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Analysis of Social Health Insurance in Nigeria and Its Challenges

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Abstract

In an effort to achieve universal healthcare access, the Nigerian government enacted the Social Health Insurance (SHI) policy in 1999. Supported by the World Health Organization in 2005, SHI aims to enhance healthcare access for the nation's most vulnerable populations through resource risk pooling. The National Health Insurance Scheme was established to regulate and implement this policy as part of broader healthcare reforms. Despite these initiatives, the SHI policy in Nigeria has experienced slow uptake and limited coverage, hindering the government's goal of comprehensive population coverage. This dissertation analyzes the implementation of SHI in Nigeria through a theoretical review, utilizing secondary literature to develop a conceptual framework grounded in key theories: Solidarity and Risk Sharing, Social Capital, Social Mobilization, and Social Contract. The analysis identifies several challenges, including insufficient political will, lack of fiscal commitment, socioeconomic and institutional barriers, as well as cultural and religious beliefs affecting individual participation. Drawing on these theoretical frameworks, the study offers recommendations such as mandatory insurance contributions, the establishment of vulnerable group funds, subsidy gap funding, enhanced state and community resource pooling, and increased education and advocacy efforts at the rural level. It also emphasizes the need for greater collaboration among government agencies and calls for research into the barriers contributing to low enrollment in SHI.

Keywords: Social Health Insurance, Solidarity and Risk Sharing, Social Capital, Social Mobilization, and mandatory insurance contributions

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Introduction

The Nigerian Healthcare System is run by three tiers of government, namely: tertiary, secondary and primary levels. The central/federal government manages the tertiary level of services, while the respective state governments manage the secondary level of services, and the local government authority manages the primary level of services (FMOH, 2005). There are also relationships at different levels between private hospitals, NGOs and traditional medicine in health care delivery in Nigeria. Administration of the health sector is through guidelines set by the cabinet made up of members of the National Advisory Council on health (FMOH, 2005). The administrative structure of the Nigerian healthcare system is as follows: the Federal Ministry of Health (FMoH), the State Ministry of Health (SMoH), local government departments of health (FMOH 2005

A healthy population is the bed rock of socio-economic development for any nation in the world. Basd on the above, every nation in the world places emphasis on how to improve the health status of their population. The reforms of Nigeria's government in the health sector are intended to improve efficiency in both the public and private healthcare markets and to cover the poor, who have previously been neglected. Health care reform aims to refine the performance of current structures in order to be more effective and equitable. It has also been defined as justifiable, decisive change directed at health sector improvement (Berman, 1995). The reform in the health sector was said to be fundamentally a political development introduced by a political Act, i.e. the National Health Insurance Scheme is a body set up by Decree No. 35, of 1999 now Act 35 to provide accessible, affordable and qualitative healthcare for all Nigerian and legal residents. Reform has been driven by displeasure at the pre-existing physical and financial barriers to delivering health results and a successful implementation of the programme. The primary impetus is to address the difficulties of healthcare funding, poor quality of care, inequalities and limited access to health, inefficiencies in the delivery of services, level of accountability and insufficient responsiveness to client needs.

Background to the Study

The NHIS was first considered in 1962 in Nigeria by government in the First Republic and was aimed at the federal public and civil servant workers and supposed to be compulsory (Johnson & Stoskopt, 2009). However, following the Nigerian civil war the operation of the scheme was obstructed but later revived in 1984 by the Nigerian Council on Health through the National Health Insurance Committee setup by the federal government (Johnson & Stoskopt, 2009).

And in 1988, the then Minister of Health Professor Olikoye Ransome Kuti commissioned the Emma-Eronmi led committee that submitted her report which was approved by the Federal Executive Council in 1989 (Johnson & Stoskopt, 2009). The guide lines for implementation, draft legislature and cost implication for the scheme were drawn up by consultants from the International Labour Organization (ILO), and the United Nations Development Programme (UNDP) through feasibility studies that had been carried out (Adesina, 2009). The Federal Ministry of Health was directed by the federal government in 1993 to commence the implementation of the NHI Scheme in the country (Adesina, 2009). In 1999, the scheme was modified to cover more people via Decree No.35 of 10 May 1999 which was promulgated by the then head of state, NHIS Decree No. 35 of 1999 (FMOH, 2001). The law empowered the NHIS to collect premiums and pay for healthcare services for federal government employees (i.e. the formal sector) (NHIS, 2011).

