ACCESS TO HEALTHCARE SERVICES IN BENUE STATE:

EVIDENCE FROM OBI AND USHONGO LOCAL GOVERNMENT AREAS

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ABSTRACT

This study investigated the critical issues that surround access to needed healthcare services in Benue State. . A total of 1019 households were surveyed using a cluster survey method to collect data on socio-economic and health-service- related information from Obi and Ushongo LGAs. Descriptive methods such as frequencies, percentages and averages were used at various stages in the analysis of data. The findings of the study among others were high cost of health services limiting access; absence of qualified medical personnel; low patronage of rural health centres; and poor outcome of healthcare services. The study recommends among others a review of the National Health Policy on Financing with particular reference to user fees that limits access to healthcare by the poor households.

Key Words: Access, Healthcare, Utilization, Households, Poverty.

Introduction

Access to healthcare is a health and development issue. Most governments declare that their citizens should enjoy universal and equitable access to good healthcare. This is due to the fact that poverty and ill-health are intertwined. It is observed that within countries, poor people have worse health outcomes than better-off people (Wagstaff, 2002). The association between poverty and ill-health reflects causality running in both directions. Poor people are thus caught in a vicious circle: poverty breeds ill-health, ill-health maintains poverty. This makes a study on access to health care in the light of livelihood insecurity an imperative especially in a poverty ridden State like Benue.

Of all the risks facing poor households, health risk probably poses the greatest threat to their lives and livelihoods. A health shock leads to direct expenditures for medicine, transport

and treatment as well as to indirect costs related to a reduction in labour supply and productivity (Asfaw, 2003). Access to healthcare in Nigeria is limited in terms of distance and cost. A core welfare indicator questionnaire survey by the National Bureau of Statistics (2006) revealed that the ability to reach a health facility within 30 minutes at the national level was 55.5 percent for the population; and only 42.0 percent for Benue state. The introduction of user charges without reference to clients' needs and resources in the health financing policy also holds grievous implications for the poor and thus makes a study on access to health care services in the State an imperative.

In view of the importance of healthcare in the poverty alleviation process, it is pertinent to critically examine if households have access to the medical care they need. Thus the main thrust of this study is to investigate the critical issues that surround access to needed healthcare services in Benue State.

The specific objectives include:

- To examine availability of medical care facilities;
- To ascertain utilization of healthcare services in the State;
- To investigate ease of physical access to healthcare facilities; and
- To ascertain satisfaction from utilization of healthcare services.

Two local government areas Obi and Ushongo were selected by design to fully capture the effects of access to healthcare services across the State. Obi LGA was selected as result of been identified with high level of poverty (DFID 2002) and also the fact that poor people are worst hit by health shocks (Asfaw, 2003). Ushongo LGA on the other hand was selected based on it been predominantly rural where the poor usually reside and its location in Senatorial Zone A where access to healthcare services is lowest (FOS 2001).

Conceptual Issues and Literature Review

Access to Health Care

Access is a complex notion. It encompasses a number of dimensions which mean that it is not synonymous with use. Mooney (1983) points out that 'equality of access is about equal opportunity: the question of whether or not the opportunity is exercised is not relevant to equity defined in terms of access.' Therefore, looking at health service utilization alone does not explain what form of access people have, or whether their or others' health care needs are being met. What people do when they are ill, or need preventive health care, is determined by a range of factors including knowledge, beliefs, availability of health facilities, drugs and money (Hausmann-Muela *et al*., 2003).

For instance, if people do not attend a health facility, does it mean:

- that they do not need to attend it?
- that they do not realize that they need to attend it?
- that they do not know it is there?
- that they cannot afford to get to it?
- that they do not like it and would prefer to go elsewhere?

Aday and Anderson (cited in Gulliford *et al*., 2002) first made the distinction between 'having access' (potential to utilize a service if required) and 'gaining access' (initiation into the process of utilizing a service). Building on this, Gulliford *et al*. proposed a number of components to equity of access:

i. *Health service availability* – is an adequate supply of health services available?

ii. *Health service utilization* – which may include overcoming personal barriers, financial barriers, or organizational barriers.

iii. *Health service outcomes* – what is the relevance and effectiveness of the services? Are they of decent quality?

iv. *Equity of access* – do different groups of people get access to services in equal proportion according to their need?

An initial prerequisite of access is the availability of services, but whether these services can be used by their intended beneficiaries is of equal importance. Factors that will determine this second type of access (utilization) include geographical availability and financial and cultural accessibility. Determinants of the acceptability of services include the attitude of health workers to patients, the condition of premises, waiting times and the duration of consultations. Even strong performance in these features does not, however, equate to access to good health service outcomes, the third aspect of access. Even if services are accessible for the poor, there is still the question of whether they meet their health needs. Consumers are often poorly equipped to judge the technical merits of alternative services. Therefore, they may access services that provide poor quality of care. They may do so because there are no alternatives or because such services meet other qualitative criteria that they value (e.g. short waiting times, low cost). Equally, they may not attend a service that is of good technical quality because they perceive it to be of poor quality (for instance, because it is a public sector clinic) or because they fear that they will be treated badly (Sara *et al*.,2008). The various aspect of access discussed above shall be investigated from the selected local government areas in the State.

