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(REVIEW ARTICLE)

Health care financing and achieving universal health care in Bayelsa: Changing the narrative through health insurance

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Abstract

Numerous nations struggle with limited and unequal access to high-quality healthcare, which hinders public health efforts. The achievement of universal health coverage is contingent upon the manner in which a nation allocates financial resources to support its healthcare system. This factor impacts the level of accessibility of healthcare services for individuals with the financial means to afford them. The Bayelsa State Health sector faces many challenges in establishing the most effective health service methods. The health performance of Bayelsa State is below average, although an official ranking of Nigeria is not available. Transportation and accessibility for health services and research are further challenged by the State's difficult geographic terrain. Thus, it is impossible to assess facility status and identify areas of need. Bayelsa health insurance policies are needed to improve health outcomes, especially for the poor and vulnerable. The initiatives cover outpatient care, pharmaceutical care (including essential drug lists), diagnostic tests, maternal care for up to four live births, preventive care (including immunisation, health education, antenatal and postnatal care), hospital care, eye care, and preventive dental care. Although a majority of the programme's services were linked to favourable self-reported health status and high participant satisfaction, there are still concerns about pharmaceuticals and healthcare facilities. In the BHIS framework, the government and stakeholders must emphasise medications, competent healthcare professionals, and well-equipped healthcare facilities. Effective referral systems can reduce the negative effects of health conditions on public and private sector personnel, improving the healthcare system.

Keywords: Bayelsa State; Bayelsa Health Insurance Scheme; Health care financing; Universal health care; Health Insurance

1. Introduction

The health care financing system refers to the process of collecting revenues from various sources, including out-of-pocket payments, taxes, donor funding, co-payment, and prepayments, both voluntary and mandatory. These funds are then pooled together to distribute the risk among larger population groups. The accumulated revenues are used to procure goods and services from both public and private providers to meet the identified health care needs of the population. Different payment mechanisms such as fee-for-service, capitation, budgeting, and salaries are employed for this purpose [1].

Ultimately, the primary source of revenue for the healthcare system is derived from households, whether through out-of-pocket payments, taxation, or health insurance. Consequently, health care finance can be succinctly characterised as the monetary transactions occurring between patients and healthcare providers, wherein patients remunerate providers in return for rendered services. The financial framework of a healthcare system serves as an indicator of

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whether patients encounter financial difficulties during the course of receiving essential medical services. An effective healthcare financing strategy should possess the capability to effectively allocate resources towards healthcare, promote fairness and effectiveness in healthcare expenditure, guarantee accessibility and quality of healthcare services, adequately provide essential healthcare goods and services, and, more recently, ensure prudent spending to facilitate the attainment of the Millennium Development Goals (MDGs) [2].

The provision of a health care finance system should be designed to provide sufficient financial protection, preventing any household from encountering economic adversity due to the need for health services. One potential strategy for providing protection against unforeseen medical expenses is the integration of a risk-sharing plan into the framework of health care financing. This approach effectively distributes the financial burden of unexpected healthcare costs among various individuals and households [3]. One objective of universal health coverage (UHC), as stated by the World Health Organisation (WHO, 2010), is to ensure that individuals have sufficient access to their healthcare requirements without facing substantial out-of-pocket expenses at the time of receiving care. Risk pooling can be achieved through the use of tax-funded or social health insurance (SHI) mechanisms, as suggested by the World Health Organisation [4].

The implementation of the National Health Insurance Scheme (NHIS) One potential strategy that governments can employ to enhance universal coverage is the implementation of a Social Health Insurance (SHI) plan. The National Health Insurance Scheme (NHIS) of Nigeria was formed in 2005 with the primary objective of providing healthcare access to the country's population. Since its inception, the National Health Insurance Scheme (NHIS) in Nigeria has witnessed limited enrollment, with just a fraction of the country's working population, specifically those employed in the federal formal sector, accounting for approximately 5%, being beneficiaries of the scheme. The proposal entailed the adoption of the scheme by state governments for their employees, thereby expanding the scope of coverage provided by the insurance programme [5].

Seventeen years following its establishment, Bayelsa state has become one of the nineteen states that have implemented the programme and are experiencing significant advancements. Therefore, this review aims to explore the topic of health care financing and the attainment of universal health care in Bayelsa state, specifically focusing on the transformative impact of health insurance schemes.

2. Health financing and system performance

The foundation of the methodology employed may be traced back to the World Health Report 2000, which focused on evaluating the effectiveness of health systems [6]. The report utilised a framework that established three overarching objectives and four fundamental functions of health systems. The World Health Organisation (WHO) later reorganised these four functions into six "building blocks" in 2007. However, for the purpose of this study, the framework remains unchanged, as it is specifically applied to health funding policy. The primary objective of a health system is to optimise the achievement of goals, taking into account the varying degrees of importance assigned by a country to each goal. This optimisation is influenced by external contextual factors that impact the level of goal attainment that can be feasibly reached, such as a country's income, education levels, and political factors [1].

