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Original Article

Tertiary Institutions' Social Health Insurance Program: Awareness, Knowledge, and Utilization for Dental Treatment Among Students of a Nigerian University

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Abstract

Background: Awareness and knowledge can play key roles in influencing the utilization of health insurance programs in Nigeria. **Objectives:** This study aims to investigate the awareness and use of the Tertiary Institutions/ Voluntary Participant Social Health Insurance Program (TISHIP) for undergraduate dental services. **Materials and Methods:** A cross-sectional descriptive study was conducted in the Enugu Campus of the University of Nigeria and the study population comprised full-time undergraduate students of the institution with a total sample size of 400. **Results:** Majority (66.7%) of the respondents were aware of the TISHIP, but 37% were aware that it covered dental treatments, and 16.1% had received dental treatment under TISHIP. Fifty point eight percent (50.8%) of the respondents were not registered under the insurance program. The reason respondents had not registered was because majority (49.7%) were not aware of the compulsory registration into the scheme. Respondents agreed that TISHIP would promote equity in healthcare delivery (57.5%), promote improved health facilities (39.4%), and 52.5% were willing to participate in the scheme while 47.9% were undecided on whether TISHIP was worth the financial contribution. Presumed high cost of dental treatment (51.9%) and non-availability of materials for dental treatment at dental facilities (50.8%) were factors that affected the utilization of TISHIP ($P < 0.05$). **Conclusion:** Despite the positive effect of TISHIP in cushioning the cost of dental care, utilization is poor, thus there is a need to scale up awareness among the students' population.

Keywords: *National Health Insurance Scheme (NHIS), Nigeria, students, Tertiary Institutions Participant Social Health Insurance Program (TISHIP)*

Introduction

Reducing financial hardship while accessing health care is at the heart of Universal Health Coverage. With sustainable health insurance packages, difficulties that come with paying for health care should be addressed. This should maximally benefit low-income groups and dependents, such as students. In Nigeria, there are provisions for health insurance for different population groups and a diverse range of health services, such as dental care. The National Health

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Insurance Scheme (NHIS) of Nigeria, which was launched in 2005, seeks to ensure that diverse groups of Nigerian citizens benefit from health insurance for various health services, of which dental care is the focus in this paper.[1-3] However, there have been cases of suboptimal knowledge and utilization with regard to the use of Tertiary Institutions/Voluntary Participant Social Health Insurance Program (TISHIP).

The TISHIP is a social security system designed to take care of the health needs of students of Nigerian tertiary institutions who were not able to benefit from the original NHIS model.[4] The program promotes the health of students to support uninterrupted academic activities due to poor health.[5] Students who are enrolled in TISHIP can access healthcare services at the medical center of their institution or, in cases of emergencies, can access care at the nearest NHIS-accredited facility.[6] Despite the services offered by the TISHIP and their relevance in optimizing dental care services for students, low utilization continues to be a problem.[7]

Nobles *et al.*[8] in their study of a public college in Virginia, USA examined the college students' ability to use health insurance effectively or their literacy of the subject. They found that 80% of students could not determine their cost-sharing for the two presented scenarios. Approximately half of the students expressed confusion about their health insurance plan, with one-quarter of students stopping or delaying medical care due to the same reason. Another study, which was done in a college in India, sought to examine the students' awareness level of health insurance. They found that the majority (72%) of the students were aware of the scheme and 33.2% were aware that benefits included emergency care; however, utilization was still low.[9]

Awareness and knowledge can play key roles in influencing the utilization of health insurance programs in Nigeria. For instance, a study conducted in southeast Nigeria[10] found that the majority of students (65%) knew about the existence of TISHIP with students of the faculties of medical and health sciences being more aware of the program than students of other faculties. The students were aware of the services covered by the program and where they could access the services but were unaware that the mode of contribution to the scheme was through their school fees. Another study[5] found that students showed a high level of awareness of TISHIP; however, most of them had never benefitted from the scheme.[10]

Sule[11] found that factors such as the poor implementation of TISHIP, poor awareness, and mobilization of students for TISHIP, poor communication between the TISHIP management committee and student populations influenced the utilization of the scheme. The students' awareness and knowledge of the existence of healthcare providers enrolled in the scheme, utilization, and acceptance are quite crucial in guaranteeing the success of TISHIP.[12] Most students are not aware of the TISHIP program and those who are sensitized still doubt the authenticity of the program, thus limiting their participation in the program. Studies[4,5,13] have also shown that in any given institution, not every student in the institution is covered by the program. For example, a study done in Ahmadu Bello University Nigeria[13] discovered that the TISHIP program initially started with only coverage of regular undergraduate students, before subsequent expansion to cover all diploma, postgraduate, and non-degree students in the institution. To raise funds for the TISHIP, most institutions incorporate the premium into the students' school fees and make it available to the TISHIP providers of the institution.[4,5]