Empirical Literature on Access to Healthcare Services

In their study on access, Bulatao and Ross, (2002) carried out rating of maternal and neonatal services in 49 developing countries. Using the survey method, their findings revealed that 68 per cent of urban pregnant women and 39 per cent of rural pregnant women have access to an adequate range of maternal health services. Full immunization coverage is also alarmingly low in many countries. Waters *et al*., (2004) in their study on Coverage and costs of childhood

immunizations in Cameroon came to the conclusion that only between 34 and 37 percent of children in the country were fully immunized. In Nigeria, 39 per cent of children below one year of age have been routinely immunized with at least three doses of oral polio vaccine (OPV).

As for curative care, studies suggest that a large number of those who report having been ill did not access any form of formal care. For instance, Ahmed *et al.,* (2003) in their study on changing health care seeking behavior in Matlab, Bangladesh found that 55 per cent of people who had had fever, bodily pain or gastrointestinal illness reported that they self-treated. In Kenya, Ruebush *et al*., (1995) investigated self-treatment of malaria in a rural area of western Kenya and found that of 138 episodes of febrile illness, 60 per cent were treated at home with herbal remedies or with medicines purchased from a local shop. In Ghana, Hill *et al*. (2003) in their study on recognizing childhood illnesses and their traditional explanations asked respondents to rank the severity of the illness and found that, 50 per cent of children considered by their caregivers to have had an illness that was 'severe/could have killed' were not taken to a health facility. Prata *et al*., (2005) analyzed demographic health survey (DHS) data from 22 countries and found that only 34.3 per cent of children from the poorest quintile who were sick with diarrhea consulted a medical practitioner.

A study by Cunningham and Kemper (1988) on the ability to obtain medical care for the uninsured across communities in the United States (US), using the survey method showed significant community variation in reported access to healthcare for the uninsured after accounting for need and a set of socio-demographic variables. Adedini *et al*., (2014) looked at barriers to accessing healthcare in Nigeria: implications for child survival using data from 2008 Nigeria Demographic and Health Survey. Applying Cox Proportional hazard models in the analysis they found higher under-five mortality risk for children whose mothers had cultural, resource-related and physical barriers in accessing health care relative to children whose mothers reported no barriers.

Methodology

Measure of Access to Care

The measure of access to care is derived from the Household survey 2013 from Ushongo and Obi local government areas of Benue State. A total of 1019 households were surveyed using a cluster survey method to collect data on socio-economic and health-service- related information. Household heads were interviewed using a pretested questionnaire containing structured and open-ended questions. The measure used was very similar to that developed in the Cunninghan and Kemper (1998) study. Individuals were asked two questions. (1) During the past 12 months was there any time when you didn't get the medical care you needed? (2) Was there any time during the past 12 months when you put off or postponed getting medical care you thought you needed? Follow up questions identified specific reasons as to why care was postponed. Access to care was measured dichotomously. Individuals were considered to have had difficulty accessing health care if they answered "yes" to the first question or "yes" to the second question and if the reasons cited for the second question included the cost of care, problems with health insurance or referrals, difficulty finding physicians or making appointments, or proximity to clinicians. We selected these types of access problems to reflect the major obstacles to receipt of needed care; other choices such as "bad experience with doctor," caring for family members, or "didn't think it was serious enough" were not considered genuine health care system related access problems.

Simple statistics such as frequencies, percentages and averages were used in the cross tabulation and analysis of the data.

Presentation and Analysis of Data

Access to Healthcare

In examining access to healthcare services in the study area; the study considered the issue in terms of availability, utilization, physical accessibility and outcomes of the healthcare services.

Availability of Healthcare Services

Information sought from respondents in respect of health centres/hospitals available in the various communities of the sampled local government areas is presented below.

Table 1: Availability of Health Centers/Hospitals in Communities of Sampled Local Government Areas.

RESPONSE	FREQUENCY	PERCENTAGE (%)
Available	976	95.8
Not Available	43	4.2
Total	**1019**	**100**

Source*: Household survey 2013*.

From table 1, it can be seen that healthcare services are available in the sampled communities since over 95% of the respondents have indicated so. This implies that healthcare services are available in the state and may not be considered as a major challenge to access.

Utilization of Healthcare Services

In order to investigate issues surrounding utilization of healthcare services in the state, respondents were asked two questions as to whether they had ever put off or postponed getting medical attention they needed and reason(s) for the postponement. The responses were as presented in tables 2 and 3.

Table 2: Ability to Access Healthcare Services.

Responses	Frequency	percentage (%)
Able to access healthcare services	613	60.2
Not able to access healthcare services	406	39.8
Total	**1019**	**100**

Source*: household survey 2013.*

Table 3: Reasons for Inability to Access Healthcare Services.

