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Socioeconomic Determinants of Household Healthcare Provision in Nigeria: An Outlook at Yola, Adamawa State of Nigeria

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Abstract. Healthcare access remains a critical challenge for many households in Nigeria, often influenced by socioeconomic factors such as income, education, and family size. This study examines how these variables impact household healthcare decisions and outcomes. Using descriptive statistical analysis, data were collected from a diverse population to evaluate health-seeking behaviours, health status, and financial barriers. Results indicate that lower income, larger family size, and limited educational attainment significantly hinder access to quality healthcare, leading to reliance on over-the-counter medications. The findings underscore the need for policies promoting health insurance coverage and financial support to alleviate out-of-pocket (OOP) expenditures and improve healthcare equity in Nigeria.

1. Introduction

In Nigeria, out-of-pocket (OOP) expenditure, estimated at 76.6% of the Current Health Expenditure (CHE) in 2017, poses a huge barrier to accessing health services, worsening inequities in health outcomes and exposing the poor to impoverishment as a result of catastrophic health spending. The 2017 National Health Account estimated total expenditure on malaria at N1.9 trillion ($5.3 billion), with out-of-pocket (households) payments accounting for 78.4% of all malaria spending (NMSP, 2021).

Healthcare access and utilisation in developing countries, including Nigeria, are deeply intertwined with socioeconomic factors. Households often face significant barriers, including financial constraints, low educational attainment, and large family sizes, which shape their health-seeking behaviours. Despite interventions by governmental and non-governmental organisations, access to quality healthcare services remains uneven, particularly for low-income families.

Income disparities influence the ability of households to afford care, often leading to reliance on suboptimal options such as over-the-counter medications. Similarly, educational levels play a crucial role in shaping health literacy and attitudes toward seeking professional care. Family size further compounds these challenges, with larger households experiencing greater financial strain and higher risks of disease spread.

This study aims to explore the relationship between socioeconomic factors and household healthcare provision in Nigeria, leveraging descriptive statistics to uncover insights that can inform targeted interventions.

2. Methodology of the study

This study employed a descriptive statistical approach to analyse data collected from 323 respondents in Nigeria. A structured questionnaire was administered to gather information on demographic variables, income levels, family size, educational attainment, health insurance coverage, and healthcare-seeking behaviours.

The analysis focused on identifying patterns and associations among variables to highlight socioeconomic disparities in healthcare access. Descriptive statistics, including mean, standard deviation, and frequency distributions, were used to present the data. Ethical approval was obtained, and

informed consent was secured from all participants. Limitations include the reliance on self-reported data, which may introduce recall bias.

3. Literature Review

Previous studies have consistently highlighted the role of socioeconomic factors in shaping healthcare access in low- and middle-income countries. Rosenstock's Health Belief Model (1966) emphasises that perceived barriers and benefits significantly impact health-seeking behaviour. Similarly, Ajzen and Fishbein's Theory of Planned Behaviour (1980) underscores the influence of attitudes, subjective norms, and perceived control over healthcare decisions.

Research by Onoka et al. (2013) and WHO (2021) demonstrates that financial barriers remain a critical impediment to universal health coverage in Nigeria. Studies also reveal that educational attainment correlates with health literacy, affecting individuals' ability to navigate healthcare systems effectively (Jin et al., 2022). However, gaps remain in understanding how these factors interact in the Nigerian context, particularly concerning family size and external support.

This study contributes to the literature by providing an updated analysis of these variables, offering actionable insights for policymakers and stakeholders.

Results and Discussions: The results reveal significant associations between socioeconomic factors and healthcare access:

Health Status:

Table 1: Household Health Status.

How would you rate your health status?	1 (Very Poor)	2 (Poor)	3 (Good)	4 (Very Good)	5 (Excellent)
	6%	26%	40%	21%	7%

Source: *Field Survey, 2023.*

Self-reported health status varied across income groups. While 68% of respondents rated their health as "Good" or better, those in lower income brackets reported higher rates of "Poor" or "Very Poor" health.

Family Size:

Table 2: Family Size of respondents.

