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SUB-THEME: Financing and Sustaining Community Health in an Emerging Economy in Nigeria

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Abstract: Community Health is the ability for the members of the community to perform their optimal roles. Community health can also be the act of Preventing disease, prolonging life, promoting Health and efficiency through organized Community efforts. Financing and Sustaining Community Health is the mechanisms used to mobilize, pool, and allocate resources to pay for healthcare services at the grassroots level. Emerging economy: This is a situation where Countries initially with low economy are now moving out of low- income into becoming developing Status, industrialized economy, but isn't there yet. It's in a state of transition: growing fast, opening up to global trade and investment, but still with lower income levels and less mature institutions than advanced economy. Research Technique employed in this case is an evaluation of relevant literatures patterning Financing and Sustaining Community Health in an Emerging Economy. Nigeria as a Country like Vietnam, or Brazil is in the transition phase. BRICS: Brazil, Russia, India, China, South Africa (now expanded to include Egypt, Ethiopia, Iran, UAE, Indonesia, and Saudi Arabia, Mexico and Nigeria are frequently cited as emerging economies: These nations are often moving from "Low Income" to "Middle Income," Analytical Tools used is the assessment of the empirical studies conducted by relevant bodies. Emerging economies now account for a large and growing share of global GDP and trade. Recommendation: Nigeria needs the following strategic plains to be implemented; Domestic Resource Mobilization (DRM): Tax-funded government budgets which include External Aid: Grants from global NGOs or organizations like the WHO; Conclusion;, there is no perfect health care funding system fund Worldwide hence, Nigeria needs a rebus type of health system with the following: Good health policy and strong health system transfer adapted to local condition to help her makes better policy decisions, and proceed sensibly in the face of health care financing challenges.

Keywords: *Community Health Universal Health Coverage (UHC), Domestic Resource Mobilization (DRM), Primary Health Care (PHC) Level, Innovative and Mixed Funding, Grassroots Community-Led Models.*

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I. INTRODUCTION

Every country is moving into global development economy on how to fund health at the "grassroots" level Such nations are moving fast but often lack the deep financial power. In an emerging economy, community health isn't just a moral imperative; it's a macroeconomic necessity. Any health-care system aims to maximize the health and welfare of the population with the resources that it has available such as people, time, facilities, equipment, and knowledge. In facts no society has enough resources to maximize the welfare of her citizens. Choices must be made about which services to provide with the resources available. Decision-makers rarely have all the data required to consider costs and benefits of alternate allocations and efficiency changes. Efficiency, in this sense, is defined as the maximum possible benefit that can be achieved with the given resources. (AlMansur Sumayya Auwa,Jimwan Nankam,reuben BiyamaChama, ali simibiat,alMansur umaima, Jang byencit, shall joshua, Obeta Maureen, 2023)

Financing community health in emerging economies is a bit tasking but it is worth doing as it is the first level of contact with the members of the community (at the grassroots). It requires a mix of traditional public funding, innovative private capital, and a lot of grassroots engagement. The following terms are critically examined:

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II. UNIVERSAL HEALTH COVERAGE (UHC)

WHO defined health financing as the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system" (Popoola, Oluwafeyikemi Eunice, Irinoye, Omolola Oladunni, Oginni, Monisola Omoyeni, 2015). This concept ensures all people of different countries have access to the health services they need without suffering financial hardship. This is a global declaration which Nigeria must strive to achieve by providing a leveling system that takes care to prevent inequality in Health coverage in remotely disadvantage areas. Nigeria (Isaac, Akintoyese Oyekole, John Olusegun Ojedia Olidele, Albert Ajani, Eytayo Joseph Oyeyinpo Banmidele Rasak, 20020)

➢ *Sources of Funding in Nigeria*

There are two main approaches to healthcare financing in Nigeria- the public and private approaches. The major sources of finance for the health sector in Nigeria are the three tiers of government (Federal, State and Local Government), public general revenue accumulated through various forms of taxation, the health insurance institutions (private and public), the private sector (firm and households), donors and mutual health organizations

➢ *The Strategic Frameworks that Nigeria can Embark on to have Effective Heath Care Financing*

These define the "why" and the "how" of where large-scale health funding is gotten.