Social factors coming from outside the health system have an impact on its goals, but the policy is focused on the activities and policies of the health system. To put it more simply, given the influence of extra-sectoral issues in the setting of a particular country, how does the system's design and operation affect the degree to which the goals are attained? What factors link poor goal achievement to issues with the health system, and how may deliberate modifications to the way the health system functions (i.e. reforms) lead to better goal attainment? Understanding the connections between the system and the goals is necessary to "fill in the missing middle" of the health system architecture. The concern here is how the finance function can affect the achievement of the goals, even if this is a general issue for health systems and thus involves each of the four functions (separately and collectively) [7].

By using this method, it is possible to identify a more focused set of financial policy goals that can be the subject of future health funding policy initiatives. These include policy goals that are nearly identical to the broad health system goals, such as promoting universal financial risk protection and a more equitable distribution of the system's financial burden, as well as policy goals that are intermediate and crucial to the broad health system goals, as depicted in Figure 1 [7].

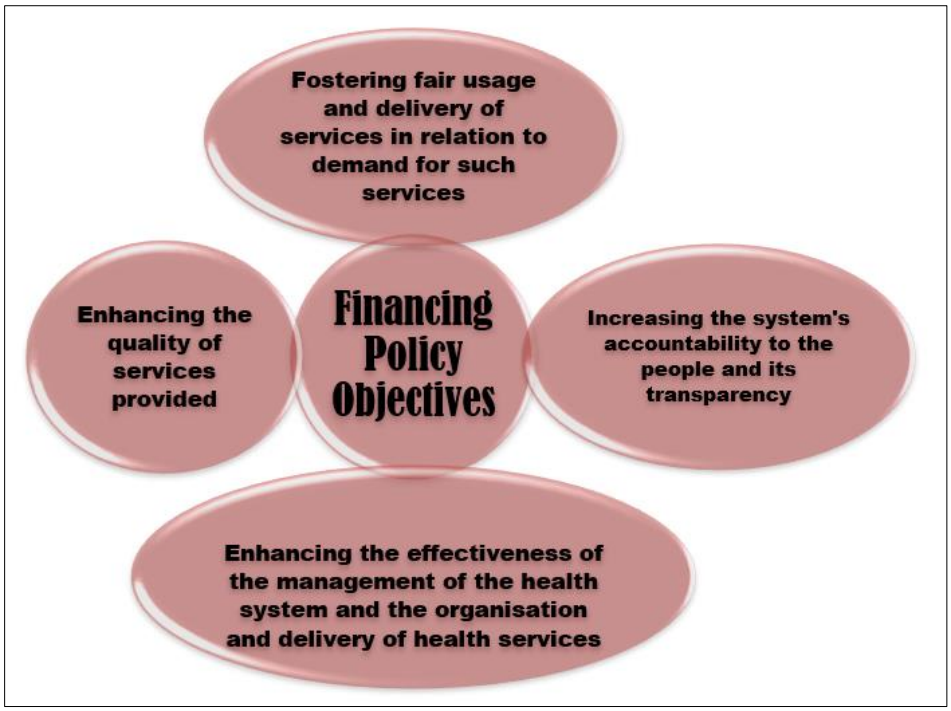

Figure 1 Financing Policy Objectives

A key idea in the health care system is that the health financing system cannot affect intermediate and ultimate goals alone; coordinated policy and implementation across all health system functions are necessary to advance the desired goals, such as raising the standard of care. Furthermore, many nations experience issues with the availability of human resources and physical access to healthcare services, and once again, financial policy cannot solve these issues on its own. The aims are significantly influenced by these additional health system functions.

The structure of health finance systems often has a substantial impact on many social goals, which holds major implications for public policy. Particularly, the ways in which health care is financed might affect people's employment-related decisions and opportunities. People are free to shift occupations without worrying about losing their health coverage in nations with a national system of coverage and a unified set of benefits, such as the majority of Western Europe. Contrarily, in countries like the United States of America where health insurance is linked to employment and neither mandatory coverage nor uniform entitlement exist, many people are "locked" into a job because they run the risk of losing coverage if they accept a new position with a different company [8].

Bansak and Raphael [9] conducted a study that demonstrated the efficacy of a policy reform aimed at decoupling healthcare coverage from employment, resulting in enhanced occupational mobility for individuals. Additionally, there is some evidence that publicly funded coverage programmes in Thailand [10] and Mexico [11] have slowed the rate of labour market formalisation because they have eliminated the need for individuals to make formal social security contributions in order to obtain adequate health coverage [9].

