Islamic Cooperative Societies and Health Economics in Nigeria: A Critical Review of Their Potential for Financial Protection, Equity and Community-Based Health Financing

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Abstract

Background: Islamic cooperatives are increasingly discussed in Nigeria as ethical, interest-free institutions for savings, credit, welfare and community empowerment. Their relevance to health economics, however, remains underdeveloped. This review examines whether Islamic cooperatives can move beyond general socioeconomic support to become practical instruments for financial risk protection, strategic purchasing and equitable health financing in Nigeria.

Methodology: This was a critical narrative review. The source seminar on Islamic cooperatives was treated as the primary conceptual material, while verifiable literature on health economics, Nigerian health financing, Islamic finance, community-based health financing, cooperative development, catastrophic health expenditure and health insurance reform was purposively reviewed. The review was organised around core health-economic functions: revenue mobilisation, pooling, purchasing, benefit design, governance, equity and system integration.

Results: The seminar provides a strong normative foundation centred on ta'awun, Maqasid al-Shariah, prohibition of riba, risk-sharing, transparency and ethical investment. Yet, in its present form, the model remains economically incomplete for health financing because it under-specifies actuarial design, provider payment, benefit packages, adverse-selection control and regulatory interoperability with the National Health Insurance Authority. A health-economic reinterpretation suggests that Islamic cooperatives could support household health savings, qard hasan emergency funds, cooperative takaful-type risk pools, subsidised coverage for vulnerable groups through zakat and waqf, and formal partnerships with State Social Health Insurance Agencies and the Basic Health Care Provision Fund. Their strongest comparative advantage lies in informal-sector trust, faith-linked mobilisation and local accountability. Their main risks are small pool size, weak technical capacity, exclusion in multicultural settings and insufficient governance.

Conclusion: Islamic cooperatives could become useful complements to Nigerian health financing if they are redesigned from simple thrift-and-loan platforms into professionally governed, Shariah-compliant community financing institutions linked to universal health coverage architecture. The most promising pathway is a hybrid model that combines cooperative savings, cooperative risk pooling, compassionate finance and public purchasing. This review proposes such a model and argues that its relevance may extend beyond Muslim-majority settings to any context seeking ethical, solidarity-based health financing.

Keywords: Islamic cooperatives, health economics, Nigeria, financial risk protection, Maqasid al-Shariah.

Introduction

Health economics concerns how scarce resources are raised, pooled, allocated and used to improve health as fairly and efficiently as possible [1]. Across Africa, the field has increasingly focused on financing gaps, high out-of-pocket spending, weak insurance coverage and the need for practical models that protect households from avoidable financial hardship [1]. Nigeria remains a compelling case. Direct household payment for care is still high, and out-of-pocket expenditure continues to expose families to catastrophic health spending and poverty [2,3].

Nigeria has introduced important reforms. The National Health Insurance Authority Act 2022 provides a stronger legal basis for mandatory health insurance and gives the Authority a wider regulatory and integration mandate [4]. Commentaries on the Act have noted its potential to expand coverage, including for poor and vulnerable groups, while also warning that implementation will depend on state-level structures, public trust and financing capacity [5-7]. The Act also provides for the Vulnerable Group Fund, while the Basic Health Care Provision Fund remains a key pathway for financing basic services for poor and vulnerable populations [4,8,9].

These reforms are important, but formal legislation alone does not solve the problem of local trust, irregular income and weak enrolment among informal-sector workers.

Community-based health financing remains relevant in this setting. Nigerian evidence shows that community-linked schemes can improve financial access where they are trusted, affordable and well organised, although uptake and integration with wider insurance architecture have been persistent challenges [10,11]. This is where Islamic cooperatives deserve closer scrutiny. They are not merely savings groups. At their best, they are moral-economic institutions built around mutual assistance, shared responsibility, member participation and ethical use of funds.

The source seminar frames Islamic cooperatives as Shariah-compliant enterprises built on mutual assistance, savings discipline, ethical investment, risk-sharing and social justice. It identifies Maqasid al-Shariah, prohibition of riba, avoidance of gharar and maysir, democratic participation, transparency, and products such as murabaha, mudarabah, musharakah, ijara, qard hasan and takaful as defining features. This is conceptually important because it locates cooperative finance within a moral economy rather than a purely commercial one.