- *Domestic Resource Mobilization (DRM):*

This is the principle of "funding from within." It refers to a country's ability to generate its own revenue (taxes, levies) to fund health, reducing dependence on foreign aids. Nigerian Government should budget up to 15% of the total Capital for country's Health care system as stated in the Abuja Declaration of 2001 as a landmark commitment by African Union (AU) member states to improve healthcare, specifically pledging to allocate at least **15%** of their annual budgets to the health sector (Ogbodo, 2023) **.**

- *Primary Health Care (PHC) Level:*

what we called the "front line." In emerging economy is increasingly shifting here because it's more cost-effective to prevent a disease in a village than to treat it in a city hospital. Community based health financing or community financing for healthcare is referred to as a mechanism whereby households in a community (the population in a village, district or other geographical area, or a social economic or ethnic population group) finance or co-finance the current and/or capital costs associated with a given set of health services, thereby also having some involvement in the management of the community financing scheme and organization of health services (Oluwafeyikemi Eunice, etal 2015)

➢ *Innovative and Mixed Funding*

Where government budgets fall short, these mechanisms bridge the gap by mixing different types of money. This is a sustaining and disruptive innovative model sited by (Christensen et al., 2015) in (Pezzuto, 2019) page 4

➢ *Blended Finance:*

Blended financing is a principle of using different financial mechanisms to achieve its objectives, making it possible to leverage borrowing for the social sector and work more closely with other financing partners to strengthen health and community systems, and fight HIV, TB and malaria. Blended finance uses developmental funds (from donors or NGOs) to "de-risk" a project so that private investors feel safe putting their money in (Amy Lin and Priya Shama)

- *Results-Based Financing (RBF):*

Also known as "Pay-for-Performance." Health Results-Based Financing (HRBF) is a cash payment or non-monetary transfer made to a national or subnational government, manager, provider, payer, or consumer of health services after predefined results have been achieved and verified. HRBF is one tool that can be used by governments to increase coverage of the population with high-impact interventions, such as immunization or institutional deliveries. There are different kinds of HRBF mechanisms Instead of paying for supplies upfront, the money is released only when specific health milestones are hit (e.g., "You get the bonus once 90% of local infants are vaccinated"). (Logan Brenzel and Joseph Naimoli, 2009)

- *Impact Investing:*

Capital that seeks a "double bottom line"—a financial return for the investor plus a measurable, positive impact on community health.

- *Development Impact Bonds (DIBs):*

A specific type of results-based financing where private investors provide the initial capital, and a "donor" (like USAID or the World Bank Grand) pays them back with interest only if the health project succeeds (Ogbodo, 2023)

➢ *Grassroots and Community -Led Models*

These terms focus on how the money actually reaches the person in the field. Real- time citizen data on the state of 13,000 plus, Primary Healthcare Centers (Foundetion, 2023)

- *Community-Based Health Insurance (CBHI):*

Small-scale, local schemes where community members pool their resources to cover healthcare costs. They have it as cooperatives. They considered it safer and they have trust in their numbers at the village level. (Pezzuto, 2019)

- *Micro-Insurance:*

Low-premium, low-coverage insurance products tailored for low-income individuals who can't afford traditional plans.

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➢ *Conditional Cash Transfers (CCTs):*

Conditional cash transfers (CCT) provide monetary transfers to households on the condition that they comply with some pre-defined requirements. CCT programmes have been justified on the grounds that demand-side subsidies are necessary to address inequities in access to health and social services for poor people. Giving money directly to families, but with strings attached—for example, the family only receives the payment if they send their children for regular yearly health check-ups. (Lagarde M, Haines A, Palmer N, 2009)

- *Task-Shifting:*

Task shifting is an approach to help address the shortage of healthcare workers through reallocating human resources to perform some specific task under supervision. While not a finance term per se, it's a massive **cost-saver**. It involves training community health workers (CHWs) to perform tasks usually reserved for doctors, making the most of a limited budget. (Siew Lian Leonga, Siew Li Teohb, Weng Hong Funb,c and Shaun Wen Huey Lee, 2021)

➢ *The "Check and Balance" Terms*

- *Fiscal Space:*

This is the room in a government's budget to spend on health without compromising its financial stability. In emerging markets, this space is often very tight.

- *Out-of-Pocket (OOP) Expenditure:*

The money people pay directly at the point of service. High OOP is the enemy of community health, as it often pushes families into poverty even though it can not be ruled out in Nigeria but can be reduced (Hughes, 2008).

- *Allocation Efficiency:*

Doing the most good with the money you have. It's the art of choosing to fund a most useful and immediate needs instead of one high-tech MRI machine for a private clinic.

