

# IMPACT OF HEALTHCARE MANAGEMENT ON PRIMARY HEALTHCARE SYSTEM IN KWARA STATE

**Eyitope Samuel Ogunnigbo**  
Global Health Care Limited, Lagos, Nigeria

**Adeola Aminat Odebode, Ph.D.**  
Department of Educational Guidance and Counselling, University of Ilorin, Nigeria

**Oluwayomi Omotayo Olota, Ph.D.**  
Department of Business Administration, University of Ilorin, Nigeria

## ABSTRACT

*The healthcare management and primary healthcare system in Kwara State face numerous challenges that hinder the delivery of effective and equitable healthcare services. This study examined the impact of healthcare management on the primary healthcare system in Kwara State. Specifically, it evaluated the effect of healthcare planning on quality healthcare service delivery, determined the impact of healthcare financing on poverty reduction, and examined the influence of access to healthcare facilities on the well-being of poor people in Kwara State. A survey research design was adopted with a population of 3,444 primary healthcare workers. Using simple random sampling technique, a sample size of 385 respondents was selected. Data collected were analysed using multiple regression analysis. The findings revealed that healthcare planning, healthcare financing, and access to healthcare facilities were the major healthcare management strategies implemented by primary healthcare facilities in Kwara State. The study also found that the primary healthcare system in the state is effective in delivering quality healthcare services, improving the well-being of poor people, and contributing to poverty reduction in rural areas. Furthermore, healthcare planning was found to have a significant effect on quality healthcare service delivery, healthcare financing had a significant impact on poverty reduction, and access to healthcare facilities significantly influenced the well-being of poor people in Kwara State. The study concluded that effective healthcare management has a significant positive effect on the performance of the primary healthcare system in Kwara State. It was therefore recommended that government should ensure adequate and sustainable healthcare financing and improve access to healthcare facilities, particularly in rural areas, to enhance service delivery, reduce poverty, and promote the well-being of the poor.*

**Keywords:** Management, Health Care, Health Care System, Kwara State

## INTRODUCTION

Healthcare systems across the world increasingly recognize that effective management is essential for ensuring efficient service delivery and improved health outcomes. Healthcare management involves the planning, coordination, organization, and control of human, financial, and material resources within healthcare institutions to achieve optimal patient care and organizational performance. According to Abimbola, Baatiema, and Bigdeli (2023), effective healthcare management ensures that health personnel, facilities, equipment, and financial resources are properly organized and utilized to meet the health needs of the population. When healthcare systems are well managed, services are delivered more efficiently, patients receive timely and appropriate care, and health institutions are better positioned to respond to emerging health challenges such as disease outbreaks and changing health patterns (Awofeso & Irabor, 2021). As global healthcare demands continue to increase due to population growth and evolving disease burdens, the importance of competent and strategic healthcare management has become more pronounced.

In modern healthcare systems, the role of healthcare managers extends beyond routine administrative functions. Healthcare managers are responsible for strategic planning, coordinating healthcare workforce activities, managing financial resources, implementing health policies, and ensuring that healthcare services meet established quality and safety standards. These responsibilities are critical for maintaining effective

and responsive healthcare systems. Effective management practices help healthcare organizations operate efficiently, improve patient satisfaction, and ensure the sustainability of healthcare services in both developed and developing countries (Ogah et al., 2024; Kruk et al., 2021). Strong leadership and management structures also enable healthcare institutions to adapt to emerging healthcare challenges, integrate new technologies, and continuously improve the quality of care provided to patients.

Globally, health policy discussions have increasingly emphasized the need to strengthen management systems at the primary healthcare (PHC) level. Primary healthcare serves as the foundation of most national health systems and represents the first point of contact between individuals and healthcare providers. Through PHC facilities, individuals and communities are able to access essential services such as disease prevention, maternal and child healthcare, immunization, health education, and treatment of common illnesses. These services are particularly vital in low- and middle-income countries where a large proportion of the population relies on primary healthcare centres for affordable and accessible medical care (Ameh et al., 2022; Ogah et al., 2024).

Apart from the provision of basic medical services, effective primary healthcare systems contribute significantly to improving overall population health and achieving universal health coverage. Well-managed PHC facilities enhance healthcare accessibility for underserved populations, reduce inequalities in healthcare access, and promote preventive health behaviours within communities. Addressing health problems early and providing continuous care, strong PHC systems reduce the need for expensive treatments at secondary and tertiary healthcare facilities. Consequently, they help reduce the burden on higher-level hospitals while promoting efficient utilization of healthcare resources. Studies have shown that countries with strong primary healthcare systems record better health outcomes (Kruk et al., 2022; Uzochukwu et al., 2022).

