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ASSESSING THE CHALLENGES OF PRIVATE HEALTHCARE DELIVERY IN SOUTHEAST NIGERIA: AN EMPIRICAL ANALYSIS OF ACCESSIBILITY, AFFORDABILITY, AND QUALITY CONCERNS

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Abstract
The private healthcare sector in Southeast Nigeria has grown to be an essential part of the region's healthcare system, supposedly completing the gaps left by public healthcare institutions. However, its delivery is fraught with significant challenges that impact population health outcomes and economic well-being. This study assesses the tripartite challenges of accessibility, Affordability, and Quality of care within private healthcare delivery in Southeast Nigeria. Utilizing a quantitative cross-sectional research design, data were collected via an online survey from 512 residents across the five southeastern states. The survey instrument measured perceptions across three validated scales. Findings indicate that while geographical accessibility is moderate in urban centers, financial Affordability remains a critical and pervasive barrier for a majority of the population. Furthermore, perceived Quality is highly uneven and demonstrates a strong, positive correlation with a patient's ability to pay, indicating a two-tiered system. According to regression analysis, accessibility and Affordability are significantly predicted by geography and income, respectively. The study concludes that the private sector's ability to contribute to health goals in Southeastern Nigeria would remain largely unmet in the absence of strategic regulation, innovative financing structures, and successful public-private collaborations. Recommendations are offered for policymakers, private healthcare providers, and researchers.

1. INTRODUCTION

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The pursuit of universal health coverage (UHC) is a central goal of health systems worldwide, aiming to ensure that all individuals and communities have access to the necessary health services without facing financial hardship (World Health Organization, 2021). In Nigeria, Africa's most populous nation, the path to UHC is fraught with systemic challenges, stemming from a healthcare system characterized by a complex and often fragmented duality. This is a system comprised of a publicly funded, constitutionally mandated system of accessible and equitable care, alongside a growing, diverse, private sector that cares for an expanding, significant majority of the population (Onwujekwe et al., 2019). The country's government health expenditure continues to be among the lowest globally, consistently under 15% of the annual budget since the 2001 Abuja Declaration, thereby leaving a wide gap in service and infrastructure provision (Okpani & Abimbola, 2018). This chronic underfunding has catalysed the proliferation of private health facilities, which operate as for-profit entities, faith-based organizations, and non-governmental initiatives.

Within the Nigerian context, the southeastern geopolitical zone presents a unique case study. Comprising the five states of Abia, Anambra, Ebonyi, Enugu, and Imo, the area is entrepreneurially oriented and characterized by an advanced culture of self-sufficiency. These elements have exercised a determining influence upon the development of its private healthcare sector (Uzochukwu et al., 2020). The region has witnessed a record increase in private hospitals, clinics, diagnostic centers, and pharmacies, driven by such elements as perceived inefficiencies and persistent industrial action in public health institutions, improved patient need for efficient and respectful treatment, and greater investment by medical entrepreneurs and firms (Aguocha et al., 2022). This proliferation positions private providers not merely as alternatives but often as the first-line points of care for many middle- and upper-class families, making their role in the regional health ecosystem critically important for achieving health objectives.

However, the expansion of private healthcare delivery is not synonymous with equitable, affordable, or adequate healthcare provision. Particularly in a developing setting with lax regulatory frameworks and notable socioeconomic disparities, the private model frequently raises concerns about the core goals of any health system—ensuring accessibility, guaranteeing Affordability, and providing

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quality care (Aregbeshola & Khan, 2018). These issues are particularly acute in Southeastern Nigeria, an area currently dealing with the socioeconomic fallout from past conflicts and facing specific developmental challenges. The way the private sector operates in this environment presents urgent moral and practical issues regarding its proper role in public health vs its role as a business.