Using Theory of Emergent Approach to management; Total Quality Management (TQM) and Continuous Quality Improvement (CQI) theories to community health financing in Nigeria is a shift from traditional, rigid administrative models to dynamic, evidence-based systems. In the context of an emerging economy, these frameworks treat health services as a service product that must be consistently optimized to retain community trust—a vital component for financial sustainability (Hughes, 2008)

➢ *TQM & CQI: The Conceptual Shift*

While TQM focuses on long-term success through customer satisfaction and organizational-wide participation, CQI provides the methodology for the incremental, ongoing improvements necessary to achieve those goals (Hughes, 2008)

- Customer-Centric Financing: In a community health context, the "customer" is the patient. Sustainability is achieved when the community sees value in the service, increasing their willingness to participate in insurance schemes or pay user fees.
- Process Optimization: Instead of viewing funding shortages as an isolated budgetary issue, TQM forces an audit of the *processes* that lead to waste, such as procurement inefficiencies, drug stock-outs, or patient waiting times that drive individuals to private, more expensive alternatives.

To integrate TQM into the administration of Primary Health Care (PHC) in Nigeria, management can adopt the following pillars:

Table 1 showing Pillars of Total Quality Management theory of Healthcare in Nigeria

TQM Pillar	Application in Nigerian PHCs
Customer Focus	Engaging Community stakeholders in designing health insurance benefit pages to ensure they align with local health needs
Total Employee Involvement	Empowering frontline health workers and administrative staff to identify bottlenecks in revenue collection or service delivery
Process-Centered	Using standardized protocols for financial reporting to minimizes leakage and corruption
Integrated system	Aligning the financial management of a health facility with the clinical outcomes ensuring every naira spent is tied to a health program

➢ *Operationalizing CQI in Financial Sustainability*

CQI relies on the Plan-Do-Check-Act (PDCA) cycle. In the Nigerian context, this can be used to stabilize revenue streams: (Hughes, 2008)

- Problem identification: Identify a weakness, such as low enrollment in a local health insurance scheme due to poor service quality perception.
- Setting up objectives: setting a small-scale, targeted intervention, such as a localized "Quality Assurance" pilot in one ward or district.
- Feedback mechanism: Monitor financial data—has revenue increased? Are patient visit rates higher? Is there a reduction in waste or misallocated funds?
- Decisions Making: If successful, institutionalize the process across the Local Government Area (LGA). If not, refine the strategy and repeat.

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III. STRATEGIC RECOMMENDATION

To successfully apply these theories, Nigerian health administrators should focus on decentralized financial autonomy. By granting individual PHCs the authority to manage their own revenue (within a regulated framework), administrators create the necessary environment for TQM to function: because the facility is directly accountable for its financial sustainability, the motivation to implement CQI to improve service delivery becomes an organizational imperative rather than a theoretical goal.

A. How to Map Out a Process Flow for a Community Health Facility to Identify Areas of Financial Waste or Leakages

Mapping out a "process flow" for a community health facility is a foundational TQM tool. It transforms the often-opaque movement of money and resources into a visual map, making it easy to spot bottlenecks, redundant steps, and leakage points where financial waste occurs (Hughes, 2008).

To do this, use a Value Stream Mapping (VSM) approach, which tracks both the service (patient care) and the value (financial transactions).

➢ *Step 1: Define the Scope*

Do not attempt to map the entire hospital at once. Start with a high-impact financial process, such as:

- The Patient Revenue Cycle: From the moment a patient enters the facility to the point of payment and discharge.
- The Procurement Cycle: From the identification of a need for essential medicine to payment for and receipt of those supplies.

➢ *Step 2: Walk the Process (The Gemba Walk)*

In TQM, this is called *Gemba*—"the real place." You must physically observe and examine the process as it happens. Do not rely on written policy manuals, as the actual process is maybe different.

- Identify every actor: (e.g., Patient, Nurse, Records Officer, Account Clerk, Pharmacist).
- Track every step: Document every action, decision point (e.g., "Does the patient have insurance?"), and wait time.

➢ *Step 3: Map the Flow*

Create a visual diagram using standard flowchart symbols. Use columns to show which department/individual is responsible for each step.

