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CHALLENGES IN THE UTILISATION OF HEALTHCARE FACILITIES IN NIGERIA: EFFECT OF SOCIAL WORKERS AND SOCIAL SUPPORT SERVICES, EDUCATION ATTAINMENT AND INCOME-EXPENDITURE

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Abstract

The study sought to explore the challenges of healthcare utilisation in Nigeria and the role of social workers in advancing appropriate healthcare utilisation tendency cum propensity in Nigeria. Secondary data were used for the study. Amongst other factors, finance, health insurance coverage structural limitations which has failed to align system structures and processes to the goal of achieving universal health access and utilisation is limiting medical social-workers positive contributions. Thus, the achievement of increased healthcare utilisation for, holistic and sustainable health status that is efficient, acceptable to the people, of high-quality and therefore capable of driving growth and development for the health system and the country is lagging. Following, government needs to drive non-differential tendency for healthcare utilisation by providing strategic healthcare-, social work-, education-frameworks and investments specific to, micro-populations, sex, age, disability status among others. In addition, all health professionals,

including medical social workers, should imbibe the values/ethics of expert medical service

Keywords: Healthcare utilisation, health system, medical social workers, healthcare access and insurance

Introduction

According to Sani and Garba (2002) and the World Health Organisation (WHO) (2024) constitution, health is – the complete physical, social and mental well-being and not the mere absence of disease or infirmity. Health is a basic human need that is indispensable to the human race. That is, attaining a level of health will afford mankind a life that is socially and economically productive (Samuel and Thompson, 2018). Health is the basis for job productivity, the capacity to learn in school, and the capability to grow intellectually, physically and emotionally (Obansa and Orimisan, 2013). Good health is a treasure of inestimable value. It has implications for individual and national economic activities. Indeed – the health of people not only contribute to better quality of life but is also essential for the sustained economic and social development of a country as a whole (Barsanti and Bonciani, 2019). As with economic wellbeing of individual households, good health is critical for poverty reduction, economic growth and long-term economic development at the scale of whole societies.

According to Efe (2013), prior to the arrival of the missionaries most, rural communities relied on traditional health services for healthcare needs. The medical centres established by the missionaries were majorly concentrated in the rural areas because of the objective of evangelism, which was to get the so called rural "pagans" to embrace Christianity. These medical centres, however, were merely mobile clinics and at most community dispensary out-posts to treat primary health problems such as snake bites and minor injuries. In the latter years, when the British rule had been well grounded, the administrators promoted the creation of medical centres in the real sense of hospitals to handle outbreak of epidemics, such as sleeping sickness, small pox, malaria and other primary health concerns. However, these hospitals

were concentrated only in the urban areas where there was a high concentration of Europeans and government officials. The effect of this particular arrangement was foremost, a total neglect of rural areas in matters of healthcare and secondly, an established inequality in the urban centres between the colonialists including their black associates and general citizenry. Thus, the foundation of disparity in residential and healthcare service centres witnessed in Nigeria, that are still visible across the country despite, presently the existence of diverse range of health-care types and services in Nigeria such as; the traditional homes, bio-medical or western orthodox health-centres, synthetic healers, bone settlers among others (Oghenechoja, 2022; Home, 1983).

The emergence and evolution of private and public (government owned) healthcare facilities in Nigeria have tremendous effects on the overall healthcare service system and sector. The presence of private and public health institutions has contributed to the reduction of maternal mortality cases. There has also been reduction in the cases of disease burden and increased immunisation coverage. There is also significant increase in child deliveries handled by more hands from both the private and public health system sectors. Pregnant women now have more options and wider coverage of registering for antenatal and eventual childbirth (Swende, 2018; Zhema and Dada, 2021). However, other challenges with service delivery and utilisation of healthcare facilities in Nigeria still exists. These, on the demand side includes quality of care, health literacy and awareness, cultural and religious beliefs and; cost and affordability, geographical disparities, ethical concerns, inadequate capacity building and training on the supply side (KPA, 2022).

