Article

Healthcare Delivery and Efficiency of Osun State Health Insurance Scheme (OHIS): A Case of Osogbo Local Government Area of Osun State, Nigeria

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Abstract
Osun Health Insurance Scheme (OHIS) is the initiative of Osun State government to provide healthcare needs for the residents of the state. This was borne out of the crises in the health sector, ranging from personnel shortage, financial challenge, unaffordability, and infrastructural decay across the country. It became imperative for government to intervene in order to reverse the ugly trend. The study examined the success and challenges of OHIS scheme in Osogbo Local Government Area of Osun State, investigated awareness of residents, examined the impact of the scheme, assessed its success and investigated the challenges facing it. The study leaned on the theoretical foundation of Health Access Model (HAM) of Ronald Anderson. Primary and secondary sources of inquiry were employed to generate data. The primary data were drawn from semi-structured questionnaires and key informant interviews. Secondary data were sourced from OHIS records, government health policy documents, and previous studies on health insurance schemes in Nigeria. Only 280 respondents were purposively sampled. This consists of participants in formal and informal sectors. Hypotheses were tested with the aid of chi-square and regression analysis. Qualitative data were generated with 20 Key Interviews (KIIs), officials of OHIS, 20 In-depth interviews (IDIs), and officials of accredited health facilities in Osogbo. Qualitative data generated were content analysed. Findings revealed that formal sector workers access the scheme more than their counterparts in the informal sector. Beneficiaries were confident in the scheme. The study concluded that despite the success of the scheme, accessibility and affordability hindered its optimal performance. The study, therefore, recommended that OHIS be transformed into a more effective, comprehensive, and sustainable health insurance scheme that meet the needs of all residents. More funding, attracting more healthcare professionals, creating more awareness and providing ideal work conditions are central to the sustainability and improvement of the scheme.

Keywords
Accessibility, challenges, healthcare, insurance, scheme

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Introduction

Healthcare delivery in Nigeria has witnessed gross inefficiency in the recent history, despite its significance in national development (Balogun, 2022). The United Nations Organisation through World Health Organisation prioritized healthcare as the third goal of Sustainable Development Goals. The need for inclusive and equitable healthcare systems is germane in countries around the World (HiAP, 2013). Abah (2022) noted that healthcare system in Nigeria ranked poorly as a result of systemic inefficiency hence Nigeria ranked 187th out of 191 sampled countries (WHO, 2000). Alawode and Adewole (2021) observed that 54.1% of Nigerians have access to healthcare as the ratio of doctor to patient is 1:9083 against the recommended 1:600 by the World Health Organisation. Shortage of medical personnel, inadequate/obsolete equipment, counterfeit drugs, insecurity of lives, poor infrastructure (electricity, transportation, transportation etc), poor salary structure (including hazard allowances), poor funding of healthcare facilities and resultantly periodic and incessant strikes of health workers bedevil health service in Nigeria.

In response to these myriad challenges, the federal government introduced the National Health Insurance Scheme through NHIS act 2004 and amended in 2022. The scheme provided for universal health coverage for citizens in formal sector, self–employed (and four biological children) and the elderly (Obalum, 2012). Beneficiaries are to pay 10% for drugs. The scheme has attracted over twenty million citizens[1]. Asakitikpi (2016) stressed that the policy aimed to extend coverage and reduce out-of-pocket spendings of patients. However, implementation has fallen short, especially in informal sectors. The bureaucracy and location of facilities became factors of inaccessibility.

In a similar vein, Osun state introduced Osun State Health Insurance Scheme (OHIS) in 2018 with the aims of addressing the healthcare deficit in the state through creating a predictable healthcare financing model, minimise out-of-pocket expenses, and expand access in the state. The state partnered with 432 heath facilities and 332 primary healthcare centres across the state. Available record shows that 150,000 enrolled for the scheme[2]. This study aimed at investigating how OHIS has been able to achieve the set objectives of the scheme.