3. Universal Health Coverage

The resolution passed by the United Nations General Assembly, which calls for universal health coverage (UHC), serves as a testament to the enduring political dedication at the highest echelons towards attaining global health objectives. This commitment holds the promise of revolutionising health systems, particularly for marginalised populations [12]. In order to fully harness its potential, it is imperative to establish a precise and unambiguous definition of Universal Health Coverage (UHC). Without such clarity, there is a risk of UHC suffering a fate similar to that of the Health for All movement. Despite receiving substantial support from influential political figures, the Health for All movement ultimately fell short in implementing substantial financial and policy reforms required to attain its intended goals. Universal health care (UHC) is a concept that encompasses other terms, such as universal health-care coverage or universal coverage, as referred to in this particular viewpoint. The absence of a comprehensive framework is a challenge for policymakers aiming to enhance fairness in access and utilisation of services, with the goal of achieving more

equitable health outcomes. Additionally, the definitions and explanations of Universal Health Coverage (UHC) exhibit considerable diversity [13].

According to Kirby [14], the term "universal" in the context of UHC refers to the legal duty of the state to provide healthcare to all of its citizens, with special emphasis on ensuring inclusion of all marginalised and excluded groups. Nevertheless, as admirable as a dedication to universality may seem, it may not significantly alter the practises that many governments utilise to either actively or passively deny some residents of their boundaries access to health services. Authorities frequently view so-called stateless persons as having no legal entitlement to any rights to health care, including refugees, undocumented migrants, nomadic people, and those who are denied birth registration [15].

Other people are shut out as a result of institutionalised prejudice towards them due to their political views, ethnicity, religion, sex, or sexual orientation. Even for legal citizens, being female or belonging to an ethnic or religious minority can be a reason for being denied access to health care and other social services. If UHC is to be a reliable indicator of development, it must be clear how the goal of universal health coverage is to be balanced against how each state defines citizenship and establishes the parameters of its UHC obligations [16].

Another phrase that sparks debate is "health." The resolution passed by the United Nations General Assembly proposes a more comprehensive understanding of health that beyond the provision of basic or required healthcare services. The attainment of the "utmost achievable level of physical and mental well-being" is mandated, alongside efforts to address the factors influencing health [12]. The concept of universal health coverage (UHC) and social health insurance refers to the provision of healthcare services and financial protection to all individuals within a certain population [5].

Civil society organisations who want global UHC targets that require and encourage national action on social determinants to eliminate disparities and demand efforts beyond the health sector highly endorse this point of view. However, the transition to UHC often broadens access over time, beginning with a constrained range of basic medical services that are available to wage earners in both the public and private sectors. However, because these groups are more likely to use these services than the poor or those employed in unorganised industries, this strategy frequently worsens health inequities [17].

Experiences from nations that have expanded the definition of health suggest that UHC policies may need to establish a comprehensive social health platform that offers a continuum of care for both communicable and non-communicable diseases over the course of an individual's lifetime in order to address inequities. Other crucial policies would be covered by this platform, including those for children's health and education, workplace safety, retiree health insurance, and, in certain nations, traditional health systems. However, this strategy would need support from a number of ministries and sectors, some of which would find it difficult to prioritise health. Clarity is required regarding the scope of the health issues that UHC policies address, whether or not other sectors are involved, and, consequently, the degree of health inequities that UHC can realistically address [18].

4. Global Perspective of Social Health Insurance

Health, according to the World Health Organisation [6], is a condition of full physical, mental, and social well-being and is not merely the absence of sickness or disability. If we rigorously adhere to this criteria, no Nigerian can be considered a healthy client for the insurance market. This definition appears to be an aberration in Nigeria. Every nation aspires to offer its residents access to inexpensive healthcare. For instance, there is no publicly funded health insurance programme in South Africa. However, they may brag of having healthier health indicators than Nigeria. They have private health insurance programmes that are accessible, well-developed, and operating profitably and well [19]. We can learn more by examining the healthcare systems of certain important nations. The National Health Scheme (NHS), a publicly funded healthcare system for all UK citizens, is present in the United Kingdom (UK). There are no premiums gathered, no patient-level charges are made, and no pool is used to pay for the costs [19].

Although it is not a true insurance system, it does meet insurance's primary objective, which is to distribute financial risk brought on by illness away from general taxes. The majority of Americans' primary source of coverage, private health insurance, is significantly reliant on the US healthcare system. There are both public and private health insurance programmes in Canada; the majority of these programmes are managed at the provincial level in accordance with the Canadian Health Act, which mandates universal access to healthcare for everyone. According to Gana [19], 65% of Canadians have access to some type of supplemental private health insurance, often through their workplaces.

France has a system of solidarity. Both public and private initiatives are present. The strange thing about the French system is that when a person gets sicker, they pay less. This means that the insurance system covers all costs for patients with serious or chronic illnesses and waives co-payments. Additionally, private health insurance is offered [19].

Along with private plans, Australia has a functioning public health insurance system. The public health system (Medicare) guarantees free, universal access to hospital care as well as discounted outpatient care. A 1% tax on all taxpayers, an additional 1% tax for people with high incomes, and general government revenue are used to pay for Medicare. While certain non-profit health insurance organisations are also active, other private health insurers are for-profit businesses. In Germany, a health insurance plan known as the sickness fund is financed through contributions from both employers and employees, and is administered by non-profit entities. The distinguishing characteristics of this phenomenon are a privately operated provider base, effective management practises, adequate investment, and efficient oversight of both supplier and purchaser behaviour. Chile has both public and private healthcare systems, a trend observed in many Latin American countries, where patients are increasingly transitioning from the public to the private sector [19].