Effective healthcare management strategies play a crucial role in strengthening primary healthcare systems. These strategies are designed to improve service delivery, enhance access to healthcare services, and promote community well-being. One important strategy is community participation, which involves the active involvement of community members in planning, implementing, and evaluating health programmes. Community participation helps ensure that healthcare services are responsive to the specific needs of the population and strengthens trust between healthcare providers and the communities they serve (Sharma et al., 2021). Another key strategy is effective health workforce management, which focuses on recruiting, training, supervising, and motivating healthcare workers to provide quality healthcare services. Continuous professional development and supportive supervision are essential for improving staff competence, productivity, and service quality in primary healthcare facilities (World Health Organization [WHO], 2022).

Other important healthcare management strategies include effective health information management, efficient financial and resource management, and integrated service delivery. Health information systems facilitate the collection, analysis, and use of health data for planning, monitoring, and decision-making (Yisa et al., 2025). Proper financial and resource management ensures that essential drugs, equipment, and infrastructure are available for effective healthcare service delivery. Integrated service delivery allows different health services such as maternal and child healthcare, immunization, and disease prevention programmes to be provided in a coordinated manner within primary healthcare facilities. In addition, monitoring and evaluation systems are important management tools that help assess the effectiveness of health programmes, ensure accountability, and support continuous improvement in healthcare service delivery (World Health Organization & UNICEF, 2023; Kruk et al., 2021).

Healthcare planning also plays a critical role in improving the quality of healthcare service delivery. Healthcare planning involves identifying community health needs, allocating resources appropriately, and

coordinating healthcare services to ensure efficient service delivery. When healthcare systems are properly planned, healthcare facilities are better equipped with trained personnel, essential medicines, and adequate infrastructure required to deliver quality healthcare services. This contributes to improved patient outcomes, increased efficiency in service delivery, and greater public confidence in the healthcare system (Orji et al., 2024). Evidence suggests that effective healthcare planning significantly strengthens health system performance, particularly in developing countries where primary healthcare serves as the backbone of healthcare delivery (Kruk et al., 2021; Aregbeshola & Khan, 2022).

Healthcare financing is another crucial component of healthcare management and plays an important role in poverty reduction. Adequate healthcare financing mechanisms such as national health insurance schemes, government subsidies, and donor support help reduce the financial burden associated with accessing healthcare services. When individuals are protected from catastrophic health expenditures, they are less likely to fall deeper into poverty as a result of medical costs (Aregbeshola, 2021). Sustainable health financing systems also enhance access to essential health services for vulnerable populations. McIntyre and Meheus (2021) noted that effective healthcare financing contributes significantly to poverty reduction and economic stability among low-income households in many developing countries, including Nigeria.

Access to healthcare facilities is also a major factor influencing the well-being of poor populations. When healthcare services are geographically and financially accessible, individuals are more likely to seek early medical care, receive preventive health services, and effectively manage diseases. Improved access to healthcare contributes to reduced mortality rates, enhanced productivity, and improved quality of life, particularly among disadvantaged populations (Aregbeshola & Khan, 2022). Conversely, limited access to healthcare services often results in delayed treatment, increased disease burden, and worsening living conditions among poor households. Studies conducted in Nigeria and other developing countries have shown that expanding access to primary healthcare services significantly improves the health status and overall well-being of poor populations (Obansa & Orimisan, 2021).

Despite the importance of primary healthcare systems, many developing countries continue to face significant challenges in the management and delivery of PHC services. Weak governance structures, poor financial management, inadequate human resources, and limited healthcare infrastructure frequently undermine the effectiveness of healthcare systems in these countries. Research has shown that ineffective management practices within primary healthcare facilities often result in poor service delivery, low patient satisfaction, and inefficient utilization of available resources (Awofeso & Irabor, 2021; Binyaruka, Borghi, & Kuwawenaruwa, 2021). In many African countries, the absence of strong leadership and effective management structures has been identified as a major obstacle to achieving sustainable improvements in primary healthcare performance (Frieden et al., 2021).

Nigeria's healthcare system reflects many of these structural and managerial challenges. Although the country adopted the primary healthcare approach as a strategy for improving community-based healthcare delivery, the system continues to experience problems such as poor coordination among the three tiers of government, inadequate distribution of healthcare personnel, weak management capacity, and limited accountability mechanisms (Uzochukwu et al., 2022). These challenges often result in the underutilization of primary healthcare facilities, as many patients bypass PHC centres and seek treatment at secondary or tertiary healthcare institutions due to the perceived poor quality of services. Based on this premise, this study investigated the impact of healthcare management on the primary healthcare system in Kwara State.