Accessibility is a complicated idea that goes beyond simple proximity. According to Levesque et al. (2019), it includes the availability of appropriate services, the adequacy of necessary equipment and skilled personnel, and the acceptability of services in light of social, linguistic, or cultural norms. Private facilities may be widely available and well-equipped in the busy urban areas of states like Enugu and Anambra. Their distribution is still uneven and scant in rural and semi-urban areas, nevertheless. This maldistribution creates veritable "healthcare deserts," forcing vulnerable populations in states like Ebonyi and rural parts of Imo to travel long distances at significant cost to access even basic medical attention, thereby exacerbating existing health inequities.

The issue of Affordability is arguably the most significant barrier to accessing private care. Unlike systems built on pre-payment and risk-pooling, private healthcare in Nigeria is predominantly funded through out-of-pocket (OOP) payments, a financing mechanism widely condemned by health economists as the most regressive and a primary driver of catastrophic health expenditure (CHE) (Chima et al., 2018). For a vast majority of households in Southeast Nigeria, where poverty levels remain high despite a strong entrepreneurial base, a significant illness diagnosed or treated in a private facility can necessitate the sale of assets, depletion of meagre savings, or descent into debilitating debt. This reality forces families to make heartbreaking choices, effectively trading health for financial ruin and perpetuating a cycle of poverty.

Concurrently, deep-seated concerns about the Quality of care provided by private entities persist. The industry is notably diverse. At one extreme, upscale, multispecialty hospitals in state capitals draw medical tourists from both domestic and foreign locations by providing amenities and services on par with those found abroad. On the other hand, a large number of proprietary hospitals and smaller, for-profit clinics function with dubious standards and go unnoticed because of regulatory failures (Obinna, 2022). Issues documented range from

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inadequate diagnostic capabilities and employment of unqualified or poorly trained personnel to irrational drug prescribing practices, a lack of adherence to clinical guidelines, and poor infection control protocols. This extreme variability creates a dangerous two-tiered system where the Quality of care one receives is directly proportional to their wealth and socioeconomic status.

The regulatory environment governing private healthcare in Nigeria is often described as fragmented, under-resourced, and poorly enforced (Nnebue et al., 2021). A lack of coordination and accountability is frequently the result of multiple agencies sharing responsibilities, such as the Pharmacists Council of Nigeria (PCN), the Medical and Dental Council of Nigeria (MDCN), and different state ministries of health. This lack of regulations makes it possible for poor hospitals to operate, limits the government's capacity to enforce adherence to national health policy and quality standards, and gives patients few options for redress. The result is a disorganized and frequently exploitative market where commercial considerations are usually given precedence over patient safety and welfare.

Thus, the objective of this study is to systematically assess these related problems within the specific context of Southeastern Nigeria. Beyond anecdotal evidence and fragmented stories, it provides reliable and verifiable data on the public's experiences and perceptions of private healthcare. By focusing on the three core characteristics of accessibility, Affordability, and quality, the study aims to identify the most significant issues, assess their interrelationships, and determine the predictive power of socioeconomic indicators. The primary study question is: How significant are quality, Affordability, and accessibility as obstacles to the provision of private healthcare in Southeastern Nigeria, and how are these factors interrelated?

It is essential to understand these processes in order to create focused, research-based solutions that effectively address these problems. The results can help state and federal officials create more efficient regulatory frameworks, strategic purchasing agreements, and public-private partnerships (PPPs) that use the efficiency of the private sector for the benefit of the public. By highlighting specific areas for improvement in service delivery, ethical practice, pricing transparency, and patient participation, the results can help private providers establish sustainability and confidence. Ultimately, this research

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contributes to the broader and urgent dialogue on achieving a health system that is not only functional but also just, equitable, and protective of financial risk for the citizens of Southeast Nigeria.

The persistent neglect of these systemic issues perpetuates profound health inequities, undermines the region's human capital development, and stalls economic progress. As the private sector's footprint continues to grow unabated, a critical, evidence-based assessment of its service delivery model is not just an academic exercise but a public health imperative. This study aims to fill a significant gap in the literature by providing a contemporary, comprehensive, and focused analysis of this critical region, thereby laying the foundation for transformative change.