Objectives of the Study

A healthy population is the bed rock of socio-economic development for any nation in the world. Based on the above, every nation in the world places emphasis on how to improve the health status of their population especially its workforce. The reforms of Nigeria's government in the health sector through social health insurance is intended to improve efficiency in both the public and private healthcare for the good of the citizens who have previously been neglected National Health Insurance Scheme is a body set up by Decree No. 35, of 1999 now Act 35 to provide accessible, affordable and qualitative healthcare for all Nigerian and legal residents.

Statement of the Problem

According to Yohesor (2004) healthcare facilities and services in the country are insufficient with inadequate medical personnel, health centres and medical equipment are part of these problems. This problem is more pronounced in rural areas/communities. As of 2004 the FMoH provided ratios of 30,000 people to one doctor and 1,000 people per 2 hospital beds, while the private healthcare provider provided services for about 70% of the population and the public healthcare provider provided services to the remaining 30% (FMOH, 2004). Maintenance and upgrading of the existing facilities are poor because of insufficient funding. The deterioration of the Nigerian healthcare service could be linked to health inequality with death of young people, disability, injuries and high statistics for infant and maternal death rates in the country (WHO, 2005). According to Eboh (2012) health inequality is common among politicians that

travel abroad for medical treatments. He said that many travel with public funds for general check-ups and for treatment for common illnesses and complaints such as ligament strains and colds etc, conditions which could be treated in Nigeria. Eboh (2012) also said that the minister for finance gave the cost for overseas medical treatment from public funds as totalling N30 billion per annum. In contrast to the above, there is an extremely high mortality rate for preventable and avoidable illnesses amongst ordinary citizens and civil servants in the country (Eboh, 2012). Also, dilapidated equipment and materials improvised by healthcare personnel add to the health inequality in the country. Health inequalities are also expanded by health professionals and members of the political class setting up private hospitals and neglecting the public facilities. This private practice is subject to little or no regulation to curtail the high cost charged for healthcare because it is either owned or sponsored by wealthy politicians (Eboh, 2012). It is a fact that over 75% of the Nigerian population are in the informal sector with low means of access to healthcare services and have no cover with any health insurance (NHIS, 2012) and are thus excluded from the national health policy. The degree of health inequality that exists might be viewed alongside the example of politicians spending public funds on medical tourism (Eboh, 2012).

Research Methodology

The use of both primary and secondary data from journals, internet, newspaper and materials from NHIS was the adopted method of study

Social Health Insurance

Social Health Insurance (SHI) is a model of health funding wherein a person's right to health care stems from earnings-related contributions (McIntyre & Van den Heever, 2007; Wagstaff, 2010). The level of contribution is determined not by health risk (e.g. age, history of illnesses in family, current health problems) but by ability to pay and it is non-profit in nature (NHIS, 2012). Middle and low-income countries are implementing social health insurance schemes as their preferred model and to complement the government effort a lot of non-governmental organisations are also managing some of this health insurance at community level (Churchill, 2006; Dror, et al., 2002). Social health insurance is usually organised by national governments with the drive to pool both the health risks of its members, enterprise contribution, government and households (Carrin, 2002; WHO, 2004). Social health insurance schemes pool different sources of funds ranging from government funds, contributions and subsidy gap fund for the poorest of the poor who cannot afford to pay contributions themselves (WHO, 2004). Social

health insurance is different from tax based insurance, financing its entitlement is connected to a contribution made by, or on behalf of, particular persons in the population (WHO, 2004). The principal feature of a SHI system is that it is financed mainly through fixed earnings related contributions charged on formal-sector employees (Abel-Smith, 1992; Wagstaff, 2010).Traditionally, SHI coverage is associated with contributions and pooling. SHI is characterised by raising revenue, health care purchasing and provision, risk pooling and social protection (Abel-Smith, 1992; Wagstaff, 2010).