### ***Statement of the Problem***

Primary healthcare (PHC) is the cornerstone of Nigeria's healthcare system and plays a vital role in providing accessible, affordable, and essential health services to communities. Effective healthcare management is critical for ensuring that PHC facilities function efficiently, deliver quality services, and

meet the health needs of the population. However, in many parts of Nigeria, including Kwara State, primary healthcare facilities face persistent challenges such as poor managerial capacity, inadequate funding, weak health information systems, insufficient human resources, and limited community engagement (Abimbola et al., 2023; Uzochukwu et al., 2022). These challenges often result in low utilization of PHC services, poor quality of care, and increased reliance on secondary and tertiary health institutions for services that could be provided at the primary level. Additionally, ineffective planning, weak supervision, and inconsistent implementation of healthcare management strategies contribute to inefficiencies in service delivery and limit the ability of PHC facilities to meet the healthcare needs of vulnerable and underserved populations.

Several studies had been carried out on the impact of healthcare management on primary healthcare system. For instance, Yisa, Ogunniyi and Dine (2025) conduct a study on strengthening primary health care in Nigeria: a means to achieve universal health coverage. Dada (2023) worked on the overview of the primary healthcare system in Nigeria. Abdulraheem (2022) investigated the primary health care services in Nigeria: critical issues and strategies for enhancing the use by the rural communities. Despite the recognized importance of effective healthcare management in strengthening primary healthcare, there is limited empirical evidence on how management practices influence the performance of PHC facilities in Kwara State to the best of researcher's knowledge. This gap makes it difficult to identify specific management strategies that could improve service delivery, enhance resource utilization, and promote better health outcomes. Therefore, this study seeks to investigate the impact of healthcare management on the primary healthcare system in Kwara State, with a focus on assessing management strategies, and their effectiveness.

### ***Research Questions***

1. What healthcare management strategies are implemented in primary healthcare in Kwara State
2. How effective is the primary healthcare system in Kwara State?

### ***Research Hypotheses***

Ho<sub>1</sub>: Healthcare planning has no significant effect on quality healthcare service delivery in Kwara state.

Ho<sub>2</sub>: Healthcare financing has no significant impact on poverty reduction in Kwara state.

Ho<sub>3</sub>: Access to healthcare facilities does not significantly influence the well-being of poor people in Kwara state.

## **METHODOLOGY**

### ***Research Design***

This study adopted a quantitative research design using survey research. Survey research is suitable for collecting data from a predefined group of respondents to gain insight into specific variables of interest. In this study, structured questionnaires were used to obtain data on the impacts of healthcare management on the primary healthcare system in Kwara State.

### ***Population of the Study***

The population of this study consisted of all healthcare workers employed across 520 primary healthcare centers (PHCs) Kwara State. According to the Human Resource for Health at Primary Health Care Centers (2023), there are 3,444 healthcare workers in these facilities. These include nurses, community health officers, laboratory staff, and administrative personnel, all of whom are directly involved in primary healthcare service delivery.

### ***Sample Size and Sampling Technique***

A total of 358 healthcare workers was selected from the population using the Taro Yamane (1960) formula. The study employed a multi-stage sampling technique to ensure a representative and unbiased sample. In the first stage, a comprehensive list of all PHCs in the selected Local Government Areas (LGAs) was obtained from the Kwara State Primary Health Care Development Agency (KWSPHCDA). Using proportional random sampling, a total of 50 PHCs were selected, ensuring that both rural and urban facilities were adequately represented.

In the second stage, staff lists were obtained from each selected PHC. The number of healthcare workers sampled from each facility was determined using proportional allocation based on the total staff at each PHC relative to the total workforce in the selected PHCs. Simple random sampling was then employed to select individual respondents within each facility. This approach ensured that larger facilities contributed more respondents, while smaller facilities contributed fewer respondents, maintaining proportional representation.

### ***Research Instrument***

Data was collected using a structured questionnaire, which served as the primary instrument for obtaining information from respondents. The questionnaire was self-administered and divided into two sections. Section A captured demographic information such as age, gender, and professional designation. Section B focused on the healthcare management (healthcare planning; healthcare financing; and access to healthcare facilities) and role of primary healthcare system (quality healthcare service delivery; poverty reduction in rural area; and well-being of poor people). The instrument were structured after 5-point Likert scale rating of Strongly Agree = 5 points; Agree = 4 points; Undecided = 3 points; Disagree = 2 points; and Strongly Disagree = 1 point.

### ***Validity and Reliability***

The instruments were validated by experts in counselling psychology and educational measurement, while reliability was established through a pilot study involving 20 health workers outside the sampled primary healthcare. The collected data were analysed using Cronbach's alpha and reliability coefficients of 0.81 was indicating good internal consistency.