In spite of the presence of the National Health Insurance Scheme (NHIS), the Nigerian healthcare system acknowledges private healthcare providers as substantial contributors. The coverage provided by the NHIS is comprehensive; nevertheless, it currently does not encompass individuals engaged in street vending, farming, sole proprietorship, artisanal work, and those who are unemployed. The project does not extend coverage to all those employed in government and corporate positions, including those within the official sector. Consequently, a significant majority of our public and commercial hospitals persist in functioning under a fee-for-service model [19].

5. Concept of National Health Insurance Scheme

The National Health Insurance Scheme (NHIS) is an example of a social health insurance project within the formal sector. This refers to a type of social welfare programme wherein both the employer and the employee make financial contributions towards the expenses associated with the medical care received by the employee. This is achieved through the deduction of 5% of an employee's base income on a monthly basis, as well as an additional 10% of the employee's base salary contributed by their firm. These amounts are then aggregated and utilised for all members involved. Cross-subsidization is a phenomenon observed in social health insurance systems, whereby individuals who are in good health financially contribute to the medical expenses of those who are ill, younger individuals contribute to the healthcare costs of the elderly, and individuals with better incomes financially support those with lesser incomes. Hence, social health insurance can be regarded as a type of social security mechanism that guarantees the provision of a comprehensive set of medical services, which are financed through the pooling of contributions provided by participants [20].

6. Bayelsa State Medical Schemes

Because of the lack of facilities, poverty, lack of access, misunderstanding of its presence, and false notions about how healthcare is delivered, it is difficult to provide effective and efficient care. Because of this, the majority of individuals are unable to get, use, or afford the expense of health treatments. In order to address this, the Health Service Scheme was created to guarantee that individuals have access to healthcare through community-based healthcare facilities. However, many Nigerians still have insufficient access to and utilisation of health services, particularly in Bayelsa State [21].

Section 3 of the legislation that established the Bayelsa State Health Service Scheme delineates the scope of the scheme, confining its benefits exclusively to taxpaying individuals who are either citizens or residents of Bayelsa State. The primary objectives of the scheme, as outlined in this section, are as follows: to provide high-quality healthcare services without requiring immediate payment upon access; to establish and maintain a healthcare delivery system that is easily accessible to the population; to ensure the provision, promotion, and maintenance of affordable healthcare services; to establish and sustain a functional and professionally satisfactory healthcare delivery system; to eradicate the presence of counterfeit and adulterated drugs, as well as the issue of inadequate drug supply, within the healthcare delivery environment through the implementation of a well-coordinated drug supply and distribution system; and to enhance and encourage the involvement of the private sector in the provision of healthcare services [22].

The Bayelsa State Health Services Scheme (BSHSS) was established with a specific service scope and package to provide healthcare coverage for the enrollee, their spouse, and up to four biological children under the age of 18. The minimum benefits offered by the scheme include coverage for emergency care, such as road traffic accident (RTA) and minor

injuries, as well as general out-patient consultation and treatment. Additionally, the scheme covers specialist consultation and care, the provision of prescribed essential drugs and pharmaceutical care, hospitalisation in a standard ward for a total of 15 days per year, minor, intermediate, and major surgeries, antenatal care, delivery and postnatal care, childhood immunisation, and limited eye and dental care, among other services [23].

7. Strategic Plan

The primary objective of the health funding domain is to make sure that sufficient and long-term funds are available and allocated for the State's, including the LGAs', provision of affordable, effective, equitable, and accessible health care. Several goals are set for achievement in order to achieve this ambitious goal, as indicated in Figure 2.

Figure 2 Strategic Planning Objectives

These goals can be accomplished by a number of connected treatments and activities. As a result, a technical working group for health funding was established with the goal of creating and executing a costed, evidence-based state strategic health plan. To ensure the plan's seamless execution, considerable capacity building of authorities was undertaken. Additionally, skills in the field of accurate accounting and documentation of expenses were established. For each of these, timely and thorough financial management reports have to be produced on a regular basis. The creation of State Health Accounts (SHAs), Public Expenditure Reviews (PERs), and the monitoring of health budgets resulted in the establishment of a reliable framework for enhancing financial transparency [24].

The health sector received an appropriate fiscal allocation of financial resources in order to provide accessible, equitable, and affordable health care. In order to attain the recommended 15% allocation to the health sector, as indicated by the special session of OAU heads of States held in Abuja in 2001, this objective was pursued by annual increments in the proportion of budgetary provision.