Dental treatment places an enormous financial burden on both the students and their parents and/or guardians. The utilization of the TISHIP program would lessen this burden; however, the poor utilization of TISHIP to access dental care among tertiary students prompted the need to assess the awareness and knowledge of TISHIP for dental care among undergraduate students in tertiary institutions and factors that affect enrollment and the use of TISHIP. The findings from this study will inform better awareness creation strategies to improve utilization of TISHIP among students for dental care and thus increase universal access to equitable health care. This aim of the study was to investigate the awareness and use of the TISHIP for undergraduate dental services.

Materials and Methods

This study was conducted in the University of Nigeria, Enugu Campus (UNEC). UNEC is a satellite campus of the University of Nigeria Nsukka, situated in Enugu city and comprises of six faculties, namely: Faculties of Dentistry, Medical Sciences, Health Sciences and Technology, Business Administration, Law, and Environmental Studies. UNEC has an undergraduate student population of about 6000 students (2016). The general age distribution of the undergraduate students in UNEC lies between 16 and 35 years.[14]

This was a cross-sectional descriptive study using a quantitative research method. An estimated sample size of 360 was calculated for the study {using formula' $n = Z^2 \frac{pq}{d^2}$ }.[15] However, to capture non-responders, the sample size was increased to 400. A multistage

sampling technique was used for this study. In the first stage, the respondents were separated into strata using their course of the study. The students were sampled in six strata comprising six randomly selected departments in the six respective faculties in UNEC. The appropriate number of students were assigned to each stratum based on sample size calculation: 46 students to medicine and surgery; 26 to dentistry; 54 to law; 94 to business administration; 94 students to health sciences; and 86 students to Environmental health. A sampling ratio of 0.0666 was multiplied by the total number of students in each department to obtain the appropriate number of students from each of the departments.

Data collection

The data were collected using semi-structured self-administered questionnaires, and the content of study instruments was validated by two experts in the field. The questionnaire was used to elicit the awareness, knowledge, attitude, and utilization of TISHIP among undergraduate students of UNEC for dental treatment. Awareness and knowledge were elicited using a 3-point Likert scale graded as Yes, No, and don't know.

Reliability of instrument

Forty questionnaires (10% of the total questionnaires) were pretested on two population groups outside the study area with characteristic features similar to the main study respondents. Results obtained were seen to be similar to each other.

Data analysis

Data were analyzed using SPSS version 22 and presented as tables and narratives.

Ethical considerations

All respondents gave informed consent before the interviews were conducted. The respondents were given full information about the study and were given an opportunity to ask questions before signing the consent form. Consequently, the interviewee's consent to participate in the study was demonstrated by signing the consent form. In addition to the consent form, ethical clearance for the study was obtained from the Ethical Review Board of the University of Nigeria Teaching Hospital, Enugu, Nigeria.

Results

Table 1 shows that a total of 400 questionnaires were distributed: 339 were filled correctly giving a response rate of about 84.8%.

Awareness and perception of TISHIP

Table 2 shows that the majority (66.7%) of the respondents were aware of TISHIP; only 16.1% had received dental treatment under TISHIP. On questions regarding the perception of TSHIP, results show that 50.2% of the respondents did not know that the TISHIP is a Social Health Insurance scheme. Also, 51.9% of respondents did not know that the TISHIP was for students in the university, whereas 61.8% did not know it was for both undergraduates and postgraduate students.

Table 1: Sociodemographic characteristics of respondents

Variable	Frequency (%)
Age	
15–19	30 (8.8)
20–24	245 (72.3)
25–29	60 (17.7)
30–34	4 (1.2)
Gender	
Male	167 (49.3)
Female	172 (50.7)
Faculty	
Medicine	40 (11.8)
Dentistry	23 (6.8)
Health Sciences and Technology	79 (23.3)
Law	45 (13.3)
Environmental Sciences	79 (23.3)
Business Administration	73 (21.5)
Total	339 (100)

Table 3 shows that the majority of the respondents (69.7% and 75%) knew that dental treatment could be obtained from the university medical center and teaching hospitals, respectively. However, 59.3% did not know if treatment could be obtained from specialist hospitals. The table also shows that 35.1% of the respondents knew that TISHIP was funded by contributions from the government and the student enrollees. However, 23.3% had no idea how the scheme was funded.

