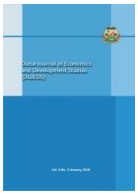
DUTSE JOURNAL OF ECONOMICS AND DEVELOPMENT STUDIES (DUJEDS)
DEPARTMENT OF ECONOMICS AND DEVELOPMENT STUDIES
FEDERAL UNIVERSITY DUTSE
E-Mail: dujeds@fud.edu.ng



IMPACT OF POVERTY AND IGNORANCE ON HEALTH INSURANCE COVERAGE IN ADAMAWA STATE NIGERIA

YAHAYA Adamu — **Economics Department, Adamawa State University, Mubi**

DANJUMA Mohammed — **Accounting Department Adamawa State University, Mubi**

Abstract
This study is on the problems of health insurance coverage in Adamawa state, the role of poverty and ignorance. The data for the study were primarily sourced through the well-structured questionnaire and interviews. Eighty questionnaires were administered to the federal, state, local government civil servants and other individuals. The data collected was analyzed using frequency, simple percentages as well as chi-square. The major finding of the study revealed that poverty and ignorance have significant effects on the health insurance coverage in the state. In line with these findings, the following recommendations were suggested: government should focus on; people empowerment program that can improve their disposable incomes, health policy in line with the changing environment aimed at achieving health coverage, creation of awareness in order to educate people on the importance of health insurance policy, field agents should make sure that the members in their various communities are registered for better health coverage.

Keywords: Health Insurance, Poverty, Ignorance, NHIS.

Introduction

The increasing cost of health care in developed and developing economies has called for a change in the way health activities are implemented. The aim of this study is to examine how poverty and ignorance affect health insurance coverage in Adamawa State .Nigeria is faced with fundamental health care related challenges coupled with recent security issues. Uncertainty prevails as health system dynamics unfold. In Nigeria, successive government realizes the needs to structure the funding of health care service as one of the ways to improve health care provision (Gilbert et al 2009). The Nigeria government took a definite step to establish National Health Insurance Scheme (NHIS) in 1999 as a social tool towards attaining equity in health service delivery.

The major increase in financial resources for health is needed to scale up health intervention and straighten health delivery system to ensure that the interventions are accessible, particularly for the poor. Historically, health insurance in Nigeria can be applied to a few instances: free health care provided and financed for all citizens, health care provided by government through a special health care scheme for government employees and private firms entering contract with private health services for medical expenses prior to health service delivery. Health insurance may apply to all limited or comprehensive range of medical services and may provide for full or partial payment of the cost of specific service. Benefits may consist of the right to certain medical service or reimbursement to the insured for specified medical cost some types of health insurance may also include income benefits for working time lost because of sickness (i.e., disability leave) or parental leave. It is sometimes used more rapidly to include insurance coverage disability or long time nursing or custodial care needs.

A healthy population takes a healthy nation and work force often with the realization of corporate objectives of organizations largely depends. However, when health problems occur among workers in their productive years, the number of available workers reduces, absenteeism increase while productivity decline. The Global Business Council on HIV/AIDS (2002) reasoned that with increasing absenteeism, organization will experience loss of skills and declining morel which is likely to lower productivity.

Literature Review

Health insurance is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expense. In Health insurance terminologies, a clinic, hospital, doctors, laboratory, healthcare practitioners, or pharmacy that treats an individual is known as the "provider". The" insured" is the owner of health insurance policy or the person with the health insurance coverage. Health insurance is a product that covers your medical expenses. Like auto insurance covers your car if you get into an accident, health insurance covers you if you get sick or injured. Health insurance also covers preventive care – i.e., doctors' visits and tests before you get sick. Health insurance doesn't always cover 100% of your costs. In fact, it's designed to share costs with you up until a certain point, called the out-of-pocket limit. After you hit the out-of-pocket limit, health insurance will pay 100% of your healthcare costs. There are a few ways that health insurance companies might share costs with you, and they make up major features of your health insurance plan that you need to be aware of: your deductible, your copayment, your coinsurance, and your out-of-pocket limit.

All health insurance plans need to cover the essential benefits. In addition, the essential benefits, health insurance plans must meet certain affordability standards, as well as other rules that vary on a state-by-state basis, in order to be included on a government-run health insurance exchange. Off-exchange plans, so called because they are not sold on government-run exchanges, must also cover the ten essential benefits and meet certain federal standards in order to be considered qualifying health coverage. These consumer protections closed loopholes that caused financial problems for policyholders in the past. As outlined by the Affordable Care Act (the ACA, also known as Obamacare), all American citizens must have qualifying health coverage. If you don't, you'll have to pay a fee on your federal tax return.