This article is structured to provide a thorough examination of the problem. Testable hypotheses are developed after a thorough literature review that examines the three main ideas and their interactions. A thorough methodology section, detailing the research design, sampling, and analytical procedures, follows. The empirical data are presented in the Results section and then thoroughly examined in light of the existing body of research. The paper concludes with actionable recommendations for stakeholders and suggestions for future research.

2. LITERATURE REVIEW

2.1. The Nigerian Healthcare Landscape and the Rise of the Private Sector

The architecture of the Nigerian healthcare system is a product of its colonial history and post-colonial policies, resulting in a system where public and private providers operate, often in parallel, with minimal coordination. Despite being designed to be the cornerstone of healthcare delivery, the public sector has been severely undermined by decades of underfunding, poor infrastructure, the departure of highly skilled medical professionals, and sporadic strikes (Okeke et al., 2021). The private sector has stepped in quickly to meet the enormous demand for trustworthy alternatives resulting from the government's failure. The private health sector in Nigeria is not a single entity, as Aregbeshola and Khan (2018) point out. It includes a wide range of establishments, including single-doctor clinics, faith-based organizations, traditional birth attendants, patent medicine vendors, and highly advanced teaching hospitals and corporate-owned chains. This diversity makes it

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challenging to regulate and generalize about, but its overall growth has been exponential, particularly in urban and peri-urban areas. Many people in Southeast Nigeria seek care in the private sector, even when it comes with a high cost, due to a cultural preference for private industry and a pervasive mistrust of state institutions (Uzochukwu et al., 2020).

2.2. Conceptual Review of Accessibility

Accessibility in healthcare is a complex, multi-dimensional concept that transcends mere physical presence. Levesque, Harris, and Russell (2019) provide an integrated model that defines access as the capacity to identify healthcare need, search for services, access resources, receive care, and have one's care met. In their model, five dimensions of accessibility are addressed: approachability, acceptability, availability and accommodation, Affordability, and appropriateness. Applying it to private healthcare in Southeast Nigeria, geographic availability is at the very top. Literature has consistently shown a high urban preference in the location of private health centers, which is driven by market forces seeking a profitable client base with higher purchasing power (Onwujekwe et al., 2019). This deliberate maldistribution leaves rural communities with severely limited options, forcing them to undertake long, costly, and often precarious journeys to access care, which can lead to delays that exacerbate health conditions.

Beyond geography, the availability of necessary resources within facilities that are physically present is another crucial aspect. A facility is not truly accessible if it lacks the required skilled health workforce, essential medicines, or functional equipment. A study by Adebayo, Oluwaseun, and Iyabo (2021) in Southwest Nigeria found that, although private facilities tended to have a higher availability of drugs compared to public facilities, this was inconsistent for non-communicable diseases and varied extensively based on the size and financing of the facility. This irregularity exposes patients to uncertainty in accessing stable and adequate care. Moreover, acceptability in relation to cultural and social factors, such as healthcare workers' attitudes, privacy, and religious compatibility, is also of great concern. Private facilities may be acceptable to some patients due to the perceptions of patient dignity and shorter lines, which can enhance their acceptability (Aguocha et al., 2022). However, this preference is often tragically tempered by the fear of prohibitive costs, creating a complex and stressful decision-

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making process for individuals and families at their most vulnerable.

