

Access to Healthcare Service Among Low Income Households in Ibadan South East Local Government Area

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Abstract— Access to healthcare service is an integral part to the health system as it determines the utilisation of healthcare within a community or region. However, a very important category of people face significant challenge especially when it comes to financing their healthcare need to receive health which oftentimes poses as a significant barrier to access healthcare. Hence the purpose of this study conducted aimed to assess the barriers of accessibility to healthcare services among low-income households in Ibadan South East in Nigeria. This study employed a descriptive cross sectional study and made use of interviewer-administered questionnaire based approach using kobo collect tool. Data was collected on socio-demographic characteristics, access to healthcare service, barriers to healthcare access and perceived impact on the barriers to healthcare accessibility. Barriers to healthcare include financial constraints, inadequate health insurance, cultural norms, and geographical limitations. Many respondents relied on out-of-pocket expenses, leading to delays in seeking care, while traditional beliefs further restricted access especially for women and rural communities. Long distances and poor transportation networks exacerbated challenges, highlighting the need for infrastructural improvements. To improve healthcare accessibility, respondents emphasized reducing costs, expanding healthcare facilities, improving service quality, and increasing affordable health insurance. The study underscores the urgent need for reforms, including strengthening infrastructure, addressing cultural barriers, and enhancing service efficiency. Policymakers must prioritize these measures to create a more inclusive and responsive healthcare system for Nigeria's diverse population.

Keywords— Access; financial constraint; healthcare; low-income households; Ibadan South East Local Government Area.

I. INTRODUCTION

Nigeria, the most populous country in Africa, grapples with significant challenges in its healthcare system, stemming from a mix of factors such as inadequate funding, infrastructure deficiencies, poor governance, and low healthcare professional-to-patient ratio. The country maintains a blend of public and private healthcare providers, with the public sector primarily responsible for delivering healthcare to the majority of the population.

The public healthcare system in Nigeria is overburdened and struggles to meet the healthcare needs of its citizens due to underfunding and mismanagement, leading many Nigerians to turn to private healthcare providers, which tend to be more expensive but often offer better quality services (12).

A critical issue facing healthcare in Nigeria is the significant health disparity between different regions of the country, with rural and underserved areas bearing the brunt of inadequate healthcare infrastructure and limited access to essential services. This has led to a situation where healthcare provision

is significantly better in urban areas compared to rural settings (9).

In Ibadan, these challenges are pronounced as limited healthcare infrastructure and funding contribute to the issue. Studies reveal that, despite a high need for healthcare, low-income households in Ibadan often avoid seeking medical care due to financial constraints and travel distance to health facilities (1). This lack of access disproportionately impacts maternal and child health, increases the prevalence of communicable diseases, and leads to poor management of chronic illnesses. Addressing this problem requires policies to improve health financing, increase public healthcare investment, and reduce the cost burden on vulnerable populations.

In recent years, the Nigerian government has made efforts to improve the healthcare system through initiatives such as the National Health Insurance Scheme (NHIS) aimed at providing universal health coverage. However, the effectiveness of these programs has been hampered by challenges such as corruption, inefficiency, and lack of political will (10).

In moving forward, addressing the systemic issues plaguing the healthcare system in Nigeria will require sustained investment in healthcare infrastructure, improved governance, and increased collaboration between the public and private sectors (12). Only through these efforts can Nigeria hope to provide quality healthcare services to all its citizens and achieve its goal of universal health coverage.

II. RESEARCH OBJECTIVES

1. To determine the proportion of low income households accessing healthcare services in Ibadan South East.
2. To determine key barriers to healthcare access among low-income among households in Ibadan South East.
3. To assess the relationship between key barriers and healthcare accessibility among low-income households in Ibadan South East.

