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A Comparative Assessment of Access to Healthcare of People Living in Ekiti and Kogi States of Nigeria

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Authors' contributions

This work was carried out in collaboration among all authors. Author CTO supervised the fieldwork, corrected and finalised the manuscript. Author AAO performed the data collection, data analysis and presented the first draft of the manuscript. Author ASA edited checked the data analysis for consistency and edited the draft manuscript while the author OAI arranged the structure and content of the analysis and proof read the final manuscript. All authors read and approved the final manuscript.

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ABSTRACT

Aim: To undertake a comparative assessment of healthcare access of people in Ekiti and Kogi States of Nigeria. This further provided hard data for health program development towards attainment of universal health coverage and health sustainable development goal.
Study Design: A comparative research design was employed using questionnaire for data collection.
Place and Duration of the Study: The study was conducted in Ekiti and Kogi States of Nigeria representing Southern and Northern parts of the nation. The fieldwork was conducted in October and December 2019.
Methodology: Multistage sampling technique was used starting from random selection of one local government area from each of the three senatorial districts in the two states. From each of the local government areas, five political wards were randomly selected from the existing number of wards. From the selected wards, equal number of 144 sampled respondents were contacted for the structured interviews to make 856 administered copies of questionnaire.

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Results: Most of the respondents could identify available health care facilities in their environment. However about 70 percent patronized secondary health facilities in Ekiti State while tertiary health facilities were visited mostly in Kogi State. Costs of health care is higher in Kogi compared to Ekiti State. 49% of Ekiti have a challenge in paying for treatment compared to 69% in Kogi State while from the two states, only about 19% have health insurance coverage. Respondents in Ekiti State experience strike actions of health workers than those in Kogi State. On appropriateness, Ekiti state has better scores while Kogi State has better score in acceptability.
Conclusion: Pronounced challenge to healthcare access is unaffordability of health care as a result of very low health insurance scheme coverage in the two states through Ekiti State has better indicators of quality healthcare.

Keywords: Healthcare; access; availability; quality; health outcome.

1. INTRODUCTION

Every nation plans to have a healthcare services that will be accessible to the people in order to significantly improve the health status of its citizens. Access to quality healthcare services is a fundamental human right of every citizens. While 193 members of UN General Assembly were mandated in 2012 to embrace the concept of universal health coverage, most countries especially in Africa are yet to fully do this. Universal health coverage is the access to good, quality and affordable healthcare services without any financial hardship to the people. Without this being done, life expectancy at birth in sub Saharan Africa including Nigeria will remain the least. This is achieved through improved preventive, curative, rehabilitative and palliative healthcare services [1]. In order to achieve universal health coverage, there must be equity, or equal opportunity for all persons, irrespective of social and cultural status, the quality of health services must be good enough to improve health needs and people must be protected from financial risk. Part of the Sustainable Development Goals (SDGs) 2030 is to make health sustained for all and the achievement of SDG 3 goal depends on how accessible healthcare services are to the people. Towards this, the health insurance scheme is recommended as a programmatic tool while African nations are to sincerely implement the Declaration of 2001 African Heads of State meeting in Abuja that minimum of 15 percent of the annual budget should be for healthcare [2].

Most citizens are stressed by high cost of medication and which make healthcare services unaffordable and discourage people from visiting and seeking for quality healthcare. This is the main reason Nigeria remains the third worst nation in terms of healthcare system [3]. For an individual to access healthcare services, it has to be affordable, accessible, available and of expected quality. Accessibility of health services is an important determinant of the utilization of health services in developed and developing countries. According to [4] access to medical care services can contribute to the improved health status of the population and subsequently increasing life expectancy. Access requires, patients getting access to sites of care where patients can receive needed services and finding providers who meet their needs. The above is corroborated with the definition of access using five dimensions of accessibility which are approachability, acceptability, availability and accommodation, affordability and appropriateness [5].