2.3. Conceptual Review of Affordability

The ability of a person or household to pay for healthcare services without experiencing financial hardship—which includes sacrificing basic necessities like food, housing, and education, or getting into debt—is referred to as affordability. The biggest obstacle to access in health systems that primarily rely on out-of-pocket (OOP) payments is affordability. OOP spending is one of the largest in the world, making up over 70% of overall health spending, which is a startling feature of Nigeria's health funding system (World Bank, 2023). Due to the lack of cross-subsidization or risk sharing mechanisms, the private sector, which mostly operates on a fee-for-service basis, contributes significantly to this financial burden.The consequences of unaffordable care are severe and well-documented. Chima, Homedes, and Mensah (2018) meticulously document that health shocks are a leading cause of poverty descent in Nigeria, pushing an estimated 5 million people below the poverty line annually.

These harmful coping strategies—which McIntyre, Thiede, and Birch (2009) categorize as (1) dissaving (using savings or selling assets like livestock or land), (2) borrowing (often from informal sources at high interest), and (3) forgoing other basic needs (like pulling children out of school or reducing food consumption)—are frequently used by households facing high medical bills. The poorest quintiles of the population are disproportionately affected by this widespread issue, which is known as catastrophic health expenditure (CHE), where even minor expenses can have disastrous consequences. Additionally, "affordability" is a relative and subjective concept. Rural subsistence farmers in Ebonyi might not be able to afford what middle-class civil servants in Enugu can. Studies have shown that the lack of widespread pre-payment mechanisms, such as health insurance, in the private sector exacerbates this issue (Adewole & Adebayo, 2022). With less than 5% of the population covered by the National Health Insurance Scheme (NHIS) and minimal penetration of private health insurance, the vast majority of users face the full, unsubsidized brunt of costs at the point of service, making Affordability a mirage for many and a source of constant anxiety.

2.4. Conceptual Review of Quality of Care

Quality of care is the extent to which health treatments for both people and populations are

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in line with current professional knowledge and increase the chance of desired health outcomes. The six domains of quality are defined by the Institute of Medicine's (2001) groundbreaking report, Crossing the Quality Chasm: safety (preventing harm to patients from necessary care), effectiveness (providing services based on scientific knowledge to all who could benefit), patient-centeredness (providing care that is respectful of and responsive to individual patient preferences), timeliness (reducing wait times and sometimes harmful delays), efficiency (avoiding waste), and equity (providing care that does not vary in quality because of personal characteristics). In Nigeria's private sector, Quality is highly variable and often unregulated, creating a dangerous lottery for patients.

At the higher end, renowned private hospitals invest in modern technology, attract skilled professionals from the diaspora, and offer Quality of care and patient experience that rivals international standards. However, the lower end of the market is flooded with small, proprietary clinics that may prioritize profit over clinical excellence and ethical practice. Poor infection control procedures, a lack of continuity of care, overprescription of injectables and antibiotics (which contributes to antimicrobial resistance), and insufficient adherence to evidence-based treatment protocols are examples of standard quality issues reported in studies (Obinna, 2022). In addition to wasting limited household resources, this actively damages patients and undermines public confidence in the healthcare system as a whole. Negligent practitioners are further emboldened by the lack of a strong system for patient redress or medical malpractice litigation.

2.5. The Interplay of Accessibility, Affordability, and Quality

It is important to realize that these three ideas interact in intricate and frequently reinforcing ways; they are not standalone ideas. For example, a facility may offer high-quality care and be geographically accessible, but it will remain inaccessible in practice if it is completely costly. On the other hand, a facility might be reasonably priced, but its subpar care puts patients' health at risk, making it an unacceptable choice. Southeast Nigerian healthcare customers must make a number of difficult trade-offs as a result of this interaction. A patient might choose a cheaper, closer, but lower-quality clinic for a minor ailment, but face an impossible choice between a distant, expensive, high-quality facility and no care at all for a serious condition. This dynamic

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perpetuates health inequalities, as the wealthy can access high-quality care easily, while the poor are forced to choose between financial ruin, poor health outcomes, or no care (Gilson & McIntyre, 2008). The regulatory failure described by Nnebue et al. (2021) is the cross-cutting enabler of these negative interactions, as it fails to enforce minimum standards that would ensure a baseline of Quality and transparency across the sector.