III. RESEARCH METHOD

The study population for this research study were low-income households living in Ibadan south East Nigeria. This research adopted descriptive cross-sectional study design. The sample size was calculated using the standard formula for sample size at a confidence interval of 95% with a 5% margin of error. The research questionnaire was administered as semi-structured form to the respondent. It entailed closed and open ended question. The researcher made use of kobo collect app during the course of the data collection which was analysed

using descriptive statistics. With the help of the Statistical Package for the Social Sciences (SPSS) software, version 27, the analysis was carried out.

IV. RESULT

4.1 Socio-demographic characteristics respondents

The study consisted of 367 respondents, representing various age categories. More than half of the respondents, 215 (58.6%) were aged 50 years and above, making this the most represented age group. The study population was predominantly female 258(70.3%), and Islam was identified as the most common religion among respondents 249 (67.8%).

TABLE 4.1: Respondents' socio-demographic characteristics

Variables	N	(%)
Age group		
< 30 years	76	20.7
31 - 40 years	20	5.4
41 - 50 years	56	15.3
≥ 50 years	215	58.6
Sex		
Male	109	29.7
Female	258	70.3
Religion		
Christianity	118	32.2
Islam	249	67.8
Marital Status		
Single	55	15.0
Married	245	66.8
Separated	49	13.3
Divorced	18	4.9
Household size		
1 – 5	217	59.1
6 – 10	147	40.1
> 10	3	0.8
Highest Level of Educational		
No formal Education	57	15.5
Primary Education	105	28.6
Secondary Education	162	44.2
Tertiary Education	43	11.7
Employment Status		
Full-time	6	1.6
Part-time	18	4.9
Self employed	318	86.7
Non employed	25	6.8
Household Monthly Income		
Below ₦30,000	85	23.2
₦30,000 - ₦50,000	206	56.1
₦51,000 - ₦70,000	76	20.7

SD- Standard Deviation; % -Percentage, F- Frequency

In terms of marital status, the majority were married 245 (66.8%), while only a small proportion were divorced 18 (4.9%). More than half of the respondents' households consisted of 1–5 members 217 (59.1%). Educational attainment varied, with the highest proportion of respondents having completed secondary education 162 (44.2%), while 57 (15.5%) had no formal education. Tertiary education was the least common 43 (11.7%).

Employment status data revealed that self-employment was the dominant category, 318 (86.7%), while only a small fraction 6 (1.6%) were engaged in full-time jobs. Regarding household monthly income, most respondents 206 (56.1%) earned

between ₦30,000 and ₦50,000, with only a few 76 (20.7%) earning above ₦50,000.

4.2 Respondents' access to healthcare services

The table below present respondents' access to healthcare services. More than half of the respondents, 187 (51.0), accessed healthcare services occasionally, while one-fifth of the respondents, 103 (28.1%), rarely sought medical care. Majority of the respondents, 340 (92.6%), who utilised healthcare services primarily sought general medical care. Similarly, most respondents, 242 (65.9%), visited healthcare facilities due to illness or injury.

Public/government hospitals were the most frequently used healthcare facilities, with 228 (62.1%) of respondents seeking care there. Additionally, more than half of the respondents, 213 (58.0) lived within a 15-minute distance from a health centre. However, only a few of the respondents, 46 (12.5%) had health insurance coverage, highlighting a significant barrier to healthcare affordability.

Overall, more than half of the respondents, 200 (54.5%), identified that they had very good access to healthcare services.