### ***Procedure for Data Collection***

This study was conducted in accordance with established ethical guidelines for educational research involving human participants. Prior to data collection, approval was obtained from the Kwara State Ministry of Health and the Head of the primary healthcare selected across the State. The confidentiality and anonymity of the participants were strictly maintained throughout the research process. Participants were assured that their responses would be used solely for academic purposes and that no identifying information would be disclosed. Data collection was carried out during the day with the assistance of trained research assistants, and completed questionnaires were retrieved immediately to minimize the risk of loss or misuse

### ***Method of Data Analysis***

Data collected were analyzed using descriptive and inferential statistical techniques. Descriptive statistics, including percentages and frequencies, were used to summarize respondents' demographic data and responses. Mean rating was use to answer the research questions. Regression analysis was conducted to test the significance of relationships between healthcare management practices and primary healthcare outcomes. All analyses were performed using SPSS version 23.

## **RESULTS**

**Table 1:** Percentage Distribution of the Respondents Demographic Variables

<b>Variable</b>	<b>Category</b>	<b>Frequency</b>	<b>Percentage (%)</b>
<b>Gender</b>	Male	125	34.9

<b>Age</b>	Female	233	65.1
	Below 20 years	27	7.5
	20–29 years	107	29.9
	30–39 years	156	43.6
	40 years and above	68	19.0
<b>Marital Status</b>	Single	139	38.8
	Married	164	45.8
	Divorced	34	9.5
	Widowed	21	5.9
<b>Educational Qualification</b>	MBBS	70	19.6
	BSc/BA/HND	114	31.8
	OND/NCE	80	22.3
	WAEC/NECO/SSCE	61	17.0
	Others	33	9.2

Table 1 presents the demographic variables of the respondents. The distribution by gender shows that 233 respondents (65.1%) were female, while 125 respondents (34.9%) were male. This indicates a higher representation of females in the study. With respect to age, the majority of the respondents were within the age range of 30–39 years, accounting for 156 respondents (43.6%). This was followed by respondents aged 20–29 years with 107 respondents (29.9%). Respondents aged 40 years and above constituted 68 respondents (19.0%), while those below 20 years were the least represented with 27 respondents (7.5%).

In terms of marital status, 164 respondents (45.8%) were married, making up the largest proportion of the sample. Single respondents accounted for 139 (38.8%), while 34 respondents (9.5%) were divorced and 21 respondents (5.9%) were widowed. Regarding educational qualification, respondents with BSc/BA/HND qualifications formed the largest group with 114 respondents (31.8%). This was followed by those with OND/NCE qualifications, representing 80 respondents (22.3%). Respondents with MBBS qualifications accounted for 70 (19.6%), while those with WAEC/NECO/SSCE constituted 61 respondents (17.0%). Respondents with other qualifications were the least represented, with 33 respondents (9.2%).

**Research Question One:** What healthcare management strategies are implemented in primary healthcare in Kwara State

**Table 2:** Mean and Standard Deviation Showing Healthcare Management Strategies Implemented by Primary Healthcare in Kwara State

S/N.	Statement	Mean	S.D	Rank
<b>Healthcare Planning</b>				
1.	Primary healthcare facilities in Kwara State have documented healthcare plans guiding their operations	3.09	.899	1 <sup>st</sup>
2.	Healthcare planning activities are regularly carried out in primary healthcare facilities in Kwara State	3.08	.855	
3.	Community health needs are considered during the planning process in primary healthcare facilities.	3.11	.864	
<i>Average Mean</i>		<b>3.09</b>		
<b>Healthcare Financing</b>				
4.	Primary healthcare facilities in Kwara State receive regular financial allocations from appropriate authorities	3.03	.880	3 <sup>rd</sup>
5.	There are established procedures for budgeting and financial management in primary healthcare facilities	3.03	.858	

6.	Financial resources are formally allocated for essential services in primary healthcare facilities	3.06	.843	
	<b>Average Mean</b>	<b>3.04</b>		
	<b>Access to Healthcare Facilities</b>			
7	Primary healthcare facilities are physically available within reasonable distance to the communities they serve	3.06	.902	
8	Primary healthcare facilities in Kwara State operate during officially designated service hours	3.11	.831	2 <sup>nd</sup>
9	Essential healthcare personnel and basic medical equipment are available in primary healthcare facilities	3.05	.879	
	<b>Average Mean</b>	<b>3.07</b>		

Table 2 shows the mean and standard deviation showing healthcare management strategies implemented by primary healthcare in Kwara State. The Table indicated that healthcare planning ranked 1st with the average mean score of 3.09. access to healthcare facilities ranked 2nd with the average mean score of 3.07 and healthcare financing ranked 3rd with the average mean score of 3.04. Since all average mean scores were above 3.00 mean cut-off point, this implies that healthcare planning, access to healthcare facilities, and healthcare financing were healthcare management strategies implemented by primary healthcare in Kwara State.