2.6. Hypotheses Development

Based on the extensive literature reviewed, the following hypotheses are formulated to guide this empirical investigation:

H_1: There is a statistically significant positive relationship between geographical location (urban vs. rural) and the perceived accessibility of private healthcare facilities in Southeast Nigeria.

H_2: There is a statistically significant negative relationship between household income level and the perceived Affordability of private healthcare services in Southeast Nigeria.

H_3: There is a statistically significant positive relationship between the perceived cost of care at a private facility and the perceived Quality of care by patients in Southeast Nigeria.

H_4: Socioeconomic factors (income, location, education) are significant predictors of overall satisfaction with private healthcare services in Southeast Nigeria.

3. METHODOLOGY

3.1. Research Philosophy and Design

This study was grounded in a positivist research philosophy, which assumes that social reality is objective and can be studied through observable, measurable facts. This approach is suitable for identifying relationships between variables and testing pre-defined hypotheses. A quantitative research approach was adopted using a cross-sectional survey design. This design is appropriate as it facilitates the collection of numerical data from a sample of the population at a single point in time to examine the relationships between the variables under study: accessibility, Affordability, and Quality of care (Creswell & Creswell, 2018). It enables the efficient collection of data from a large number of participants, allowing for the statistical generalization of the findings to the broader population of Southeast Nigeria.

3.2. Study Area

The study was conducted in the five states that constitute the Southeast geopolitical zone of Nigeria: Imo, Abia, Anambra, Ebonyi, and Enugu. The distinct socioeconomic characteristics of this region and the noted expansion of private healthcare services led to

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its selection. An estimated 20 million people live in the zone as of 2023, according to World Population Review projections. Examining urban-rural differences in healthcare access is made appropriate by the region's combination of vast rural areas and crowded metropolitan centers (such as Enugu, Onitsha, Aba, and Owerri).

3.3. Population and Sampling Technique

The target population for this study consisted of adult residents (18 years and above) from the five southeastern states who had utilized or attempted to utilize private healthcare services within the 12 months preceding the study. A minimum sample size of 385 was determined using the Cochran (1977) formula for calculating sample size for a large population, assuming a 95% confidence level (Z-score of 1.96), a 5% margin of error (e), and a conservative estimate of population variability (p = 0.5).

n0 = (Z^2 * p * q) / e^2

n0 = (1.96^2 * 0.5 * 0.5) / 0.05^2 = 384.16

This was rounded to 385. To account for potential non-response and invalid responses, the target sample size was increased by 20%, to approximately 462.

A non-probability sampling technique, specifically a combination of purposive and snowball sampling, was employed. While probability sampling is ideal, the absence of a definitive sampling frame for the entire target population made it impractical. States were purposively selected. Through internet groups and social networks, the first responders were found. The snowball technique was then used, asking them to forward the survey link to more qualified respondents in their networks. Despite its generalizability constraints, this approach was thought to be the most practical for connecting with a wide range of private healthcare consumers in the area.

3.4. Data Collection Instrument and Validation

Data were collected using a structured online questionnaire designed on the Google Forms platform. The instrument was divided into five sections:

- **Section A:** Demographic information (e.g., age, gender, state of residence, location [urban/rural], marital status, education level, occupation, and monthly income bracket).
- **Section B:** Accessibility Scale (8 items). Adapted from the tool developed by Levesque et al. (2019). Example item: “Private hospitals/clinics are conveniently located near my place of residence or work.” Measured on a

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5-point Likert scale from 1 (Strongly Disagree) to 5 (Strongly Agree).

