

Changing Patterns and Composition of Primary Health Care Financing in a Decentralised Health System: Evidence From Imo State, Nigeria, 2020–2024

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Abstract

Background: Understanding primary health care (PHC) financing requires examination of both the volume of resources reaching frontline providers and the institutional sources through which those resources are channelled. Objective: This study examined annual changes in verified facility receipts and the composition of financing in Imo State, Nigeria, from 2020 to 2024.

Methods: A retrospective longitudinal descriptive analysis was undertaken using administrative financing records for 304 PHC facilities across 27 local government areas. Annual totals, percentage changes, facility-level receipt coverage, source shares, and financing concentration and diversity indices were examined.

Results: Recorded receipts increased from ₦7.59 million in 2020 to ₦605.17 million in 2024, with an intervening decline from ₦95.79 million in 2021 to ₦58.80 million in 2022. The proportion of facilities recording positive receipts rose from 35.86% in 2020 to 98.68% in 2024. Patient payments represented all receipts captured in 2020, whereas the Basic Health Care Provision Fund (46.60%) and Imo State Health Insurance Agency (45.42%) jointly accounted for 92.02% of recorded receipts in 2024. Financing concentration declined as recorded sources diversified.

Conclusion: Facility records indicate substantial nominal growth and a pronounced compositional shift towards pooled institutional funding. These findings describe recorded inflows, not total system expenditure, real purchasing-power growth, insurance coverage or reductions in household financial hardship. Strengthening harmonised source-level reporting and linking financing flows to service outputs would improve assessment of reform performance.

Keywords: *Primary health care financing; financing composition; health insurance; Imo State.*

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1. Introduction

Primary health care (PHC) is central to health-system efforts to deliver accessible, continuous and comprehensive services. Financing arrangements shape the resources that can reach frontline providers, the predictability of those resources and the degree to which patients are required to pay at the point of care. The World Health Organization (WHO) conceptualises health financing through revenue raising, pooling and purchasing, with the design of these functions influencing progress towards universal health coverage (WHO, 2010; Kutzin, 2013). Accordingly, the amount recorded in a health budget is not equivalent to funds released, funds received by facilities or expenditure translated into services. Each represents a distinct stage in the financing process and requires its own measurement. In decentralised health systems, these distinctions are especially relevant because financial responsibilities and reporting arrangements may span different levels of government, purchasing agencies and implementing programmes. Fiscal decentralisation can allow decisions to reflect local preferences and service requirements, but its potential advantages depend on institutional capacity, clearly assigned responsibilities and mechanisms of accountability (Oates, 1972). In Nigeria, PHC financing may involve state and local government transfers, the Basic Health Care Provision Fund (BHCPF), state health insurance arrangements, programme-specific transfers and direct patient payments. These streams may enter facility accounts through different administrative processes and may not be captured uniformly in aggregate expenditure statistics. The composition of facility financing therefore warrants investigation independently of overall funding growth. An increase in nominal receipts could coincide with greater dependence on patient payments, while a stable total could conceal a shift towards prepaid or pooled mechanisms. Such shifts matter conceptually because pooling is intended to distribute financial risks across members of a population rather than leaving the entire cost of care with individuals at the moment of illness (WHO, 2010; Kutzin, 2013). Nevertheless, a higher share of insurance or statutory funding in facility accounts does not by itself demonstrate improved population coverage or financial protection: those outcomes require evidence on enrolment, utilisation, benefit design and household expenditure.