The prime objectives of social health insurance are as follows: to provide healthcare thereby eliminating out-of-pocket expenditure, to increase consumption of healthcare services, and also to improve the healthcare status of the population (International Labour Office, 2008). This study will look at the objectives, vision, goals and functions of the NHIS in relation to the social health insurance characteristics and implementation processes. Welfare improvement is one of the gains of social health insurance, achieved by improving health status and maintenance of non-health consumption goods through ensuring equitable health services and reduction in health expenditure of the citizens (Varian, 1992; Townsend, 1994). Generally, social health insurance started in advanced countries for the working class group who normally belonged to insurance programmes and it gradually reached the non-working class groups, according to Saltman (2004). Recently social health insurance has been introduced to other developing countries as another way of substituting tax based insurance and out-of-pocket expenditure in countries like Vietnam 1993, Nigeria 1997, Tanzania 2001 and Ghana 2005. Countries which already had social health insurance before are now making robust efforts to pave the way on how to reach out to the informal sectors which are largely populated with the unemployed, rural dwellers, self-employed and retired people e.g. Nigeria, Philippines, Vietnam, Colombia, and Mexico (Wagstaff, 2007). Other elements such as micro-credit have been introduced into social health insurance schemes by NGOs in a bid to ensure sustainability for community-based health insurance and enable it to continue being managed by their organisation. According to Wiesmann and Jutting (2001) SHI has good effects on members, the insurance scheme and the providers alike because there is increased demand for healthcare services. Alkenbrack (2008) argued that resourcefulness is usually weak in terms of effectiveness and sustainability but it has provided a means enabling the government to increase coverage for more of the population in the implementing country. The effects of different social health insurance schemes are currently being assessed (Hsiao, 2007).

National Health Insurance Scheme

The examination of the National Health Insurance Scheme (NHIS) operational modalities, the implementation status such as population coverage funding, service delivery system, institutional structures, registration, monitoring and evaluation and challenges with the notion of using a conceptual theoretical framework to evaluate and provide analysis of the coverage of social health insurance in Nigeria. Is based on the limited literature and research into the NHIS implementation procedure, this relies mostly on NHIS literature and is largely descriptive. In order to be more analytical efforts were made to get some other literature to support and criticise claims and assumptions on the implementation of SHI in the country, especially the challenges faced by the NHIS.

Health insurance was defined by the National Health Insurance Scheme NHIS (2012) as a system of advance financing of health expenditure through contribution, premiums or tax paid into a common pool to pay for all or part of health services specified by a policy or plan. Health Insurances can also be broadly categorised as social or private (NHIS 2012). Based on the NHIS definition, it is obvious that the Scheme operates social health insurance. So it is appropriate to look at the social health insurance concept in consonance with the mode of operations in the NHIS. The Nigerian National Health Insurance (NNHI) is a single/National Health Insurance Scheme (NHIS) with different kinds of programmes (formal and informal sector) (NHIS 2012). NHIS is a body corporate established under Act 35,of 1999 by the Federal Government of Nigeria, to promote, regulate and administer effective implementation of Health Insurance programmes to ensure easy access to qualitative and affordable health care service to all Nigerians (NHIS, 2012). The NHIS recognised that expanding healthcare coverage is a challenge that faces many countries, both developed and developing ones; this reflects the concept of universal healthcare coverage (NHIS, 2012). Correspondingly, in order to achieve equity in healthcare coverage many countries have committed themselves by including healthcare objectives in health policy constitutional documents and sign up to international declarations on social security (i.e. human right declarations and MDGs declarations) (NHIS, 2012). Poor or developing countries do this in a bid to alleviate adverse health outcomes of all the population by use of a health insurance strategy and because it is considered that achieving universal health coverage (UHC) is necessary and can be achieved through expansion of social health insurance (NHIS, 2012). UHC also infers that there should be easy access to quality healthcare services by all citizens, particularly the poorest of the poor in society, and there should be security for all persons as ill health can be catastrophic as a result of out-of-pocket expenditure (NHIS, 2012). Nigeria, one of the few African countries on a quest to achieve universal healthcare coverage (UHC) by 2015, has begun an expansion of

health insurance over the past few years (NHIS, 2009). The NHIS has just recently reviewed its operational guidelines which hopefully will significantly improve operation of the scheme and enhance the quality of service delivered to the enrolees (NHIS, 2012)

NHIS is the implementing agency for the health reform system in Nigeria; NHIS was set up as part of the effort by the Federal government to strengthen the health system through the implementation of SHI in the country. This initiative seeks to create genuine health financing system and improve the health status of Nigeria through the adoption of the National Health Policy (NHP) in 2006. This also seeks to improve the capability of health goals such as financial protection of all citizens against cost of illness, fair healthcare financial services and openness to citizen expectations.