These dimensions of access identified above are not completely independent of each other. They often influence each other and act at different times in the course of health seeking or sick role process. As Nigeria is determined to achieving the Sustainable Development Goals (SDGs) no 3 (Good health and wellbeing) in 2030, this study will add to the existing body of empirical knowledge by comparing the level of health access in Ekiti and Kogi States in Nigeria. The political and cultural structures of the two States are adequate enough to represent Nigeria's socio-cultural diversity and measures of drive towards the Sustainable Development Goals 2030 and Universal Health Coverage [6].

1.1 Theoretical Guide

Theoretical guide was the Penchansky and Thomas Theory of Access. It was developed in 1981. Here access is defined as the degree of fit between the consumer and the service, that is, the better the fit, the better the access. They conceptualized access into five specific dimensions to explain the five different dimensions of access to health care. These

dimensions are availability, accessibility, accommodation, affordability and acceptability. These dimensions of access are independent yet interconnected and each is important to assess the achievement of access [7]. According to [8], awareness is another dimension of access to modify Penchansky and Thomas's Theory of access. Awareness is integral to access. This relates with the knowledge of the services available at the health facility.

2. METHODS

The study used comparative survey research design. This provided answers to research questions that are associated with the research problem. The design was selected because it provided an accurate portrayal of the respondents' characteristics, along with the objectives of the study and allowed generalization of results for the study population.

The study was conducted in two States in Nigeria, which are Ekiti and Kogi States. Multistage sampling was used in Ekiti and Kogi States starting with senatorial districts. One local government area selected from each district to have an equal representation. The two States were purposively selected to represent the two socio-political and human development divides of North and South. The North made up of 19 states including FCT mostly located at the middle and upper stretch of the country and have relatively low health index compared to the rest of the nation (South). Kogi State is located as part of the North central states and can also represent the rest of the North West and North East parts of Nigeria. Ekiti State represents the Southern parts of the nation. As stated earlier, the Southern States have relative better health index but still below the international benchmark [9, 10].

2.1 Ekiti State

The State is located in the Southwestern part of Nigeria and bounded in the North by Kogi and Kwara States, South and East by Ondo State and West by Osun State. The State has its administrative capital in the city of Ado Ekiti. Ekiti State has 16 Local Government Areas and it is predominantly Yoruba culture with weather condition that varies between two seasons which are the rainy and dry season and with project population 2017 of 3,270.800 [11]. Ado Local Government Area, Ilejemeje LGA and Ekiti East LGA were randomly selected respectively for the purpose of this study. There are two Teaching Hospitals serving as referral points for the state and neighboring states, each owned by state and federal governments. There are 314 Primary Health Care centers operated by each Local Government and the State Primary Health Care Development Agency. There are 18 General Hospitals and three Specialist Hospitals funded by the State Government while there are 222 registered privately owned health facilities of varying degree of quality and volume of services provided. These gives a total of 559 health facilities in the State [12].

2.2 Kogi State

The state is located 158 km south of the city of Abuja and is bounded to the North also by Rivers Niger and Benue. Kogi State is in the North Central, with diverse cultural elements. The weather conditions are majorly dry season, raining season and also with a population of 4,473,500 [10]. Adavi LGA, Lokoja LGA and Ofu local government areas were randomly selected out of the 21 Local Government Areas in the State. Kogi State has an area of 29,833km, it is the 13th biggest State in Nigeria. Kogi State is the only state in Nigeria which shares a boundary with ten other states. The State is located between latitude 7048'N and longitude 6043'E. The total land area of the state is 28, 313, 53 59Km^2. Kogi State was selected being a cultural melting point where virtually all known ethnic groups are represented. The State also is categorized as one of the nineteen northern states. The State has 74 public General Hospitals (secondary health care delivery system) and about 834 basic and primary health care facilities. There is also a federal government owned Federal Medical Centre (tertiary health care delivery system).

2.3 Sampling Process

The research design for this study was the comparative study of two political States in Nigeria. The two States of Ekiti and Kogi adequately represent the south and north geo-political divides respectively of the nation. Ekiti and Kogi States were divided based on senatorial districts. One local government area was selected from each senatorial district to have an equal representation to make six local government areas. The sample size was determined using the ''table of sample size"

developed by [12]. According to the table, the sample size for every 1million population is 660. The total population for the six Local Government Areas is 1,492,700 and the sample size of 1,320 was determined from the "table of sample size". However, 65 percent of 1320 was used for this study which was 856 population. This decision was arrived at due to financial consideration of administering the whole sample size, and the challenge of insecurity of field assistants especially in Kogi State.