Challenges of healthcare delivery in Nigeria have attracted literature but there has been limited focus on localized performance evaluations (Hafez, 2018). Bamidele and Adebimpe (2012) noted in their study of artisans in Osun State that awareness, attitudes and willingness constituted banes to accessibility to healthcare delivery. Esan *et al*. (2020) in their study of Imesi – Ile community in Osun state discovered that unwillingness to pay and participate in health insurance scheme constituted hindrance to functionality of

[1](https://www.nhia.gov.ng/about-us/Accessed March 3rd 2025
[2](https://www.oshia.ng/(Accessed March 3rd 2025)

health policies. This study however investigated healthcare delivery and challenges of accessibility in Osun State Health Insurance Scheme (OHIS) by residents of Osogbo town.

The study investigated the conditions inhibiting access of residents of Osogbo to Osun State Health Insurance Scheme by interrogating the scope, challenges, level of awareness, affordability, availability and cultural beliefs on the scheme.

Literature Review

Healthcare delivery in Nigeria runs through the three tiers of primary, secondary and tertiary healthcare providers. While the Local Government authorities handle primary healthcare at the local level through local clinics and dispensaries. The facilities are meant to care for immediate health needs of the people on simple and common infirmity. Balogun (2022), while identifying the political and economic reforms needed to achieve the much-needed universal quality healthcare system noted that the objective of these facilities has been largely defeated by government as a result of neglect and poor funding, sometimes. Eneji *et al*. (2013) aligned with his position by stressing that the tier has suffered from chronic neglect. As a result of the cold attitude of government and other critical stakeholders in the sector, the poor and vulnerable – particularly women and children – continue to die from preventable conditions such as infectious diseases, and pregnancy-related complications (Gulliford *et al*., 2020).

Despite having a seemingly well-structured framework, the Nigerian health system is plagued by corruption, poor governance, fake and counterfeit drugs and inefficient performance, especially at the grassroot level. Balogun (2022) underscores that the while the core goals of the system are to preserve lives and ensure a healthy environment, institutional failures have always been a brick wall. The challenges within Nigeria's healthcare system are closely tied to the intergovernmental structure of the sector (Idris *et al*., 2024). Primary healthcare service is managed by local councils to serve as immediate respondents to minor sicknesses. Secondary and tertiary care institutions are managed by the state and federal governments respectively with focus on curative services and receive patient referrals from lower levels. These divisions shape how responsibilities and resources are distributed across the system. In the evidence of demographic health survey in sub – Sahara Africa, Ahinkorah *et al*. (2021) noted that data on healthcare facility distribution reflect both the scale and fragmentation of the system. According to them, out of the country's health facilities: Local governments manage 7,580 hospitals (44.4%), Private sector controls 7,373 hospitals (43.2%), State governments

manage 1,385 hospitals (8.1%), religious institutions operate 330 hospitals (1.93%), Communities run 249 hospitals (1.5%), while Federal government owns just 151 hospitals (0.9%). In all these, the bulk of the ownership of healthcare facilities is in the hands of the private owners. This suggests the low level of government commitment to health care in Nigeria.

These statistics highlight the dominant role of local governments and private providers. However, the credibility of these figures is uncertain. The PharmAccess Foundation (2015) reported that many facilities, particularly private ones, were unregistered. For instance, in a 2014 study across six states (Abia, Benue, Edo, Kaduna, Lagos, and Nasarawa), 32% of private facilities were not registered, and 53% of facilities listed by government records could not be independently verified, reflecting severe administrative gaps and misconduct. In total, the number of hospitals has been variably reported, with Nwakeze and Kandala (2011) estimating 17,038 hospitals nationwide, unevenly distributed across Nigeria's 36 states.

The NHIS was legally established under Decree 35 of 1999 and formally launched on June 6, 2005, with the objective of improving access to affordable and quality healthcare, particularly for formal sector workers. Health is presented not only as a personal or public good but as a strategic economic asset – essential for national development. A healthy population is a productive population, and thus, health financing is recognised as a core investment in human capital. In Nigeria, healthcare is funded through a mix of tax revenue, out-of-pocket payments, donor contributions, and insurance schemes, although overall health spending remains low relative to other African countries.