The objectives of the scheme are to ensure that every Nigerian has access to good healthcare services, to protect families from the financial hardship of huge medical bills, to limit the rise in the cost of healthcare services, to ensure equitable distribution of healthcare costs among different income groups, to maintain a high standard of healthcare delivery services within the Scheme, to ensure efficiency in healthcare services, to improve and harness private sector participation, to ensure adequate distribution of health facilities within the Federation, to ensure equitable patronage of all levels of healthcare, and to ensure the availability of funds to the health sector for improved services (NHIS, 2012).

The NHIS major programmes under Act 35, giving the social-economic groups in Nigeria three major programmes were developed by the scheme to ensure universal coverage of the population as follows; Formal sector programme, Informal sector and Vulnerable Group programmes (NHIS, 2012). The Formal sector Social Health Insurance programme commenced in 2005 (NHIS, 2012). This programme covers individuals in formal employment including public sector employees of the Federal, State and Local Government, Armed and Uniformed services, Voluntary contributors, and the private sector. Although membership is not compulsory under Act 35 that sets up NHIS, this forms part of the biggest current challenge to SHI in the country, especially in the States and LGAs as well as in the Informal sector programmes (NHIS, 2012).

Challenges

The scheme is faced with some challenging factors that slow down the coverage of Nigerian citizens as follows; the huge population of Nigeria poses a great challenge to the NHIS in providing cover to all citizens (NHIS, 2012). The social-cultural and religious beliefs of the

Nigerian population pose another problem faced by the Scheme i.e. the non-acceptability of health insurance in some parts of the country based on religion beliefs and this mirrors one of the challenges. Another challenge is the absence of a modern Information Technology (IT) infrastructure and lack of a functional and robust health information system such as the proposed e-NHIS (NHIS, 2012). One of the major challenges to the NHIS is lack of political will on the part of the political elite to formulate policy for resource allocation and healthcare delivery utilisation (Oloriegbe, 2009b). Lack of political will and fiscal commitment at all levels of governments (Oloriegbe, 2009b) where the concept of SHI is opposed in principle, requires strong government readiness. Act 35 that setup NHIS did not make health insurance compulsory for everyone (NHIS, 2012). The state and LGAs autonomy of the healthcare delivery system is another challenge facing the scheme due to states reluctant to log-on to the Scheme and the refusal of the government worker/employer to contribute their own five percent to the NHIS pool in the Formal sector programme (Oloriegbe, 2009a; NHIS, 2012). Oloriegbe (2009a) said that health delivery mechanism and responsibilities were not stipulated in the constitution in the same way as other sectors in the country such as the education sector. There is a lack of pooling across the contributing population in Nigeria, especially in the Informal sector (Oloriegbe, 2009b). There is a low level of tax payment by the informal sector. Lack of vulnerable group funds and a subsidy gap funding for the poorest of the poor present another challenge (Oloriegbe, 2009b). The above challenges can be categorised as independent variables. The newly introduced National Health Bill, signed into law by President Goodluck Ebele Jonathan on 9 December 2014, for healthcare reform in Nigeria has been one of the challenges faced by the scheme in terms of health financing but it is hoped that this will improve the Scheme implementation status eventually (The Guardian 18 December, 2014). Skirmishes and capitulations among the health sector operators about health insurance policy are another challenge faced by the Scheme (Shafiu and Hengjin, 2011). Also note the non-acceptance of payment mode by the provider i.e. fee-for-service for secondary and tertiary care level and capitation for primary level of care (Oloriegbe, 2009b). A distortion was brought to the referral system due to the multiple provider statutes approved for some healthcare providers to run their facility as primary, secondary and tertiary levels of care (Oloriegbe, 2009b). Other constraints and bottlenecks identified in NHIS implementation include poverty, inadequately trained health personnel, inadequate healthcare facilities, poor supply of drugs and vaccines, dilapidated health infrastructure and poor state of national healthcare system (Metiboba, 2011). Generally poverty, illiteracy, hunger, unemployment, gender disparity, lack of clean water, poor housing and poor sanitation have been identified as the key social determinants of ill

health and dependent variables challenging SHI in Nigeria (Metiboba, 2011). There are many challenges that threaten the performance of SHI schemes, some are related to risk or scheme design and others are related to implementation in the following context:

1. **Revenue mobilisation from the informal sector**: This is due to an inability to know the income of the informal sector group and hence it is difficult to determine the premium to be paid. Also, due to the lack of a proper means of identification in the informal sector, the premium collection mechanism is problematic. Evidence of these implementation challenges can be seen in India (Ramesh, 1999) and Tanzania (Humba, 2005). Jutting (2003) criticised a fixed premium rate for the informal sector group as inequality. Switzerland minimised the challenges of inequality through the use of HMOs to determine a premium based on knowledge of the group members and their capacity to pay (Peneger and Etler, 1997).