Stratified random sampling was then used to determine sample size for each of the six local Government Areas in each of the States. In each Local Government Area, five political wards were randomly selected from the existing number of wards and the total sample size of 856 was divided equally among the selected political wards. Respondents in each political ward was contacted through random selection of houses, and from each house, a male and female adult willing to be part of the study was interviewed until the sample size is exhausted for thepolitical ward and Local Government Area. From each Local Government Area, prospective respondents were male or female adult from 18 years of age and above.

The quantitative method involved the use of questionnaire. Socio-demographic characteristics, level of accessibility of healthcare services and the perceived access of the people towards healthcare services were included in the questionnaire. Participants who were not privileged to read, write and also had language barriers were interviewed with the use guide of questionnaire. There was an interpreter who mediated between the researcher and the participant during interview.

Also, the researcher employed six trained field assistants (three males and three females) for the purpose of the study. In order to check the validity and reliability of the research instrument, questionnaire was pre-tested among a small set of respondents from the population before the actual survey. The purpose of pretesting was to identify challenges with data collection, and revise the content of the research instrument. The data for the study were analyzed using descriptive and inferential statistics. Frequency, percentages and regression were used to analyze the descriptive statistics that were gathered from the questionnaire.

3. RESULTS AND DISCUSSION

3.1 Social Characteristics of the Respondents

As presented in Table 1. Age distributions of respondents in both Ekiti and Kogi States do not show much difference since most respondents are in the range of 20-50 years of age. Though, more respondents from Ekiti State are above 50 years of age and below 20 years of age compared to Kogi State. But Kogi State has significantly more percentage of female respondents than Ekiti State. This is explained by more willingness of Kogi State women to participate in the study compared to Ekiti State. Ekiti State pride itself as ''fountain of knowledge'' with one of the highest level of education per citizen in Nigeria. Fifty-five percent (55%) of Ekiti respondents have tertiary education compared to about 28 percent in Kogi State. Notwithstanding, since for adequate or better health related behaviours, a minimum of 10 years of education (literacy) is conceptually needed [13] and Kogi State has 44 percent respondents with up to secondary school education and Ekiti State has 31 percent though more percentage of Kogi State respondents has less than the required level of education (less than 10 years).

As stated earlier, Kogi State is a more culturally heterogeneous State unlike Ekiti State that is one of the most cultural homogenous States in Nigeria. Kogi State is native to Yoruba, Igala [13]. Ebira, Hausa, Fulani, Bassa peoples. Ibo in Kogi State are residents. In Ekiti State, Yoruba people are the native while other ethnic groups as indicated on the Table are residents. About a third of the respondents in Ekiti State are of Islamic faith while about 74 percent are Christians. However, respondents in Kogi State have about 48 percent and 48 percent as Christians and Muslims respectively and four percent are traditional religion adherents. Also, about 58 percent of respondents in Ekiti are married while about 43 percent of Kogi State respondents are married. However, a significantly higher percent is never married in Ekiti while 27 percent in Kogi State are never married. About 30 percent of Kogi State respondents are either divorced or widowed. This is a figure that should call for concern especially 17 percent widowed. Kogi State has not been spared of insecurity as a result of constant farmers-herdsmen and inter-ethnic violence in the past five years. The recorded mortality in this study cannot be extricated from the obvious insecurity especially in northern part of Nigeria.

More than 40% of Ekiti State respondents are students followed by 34% public servants. But in Kogi State, nearly half of the respondents are traders, followed by public servants. This shows that more number of respondents in Ekiti State are involved in formal sector engagement whereas more respondents in Kogi State are involved in informal sector of the economy. The same percentage of respondents in each state earn less than 30,000 naira monthly (78 dollars per month). According to poverty headcount rate in Nigeria 2019, while 40.1 percent of Nigerians lived in poverty, 28.5 percent and 28 percent of Kogi State and Ekiti State respectively lived in poverty. There is a mild conformity of this study income level with the publication [14].