The NHIS model is rooted in the principle of risk pooling and resource circulation, where healthy individuals contribute to a shared fund that can be drawn upon by those in need of care (Champion and Skinner, 2008). The scheme operates as a pre-payment system, jointly funded by employers and employees, allowing workers to access medical care without making large payments at the point of service. This model not only spreads the risk but also seeks to minimize out-of-pocket payments and safeguard households from financial hardship during medical emergencies.

Upon implementation, the scheme recorded some achievements, including the issuance of over 4 million identity cards and the registration of 62 Health Maintenance Organizations (HMOs), with[3] many more applications under review. The benefit packages under NHIS are described as comprehensive, covering essential services such as consultation, medications, consumables, and minor surgeries[4].

Despite its promising design, Adebisi *et al*. (2019) noted that the scheme faced several chronic challenges, including:

- Poor funding and low enrollment figures (only around 5 million Nigerians enrolled).

[3](https://www.nhia.gov.ng/about-us/(Accessed March 3rd 2025)

[4](https://www.nhia.gov.ng/about-us/(Accessed March 3rd 2025)

- Weak institutional governance and limited public trust.
- The exclusion of the informal sector and rural populations from meaningful participation.

To address these gaps, Nigeria pursued a number of reform strategies such as State Social Health Insurance Scheme (SSHIS) and Basic Health Care Provision Fund (BHCPF), introduced under the 2014 National Health Act, to provide foundational financing support and ensure broader access to primary healthcare services across the country. These reforms aimed to create a more adaptable, inclusive, and responsive insurance structure by fostering state-level ownership and improving local relevance (Adebisi *et al*., 2019).

The Osun Health Insurance Scheme (OHIS) is a strategic initiative by the Osun State Government to improve healthcare accessibility, affordability, and quality for its residents (Adeolu, 2023). Osun State, comprising 30 Local Government Areas (LGAs) with a population of approximately 5.1 million people (as of 2019), provides healthcare across three levels of care: 845 primary, 57 secondary, and 2 tertiary health facilities. OHIS was established in 2018 following its passage by the 7th Osun State House of Assembly on October 30, 2018, and was signed into law by Governor Rauf Adesoji Aregbesola. The scheme was created to bridge critical gaps in healthcare financing and service delivery, particularly for vulnerable and underserved populations. Its design emphasizes flexibility, affordability, and wide coverage, and it has since grown to include over 150,000 enrollees, not counting an additional 111,698 individuals on the social register who are undergoing validation (https://osha.ng/).

Beneficiaries span a broad demographic: civil servants, private sector workers, students (under the Tertiary Student Health Insurance Programme – T-SHIP), and the vulnerable. OHIS maintains a broad network of partnerships with 432 healthcare facilities across the state, including: 332 focal primary healthcare centers, 17 public hospitals (notably the University of Osun Teaching Hospital, formerly LAUTECH), and numerous accredited private hospitals.

The scheme's core mission is to provide effective, equitable, and high-quality healthcare services, ensuring that residents do not suffer financial hardship due to medical expenses. OHIS is guided by the acronym EQUITY, which encapsulates the values of Efficiency, Quintessence, Uniqueness, Integrity, Transparency, and Empathy. Also, the enrollment options are structured to encourage participation: Individual plan (₦12,066 annually) and Family plan (₦57,600 per year, for up to six members). These packages entitle enrollees to access both public and private accredited facilities, with services that include consultations, treatments, and medications, ensuring a

comprehensive and flexible coverage model. The scheme has also prioritized social welfare policies, exemplified by the November 2023 enrollment of 23,000 pensioners at no cost, spearheaded by Governor Ademola Adeleke. This reflects the administration's commitment to cushioning the financial burden on senior citizens and promoting equitable access to essential healthcare services.

