilization)

	N	Mean	Std. Deviation
Utilization	203	2.53	1.577
Q22	203	1.56	1.305
Q23	203	1.43	.526
Q24	203	3.27	1.323
Q25	203	2.11	.878
Q26	203	1.95	1.054
Q27	203	2.87	1.431
Q28	203	1.94	.926
Q29	203	1.67	.657
Q30	203	3.41	1.269
Mean		2.274	1.0946
Valid N (listwise)	203		

ABU Descriptive Statistics (Awareness)

	N	Mean	Std. Deviation
Awareness	203	1.66	.637
Q10	203	1.85	.361
Q11	203	2.56	1.313
Q12	203	2.72	1.091
Q13	203	2.48	.501
Q14	203	2.27	1.421
Q15	203	2.34	1.266
Q16	203	1.58	.831
Q17	203	2.31	1.640
Q18	203	3.99	.211
Q19	203	1.53	.616
Q20	203	3.35	.976
Mean		2.386667	0.905333
Valid N (listwise)	203		

ABU Descriptive Statistics (Satisfaction)

	N	Mean	Std. Deviation

Satisfaction	203	2.00	1.150
Q32	203	3.57	1.024
Q33	203	3.87	.848
Q34	203	1.52	.982
Q35	203	1.74	.679
Q36	203	2.05	1.049
Q37	203	4.05	.869
Q38	203	3.34	1.098
Q39	203	2.78	1.397
Q40	203	2.19	.932
Q41	203	1.99	.678
Q42	203	2.53	1.542
Q43	203	2.32	1.431
Q44	203	3.00	1.530
Q45	203	4.08	.786
Q46	203	3.48	1.453
Q47	203	3.07	1.449
Q48	203	4.52	.823
Mean		2.894444	1.095556
Valid N (listwise)	203		