Services rendered under TISHIP

Table 4 shows that a greater percentage of the respondents believed that outpatient care (56.4%), pharmaceutical care and diagnostic testing (65.7%), general and specialist consultation (55%), minor surgeries (52.1%) all fall under TISHIP. However, only 30.1% knew that TISHIP covers dental services such as extractions and tooth restorations.

Table 5 shows that 50.8% of the respondents were not registered under the insurance program. A majority of the respondents (75%) were not willing to pay to access the services not rendered under the scheme. It also showed that the reason respondents had not registered was that majority (49.7%) were not aware of the compulsory registration into the scheme.

Table 2: Respondents' awareness and perception of TISHIP

Awareness of TISHIP			
Variables	**Yes, *F* (%)**	**No, *F* (%)**	**Total, *F* (%)**
Knowledge of TISHIP	224 (66.7)	112 (33.3)	339 (100)
Knowledge of dental care as a package in TISHIP	120 (37.0)	204 (63.0)	339 (100)
If yes, have you received any dental treatment under TISHIP scheme	33 (16.1)	172 (83.1)	339 (100)

Perception of TISHIP				
Variables	**Yes, *F* (%)**	**No, *F* (%)**	**I don't know, *F* (%)**	**Total, *F* (%)**
Perception of TISHIP as a Social Health Insurance Program	136 (44.9)	15 (5.0)	152 (50.2)	339 (100)
Is it a program under the National Health Insurance Scheme?	220 (70.5)	9 (2.9)	83 (26.6)	339 (100)
Is it for students in the universities only?	73 (23.4)	77 (24.7)	162 (51.9)	339 (100)
Are both undergraduate and postgraduate students inclusive?	84 (27.5)	33 (10.8)	189 (61.8)	339 (100)
It is for all students in tertiary institutions only?	116 (37.5)	24 (7.8)	169 (54.7)	339 (100)
Is it open to both part-time and regular students in tertiary institutions?	67 (22.1)	15 (5.0)	221 (72.9)	339 (100)
TISHIP covers only a narrow range of dental services	87 (28.4)	19 (6.2)	200 (65.4)	339 (100)

Table 3: Respondents' knowledge of dental treatment centers and sources of funding for TISHIP

Knowledge of where dental treatment can be accessed				
Health institution	**Yes, *F* (%)**	**No, *F* (%)**	**I don't know, *F* (%)**	**Total, *F* (%)**
University medical center	214 (69.7)	34 (11.1)	59 (19.2)	339 (100)
Any health center	51 (16.9)	141 (46.7)	110 (36.4)	339 (100)
General hospitals	110 (35.7)	94 (30.5)	104 (33.8)	339 (100)
Teaching hospitals	234 (75.0)	9 (2.9)	69 (22.1)	339 (100)
Specialist hospitals	82 (27.2)	41 (13.6)	179 (59.3)	339 (100)

Knowledge of sources of funding for TISHIP		
Contributors	**Frequency**	**Percentage**
Only the students	15	5.4
Students and the university	43	15.4
Students and the government	98	35.1
The government	18	6.5
The university and the government	40	14.3
No idea	65	23.3
Total	**339**	**100**

Table 4: Respondents' knowledge of dental services rendered under TISHIP

Services rendered	Yes, *F* (%)	No, *F* (%)	I don't know, *F* (%)	Total, *F* (%)
Outpatient care and necessary consumables	172 (56.4)	18 (5.9)	115 (37.7)	339 (100)
Prescribe drugs, pharmaceutical care, and diagnostic testing	209 (65.7)	22 (6.9)	87 (27.4)	339 (100)
Consultation with a range of specialists	170 (55.0)	19 (6.1)	120 (38.8)	339 (100)
Hospital care in a standard ward for a total of 21 days per year	33 (10.8)	29 (9.5)	244 (79.7)	339 (100)
Dental care, e.g., tooth restorations and extractions	92 (30.1)	22 (7.2)	192 (62.7)	339 (100)
Emergency care for accident cases (e.g., jaw and facial fractures)	73 (23.4)	88 (28.2)	151 (48.4)	339 (100)
Health education	136 (44.0)	77 (24.9)	96 (31.1)	339 (100)
Major surgeries (e.g., tumor resection)	37 (12.2)	134 (44.2)	132 (43.6)	339 (100)
Minor surgeries (e.g., apicectomy, extractions)	164 (52.1)	21 (6.7)	130 (41.3)	339 (100)
Radiological services	83 (26.3)	97 (30.8)	135 (42.9)	339 (100)

Table 6 shows that a greater percentage of respondents agreed that TISHIP would reduce the burden of the dental bill (33.3%), promote equity in healthcare delivery (57.5%), and promote improved health facilities (39.4%); they were willing to participate in the scheme (52.5%). However, 47.9% of the respondents are undecided on whether TISHIP is worth the financial contribution.