Healthcare financing in Nigeria refers to the flow and management of financial resources used to provide healthcare services (Moshood *et al*., 2022). It involves mobilizing funds from patients, government, donors, and other stakeholders to support the delivery of medical care. According to Chang *et al*. (2019), financing patterns significantly influence how healthcare services are structured and delivered. However, financing in Nigeria is not just about raising money—it must also guarantee accessibility, affordability, and financial protection for all citizens. Aregbesola and Khan (2018) notes that financing analysis is often complex, particularly when funding is directed to specific areas like immunization, malaria control, or sanitation. The complexity increases when competing household needs limit people's ability to pay for healthcare.

To reduce catastrophic health spending, Nigeria has adopted risk-pooling mechanisms like the National Health Insurance Scheme (NHIS) to move closer to Universal Health Coverage (UHC) (Alawode & Adewole, 2021). However, implementation remains narrow, benefiting mostly federal civil servants—less than 5% of the workforce. Even after nine years of its launch, only a few states had adopted the NHIS, highlighting a slow decentralization process (Esan *et al.*, 2020).

Healthcare funding in Nigeria mainly comes from:

1. Pooled sources: government budget allocations, taxation, and donor aid.
2. Unpooled sources: out-of-pocket (OOP) payments, user fees, and service charges.

OOP payments account for over 70% of healthcare expenditures, making Nigeria's health financing system inequitable and unstable. Despite the large informal sector, the government struggles to collect taxes or contributions from it due to weak revenue systems and mistrust in tax administration.

Moreover, Nigeria's total health expenditure is low even by African standards. For instance, between 1998 and 2000, only 5% of GDP was allocated to health, lagging behind countries like Malawi, Kenya, Zambia, Tanzania, and South Africa. The situation is worsened by poor access to revenues from the informal economy and systemic inefficiencies in public financial management (Kim & Lane, 2013). Globally, disparities in access to health insurance and services are shaped by socio-economic and institutional factors. In such contexts, out-of-pocket (OOP) payments are a major barrier to healthcare access. Insurance coverage reduces OOPs and promotes higher

service utilization (Levesque *et al*., 2013). In countries like the United States and Germany, high insurance penetration has led to better access to preventive services (e.g., vaccinations, cancer screening).

Nigeria, however, remains far behind. With a population exceeding 200 million, only 5% to 10% citizens are insured, mainly under the NHIS and concentrated in urban areas and the formal sector. The informal sector, which represents a significant part of the economy, remains largely uninsured. Consequently, over 70% of healthcare expenses are paid directly by households, often pushing them into poverty. Without the insurance policies, many Nigerians are left with catastrophic expenses, reinforcing inequalities in service utilization and healthcare outcomes.

Theoretical Framework

The theoretical foundation of this study is anchored on the Healthcare Access Model (HCM) developed by Ronald M. Andersen in 1995.The model asserted that access to health services is influenced by three core factors: predisposing characteristics, enabling resources, and need factors (both perceived and actual medical needs). Marmot (2005) noted that the predisposing factors are existing characteristics before illness that shapes tendency to seek care. These are demographics (age, gender) social structure (education, employment) and health beliefs. Enabling factors are resources that make healthcare possible (income, insurance, transportation). The need factors are the immediate cause of utilizing healthcare facilities (symptoms) and evaluated need (diagnosis). Despite its broad use, the model has limitations. Critics argue it is too linear and static, failing to capture the complex and dynamic nature of healthcare access. Others like Figueroa *et al.* (2019) contend that it overlooks systemic issues, such as institutional bias and socio-political inequality. Still, the model remains valuable for its clarity and structure. The HCM is especially relevant to this study because it aligns with the goals of OHIS – minimizing financial barriers (enabling resources), evaluating enrollee demographics (predisposing factors), and assessing user needs and experiences. It offers a multidimensional lens through which OHIS accessibility and effectiveness in Osogbo can be evaluated.

Research Methodology

This study was carried out in Osogbo Local Government Area, the capital of Osun State, selected for its administrative importance and population diversity. These factors made it ideal for assessing the accessibility challenges of OHIS, as the area includes a wide range of potential beneficiaries across public,

private, and informal sectors. A reconnaissance survey was conducted prior to the main study to observe how OHIS operates in practice – particularly in terms of service delivery and the enrollment process. This early fieldwork informed the structure of the research instruments. The study population included OHIS enrollees (from public, private, and self-employed sectors), Non-enrollees, OHIS administrative officials, and Accredited healthcare providers.