A health economist, however, must ask a more specific question: can this moral and financial architecture be translated into a health financing instrument that protects households, improves equity and supports universal health coverage? That question is especially relevant in Nigeria, where informal-sector workers, traders, artisans, farmers, professional associations and faith communities often rely on trusted social networks more than distant formal institutions. Islamic healthcare-financing literature in Nigeria has already highlighted takaful and other Islamic finance mechanisms as possible complements to conventional insurance [12]. Islamic cooperatives may offer an even more socially proximate route, especially if they are linked to public schemes rather than left as isolated welfare clubs.

This review re-reads the seminar through a health economics lens. It argues that Islamic cooperatives should not be judged only by whether they avoid interest. They should also be assessed by whether they can mobilise prepayment, enlarge risk pools, subsidise vulnerability, purchase care strategically, reduce catastrophic expenditure and function responsibly across Nigeria's religiously and culturally plural settings.

Methodology

This paper is a critical narrative review rather than an original empirical study. A narrative approach was appropriate because the subject sits at the intersection of Islamic finance, cooperative development, health economics, Nigerian health reform and community-based health financing.

The source seminar on Islamic cooperatives served as the primary conceptual material, especially for defining doctrinal, governance and operational principles. It was not retained as a numbered reference because the details supplied are incomplete and the material is not independently verifiable as a published or archived source. [Author query: Please provide the full seminar title, presenter's full name, date, venue, organiser, and permission status if it is to be cited formally in the reference list.]

The review then triangulated the seminar's claims with verifiable literature on health economics, Nigerian health financing, Islamic health finance, community-based health insurance, Islamic cooperative development and integrated Islamic social and commercial finance [1-16]. Evidence from the IMAN Cooperative Thrift and Credit Society, Bida, was treated as a Nigerian example of a Shariah-compliant professional cooperative with socioeconomic empowerment relevance, not as direct evidence of health-financing performance [13]. Literature on Islamic cooperatives from OIC countries was used to support broader discussion of Islamic cooperative operations [14]. Evidence on integrated Islamic social and commercial finance, cash waqf and community-based health financing was used to examine the plausibility of linking cooperative finance to health protection [10,11,15,16].

The analytical framework was built around seven health-economic domains: revenue raising, pooling and prepayment, purchasing and provider incentives, benefit package design, equity and protection of vulnerable groups, governance and transaction costs, and scalability within Nigeria's federal and multicultural setting. A critical rather than promotional stance was adopted. The review

therefore examines not only the strengths of the seminar model, but also its omissions, internal tensions and practical constraints.

The review has clear limits. Literature on Islamic cooperatives in relation to health financing is sparse. Much of the available Nigerian evidence concerns cooperative poverty reduction, Islamic finance generally, or community-based insurance, rather than direct health-financing performance [10-16]. Some policy propositions in this review are therefore inferential. We interpret them cautiously as grounded conceptual proposals that require empirical testing, actuarial modelling and implementation research.

Results

Conceptual strengths of the seminar framework

The seminar provides a coherent ethical architecture for cooperative finance. It grounds Islamic cooperatives in ta'awun, justice, transparency, Shariah governance, prohibition of riba and avoidance of exploitative uncertainty. This matters for health economics because financing arrangements are never morally neutral. The way funds are collected, invested and distributed shapes who bears risk, who receives protection and whose suffering is treated as socially tolerable.

A major strength is the seminar's alignment with Maqasid al-Shariah, especially the protection of life, intellect, family and property. These objectives map naturally onto core health-economic concerns. Protection of life supports access to needed care. Protection of property supports financial risk protection. Protection of intellect relates to mental health, health literacy and rational decision-making. Protection of family supports maternal, child and household-centred care. From a health-economic perspective, this makes Islamic cooperatives more than faith-based savings mechanisms. It gives them a moral foundation for socially legitimate resource pooling.

The seminar also emphasises risk-sharing, benevolent lending and ethical investment. In health financing, this is crucial. Health shocks are uncertain, unequally distributed and often impossible for poor households to absorb alone. Any institution that can normalise prepayment and solidarity before illness occurs is already performing part of an insurance function. The question is whether this function can be formalised, regulated and sustained.

