

Financing Health for Every Somali

The case for National Social Health Insurance — and a partnership with the private sector

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What We Will Cover



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THE STARTING POINT

Somalia's Health Financing Today

How health care is paid for — and why the model is fragile.

Somalia at a Glance



~US\$500

GDP per capita — among the lowest in the world, tightly constraining fiscal space for health



<1.5%

Domestic health spending as a share of GDP — far below regional and global norms



41%

Population reached by the Essential Package of Health Services (47 of 89 districts)

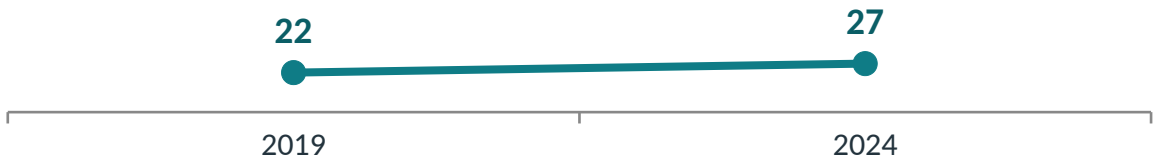


11%

Children who are fully immunised — weak pooling limits programme reach

UHC service coverage remains among the world's lowest — the index rose only from **22 (2019) to 27 (2024)** on a 0–100 scale.

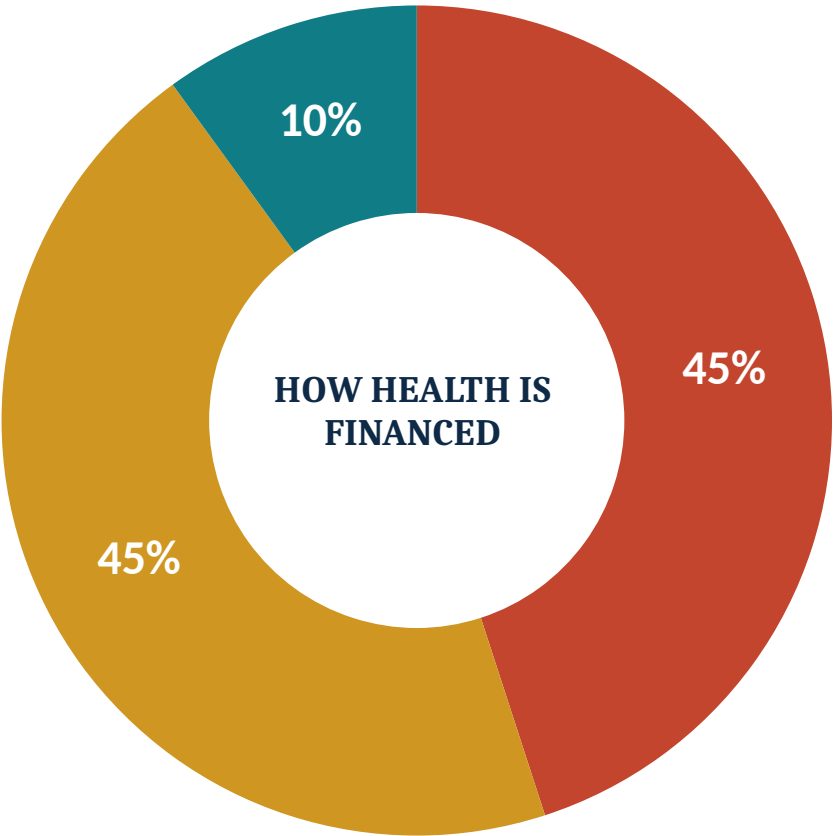
UHC SERVICE COVERAGE INDEX (0 = none, 100 = universal)



Decades of conflict have left the health system under-resourced — **financing is the engine block that everything else depends on.**

Source: Investment Case for the Somalia Health Sector 2022–2027; SHDS 2019; Discover Public Health (2025) five-year UHC retrospective.

Households and Donors Carry the Weight



-  **~45%** Paid directly out-of-pocket by households, at the point of care
-  **~45%** Financed by external donors — largely off-budget and project-based
-  **~10%** Financed through Somalia's own government budget

Over 90% of health financing is external or out-of-pocket.
≈95% of the health budget depends on external financing (WHO, 2026).

Source: Somalia Health Sector Resource Mapping & Expenditure Tracking 2018–2020; Investment Case 2022–2027; WHO Health Emergency Appeal 2026 (illustrative composition).