A sample size of 280 respondents was determined and drawn using a multi-stage sampling technique:
Stage 1: Stratified respondents into key categories (enrollees, non-enrollees, OHIS officials, and providers).
Stage 2: Further divided enrollees based on employment sectors.
Stage 3: Used purposive sampling to select officials and service providers involved in OHIS.
Stage 4: Applied random sampling to select non-enrollees across various Osogbo communities.

The data collection process included both primary and secondary sources. The primary sources are semi-structured questionnaires and interviews with stakeholders to understand demographic details, awareness levels, usage patterns, and perceived challenges. The secondary sources are official OHIS documents, policy records, and previous research to provide context and support data interpretation. The data were analysed using descriptive statistics (frequencies, percentages, means) to summarize patterns and inferential statistics (chi-square tests and regression analysis) to test the study's hypothesis regarding OHIS's impact on healthcare accessibility. Similarly, the qualitative data were analysed through content analysis.

Findings

Table 1: Socio-Demographic Characteristics of Respondents

Demographic Variable	Frequency (n = 280)	Percentage (%)
Gender		
Male	160	57.1%
Female	120	42.9%
Age Group		
18 – 25 years	45	16.1%
26 – 35 years	90	32.1%
36 – 45 years	75	26.8%
46 – 55 years	50	17.9%
56 and above	20	7.1%
Marital Status		
Single	80	28.6%
Married	160	57.1%
Divorced	25	8.9%

Demographic Variable	Frequency (n = 280)	Percentage (%)
Widowed	15	5.4%
Educational Qualification		
No formal education	10	3.6%
Primary school	35	12.5%
Secondary school	100	35.7%
Tertiary education	135	48.2%
Employment Status		
Employed (Public Sector)	80	28.6%
Employed (Private Sector)	50	17.9%
Self-employed	70	25.0%
Unemployed	80	28.6%
Income Level (Monthly)		
Below ₦20,000	60	21.4%
₦20,000 – ₦50,000	90	32.1%
₦51,000 – ₦100,000	80	28.6%
Above ₦100,000	50	17.9%
Are you an enrollee of OHIS?		
Yes	180	64.3%
No	100	35.7%
If yes, how long have you been enrolled?		
Less than 1 year	40	22.2%
1 – 3 years	75	41.7%
4 – 6 years	45	25.0%
More than 6 years	20	11.1%
Do you have any other form of health insurance apart from OHIS?		
Yes	50	17.9%
No	230	82.1%
What is your primary source of healthcare?		
OHIS-accredited facilities	140	50.0%
Private hospitals	80	28.6%
Traditional medicine	30	10.7%
Self-medication	30	10.7%

Scope of Osun Health Insurance Scheme

OHIS was introduced to shield residents – especially those in low-earning jobs – from the financial burden of healthcare. OHIS outreach is restricted mainly to major cities like Osogbo, Ilesha, and Ife and Ede, where there are government offices with little penetration into rural areas. The scheme covers

various health services including malaria treatment, child delivery, surgeries, reproductive health, family planning, and immunization, but excludes conditions like pre-existing illnesses and congenital disorders. Disease coverage is shaped by policy design, premium structure, and provider networks. According to a participant:

> People in major towns enjoy OHIS scheme better that the rural people. When there is health challenge, rural people would have to come to town to seek treatment. There is also a problem of shortage or unavailability of healthcare facilities in a number of rural areas. This may be due to the fact that some rural people have more confidence in traditional medicine that is within their vicinities. *(KII/Health officer/Osogbo/2025)*

In the view of another participant:

> The scheme is good but too expensive. I believe government should make healthcare free for all citizens. I really do not believe in paying money to government when I am not sick. I would pay based on services rendered and drugs purchased, not making payment blindly. I even understand that a lot of time, they do not give expensive drugs, they ask patient to buy it outside the facilities. *(KII/Citizen/Osogbo/2025)*

Among the 280 respondents, 57.1% are male, 42.9% female. Men's higher participation may be linked to their presence in formal employment. Also, most respondents fall between 26–35 years (32.1%) and 36–45 years (26.8%), indicating working-age adults are more engaged with OHIS. Only 57.1% are married, suggesting that family responsibilities drive insurance enrollment. 48.2% have tertiary education, showing a strong correlation between education and insurance uptake. 28.6% are public servants, 25.0% self-employed, and 28.6% unemployed. Essential part of what Andersen (1995) asserted as conditions to access healthcare is also the scope of the facility especially as it affects the nature of ailments covered.