7.1. Existing Schemes

The state, the federal government, and local governments all contribute budgetary funds to the Bayelsa State's health care system. Another source comes from individual out-of-pocket expenses and grants and aid from development organisations. The Bayelsa State Medical Scheme, a form of social insurance, provides a foundational contribution. Since its beginning, persons who work for federal institutions have had access to funding for themselves and their families through the National Health Insurance Scheme. There are numerous more plans and initiatives for improving maternal and child health, including particular leprosy and tuberculosis treatment programmes [23].

For improved performance, the Bayelsa State Medical Scheme has been streamlined to interface with the National Health Insurance Scheme. To increase effectiveness and ensure good coordination, additional social health protection models that are geared towards the underprivileged and vulnerable populations are also incorporated. This plan's main goal is to improve the financial mix for better coordination and productivity. Figure 3 depicts the gradual evolution of the Bayelsa Health Insurance programmes.

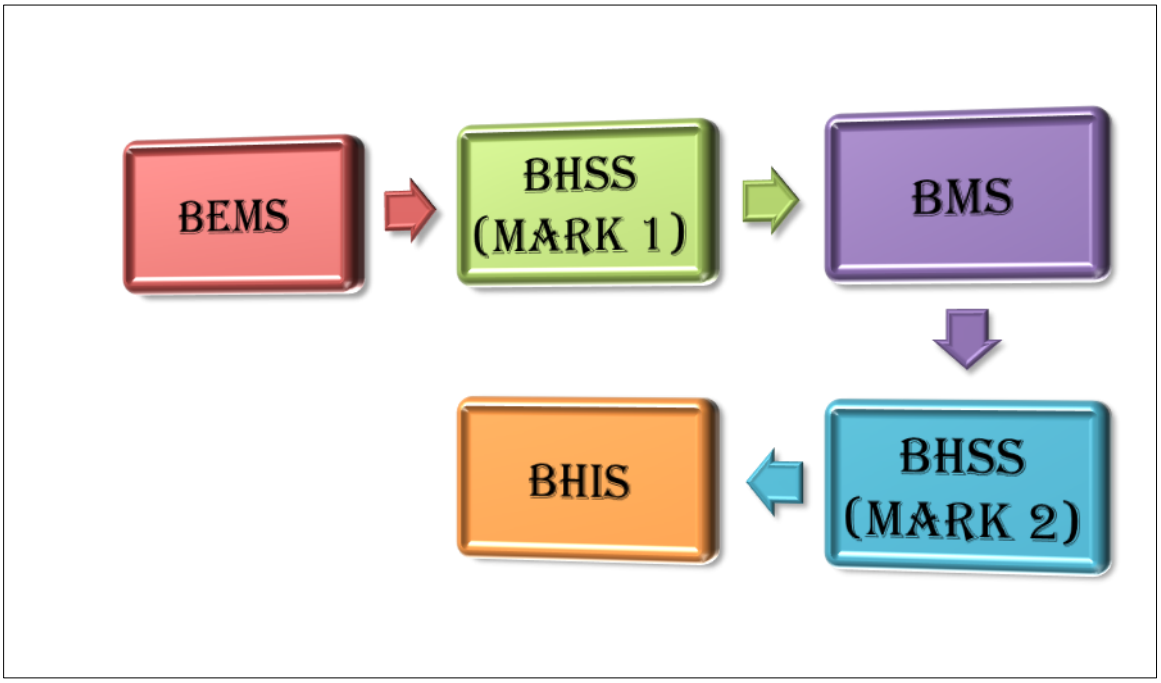

Figure 3 The progressive development of Bayelsa Health Insurance schemes

In 2000, the Bayelsa Health Service Scheme and the Bayelsa Emergency Medical Scheme (BEMS) were jointly launched. It was referred to as BASS, or Bayelsa Ambulance Service. In order to fulfil the government's mandate to give practical healthcare to all residents of Bayelsa State, it was still in operation.

BEMS's efforts included:

- Highway coverage: This involved giving accident victims first aid and evacuating them from roads and highways.
- Home coverage: This involved answering calls from residences for medical emergencies.
- Disaster management: It organised emergency medical care in a crisis, provided personnel and supplies, collaborated with non-governmental organisations, volunteer relief organisations, and other responders to offer medical and other support.
- Mobile clinic services were offered when needed.
- Transport of referred cases: Patients who were referred for a diagnosis or treatment received comfortable inter-hospital care from the BEMS.
- Providing education and training to the public on emergency response and management: The BEM planned and carried out training seminars, presentations, and workshops aimed at boosting knowledge and public awareness of emergency response and management. The primary goal of the BEMs was to provide coverage for medical emergencies across the entire state.

8. The Bayelsa Health Services Scheme (BHSS Mark 1)

The BHSS was first used in Bayelsa State in 2001. It was a plan for financing health care that was created to give the public high-quality medical care. It operated somewhat similarly to the National Health Insurance Scheme (NHIS), but was modified to fit the needs of the residents of Bayelsa State in terms of the local environment and financial resources. Being a brother's keeper was the guiding principle, and it was designed to be applied at the primary, secondary, and tertiary levels of care. Stakeholders included the federal, state, and municipal governments, businesses, and citizens of the state. The programme was introduced to the formal sector and was mandatory in that the premium was withheld

from employees' salaries. More than 6,000 people had joined with the scheme less than three years after it began. 3,824 civil servants and 3,199 additional participants who paid cash to the programme made up this group. By 2006, there were monthly donations from others and 200 naira per employee for civil servant deductions, totaling 2.6 million naira. This indicates a rise in contributors, with higher awareness and better service providing the explanation.