- *Symbols to Use:*

✓ Oval: Start/End of the process.
✓ Rectangle: An action step (e.g., "Issue invoice").
✓ Diamond: A decision point (e.g., "Is payment confirmed?").
✓ Arrow: Direction of the process flow

➢ *Step 4: Identify Financial Waste (The "Value-Added" Audit)*

Once the map is complete, categorize each step:

- Value-Added (VA): Steps the patient is willing to pay for and that directly improve health outcomes (e.g., medical examination, drug administration).
- Non-Value-Added (NVA): Waste that adds no value but is currently necessary (e.g., filling out redundant paper forms).
- Pure Waste (Muda): Steps that add cost without any benefit.

- *Look specifically for these "Financial Leakage" indicators:*

✓ Waiting/Idle Time: Staff sitting idle while patients wait creates overhead costs per patient.
✓ Redundancy/Duplication: Is data being entered into three different ledgers? This increases labor costs and the probability of errors.
✓ Inventory Bloat: Large stockpiles of drugs that are nearing their expiration date (a major source of financial loss in Nigerian PHCs).
✓ Decision Bottlenecks: Does a purchase require multiple signatures from distant offices? This delay often leads to "emergency purchasing" at higher, non-contracted prices.

➢ *Step 5: Design the "To-Be" Map*

Create a new, streamlined version of the flow.

- Eliminate: Remove steps that do not provide value.
- Automate: Can a manual ledger be replaced by a simple digital log?
- Standardize: Ensure everyone follows the exact same path to reduce variation and errors.

Table 2. Checklist for Identifying Financial Waste

Category of Waste	What to Look for
Over-processing	Multiple manual recording of the same patient information
Inventory	Expired medical supplies or unused, dusty equipment
Waiting	Patients waiting hours due to slow administrative verification
Defects	Billing errors requiring manual reconciliation or resulting in lost revenue
Transportation	Staff walking long distances to retrieves files or supplies due to poor facility layout

IV. THE NIGERIA RESILIENCE BLUEPRINT

There are two main approaches to healthcare financing in Nigeria- the public and private approaches. The major sources of finance for the health sector in Nigeria are the three tiers of government (Federal, State and Local Government), public general revenue accumulated through various forms of taxation, the health insurance institutions (private and public), the private sector (firm and households), donors and mutual health organizations (Popoola, Oluwafeyikemi Eunice, Irinoye,

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Omolola Oladunni, Oginni, Monisola Omoyeni, 2015). Financing and sustaining community health in Nigeria remains a critical challenge, primarily characterized by a heavy reliance on out-of-pocket (OOP) payments, which exacerbates health inequities and hinders the achievement of Universal Health Coverage (UHC) (Uzochukwu et al., 2015; Akintoyese Oyekola et al., 2020).

A. Financing and Sustaining Community Health in an Emerging Economy (Nigeria, 2022)

As of 2026, Nigeria stands at a critical crossroads. With the Official Development Assistance (ODA) to Africa having plummeted by 70% over the last five years, the "emerging economy" label now demands a shift from donor dependency to domestic self-reliance. This presentation outlines the 2026 strategy for financing and sustaining health at the last mile.

➢ *The 2026 Financial Landscape: "Releases over Allocations"*

In the 2026 Federal Budget, Nigeria has targeted a 6% health allocation (approximately ₦2.48 trillion). While this is the highest in history, the real challenge remains the "liquidity gap"—the difference between what is promised on paper and what is actually released to primary health centers (PHCs). Appropriation Bill(2026)

- BHCPF 2.0: The "Basic Health Care Provision Fund" has evolved. In January 2026, a ₦32.9 billion disbursement was triggered to support over 13,000 facilities in Nigeria.

- The Workload Model: Unlike the old flat-rate system, PHCs now receive funding based on patient volume which helps to improve performance and patronages . Patients Volume such as:

✓ Low-volume facilities: ₦600,000 / quarter
✓ High-volume facilities: ₦800,000 / quarter
✓ Mandatory Insurance: Under the NHIA Act, health insurance is now mandatory. As of 2025, coverage reached 21.7 million Nigerians, with a 2026 target to bring this to 15% of the population. Appropriation Bill(2026)

➢ *Innovative Financing Models*

To bridge the gap created by declining foreign aid, Nigeria is leveraging "Blended Finance" and social solidarity models. (Pezzuto, 2019)

Table 3. Innovative Financing Models

Models	Mechanism	Pros	Cons
Domestic Resource mobilization	Increase tax allocation/sin taxes	High sovereignty; stable	Politically difficult; slow
Social Health Insurance (SHI)	Compulsory Contributions from workers/employees	Pools risk effectively	Hard to capture the informal sector
Blended Finance	Combining public grants with private capital	Scale quickly; shares risk	Complex to negotiate
Micro-Insurance	Low premium, community-based schemes	Accessible to the poor	Low payout ceiling