Overview of Health System

The ministry of health heads the National Council on health (NCH) which coordinates the activities of the federal and state ministries (FMOH/SMOH), and health agencies including the (NHIS). Health care is delivered by public and private sector provider who are regulated by the ministries and local government departments of health (LGDH). Broadly, the providers use modern and traditional methods of health care delivery (FMOH, 2014). Public hospital including federal government administered tertiary hospital which is mainly university teaching hospital, federal medical center and other specialist hospitals. Other are state owned general hospitals, government owns staff hospitals and clinics, local government area health centers and village head posts (FMOH, 2017). International non- governmental organizations also partner with the public sector in delivering some vertical health services like TB control, malaria control and HIV/AIDS program (JCIES, 2009). The private health sector has involved into a serious player in health care services delivery especially in urban area.

Theories of Health Insurance:

Conventional health insurance theory

John Nyman explains this theory of health insurance in intuitive terms. It begins with the observation that health care spending is encouraged by health insurance. Conventional health insurance theory provided a ready evaluation of this increased spending. It represents a welfare loss and should be reduced. Conventional health insurance theory also provided the policy solution impose coinsurance payment and deductibles to increase the price of medical care to insure consumers and reduce this inefficient expenditure. In the 1970s many insurer adopted copayment to reduce health care spending. In the 1980 and 1990s economist also promoted utilization review capitated payments to providers as further ways to reduce moral hazard. The managed health care system we have now is largely a product of this theory. Conventional theory holds that people purchase insurance because they prefer certainty of paying a small premium to the risk of getting sick and paying a large medical bill. Conventional theory holds that any additional health care that consumers purchase because they have insurance is not worth the cost of producing it. Therefore, economists have promoted policies-copayments and manage care to reduce consumption of this additional seemingly low-value care. In essence, conventional explanation for purchasing insurance is to transfer risk.

Theory of Demand for Health Insurance:

This theory holds that people purchase insurance to obtain additional income when they become ill. In effects, insurance companies act to transfer insurance premiums from those who remain healthy to those who become ill. This additional income generate purchases of additional high value care, often allowing sick persons to abstain life-saving care that they could not otherwise afford. Regarding risk, this theory relies on empirical studies shows that consumers actually prefer of a lager loss to incurring a smaller loss with certainty. Therefore, if consumers purchases insurance, it is not because the desire to avoid risk. Instead, this new theory suggest that consumer simply pay a premium when healthy in exchange for a claim on additional income (infected when insurance pays for the medical care) if they become ill. Under this

theory, health insurance substantially is more valuable to the consumer. This theory moreover, implies that copayments and managed care –central health care policies of the 3 years-were directed at solving problems that largely did not exist. Because these policies either reduced the amount of income transfer to ill persons or limited access to valuable health care, they may do more harm than good. This theory also provides a solid theoretical justification for insuring the uninsured and for implementing national health insurance.

Theories of Decision-Making:
In the contest of health insurance, this theory reveals economic and social theories on decision-making and relates them to empirical finds on the insurance demand.

Consumer theory:
This theory assumes that if consumers are perfectly informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and preferences. Change in prices and income influence how much different goods rational consumer will buy (Begg et al. 2000). Health insurance is expected to be normal good with a positive income elasticity of demand, implying that the poor are less likely to insure. A price increase for a substitute for insurance – such as user fee – expected to raise the insurance demand, as is a decrease in insurance premium. However, due to uncertainty about the unknown future health, insurance choice is not made based utility alone but on consumer's expectation about factors such as the health status (Cameron et al. 1988)**.**

Expected utility (EU) theory:
Insurance demand is a choice between an uncertain loss that occurs with probability when uninsured and a certain loss like paying a premium (manning and marquis 1996). EU theory assumes that people are risk averse and make choices between taking a risk that has different implication of wealth. At the time of insurance consumers are uncertain whether they will be ill or not, and of the related financial consequences. Insurance reduces this uncertainty. Through insurance they can level out their income over two different states, ill/not ill, which will makes the aggregate outcome relatively certain. This certainty allows the insured to reach a higher utility in case of illness than those without insurance. Accordingly, the insurance demand reflect individuals risk aversion and demand for certainty, implying that the more risk averse individuals are, the more insurance coverage the will buy (Begg et al. 2000) this theory is silent about the level of consumers income and its impact on the insurance choice.

