
Accessing Paediatric Healthcare Services In Nigeria: The Burden Of Out-Of-Pocket Payments And Policy Implications

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Abstract

Access to paediatric healthcare services remains a major public health challenge in Nigeria, particularly in the context of persistent dependence on out-of-pocket (OOP) healthcare financing. This paper critically examined the barriers to accessing paediatric healthcare services in Nigeria with specific focus on the burden of out-of-pocket payments and their policy implications. The study adopted a qualitative and analytical approach through extensive review of existing literature, policy documents, and institutional reports relating to healthcare financing and child healthcare access in Nigeria. The paper identified several interconnected barriers affecting paediatric healthcare utilization, including high out-of-pocket healthcare expenditure, weak health insurance coverage, poverty, poor primary healthcare infrastructure, rural–urban disparities, and weak implementation of healthcare policies. The study revealed that excessive dependence on direct household healthcare payments contributes significantly to delayed treatment-seeking behaviour, catastrophic health expenditure, household impoverishment, inequitable healthcare access, and preventable child morbidity and mortality. The paper further established that despite various healthcare reforms such as the National Health Insurance Authority (NHIA) Act and the Basic Health Care Provision Fund (BHCPF), financial risk protection for many Nigerian households remains inadequate. The study concluded that improving paediatric healthcare access in Nigeria requires comprehensive healthcare financing reforms, increased public sector investment in healthcare, expansion of health insurance coverage, strengthening of primary healthcare systems, and effective implementation of health policies aimed at achieving Universal Health Coverage (UHC). The paper recommended reduction of out-of-pocket healthcare payments, expansion of child-focused health insurance schemes, revitalization of primary healthcare centres, strengthening of rural healthcare services, and adoption of equity-driven healthcare policies to improve child health outcomes in Nigeria.

Keywords: Paediatric Healthcare, Out-Of-Pocket Payments, Healthcare Financing, Child Health, Healthcare Access, Universal Health Coverage, Nigeria

INTRODUCTION

Child health remains one of the most sensitive indicators of a nation's health system performance, and in Nigeria, it continues to reflect persistent structural weaknesses in healthcare financing, access, and service delivery. Despite multiple health sector reforms and policy commitments, Nigeria still records a disproportionately high burden of preventable childhood morbidity and mortality, particularly from malaria, pneumonia, diarrhoeal diseases, malnutrition, and vaccine-preventable conditions. These conditions are largely treatable, yet they continue to contribute significantly to under-five mortality, reflecting deep inequities in timely access to healthcare services (World Health Organization [WHO], 2024).

However, access to paediatric healthcare services in Nigeria is not determined solely by medical need or geographic availability of facilities, but increasingly by the financial capacity of households to pay at the point of service delivery. This reality reflects a structural weakness in Nigeria's health financing system, where out-of-pocket (OOP) payments remain the dominant mode of healthcare financing. In practical terms, caregivers—often already under severe economic pressure—are required to make immediate cash payments before children can receive essential services such as consultations, diagnostics, and medications. For many households, particularly those in rural and low-income urban settings, these costs constitute a major barrier to timely healthcare utilization.

Nigeria's persistent reliance on out-of-pocket expenditure has significant implications for equity and child survival. High OOP spending has been widely recognized as a key driver of catastrophic health expenditure and delayed care-seeking behavior in low- and middle-income countries (WHO, 2023). In Nigeria specifically, evidence from the National Demographic and Health Survey (NDHS) indicates that a substantial proportion of households cite lack of money, distance, and cost of treatment as major barriers to accessing healthcare for sick children, particularly in rural and low-income populations (National Population Commission [NPC] & ICF, 2019). This highlights the real-world impact of financial constraints on paediatric healthcare utilization. In many cases, careseekers delay seeking formal care, resort to self-medication, or patronize informal providers, resulting in preventable complications and avoidable child deaths.

Although Nigeria has introduced key health financing reforms, including the National Health Insurance Authority (NHIA) Act and the Basic Health Care Provision Fund (BHCPF), their impact remains limited due to weak implementation and low population coverage. A significant proportion of Nigerians, particularly those in the informal sector, remain outside formal health insurance coverage. Consequently, paediatric healthcare services are still largely financed directly by households, undermining progress toward Universal Health Coverage (UHC) and perpetuating inequities in access to essential child health services.

Against this background, this paper critically examines the barriers to accessing paediatric healthcare services in Nigeria, with a particular focus on the burden of out-of-pocket payments and its policy implications for health financing reform and child health equity.

Despite several health sector reforms and policy interventions aimed at improving access to healthcare in Nigeria, access to paediatric health services remains critically constrained by financial barriers, particularly the heavy reliance on out-of-pocket (OOP) payments. In principle, the introduction of the National Health Insurance Authority (NHIA) Act and the Basic Health Care Provision Fund (BHCPF) was intended to reduce financial hardship and expand equitable access to essential healthcare services, including child health services. However, in practice, a large proportion of Nigerian households remain uninsured, and

healthcare financing continues to depend predominantly on direct household expenditure at the point of service.

Findings from national surveys indicate that cost-related barriers—including lack of money for treatment, transportation costs, and user fees—remain major determinants of whether caregivers seek formal healthcare for sick children (National Population Commission [NPC] & ICF, 2019). As a result, many children do not receive timely medical attention, leading to avoidable complications, worsening disease progression, and in severe cases, preventable mortality. This situation is particularly pronounced among low-income households and rural populations, where economic vulnerability intersects with limited access to health insurance coverage and functional primary healthcare services.