- **Section C:** Affordability Scale (8 items). Adapted from the World Health Organization's Health Financing Progress Matrix. Example item: "I often worry about being able to pay for care if I need to visit a private hospital." Measured on a 5-point Likert scale.
- **Section D:** Quality of Care Scale (10 items). Adapted from the SERVQUAL model and IOM dimensions. Example items: "The private hospital I use has modern, functioning equipment" (Tangibles), "Doctors in private hospitals spend enough time with me during consultations" (Responsiveness). Measured on a 5-point Likert scale.
- **Section E:** Overall Satisfaction and Open-ended Feedback (2 items).

The instrument was validated by two experts in public health and health economics from a Nigerian university to ensure content validity. A pilot study was conducted with 40 respondents to assess the clarity, reliability, and internal consistency of the instrument. Cronbach's Alpha coefficients were calculated for the pilot data: Accessibility ($\alpha = 0.78$), Affordability ($\alpha = 0.87$), and Quality ($\alpha = 0.83$). All values exceeded the acceptable threshold of 0.7, indicating good internal consistency and reliability of the scales.

3.5. Data Collection Procedure

Data collection took place over eight weeks. The survey link was disseminated through multiple channels, including WhatsApp groups specific to towns and communities in the southeast, Facebook pages of major socio-cultural organizations (e.g., Ohanaeze Ndigbo), Twitter threads with relevant hashtags (#HealthInSENigeria, #NigerianHealthcare), and emails to alum associations of universities in the region. A brief introduction explained the study's purpose, ensured anonymity and confidentiality, and obtained informed consent digitally before participants could proceed to the questions.

3.6. Ethical Considerations

Ethical approval for the study was obtained from the [Blinded for Review] Research Ethics Committee. Participation was entirely voluntary, and respondents could withdraw at any point. No personally identifiable information was collected. Data was stored on a password-protected server, and findings are reported in aggregate to ensure anonymity.

3.7. Data Analysis

Data collected were downloaded from Google Forms and analyzed using the Statistical

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Package for the Social Sciences (SPSS) version 28. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize the demographic data and the main variables (accessibility, Affordability, and Quality). Inferential statistics were used to test the hypotheses. An independent samples t-test was used to compare accessibility scores between urban and rural dwellers (H1). Pearson correlation analysis was used to examine the relationships between income and Affordability (H2) and between cost and Quality (H3). Multiple linear regression analysis was conducted to test H4, determining the predictive power of socioeconomic factors on overall satisfaction. The threshold for statistical significance was set at $p < 0.05$.

4. RESULTS

4.1. Demographic Characteristics of Respondents

A total of 512 responses were received and found valid for analysis. The demographic profile is summarized in Table 1. The sample was relatively balanced in gender (53.1% female, 46.9% male). A majority (68.2%) resided in urban areas, reflecting both the demographic concentration and the inherent sampling bias of online surveys. Respondents were fairly distributed across the five states. The age distribution was skewed towards younger adults (62.5% between 18 and 35 years), which is typical of online surveys in Nigeria. Over 80% had at least a tertiary education. The income distribution showed that 41.8% of the respondents earned below ₦50,000 monthly, 35.5% earned between ₦50,000 and ₦150,000, and 22.7% earned above ₦150,000.

Table 1: Demographic Characteristics of Respondents (N=512)

Characteristic	Category	Frequency	Percentage
State	Abia	98	19.1%
	Anambra	112	21.9%

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	Ebonyi	87	17.0%
	Enugu	108	21.1%
	Imo	107	20.9%
Location	Urban	349	68.2%
	Rural	163	31.8%
Monthly Income	<₦50,000	214	41.8%
	₦50,000 - ₦150,000	182	35.5%
	>₦150,000	116	22.7%

4.2. Descriptive Analysis of Key Variables

The mean scores and standard deviations for the key variables were calculated. Perceived accessibility yielded a mean score of 3.15 (SD = 0.91), suggesting a moderately positive perception, though with considerable variation. Affordability had the lowest mean score of 2.08 (SD = 0.97), indicating a strong consensus on the high and often prohibitive cost of care. The perceived Quality of care had a mean score of 3.28 (SD = 0.88), indicating a generally average perception of Quality, with significant variability.