Recent Nigerian research has highlighted the importance of governance and accountability in PHC financing. Adeoye et al. (2024) examine stakeholder perspectives on the BHCPF, while Agwu et al. (2026) address subnational accountability problems. Work on state health insurance arrangements similarly directs attention to the institutional conditions affecting financing reform (Ogunkoya et al., 2025). These contributions establish a useful policy context, but the temporal movement of funds across financing categories is a separate empirical question. Without disaggregated annual records, it is difficult to identify whether changing aggregate receipts reflect the growth of an established funding source, the introduction or expansion of another source, or a change in the completeness of administrative reporting. Imo State offers an informative setting for examining these issues at the point of service delivery. Its 27 local government areas contain PHC facilities operating within a common state policy environment while receiving funding through multiple channels. A five-year series covering 2020–2024 permits examination of the direction and consistency of recorded financing changes, including the relative contributions of patient payments, BHCPF and the Imo State Health Insurance Agency (IMSHIA). The analytical interest is not simply whether receipts

rose but how their source composition changed and how widely positive receipts appeared across facilities. This study consequently contributes facility-based longitudinal evidence to debates on decentralised health financing. It distinguishes verified facility receipts from statewide budget allocations, describes both absolute and proportional change, and interprets source diversification as an accounting characteristic rather than as proof of improved welfare outcomes. The resulting evidence can inform more transparent monitoring of frontline resource flows and help identify the additional information needed to evaluate purchasing effectiveness, financing adequacy and household financial protection.

Aim and Objectives of the Study

The aim of the study is to examine changes in the pattern and composition of primary health care financing in Imo State from 2020 to 2024.

The specific objectives are to:

1. Examine the annual trend in primary health care financing in Imo State from 2020 to 2024.
2. Analyse changes in the relative contribution of major financing sources to total primary health care financing during the period.

Research Questions

1. How did primary health care financing in Imo State change from 2020 to 2024?
2. How did the relative contribution of major financing sources change during the period?

Analytical propositions

P1: The annual volume of verified PHC facility receipts changed during 2020–2024.

P2: The relative contribution of major PHC financing sources changed during 2020–2024.

2. Literature Review

2.1 Conceptualising Primary Health Care Financing and Financing Composition

PHC financing involves the mobilisation, pooling, allocation, purchasing and use of resources to support first-contact and community-oriented services. The distinction between financing functions is important: revenue raising identifies where money originates; pooling concerns how financial risks and funds are combined; purchasing concerns how resources are transferred to providers for services (Kutzin, 2013). A facility-level receipt dataset captures a downstream portion of this system. It provides evidence on funds recorded as reaching providers but may omit central procurement, salary payments, in-kind support and other expenditure not entered in facility ledgers. Financing composition refers to the proportion of recorded receipts attributable to each source during a specified accounting period. Changes in source shares can occur because a particular source grows, another declines, or the overall denominator changes. For this reason, percentage shares should be presented alongside absolute values. The distinction is especially important when baseline receipts are low: very large percentage increases may partly reflect an unusually small starting value rather than a proportionate expansion in service capacity. Direct patient payments, insurance payments and statutory transfers represent different financing relationships. Point-of-service payments are tied to individual service use, whereas insurance and statutory funding are organised through institutional arrangements that may involve

prepayment and pooling. WHO (2010) identifies reduced reliance on direct payment at the point of service as an important dimension of financial protection policy. However, the share of patient payments in facility receipts is not the same as the household out-of-pocket share of total health expenditure, because households may purchase medicines and services outside the reporting facilities. A reduction in the recorded patient-payment share must therefore be interpreted as a compositional change within the observed facility accounts. Concentration and diversity indices provide complementary summaries of the financing mix. A Herfindahl-type concentration measure sums squared source shares and rises as receipts become more concentrated in a small number of sources. A simple diversity measure, defined as one minus concentration, rises as the recorded mix becomes more diversified. These measures describe accounting composition; they do not establish the reliability, fairness or adequacy of each funding stream. The number and classification of sources must also remain consistent across years for meaningful comparison.