Furthermore, while existing policies emphasize universal health coverage and financial risk protection, implementation gaps continue to undermine their effectiveness. The limited reach of health insurance schemes, weak enforcement of subsidy mechanisms, and inadequate funding of primary healthcare facilities mean that the burden of financing paediatric care still rests largely on households. This creates a system in which access to essential child health services is not determined by clinical urgency but by the immediate financial capacity of careseekers.

The central problem, therefore, is that despite policy commitments to improve child health outcomes and reduce financial barriers to care, Nigeria's health financing structure continues to expose households to high out-of-pocket payments, thereby limiting equitable access to paediatric healthcare services. This persistent financial barrier undermines progress toward Universal Health Coverage and contributes significantly to preventable child morbidity and mortality in the country.

CLARIFICATION OF CONCEPTS

Concept of paediatric Healthcare Services : paediatric healthcare services refer to the range of preventive, curative, rehabilitative, and emergency healthcare interventions specifically designed to address the health needs of infants, children, and adolescents (individuals below 18years old). These services are aimed at ensuring optimal physical, mental, emotional, and developmental health among children from birth through adolescence. paediatric healthcare services include immunization, growth monitoring, nutritional support, diagnosis and treatment of childhood illnesses, neonatal care, health education, and management of chronic childhood conditions.

In the Nigerian context, paediatric healthcare services are delivered through primary, secondary, and tertiary healthcare facilities, although primary healthcare centres (PHCs) constitute the first point of contact for most children, especially in rural communities. However, the effectiveness and accessibility of these services are often undermined by inadequate funding, shortages of healthcare personnel, weak infrastructure, and high out-of-pocket payments. Consequently, many Nigerian children are unable to access timely and quality healthcare despite the existence of formal health institutions.

The importance of paediatric healthcare services extends beyond individual child survival to broader national development outcomes. Healthy children are more likely to achieve better educational outcomes, contribute productively to society, and reduce future healthcare burdens on households and government. This explains why child health remains central to global health priorities and the Sustainable Development Goals (SDGs), particularly Goal 3, which focuses on ensuring healthy lives and promoting well-being for all ages (World Health Organization [WHO], 2024).

Access to Healthcare: Access to healthcare refers to the ability of individuals or populations to obtain appropriate, affordable, timely, and quality healthcare services when needed. Healthcare access goes beyond the mere existence of health facilities; it encompasses the ease with which healthcare services can

be reached, utilized, and financed without undue hardship. Scholars and health policy institutions commonly conceptualize healthcare access in terms of availability, affordability, accessibility, acceptability, and quality of services.

Within the context of paediatric healthcare in Nigeria, access is influenced by several interrelated factors including household income, geographic location, transportation systems, availability of healthcare workers, quality of care, and healthcare financing arrangements. Financial accessibility is particularly significant because many Nigerian households rely on direct out-of-pocket payments to finance child healthcare services. As a result, the inability to afford treatment costs frequently leads to delayed care-seeking, reliance on informal healthcare providers, or complete avoidance of formal healthcare services.

Healthcare access is also closely linked to the principle of equity. Equitable access implies that children should receive healthcare services based on health needs rather than socioeconomic status or geographic location. However, disparities between rural and urban populations, as well as between low-income and high-income households, continue to shape unequal access to paediatric healthcare services in Nigeria (*National Population Commission [NPC] & ICF, 2019*).

Out-of-Pocket (OOP) Payments: Out-of-pocket (OOP) payments refer to direct payments made by individuals or households to healthcare providers at the point of receiving healthcare services, without reimbursement from insurance schemes or government support. Such payments may include consultation fees, diagnostic charges, medication costs, transportation expenses, and hospitalization fees. OOP expenditure is widely used in many low- and middle-income countries where health insurance coverage remains limited.

In Nigeria, OOP payments constitute the dominant source of healthcare financing, placing a significant financial burden on households. This financing arrangement exposes families to catastrophic health expenditure, particularly when unexpected illnesses occur among children. Because childhood illnesses often require urgent medical attention, caregivers are frequently compelled to make immediate financial decisions regarding treatment, even when household resources are insufficient.

The implications of high OOP payments are especially severe for poor and vulnerable households. Many families are forced to delay treatment, borrow money, sell assets, or resort to self-medication in order to cope with healthcare expenses. Consequently, OOP expenditure not only limits access to paediatric healthcare services but also contributes to worsening poverty and inequality within society. The World Health Organization identifies excessive OOP expenditure as a major obstacle to achieving Universal Health Coverage (WHO, 2023).

Health System Financing is the process of collecting, pooling and managing financial resources for purchasing healthcare services needed by the society in order to promote, restore or maintain their health while financially protecting them against health cost. Financing as one of the most important functions of the health system, plays an important role in achieving universal health coverage. (*Mosadeghrad 2020*)

Nigeria's healthcare financing system is characterized by a mixture of public funding, donor support, health insurance schemes, and out-of-pocket payments. However, the system remains heavily dominated by direct household expenditure due to low government health spending and limited health insurance coverage (*Okechuhwu 2023*).

Within the context of paediatric healthcare, healthcare financing is particularly important because children are highly dependent on caregivers for access to medical services. Where financing systems fail to provide adequate financial risk protection, child healthcare utilization becomes heavily dependent on household

income and ability to pay. This creates inequities in healthcare access and undermines efforts toward achieving Universal Health Coverage in Nigeria.