Factors affecting utilization of TISHIP for dental treatment

Table 7 showed that the high cost of dental treatment, availability of dental materials at the dental clinic,

Table 5: Respondents' registration status and their willingness to access services rendered under TISHIP

Registration status	Yes, *F* (%)	No, *F* (%)	Total, *F* (%)
Registered for TSHIP	161 (49.2%)	166 (50.8%)	339 (100%)
Respondents' willingness to pay to access services not rendered under TISHIP	71 (24.6%)	218 (75%)	339 (100%)
Reasons for non-registration			
Reasons		**Frequency**	**Percentage**
Lack of registration knowledge		83	49.6
Lack of need for dental services/care		45	27.6
Registration takes too long		3	1.8
Lack of time to go and register		19	11.4
Total		**166**	**100**

Table 6: Attitude of respondents toward using TISHIP for dental treatment

Attitude	Strongly disagree, *F* (%)	Disagree, *F* (%)	I don't know, *F* (%)	Agree, *F* (%)	Strongly agree, *F* (%)	Total, *F* (%)
TISHIP reduces the burden of dental bills	18 (5.6)	19 (5.9)	97 (30.2)	107 (33.3)	80 (24.9)	339 (100)
TISHIP will promote equity in healthcare delivery	15 (4.7)	16 (5.0)	50 (15.7)	183 (57.50	54 (17.0)	339 (100)
TISHIP will promote improved utilization of health facilities	15 (4.8)	37 (11.9)	78 (25.0)	123 (39.4)	59 (18.9)	339 (100)
Willingness to participate in the scheme	23 (7.2)	17 (5.3)	54 (17.0)	178 (52.5)	46 (14.5)	339 (100)
Adverse consequences associated with the scheme	48 (15.1)	84 (26.4)	152 (47.8)	28 (8.8)	6 (1.9)	339 (100)
Importance of the program	9 (2.8)	19 (6.0)	44 (13.8)	177 (55.7)	69 (20.4)	339 (100)
TISHIP is worth the financial contribution	13 (4.1)	15 (4.8)	151 (47.9)	92 (27.1)	44 (14.0)	339 (100)
TISHIP should be discontinued	100 (31.4)	140 (44.0)	53 (16.7)	15 (4.7)	10 (3.1)	339 (100)

Table 7: Factors that affect respondents' utilization of TISHIP for dental treatment

Factors	Strongly disagree, *F* (%)	Disagree, *F* (%)	I don't know, *F* (%)	Agree, *F* (%)	Strongly agree, *F* (%)	Total, *F* (%)	X^2 (*P*-value)
Poor access roads to the medical center	41 (12.7)	103 (31.8)	87 (26.9)	77 (23.80)	16 (4.9)	339 (100)	1.218 (0.269)
Poor transportation network to medical center	44 (13.6)	104 (32.1)	80 (24.7)	80 (24.7)	16 (4.9)	339 (100)	0.001 (0.974)
Long waiting time at the dental clinic	27 (8.3)	38 (11.7)	98 (30.2)	108 (33.3)	53 (16.4)	339 (100)	3.974 (0.041)
Bad attitude of dental staff	26 (8.0)	94 (29.0)	29 (9.0)	103 (31.8)	72 (22.2)	339 (100)	0.001 (0.974)
Poor communication skills of dental staff	12 (3.7)	141 (43.9)	38 (11.8)	74 (23.1)	56 (17.4)	339 (100)	0.172 (0.678)
Radiological investigations not covered by the scheme	19 (5.9)	32 (10.0)	199 (62.2)	42 (13.1)	28 (8.8)	339 (100)	2.081 (0.149)
Minor oral surgeries not covered by the scheme	20 (6.2)	47 (14.6)	183 (57.0)	52 (16.2)	19 (5.9)	339 (100)	0.734 (0.391)
Major oral surgeries not covered by the scheme	13 (4.0)	23 (7.2)	183 (57.0)	77 (24.0)	25 (7.8)	339 (100)	1.928 (0.164)
Drugs covered do not meet all the healthcare needs	12 (3.7)	79 (24.6)	110 (34.3)	87 (27.1)	33 (10.3)	339 (100)	3.676 (0.055)
High additional costs required for services not covered	13 (4.0)	26 (8.0)	144 (44.4)	96 (29.6)	45 (13.9)	339 (100)	2.901 (0.088)
Availability of modern facilities/equipment	26 (8.3)	48 (15.4)	91 (29.2)	117 (37.5)	30 (9.6)	339 (100)	8.561 (0.003)
High cost of dental care	10 (3.1)	52 (16.4)	36 (11.3)	165 (51.9)	55 (17.3)	339 (100)	5.021 (0.025)
Availability of dental materials at the dental clinic	13 (4.0)	40 (12.5)	40 (12.5)	163 (50.8)	65 (20.2)	339 (100)	4.341 (0.024)

and availability of modern equipment influence the utilization of TISHIP ($P < 0.05$).