Table 1. Percentage distribution of Respondents' Social Characteristics

	Ekiti State (N=418)	**Kogi State (N=430)**
Age	**%**	**%**
Less than 20	12.2	8.6
21-30	33.7	34.7
31-40	12.9	34.9
41-50	30.9	13.0
51 Above	10.3	8.8
Gender		
Male	54.3	36.3
Female	45.7	63.7
Educational Background		
Koranic School	5.5	5.1
Primary Education	3.6	13.5
Secondary education	31.3	44.4
Tertiary Education	55.5	27.7
Ethnic Group		
Yoruba	57.2	22.1
Igala	4.1	30.5
Ebira	11.0	27.4
Hausa/Fulani	6.2	6.3
Bassa	-	6.3
Igbo	21.5	7.4
Occupation		
Student	43.1	12.1
Public Servant	34.2	25.1
Trading	13.6	47.9
Artisan	9.1	14.9
Religion		
Christian	73.9	47.9
Islam	26.1	48.1
Traditional	-	4.0
Marital Status		
Single	40.4	27.2
Married	57.7	43.3
Widowed	-	17.0
Divorced	1.9	12.5
Monthly Income		
Below N30,000	43.1	43.7
N31,000-N60,000	38.0	32.8
Above N60,000	18.9	23.5

Note: total number of respondents could not add to 856, but 848 due to removal of non-completion of 6 copies of the questionnaire.

Source: Field Survey, (2020)

3.2 Level of Accessibility to healthcare services

The level of access to healthcare services will be explained with how available, affordable and appropriate and acceptable the healthcare services is to the respondents in Ekiti and Kogi States.

3.3 Availability of Healthcare Facilities

This study reveals from Fig. 1 that less than 20 percent of all the respondents in the two States affirmed the availability of primary health facilities (PHF) while about the same percentage also visited them. More than half of the respondents identified secondary health facilities (SHF) which include the general and specialist hospitals, as the most available and visited. However, Kogi State has more availability and visit of secondary healthcare than Ekiti State with more than 10 percent margin. The Teaching Hospitals (THF) serve as the referral health facilities in the two States, and in this study, just about 1.2 percent in Kogi State visited the available hospital while 4.8 percent in Ekiti States visited the 5.7 percent available referral hospitals. The higher percentage in Ekiti State is explained because of the availability of two teaching hospitals owned by state and federal governments respectively. Also, more respondents in Ekiti State recognized the availability of private clinics (PHF) and hospitals than Kogi State. Over 10 percent shows that private health practitioners are more available in Ekiti State than Kogi State. The patronage of traditional and spiritual healers (T/SF) across the two States is less than four percent while Ekiti State has more availability of non-modern healing centres. This shows that secondary health facilities were the most accessed in the State. This also can be explained with the reality that secondary health facilities mostly have ideally complements of doctors, nurses, laboratory health technicians and pharmacists compared to primary health facilities mostly without doctors and trained pharmacists but where available nurses and community health workers working as general practitioners [15].