2. **Moral hazard**: This refers to the over consumption of health insurance services provided. This may be caused by illiteracy because people in the informal sector do not have good or sound knowledge of how it is supposed to work (NHIS, 2009). Ahuja and Jutting (2003) said that overuse may arise from an increase in demand for health care services from the members, while the provider may also tend to overprescribe services and drugs to members. The NHIS (2009) is addressing this in Nigeria by the use of a gatekeeping mechanism. The NHIS has actuarially determined a benefit package and implementation guideline for services to address moral hazard (NHIS, 2009). The use of co-payment on drugs was introduced in Nigeria to erase the moral hazard on the part of the patients (NHIS, 2009). Payment of capitation to the provider based on the numbers enrolled was also used to address the moral hazard on the part of the provider by the NHIS (NHIS, 2009).

3. **Adverse selection**: This is a situation whereby health costs are higher than the sign up in a particular scheme. Carrin (2003) said that adverse selection is a limitation on achieving successful implementation of SHI if enrolment is not made compulsory but remains voluntary. Perket et al (2010) believed adverse selection hinders the implementation of SHI where membership is voluntary. Making SHI voluntary will lead to a situation whereby greater numbers of the sick will log-in to the health insurance than the healthy (Tabor, 2005). The NHIS made use of a waiting period which ensures that enrolees have to wait for a defined period before accessing health care (NHIS, 2009). Ramesh and Dilleep (2000) said that this is a big problem in a situation where a country operates multiple insurance schemes. Taiwan also addresses this by operating a single insurance scheme (Liu and Lee, 1998).

4. Cultural challenges: Ramesh and Dilleep (2000) stated that cultural perception of illness is a big problem to SHI. Also, in Nigeria there is the cultural perception of insurance, especially in the northern part of the country (NHIS). According to Jutting (2003) cultural beliefs hinder people from joining the SHI because it is seen as wishing oneself ill health.

5. Social and political factors: This is based on religious, cultural and ethnic diversity in some countries and a political willingness to implement and enact laws to make participation compulsory (NHIS, 2012). Doherty et al (2000) said that political hindrance is the problem preventing SHI implementation in South Africa and in other countries on the continent of Africa, including Nigeria.

6. Poverty: There is poor economy in most African countries and this leads to an inability of the informal sector population to pay their premium as and when it is due and this in turn leads to poor implementation of SHI in low-income countries (Jutting, 2003). Humba (2005) says that poverty affects the spread of SHI to rural areas in Tanzania. Correspondingly, Ramesh (1999) said that poverty hindered the coverage of SHI in the informal sector in India. Jutting (2003) was of the opinion that Rwanda, Mali and Senegal are experiencing implementation problems due to the levels of poverty in the respective countries.

Analysis and Evaluation of Social Health Insurance (Shi) Policy in Nigeria

The analytical theoretical framework will form the basis of the evaluation and discussion of this on Implementation analysis of Social Health Insurance policy in Nigeria. This study offers a critical assessment of policy and programmes on implementation of SHI by using theories in relation to causes and effects for the successful implementation of the NHIS objectives of SHI programmes. It is a known fact that the relationship between theories and practice cannot be overemphasised due to the need of appropriate theories, concepts and perspectives to guide programme implementation. Due to the broader nature of SHI concept and practices this study will use a conceptual theoretical framework combines a number of theoretical approaches (i.e. solidarity and risk sharing theory, social capital theory, social mobilisation theory and social contract theory) (This work will apply the above theories to analyse the implementation of SHI in Nigeria by the NHIS