2.2 Decentralised Health Financing and Theoretical Framework

Fiscal decentralisation theory provides the organising perspective for this analysis. Oates (1972) argues that, under specified conditions, decentralised provision can better reflect differences in local preferences and circumstances than uniform central provision. In health financing, this perspective suggests that subnational institutions may be positioned to adapt resource allocation and purchasing arrangements to local service demands. It does not imply that decentralisation necessarily increases financing, improves governance or reduces household costs. These outcomes depend on intergovernmental transfers, administrative capacity, accountability and the rules governing resource use. This study applies the theory to an observable financial outcome: the changing distribution of facility receipts across institutional sources. The expansion of BHCPF or IMSHIA receipts may indicate a changing operational role for pooled financing arrangements in the state. Conversely, instability across years may point to the importance of transfer timing, implementation arrangements or reporting practices, although the administrative totals alone cannot identify which mechanism caused a particular change. The theoretical value of the analysis is therefore to relate financing structure to the institutional architecture of decentralised service delivery without inferring causal reform effects from a descriptive series. A complementary health-financing perspective is provided by Kutzin (2013), who emphasises the alignment of revenue raising, pooling and purchasing with coverage objectives. From this standpoint, a financing transition is analytically meaningful when it changes not only the source of money but also the conditions under which providers receive funds and patients obtain services. The present analysis examines the first of these dimensions—recorded provider inflows—and identifies the additional provider and household measures required to evaluate the latter dimensions.

2.3 Review of Previous Studies

The literature on Nigerian health financing brings together three relevant strands: the governance of pooled funds, the expansion of state insurance arrangements and the functioning of frontline services. Adeoye et al. (2024) examine stakeholder perspectives on BHCPF governance and accountability, highlighting the importance of tracing funding arrangements beyond formal policy commitments. Their contribution is relevant to interpreting institutional receipts, although governance findings cannot substitute for a quantified source-by-year account of financing. Agwu

et al. (2026) likewise foreground subnational governance and accountability as potential influences on PHC performance. These analyses suggest institutional questions for investigation but do not establish the causes of changes in Imo State's annual receipts. A second strand addresses health insurance and financial protection. Ogunkoya et al. (2025) review a state-developed health insurance initiative, illustrating the importance of studying insurance arrangements within their particular implementation context. At the international level, WHO (2010) and Kutzin (2013) provide the conceptual basis for distinguishing pooled financing from direct point-of-service payment. These sources support examination of changing financing composition but also reinforce the need to avoid treating facility receipt shares as direct estimates of financial hardship or universal health coverage. A third strand concerns institutional fragmentation and service delivery. Nabena (2024) addresses health expenditure and institutional arrangements, while Yunusa et al. (2026) situate financing challenges within broader Nigerian health-system constraints. The literature collectively indicates that aggregate financing and service delivery are connected through administrative processes, provider incentives and reporting systems. What is less visible in these broader discussions is a consistent annual account of the amounts and proportions received from each financing channel by facilities within one state. The empirical contribution here is therefore deliberately specific. Rather than attempting to infer population health effects, the analysis documents the timing and magnitude of recorded receipts, the changing roles of BHCPF and IMSHIA, and the movement from a highly concentrated to a more diversified recorded source structure. It complements institutional and insurance research by supplying a descriptive financing trajectory that can be examined alongside future evidence on enrolment, service volume, quality and financial protection.

2.4 Research Gap

An important evidence gap concerns the distinction between policy-level financing commitments and source-specific financial inflows recorded at frontline facilities. Statewide budgets can indicate intended resource mobilisation, but they do not establish the timing or composition of receipts entering individual facility accounts. Likewise, studies focused on one insurance programme may not reveal the relative position of that programme within the wider PHC financing mix. A longitudinal facility-level approach addresses these limitations by following the same reporting framework across multiple years and by examining absolute totals and relative shares together. For Imo State, the 2020–2024 administrative series enables a focused description of how financing patterns evolved during a period in which different institutional sources assumed changing roles. The research asks two questions: how did annual recorded facility receipts change, and how did the contribution of each major financing source change? It also considers the proportion of facilities with positive recorded receipts as an indicator of the reach of recorded financial flows. These are descriptive questions suited to the available data; the findings do not require attributing changes to any single reform or inferring unobserved health outcomes.