Where the seminar remains economically incomplete

Despite these strengths, the seminar is not yet a health financing model. It is better described as a morally rich cooperative framework with partial financial operations and a health-relevant orientation. It mentions health-related support and halal financing for health, but it does not specify a benefit package, contribution formula, claims rules, gatekeeping arrangements, covered services or provider reimbursement methods. These are not minor technical details. They determine whether a financing scheme is equitable, sustainable and resistant to collapse.

The seminar also gives limited attention to classic health-financing risks: adverse selection, moral hazard, free-riding, under-capitalisation, fraud control, reserve requirements and transaction costs of claims verification. It does not clearly separate savings, welfare support, investment funds and insurable health risks. Without such ring-fencing, members may assume wrongly that the same pooled money is available for emergency liquidity, investment returns and catastrophic healthcare.

A second critical issue is the seminar's "Muslims only" membership orientation. As a faith-based organisation model, this may have strategic value. It can mobilise strong religious solidarity, shared ethical expectations and high local accountability. It may also reach conservative Muslim women, Qur'anic school teachers, almajiri guardians, Islamic school workers and self-employed artisans who may prefer Shariah-compliant structures.

Yet this design also narrows the risk pool and creates questions of legitimacy in mixed Nigerian settings. From a health-system perspective, the key trade-off is between depth of trust within a defined faith community and breadth of pooling across a wider population. A pragmatic solution is not to erase the faith identity of Islamic cooperatives. Rather, it is to build federated models where Islamic, Christian, secular and occupation-based cooperatives can integrate with state-level health equity funds, SSHIAs or NHIA-linked purchasing platforms. This preserves cohort-specific outreach while reducing pool fragmentation.

Relevance to Nigeria's health financing crisis

Nigeria's health financing profile makes the search for complementary models urgent. Out-of-pocket expenditure remains a major share of current health expenditure, and direct payment continues to expose households to financial hardship [2,3]. Earlier national analysis found substantial catastrophic health expenditure and estimated that out-of-pocket payments pushed many Nigerian households below the poverty line [3]. Although policy reform has advanced since that study, the structural problem of household exposure remains highly relevant.

The NHIA Act 2022 established a stronger legal framework for health insurance and made health insurance mandatory for residents [4-7]. It also created the Vulnerable Group Fund and strengthened links with mechanisms for poor and vulnerable populations [4,8]. The Basic Health Care Provision Fund provides another financing pathway for basic health services and vulnerable groups [9]. These reforms are significant. Still, public architecture alone does not remove the need for localised trust, mobilisation and contribution platforms, particularly among informal workers and communities that remain hard to reach.

Islamic cooperatives may fill this meso-level institutional gap. They can sit between isolated households and large public insurers. They may help collect contributions regularly, verify local vulnerability, reduce information asymmetry and make prepayment culturally intelligible. They should not replace public insurance. Their stronger role is to improve enrolment, retention, subsidy targeting and trust within formal health coverage pathways.

Health-economic functions that Islamic cooperatives could perform

First, Islamic cooperatives can support revenue raising. Regular member contributions, earmarked health savings, workplace-based deductions and community donation streams can create predictable prepayment channels. This function is especially useful in informal and semi-formal labour markets where income is irregular and trust in remote institutions is low.

Second, they can support pooling. Community-based health financing literature in Nigeria shows that prepayment and local risk pooling can reduce financial barriers when schemes are well organised, although scale and integration remain difficult [10,11]. A cooperative can aggregate contributions across members and redistribute resources towards those facing illness, especially if it combines household savings with a protected solidarity fund.

Third, they can support subsidisation. Islamic social finance offers pathways for integrating zakat, sadaqah, waqf and benevolent funds with commercial or contributory structures [15]. This is relevant for low-income members, widows, persons with disability, displaced persons, pregnant women and older members who cannot sustain regular contributions. Evidence from Kano suggests that cash waqf could complement public funding and improve continuity of healthcare support, although this evidence remains early and context-specific [16].

Fourth, they can support purchasing. This is the least developed but most important frontier. A mature Islamic cooperative health model should not merely reimburse members after illness. It should contract providers, define referral pathways, negotiate package prices for primary care and essential medicines, and purchase care in ways that reward quality and cost control. Without this shift from passive welfare disbursement to strategic purchasing, the model will remain charitable rather than health-systemic.