The Programme, however, faced a number of difficulties, including erratic funding from the Government. For instance, the State Government contributed 20 million naira every month for more than a year at the time of its launch. After, the payment was lowered to 10 million Naira every month. However, this wasn't typically made available. According to estimates, it would cost fifty-five million naira to administer the scheme with 400,000 donors in each of its many categories. But despite its quick execution, this was not realised.

The private medical practitioners' N 480,000.00 monthly fixed capitation demand, in contrast to the government's N 180,000.00 offer, was another issue with the programme. It should be emphasised that the BHSS included private practitioners from the beginning. However, their romance was broken when the government refused to give them the N 480,000.00 they had requested. The programme had another difficulty because it had three managers less than three years after its launch. The fact that primary health care, which is the foundation of government policy, is not well administered in the state presents a more challenging issue. Despite these difficulties, the BHSS was still deemed successful since, while consumer satisfaction with public health services was 47% prior to the scheme's establishment, it increased to 56% after its implementation. In 2008, Bayelsa Medicare Scheme (BMS) took the role of the Bayelsa Health Service Scheme (BHSS) [23].

9. The Bayelsa Medicare Scheme (BMS)

In 2007, a new management changed the name of BHSS Mark 1 to BMS [25]. However, because it divided donors into standard, premium, and gold insurance holders as indicated in Figure 4, the BMS was expected to be more expensive. The Bayelsa Medicare Scheme (BMS) was designed to carry out health and related duties more effectively, consciously, methodically, and dynamically. BMS was founded with the intention of altering peoples' typical financing-related behavioural patterns. BMS is adamant that financing healthcare should be viewed, acknowledged, and handled as a shared social duty.

Figure 4 BMS Categorized Contributions

BMS was resolved to have an impact on the health of all Bayelsans and believed that the healthcare worries of one man, particularly in the area of financing, should be the concerns of all. Figure 5 displays the primary goals of the Bayelsa Medicare programme.