3. Materials and Methods

A retrospective longitudinal quantitative design was used to describe annual PHC financing receipts in Imo State, southeastern Nigeria, between 2020 and 2024. The analytic dataset comprised administrative financing records for 304 PHC facilities distributed across the state's 27 local government areas. All facilities with eligible

records were included, making the approach a census of the available reporting frame rather than a probability sample of all possible providers. The unit of observation for source composition was the facility-year receipt record, aggregated to the state-year level for annual comparisons. Recorded financing channels included state government transfers, local government transfers, the BHCPF, IMSHIA, the IMPACT programme and direct patient payments. For each facility and year, receipts were organised by source and summed to obtain the annual recorded total. Facility identifiers and local government names were standardised to support longitudinal aggregation. Summary rows were excluded to prevent double counting; where calculated totals were inconsistent, source-level entries were used to reconstruct totals. Missing entries were not automatically treated as zero. A zero receipt therefore refers to a recorded zero within the available dataset, not necessarily proof that a facility received no support of any kind. Annual state totals were calculated by summing verified facility receipts for each year. Annual percentage change was defined as $100 \times (R_t - R_{t-1})/R_{t-1}$, where R_t denotes receipts in year t and the denominator is positive. A 2020-based index was calculated as $100 \times R_t/R_{2020}$. The compound annual growth rate over four intervals was calculated as $(R_{2024}/R_{2020})^{(1/4)} - 1$; because the 2020 base was small, this statistic was treated as a descriptive summary rather than a stable forecast of future financing. Means and medians of facility receipts were used to characterise distribution, while the proportion of facilities recording positive receipts described the spread of recorded financial inflows.

The annual share of source s was defined as $p_{st} = R_{st}/R_t$, with all shares summing to one where the reporting categories exhaust the total. The concentration index was calculated as $H_t = \sum_s p_{st}^2$, and the diversity index as $D_t = 1 - H_t$. Under these definitions, concentration approaches one when a single source dominates and diversity increases as receipts are distributed among several sources. These indices are sensitive to the number and classification of sources, so consistent source categories are necessary. Results were reported descriptively; annual aggregates alone were not treated as a basis for inferential claims about the statistical significance of change. Statewide PHC budget figures were considered contextual information rather than a denominator for facility-level execution rates, because the budget and receipt series cover different accounting boundaries. Monetary amounts were analysed in nominal naira; without a consistently applied deflator, increases cannot be interpreted as equivalent increases in real purchasing power. Records did not include patient-level identifiers. The analysis was limited to administrative financial flows and did not measure enrolment, service quality, household spending or health outcomes. These boundaries guided the interpretation of all results.

4. Results

4.1 Trend in Primary Health Care Financing in Imo State, 2020 to 2024

Verified receipts increased from ₦7.59 million in 2020 to ₦95.79 million in 2021, fell to ₦58.80 million in 2022, and subsequently rose to ₦452.24 million in 2023 and ₦605.17 million in 2024. The 2021–2022 decline was 38.61%, while receipts rose by 33.82% between 2023 and 2024. The five-year trajectory was therefore characterised by substantial nominal expansion alongside a pronounced mid-period interruption. The 2020 starting value was particularly low, so ratios based on that year should not be interpreted as evidence of proportional increases in service capacity. Figure 1 presents the annual series.