Policy Implications: Policy implications refer to the practical consequences or lessons that research findings hold for government institutions, healthcare administrators, policy makers, and other stakeholders involved in healthcare planning and delivery. In this study, policy implications relate to the need for reforms that can reduce financial barriers to paediatric healthcare services and strengthen equitable access to child healthcare in Nigeria.

The persistence of high out-of-pocket payments suggests that existing healthcare financing policies have not sufficiently protected households from financial hardship. Therefore, policy responses may include expanding health insurance coverage for children, increasing government investment in primary healthcare, strengthening implementation of the NHIA and BHCPS, subsidizing essential child health services, and improving healthcare infrastructure in underserved areas. (Okechuhwu C. Ogbodo (2023). *Trends and Challenges of Healthcare Financing in Nigeria. International Journal of Medical Case Reports and Reviews. BioRes Scientia Publishers. 2(5):1-12.*).

THEORETICAL FRAMEWORK

Theoretical frameworks provide the intellectual foundation for explaining relationships among variables within a study. In examining the barriers to accessing paediatric healthcare services in Nigeria, particularly the burden of out-of-pocket (OOP) payments and its policy implications, several theories offer useful explanatory perspectives. This study specifically identifies three major theories relevant to healthcare access, healthcare utilization, and healthcare financing behaviour. These are: Andersen's Behavioral Model of Health Services Utilization, the Health Belief Model (HBM), and the Theory of Human Capital. Each theory provides insight into how financial, social, institutional, and behavioural factors influence access to paediatric healthcare services in Nigeria.

I. Andersen's Behavioral Model of Health Services Utilization

The Andersen Behavioral Model of Health Services Utilization was originally developed by Ronald Andersen in 1968 and later modified in subsequent years to explain factors influencing individuals' use of healthcare services. The model posits that healthcare utilization is influenced by three major categories of factors: predisposing factors, enabling factors, and need factors (Andersen, 1968).

Predisposing factors include demographic and social characteristics such as age, gender, education, family structure, and cultural beliefs that influence healthcare-seeking behaviour. Enabling factors refer to the resources and conditions that facilitate or hinder access to healthcare services, including income, health insurance coverage, transportation, healthcare infrastructure, and availability of healthcare personnel. Need factors relate to perceived or actual health conditions requiring medical attention.

The relevance of Andersen's model to this study lies particularly in its emphasis on enabling factors, especially financial capacity and healthcare financing arrangements, as determinants of healthcare utilization. In the Nigerian context, the ability of care seekers to pay for paediatric healthcare services significantly determines whether children receive timely medical care. High out-of-pocket payments, poverty, weak insurance coverage, and inadequate healthcare infrastructure all function as enabling or disabling factors influencing healthcare access.

The theory also explains rural–urban disparities in healthcare utilization. Households in rural areas often experience weaker enabling conditions, including poor transportation systems, fewer healthcare facilities, and lower household income, thereby reducing paediatric healthcare utilization.

Limitations of the Theory: Despite its relevance, Andersen's model has certain limitations. The theory has been criticized for placing greater emphasis on healthcare utilization rather than healthcare quality and health outcomes. It also does not sufficiently explain broader structural and political determinants such as corruption, policy failures, and macroeconomic instability that affect healthcare financing in developing countries like Nigeria. Additionally, the model assumes rational healthcare-seeking behaviour, whereas cultural beliefs and informal healthcare practices may also significantly influence healthcare decisions.

II. Health Belief Model (HBM)

The Health Belief Model (HBM) was developed by Rosenstock in 1958 to explain health-related behaviours and decision-making processes among individuals. The theory argues that individuals' willingness to engage in health-seeking behaviour is influenced by their perceptions regarding susceptibility to illness, severity of illness, benefits of action, barriers to action, and cues to action (Rosenstock, 1958).

According to the model, careseekers are more likely to seek paediatric healthcare services if they perceive childhood illnesses as serious and believe that medical intervention will provide benefits that outweigh the barriers associated with seeking care. Conversely, where barriers such as high treatment costs, transportation expenses, or poor healthcare experiences exist, careseekers may delay or avoid seeking formal healthcare services.

The HBM is relevant to this study because it explains how financial barriers, particularly out-of-pocket payments, influence careseekers' healthcare-seeking decisions for children. In Nigeria, many careseekers may recognize the severity of a child's illness but still postpone seeking healthcare due to inability to afford treatment costs. The theory therefore highlights the interaction between perception and financial constraints in determining healthcare utilization.

The model also helps explain the role of education and awareness in healthcare utilization. Careseekers with higher levels of health literacy are more likely to recognize symptoms early and seek appropriate medical intervention for children.

Limitations of the Theory: one major limitation of the Health Belief Model is that it focuses primarily on individual perceptions and behaviours while paying limited attention to structural and institutional barriers such as healthcare financing systems, poverty, and weak health infrastructure. The theory may therefore be insufficient for explaining healthcare access challenges within broader socioeconomic and political contexts. Additionally, the model assumes that individuals make rational decisions based on perceived risks and benefits, whereas healthcare decisions in many communities are also shaped by cultural norms, social influence, and traditional beliefs.

III. Theory of Human Capital

The Theory of Human Capital was developed by Theodore Schultz (1961) and later expanded by Gary Becker (1964). The theory argues that investment in health, education, and human development contributes to improved productivity, economic growth, and societal development. Health is therefore viewed as a form of capital that enhances human capacity and long-term economic potential.

Within the context of paediatric healthcare, the theory suggests that investing in child health is essential for national development because healthy children are more likely to become productive adults. Access to quality healthcare services during childhood contributes to improved cognitive development, educational attainment, and future labour productivity.