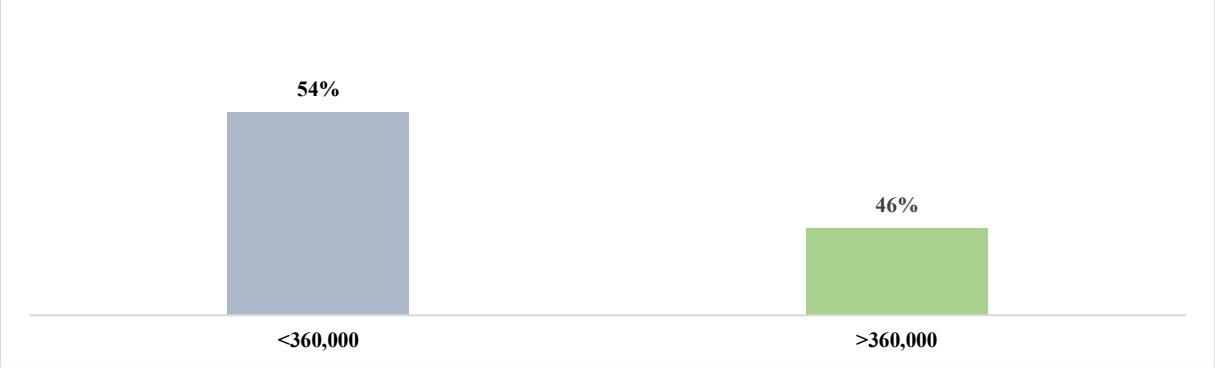
	<5	5-10	>10
What is the family size?	32%	18%	50%

Source: *Field Survey, 2023.*

Larger families (≥10 members) constituted 50% of the sample, highlighting the financial burden of healthcare costs and the potential for rapid disease transmission within households.

Income Levels:

Figure 2: Annual Household Income of the respondents.



Source: *Field Survey, 2023.*

Over half (54%) of respondents reported annual household incomes below N360,000, underscoring the challenge of affording healthcare. Limited financial resources were associated with delayed treatment and reliance on informal care.

Age Distribution:

Table 3: Age Distribution of Respondents.

	16 - 30	31 - 45	46 - 60	61 - 75
Age	49 (15%)	152 (47%)	110 (34%)	12 (4%)

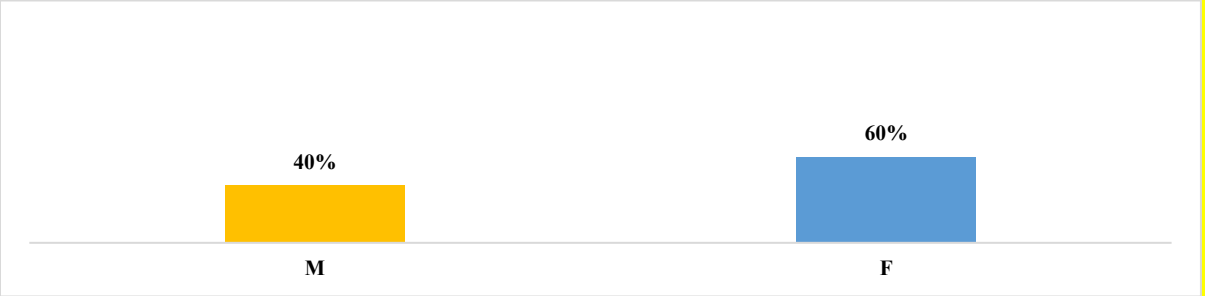
Source: *Field Survey, 2023.*

The age distribution of the respondents, in Table 3, revealed that 47 per cent were in the age range of 31 – 45 years, while those in the age range of 61 – 75 years were 4 per cent. However, this may not be unrelated because 31 – 45 years is the active age range and probably employed by either the government or private institutions. It also highlights the active age range's likelihood of employment and access to health insurance (Reichard, Stransky, Brucker, & Houtenville, 2019).

Being employed could provide access to direct support through health insurance, hence the ability to seek health care attention when sick with little OOP expenditure. The age distribution highlighted in Table 3, with a significant proportion in the 31-45 age range, has implications for healthcare decision-making based on TPB, HBM, and TRA. Employment status in this age group may positively impact perceived behavioural control, attitudes, perceived threat, and subjective norms regarding healthcare utilisation (Glanz, Rimer, & Viswanath, 2008; Rosenstock, 1966; Ajzen & Fishbein, 1980). This group may be more likely to seek healthcare services and incur lower out-of-pocket expenditures due to their employment-related benefits.