As one institutional effort to these challenges of service delivery and overall utilisation of private and public healthcare in Nigeria, social workers engage stakeholders and the overall private healthcare structure cum system to reduce the challenges of service delivery and utilisation of private and public healthcare facilities in Nigeria. Thus, social workers otherwise hospital social workers perform various functions in aiding enhanced service delivery and improved utilisation by, helping patients and their families understand a particular illness, work through

the emotions of a diagnosis, and provide counselling about the decisions that need to be made (Ashcroft *et al.*, 2018). Social workers are also essential members of interdisciplinary hospital teams, working in alliance with doctors, nurses, and allied health professionals. Also, social workers sensitize other healthcare providers to the social and emotional aspects of a patients' illness (Ambrose-Miller & Ashcroft, 2016). Further, hospital social workers use case management skills to help patients and their families address and resolve the social, financial and psychological problems related to their health condition. In addition, hospital social workers report an increase in the severity of client problems, caseload size, paperwork and waiting lists for services (Whitaker *et al.*, 2006).

Although medical social work is a rapidly growing field with phenomenal contribution to lessening the problems and challenges of healthcare utilisation; healthcare needs that are increasing challenges with healthcare utilisation has undergone great change over the past few decades. People now use health-care services to diagnose, cure, or ameliorate disease or injury; to improve or maintain function; or to obtain information about their health status and prognosis. Thus, need for increased role of social workers.

Again, despite medical social work profession's phenomenal growth and development throughout the world that is a clear indication of its contribution to the alleviation of health and social problems; medical social workers have not been adequately utilized over the years. Thus, adversely affecting overall healthcare utilisation, management process and healthcare services delivery globally and particularly in Nigerian hospitals. As a matter of fact, health-care utilization persistently has been inappropriate, of low quality, and of high cost globally. This may be adduced to these: medical social workers in Nigeria have not been able to cater for patients who come into the hospital with multiple psycho-social issues. In fact, it is uncommon for medical social workers in Nigerian hospitals to treat cases involving homelessness, chronic unemployment, lack of income, lack of health insurance coverage, history of incarceration, and substance abuse

problems that all; hinder effective recovery and timely discharge of patients.

Again, issues with the evolution of the health-care delivery system that has undergone great change over the past few decades compounds healthcare utilisation. Following, new; drugs, devices, procedures, tests, imaging, machinery and; changed patterns of care have emerged (NCHS, 2003). Also, the need for surgery – ambulatory and others; need for anaesthesia and analgesia influenced by the growth and development of non-invasive, less invasive or minimally invasive issues; new procedures with physicians' engagement and; new procedures to treat a number of previously untreatable conditions and in a variety of new sites; cases of lengthier disease course; issues with technology and even combinations of technologies; the combination of drugs now used to treat HIV/AIDS; combination chemotherapy for many types of cancers; the recent creation of scanning machines for positron emission tomography, computed tomography or positron emission tomography and magnetic resonance imaging keeps, compounding already aggregated low overall healthcare utilisation challenge. Further, complex; equipment's, hospitals and institutional settings, surgery centres, provider offices, outpatient facilities, imaging centres, and even technologies analogous to compounding overall healthcare utilisation exists. In addition, the average length of hospitalizations post-2010 despite the diffusion of new technologies has not amounted to significant improvements compared to healthcare utilisation (NCHS, 2016). Thus, the need for this work.

On the other hand, increased hospitalisation costs; changing environments and increasing exposure to toxic and hazardous substances in/within micro-environments; characteristic and peculiar socioeconomic environments; people-individual characteristics with their biology and genetics; inherited diseases and conditions that require medical care and; the prevalence of health conditions given differences in sex, age, race and ethnicity, employment status, among other factors influencing low healthcare utilisation; is budding a concerted push toward patient-centered healthcare and advocacy to increase healthcare

utilisation – a vital ingredient for overall healthy society. This concerted push toward person-centered, integrated care is being advocated at the global level by the WHO and other key donors in health and social service system development, including the United Nations Children's Fund (UNICEF) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) (World Health Organization 2022a; 2022b; UNICEF, 2021a; b; 2019; PEPFAR 2022; 2020; WHO, 2017a; b).