The theory is relevant to this study because it highlights the broader economic implications of poor

paediatric healthcare access in Nigeria. High out-of-pocket payments that limit access to healthcare not only affect immediate child survival but also undermine long-term human capital development within society. Preventable childhood illnesses, malnutrition, and untreated medical conditions may negatively affect children's educational performance, productivity, and future contribution to national development.

The theory also supports arguments for increased government investment in healthcare financing and child health protection. By reducing financial barriers to paediatric healthcare services, governments can improve population health outcomes and strengthen future economic productivity.

Limitations of the Theory: The Theory of Human Capital has been criticized for viewing health primarily from an economic and productivity perspective while paying less attention to social justice, equity, and human rights dimensions of healthcare access. The theory also does not sufficiently explain immediate healthcare utilization behaviour or structural healthcare system weaknesses such as corruption, governance failures, and inadequate healthcare infrastructure. Furthermore, it may oversimplify healthcare access by emphasizing economic returns rather than social and cultural realities affecting healthcare utilization.

Preferred Theory - Andersen's Behavioral Model of Health Services Utilization

Among the three theories discussed above, this study adopts Andersen's Behavioral Model of Health Services Utilization as the preferred theoretical framework because it provides the most comprehensive explanation of the factors influencing access to paediatric healthcare services in Nigeria

The theory is particularly suitable because it directly explains how enabling factors such as household income, out-of-pocket payments, health insurance coverage, transportation systems, and healthcare infrastructure determine healthcare utilization. Since this paper focuses specifically on financial barriers and healthcare access, Andersen's emphasis on enabling resources aligns closely with the realities of Nigeria's healthcare financing system.

The model also accommodates the influence of social, demographic, and structural variables on healthcare access, making it more holistic than theories that focus solely on individual behaviour or economic productivity. Unlike the Health Belief Model, which concentrates mainly on personal perceptions, Andersen's framework recognizes the role of systemic and institutional factors in shaping healthcare utilization. Similarly, while the Human Capital Theory highlights the developmental importance of child health, Andersen's model more directly explains actual healthcare-seeking behaviour and service utilization patterns.

Furthermore, the theory is highly applicable to the situation in developing countries where healthcare access is strongly influenced by poverty, weak insurance systems, inadequate healthcare infrastructure, and social inequalities. In Nigeria, where healthcare financing remains heavily dependent on out-of-pocket expenditure, Andersen's model provides a robust analytical framework for understanding how financial constraints shape access to paediatric healthcare services. Therefore, Andersen's Behavioral Model offers the most suitable theoretical foundation for analyzing the burden of out-of-pocket payments and the barriers to paediatric healthcare access in Nigeria.

ACCESS TO PAEDIATRIC HEALTHCARE SERVICES IN NIGERIA

The issue of access to paediatric healthcare services has remained a critical public health concern in Nigeria, particularly within the context of rising healthcare costs, widespread poverty, and persistent dependence on out-of-pocket (OOP) healthcare financing. Existing literature demonstrates that although Nigeria has implemented several health sector reforms aimed at improving healthcare access and financial protection, significant barriers continue to restrict utilization of paediatric healthcare services, especially among vulnerable populations. These barriers are multidimensional, encompassing financial, geographic,

structural, institutional, and socioeconomic factors. Among these, the burden of out-of-pocket payments has emerged as one of the most dominant determinants of healthcare access and utilization in Nigeria.

Scholars have consistently argued that the inability of households to afford healthcare services contributes significantly to delayed treatment-seeking behaviour, avoidable child morbidity, catastrophic household expenditure, and preventable mortality among children (Aregbeshola & Khan, 2018). Nigeria's healthcare financing structure, characterized by weak insurance penetration and low public sector funding, continues to shift healthcare costs directly to households, thereby worsening inequalities in healthcare access and outcomes (Okungbowa, 2023). This discussion (which focused on literature from 2015 to 2024) therefore examines existing studies and scholarly perspectives on paediatric healthcare access, out-of-pocket healthcare expenditure, healthcare financing systems, structural barriers, and policy responses within the Nigerian context.

paediatric healthcare access refers to the ability of children to obtain timely, affordable, acceptable, and quality healthcare services whenever the need arises. In Nigeria, healthcare access remains highly unequal and influenced by socioeconomic status, geographic location, education level, and healthcare financing arrangements. Although progress has been recorded in some child health indicators over the years, Nigeria continues to account for one of the highest rates of under-five mortality globally (*World Health Organization* [WHO], 2024).

According to the National Population Commission (NPC) and International Children Fund (ICF) (2019), many Nigerian caregivers still face significant barriers in seeking healthcare for children, particularly financial constraints, transportation difficulties, and long distances to healthcare facilities. The report further indicated that children from poor households and rural communities are significantly less likely to receive timely treatment for common childhood illnesses compared to children from wealthier urban households. This demonstrates the persistent inequities within Nigeria's healthcare system.

Existing studies have further shown that the quality and functionality of healthcare facilities influence healthcare-seeking behaviour among caregivers. Many primary healthcare centres (PHCs), especially in rural areas, suffer from shortages of healthcare workers, inadequate medical equipment, poor drug supply systems, and weak referral mechanisms. Consequently, careseekers often bypass PHCs in favour of secondary or private healthcare facilities, thereby increasing the overall cost of treatment and reducing affordability of care (Aregbeshola & Khan, 2018).