State – dependent utility theory:
This theory suggest that consumers utility level and taste are in fleeced by their, such as their health or socio-economic status. Accordingly, people may have different degree of risk aversion, which could influence their insurance decision and the magnitude of their expected insurance pay – off. Most people insure when they are healthy. A healthy person might optimistically expect to remain healthy in the future, which has implication on the insurance choice. The resulting insurance coverage may be below full loss coverage, if the anticipated insurance pay-off is below the real loss in case of illness. Hence, the anticipated need for medical care given the current state and the magnitude of the related insurance pay-off in case of sickness affect individual's insurance demand (Phelpe 1973).

Manning and marquis (1996) estimate insurance demand by adding the value of medical care to the value of risk available in the purchaser's utility function. The poor may expect less payoff when sick, which could influence their insurance decision. They may anticipate purchasing single tablet of medicine from a market vendor for self-treatment, not covered by insurance.

Methodology
Population and Sampling
The study population covers all people in Adamawa state within the study period. It is practically impossible to investigate the entire population, therefore, some selected state ministries such as ministry of health, ministry of education, ministry of agriculture, agencies like federal road safety commission (FRSC), parastatals, and industry practitioners are contacted in order to observe the opinions of people towards health insurance coverage under the study.

Methods of Data Collection
For the purpose of this study, the related data are primary data. Questionnaire was designed with the aim of collecting factual information and views from respondents by making the respondents to answer certain questions. Therefore, the research instrument, used in this study is purely questionnaire (primary data) given the size of the population. The questionnaire was chosen as the suitable instrument for data collection considering the fact that it is cost effective,ensuring uniformity,avoid ambiguity, avoids errors,save time and has a relatively high degree of standerdization. A structured questionnaire with close-ended type was used for this research work with 1-5 Likert scale which consist of strongly disagreed to strongly agreed to answer the research questions, YES or NO options will be used to

measure the responses of the respondents of this study.

Data Analysis

The chi-square method was used in testing the hypothesis formulated for this study in order to decide whether to accept the null hypothesis or to reject it. The hypothesis is repeated below:

Ho_1: Poverty has no significant effect on health insurance coverage

Ho_2: Ignorance has no significant effects on health insurance coverage.

A total number of 80 questionnaires were given out to the respondent which includes federal civil servant, state civil servants, local government civil servants and others but only 61 were filled and returned. The questionnaire is divided into two sections.

Section "A" is the introductory part of the questionnaire which contains six (6) items, while section "B" is the main questionnaire which contains ten (10) items all of which are in the form of close ended response except the tenth question.

Estimation Techniques

Frequency and simple percentage table as well as chi-square test were used.

Presentation and Analysis

The data collected from the questionnaire are presented in form of table, frequency and percentage below

Table 1: Age

Respondents	Frequency	Percentage (%)
18 – 24	8	13.1
25 – 32	7	11.5
33 – 40	25	41
41 – Above	21	34.4
Total	61	100

Source: Field Survey May, 2018

Table 1 above shows the distribution by age of those who were administered with questionnaire, 13.1% representing 8 respondents are within the age of 18-24, 11.1% representing 7 respondents are within the age of 25-32, 41% representing 25 respondents are within the age of 33-40, and 34.4% representing 21 respondents are within the age of 40 & above. This implies that the age group between 33 – 40 representing 25% of the respondents answered most the questionnaire than the other age group.

Table 2: Sex

Respondents	Frequency	Percentage (%)
Male	41	67.2
Female	20	32.8
Total	61	100

Source: Field Survey, May 2018

Table 2 above shows the distribution by sex of those who were served with questionnaire, 67.2% representing 41 respondents are male, 32.8% representing 20 respondents were female. This implies that more men answered the questionnaire than women.

Table 3: Marital Status

Respondents	Frequency	Percentage (%)
Single	**11**	**18**
Married	**50**	**82**
Total	**61**	**100**

Source: Field Survey, May 2018

Table 3 above shows the distribution by marital status of those who were served with questionnaire, 18% representing 11 respondents are single, 82% representing 50 respondents are married. This implies that more married people answered the questionnaire than single people.