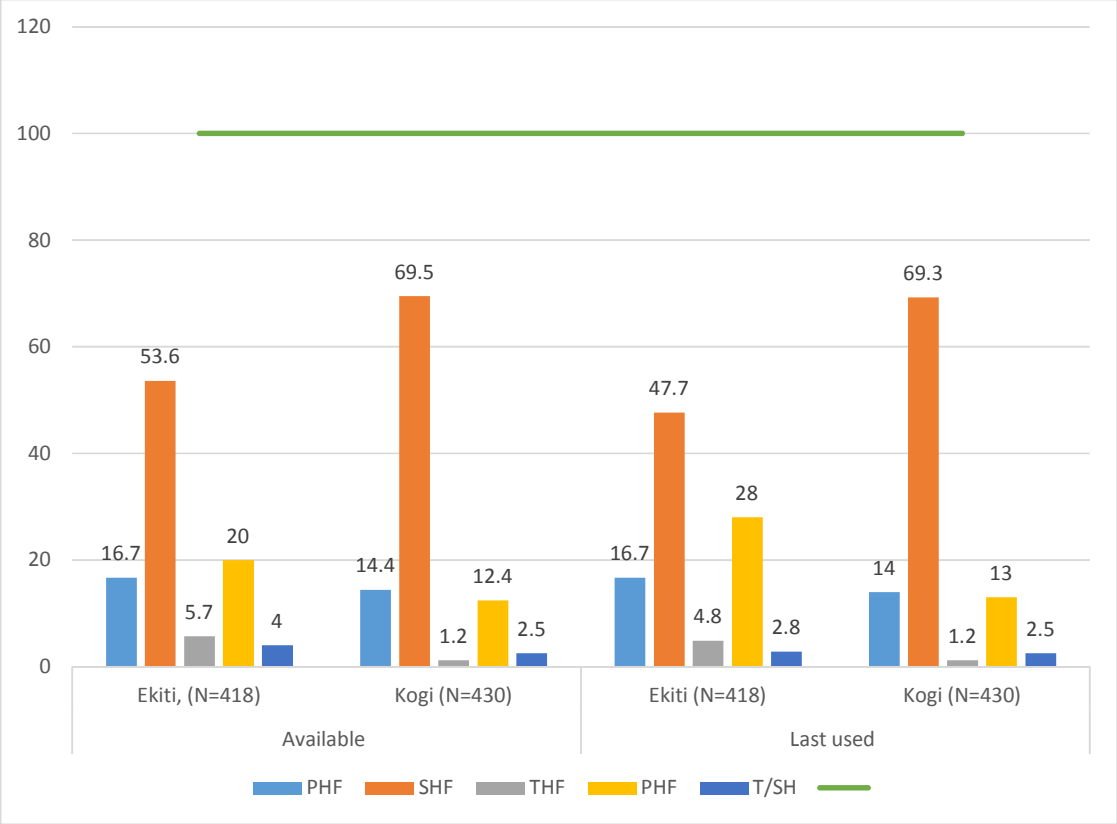

Fig. 1. %age of respondents showing available and last used health facilities in the two states

3.4 Affordability of Healthcare Facilities

It focuses on the economic capability of the people to spend resources in accessing healthcare services**.** From Table 2, level of awareness of Health Insurance Scheme was significantly higher in Ekiti State while more percentage of Ekiti State respondents are under health insurance. However, none of the two States have started community based health insurance but federal government coordinated national health insurance scheme [14,15] as at the time of research report writing. Equally, most of the patients do not have the health insurance cover, majority therefore depend on payment at the point of service, 89% in Ekiti State and 93% in Kogi State. The cost of payments mostly is less than N5000 (about 13 dollars). It has been well factorized that Nigeria government spend the least on health care compared to over 98 percent of nations in the world, while 75 percent of total health expenditure is out of pocket expenditure by households and individuals, further pauperizing citizens in a nation tagged the poverty capital of the world [16], though the majority of the respondents in the two States responded that the payment is affordable, they would not have said otherwise given the in Yoruba language dictum, *Ilera l'oogun oro*, meaning health is the antidote for wealth, so any payment must be made to remain healthy. However, about 49% and 63% of Ekiti State and Kogi State respondents respectively affirm that they have been unable to afford healthcare before. Osakitikpi [14] equally in a succinct historical and structural review of health system in Nigeria lamented the poor state of health care delivery and hinged it on high cost of health services and government's poor implementation of health insurance programme [17]. This makes quality health care services expensive and unaffordable to majority of the people and invariably compromises universal health coverage principle.

From Fig. 2 More than half of Ekiti State respondents spent less than one dollar (about N350) compared to about one quarter of Kogi State respondents. Equally, about nine percent of Ekiti State respondents could walk or trek to nearby health facility compared to about four percent in Kogi State. By extension, more percentage of Kogi State respondents spend more resources (financial and physical) to access available health facility. Issues of distance to nearby health facility is a measure of health care responsiveness to emergency health needs.