A proposed Nigeria Islamic Cooperative Health Protection Model

Based on the review, this paper proposes a five-layer Nigeria Islamic Cooperative Health Protection Model.

Layer 1 is mandatory micro-savings for health and welfare. This supports predictable contributions and helps members build a health-specific savings culture.

Layer 2 is a ring-fenced qard hasan emergency fund for short-term liquidity. This can support urgent transport, medicines or surgery deposits, while preventing the emergency fund from being confused with savings or investment returns.

Layer 3 is a cooperative risk-pooling window for defined outpatient and inpatient benefits. This layer should be structured on Shariah-compliant principles and managed with clear actuarial rules.

Layer 4 is a vulnerability subsidy layer funded through zakat, waqf, sadaqah and donor partnerships. This layer should protect poor, older, disabled,

pregnant and high-risk members who cannot afford regular contributions.

Layer 5 is formal integration with NHIA, SSHIAs and BHCPF. This prevents cooperative members from remaining isolated in informal welfare arrangements and links them to recognised health coverage pathways.

This layered design is useful for two reasons. First, it separates savings, benevolent lending and insurance-like pooling instead of collapsing them into one vague fund. Second, it aligns Islamic moral economy with modern health financing functions: prepayment, pooling, purchasing, subsidisation and regulation.

Multicultural and federal implications for Nigeria

Nigeria's diversity makes design choices decisive. In Muslim-majority northern states, Islamic cooperatives may scale through mosques, professional associations, market unions and Islamic welfare bodies. In North-Central and urban mixed settings, a rigid confessional structure may reduce efficiency and legitimacy. There, a more workable framing may be an ethical, non-interest cooperative with Shariah governance but open membership for anyone who accepts the rules. Such openness enlarges the pool without necessarily diluting the ethical core.

The same applies to women's participation, youth enrolment and occupational diversity. Evidence from community-based health financing in Anambra State shows that uptake is shaped by socio-demographic and economic factors [11]. Islamic cooperative health models should move beyond generic member categories. They need explicit inclusion strategies for petty traders, transport workers, farmers, artisans, teachers, health workers and home-based women entrepreneurs. Multilingual communication, trust-sensitive marketing and interfaith neutrality in service purchasing will matter in mixed states.

Professional and workplace cooperatives also deserve attention. The IMAN Cooperative case from Bida shows that organised professional groups can sustain a Shariah-compliant thrift and credit structure with socioeconomic empowerment value [13]. If adapted for health financing, such groups could become pilot sites for cooperative prepayment, provider contracting, preventive care packages and digital claims systems.

Discussion

This review suggests that the greatest contribution of Islamic cooperatives to Nigerian health economics is not doctrinal differentiation alone. It is institutional

Table 1: Health-economic reinterpretation of Islamic cooperative instruments

Health-economic function	Islamic cooperative instrument	Possible Nigerian health application	Main implementation risk
Revenue mobilisation	Regular member contributions; earmarked health savings	Monthly prepayment for primary care, medicines and referrals	Irregular income and contribution lapses
Risk pooling	Cooperative solidarity fund; takaful-type pooling	Defined outpatient and inpatient package for members	Small pool size; adverse selection
Emergency liquidity	Qard hasan	Short-term support for urgent surgery, drugs or transport	Moral hazard if not ring-fenced
Subsidy for vulnerable groups	Zakat, sadaqah, waqf and donor support	Coverage for indigent members, widows, persons with disability and pregnant women	Leakage, weak targeting and politicisation
Strategic purchasing	Negotiated provider agreements	Package pricing with PHC centres, mission hospitals and accredited private providers	Weak contracting and quality oversight
Capital support	Murabaha, ijara and musharakah	Equipment acquisition, clinic support, ambulance leasing and medicine revolving funds	Poor governance and asset misuse