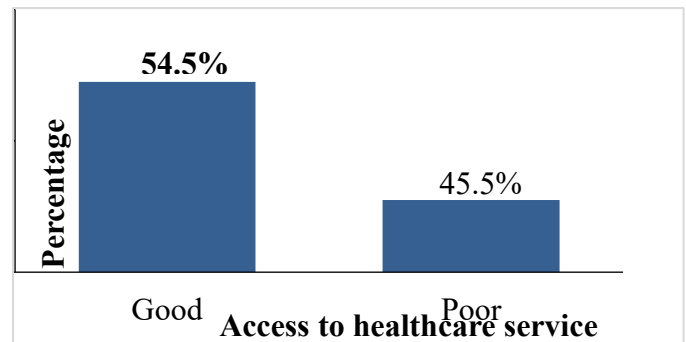


Fig. 1: Respondents' rating of their access to healthcare services

TABLE 4.2: Respondents' access to healthcare services
N = 367

Access to Healthcare Services	N	%
Frequency of healthcare service		
Regularly	69	18.8
Occasionally	187	51.0
Rarely	103	28.1
Never	8	2.2
Type of Healthcare service		
General medical care	340	92.6
Maternal and child health services	12	3.3
Specialized care	27	7.4
Vaccinations and preventive services	9	2.5
Reasons for seeking healthcare services		
Routine check-up	123	33.5
Illness or injury	242	65.9
Place of seeking healthcare service		
Public/government hospital	228	62.1
Private clinic/hospital	51	13.9
Pharmacy or Chemist	66	18.0
Traditional healer	22	6.0
Distance to the nearest health facility		
Less than 15mins	213	58.0
15 – 30mins	114	31.1
30 – 60mins	31	8.4
Above 1 hour	9	2.5
Current health insurance status		
Insured	46	12.5
Not insured	321	87.5

4.3 Respondents perceived significant barriers

The table below showed that less than half of the respondents, 173 (47.1%) identified high cost of healthcare services as a significant barrier to healthcare access. Additionally, one third of the respondents, 126 (34.3%), identified long waiting times as a notable challenge, affecting their access healthcare services.

However, respondents identified long distance to healthcare facilities, lack of transportation, and long waiting times as non-significant barrier to healthcare service.

TABLE 4.3 Respondents perceived significant barriers
N = 367

Barriers	Significant n (%)	Non-significant n (%)
High cost of services	173 (47.1)	194 (52.9)
Long waiting times	126 (34.3)	241 (65.7)
Distance to healthcare facilities	59 (16.1)	308 (83.9)
Lack of information about available services	13 (3.6)	354 (96.4)
Belief in traditional medicine over modern Medicine	97 (26.4)	270 (73.6)
Poor quality of services	44 (12.0)	323 (88.0)
Limited availability of drugs	59 (16.1)	308 (83.9)

Table 4.4: Relationship between barriers and access to healthcare services

The chi-square test below revealed a significant association between different barriers and respondents' access to healthcare services. More than half of the respondents, 54 (56.8%), who identified long distance to healthcare facility as a significant barrier had poor access to healthcare services compared to those who did not have ($p > 0.05$).

Similarly, majority of respondents, 28 (90.3%), who stated that transportation was a barrier to access healthcare had poor access to healthcare compared to those who did not, 139 (41.4%). This was statistically significant ($p > 0.001$). Also most of the respondents, 49 (71.0%) who identified poor quality of healthcare as a barrier had poor access to healthcare services. This was statistically significant ($p > 0.001$).

TABLE 4.4: Relationship between barriers and access to healthcare services

Barriers	Access to healthcare services		χ^2	P-value
	Good n (%)	Poor n (%)		
High cost of services				
Yes	126 (61.5)	79 (38.5)	9.092	0.003
No	74 (45.7)	88 (54.3)		
Long distance to healthcare facilities				
Yes	41 (43.2)	54 (56.8)	6.645	*0.001
No	159 (58.5)	113 (41.5)		
Lack of transportation				
Yes	3 (9.7)	28 (90.3)	27.428	*<0.001
No	197 (58.6)	139 (41.4)		
Poor quality of services				
Yes	20 (29.0)	49 (71.0)	22.301	*<0.001
No	180 (60.4)	118 (39.6)		

*: Statistically significant

V. DISCUSSION OF THE STUDY

The gender distribution indicated that the majority of respondents were female (70.3%), suggesting that women are

more engaged in healthcare-seeking behaviour. Age distribution data from the study indicated that individuals aged 50 and above constituted the majority (58.6%). This finding corroborates the literature [8], which stated that older adults are more likely to require medical attention due to age-related health challenges.