Nobles, Serban, and Swann (2015) emphasized that healthcare accessibility should not be viewed merely in terms of the physical presence of health facilities but should also include affordability, service quality, and the ability of populations to utilize services effectively. Their findings support the argument that healthcare access in developing countries is shaped by broader structural inequalities that extend beyond infrastructure alone (Nobles et al., 2015).

Recent literature has also explored the potential role of telemedicine in improving healthcare access in Nigeria. Peter (2025) argued that telemedicine could significantly improve paediatric healthcare access in underserved areas by reducing transportation costs and increasing availability of specialist consultation. However, the study identified barriers such as poor internet infrastructure, low digital literacy, inconsistent electricity supply, and poverty as major limitations to telemedicine adoption in Nigeria (*Peter et al.*, 2025).

Out-of-Pocket Payments and paediatric Healthcare Utilization

Out-of-pocket healthcare expenditure remains one of the most extensively discussed barriers to healthcare access in Nigeria. OOP payments refer to direct payments made by households at the point of healthcare utilization without reimbursement from insurance schemes or government subsidies. In Nigeria, OOP

expenditure constitutes the dominant source of healthcare financing and continues to expose households to severe financial hardship

Aregbeshola and Khan (2018) found out that Nigeria's healthcare financing system is heavily dependent on out-of-pocket payments, resulting in catastrophic healthcare expenditure and impoverishment among households. Their study revealed that approximately 16.4% of Nigerian households experienced catastrophic healthcare expenditure, while healthcare payments pushed many households deeper into poverty. The authors argued that the dominance of OOP financing reflects weak financial risk protection mechanisms within Nigeria's healthcare system.

Similarly, Iloka, Edeme, Edeh, and Ikeagu (2018) observed that healthcare financing in Nigeria is regressive because poorer households spend a disproportionately larger share of their income on healthcare services compared to wealthier households. Their study concluded that out-of-pocket payments worsen social inequality and reduce equitable healthcare access among vulnerable populations (Iloka 2018).

The burden of OOP payments is particularly severe within paediatric healthcare because childhood illnesses often require urgent medical intervention. Seyi-Olajide (2020), in their study on catastrophic healthcare expenditure among children receiving surgery for typhoid perforation in Nigeria, reported that many families experienced severe financial distress due to healthcare costs. The study found that careseekers frequently borrowed money, sold assets, or delayed treatment due to inability to afford healthcare expenses. The authors concluded that OOP payments constitute a major barrier to equitable paediatric healthcare access in Nigeria (Seyi-Olajide 2020).

Odunuga, Makanju, Badru, and Otusanya (2019) further observed that household healthcare expenditure significantly affects under-five child health outcomes in Lagos State. Their findings indicated that households lacking financial protection mechanisms were more likely to delay seeking healthcare for children, thereby worsening disease outcomes and increasing mortality risks (Odunuga 2019).

More recent studies suggest that catastrophic health expenditure remains widespread despite healthcare financing reforms introduced by the government. Aniebo, Lawani, and Eze (2025) found that out-of-pocket payments continue to impose catastrophic financial burdens on Nigerian households, particularly among poor, rural, and female-headed households. The study further established that healthcare expenditure contributes significantly to household impoverishment and socioeconomic inequality in Nigeria (Aniebo 2025).

Opeloyeru (2024) also argued that excessive out-of-pocket expenditure has impoverishing effects on households because many families spend substantial portions of their income on healthcare at the expense of food, education, and other essential needs. The study concluded that Nigeria's overreliance on direct household payment for healthcare is incompatible with the goals of Universal Health Coverage (UHC) (Opeloyeru, 2024).

Healthcare Financing and Insurance Coverage in Nigeria

Healthcare financing plays a central role in determining healthcare accessibility and equity. Effective healthcare financing systems are expected to provide financial risk protection, ensure equitable distribution of healthcare resources, and reduce financial barriers to care. However, Nigeria's healthcare financing system remains characterized by fragmentation, weak insurance penetration, inadequate government funding, and excessive dependence on OOP payments.

Okungbowa (2023), in assessing Nigeria's progress toward Universal Health Coverage between 2015 and 2022, argued that poor governance and inadequate public healthcare financing remain major obstacles to

effective healthcare delivery in Nigeria. The study found out that out-of-pocket expenditure still dominates healthcare financing despite ongoing reforms and policy commitments toward UHC (Okungbowa, 2023).

Evidence from state health accounts studies further revealed that household out-of-pocket expenditure accounts for a disproportionately high percentage of total health expenditure in Nigeria, thereby exposing households to severe financial risks and worsening healthcare inequities (WHO, 2023).

The National Health Insurance Authority (NHIA) Act and the Basic Health Care Provision Fund (BHCPF) were introduced to improve financial protection and healthcare accessibility. However, existing studies suggest that implementation challenges continue to undermine their effectiveness. Insurance coverage remains concentrated within the formal sector, leaving millions of Nigerians in the informal economy without financial protection against healthcare costs (Okungbowa, 2023).

Several scholars also attribute Nigeria's healthcare financing crisis to low government budgetary allocation to healthcare. Nigeria has consistently failed to meet the Abuja Declaration target of allocating 15% of national budgets to healthcare (Edo State, 9.4% as at 2025 budget). Consequently, inadequate public investment has shifted the burden of healthcare financing to households, thereby increasing dependence on OOP payments and worsening inequities in healthcare access (Aregbeshola & Khan, 2018).