Table 4: Educational Qualifications

Qualifications	Frequency	Percentage (%)
PhD/MSC	**8**	**13.1**
BSC/ HND	**37**	**60.7**
NCE/ ND	**13**	**21.3**
SSCE & Others	**3**	**4.9**
Total	**61**	**100**

Source: Field Survey, May 2018

Table 4 shows that 13.1% representing 8 respondents are PHD/MSC holders as their highest qualification, 37 respondents representing 26.6% poses BSC/HND as their highest qualification, 13 respondents representing 21.3% of the respondents in this category poses national diploma and national certificate in education as their highest qualification, while the remaining 3 respondents representing 4.9% of the respondents of this category have SSCE/OTHERS as their highest qualification. This implies that the questionnaires have been distributed across all the qualifications, with BSC/HND as the highest 60.7%.

Table 5: Occupation

Occupation	Frequency	Percentage (%)
Federal civil Service	**21**	**34.4**
State Civil Servant	**13**	**21.3**
Local Government Civil S	**7**	**11.5**
Others	**20**	**32.8**
Total	**61**	**100**

Source: Field Survey, May 2018

Table 5 presents the occupational distribution of the respondents, 21 respondents representing 34.4% are federal civil servants, 13 respondents representing 21.3% state civil servants, 7 respondents representing 11.5% are local government civil servants and 20 respondents representing 32.8% are others

Table 6: Senatorial District

Senatorial District	Frequency	Percentage (%)
Adamawa North	**30**	**49.2**
Adamawa South	**18**	**29.5**
Adamawa Central	**13**	**21.3**
Total	**61**	**100**

Source: Field Survey, May 2018

Table 6 presents the senatorial district distribution of the respondents, 30 respondents representing 49.2% are from Adamawa north, 18 respondents representing 29.5% are from Adamawa south, while 13 respondents representing 21.3% are from Adamawa central. The questionnaires were issued equally to the respondents in the three senatorial districts.

Table 7: Are you aware of the health insurance?

Response	Frequency	Percentage (%)
Yes	**48**	**78.7**
No	**13**	**21.3**
Total	**61**	**100**

Source: field survey, May 2018.

The analysis on the table 7 above shows that 48 respondent representing 78.7% are aware of the health insurance while 13 respondent representing 21.3% are not aware of the health insurance, and in the researchers opinion, there is high reliability of their responses since more than half are fully disposed to the research topic.

Table 8: Are you covered?

Response	Frequency	Percentage (%)
Yes	32	52.5
No	29	47.5
Total	61	100

Sources: Field survey, May 2018.

Based on the analysis of table 8 above, 32 respondents representing 52.5% are covered by the health insurance coverage while 29 respondent representing 47.5% are not covered. In the researcher's opinion, since the reliability and validity of the respondents responses had been tested, then the responses of the respondents are deemed reliable.

Table 9: If No, why are you not covered?

Responses	Frequency	Percentage (%)
Poverty	**12**	**19.7**
Ignorance	**4**	**6.6**
Others	**17**	**27.9**
No response	**28**	**45.9**
Total	**61**	**100**

Source: Field survey, May 2018.

The analysis on the table 9 above shows that 12 respondents representing 19.7% believes that poverty hinders them from being covered by health insurance, while 4 respondent representing 6.6% are of the views that ignorance can hinders them from being covered by health insurance, while 17 respondents representing 27.9% has different view that neither poverty nor ignorance hinders them from being covered but others reasons, 28 respondents representing 45.9% did not respond. This implies that they are not covered by the health insurance not because of poverty nor ignorance but because of others reasons. Therefore, since all the responses from the respondents are consistent and valid, then the response of the majority is deemed reliable.

Table 10: Can poverty hinders people from health insurance coverage?

Responses	Frequency	Percentage (%)
Strongly Agree	**33**	**54.1**
Agreed	**15**	**24.6**
Neutral	**4**	**6.6**
Disagree	**4**	**6.6**
Strongly Disagree	**5**	**8.2**
Total	**61**	**100**

Source: Field survey, May 2018.

The analysis on the table 10 above shows that 33 respondents representing 54.1% strongly agree that poverty can hinder people from health insurance coverage, while 15 respondent representing 24.6% agreed that poverty can hinder people from health coverage participation, 4 respondent representing 6.6% disagreed that poverty cannot hinder people from health insurance while 5 respondent representing 8.2% strongly disagreed that poverty cannot hinders people from participating in health insurance coverage.