A System Built on Aid — and Aid Is Retreating



95%

of the national health budget depends on external financing



618

health facilities may close in 2026 due to funding cuts — 51 hospitals, 413 health centres, 154 primary units



20%

the share of the 2025 Humanitarian Response Plan (US\$1.42 bn) that was actually funded



Global aid is plateauing. Somalia cannot build Universal Health Coverage on external funding alone — a domestic, pooled financing base is now essential.

Source: WHO Health Emergency Appeal — Somalia 2026.



THE HUMAN COST

What Somalis Pay to Get Care

When paying for health means going without food, schooling — or care itself.

OUT-OF-POCKET PAYMENT

A Barrier at the Door, a Trap for the Poor



~45%

of all health spending is paid out-of-pocket by households



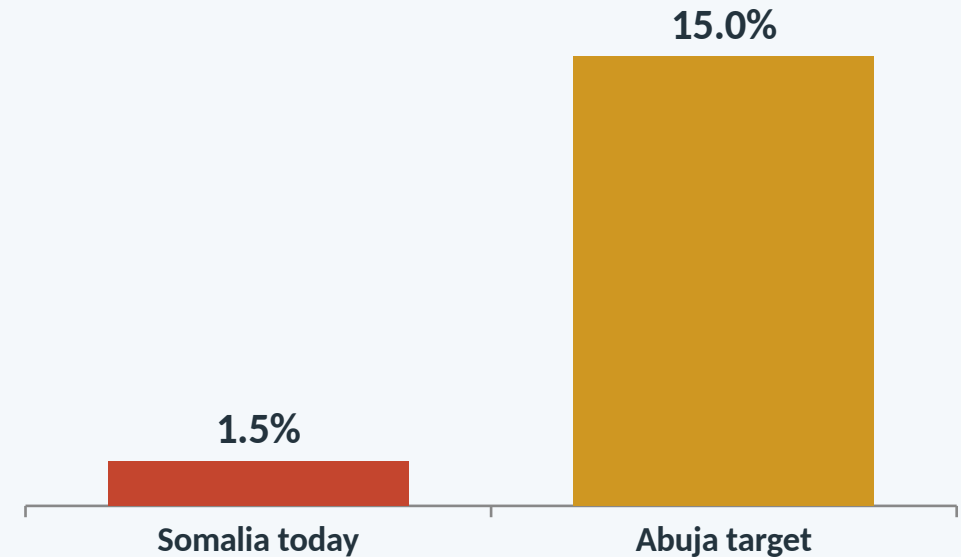
~70%

of medicines are procured through the private, largely unregulated market

Out-of-pocket payment is the most regressive way to fund health. It hits the poorest hardest, deters people from seeking care, and turns illness into debt.

THE FISCAL COMMITMENT GAP

Government health spending, share of GDP



Source: Resource Mapping & Expenditure Tracking 2018–2020; Investment Case 2022–2027; Abuja Declaration 15% target; private-medicine share addressed by INMRA (2023).

How a Single Illness Pushes a Family into Poverty



CATASTROPHIC HEALTH EXPENDITURE (CHE)

When a household's health spending exceeds the share of income it can bear — forcing cuts to food, schooling and other essentials to pay for care.



It can be prevented. Community-based insurance pilots have already cut catastrophic spending for enrolled households.

Source: Health Financing module (NSHIA); Discover Public Health (2025) five-year UHC retrospective.



THE RATIONALE

Why Insurance? Why a Domestic Fund?

Pooling risk at home is how fragile systems build lasting financial protection.

From Many Small Pools to One National Pool



Source: Health Financing module (NSHIA) — pooling and consolidation principles.

Four Reasons to Insure — and to Own It



Sustainability & ownership

Finance health from Somalia's own resources and reduce the >90% dependency on external aid.



Financial risk protection

Remove payment at the point of care and end catastrophic, impoverishing health spending.



Strategic purchasing

Use pooled funds to buy defined, quality-assured services from accredited providers — not passive spending.