Gender:

Figure 3: Gender Distribution.

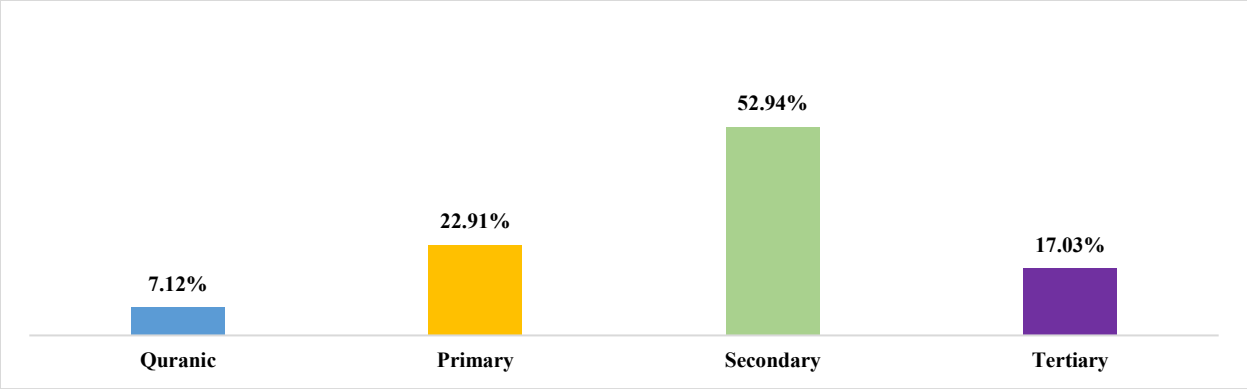


Source: *Field Survey, 2023.*

In Figure 3, sixty per cent (60%) of the respondents were of the female gender, while males constituted the remaining forty per cent (40%). The high percentage seen in the female gender indicates that health-seeking behaviour is more prevalent in that class than in males. Women exhibited higher health-seeking behaviour compared to men (Schmitz & Lazarevič, 2020). The gender distribution presented in Figure 3, with a higher percentage of females, has implications for healthcare decision-making based on TPB, HBM, and TRA. It suggests that females may have more positive attitudes, higher perceived threats, and more supportive subjective norms related to healthcare utilisation than males, potentially resulting in higher health-seeking behaviour among women (Rosenstock, 1966; Ajzen & Fishbein, 1980).

Educational Attainment:

Figure 4: Educational Background of the respondents.



Source: *Field Survey, 2023.*

Respondents with secondary education constituted 52.94%, while only 7.1% had Qur'anic education. Educational disparities were linked to variations in health-seeking behaviour, with lower education correlating to reduced utilisation of formal healthcare services.

Occupation:

Table 4: Occupation of the respondents.

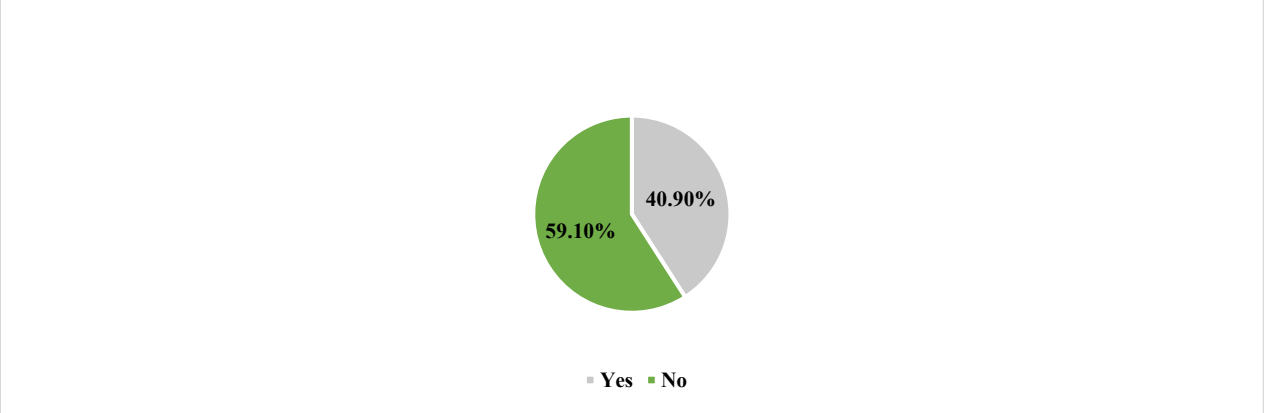
Main Occupation	Trading	Farming	Government Employment	Private Employment	Self employed	Unemployed
	36 (11%)	61 (19%)	145 (45%)	13 (4%)	55 (17%)	13 (4%)