4.3. Inferential Analysis and Hypothesis Testing H1: Geographical Location and Accessibility

An independent samples t-test was conducted to compare accessibility scores for urban and rural dwellers. There was a significant difference in scores for urban (M=3.62, SD=0.74) and rural (M=2.11, SD=0.83) conditions; t (510) = 20.17, p = .000. The result is significant at p < .05. **H1 is supported.**

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H2: Household Income and Affordability. A Pearson correlation was run to determine the relationship between monthly income (coded ordinally) and perceived Affordability. There was a strong positive correlation between the two variables, r = .702, n = 512, p = .000. This indicates that as monthly income increases, perceptions of Affordability significantly improve (i.e., lower financial burden). **H2 is supported.**

H3: Cost of Care and Perceived Quality A Pearson correlation was run to assess the relationship between the perceived cost of care (a single item measured on a 5-point scale from "Very Inexpensive" to "Very Expensive") and the overall perceived quality scale. A moderate positive correlation was found, r = .551, n = 512, p = .000. This suggests that respondents who perceived the cost of care to be higher also tended to report higher Quality of care. **H3 is supported.**

H4: Predictors of Overall Satisfaction. A multiple linear regression analysis was conducted to predict overall satisfaction based on income, location (coded as a dummy variable), and education. The regression model was statistically significant, $F(3, 508) = 45.22$, $p < .001$, adj. $R^2 = .206$. Income ($\beta = .312$, $p < .001$) and location ($\beta = .288$, $p < .001$) were significant positive predictors of satisfaction. Education was not a significant predictor ($\beta = .045$, $p = .251$). **H4 is partially supported.**

5. DISCUSSION

5.1. Interpretation of Findings

The results of this study provide robust empirical evidence confirming the severe tripartite challenges plaguing private healthcare delivery in Southeast Nigeria. The strong support for H1 underscores the profound urban-rural divide in accessibility. The significantly lower mean score for rural respondents (2.11 vs. 3.62) is not just a statistical difference but reflects a critical equity issue with real-world consequences. This finding aligns perfectly with the work of Uzochukwu et al. (2020). It confirms that the market-driven distribution of private facilities actively neglects rural populations, perpetuating geographic health disparities and violating the principle of equitable access.

The very low mean score for Affordability (2.08) and the strong positive correlation with income (r = .702) provide incontrovertible evidence that cost is the single most significant barrier to private healthcare in the region. This finding powerfully validates the extensive literature on catastrophic health expenditure in Nigeria (Chima et al., 2018; World Bank, 2023). It

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demonstrates that the private sector, in its current fee-for-service model, is fundamentally exclusionary. Healthcare becomes a commodity accessible only to those with sufficient income, transforming a fundamental right into a privilege and directly contributing to the medical poverty trap. The coping strategies described by respondents in the open-ended section—such as selling land, withdrawing children from school, and taking high-interest loans—are a tragic testament to this reality.

The positive correlation between cost and perceived Quality (r = .551) is a damning indictment of the regulatory environment. It confirms the existence of a two-tiered system, as suspected by Obinna (2022), where Quality is a variable that can be purchased. This finding suggests that in the absence of enforced minimum standards, the market operates on a "you get what you pay for" basis. This is unacceptable in healthcare, where a basic standard of safety and effectiveness should be non-negotiable. It places an unfair burden on patients to navigate a complex and opaque market, distinguishing between adequate and dangerous care, a task for which they are ill-equipped.

The regression analysis for H4 further emphasizes the role of socioeconomic status in shaping healthcare experiences. That income and location are significant predictors of overall satisfaction, while education is not, suggests that financial and geographic capital are more decisive than informational capital in navigating the private healthcare market. This reinforces the conclusion that the system is structurally biased against people with low incomes and those living in rural areas.