The largest absolute increases occurred after 2022, when the annual total rose sharply from ₦58.80 million to ₦452.24 million. This temporal pattern is consistent with an expansion in the receipts captured from institutional sources, as discussed in the composition analysis. However, the data do not isolate the extent to which the change reflected new programme financing, different transfer schedules, broader facility participation or improvements in recording completeness. The appropriate empirical conclusion is that the value of recorded facility inflows rose markedly, particularly in 2023 and 2024. Facility-level summary measures show that the increase extended beyond aggregate totals. Mean recorded receipts per facility increased from approximately ₦0.025 million in 2020 to ₦1.991 million in 2024. The median increased from zero to approximately ₦2.041 million, indicating that the typical facility had positive recorded receipts by the end of the period. In 2020, 109 facilities (35.86% of the 304 reporting facilities) recorded positive receipts. This proportion rose to 94.41% in 2023 and 300 facilities (98.68%) in 2024. These figures provide an important complementary perspective: the growth in receipts was accompanied by a broader distribution of positive recorded inflows across the facility reporting frame. A positive receipt is not equivalent to adequate financing, timely disbursement or service readiness. Nor does a zero entry conclusively demonstrate the absence of government support, given the possibility of in-kind procurement and centrally paid inputs. Nevertheless, the change in the number of facilities with recorded inflows is relevant to monitoring the operational reach of the accounting system and can help direct subsequent investigation of facilities that continued to report no positive receipts. For contextual comparison, statewide PHC budget allocations were reported as ₦6.03 billion in 2021, ₦7.56 billion in 2022, ₦8.64 billion in 2023 and ₦10.52 billion in 2024. These figures describe a broader budgetary category than the verified receipts captured in the facility accounts. Consequently, they should not be combined into a facility-level budget execution ratio or interpreted as evidence that the difference between the two series represents unspent funding. The two series are best understood as indicators from different points in the public financial management chain.

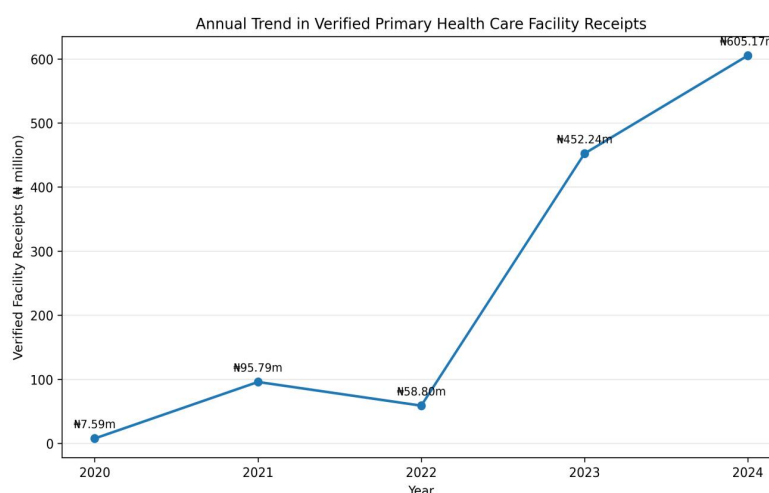


Figure 1: Annual Trend in Verified Facility Level Primary Health Care Receipts, Imo State, 2020 to 2024

The above figure 1 demonstrates the non-linear pattern of recorded receipts. Its policy relevance lies in the combination of a marked upward trajectory and substantial year-to-year variation. An annual financing review that reports only the latest total would

obscure the 2022 contraction and the changing sources underlying the subsequent increase. For monitoring purposes, annual totals should therefore be accompanied by source-specific amounts, facility coverage and information on the timing of disbursements.

4.2 Changes in the Composition of Primary Health Care Financing

The composition of verified facility receipts changed considerably across the five years. In 2020, the ₦7.59 million captured in the administrative series was entirely classified as patient payments. No positive facility-level receipts were recorded under the other named source categories in that year. This describes the observed accounts, not the complete financing of the state PHC system: centrally administered salaries, procurement or programme expenditure may have occurred outside the facility-level reporting frame. By 2021, BHCPF receipts were ₦83.60 million, representing 87.27% of the annual total. Patient payments were ₦10.40 million (10.86%), while IMSHIA contributed 1.24%. In 2022, BHCPF remained the largest recorded source at ₦39.37 million (66.95%); patient payments accounted for 22.17% and IMSHIA for 10.87%. The decline in overall receipts during 2022 therefore coincided with changes in both the absolute volume and relative contributions of financing channels. The composition changed more substantially in 2023. BHCPF receipts reached ₦155.43 million (34.37%), while IMSHIA receipts reached ₦255.67 million (56.53%), making IMSHIA the largest single recorded source that year. In 2024, BHCPF represented 46.60% and IMSHIA 45.42% of recorded receipts. Together, these two institutional channels accounted for 92.02% of the 2024 total. Figure 2 depicts the changing annual shares. This shift establishes an increasing recorded role for pooled institutional channels; it does not, by itself, demonstrate that the same proportion of patients was insured or that household out-of-pocket expenditure declined by an equivalent amount.