Reasons	Frequency	percentage (%)
Cost of healthcare	343	84.5
Absence of health insurance	10	2.5
Absence of health facilities	8	2.0
Absence of qualified medical personal	18	4.4
Distance to nearest health post	11	2.7
Other reasons	16	3.9
Total	**406**	**100**

Source*: Household survey 2013.*

Table 2 indicates that about 40% of the respondents could not access healthcare services due to various reasons. The break down as presented in table 3 shows that over 84% of the respondents that could not access healthcare services was due to cost of healthcare. By implication, healthcare cost is identified as a major factor limiting access to healthcare services in Benue State. It is important to also identify the socio-economic groups based on occupation that suffer most inability to access health care services.

Table 4: Distribution by Occupation of Households Unable to Access Healthcare Services .

Occupation	Number of Households	Percentage (%)
Farming	241	59.4
Trading	46	11.3
Civil Service	61	15.0
Artisan/Crafts	58	14.3 .
Total	**406**	**100**

Source*: Household survey 2013.*

The distribution by occupation of households that were not able to access health care services in Table 4 showed that 59.4% of households whose heads were engaged in farming had the highest challenge in accessing health care services. Next to farming is civil service with 15% followed by artisan/crafts with 14.3% and lastly trading with 11.3%.

Physical Accessibility of Healthcare Facilities

From the household survey 2013, it was established from table 1 that over 95% of the respondents indicated that there was availability of healthcare posts in their communities. Granted that health centres/hospitals are found in most of the communities which are mostly less than ten kilometers in radius is an indication that healthcare services are available to most of the people within 30 minutes reach that is considered ideal (NBS 2006). By implication, access to healthcare facilities in Benue State in terms of distance may not be considered a major challenge.

Outcome of Healthcare Services

About 4.4% of the sampled population that were unable to access healthcare services expressed dissatisfaction with the services rendered. The major reason being the absence of qualified medical personnel. This finding correlates that of FOS 2001 where 31% of patients that made use of health services in the state reported failure of treatment received.

Discussion of Findings and Policy Implications

Arising from the household survey information in tables 2 and 3 on households' access to healthcare services in Benue State; it was found that about 40% of the population where unable to access healthcare services. It was also alarming to discover that over 84% of those that could not access healthcare services were on the ground of high cost of care. These findings correlate with that of FOS 2001 where they reported that only 5% of patients made use of health centres

and all from rural areas. The findings point to the gravity of the issue of high cost of services since over half of healthcare posts in the State are health centres located in rural areas (SMOH, 2006). The implication of the high cost limiting access to healthcare services on the households is that the poor people would continue to remain poor partly due to poor health condition that limits their productivity. This calls for a review of the healthcare financing policy especially with respect to user fees and the principle of self-sustainability that is currently been pursued. Obviously the principle of self-sustainability of the healthcare delivery system as enshrined in the National Health Policy does not give room for the desired subsidy for the needy and runs contrary to the National philosophy of health for all Nigerians.

Upon classification by occupation of those that could not access health care services in the study area, it was discovered that 59.4% of the households were those whose heads were into farming. This state of affairs spells doom for the economy of the State since it heavily dependents on agriculture that sustains over 60% of the population. It could also imply that Nigerians may not experience a drop in food prices given that farmers in the acclaimed food basket State of the Nation have serious healthcare access challenges that stands against their productivity. This finding lend support to the poverty head count report on Benue from the National Bureau of Statistics (NBS) (2008) indicating an increasing trend that estimated the poverty head count in 2004 to be as high as 80.85% of the population.

It was found that poor health outcome upon utilization of services was a limiting factor to use of healthcare services in the State. Absence of qualified medical personnel hindered access to medical services by 4.4% of those that reported inability in accessing healthcare services. Inability in utilization of health facilities in the rural areas apart from cost which accounted for 84.5% was majorly not unconnected to the absence of qualified medical personnel. As such there is every need for the government to make deliberate effort to staff the rural health centres with qualified medical personnel. The policy implication is for the government to put in place policies/incentives that would encourage qualified medical personnel to accept posting to rural areas.

Conclusions and Policy Recommendations

Conclusions

Giving findings about access to healthcare services in the State, the study came to the conclusion that healthcare facilities are available in sufficient quantities; however their utilization is limited due to various reasons. Some of the reasons identified includes: high cost of care; absence of qualified medical personnel and failure in healthcare services outcomes. The study also came to the conclusion that households' productivity shall be limited due to their inability to access healthcare services; thus leading to perpetuation of poverty in the State.

Policy Recommendations

(i) The National Health Policy on financing of healthcare services has to be reviewed to reflect the socio-economic conditions in the society. Payment for healthcare services should be based on individuals' ability to pay and not equity in payment for services as it is today.

(ii) There is need for Benue State government to put in place policies and incentives that would make working in rural areas attractive to medical personnel.

(iii) There is every need for the government to have a change of attitude in terms of giving the health sector its' desired attention as one of the top priority sector, especially at this level of our development where unskilled labour is the major source of production.

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