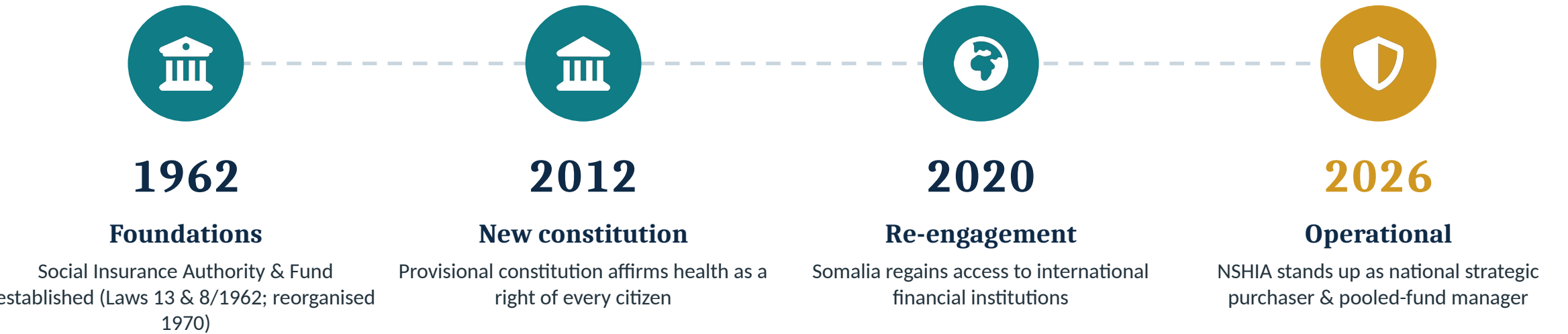


Equity & solidarity

A Sharia-compliant Takaful model: contribute by ability to pay, receive care by need.

NSHIA Is Established

NSHIA re-operationalises and unifies Somalia's national social insurance system — turning decades of legal foundations into a modern, Sharia-compliant health financing authority.



Source: NSHI Regulation (re-operationalisation & unification); Legal Foundations Report 1950–1991; Provisional Constitution 2012.

A Trusted Purchaser — Not a Paper Institution



POOL

Collect and manage contributions in one national fund



PURCHASE

Strategically buy quality-assured services from accredited providers



PROTECT

Shield members from catastrophic costs — real financial protection



GOVERN

Sharia-compliant, transparent and accountable stewardship

HOW WE BUILD IT — DELIBERATELY, IN SEQUENCE

- Cost before promise
- Pilot before scale-up
- Governance before growth

Source: NSHIA Implementation Acceleration Action Plan; NSHI Regulation, Articles 7–8, 12.



ENGINE OF DELIVERY

The Private Sector in the Rollout

Reform must work with the realities of Somalia's mixed health market.

Most Care Is Already Delivered Privately

~70%

of medicines are procured
through the private sector

*NSHIA cannot succeed without
you*

The private actors that shape access, price and quality:



Private hospitals



Clinics



Pharmacies



Laboratories



Diagnostics



Commercial insurers



Employers



Digital & health-tech

Source: Investment Case for the Somalia Health Sector 2022–2027; NSHIA Private Sector Engagement Framework.

WHERE YOU COME IN

The Rollout Value Chain — Six Points of Partnership



Accreditation & quality standards

Meet minimum quality requirements to join the NSHIA network.



Provider empanelment & contracting

Clear, written obligations, referral rules and reporting.



Fair tariffs & timely claims

Transparent tariff-setting and predictable, prompt payment.



Digital claims, membership & data

Interoperable claims, verification and minimum data sets.



Commercial insurance interface

Complementary & supplementary roles — without fragmenting the pool.



Employer & business contributions

Payroll-based enrolment for the formal sector, phased in.

Source: NSHIA Private Sector Advocacy, Engagement & Implementation-Enforcement Concept Note (technical tracks).

What Each Side Brings to Universal Health Coverage



NSHIA BRINGS

- ▶ A larger, insured patient base and pooled demand
- ▶ Transparent, rules-based contracting
- ▶ Quality-linked, predictable payment
- ▶ A national platform and public trust
- ▶ Financial protection that keeps patients coming



THE PRIVATE SECTOR BRINGS

- ▶ Delivery capacity and national reach
- ▶ Clinical quality and innovation
- ▶ Investment and operational efficiency
- ▶ Data systems and digital capability
- ▶ Responsiveness to patients and markets

Shared goal: financial protection for every Somali · sustainable, quality health care for all.

A CALL TO PARTNERSHIP

Let's Build It Together



Join the platform

Join the NSHIA private-sector engagement platform as a founding partner.



Co-design the tools

Help shape accreditation, tariffs, claims and quality standards.



Commit to a pilot

Back a phased 30–60–90 day roadmap from readiness to controlled pilot.



Shape the interface

Define complementary insurance and employer contribution models.

Dr Abdulrazaq Yusuf Ahmed · Director-General, NSHIA · Federal Ministry of Health & Human Services, Mogadishu



Financial protection for every Somali — **built at home, delivered together.**

National Social Health Insurance Authority (NSHIA) • Federal Republic of Somalia

هيئة التأمين الصحي الاجتماعي الوطنية

THANK YOU