**Research Question Two:** How effective is the primary healthcare system in Kwara State?

**Table 3:** Mean and Standard Deviation Showing Effectiveness of Primary Healthcare in Kwara State

S/N.	Statement	Mean	S.D	Rank
	<b>Quality Healthcare Service Delivery</b>			
1.	The attitude of healthcare staff in the hospital is welcoming and good.	3.03	.877	
2.	It takes minimum time for patients to wait in the hospital.	3.05	.929	2 <sup>nd</sup>
3.	The hospital is always cleaned by the hospital sanitation department.	3.06	.838	
	<b>Average Mean</b>	<b>3.04</b>		
	<b>Poverty Reduction in Rural Area</b>			
4.	Not been sick and always active has always helped me to get an income paying job.	3.03	.916	
5.	The sound health I enjoy prompted me to venture into income generating businesses.	3.06	.887	3 <sup>rd</sup>
6.	The rate of income generation increased due to job opportunities provided to healthy workers in the community.	3.02	.879	
	<b>Average Mean</b>	<b>3.03</b>		
	<b>Well-Being of Poor People</b>			
7	Our wellbeing has improved due to the modern treatment we receive from rural hospitals.	3.05	.895	
8	I barely have issues with my health nowadays.	3.11	.891	1 <sup>st</sup>
9	We go for regular checkups to receive quality treatment given by rural area healthcare specialists.	3.11	.833	
	<b>Average Mean</b>	<b>3.09</b>		

Table 3 shows the mean and standard deviation indicating the effectiveness of the primary healthcare system in Kwara State. The Table revealed that well-being of poor people ranked 1st with an average mean score of 3.09, followed by quality healthcare service delivery which ranked 2nd with an average mean score of 3.04, while poverty reduction in rural areas ranked 3rd with an average mean score of 3.03. Since all the average mean scores were above the 3.00 mean cut-off point, this implies that primary healthcare in Kwara State is effective in improving the well-being of poor people, delivering quality healthcare services, and contributing to poverty reduction in rural areas.

**Test of Hypotheses**

This section addresses the objectives of the study through the formulated hypotheses using regression analysis.

**Hypotheses one:** Healthcare planning have no significant impact on the quality healthcare service delivery in Kwara state.

**Table 4a: Model Summary**

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.863 <sup>a</sup>	.826	.825	.26302

a. Predictors: (Constant), Healthcare Planning (documented healthcare plans, activities are regularly carried out, Community health needs are considered)

Table 4 presents the regression analysis of the effect of healthcare planning on quality healthcare service delivery. The R square value of 0.826 derived showed that 82.6% variation in Quality healthcare service delivery was explained by Healthcare planning. The implication is that 82.6% of quality healthcare service delivery can be explained by quality healthcare planning. Therefore, the null hypothesis which states that healthcare planning has no significant effect on Quality healthcare service delivery was rejected.

**Table 4b: ANOVA<sup>a</sup>**

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	409.600	4	102.400	1480.157	.000 <sup>b</sup>
	Residual	23.453	339	.069		
	Total	433.052	343			

a. Dependent Variable: Quality healthcare service delivery

b. Predictors: (Constant), Healthcare Planning (documented healthcare plans, activities are regularly carried out, Community health needs are considered)

The F-statistics as shown from the ANOVA table is significant since the ANOVA significance of .000 is less than the alpha level of 0.05, thus the result is achieved. Also, the regression sum of square of 409.600 is greater than residual sum of square of 23.453, this further show the significance of the overall model therefore the model is fit.

**Table 4c: Coefficients<sup>a</sup>**

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.035	.083		-.417	.677

documented healthcare plans guiding their operations	.360	.060	.319	5.985	.000
activities are regularly carried out	.214	.047	.232	4.566	.000
Community health needs are considered	.494	.040	.531	12.275	.000

a. Dependent Variable: Quality healthcare service delivery

In table 4c, it is revealed that changes in documented healthcare plans guiding their operations has significant effect on quality healthcare service delivery, this is indicated by the Beta (B) value of 0.319 and P-value of  $0.000 < 0.05$ ; also, healthcare planning activities are regularly carried out has significant effect on quality healthcare service delivery, this is indicated by the Beta (B) value of 0.232 and P-value of  $0.000 < 0.05$ ; while community health needs are considered has significant effect on Quality healthcare service delivery, this is indicated by the Beta (B) value of 0.531 and P-value of  $0.000 < 0.05$ . The overall analysis suggests that the healthcare planning has significant effect on Quality healthcare service delivery.

**Hypotheses two:** Healthcare financing has no significant impact on poverty reduction in rural areas.

**Table 5a:** Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.887 <sup>a</sup>	.865	.865	.12929

a. Predictors: (Constant), Healthcare financing (financial allocations, budgeting and financial management, Financial resources are formally allocated)

Table 5a presents the regression analysis of the effect of healthcare financing on poverty reduction in rural areas. The R square value of 0.865 derived showed that 86.5% variation in poverty reduction in rural areas was explained by healthcare financing. The implication is that 86.5% of poverty reduction in rural areas can be explained by healthcare financing. Therefore, the null hypothesis which states that healthcare financing has no significant effect on poverty reduction in rural areas was rejected while the alternative hypothesis was accepted.