Increasing healthcare utilisation: issues and concerns

Health status and the need for health-care services to improve or maintain health are major determinants of health-care utilization. Recent attention to individual behaviours, such as; smoking or lack of exercise and overeating causing health conditions that require utilising healthcare services (ODPHP, 2017a; b); social determinants of health, such as; education, economic stability, community safety, and availability of adequate housing and healthful food; people's individual characteristics including their biology and genetics, inherited diseases and conditions all; requiring utilising medical care is emergingly fingered as hazardous to low healthcare utilisation. The prevalence of these conditions different, by sex, age, race and ethnicity, employment status and; exposure to pollutants or other environmental health hazards in physical environments affect health and has been shown to correlate with increased healthcare utilisation crises and reduced healthier population (ODPHP, 2017a; b). People who have unmet social needs are more likely to either; have repeat "no-shows" for medical appointments, have poorer glycaemic and cholesterol control and; frequent hospital emergency departments (EDs) long-term compared, to those who are able to increase medical healthcare utilisation and meet their socio-health needs (Thomas-Henkel & Schulman, 2017).

Health-care utilization is determined; by the need for care; by whether people know that they need care; by whether they want to obtain care; and by whether care can be accessed. Quality is a construct separate from access and is related to the achievement of favourable outcomes associated with utilization, not to whether health-care

utilization occurs at all or to difficulties in obtaining care. In theory, health-care utilization should correlate highly with the need, however defined, for services. Ideally, need should be the major determinant of health-care utilization, but other factors clearly have an effect. One of those factors is the ability to access care – including whether it is available, timely and convenient, and affordable (Figueroa *et al.*, 2017). Some services are needed but not obtained, and others are utilized but not clearly indicated, or are indicated only after other protocols are followed (Kale *et al.*, 2013; Kressin & Groeneveld, 2015; Lyu *et al.*, 2017).

Various technologies needs be addressed in lieu of been useful for increased healthcare utilisation of people with disability. For example, because technologies are insufficient, telehealth is not widely used in and throughout most countries, and the medical field continues to try to determine how it can be used most effectively to increase healthcare utilisation for overall healthy society. This is because, for such assessments, data and national assessment committees are, however not available (WHO, 2017a; b).

Healthcare access dimensions of healthcare utilisation

Several documents (Zwi, 2001; Aghion, Peter and Fabrice, 2010; Titus, Adebisola and Adeniji, 2015) reaffirm the under-utilization of health services especially in developing countries, to be founded on issues with access to healthcare (Zwi, 2001; Aghion, Peter and Fabrice, 2010; Titus, Adebisola and Adeniji, 2015). Using personal healthcare services on time to attain the best possible health outcome is the definition of having access to health care (IOM, 1993; 2002). Access entails entering the healthcare facility or system, gaining admittance to the healthcare treatment facility where patients may obtain necessary services, and locate clinicians who can satisfy patients' needs and with whom patients can establish a rapport based on trust and communication (AHRQ, 2010). However, in Nigeria, a recent report posit Nigeria would require 386,000 additional beds and $82 billion of investment in health-care hospital facility assets to reach the global average for healthcare access

and utilisation (Smith, 2021). Thus, healthcare professionals condemn the high number of Nigeria's maternal deaths (10 percent of the world's total) yet, one of worst health indices in the world (Titus, Adebisola & Adeniji, 2015).

This is worse-off in rural instances. Thus, healthcare access and utilization are of major interest to rural development (Aghion *et al.*, 2010). In rural areas, in lieu, they also emphasize that prompt access to healthcare is critical because it may help patients and doctors prevent disease, manage acute episodes, or treat chronic disorders – all of which may help prevent a condition's worsening or complications (NCHS, 2017b) – intricate ingredients and vital elements of wellbeing and components of human capital.

Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. Consequently, there are many ways to think of access with regards to healthcare utilisation. Levesque *et al.* (2013) defined access in lieu of healthcare utilisation by presenting five dimensions of accessibility, approachability, acceptability, availability and accommodation, affordability, and appropriateness. The report saw access as the opportunity to identify health-care needs; to reach, obtain, or use health-care services; and to have the need for services fulfilled. Access can be seen as a continuum. Even if care is available, many factors can affect ease of access, for example; the availability of providers who will accept a person's insurance (including NHIS cover); ease in making an appointment with a given provider; the ability of a patient to pay for care (given cost-sharing co-payments and deductibles with NHIS patient insurance); and the difficulty of arranging transportation to and from healthcare facilities (AHRQ, 2010; MACPAC, 2016). Some of these influences compound, the boarder view of healthcare access in lieu of healthcare utilisation to designate certain factors or characteristics as component-measures influencing healthcare utilising such as one's initial contact with or use of healthcare services (Meit *et al.*, 2014; Douthit *et al.*, 2015).

Differences in health-care utilisation associated with selected characteristics

Ideally, utilization of health-care services reflects a need for care, but that is not the case, for several reasons. Many factors affect health-care utilization independently of need and are reflected in differences – some of which are remediable, among population groups. Some of these factors are related to biologic or environmental differences among groups, such as disproportionate residence in polluted environments, access to healthful food and adequate housing, and education associated with effective use of health care. Others are related to differences in access, such as health insurance coverage or income needed to obtain services, ease of obtaining services, and discriminatory practices of providers. Sections following review factors influencing differences in healthcare utilization according to selected characteristics.

Sex

Women overall have higher health-care utilization than men. Although it had been thought that women receive health care primarily during child-bearing years for reproductive health, many health-care utilizations occur during and after menopause for such issues as cardiovascular disease and osteoporosis (Owens, 2008). Other studies have shown that women make more primary care visits and receive more diagnostic services, screening services, diet and nutrition counselling, and sexual health care than men even though men generally have higher rates of obesity and cardiovascular problems (Salganicoff *et al.*, 2014).

Among people 18–64 years old, in certain studies, women have higher rates of disability and self-reported fair or poor health status. Among all people 18 years and older, women are more likely to delay or not receive care, or to not receive prescription drugs, because of cost. Women are more likely to have between one and up to 10 or more health-care visit in a given year, aside emergency departments' (EDs) visit in some cases or hospitalization (NCHS, 2017b). These findings

indicate that although women utilize health-care resources at greater rates, health-care needs go unmet.

Working age adults

There is no question that increased functional limitations such as age reflect on health-care utilization. This is true for working-age people and for older adults (NCHS, 2017b). The average retirement age in the United States in 2013 was 64 years for men and 62 years for women (Munnell, 2015). However, because of disability that may occur in people as they age; or for other reasons, many workers leave the workforce before social security retirement age or before they become eligible for pensions or vested savings. Further, and in comparison, while; about 4 percent of people who were 18–44 years old had self-reported heart disease compared with about 12 percent of people 45–64 years old; there existed health-care utilization functional limitations in increasing rates for people 45–64 years old (Freid *et al.*, 2012). Again, corresponding rates of cancer were 2 percent and 7 percent self-reported, respectively for 18-44 years and 45-64 years old age-groups while; almost 25 percent of people 18–44 years old reported low back pain compared with 35 percent of people 45–64 years old (NCHS, 2017b). However, more health-care utilization functional limitations in increasing rates existed for people in 45–64 years old age-group. In contrast, on the other hand, self-reported disability and healthcare utilisation among working-age adults and mental illness among all people 18 years and older have remained stable for both in recent years (Ahrnsbrak *et al.*, 2017; NCHS, 2017b).

Previous studies in Nigeria (Uwakwe et al., 2020a; b; Gulumbe, Alabi, Omisakin and Omoleke, 2018; Asogwa, Ezenekwe, Nzeribe, Uzonwanne and Ogbonna, 2018; Ugbor, David-Wayas, Arua & Nwanosike, 2017; Onyeneho et al., 2016; Obiyan and Kumar, 2015); Ghana (Akowuah, Agyei-Baffour and Awunyo-Vitor, 2018; Buor, 2003); Guinea-Bissau (Yaya, Bishwajit and Gunawardena, 2018), posit healthcare utilisation predictors to include; economic status, education, birth level, birth interval, distance (to healthcare centre)/transportation

means reliability, residents' sociodemographic characteristics (as urban, rural, peri-urban, metropolitan and nonmetropolitan, occupation status. Others were healthcare service deliverables such as level of antenatal care among others also, wealth of pregnant women, household size significantly had positive and negative influence respectively on healthcare utilisation or otherwise via the capability to access healthcare.