Analysis and Evaluation

The analysis is conducted through the conceptual theoretical framework mentioned above. In line with the objectives of the study which is to analyse SHI in relation to health sector reform

in Nigerian SHI implementation in line with the country's health policy and to make possible recommendations on gaps/challenges identified in the implementation process. The main question is why there is low coverage of the SHI in Nigeria. Thus, based on the above question and the implementation of SHI by the NHIS, issues and levels are identified and these will concern how to make people join the NHIS, especially the informal sector which constitutes about 70% of the population in Nigeria (NHIS, 2012).The advantage of the NHIS is that it was built on social welfare and social policy to promote and to provide national coverage of SHI in Nigeria. The bulk of the analysis is centred on the obligation of the Federal Government to the citizens based on the fact that the government has a duty to carry out certain responsibilities, especially on the issues of social welfare and social responsibility. Also, Tang, Eisenberg & Meyer (2004) are of the opinion that health related issues/policies are better sorted out at government level because the market alone cannot ensure access to quality healthcare. This is because government needs to protect the interests of its citizens by regulation in the healthcare system and an implementation programme to cater for all categories of people in the country and especially to ensure access to quality care for vulnerable populations.

Summary

This analyses the implementation of SHI policy with the conceptual theoretical framework as follows; solidarity and risk sharing examined the pooling of funds in the formal and informal sector programme, social capital theory examined the bonding of the mutual in the informal sector and social mobilisation examined the sensitisation and advocacy processes to achieve universal coverage, while the social contract examined the obligation of the government to its citizens in universal health coverage for the people. The recommendation below will be in line with the challenges identified and theories used for the evaluation and analysis.

Recommendations

Based on the analysis and evaluation of the SHI implementation in Nigeria above and having analysed the challenges that hinder universal coverage of health insurance through the conceptual theoretical framework, it is therefore recommended that the following should be looked into in order to improve coverage for health insurance; The Federal Government and SHI agency implementing the NHIS need to set up a vulnerable group fund, there is also a need to set up a subsidy gap funding for the poorest of the poor in society based on the concept of social contract as a government obligation to the people and a study should be carried out to design eligibility criteria for the poor who will benefit from the subsidy fund. Also, based on

social contract government obligation the Federal Government should make an effort to make SHI compulsory in the country since this is one of the main factors for successful SHI implementation around the world for the reason that in order to scale up and achieve universal coverage there is a need for mandatory insurance contributions. The NHIS should carry out a study on barriers that slow down enrolment into CBHI in Nigeria and in doing so this will give an in-depth analysis on how best to capture this population group with a view to seeing how the concept of solidarity and risk pooling could be of advantage to the scale up of SHI in the country. The NHIS needs to champion the development of a comprehensive social security system in the country through the implementation of SHI and have it backed up with the concept of a social contract. Through the notion of the social capital, social solidarity and risk pooling of resources the NHIS needs to set up a model that will see to the pooling of the informal sector CBHIs in the community in order to have a sustainable funding. Also due to the differences in culture and religious background in communities across Nigeria, it is important to employ the use of social capital by suggesting that NHIS take into consideration the formation of local health insurance board at the world level across the nation in order to build up the need for health insurance for the people from the community level. In consonance with the concept of social contract theory health infrastructure should be maintained and increased at the rural level to cater for the growing population. Through the concept of social mobilisation there is a need to intensify education, mobilisation and advocacy in the rural communities by the NHIS to rural leaders, religious leaders and social groups in the community a desire to campaign for awareness to encourage behavioural change in individuals in order to scale up coverage for the SHI and encourage incorporation of hybrid mobilisation approach by involving the local NGOs in this process. Based on the responsibility of the government to the people as regards to social contract the State and local government should be encouraged to legislate and have fiscal commitment for the SHI in their respective domains. Also encourage states SHI sponsored schemes and funds pooling in line with the concept of social solidarity and risk pooling. There is need for robust IT facilities to cater for the data of enrolees at the rural level as part of government rule. Intersectoral partnership should be encouraged to link SHI programme implementation e.g. there should be collaboration between NHIS and the corporate affairs commission (CAC) on ways to reduce company registration for the self-employed such as market women, artisans, local traders etc in order to capture them in a data base for registration purposes, premium collection and direct tax payment for the purpose of SHI benefit with the principles of social capital and social mobilisation as a basis. The NHIS should carry out a study on SHI impact on enrolees, on infrastructural development through

SHI in participating facilities in order to advise on how best funds should be utilised and for evaluation purposes based on the concept of social solidarity and risk pooling. There is need to have a meaningful resources pooling and investment partnership between the federal, states and the local governments for SHI implementation based on the concept of social capital based on the fact that all are autonomous in their health system. Also bridging social capital at the community level should be explored by the NHIS in order to bind community based health insurance implementation with social capital by aligning it with the values, power and goal of the community.

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