**Table 5b:** ANOVA<sup>a</sup>

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	381.638	4	95.410	5707.94	.000 <sup>b</sup>
	Residual	5.666	339	.017		
	Total	387.305	343			

a. Dependent Variable: Poverty reduction in rural areas

b. Predictors: (Constant), Healthcare financing (financial allocations, budgeting and financial management, Financial resources are formally allocated)

The F-statistics as shown from the ANOVA table is significant since the ANOVA significance of 0.000 is less than the alpha level of 0.05, thus the result is achieved. Also, the regression sum of square of 381.638 is greater than residual sum of square of 5.66, this further show the significance of the overall model therefore the model is fit.

**Table 5c:** Coefficients<sup>a</sup>

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.091	.040		-2.277	.023
	financial allocations	.189	.020	.176	9.327	.000
	budgeting and financial management	.218	.024	.244	8.930	.000
	Financial resources are formally allocated	.491	.026	.474	19.208	.000

a. Dependent Variable: Poverty reduction in rural areas

In table 5c, it is revealed that changes in primary healthcare receive regular financial allocations from appropriate authorities has significant effect on poverty reduction in rural areas, this is indicated by the Beta (B) value of 0.176 and p-value of  $0.000 < 0.05$ ; also, there are established procedures for budgeting and financial management has significant effect on poverty reduction in rural areas, this is indicated by the Beta (B) value of 0.244 and p-value of  $0.000 < 0.05$ ; while financial resources are formally allocated for essential services has significant effect on poverty reduction in rural areas, this is indicated by the Beta (B) value of 0.474 and p-value of  $0.000 < 0.05$ . The overall analysis suggests that the healthcare financing has significant effect on poverty reduction in rural areas in Ilorin metropolis.

**Hypotheses three:** Access to healthcare facilities have no significant impact on the well-being of poor people in rural areas.

**Table 6a:** Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.881 <sup>a</sup>	.872	.872	.14651

a. Predictors: (Constant), Access to healthcare facilities (physically available within reasonable, operate during officially designated service hours, Essential healthcare personnel and basic medical equipment are available)

Table 6a presents the regression analysis of the effect of access to healthcare facilities on well-being of poor people. The R square value of 0.872 derived showed that 87.2% variation in well-being of poor people was explained by access to healthcare facilities and the remaining 12.8% represent residual which are the variables that are not captured in the model. This implies that the model is fit. The implication is that 87.2% of well-being of poor people can be explained by access to healthcare facilities. Therefore, the null hypothesis which states that access to healthcare facilities has no significant effect on well-being of poor people was rejected while the alternative hypothesis was accepted.

**Table 6b:** ANOVA<sup>a</sup>

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	405.494	4	101.373	4722.636	.000 <sup>b</sup>
	Residual	7.277	339	.021		
	Total	412.770	343			

a. Dependent Variable: Well-being of poor people

b. Predictors: (Constant), Access to healthcare facilities (physically available within reasonable, operate during officially designated service hours, Essential healthcare personnel and basic medical equipment are available)

The F-statistics as shown from the ANOVA table is significant since the ANOVA significance of .000 is less than the alpha level of 0.05, thus the result is achieved. Also, the regression sum of square of 405.494 is greater than residual sum of square of 7.277, this further show the significance of the overall model therefore the model is fit.

**Table 6c:** Coefficients<sup>a</sup>

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-.249	.038		-6.511	.000
	physically available within reasonable distance to the communities	.188	.025	.189	7.388	.000
	operate during officially designated service hours	.438	.018	.440	23.939	.000
	Essential healthcare personnel and basic medical equipment are available	.249	.026	.287	9.559	.000

a. Dependent Variable: Well-being of poor people

In table 6c, it is revealed that changes in physically available within reasonable distance to the communities has significant effect on well-being of poor people, this is indicated by the Beta (B) value of 0.189 and P-value of  $0.000 < 0.05$ ; also, operate during officially designated service hours has significant effect on well-being of poor people, this is indicated by the Beta (B) value of 0.440 and p-value of  $0.000 < 0.05$ ; while essential healthcare personnel and basic medical equipment are available has significant effect on well-being of poor people, this is indicated by the Beta (B) value of 0.287 and P-value of  $0.000 < 0.05$ . The overall analysis suggests that the access to healthcare facilities has significant effect on well-being of poor people.