Table 2: Suggested implementation pathways across Nigerian state contexts

State or market context	Preferred cooperative design	Equity and inclusion requirement	Health-economic priority
Muslim-majority northern states	Mosque-, workplace- or market-linked Shariah-compliant health cooperative	Protect the poor through zakat or waqf subsidy and women's participation rules	Rapid enrolment and prepayment
Mixed North-Central and FCT settings	Open ethical non-interest cooperative with Shariah governance	Open membership beyond Muslims while preserving ethical rules	Pool enlargement and legitimacy
Urban southern mixed markets	Occupation-based cooperative linked to SSHIA or accredited private plans	Interfaith neutrality in purchasing and communication	Retention and provider contracting
Rural underserved communities	Village or ward-level cooperative linked to PHC and BHCPF	Target transport, maternal care and medicine access	Financial access to basic services
Professional associations and hospital-based groups	Payroll-linked cooperative health plan	Transparent governance and digital claims records	Pilot testing of strategic purchasing

differentiation. Islamic cooperatives can function as trusted intermediate institutions that convert moral obligation into practical prepayment and local governance. That is their comparative advantage. In a system where many citizens distrust insurers, fear hidden charges or struggle with irregular income, a trusted cooperative may achieve what top-down policy often cannot: repeated small contributions made credible by proximity and shared norms.

Trust, however, is not enough. Health financing fails when goodwill substitutes for design. A cooperative that offers undefined promises, weak accounting or unrestricted withdrawals cannot deliver financial protection. Pooling arrangements require technical management, reserve policy, transparent eligibility rules, anti-fraud mechanisms and some form of strategic purchasing [1,10,11]. The seminar's ethical principles remain valuable, but they must be translated into operational economics.

A second implication concerns equity. The Maqasid framework gives Islamic cooperatives a strong normative basis for protecting life and property. Those goals are weakened if schemes exclude the poorest, women with irregular incomes, non-Muslims in mixed communities or people with high disease burden. Equity in health economics is not achieved by moral aspiration alone. It requires deliberate subsidy design and cross-subsidisation. The Vulnerable Group Fund, state insurance mechanisms and BHCPF architecture create openings for this type of collabouration [4,8,9]. Islamic cooperatives should therefore position themselves as community mobilisers and co-financing platforms within universal health coverage, not as detached alternatives to public systems.

Governance must also be dual: Shariah governance and technical governance. Many Islamic finance discussions stop at permissibility. A health financing institution must also answer questions of solvency, purchasing efficiency, clinical accountability, digital record integrity and complaints redress. Shariah advisory boards should therefore work alongside actuaries, health economists, public health physicians, accountants, provider managers and digital systems specialists.

This review also broadens the meaning of Islamic health finance in Nigeria. Earlier literature has highlighted takaful as a viable alternative within Nigerian health financing [12]. This review extends that insight by arguing that cooperative institutions may be a more socially proximate route for many

communities than standalone insurance products. In practice, a cooperative may become the enrolment, contribution, literacy and trust platform through which takaful-type or NHIA-linked health coverage becomes feasible.

The policy implication is clear. Future work should move from theory to actuarial pilots. At least four questions require field study. What contribution level is feasible for different occupational groups? What benefit package is sustainable at cooperative scale? How should vulnerable-member subsidies be targeted? What governance model best balances Shariah compliance with insurance regulation? Without these answers, the model will remain attractive but under-institutionalised.

Conclusion

The source seminar succeeds in clarifying the ethical and operational logic of Islamic cooperatives. Its major contribution lies in showing that finance can be organised around justice, mutual aid, transparency and divine accountability rather than interest and speculation. From a health economics perspective, however, the seminar is only a beginning. It does not yet provide a complete answer to the practical problem of how Nigerians can prepay for healthcare, pool risk fairly, subsidise vulnerability and purchase needed services efficiently.

This review argues that Islamic cooperatives can become a transformative complement to Nigeria's health financing system if four shifts occur. First, they must move from general thrift-and-credit logic to explicit health financing design. Second, they must separate savings, benevolent lending and risk-pooling functions. Third, they must build partnerships with NHIA, SSHIAs and BHCPF rather than operate as isolated welfare clubs. Fourth, they must adapt intelligently to Nigeria's multicultural and federal realities through inclusion-sensitive design.

The broader lesson is that Islamic perspectives can contribute to health economics in Nigeria not merely by prohibiting riba, but by enriching how we think about solidarity, obligation, welfare, stewardship and the protection of both life and property. If developed rigorously, Islamic cooperatives could become one of the country's most culturally resonant pathways for strengthening financial protection in health.

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