Source: *Field Survey, 2023.*

Table 4, which shows the respondents' occupations, indicates that 45 per cent were government employees. The smaller percentage of the respondents, with 4 per cent each, were the unemployed and those employed by private firms. This result could explain why those employed by the government are likely to have some support in the form of health insurance coverage to alleviate the burden of health-seeking through the OOP expenditure (Reichard, Stransky, Brucker, & Houtenville, 2019). The occupational backgrounds presented in Table 4, with a significant percentage being government employees, have implications for healthcare decision-making based on TPB, HBM, and TRA. Government employees may have more positive attitudes, higher perceived benefits, and better perceived behavioural control related to healthcare-seeking due to their access to health insurance, potentially resulting in higher health-seeking behaviour and reduced OOP expenditure (Glanz, Rimer, & Viswanath, 2008; Janz & Becker, 1984; Ajzen & Fishbein, 1980).

Health Insurance:

Figure 5: Proportion of respondents who have Health Insurance.



Source: *Field Survey, 2023.*

Only 40.9% of respondents had health insurance, primarily among government employees. The lack of coverage exacerbates the reliance on OOP expenditures, which disproportionately affect low-income families.

NGO Support:

Table 6a: Support from NGOs towards OOPs.

Is there any support from the NGOs to alleviate OOPs?	Yes	No
	0%	100%

Source: *Field Survey, 2023.*

None of the respondents reported receiving NGO support to offset healthcare costs, highlighting a gap in external assistance. These findings align with the Theory of Planned Behaviour (TPB) and the Health Belief Model (HBM), illustrating how attitudes, perceived threats, and financial barriers influence healthcare utilisation. For example, individuals with limited income may perceive healthcare costs as insurmountable, reducing their likelihood of seeking timely care.

Table 7: Descriptive Statistics.

	Mean	Std. Deviation	N
Gender	1.59	0.493	323
Health insurance	0.49	0.501	323
Govt support	1.59	0.492	323
Support extent	0.51	0.68	323
NGO's support	0	0	323
NGO's support impact	3	0	323

Source: *Field Survey, 2023.*

Table 7 is a descriptive statistic for several variables assessing the impact imposed on households because of out-of-pocket spending on healthcare services. The statistics presented in Table 7 provide insights into the impact of out-of-pocket spending on healthcare services, which can influence perceived behavioural control, attitudes, perceived benefits, and barriers related to healthcare-seeking behaviour. The variability in these variables and the absence of support from NGOs can have significant implications for healthcare decision-making based on TPB, HBM, and TRA (Glanz, Rimer, & Viswanath, 2008; Rosenstock, 1966; Ajzen & Fishbein).

4. Conclusion

This study highlights the profound impact of socioeconomic factors on household healthcare provision in Nigeria. Income levels, educational attainment, and family size emerged as critical determinants of health-seeking behaviours and access to quality care. The reliance on OOP expenditures and limited health insurance coverage exacerbate disparities, leaving vulnerable populations at risk.

To address these challenges, targeted interventions are necessary. Expanding health insurance coverage, subsidising healthcare costs for low-income families, and enhancing health literacy through educational programs can improve healthcare equity. Additionally, increased NGO involvement in alleviating financial barriers could bridge critical gaps in support. Policymakers must prioritise these strategies to ensure equitable access to healthcare for all Nigerians.

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