5.2. Implications of the Study

The implications of these findings are profound. For **policymakers**, the study is a clear call to action. It highlights the urgent need to move beyond laissez-faire oversight of the private sector. Strengthening regulatory capacity is not optional; it is essential to ensure a baseline of Quality and protect citizens from harm. Furthermore, the affordability crisis demands a radical shift in health financing. Expanding social health insurance through schemes like the new National Health Insurance Authority (NHIA) Act is critical to pool risks and reduce OOP payments.

For **private healthcare providers**, the results indicate a risk to their own sustainability. A reputation for exploitation and variable Quality can erode public trust. Providers should champion transparency in pricing, invest in continuous quality

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improvement, and explore innovative pricing models (e.g., sliding scales) to enhance equity and their social license to operate.

For **the public and civil society**, these findings provide evidence to advocate for their right to health. They can use this data to demand accountability from both government regulators and private providers, pushing for reforms that prioritize patient welfare over profit.

5.3. Limitations of the Study

This study has limitations. First, the use of online snowball sampling means the sample is not perfectly representative, likely underrepresenting individuals who are very poor, the elderly, and those residing in the most remote rural areas, where they have limited internet access. Second, the cross-sectional design provides a snapshot in time and cannot establish causality. Third, the study relied on self-reported perceptions of Quality and cost, which may not always align with objective clinical measures or actual pricing data. Future research should employ mixed methods, incorporating interviews with providers, mystery client studies to assess Quality objectively, and analysis of actual health expenditure data from household surveys.

6. CONCLUSION AND RECOMMENDATIONS

6.1. Conclusion

This study set out to empirically assess the challenges of private healthcare delivery in Southeast Nigeria through the lenses of accessibility, Affordability, and Quality. The findings conclusively demonstrate that the sector is plagued by a triad of severe, interconnected challenges that fundamentally limit its potential to contribute equitably to the health of the population. While geographical accessibility is a significant concern that reinforces the urban-rural divide, the overarching barrier is financial Affordability, which systematically excludes the poor and middle class. Furthermore, the Quality of care received is not guaranteed but is instead a function of a patient's ability to pay, resulting in an unethical and dangerous two-tiered system. These problems are enabled by a weak regulatory framework that fails to protect patients or ensure market efficiency. The private sector, therefore, currently operates as a paradox: a vibrant and growing industry that is simultaneously inaccessible, unaffordable, and unreliable for a large segment of the population it is intended to serve.

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6.2. Recommendations

Based on the findings, the following recommendations are proposed:

1. For Policy Makers (State and Federal):

a. **Strengthen Regulation:** State Ministries of Health must be empowered with funding and training to conduct regular, unannounced inspections of all private facilities. A mandatory accreditation system with clear, publicly displayed ratings (e.g., Grade A, B, C) should be implemented to drive quality improvement and inform patient choice.

b. **Expand Health Insurance:** aggressively implement the NHIA Act to achieve mandatory enrollment, particularly for the informal sector. State governments should develop and subsidize equity-focused schemes for vulnerable populations.

c. **Strategic Purchasing:** Develop Public-Private Partnerships (PPPs) where the government contracts private providers in underserved rural areas to deliver a defined package of essential primary care services, ensuring geographical equity.

2. For Private Healthcare Providers:

a. **Embrace Transparency:** Publicly display standardized fee structures for standard services and procedures to foster trust and facilitate price comparison.

b. **Invest in Quality:** Adhere to national treatment guidelines, invest in continuous professional development for staff, and pursue international quality certifications (e.g., ISO) to improve standards.

c. **Innovative Financing:** Explore sliding fee scales based on income, installment payment plans, and community-based health financing options to improve Affordability.

3. **For** future research, conduct longitudinal and mixed-methods studies that include the most marginalized populations. Research should also focus on evaluating the impact of specific interventions, such as the NHIA Act or new regulatory frameworks, on these tripartite challenges.

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