This implies that poverty can hinder people from health insurance coverage based on the responses of the majority. In order word, the reliability, consistency and validity of the responses of the respondent had been tested, and then the responses of the majority are deemed reliable.

Table 11: Can ignorance hinder people from health insurance coverage?

Responses	Frequency	Percentage (%)
Strongly agree	**28**	**45.9**
Agreed	**22**	**36.1**
Neutral	**4**	**6.6**
Disagree	**6**	**9.8**
Strongly Disagree	**1**	**1.6**
Total	**61**	**100**

Sources: Field survey, May 2018.

Based on the analysis on the table 11 above, it shows that 28 respondents representing 45.9% strongly agreed that ignorance can hinder people from health insurance coverage, while 22 respondents representing 36.1%agreeed with the view that ignorance can hinder people from health insurance coverage, while 4 respondents representing 6.6% have a neutral view but 6 respondents representing 9.8% disagreed with the view while 1 respondent representing 1.6% strongly disagreed that ignorance cannot hinder people from health insurance coverage. Therefore, since the reliability and validity of the responses of the respondents had been tested, then the responses of the majority are deemed reliable

Table 12: Do Nigerian citizens have access to good health insurance?

Responses	Frequency	Percentage (%)
Yes	21	34.4
No	40	65.6
Total	61	100

Sources: Field survey, May 2018.

The analysis on the table 12 above shows that 21 respondent representing 34.4% believes that Nigerian citizens has good access to health insurance, while 40 respondent representing 65.6% has a contrary views that Nigerians has no good access to health insurance. This shows that, the Nigerian citizen has a limited or no access to good health insurance that can enable them to participate in the scheme.

Table 13: Health insurance implementation embarked upon by the government will improve life expectancy of the Nigerian citizens.

Responses	Frequency	Percentage (%)
Strongly Agree	**30**	**49.2**
Agreed	**25**	**41.0**
Neutral	**5**	**8.2**
Disagreed	**1**	**1.6**
Strongly Disagreed	**0**	**0.0**
Total	**61**	**100**

Sources: Field survey, May 2018.

Table 13 above shows that 30 respondents representing 49.2% strongly agreed that the health insurance implementation embarked upon by the government will improve the life expectancy of the Nigerian people**,** while 25 respondent representing 41.0% agreed as well, 5 respondent representing 8.2% has a neutral view while 1 respondent representing 1.6% disagree that the implementation of health insurance by the government will not improve the life expectancy of Nigerians.

Based on the percentage, it implies that the implementation of health insurance embarked upon by the government will improve the life expectancy of Nigerian citizens.

Table 14: Government has given unguided awareness of health insurance coverage.

Responses	Frequency	Percentage (%)
Strongly Agreed	**3**	**4.9**
Agreed	**26**	**42.6**
Neutral	**10**	**16.4**
Disagree	**17**	**27.9**
Strongly Disagreed	**5**	**8.2**
Total	**61**	**100**

Sources: Field survey, May 2018.

From table 14 above, 3 respondents representing 4.9% strongly agreed that the government has given a freehand awareness of health insurance coverage, while 26 respondents representing 42.6% agreed that government has given freehand awareness of health insurance coverage, 10 percent respondents representing 16.4% has a neutral opinion while 17 respondents representing 27.9% disagreed with the view and 5 respondents representing 8.2% strongly disagreed with the opinions of others that government has not given freehand health insurance awareness to the public.
Based on the percentage, it shows that government has giving a freehand awareness of health insurance coverage to its citizens.

Table 15: How do you rate health insurance coverage?

Responses	Frequency	Percentage (%)
Poor	**17**	**27.9**
Fair	**29**	**47.5**
Good	**12**	**19.7**
Very good	**3**	**4.9**
Total	**61**	**100**

Sources: Field survey, May 2018.

The above table 15, shows that 17 respondent representing 27.9% believes that health insurance scheme are performing poor, while 29 respondent representing 47.5% are of the opinion that the performance of health insurance are fair, 12 respondent has the contrary opinion that the health insurance coverage is good, while 3 respondents are of the views that the health insurance coverage is very good.
This implies that, the performance of health insurance is poor and fair based on the responses of the respondents.

Table16: What advice can you give to those that are not insured?

Responses	Frequency	Percentage (%)
They should be insured	**51**	**83.6**
Government should create an avenue to the people so that people can participate	**10**	**16.4**
Total	**61**	**100**

Source: Field survey, May 2018.