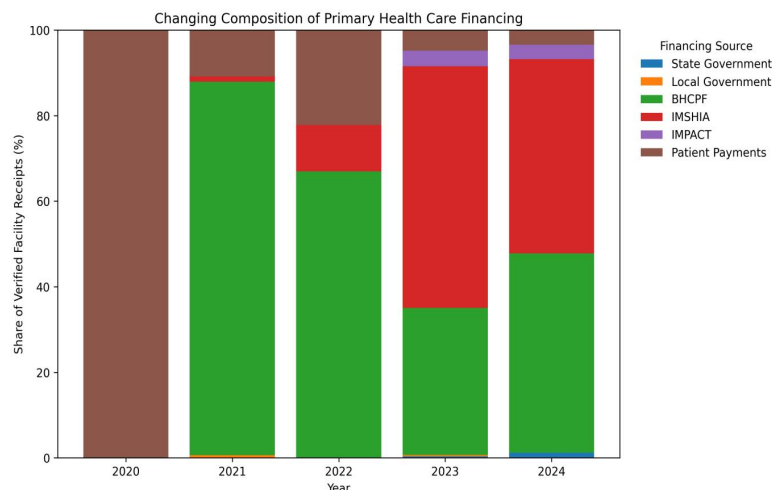


Figure 2: Changing Composition of Primary Health Care Financing by Source, 2020 to 2024

Across the five-year period, total verified facility receipts amounted to approximately ₦1.21959 billion. The aggregate series should be distinguished from source-specific contributions: ₦1.21959 billion represents the combined recorded total, not the contribution of BHCPF alone. IMSHIA accounted for a reported 44.12% of cumulative receipts, while patient payments accounted for 6.02%. The remaining recorded receipts were distributed across BHCPF and other financing channels. These cumulative shares summarise the period as a whole and are influenced heavily by the

larger receipt totals in 2023 and 2024. The financing concentration index declined from 1.000 in 2020 to 0.774 in 2021, 0.509 in 2022, 0.441 in 2023 and 0.426 in 2024. The corresponding diversity index increased from 0.000 to 0.226, 0.491, 0.559 and 0.574. Figure 3 displays the two series. These values indicate that the recorded funding mix became less dependent on a single source, even though two institutional sources together dominated receipts in 2024. Greater diversity should not automatically be equated with greater financial resilience: reliability also depends on the timing, stability and rules of each financing stream.

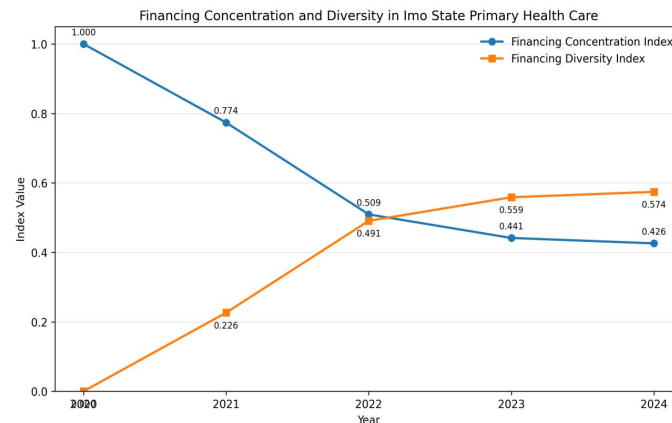


Figure 3: Financing Concentration and Diversity in Imo State Primary Health Care, 2020 to 2024