Socioeconomic and Structural Barriers to paediatric Healthcare

Beyond financial barriers, poverty, unemployment, poor infrastructure, and weak healthcare systems as major determinants of paediatric healthcare access in Nigeria. Poverty reduces the ability of households to seek timely healthcare and increases reliance on self-medication and informal healthcare providers (NPC & ICF, 2019).

Rural communities are disproportionately affected due to poor road networks, inadequate transportation systems, and uneven distribution of healthcare facilities. Many rural healthcare centres lack qualified healthcare personnel, essential drugs, diagnostic facilities, and functional referral systems. These conditions increase indirect healthcare costs and discourage careseekers from seeking formal healthcare services for children (WHO, 2024).

Healthcare workforce shortages also constitute a major challenge within Nigeria's paediatric healthcare system. The increasing migration of Nigerian healthcare professionals to foreign countries has weakened healthcare delivery capacity and worsened staffing shortages across healthcare facilities. This trend has particularly affected rural and underserved areas where healthcare personnel are already inadequate (Okungbowa, 2023).

Studies have also shown that the level of maternal education significantly influences paediatric healthcare utilization. Caregivers with higher levels of education are more likely to recognize symptoms of childhood illnesses, seek early treatment, and utilize formal healthcare facilities compared to less educated caregivers (NPC & ICF, 2019). Cultural beliefs and traditional treatment practices also influence healthcare-seeking behaviour, particularly in rural communities where some caregivers initially rely on herbal remedies or spiritual interventions before seeking formal medical care.

Universal Health Coverage and Policy Responses

Universal Health Coverage (UHC) has emerged as a major global and national policy goal aimed at ensuring that individuals receive needed healthcare services without financial hardship. In Nigeria, UHC policies seek to improve financial risk protection, strengthen primary healthcare systems, and expand healthcare access to vulnerable populations.

The World Health Organization (2023) identifies excessive out-of-pocket expenditure as one of the

greatest obstacles to achieving UHC in low- and middle-income countries. Scholars have therefore argued that Nigeria cannot achieve meaningful progress toward UHC without significantly reducing reliance on OOP healthcare financing (WHO, 2023).

Existing studies recommend expanding health insurance coverage, increasing public healthcare expenditure, strengthening PHCs, subsidizing child healthcare services, and improving governance within healthcare financing systems (Aregbeshola & Khan, 2018). Scholars also emphasize the need for stronger political commitment and accountability mechanisms to ensure effective implementation of healthcare reforms.

The National Health Insurance Authority (NHIA) Act is expected to improve healthcare access through mandatory health insurance coverage and expansion of financial risk protection. However, scholars argue that implementation capacity, public awareness, funding limitations, and weak institutional coordination may continue to hinder its effectiveness if not properly addressed (Okungbowa, 2023).

Without substantial reforms, the continued dominance of out-of-pocket payments may further widen inequalities in healthcare access and undermine efforts to improve child health outcomes in Nigeria.

Literature Gap

Although existing literature has extensively examined healthcare financing, catastrophic health expenditure, and healthcare access in Nigeria, many studies focus broadly on general healthcare financing without specifically examining the implications of out-of-pocket payments for paediatric healthcare access. Similarly, while several studies discussed child health outcomes, fewer studies comprehensively connect paediatric healthcare access, household financial burden, and healthcare financing policy implementation within a unified analytical framework.

This study therefore fills an important scholarly and policy gap by specifically examining the barriers to accessing paediatric healthcare services in Nigeria through the lens of out-of-pocket healthcare payments and their implications for health equity, financial protection, and Universal Health Coverage.

ACCESSING PAEDIATRIC HEALTHCARE SERVICES IN NIGERIA: A CRITICAL ANALYSIS

The challenge of accessing paediatric healthcare services in Nigeria remains deeply rooted in structural weaknesses within the country's healthcare financing and service delivery systems. Although Nigeria has introduced several reforms aimed at improving healthcare access and financial protection, millions of children continue to face severe barriers to obtaining timely and quality healthcare services. These barriers are multidimensional and interconnected, ranging from financial and infrastructural limitations to institutional weaknesses and socioeconomic inequalities. Among all these barriers, the burden of out-of-pocket (OOP) healthcare payments remains the most dominant and pervasive. In a healthcare system where households bear a substantial proportion of healthcare costs directly at the point of service utilization, access to paediatric healthcare services is increasingly determined by household income rather than medical necessity. Consequently, children from poor and vulnerable households are disproportionately affected by delayed treatment, underutilization of formal healthcare services, worsening disease outcomes, and preventable mortality.

This section critically discusses the major barriers to accessing paediatric healthcare services in Nigeria and examines their implications for healthcare policy, financial protection, equity, and Universal Health Coverage (UHC).

1. Financial Barriers: The Burden of Out-of-Pocket Payments

Financial barriers constitute the most significant obstacle to paediatric healthcare access in Nigeria.

Out-of-pocket healthcare payments continue to dominate Nigeria's healthcare financing structure despite policy reforms aimed at improving financial risk protection. Households are often required to make direct cash payments before healthcare services are provided, including consultation fees, laboratory investigations, medication costs, hospital admission charges, and transportation expenses.

The implications of this financing structure are particularly severe for paediatric healthcare because childhood illnesses frequently require urgent medical attention. In many Nigerian households, especially among low-income earners, caregivers delay seeking healthcare until illnesses become severe due to inability to afford immediate treatment costs. Such delays contribute significantly to avoidable child morbidity and mortality.