3.5 Appropriateness and Acceptability of Healthcare Facilities

Another measure of healthcare access is appropriateness and acceptability as shown in Table 3. It is indicated by waiting time and other related indicators which equally measure the quality of healthcare services. Quality of healthcare services from the patients' perspective primarily means patient's purpose of visit is desirably fulfilled and could guarantee a return visit if need be, defined as the health care that respects and responds to the individual patients preferences, needs and values and ensures clinical decision incorporate patients value [18]. Patients are aware that they should wait to see a doctor or health care provider. However, there is no known acceptable 'waiting' or 'consultation' time. Evidence shows that patients are less likely to be dissatisfied if their waiting time is within 30 minutes and in Nigeria more patients spend more than 30 minutes due to low inadequate medical personnel at health facilities [19]. More than half of the Ekiti State respondents spent less than 30 minutes waiting for healthcare provider compared to about 42 percent in Kogi State and less percentage of Ekiti State respondents spent more than one hour compared to Kogi State respondents. Ekiti State respondents significantly have higher positive assessment, mostly more than half while in Kogi State is less than half.

However, a menace of sustained healthcare in Nigeria is the notoriety of strike actions of doctors and other medical personnel. This can go on for months with actual loss of lives of patients and prolonged psycho-medical debilitation. Thirty-four percent (34%) of Ekiti State respondents experienced strike action compared to about four percent in Kogi State. The menace of strike actions in the healthcare sector is a mark of government's poor commitment to health care development especially improving manpower development both at federal and state levels and equally one of the drivers of high mortality and widespread morbidities in Nigeria. In a review of the challenges of incessant strike actions in Nigeria health sector [20], the cause of incessant and long period of strike actions by healthcare workers was mostly alluded to poor leadership and management of health system in Nigeria. The World Health Organization (WHO) target for

doctor to population ratio is one per 600 [21]. In Nigeria however, there are 3.8 doctors to 10,000 population [22]. This reduces the level of access to medical personnel and often result in prolong waiting hours and equally account for the labour burn out and turn over [23]. According to [24] 237,000 medical doctors are needed to meet the World Health Organization standard and meet the SDGs no 3 goal in Nigeria.

Table 2. Percentage distribution of respondents by affordability of healthcare services

Questions	Responses	Ekiti state N (418)	Kogi state N(430)	Total 848
Are you aware of health insurance scheme?	Yes	209(50.0)	131(30.5)	340(40.2)
	No	209(50.0)	299(69.5)	508(59.8)
Are you under any health insurance coverage?	Yes	87(20.8)	69(16.0)	156(18.5)
	No	331(79.2)	361(84.0)	692(81.5)
Do you make payment at the point of accessing health care services?	Yes	371(88.8)	400(93.0)	771(90.8)
	No	47(11.2)	30(7.0)	77(9.2)
Cost of treatment?				
Less than N5,000 (<$13)		336(80.4)	327(76.0)	663(78.1)
N5,000 - N10,000 (<$26)		39(9.3)	57(13.3)	96(11.3)
10,001 - N15,000 (<<40)		16(3.8)	0(0)	16(1.9)
Above N15,000		3(0.7)	1(0.2)	4(0.5)
No response		23(5.5)	45(1.4)	68(8.0)
In your own view is the payment expensive or affordable?	Expensive	120(28.7)	110(25.6)	230(27.1)
	Affordable	298(71.3)	320(74.4)	618(72.8)
Have you ever been unable to access healthcare services as a result of financial challenges?				
Yes		203(48.6)	270(62.8)	473(55.7)
No		215(51.4)	160(37.2)	375(44.2)

Source: Field Survey, (2020)