The analysis on the table 16 above shows that 51 respondents representing 83.6% advised that, people that are not insured by the health insurance should try and insured so that benefits of health insurance can be enjoyed, while 10 respondents representing 16.4% has a contrary view towards the

question asked that government should create awareness to the public and make health insurance affordable to its citizens. Therefore, since the responses from the respondents are consistent and valid, then the responses of the majority are deemed reliable.

Table 17: Observed response table:

Responses	Item 4	Item 5	Total
Strongly Agreed	**33**	**28**	**61**
Agreed	**15**	**22**	**37**
Neutral	**4**	**4**	**8**
Disagreed	**4**	**6**	**10**
Strongly Disagreed	**5**	**1**	**6**
Total	**61**	**61**	**122**

Sources: Field survey, May 2018.

Computed chi-square (x^2)

Chi-square = x^2

$$X^2 = \frac{\sum(fo-fe)^2}{Fe}$$

Where:

Fo = observed value of frequency

Fe = expected value of frequency

$$Fe = \frac{CL \times RL}{\text{Grand total}}$$

CL = Column total

RL = Row total

Table18: Computed chi-square (x^2)

Responses (questions)		fo	Fe	Fo-fe	$(fo-fe)^2$	$\frac{(fo-fe)^2}{fe}$
Strongly Agreed	(4)	33	20.4	12.6	158.76	4.811
Strongly Agreed	(5)	28	20.4	7.6	57.76	2.063
Agreed	(4)	15	20.4	-5.4	29.16	1.944
Agreed	(5)	22	20.4	1.6	2.56	0.116
Neutral	(4)	4	20.4	-16.4	268.96	67.240
Neutral	(5)	4	4.0	0	0	0.000
Disagreed	(4)	4	4.0	0	0	0.000
Disagreed	(5)	6	4.0	2	4	0.667
Strongly Disagreed	(4)	5	4.0	1	1	0.200
Strongly Disagreed	(5)	1	4.0	-3	9	9.000
Total		122	122	0	531.2	86.041

Source: Computed by the Author 2018

The calculated value of the chi-square is 86.041.

The degree of freedom "df" is given as;

$$DF = (r-1)(c-1)$$

Where:
R = number of rows
C = number of columns
Where,
R = 5
C = 2
Therefore, df = (5-1) (2-1)
df = (4) (1)
df = 4
Using 4 degree of freedom and 0.05 level of significance, the chi-square distribution table is 9.488.

Decision Rule:
If the calculated value of chi-square (x^2) (tested statistics) is less than the observed value (critical value), then H_O hypothesis should be accepted and the Hi hypothesis should be rejected if otherwise.

Interpretation of Result
From the calculation, it is clear that the computed value or calculated value of chi-square X^2 (tested statistic) is more than the observed value (critical value) or table value of chi-square. That is 86.041 > 9.488. Therefore, we reject the null hypothesis Ho1 and Ho2 which stated that poverty or ignorance has no significant effect on the health insurance coverage and accept alternate hypothesis that poverty or ignorance has significant effect on the health insurance coverage. This implies that poverty or ignorance has negative significant effect on health insurance coverage.

Conclusion and Recommendations
Based on the study done concerning this work, it is obvious from the foregoing that the health insurance scheme is a well come development in Nigeria; hence should be sustained. To do this,

there is need to be guided by the principle of transparency and accountability in the administration to the scheme. Transparency and accountability on the part of the government and the health service providers will go long way to curb corruption in the administration of the program, the minimum standard for the service provider must be clearly define by the government followed by proper supervision by the supervisory agencies, health insurance providers must endeavors to render cutting edge service to their registered members through improving on the quality of drugs and attention to patients, regular training should be organized for the field agents to enhance the performance of their duties, for health facilities should be opened in the various communities to reduce the incidence of travelling long distance to access health insurance as a means of insuring the sustainability of the scheme, government should put policies in place and back the up with legal muscle to ensure that the earlier target of 90% coverage is kept in focus through high performance and quality improvement, field agents should educate general public on some pertinent issues like the need to register with the health insurance scheme, the registered members should appreciate the important of health insurance coverage by giving them quality health insurance care when the visit the health providers with their health insurance card.

References

Bennett S, Creese A, Monasch R. (1998). Health insurance schemes for people outside formal Sector Employment. Geneva: World Health Organization.