Financial hardship associated with healthcare expenditure also exposes households to catastrophic health expenditure. Many families are compelled to borrow money, sell productive assets, withdraw children from school, or divert resources from food and housing in order to finance healthcare treatment. This creates a vicious cycle where illness worsens poverty, while poverty further limits healthcare access.

Children suffering from chronic illnesses, malnutrition, severe infections, congenital conditions, or surgical emergencies are particularly vulnerable because treatment often requires repeated hospital visits and prolonged healthcare expenditure. For many households without health insurance coverage, these expenses become unsustainable.

The dominance of OOP payments also contributes significantly to inequity within healthcare access. Wealthier households are better able to absorb healthcare costs and therefore more likely to seek early medical intervention. Poor households, on the other hand, frequently resort to self-medication, informal drug vendors, traditional healers, or delayed care-seeking behaviour due to financial constraints.

Policy Implications

The persistence of excessive out-of-pocket expenditure indicates major weaknesses in Nigeria's healthcare financing system. Policymakers must prioritize the expansion of financial risk protection mechanisms through wider health insurance coverage, especially for children and vulnerable populations. The National Health Insurance Authority (NHIA) must strengthen enrollment among informal sector populations where the majority of Nigerians are employed.

The government should also introduce targeted paediatric healthcare subsidies and free child healthcare programs for essential services such as treatment of malaria, pneumonia, diarrhea, neonatal care, and immunization-related services. Strengthening social protection systems and reducing user fees at primary healthcare centres are critical for reducing catastrophic healthcare expenditure among households.

Furthermore, increased public sector investment in healthcare financing is essential. Nigeria's continued failure to meet the Abuja Declaration benchmark of allocating 15% of the national budget to healthcare undermines progress toward Universal Health Coverage.

2. Weak Health Insurance Coverage

Weak health insurance penetration remains another major barrier to paediatric healthcare access in Nigeria. Although the National Health Insurance Scheme (NHIS), now National Health Insurance Act (NHIA), was introduced to improve financial protection and healthcare accessibility, insurance coverage remains extremely limited and concentrated largely among formal sector employees. The majority of Nigerians operate within the informal economy and remain outside insurance coverage. Consequently, most households continue to finance healthcare directly through out-of-pocket payments. This weakens financial protection and exposes families to severe economic vulnerability whenever illnesses occur.

Children are disproportionately affected because they depend entirely on caregivers for healthcare financing decisions. In situations where parents lack insurance coverage or stable income, access to paediatric healthcare becomes uncertain and inconsistent. Additionally, even among insured populations, many paediatric healthcare services may not be fully covered. Caregivers frequently incur additional expenses through purchase of unavailable medications outside hospitals, transportation costs, feeding expenses, and specialized investigations not included within insurance packages. Low awareness and poor public confidence in health insurance programs also contribute to low enrollment levels. Many Nigerians perceive insurance systems as ineffective due to concerns regarding poor service delivery, bureaucratic bottlenecks, and limited provider networks.

Policy Implications

There is therefore an urgent need for aggressive expansion of health insurance coverage across both formal and informal sectors. The government should implement mandatory child-focused health insurance mechanisms and strengthen community-based health insurance schemes targeting rural and low-income populations.

Public awareness campaigns are also necessary to improve understanding and acceptance of health insurance programs. Additionally, insurance benefit packages should be expanded to include comprehensive paediatric healthcare services, including emergency care, diagnostics, medications, nutrition support, and specialized child healthcare interventions. Strengthening transparency, accountability, and efficiency within the NHIA system is equally important for improving public trust and increasing enrollment.

3. Poverty and Socioeconomic Inequality

Poverty remains one of the strongest determinants of healthcare access in Nigeria. A large proportion of Nigerian households live under difficult economic conditions characterized by unemployment, inflation, food insecurity, and unstable income. Under such circumstances, healthcare becomes financially inaccessible for many families.

Poor households are more likely to delay healthcare utilization due to inability to afford consultation fees, medications, transportation, and diagnostic investigations. Caregivers may also prioritize immediate survival needs such as food and shelter over healthcare expenditure.

Socioeconomic inequality further worsens paediatric healthcare disparities. Children from wealthy households often receive earlier diagnosis, better nutrition, higher immunization coverage, and access to quality healthcare facilities. Conversely, children from poor households are more exposed to malnutrition, untreated illnesses, poor sanitation, and delayed healthcare intervention.

Policy Implications

Reducing healthcare inequities requires broader social and economic policy interventions beyond the healthcare sector alone. The government must strengthen poverty reduction programs, improve household income opportunities, and expand social welfare interventions targeting vulnerable families. Conditional cash transfer programs linked to child healthcare utilization and immunization attendance may improve healthcare-seeking behaviour among poor households. Educational empowerment, especially among women and mothers, should also be prioritized because maternal education significantly influences child health outcomes.

4. Weak Primary Healthcare Infrastructure

Primary healthcare centres (PHCs) are expected to provide the first level of healthcare contact for children

and families. However, many PHCs in Nigeria remain poorly equipped and inadequately staffed. Common challenges include shortage of healthcare workers, inadequate medical equipment, poor electricity supply, insufficient drug availability, weak referral systems, and deteriorating infrastructure. Many facilities lack basic paediatric care equipment and emergency response capacity.

As a result, caregivers often bypass PHCs and seek care directly in private hospitals or tertiary facilities where treatment costs are considerably higher. This increases healthcare expenditure and further worsens affordability challenges. Poor infrastructure also contributes to reduced public confidence in government healthcare facilities. Many caregivers perceive public facilities as unreliable due to long waiting times, poor staff attitude, and inconsistent availability of medications.