4.3 Discussion of Findings

The central finding is a simultaneous change in the scale and structure of recorded PHC financing in Imo State. Facility receipts expanded substantially in nominal terms, particularly after 2022, while the relative importance of patient payments declined and institutional channels became dominant. Considering these developments together provides a more informative account than either aggregate totals or source shares alone. The former describes the magnitude of recorded inflows; the latter identifies which financing arrangements accounted for those inflows. The emergence of BHCPF and IMSHIA as the leading recorded channels is consistent with the policy emphasis on pooling and organised purchasing described in the international health-financing literature (WHO, 2010; Kutzin, 2013). In particular, the 2024 composition indicates that a large proportion of funds captured in facility accounts flowed through these institutional mechanisms. This is an important accounting observation, but its implications for financial protection remain conditional. Financial protection concerns the extent to which people can obtain needed services without financial hardship, whereas the present analysis records the sources from which facilities received money. Additional household and service-use data are necessary to connect the two.

The fluctuating annual totals also matter. The decline in 2022 followed by rapid growth in 2023 suggests that year-specific conditions can substantially affect recorded frontline financing. Several explanations are possible, including transfer schedules, programme implementation changes, coverage of facility reporting and variations in the operation of financing channels. Because these mechanisms were not independently measured, the analysis does not attribute the observed changes to one cause. This distinction preserves the strength of the descriptive evidence while identifying the appropriate scope for subsequent explanatory research. The results complement the institutional concerns discussed by Adeoye et al. (2024) and Agwu et

al. (2026). Their emphasis on governance and accountability is relevant because a financing system may appear diversified at the point of receipt while still facing challenges in budgeting, purchasing, reporting and expenditure control. Likewise, the literature on state health insurance arrangements (Ogunkoya et al., 2025) provides a rationale for examining the role of IMSHIA, but it does not permit direct conclusions about enrolment or benefits from the receipt data. The combined interpretation is that source-level financial monitoring is a necessary, though insufficient, element of health financing evaluation. The facility coverage findings add a further dimension. An increase from 35.86% to 98.68% of facilities with positive recorded receipts suggests that the recorded inflows were not confined to a small subset of providers by 2024. This does not establish that resources were distributed equitably, since equity requires adjustment for population, workload, remoteness and facility need. It does, however, identify a measurable administrative outcome that can be monitored alongside the amount and composition of funding. Future analysis should connect these indicators to service delivery and need-adjusted allocations. Finally, the nominal nature of the monetary series is important in the Nigerian context. Without conversion to constant prices, changes in receipts cannot be read as equivalent changes in the quantity of medicines, equipment, staff time or other inputs that facilities could purchase. The most defensible conclusion is therefore one of recorded financial expansion and compositional transformation, with the real resource and welfare implications remaining open empirical questions.

5. Contribution to Knowledge

This study contributes a structured, five-year account of PHC facility receipts across 304 facilities in all 27 local government areas of Imo State. Its first contribution is empirical: it documents annual movements in verified receipts, including the 2022 contraction and the subsequent expansion, rather than relying on a single cross-sectional estimate or statewide budget allocation. Its second contribution is analytical: it distinguishes financing volume from financing composition and quantifies the changing roles of patient payments, BHCPF and IMSHIA. Its third contribution is methodological: it combines aggregate source shares with concentration and diversity measures and facility-level positive-receipt coverage to describe different aspects of recorded financing. These contributions are relevant to decentralised health financing because they demonstrate how a state-level funding profile can change materially even when broad institutional categories remain the same. They also show why source-specific facility accounts should be interpreted alongside, rather than as substitutes for, budget documents, service delivery indicators and household financial protection measures. The framework is transferable as a monitoring approach to other states where consistent facility-level financial records are available.