Affordability

The high unemployment rate raises concerns about affordability and access to OHIS. However, 32.1% earn ₦20,000–₦50,000, while 21.4% earn below ₦20,000, indicating that many enrollees fall into low-income categories where cost is a major barrier. Affordability may not necessarily lack of money but the inherent disbelieve in the financial pooling system whereby the rich would protect the weak. A participant asserted thus:

> I can't pay 50k per annum for a service that I may not enjoy. It is like robbing Peter to pay Paul. What if nobody in my family falls sick? I would rather pay for service when I am in need. *(IDI/artisan/Osogbo/2025)*

Another participant expressed thus:

> It is wrong for government to ask us to pay for health service. Most of us are very poor in this state. We can barely feed ourselves and provide decent lives for ourselves and children. Only the rich can afford quality health and education service. What exactly are we benefitting from government? The cost of living is high and there are no good jobs for us and our children that have graduated. We are in a poor state. The money they ask us to pay for OHIS is enough to start some businesses here in Osogbo. I cannot afford OHIS bill and so I patronize herbal and Islamic medicine and I get good results. *(IDI/artisan/Osogbo/2025)*

Awareness of OHIS Scheme

Findings show that awareness of OHIS is limited, even among public and private sector workers. Many only become aware of the scheme when prompted by employers, and knowledge about the scheme's scope, benefits, and coverage remains low, unlike South Africa's NHI, where media and community campaigns increased awareness. A participant asserted thus:

> Most people do not really know about OHIS. The radio jingle is perhaps the only means of advertising it whereas people at the grassroot do not own or listen to radio. People rely more on Yoruba movies to cushion the effects of hardship than listening to news that always bring bad news that would worsen the mental health of the people in the harsh economy that we face. *(KII/community leader/Osogbo/2025)*

The most highly rated challenge is low public awareness, with 71.5% of respondents acknowledging a lack of information about the scheme. This suggests that even with OHIS in place, many residents may not understand the

scheme's benefits, procedures, or coverage scope. Onoka *et al.* (2013) also highlighted inadequate awareness as a critical obstacle to insurance uptake in Nigeria. This underscores the need for targeted public education campaigns, community-based sensitization, and better visibility across all local government areas.

According to Andersen (1995) in his Health Access Model (HAM), enabling resources and predisposing factors are germane. Those not covered by the scheme was not by the policy of the scheme but rural people may not likely key into it due to lack of financial resources and information. Yusuf *et al*. (2019) stressed the need the knowledge of health insurance by the generality of the citizens for it to succeed.

Users' Satisfaction of OHIS Scheme

Some of the key challenges facing OHIS are affordability (many citizens, especially families, find the premiums difficult to sustain), accessibility (employment status, rural location, and income level limit many residents' ability to enroll or access services) and mixed consumer experiences (while some enrollees are satisfied, others report issues such as delayed claim processing, limited coverage for mental health, and problems with pre-authorization).