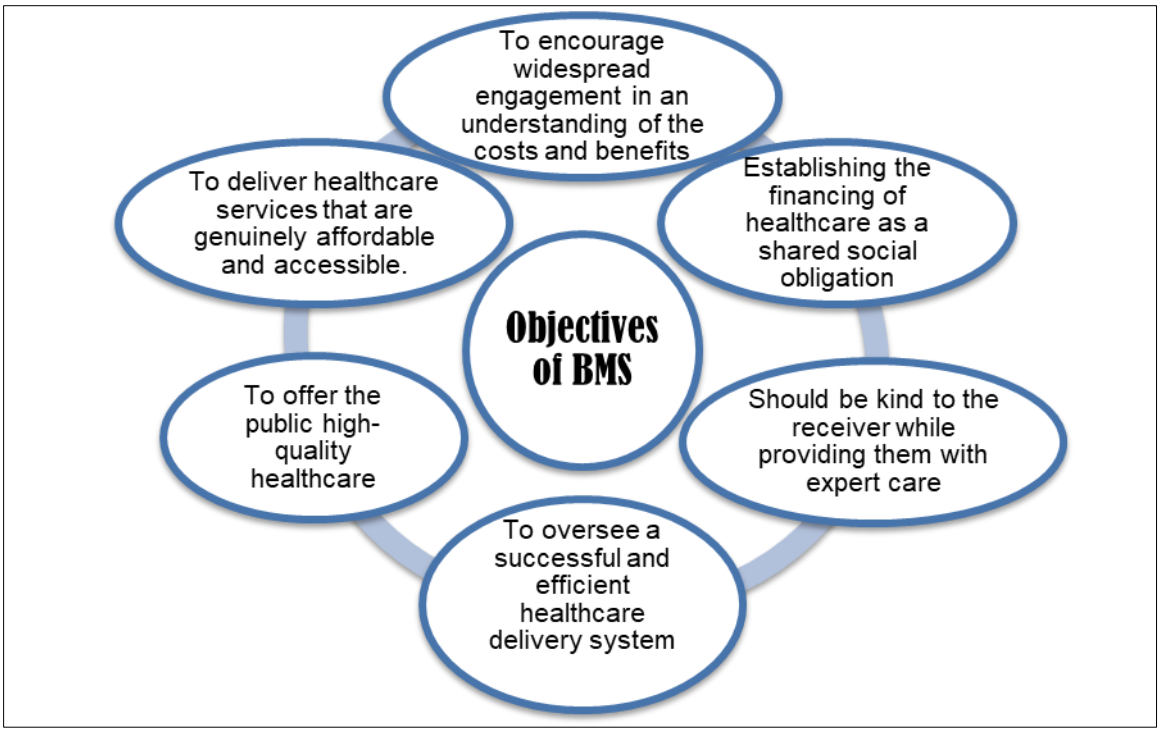

Figure 5 Objectives of BMS

9.1. BMS Contributions [26]

- State government employees' contribution rates:
  - State government contributes the equivalent of 3.5% of each employee's annual consolidated salary.
  - Each employee contributes 1.75 percent of their annual consolidated compensation to the
  - The State Government contributes 10% of each employee's basic pay and 5% of the basic pay annually in equity.
- The contribution rate for workers in local government is:
  - The equivalent of 10% of each employee's basic annual wage is paid by the local government.
  - Each employee contributes 5% of their annual base salary towards equity.
- Political office holders' contribution rates:
  - The government contributes the equivalent of 7.5% of the combined annual salary of each political official.
  - Each political officer contributes equity equal to 7.5% of the annual consolidated salary.
- The percentage of Bayelsa State institutions' tertiary students who contribute:
  - Students in all Bayelsa State Tertiary institutions paid a flat annual contribution of N3,000 together with the sessional tuition.
- The organised private sector's contribution rates are as follows:
  - Total of 3.5% of each employee's annual consolidated salary is paid by the company.
  - Either the employee contributes equity equal to 1.75 percent of the yearly consolidated wage,
  - The employer contributes what would be 10% of each employee's basic yearly compensation.
  - The employee contributes 5% of their base wage as equity.
- Urban information sector's contribution
  - N12,000.00 per person, every year
  - N36,000.00 per household year (maximum family size is 6)
- Rural sector contribution rates:
  - N6,000 per person, every year
  - N18,000 per household per year (up to six people per family).
- Donor organisations made donations to the programme.
- b. International companies (oil exploration, building, and servicing) paid a premium for localities in their operating zones.
- c. To fund the program's execution, the Bayelsa State Government deducted 10% from each contract it issued.

Additionally, throughout the pilot phase, the BMS had no lower order facility base and only higher order health facilities. This created the illusion of a building without a base in the design. Therefore, the BMS had no foundation within the state's (national) health policy from which to effectively operate because lower order institutions (Primary Health Centres) had not been taken into consideration at the outset. Because of this, the plan was doomed from the start. An updated BHSS (BHSS Mark 2) was created (BSH 2009).

10. Bayelsa Health Services Scheme (BHSS Mark 2)

In March 2013, the newly established government under the leadership of Governor Henry Seriake Dickson initiated the establishment of a committee known as the Bayelsa Health Insurance Policy Formulation Committee (BHIPFC). This group, consisting of 24 members, was tasked with specific responsibilities as outlined in the Bayelsa Health Insurance Policy group's official documentation (2013) [24].

1. The objective is to propose a complete health insurance policy for Bayelsa State. 2. The aim is to suggest a suitable governance structure to ensure efficient implementation of the health insurance system. 3. The objective is to propose the range of health services that should be provided or included in the scheme. 4. The aim is to propose the terms and conditions that prospective subscribers should adhere to when subscribing to the scheme. 5. Additionally, efforts will be made to enhance the efficiency of the scheme and ensure that it meets international standards.

In order to enhance the efficacy and align the plan with global benchmarks, it is important to undertake supplementary measures.

After its formation, the Committee held a workshop for stakeholders where several Health Maintenance Organisations (HMOs) gave presentations. Early in April 2013, the Committee divided into smaller groups and travelled to several areas throughout the state to identify persons without access to healthcare facilities.

The BHIPFC also paid visits to the NHIS's headquarters in Abuja and states like Cross River and Lagos that have adopted health insurance programmes. The Committee conducted extensive research on health insurance in industrialised nations and held numerous consultations. Two models for developing a health insurance programme were detailed in its proposals. However, this investigation discovered that the models were identical to those that had previously been tried. For instance, Model 2 featured contributions that were ranked according to the status of the workers in the formal economy. The NHIS and the BMS were comparable to Model 1[2].

11. The Bayelsa Health Insurance Scheme (BHIS)

Based on the Bayelsa State Health Services Scheme Law, 2013, Laws of Bayelsa State, the Bayelsa Health Insurance Scheme was initially founded as the Bayelsa State Health Services Scheme. This was overturned and re-enacted as the Bayelsa Health Insurance Scheme Law, 2019, Laws of Bayelsa State, making health insurance a requirement for all residents of Bayelsa State. All other private health insurance policies outside of the National Health Insurance Scheme and the Bayelsa Health Insurance Scheme are considered supplemental health insurance policies [25].

A social security programme called BHIS aims to achieve UHC as a prerequisite for an open-access social safety net. All Bayelsans now have access to high-quality, critical healthcare services, quality, cheap vital medicines and vaccines, and financial risk protection. In light of this, the State Government created BHIS through the BHIS LAW, 2019, a set of legislation for Bayelsa State that mandate participation for all citizens. In order to ensure equal access to and utilisation of healthcare services across all income and social strata, as well as health-risk and demographic distribution of the state, the BHIS is empowered to design sustainable and equitable domestic health finance systems and policies [23].