B. Sustainability

Sustaining Innovation is an improvement in the performance and profit margins of established products that mainstream customers in major markets have historically valued. It uses its existing business model, value networks, culture, and capabilities to continue to offer new and improved products to its most demanding and strategic customers. Sustaining innovation can be either incremental or radical (Pezzuto, 2019)

➢ *Sustainability Calculation:*

- To calculate the funding gap (G), we look at the required resources (R) against the sum of public (S_p), private (S_v), and external (S_e) sources:

$$G = R - (S_p + S_v + S_e)$$

In emerging economies, G is often a moving target due to inflation and population growth.

- To maintain a PHC, the Sustainability Index (S_i) must be greater than I 1:

$$S_i = \frac{\{ I_g + I_p + I_i \}}{\{E_o + E_c\}} > 1.$$

Where I_g is government grant, I_p is private/philanthropic input, I_i is insurance reimbursement, E_o is operational cost, and E_c is capital depreciation.

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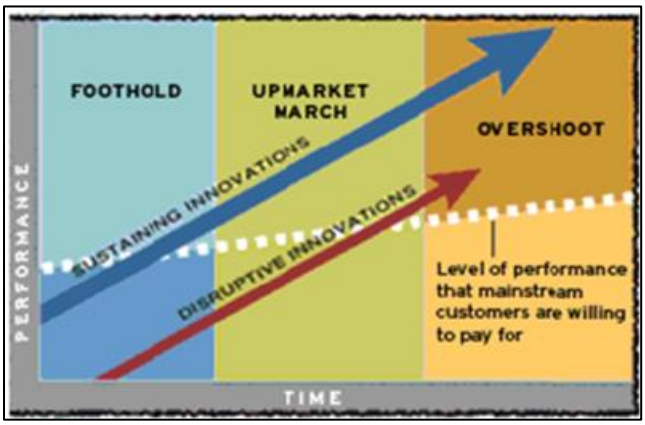

Fig 1 Disruptive and Sustaining Innovation
(Pezzuto, 2019)

- *Pillars of Sustainability*

Sustainability is about more than just cash flow; it's about resilience.
(Nigeria, 2022)

V. CONCLUSION

This study evaluated the multi-faceted architecture of financing and sustaining community health within Nigeria's complex, emerging macroeconomic landscape. The empirical evidence underscores a critical paradox: while various localized health financing frameworks and policy declarations exist, the current primary healthcare infrastructure remains fragile, inequitable, and largely unsustainable.

Nigeria's Community health system remained constrained by an over-reliance on out-of-pocket spending (OOPs). This actually exposes vulnerable rural communities to catastrophic health expenses, as the cycle of poverty remains thereby rendering true Universal Health Coverage (UHC) unattainable under existing paradigms. State and local government budgetary allocation constantly fall short of national and international benchmarks of 15% Abuja Declaration target, leaving a larger population within Nigeria's community heavenly dependent on erratic donor funding and fragmented federal subsidies. Community-Based Health Insurance (CBHI) and the basic health Care provision fund (BHCPF)only provide theoretical aspect of risk-pooling while real-world impact constrained by low enrollment rates, administrative inefficiencies, lack of local community trust, and poor sustainability. This study demonstrates that solving the population health crises in an emerging economy like Nigeria is not a matter of increasing the volume of capital, but fundamentally restructuring the efficiency, composition, and governance of the capital.

➢ *Strategic Recommendations*

The transition from fragile, short-term financing to a resilient, self-sustaining community health ecosystem involves the following strategies:

➢ *Mandatory Risk Pooling and Decentralized Consolidation:*

Here, Nigeria must aggressively move away from Voluntary CBHI models to consolidated compulsory state, LGA –level of health insurance schemes. Fragmented community pools needs to be merged for risk equalization and long-term financing viability.

➢ *The Federal Government Involving Public-Private Partnerships (PPPs):*

A private sector capabilities through structured co-financing, corporate social responsibility mandates and specialized syntaxes to fence grassroots healthcare.

➢ *Empowering Grassroots Governance:*

Financial sustainability should be activated and institionalies Village or ward development Committees to ensure that healthcare resources are adequately managed transparently, increasing service utilization and reducing corruption and fostering strong community demand for quality care.

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