In terms of medical staffing, 62.5% of respondents believe OHIS facilities have sufficient personnel. However, a significant minority remains uncertain or dissatisfied, implying that while staffing levels may meet minimum standards, they may not be adequate to ensure prompt and comprehensive care. Service quality under OHIS receives high approval, with 73.2% of respondents stating that the scheme provides access to good-quality healthcare. However, a minority of respondents expressed dissatisfaction, indicating that the quality of service delivery may vary by facility or location. Punch online attributed shortage of health personnel to the labour migration syndrome otherwise called *japa* in Nigeria.[5]

A central goal of OHIS is to enhance accessibility and expand universal healthcare coverage across Osun State. The study findings show a largely positive perception: 71.5% of the respondents believe that OHIS has improved healthcare accessibility in Osogbo. This aligns with Adeolu (2023), who stress that health insurance significantly reduces financial burdens and ensures quicker access to care. Affordability, a key component of accessibility, was also positively rated by 66.1% of respondents. This indicates that for many enrollees, OHIS premiums and service costs are within reach. However, data from the demographic section show that a large portion of respondents fall into low-income brackets, suggesting that affordability remains relative. For unemployed or informal sector workers, the current cost structure may still be

[5]https://punchng.com/doctor-patient-ratio-worsening-over-japa-nma-laments/). Accessed April 15, 2025)

a barrier. Aregbeshola and Khan (2018) argue that while subsidies help, many poor residents require additional financial support mechanisms to encourage enrollment.

In terms of waiting time and delays, a higher percentage of respondents agreed that enrollees receive healthcare services without unnecessary delays. However, the existence of neutral and negative responses indicates that delays still occur, particularly when accessing specialist care. One of the more concerning findings relates to ***rural access***. Only 53.5% respondents agree that OHIS is easily accessible to rural residents and this highlights significant geographical disparities in coverage, confirming Omoleke and Taleat (2017)'s assertion that rural areas often lack sufficient accredited facilities and face infrastructural limitations. These gaps prevent OHIS from achieving true universal coverage and call for targeted policy interventions, such as establishing more rural clinics and improving transportation links to care. ***Emergency care access*** also scored modestly, with findings suggesting that while OHIS provides some level of emergency support, coverage during off-hours or for urgent, critical needs may be insufficient – particularly if services are only available during normal working hours.

Challenges of Osun Health Insurance Scheme

The study identifies multiple systemic challenges that limit the operational effectiveness and user satisfaction of the Osun Health Insurance Scheme (OHIS). These issues, as perceived by respondents, reflect broader trends found in similar public health insurance schemes across Nigeria. One of the most pressing concerns is the inadequacy of accredited healthcare facilities, with 71.4% of respondents agreeing that OHIS lacks sufficient provider coverage. The shortage of facilities may lead to overcrowding, delays in care, and limited access to specialized services—especially in rural or semi-urban areas. This confirms findings by Okonofua *et al*. (2018), who noted that Nigeria's public health insurance schemes often suffer from an unequal distribution of healthcare infrastructure. Funding limitations are another major barrier, also receiving 71.5% agreement. Respondents emphasized that inadequate funding contributes to delays in provider reimbursements, essential drug shortages, and inhibited programme expansion. Aregbeshola and Khan (2018) similarly argue that funding shortfalls severely constrain the sustainability of public health insurance programs in Nigeria, ultimately leading to reduced service quality and poor enrollee retention. A participant opined that:

> Part of the reasons for low patronage of OHIS is that there are other such schemes that are side by side with OHIS. National Health Insurance is doing well and being patronized. There are also private organisations that are into Health Management (HMO). All these compete with OHIS. *(KII/Health Officer/Osogbo/2025)*

The limited scope of services under OHIS is also a concern. With 66.1% of respondents indicating that not all essential healthcare services are covered, the study suggests that out-of-pocket expenses are still being incurred, especially for specialist care, diagnostics, or chronic illness management. Respondents also reported difficulties in accessing specialist care. This may be due to a shortage of accredited specialists, slow referral systems, or restrictive policies within OHIS coverage plans.