## DISCUSSION OF RESEARCH FINDINGS

The finding of the study revealed that healthcare planning, access to healthcare facilities, and healthcare financing were healthcare management strategies implemented by primary healthcare in Kwara State. The finding implies that primary healthcare (PHC) facilities in Kwara State rely on structured planning, physical and geographical access to services, and financial mechanisms as core strategies for managing healthcare delivery. This could be that Nigeria’s PHC system operates within a framework that emphasizes planning and coordination, particularly following the revitalisation of PHC under one roof (PHCUOR), which requires facilities to align activities with state and national health plans. The finding is in tandem with the study of Aregbeshola and Khan (2022) who reported that strategic planning and adequate financing significantly influence the efficiency and service coverage of primary healthcare facilities. Similarly, Uzochukwu et al., (2022) found that access to PHC facilities, particularly in rural communities, is closely linked to utilisation of services and improved health outcomes. Conversely, Okpani and Abimbola (2023) argued that weak implementation, poor accountability, and limited managerial capacity often undermine the effectiveness of healthcare planning and financing at the PHC level in Nigeria.

Another finding revealed that primary healthcare in Kwara State is effective in improving the well-being of poor people, delivering quality healthcare services, and contributing to poverty reduction in rural areas. This finding means that primary healthcare (PHC) services in Kwara State are playing a positive and practical role in the lives of poor and rural residents. Specifically, PHC facilities are not only improving people’s physical well-being through access to basic health services, but are also delivering care that is perceived as satisfactory in quality. One major reason for this finding is the proximity and affordability of primary healthcare facilities in rural communities. The finding is in line with the study of World Health Organization (2022) who reported that strong primary healthcare systems are associated with better health

outcomes, improved equity, and financial protection for vulnerable populations. In Nigeria, Obansa and Orimisan (2021) showed that functional PHC facilities in rural Nigerian communities improved maternal and child health outcomes and enhanced overall quality of life. On a contrary, Aregbeshola and Khan (2022) reported that inadequate funding, shortages of skilled personnel, and poor infrastructure limit the impact of PHC services in some rural Nigerian settings.

The finding of the study showed that healthcare planning has significant effect on quality healthcare service delivery in Kwara state. This means that the extent to which primary healthcare facilities engage in systematic planning directly influences how well healthcare services are delivered to patients. In practical terms, facilities with clear, documented, and regularly reviewed healthcare plans are more likely to provide timely, efficient, coordinated, and patient-centred services. This could be that planning helps managers prioritise needs, forecast patient demand, and deploy resources strategically, thereby reducing inefficiencies and service gaps. Additionally, healthcare planning provides a framework for setting service delivery standards, monitoring performance, and guiding staff responsibilities. Frieden et al. (2021) found that effective healthcare planning significantly improved service efficiency and patient satisfaction in public health facilities in South-West Nigeria. Similarly, World Health Organization (2020) reported that health systems with strong planning and management structures consistently demonstrate better service delivery outcomes, including improved access, quality, and continuity of care.

Another finding showed that healthcare financing has significant impact on poverty reduction in Kwara state. This means that increased and better-organised funding of the healthcare system contributes meaningfully to reducing poverty levels among residents. In practical terms, when government and other stakeholders invest more in healthcare individuals and households spend less out-of-pocket on medical care. One major reason for this relationship is that adequate healthcare financing lowers catastrophic health expenditures, which are a common cause of poverty in low- and middle-income settings such as Nigeria. The finding corroborates with the study of McIntyre and Meheus (2021) who found that increased public spending on healthcare significantly reduced poverty and inequality by limiting out-of-pocket health payments in low-income countries. However, Tandon and Cashin (2020) argued that inefficient allocation of health funds, corruption, and inequitable access can limit the poverty-reducing effects of healthcare spending.

The finding of the study revealed that access to healthcare facilities have significantly influence the well-being of poor people in Kwara state. This means that when low-income individuals are able to reach, afford, and use healthcare services, their overall quality of life improves. One major reason for this result is that poor populations are disproportionately exposed to health risks such as malnutrition, poor housing conditions, and limited sanitation, making regular healthcare especially critical. The finding agrees with the study of Sharma et al., (2021) who reported that equitable access to healthcare services significantly improves health outcomes among disadvantaged populations. Similarly, Ameh et al. (2022) found that improved physical and financial access to healthcare in low-income settings leads to better utilisation of services and improved well-being.

## **CONCLUSION**

In conclusion, the study establishes that primary healthcare in Kwara State is effective in improving the well-being of poor people through the delivery of quality healthcare services and its contribution to poverty reduction, particularly in rural areas. The findings further show that effective healthcare planning significantly enhances quality healthcare service delivery by ensuring proper coordination, efficient use of resources, and improved service standards, while adequate healthcare financing plays a vital role in reducing poverty by lowering out-of-pocket health expenditures and preventing further impoverishment among poor households. Additionally, access to healthcare facilities significantly influences the well-being of the poor, as accessible and affordable services promote early treatment, preventive care, and better health

outcomes. Overall, the study highlights that strengthened primary healthcare systems, supported by sound planning, sustainable financing, and improved access, are essential for improving well-being and reducing poverty among poor populations in Kwara State.