6. Limitations of the Study

Several considerations define the scope of interpretation. First, the analysis relies on administrative records and is therefore sensitive to completeness, coding practices and the treatment of missing entries. Source-level reconstruction reduced the risk of double counting or formula errors but cannot establish that every relevant flow was captured. Second, the facility receipt series excludes expenditure not recorded in the facility accounts, potentially including centrally purchased commodities, staff remuneration and in-kind support. Third, the 2020 baseline was small and recorded entirely as patient payments, which makes subsequent percentage growth and

compositional change sensitive to differences in initial reporting coverage. Fourth, financial amounts are expressed in nominal naira. Without deflation, they cannot establish changes in real purchasing power. Fifth, the analysis does not include household expenditure, insurance enrolment, claims, service utilisation or quality measures; therefore, it cannot determine whether the changing funding mix reduced financial hardship or improved health outcomes. Sixth, the statewide budget series and facility receipts represent different accounting boundaries and should not be treated as directly comparable. Finally, five annual observations are insufficient for strong causal or long-run trend claims. These limitations do not negate the observed administrative patterns; they identify the additional evidence required for broader conclusions.

7. Conclusion, Implications and Recommendations

Between 2020 and 2024, verified PHC facility receipts in Imo State increased substantially, although the trajectory was uneven. Receipts rose from ₦7.59 million in 2020 to ₦95.79 million in 2021, declined to ₦58.80 million in 2022 and then increased to ₦605.17 million in 2024. Over the same period, the recorded financing mix shifted from exclusive reliance on patient payments in the 2020 facility accounts towards dominance by BHCPF and IMSHIA, which jointly represented 92.02% of receipts in 2024. Financing concentration decreased and the proportion of facilities with positive recorded receipts increased markedly. Together, these results demonstrate a substantial change in the volume, recorded reach and composition of frontline financing. The policy implication is the value of managing PHC financing as a traceable flow rather than treating annual appropriations as the sole measure of resources reaching providers. State health authorities and financing agencies could establish a harmonised reporting framework that separately identifies approved budgets, releases, transfers, facility receipts and expenditures by source and year. Standardised facility identifiers and clear rules for recording in-kind support would make annual reconciliation more reliable. Reporting should distinguish funds channelled through BHCPF, IMSHIA and other programmes to avoid double counting and to clarify each mechanism's contribution.

Predictability should also be monitored. A quarterly reporting dashboard could record the amount and timing of receipts, the proportion of facilities receiving positive transfers, and differences across local government areas. Where administrative capacity permits, these indicators could be linked to facility workload, catchment population, staffing, medicine availability and service outputs. Such linkage would allow policymakers to examine whether changing financing composition is accompanied by improvements in operational readiness and equitable access.

Finally, any assessment of financial protection should be supported by evidence beyond facility receipts, including patient charges, household out-of-pocket spending, enrolment and claims data. The growing role of institutional financing is a potentially important platform for improved purchasing and protection, but its benefits should be evaluated through measurable service and household outcomes rather than inferred solely from source shares.

8. Suggestions for Future Research

Further research could extend the series beyond 2024 to assess whether the observed source composition persists and whether the year-to-year fluctuations diminish. Reconstructing constant-price receipts would distinguish nominal financing growth from changes in purchasing power. A linked financing-flow study could follow resources from appropriation and release through agency transfer, facility receipt and expenditure, clarifying the share of public spending visible in facility accounts.

Facility-level studies could additionally examine whether financing varies with catchment population, service workload, rurality and baseline infrastructure needs. Combining receipts with insurance enrolment, claims and utilisation data would help evaluate the purchasing role of IMSHIA and BHCPF. Household surveys would be required to determine whether a lower recorded share of patient payments corresponds with reduced financial hardship. Comparative studies across southeastern Nigerian states could then establish which patterns are specific to Imo State and which reflect broader institutional developments.

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