Another notable issue is long waiting times, flagged by 67.8% of respondents as a problem. Delays in receiving care reduce user satisfaction and can discourage continued enrollment. Nwankwo *et al*. (2013) also documented that inefficient service delivery and wait times are widespread problems in Nigerian public health facilities. Concerns about maternity-related healthcare were also raised. 57.1% respondents believe OHIS does not adequately cover maternal services, which raises red flags about the scheme's ability to protect vulnerable populations like pregnant women and infants. Greer *et al*. (2022) similarly observed that insufficient maternal coverage under public insurance schemes increases out-of-pocket costs and lowers utilization of prenatal and postnatal care. Lastly, bureaucratic inefficiencies are seen as a significant operational challenge. 67.9% respondents agreed that administrative bottlenecks weaken OHIS performance. These issues include delays in claims processing, cumbersome procedures, and poor provider reimbursement systems. Nwakanma and Nnamdi (2013) affirm that overregulation and poor administrative structures are common weaknesses in Nigeria's health insurance sector. Streamlining operations and improving institutional efficiency could enhance OHIS's credibility and user satisfaction.

Experiences of enrollees of Osun Health Insurance Scheme

The effectiveness of OHIS in meeting its objectives is closely tied to how well it is structured and functions operationally. The study reveals that a majority of respondents (71.5%) perceive the scheme as adequately structured to serve healthcare needs. This suggests that OHIS has laid a solid administrative and policy foundation, resonating with Alegbeleye (2019), who argue that structural soundness enhances access by minimizing financial barriers and improving system organization. Nonetheless, not all respondents agree, indicating that while the scheme appears stable on the surface, gaps may exist in implementation or service delivery consistency. One such gap is in the

distribution of healthcare facilities, where only 50% believe that OHIS facilities are evenly distributed across Osogbo. This points to uneven facility placement that may hinder access particularly in underserved communities.

Conclusion

This study assessed the structure, accessibility, perception, and challenges of the Osun Health Insurance Scheme (OHIS), focusing on its effectiveness in delivering healthcare services to residents of Osogbo. Findings show that while OHIS has contributed significantly to improving healthcare access and affordability, systemic issues continue to undermine its full potential. Demographic analysis revealed that enrollment is influenced by gender, education, income, and employment type, with higher participation among working-age individuals and educated residents. However, affordability remains a key barrier for unemployed and low-income groups, preventing universal coverage. Respondents generally view OHIS as well-structured and beneficial in delivering quality care, but problems such as facility shortages, funding gaps, limited-service coverage, staff inadequacy, and bureaucratic inefficiencies hinder optimal performance. Delays in service delivery and insufficient awareness campaigns also affect the public's full utilization of the scheme. Although public perception is largely favourable, many users express the need for expanded coverage, improved coordination with private providers, and increased education about the scheme. Statistical insights confirm that while service quality and affordability drive accessibility, awareness alone does not necessarily lead to higher enrollment. Addressing these issues through targeted policy reforms is essential for enhancing OHIS's sustainability, inclusivity, and trustworthiness.

Recommendations

1. Increase Funding and Ensure Financial Sustainability: By boosting government budget allocations to OHIS, exploring alternative financing (e.g., employer contributions, partnerships, donor aid), and providing subsidized or free plans for low-income residents, the scheme can witness an increase in funding.
2. Expand Facility and Workforce Coverage: Through increase in OHIS-accredited facilities, especially in rural areas, recruiting and fairly distributed healthcare professionals, including specialists, and investing in telemedicine and mobile health outreach, OHIS can expand workforce and facility coverage.

3. Intensify Awareness and Community Engagement: Launch mass sensitization campaigns and community outreach, focus on the informal sector and vulnerable groups, and use digital platforms and social media for broader engagement.
4. Address Administrative Bottlenecks: Streamline enrollment, claims, and reimbursement processes, integrate digital systems to improve speed and accuracy, and create a responsive feedback and complaint mechanism for enrollees can be very effective for the scheme's progress.
5. Broaden Coverage for Chronic and Essential Health Needs: Incorporating treatments for hypertension, diabetes, and cancer, enhance maternal and child healthcare (prenatal and postnatal), as well as integrating mental health services for holistic care helps broaden the essential health need.
6. Strengthen Public-Private Collaboration: Accrediting more private facilities under OHIS and promoting public-private partnerships to enhance service delivery and expand options can help strengthen public-private collaboration.

By implementing these recommendations, OHIS can evolve into a more inclusive, efficient, and sustainable healthcare model – capable of meeting the diverse needs of Osun residents and advancing the goal of universal health coverage.

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