Discussion

This study showed that awareness of TISHIP by undergraduate students was poor. A majority of the respondents claimed to be aware of the existence of TISHIP; however, this awareness can be questioned and rather seen as just having heard of the program. This is because among those who claimed awareness of TISHIP, the majority of them had no idea that it covered dental treatment or only a narrow range of dental services. More than half of them were not aware that it is a social health insurance program or that it is for students who have already been enrolled in the university. Most of the respondents were not aware that the program covered both undergraduate and postgraduate students, although they all claimed keen knowledge of the program under NHIS. This is contrary to the findings of Anetoh *et al.*[5] in Awka and Malgwi *et al.*[13] in Zaria, Nigeria, who found a high level of awareness among their study respondents.

Respondents' level of knowledge of TISHIP was poor, and results showed that they believed that treatment under TISHIP could only be accessed at the university's medical center and teaching hospitals. Respondent's knowledge was tested further by trying to find out what they knew about the sources of funding under TISHIP. The TISHIP is funded primarily through a mandatory premium contribution from students.[6] However, this could imply that students do not read the documentation relating to their admission or registration in school, or do not fully understand the implications of what they are reading. In addition to having little or no knowledge of TSSHIP, which can be seen as a flaw in communication and advocacy, the students do not look out for it in their school documents.

Other sources of funds, as stipulated in the operational guidelines of the NHIS, are charitable or philanthropic organizations, corporate social responsibility initiatives, government mandates, and subsidies.[6] However, findings showed that less than half of the respondents knew this and considered students alone as the primary contributors. This could imply that the students and their guardians were unsure or not knowledgeable of the other primary contributors and thus contribute in ignorance.

A test of the respondents' knowledge of the services under TISHIP showed that most students believed that outpatient care and medical consumables, pharmaceutical care, diagnostic testing, consultation, and minor surgeries were the only type of services covered by the TISHIP program but did not consider that dental care, health education, and emergency care for accidents were also under the scheme. This inadvertently shows their limited knowledge of TISHIP, and it is contrary to the results of a study by Anetoh *et al.*,[5] who found knowledge of TISHIP to be high among their study subjects. The knowledge of the Social Health Insurance program and its benefits as provided by any country is a key driver in accessing healthcare services such as TISHIP.[13] Thus, it can be implied that this poor knowledge of TISHIP from the study respondents negatively impacts on utilization of the program.

Findings from this study showed that more than half of the respondents did not register for TISHIP mainly because they had no idea that they had to register or had no use for it. Our study findings also showed that the factors that affect utilization of TISHIP for dental treatment were poor awareness, poor knowledge, high cost of dental treatment, long waiting time, and non-availability of dental materials at the dental clinic. Though the results showed the high cost of dental care as one of the leading reasons for low utilization of care, observations show that low awareness and knowledge of TSSHIP is key, because, with knowledge of this program, the high cost of dental care will be reduced. A similar study by Sule[11] found that factors that challenged the implementation of TISHIP were the failure of the student union government to educate its membership on the benefits and modalities of the Scheme, low-level participation of the university in mobilizing students for TISHIP, and a poor communication network between TISHIP Management Committee and the student population. Our findings are a further indication that awareness and knowledge are important/major factors affecting the utilization of TISHIP for dental treatment.

Conclusion

The level of awareness and knowledge of the students in this study regarding the use of TISHIP for dental treatment is very low. However, as they have shown their willingness to participate in the program in the future, their attitude toward it can be explained as positive.

Factors affecting the use of TISHIP for dental treatment are lack of awareness, low knowledge, high cost of dental treatment, long waiting time, and lack of availability of dental materials in the dental office. However, poor awareness and knowledge of TISHIP for dental treatment can be an important factor influencing usage.

As a recommendation, multicenter studies looking into the utilization of TISHIP in UNEC may enable the NHIS to re-evaluate the proper implementation of this program to maximally benefit students of tertiary institutions in Nigeria.

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Conflicts of interest

No conflict of interest.

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