Bell D. (1982). Regret in decision making under uncertainty. Operational Research **30**: 961-981.

Bennett, S. (2004). The role of community-based health insurance within the health care financing system: *a Frame work for analysis.* Health policy and planning; 19(3): 147- 158.Oxford university press. Dol: 10.1093/heapol/ c2h018.

Begg D, Fischer S, Dornbusch R. (2000). *Economics*. London: The McGraw-Hill Companies.

Cameron AC, Trivedi P, Milne F, Piggott J. (1988). A micro econometric model of the demand for health care and health insurance in Australia. *Review of Economic Studies* **LV**:85– 06.

Case A, Deaton A. (2002). Consumption, health, gender and poverty. *Princeton University:Research Program In Development Studies.*

Collins SR, White C, Kriss JL (2007). Whither employer base health insurance? The current and future role of united state companies in the provision and financing health insurance. *The commonwealth find Publication number 1059. 2007. Available at www.Cmmonwealthfund. org.*

Deaton, Angus (2003). Health, inequality, economic development. *Journal of Economic Literature, Vol XLM:113-158.*

Emmanuel, N (2014). Challenges of implementing sustainable Health Care delivery in Nigeria Under Environmental Uncertainty. *Journal of Hospital Administration, 3(6), 115-117.*

Falegan, I.J.(2008). Health care financing in the developing World: is Nigeria national Health Insurance Scheme a viable option? *Jos journal of medicine 3(i):5-6.*

Gilbert, K., Fleisher, L., Kariisa, E., Arur, A., Sanjana, P., Paina, L. Dare, L., Abubakar, A.,Baba, S.,Ubak- Udome, E. and Unom, S. (2009). Nigerian Health System Assessment2008. Federal ministry Of Health, Nigeria and Health system 20/20, *Abt Associates Incorporated. Maryland, USA.AvailableFrom:http://www.Healthsystems2020.org/content/resource/details/2326/*

Ibiwoye, A. and A.A. Adeleke,(2007).The impact of health insurance on health care Provision in developing Countries. *Ghana Journal of Development 4(21), 49 58www.ajoi.info/viewarticle.php.*

Kahnemann D, Tversky A. (1979). Prospect theory: an analysis of decision under Risk *Econometrical **47**: 263–91.*

Michael, S. (2010). Perceived impact of the National Health Insurance Scheme (NHIS). Among Registered Staff in Federal Polytechnics Idah, Kogi State Nigeria. *Studies in Sociology Science, 1(1),44-49.*

Manning WG, Marquis SM. (1996). Health insurance: the tradeoff between risk pooling And moral hazard. *Journal of Health Economics **15**: 609–39.*

Nyman, John A. the theory of demand for health insurance. Stanford, CA: s*tanford University press, 2003.*

Ononokpono, E (2008). NHIS and the challenge of Health care delivery. *The Daily Trust. http://www.dailytrust.dailytrust.com /content / view5/4297/88.*

Phelps CE. (1973). Demand for health insurance: a theoretical and empirical investigation. Santa Monica, CA:RAND Corporation. Proper C. 1993. Constrained choice sets in the UK: demand for private medical

Insurance. *Journal of Public Economics* 287–307.

Ranson, M, (2008). Reduction of catastrophic of Health care expenditure by a community- based health Insurance scheme in Gujarat, India: *current experiences and challenges bulletin of the world Health Organization 80(8): 613-621*.

Saches, Jeffrey; (2014). Health in the developing world: *achieving the millennium Development Goals Bulleti of the World Health Organization 82(12):947-952.*

Tversky A, Kahneman D.(1992). Advances in prospect theory: cumulative representation of Uncertainty.*Journal of Risk and Uncertainty***5**: 297–323.

Woolhandler, S; and David U.Himmelstein, (2002). Paying for national health insurance-And not getting it. *Health affair 21(4):88-98.*

Woolhandle, S.et al (2003). Cost of Health care Administration in United Stand Canada . *N. Engl. J.Medi349 (8)76775.http://www.pnhp.org/publications/nejmadmin,pdf.electronic.*

WHO (2004). Macroeconomics and health: *an update. April2004, World Health Organization.*

WHO: World Health Report: Health Systems Improving Performance. *2000 Geneva, Switzerland: WHO Google Scholar.*

World Bank (1993). *World Development Report 1993-lavesting in health. Oxford University press.*