Education level plays a crucial role in healthcare access, with the study showing that respondents with secondary education formed the largest group (44.1%). The literature supports this trend, arguing that higher education levels improve health awareness and service utilization [8]

The findings of this study showed that respondent's healthcare access highlight significant barriers to healthcare services among low-income households, particularly in Nigeria. The literature underscores financial constraints, socioeconomic disparities, and household characteristics as critical determinants of healthcare access. Similarly, the of respondents' healthcare-seeking behaviour aligns with these findings, reinforcing the importance of affordability, accessibility, and social determinants in shaping healthcare utilization patterns.

A primary barrier to healthcare access among low-income households is out-of-pocket spending (OOPS). Studies by [7]-[11] illustrate that the reliance on OOPS disproportionately affects low-income households, leading to delayed or forgone medical care. The analysis of respondents' healthcare access further supports this, as only 12.5% of respondents had health insurance coverage

The geographic accessibility of healthcare facilities also plays a significant role in healthcare utilisation. The literature points to disparities between urban and rural settings, where individuals in rural areas face more significant challenges in accessing healthcare (4). The study findings indicated that while 58.0% of respondents lived within a 15-minute distance from a health facility, a considerable proportion (42.0%) faced longer travel times. This suggests that although healthcare facilities are relatively accessible for a majority, distance still remains a challenge for a significant subset of the population, particularly for those in rural or peri-urban settings.

Financial constraints were a major impediment to healthcare access. The study revealed that 21.5% of respondents who identified high healthcare costs as a barrier had poor access to services ($p > 0.05$). This finding is consistent with previous studies indicating that out-of-pocket expenses significantly hinder healthcare utilization, particularly in low-income populations [2-13]. While financial limitations remain a critical issue, policy interventions such as subsidized healthcare and expanded insurance coverage could mitigate these challenges.

Traditional beliefs and reliance on alternative medicine were also significant determinants of healthcare access. A notable 31.3% of respondents who prioritized traditional medicine over modern healthcare experienced poor access to medical services, a statistically significant association ($p < 0.001$). This finding supports previous research by [2], which suggests that cultural perceptions and distrust of modern medicine contribute to healthcare avoidance, especially in rural communities. Addressing this challenge requires culturally

sensitive health education programs to bridge the gap between traditional and biomedical healthcare approaches.

Geographical distance also played a role in limiting healthcare access. The study found that 21.5% of respondents citing long distances as a barrier had poor access to healthcare ($p=0.022$). This finding aligns with [6], who noted that proximity to healthcare facilities increases service utilization. Although transportation challenges were less frequently reported, they contribute to the broader issue of healthcare inaccessibility.

In contrast, systemic inefficiencies such as long waiting times ($p=0.892$) and limited drug availability ($p=0.845$) were not significantly associated with poor healthcare access. While these factors may cause inconvenience, they do not appear to be decisive in whether individuals seek medical care. However, previous research suggests that persistent dissatisfaction with service quality can erode trust in healthcare systems over time [5].

VI. CONCLUSION

The study underscores the persistent challenges and systemic barriers that hinder healthcare accessibility and quality in Nigeria. The socio-demographic characteristics of respondents reveal that gender, age, and education levels significantly influence healthcare-seeking behaviour. Women, who constituted the majority of respondents, were more engaged in healthcare access, aligning with previous research highlighting their increased healthcare needs.

However, financial constraints and cultural norms still present obstacles, limiting their ability to fully utilize available services. Healthcare access remains largely constrained by economic disparities, out-of-pocket healthcare expenses, and the limited reach of health insurance.

Traditional beliefs and reliance on alternative medicine further contribute to healthcare avoidance, especially in rural communities. Geographical and transportation barriers remain critical concerns, particularly for those residing in rural areas.

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