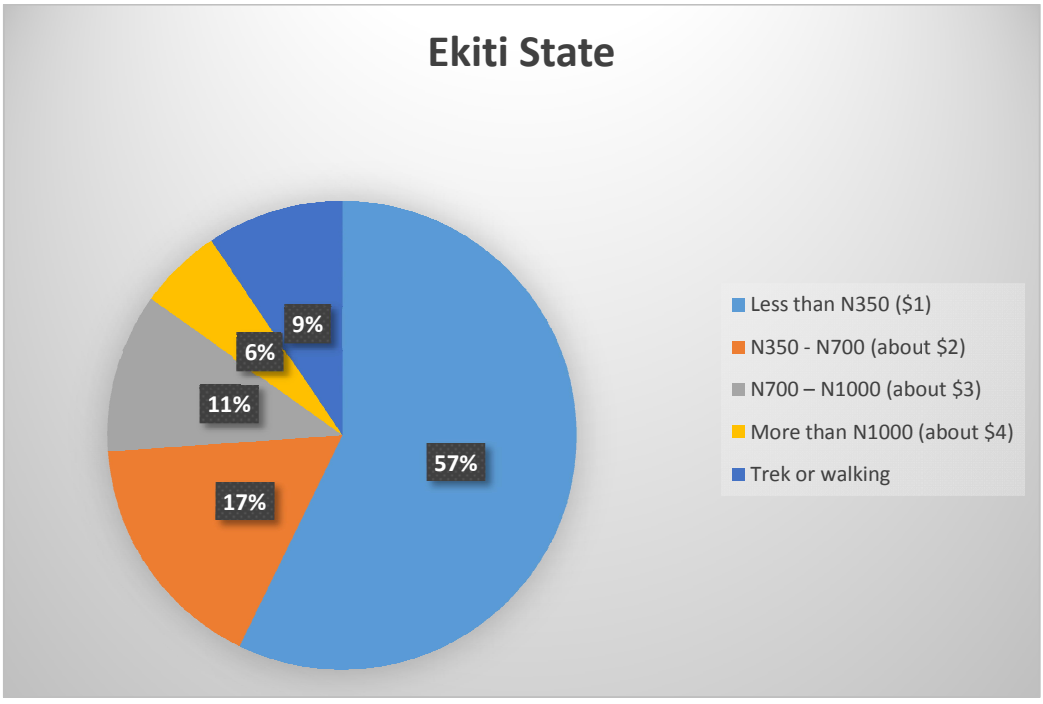

Fig. 2. showing cost of transportation by respondents to health facilities in the two states

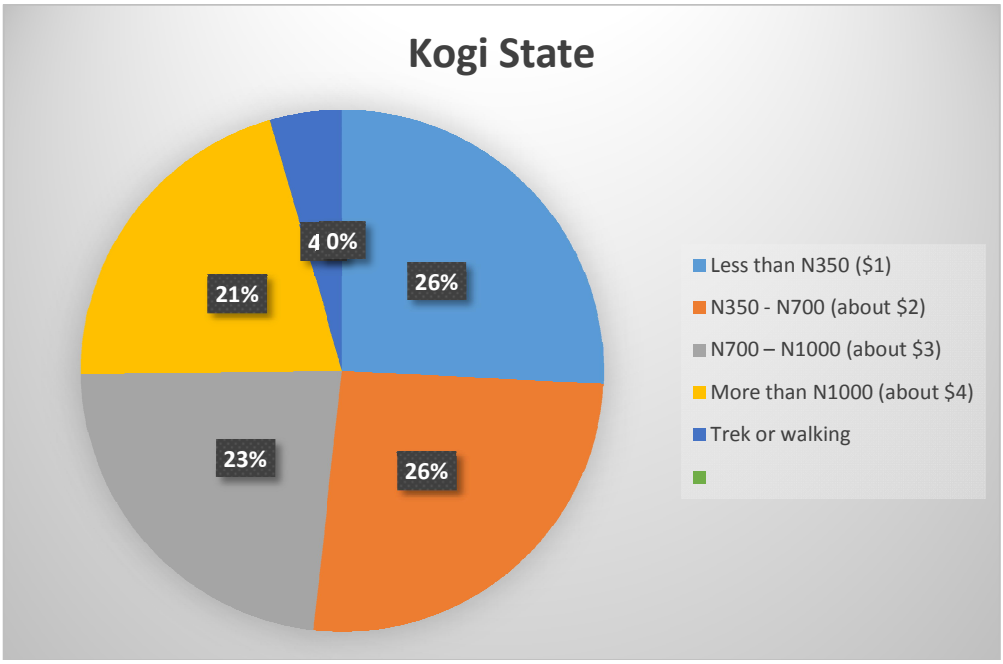

Fig. 3. Showing costs of transportation of respondents to health facilities in Ekiti and Kogi states