Materials and methods

The methodological frame employed is in line with the study objectives and follows the health-behavioural model (Andersen, 1968) to determine contributory and co-contributory effects of predictor variables on health-individual characteristics. Following, utilisation of healthcare services depends on: pre-disposing characteristics, enabling characteristics and, need-base characteristics. In accordance with other health-behavioural reports (Anderson and Newman, 2005; Long and Freese, 2014; Crowson, 2023) vis-à-vis Wagner's theory of spending expansion on health, the analytical framework adopted for this study address effectively in addition, structural socio-economic factors-effect on healthcare utilisation tendency cum propensity.

On advance to literature, the analytical specification utilised in this study augment on the inflated reliance on Nigeria Living Standard Survey data conventionally used in previous studies by capturing the dynamics in-country into an aggregate function design via comparatively incorporating multi-mix datasets in stretching overall study extrapolation. Thus, data from Observatory data for Africa (2024), World Health Organisation (2024a; b), United Nations Children Fund (2024), World Bank (2024) and the Nigeria Living Standard Survey (NLSS) (2018/2019) (NBS, 2024) were all used to build better inference. The analytical model specification is thus given as follows (Andersen, 1968; Anderson and Newman, 2005; Long and Freese, 2014; Crowson, 2023):

$$ANC_{\square} = \alpha_0 + \beta_1(SWWkF) + \beta_2(CbIS) + \beta_3(SoHCF) + \beta_4(OOPEoH) + \beta_5(PPP) + \beta_6(EA) + \epsilon_i \ \ldots (1)$$

Where:

ANC = Antenatal healthcare utilisation
SWWkF = Social workers work-force in Nigeria
CbIS = Coverage by insurance services
SoHCF = Overall status of healthcare facilities in Nigeria
OOPEoH = Out-of-Pocket expenditure on health
PPP = Medical physicians per 1000 people
EA = Educational attainment
α = intercept
β = slope coefficient for the respective independent factors
ε = error term/stochastic error term

Results and discussion

Predictor factors influencing healthcare utilisation in Nigeria

Table 1: Poisson regression results summary

VARIABLES	Healthcare utilisation
Status of healthcare facilities	0.0165
	(0.0132)
	(*1.016618*)
Coverage by essential health-insurance	-0.00371
	(0.0133)
	(*.9962952*)
Out-of-pocket expenditure on health	0.0258
	(0.0372)
	(*1.026128*)
Social workers work-force	2.49e-06
	(2.01e-06)
	(*1.000002*)
Physicians per 1000 people	-1.297
	(1.182)
	(*.2734025*)
Educational attainment	0.114*
	(0.0597)

	(*1.121284*)
Constant	1.516
	(2.824)
P>chi2	0.0874

Standard errors in parentheses; incidence rate ratio in italics
*** p<0.01, ** p<0.05, * p<0.1

The results in table 1 show that for every unit increase of social workers, healthcare utilisation tendency cum propensity multiplies by 1.0000022. Also, for every leap in educational attainment, healthcare utilisation tendency cum propensity multiplies by 1.121284. Further, status of healthcare facility has a positive effect on healthcare utilisation tendency by 1.016618. Contrary to a-priori expectation, in view of Nigeria, Out-of-pocket expenditure on health do not overall, culminate in negative tendency for healthcare utilisation. This scenario is woeful and needs urgent government concern in view of Nigeria given the limited public funding of healthcare and, the incidence of direct healthcare funding in Nigeria that rests disproportionately on the poor households. These households, in comparison to their wealthy counterparts, spend about 9 times more of their per capita total expenditure on OOP health care (Olaniyan et al., 2020). Thus, Out-of-pocket (OOP) payments for healthcare – currently the predominant form of private health financing in Nigeria, make up approximately 74.68% of the total healthcare funding in Nigeria, a figure higher than that of other sub-Saharan countries with lower GDPs. This position in reality for Nigeria, and in comparison, to, Angola, Gabon, South Africa, and Botswana that allocates 37.14%, 20.13%, 5.36%, 4.64% lower OOP payments for healthcare respectively (World Bank, 2022) will, put pressure on low-income earners thereby exacerbating poverty and lower per capita income, amongst other things.