The purpose of BHIS is to serve as the state's sole publicly owned and managed strategic purchaser of healthcare services. The goal of the programme was to guarantee that all Bayelsa State inhabitants had access to the necessary healthcare services and that these services were readily available, easily accessible, reasonably priced, effective, efficient, and of high quality. The goal was to establish a uniform system of purchasing health services in Bayelsa State that would ensure and provide all Bayelsans of all socioeconomic classes with simple access to necessary medical care that was readily available, reasonably priced, and most importantly, of high quality without putting them in financial hardship. The following are a few of the scheme's objectives:

- To offer top-notch medical care without charging at the point of access;
- Establish and maintain a system for the delivery of accessible healthcare;

- Offer, Market, and Uphold Accessible Healthcare Services;
- Establish and sustain a healthcare delivery system that is professionally effective and functional;

Through a well-coordinated medicine supply and distribution system, eradicate the effects of fake and contaminated drugs as well as out of stock syndrome in the healthcare delivery environment; Enhance and maximise the contribution of the private sector to healthcare services. As seen in Figure 6, the goal of BHIS is to provide health services to all Bayelsans from all socioeconomic classes. In accordance with appropriateness, social solidarity, progressive universalism, and equity, the objective is to establish a robust, dynamic, and highly responsive healthcare finance system that is focused on making necessary health services available, accessible, and cheap to all Bayelsa State inhabitants [8].

Figure 6 BHIS Mission

The National Health Insurance Scheme (NHIS) and the Bayelsa Health Insurance Scheme (BHIS) were both developed to improve access to healthcare for those residing in and working in Bayelsa State, Nigeria. For the majority of services, including clinical consultations, there is no OOP payment required at the BHIS point of access to healthcare. The government, the formal economy (for which it is essentially mandatory), and voluntary payments from the informal economy all contribute to the scheme's funding. With this in place, it is anticipated that all individuals with health insurance will be able to obtain the necessary medical care when ill [16].

11.1. Benefits of BHIS

The scheme offers several advantages, such as outpatient care, pharmaceutical care based on the BHIS essential drug list, diagnostic tests according to the BHIS diagnostic test list, maternal care for a maximum of four life births, preventive care including immunisation, health education, antenatal and postnatal care, limited hospital care of up to 15 days per year in the general ward, as well as eye care and preventive dental care. Beneficiaries are not compelled to pay for treatment when it is necessary. Thus, it is possible to avoid the customary practise of turning assets into cash, especially in the case of severe sickness. In fact, according to the ministry of health, the benefit package offered by the programme is the most complete in the world.

Limitations

Although there are other factors that could affect how well the Health Service Scheme is used in Bayelsa, such as the region's challenging geography and high transportation costs, the centralization of the health budget approval process and the withholding of some funds, the lack of strong connections between parastatals that are involved in health

promotion programmes and state and local government levels, and the ineffective coordination between the federal, state, and local governments, Moral risks and the government's commitment to the equity fund are further difficulties. Discrimination in the unorganised sector, gaming-related abuse, incitement, and misrepresentation, acceptability in society/cultural norms, de-marketing through stakeholder benefit, excessive political involvement, inflation, rising healthcare technology and skill costs and lack of health personnel and human resources

12. Conclusion

The issue of implementing UHC in Nigeria has persisted due to the inability to secure health care funds. Population health and happiness are significantly influenced by health financing. A social security programme called the Bayelsa State Health Insurance Scheme aims to achieve UHC as a foundation for an open-access social safety net. Additionally, it ensures that everyone in Bayelsa has access to quality healthcare services, safe, effective, quality, and inexpensive needed medications, and financial risk protection. This analysis uncovered some of the program's accomplishments, such as outpatient care, pharmaceutical care in accordance with the BHIS essential drug list, diagnostic tests in accordance with the BHIS diagnostic test list, maternal care for up to four live births, preventive care (immunisation, health education, antenatal and postnatal care), hospital care, eye care, and preventive dental care. Beneficiaries are not compelled to pay for treatment when it is necessary. The study demonstrates that there are still many flaws, including inadequate supplies of pharmaceuticals, medical staff, and facilities, as well as subpar referral processes. When immediate medical attention is needed for both acute and chronic diseases, this could have detrimental effects. The programme also has to be updated to include new services and insured groups, such as families with more than four children. Hence, it is imperative for the government and relevant stakeholders to prioritise the provision of sufficient pharmaceuticals, proficient healthcare personnel, and well-equipped medical facilities within the BHIS. This is crucial in addressing the prevailing disparities in both social and health domains. Additionally, concerted endeavours should be made to establish effective referral systems that can effectively alleviate the impact of various health conditions experienced by these employees.

Compliance with ethical standards

Disclosure of conflict of interest

No conflict of interest to be disclosed

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