Policy Implications

The government must prioritize revitalization of primary healthcare systems across Nigeria. Increased investment is needed for infrastructure rehabilitation, equipment procurement, drug supply systems, electricity provision, and healthcare workforce recruitment. The Basic Health Care Provision Fund (BHCPF) should be effectively implemented to strengthen PHCs and improve access to affordable child healthcare services. Strengthening PHCs will reduce pressure on tertiary facilities and improve early treatment-seeking behaviour among caregivers.

5. Geographic and Rural–Urban Barriers

Geographic inequality remains a major barrier to paediatric healthcare access in Nigeria. Healthcare facilities and specialized paediatric services are unevenly distributed across the country, with urban areas possessing significantly better healthcare infrastructure than rural communities.

Many rural populations travel long distances to access healthcare facilities. Poor road networks, inadequate transportation systems, insecurity, and transportation costs frequently discourage caregivers from seeking timely healthcare for children. The shortage of paediatric specialists in rural areas further worsens healthcare disparities. Rural healthcare centres are often understaffed and lack capacity to manage severe paediatric conditions.

Policy Implications

The government should prioritize equitable distribution of healthcare infrastructure and healthcare personnel across rural and urban communities. Rural healthcare development programs, mobile healthcare services, telemedicine expansion, and rural healthcare incentives for healthcare workers are essential for improving healthcare access. Improved transportation infrastructure and emergency referral systems are also critical for reducing delays in accessing paediatric healthcare services.

6. Governance and Policy Implementation Challenges

Nigeria has introduced several healthcare reforms aimed at improving healthcare access, including the NHIA Act and BHCPF. However, weak implementation, corruption, poor accountability, inadequate funding, and policy inconsistency continue to undermine these reforms. Many healthcare policies remain poorly coordinated and inadequately monitored. Corruption and inefficient resource allocation reduce the effectiveness of healthcare financing interventions and limit availability of essential healthcare services.

Policy Implications

Strengthening governance, accountability, transparency, and monitoring systems within the health sector is critical. The government must ensure effective implementation of healthcare reforms and improve financial accountability mechanisms. Sustained political commitment and increased healthcare funding are necessary for achieving equitable paediatric healthcare access and Universal Health Coverage in Nigeria.

CONCLUSION

This paper examined the barriers to accessing paediatric healthcare services in Nigeria with particular emphasis on the burden of out-of-pocket (OOP) healthcare payments and their broader policy implications. The discussion revealed that although Nigeria has made several policy commitments toward improving healthcare access and achieving Universal Health Coverage (UHC), significant structural, financial, and institutional barriers continue to limit equitable access to paediatric healthcare services across the country.

The paper established that out-of-pocket expenditure remains the dominant mode of healthcare financing in Nigeria, thereby placing enormous financial pressure on households and significantly influencing healthcare-seeking behavior among caregivers. For many families, especially those within low-income and rural communities, the inability to afford healthcare costs results in delayed treatment, self-medication, dependence on informal healthcare providers, and in some cases complete avoidance of formal healthcare services. These realities contribute substantially to preventable child morbidity and mortality from conditions that are medically manageable when treated early. Beyond financial barriers, the paper further highlighted the interconnected roles of poverty, weak health insurance coverage, poor primary healthcare infrastructure, healthcare workforce shortages, geographic inequalities, and weak policy implementation in restricting paediatric healthcare access. These factors collectively reinforce health inequities within the Nigerian healthcare system, where access to quality healthcare services is often determined more by socioeconomic status and geographic location than by medical need.

The paper also demonstrated that existing healthcare reforms, including the National Health Insurance Authority (NHIA) Act and the Basic Health Care Provision Fund (BHCPF), possess significant potential for improving healthcare accessibility and financial protection. However, weak implementation, inadequate funding, poor institutional coordination, and limited population coverage continue to undermine their effectiveness. As a result, millions of Nigerian children remain exposed to avoidable health risks and inadequate healthcare access.

Importantly, the findings of this paper underscore that paediatric healthcare access is not merely a medical issue but also a socioeconomic, developmental, and governance concern. Child health outcomes are closely linked to national productivity, human capital development, poverty reduction, and social equity. Therefore, failure to address barriers to paediatric healthcare access threatens not only child survival but also Nigeria's broader developmental aspirations.

In a nutshell improving paediatric healthcare access in Nigeria requires comprehensive and sustained healthcare financing reforms aimed at reducing dependence on out-of-pocket payments and strengthening financial risk protection mechanisms. Achieving equitable child healthcare access will depend on increased government investment in healthcare, expansion of health insurance coverage, revitalization of primary healthcare systems, improved healthcare workforce retention, stronger governance structures, and effective implementation of existing health policies. Without deliberate and sustained policy action, the goal of Universal Health Coverage and improved child health outcomes in Nigeria may remain difficult to achieve.

RECOMMENDATIONS

To address the barriers to accessing paediatric healthcare services in Nigeria and reduce the burden of out-of-pocket (OOP) healthcare payments; Expansion of Health Insurance Coverage, Reduction of Out-of-Pocket Healthcare Payments, Increased Government Investment in Healthcare, Strengthening Primary Healthcare Systems, Strengthening Implementation of Existing Health Policies and Expansion of Rural Healthcare Services, Strengthening Social Protection and Poverty Reduction Programs,

Improvement of Health Education and Public Awareness and Promotion of Equity-Oriented Healthcare Policies will help improve child survival, reduce healthcare inequalities, and achieve Universal Health Coverage in Nigeria.

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