On the other hand, coverage by essential health-insurance have negative effect on healthcare utilisation in Nigeria. This is in line with Freid et al. (2012), NCHS (2017b), AHRQ (2010) and, MACPAC

(2016) reports' that there existed health-care utilization functional limitations particularly with insurance cover in increasing rates especially for people 45–64 years old vis-à-vis utilising and accessing healthcare. Unfortunately, these functional limitations with patient-insurance cover emphasize protocols that affect prompt (timely and convenient) access to healthcare impeding healthcare utilisation. While critical for bureaucratic processes these protocols cum functional limitations may be counter-productive especially when it does not ultimately help/aid patients and doctors prevent; disease, a condition worsening or complicating; manage acute episodes, or treat chronic disorders – vital health insurance cover objectives to wellbeing and human capital enrichment.

Unfortunately, in view of Nigeria, number of physicians per 1000 people do not overall, culminate in positive tendency for healthcare utilisation. This is consistent with previous reports (Schieber et al., 2006; World Health Organization, 2017; Guardian, 2017; Onyeji, 2017; WHO, 2018a; b; Aregbeshola & Khan, 2018; Oburota & Olaniyan, 2020; PHCPI, 2020; Payne, 2021; Smith, 2021; Goddard & Patel, 2021; World Bank, 2022; Gizaw et al., 2022; Abah, 2023; Dominic, 2023; Abu, 2024) that posit brain-drain medical health-workers migration effects on the Nigerian-health system. This puts pressure on the carrying-system and according to WHO (2018a; b) usually translating to low-quality, expensive and dangerous healthcare service. In other instances, in lieu of handling the pressure put on the carrying-system (medical/health personnels), a fundamental misconstruction (lack of quality management framework of the system) results where the system combines a mix of non-professional service providers resulting in lack of the culture of quality and quality management mindset among healthcare providers and other workers across all strata within and beyond the health system. These reports (Abu, 2024; Dominic, 2023; World Bank, 2022; Gizaw et al., 2022; Goddard & Patel, 2021; Smith, 2021; Oburota & Olaniyan, 2020; Aregbeshola & Khan, 2018; Schieber et al., 2006) argue the effect of; no strategic approach to addressing both the gaps in the healthcare system of Nigeria and the efflux of healthcare

workers from Nigeria combined with 386,000 additional beds and $82 billion of investment in health-care assets needed, on the minimum, to reach the global average; to include; under-staffing, inadequate staff training, low staff welfare that persists. Overall, compounding to dangerous, poor/low-quality healthcare all, undermining tendency to use medical treatment cum utilise healthcare.

Conclusion and recommendation

This study undertook to unknot healthcare utilisation challenge – a universal phenomenon. This tendency for healthcare utilisation and access is determined by a person's individual characteristics and behaviours, physical environment, and socioeconomic environment and other factors that were studied. Those factors influence differential health-care utilization or otherwise. Unfortunately, and based on the results of this study, differential health-care utilization undermines a healthier population and is one thru link to; overall breakdown of society and her vital support systems including, the principal healthcare system. Following, government needs to evolve higher tendency for healthcare utilisation by providing strategic healthcare-, social work-, education-frameworks and investments specific to, micro-populations, sex, age, disability status among others. In addition, to; aid structural components and operations that will raise the current social work labour-force whilst encouraging functional overall healthier population via healthcare utilisation and health-literacy leap; states and local governments should support social work movements cum groups in maintaining all-year round, round-the-clock medical social-worker presence even down to cottage and basic-healthcare centres in all wards. Finally, insurance policy-review is expedient if functional limitations imposed by bureaucratic processes on prompt (convenient and timely) health-care access cum utilization by people particularly people with disabilities will be delimited.

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