Table 3. Showing convenience in waiting time and satisfaction

Questions		Ekiti (N= 418)	Kogi (N=430)	Total (848)
Waiting time at last visit				
Less than 30 minutes		239(57.2)	182(42.3)	421(49.6)
30-60 minutes		119(28.5)	152(35.3)	271(31.9)
More than 1 hour		60(14.4)	96(22.3)	156(18.4)
Is the healthcare in your area equipped with needed medical facilities?	Yes	218(51.9)	119(27.4)	337(39.5)
	No	200(47.8)	311(72.4)	511(39.5)
Do you find health worker capable enough to attend to your health need whenever you visit the health Centre?	Yes	263(62.7)	124(28.8)	387(45.5)
	No	155(37.1)	306(71.2)	461(54.3)
As there been strike action in the past one year that shut health facility in your area	Yes	144 (34.4)	15 (3.5)	159 (18.7)
	No	274 (65.6)	415 (96.5)	689 (81.2)
Did you have cause to avoid using available health facility in the past one year	Yes	85 (18.9)	57 (13.0)	142 (15.9)
	No	333 (79.7)	373 (86.7)	706 (83.2)
Are you satisfied with health workers attention and treatment	Yes	326 (77.5)	350 (80.9)	676 (79.2)
	No	92 (22.0)	80 (18.6)	172 (20.3)

Source: Field Survey, (2020)

4. CONCLUSION

From the findings above, secondary health facilities, hospitals are the mostly available to the people and mostly accessed for health care services. Payment for service and affordability are better in Ekiti State than Kogi State. About 40 percent of the respondents depend on one dollar for transportation and about seven percent trek or walk to the health facility. More percentage of Ekiti state respondents expressed convenience in physical access than Kogi State. Physical access to health facility is significantly more expensive than in Ekiti State. This is a critical

factor in emergency health care and a contributor to avoidable deaths. Respondents in Ekiti State show better appreciation of waiting time, health infrastructure and personnel.

5. RECOMMENDATIONS

In order to improve the health outcomes to general population by increasing access of the people to healthcare services, the following recommendations are given:

1. Much attention needs to be paid to secondary healthcare just like the constant calls for PHC services. Public hospitals care for the general population including mothers and children, in terms of adequate health infrastructure and skilled personnel.
2. It is obvious that out of pocket expenses in health care is still predominant, state governments should as a matter of priority the establishment of health insurance scheme for its citizens and at the same time along with community based health insurance. This will make state governments to take much advantage of the 2014 National Health Act and increase access of the people to quality health care at all levels.
3. The notoriety of strike actions by medical doctors and other medical personnel is the greatest bane of sustained health access in Nigeria. Governments should show obvious commitment to the health of the citizens and residents by providing sincere conditions of service and integrity to honour agreement with the health unions. This will make health personnel committed to their duties and reduce brain drain.
4. Governments' commitment to sustainable development goal 3, good health, and universal health coverage, have not been shown in their programmes to transform the health sector, eliminate extreme poverty and making good health the right of the people. In this direction is to follow global standards in health budget, job creation, and improved medical manpower especially in the state government controlled health facilities.

CONSENT

Participation by prospective respondents was basically voluntary after explaining the academic purpose of the study and assuring them of confidentiality, anonymity and no risky outcome for the respondents. Consent of the respondents was taken through their respective signatures on the Consent Form or thumb printing for less literate respondents indicating approval.

ETHICAL APPROVAL

As noted earlier, approval was sought and obtained from Ekiti State University Research and Development Ethical Review Board with approval number ORD/AD/EAC/19/0054. Culture and gender specific rights of respondents were adequately preserved in the course of fieldwork and data analysis. The Board was equally involved in reviewing the data analysis and report writing process.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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