## **RECOMMENDATIONS**

A crucial assessment of the impact of healthcare management on primary healthcare system with a particular reference to primary healthcare centers in Kwara state was made and conclusions were reached. In view of the findings given above, the following recommendations were suggested;

1. Government should ensure there is adequate Healthcare planning for the healthcare sector of the state so as to enhance the Quality healthcare service delivery of the healthcare sector. This can be done by considering adequate planning for resource allocation, ensuring healthcare workforce are well managed and patients care responses are fast and of topnotch.
2. Government should ensure it provide healthcare finance in vital health sector so as to helps achieve poverty reduction in rural areas. This can be done through placing priority on the health sector which will reflect on the health sector financing. This will culminate into an upgrade of the healthcare facilities to meet the global standards and above all, increase the universal health coverage due to increase budget for health insurance.
3. Government should ensure it enables easy access to healthcare facilities for rural households to enhance the well-being of rural areas. This can be achieved by attracting more Health Service Provider to the scheme through incentive scheme. This can be through better financial rewards and concessions, provision of more health facilities among others. This will address the problems of refusal to take on more clients and withdrawing from the scheme by private sector health institutions. This will make healthcare available and accessible.

## **REFERENCES**

- Abdulraheem, I. S. (2022). Primary health care services in Nigeria: Critical issues and strategies for enhancing the use by the rural communities. *Journal of Public Health and Epidemiology*, 4(1). <https://doi.org/10.5897/jphe11.133>
- Abimbola, S., Baatiema, L., & Bigdeli, M. (2023). The impacts of decentralization on primary health care systems in low- and middle-income countries. *BMJ Global Health*, 8(2), e010489.
- Ameh, S., Klipstein-Grobusch, K., D'Ambruoso, L., Kahn, K., Tollman, S., & Gómez-Olivé, F. (2022). Quality of integrated primary health care in low- and middle-income countries: A systematic review. *International Journal for Quality in Health Care*, 34(1), mzab145.
- Aregbeshola, B. S. (2021). Out-of-pocket payments in Nigeria: Implications for households and poverty reduction. *International Journal of Health Planning and Management*, 36(2), 1–12.
- Aregbeshola, B. S., & Khan, S. M. (2022). Primary health care financing in Nigeria: Challenges and opportunities for universal health coverage. *Health Systems & Reform*, 8(1), 1–10.
- Awofeso, N., & Irabor, P. (2021). Health workforce management challenges in Nigeria's primary healthcare system. *African Journal of Primary Health Care & Family Medicine*, 13(1), a2877.
- Binyaruka, P., Borghi, J., & Kuwawenaruwa, A. (2021). Improving health facility management and primary healthcare performance in sub-Saharan Africa. *Health Systems & Reform*, 7(1), e1899660.
- Dada, S. (2023). An overview of the primary healthcare system in Nigeria. *International Journal of Applied and Scientific Research*, 1(3), 289–304. <https://doi.org/10.59890/ijasr.v1i3.572>
- Frieden, T., Lee, C., Lamorde, M., Nielsen, M., & McClelland, A. (2021). Strengthening primary health care through effective management and leadership. *The Lancet Global Health*, 9(8), e1045–e1046.
- Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., Adeyi, O., Barker, P., Daelmans, B., Doubova, S. V., English, M., García-Elorrio, E., Guanais, F., Gureje, O.,

- Hirschhorn, L. R., Jiang, L., Kelley, E., Lemango, E. T., Liljestrand, J., & Pate, M. (2021). High-quality health systems in the Sustainable Development Goals era: Time for a revolution. *The Lancet Global Health*, 9(11), e1600–e1615.
- McIntyre, D., & Meheus, F. (2021). Fiscal space for domestic funding of health and other social services. *Health Economics, Policy and Law*, 16(2), 1–13.
- Obansa, S. A. J., & Orimisan, A. (2021). Health care financing and economic development in Nigeria: The role of primary healthcare. *Journal of Economics and Sustainable Development*, 12(6), 45–53.
- Ogah, P. O., Uguru, N., Okeke, C., Mohammed, N., Ogbe, O., Ashiver, W. G., & Aina, M. (2024). Primary health care in Nigeria: Best practices and quality of care in Nigeria. *BMC Health Services Research*, 24, 963.
- Okpani, A. I., & Abimbola, S. (2023). Operationalizing universal health coverage in Nigeria through social health insurance. *Health Reform Observer*, 3(2), 1–10.
- Orji, I. A., Baldrige, A. S., Ikechukwu-Orji, M. U., Okoye, C., & Eze, C. (2024). Evaluating diabetes care in primary healthcare centers in Abuja, Nigeria. *BMC Primary Care*, 25, 243.
- Oseni, T. I. A., Olawumi, A. L., Salam, T. O., Issa, A., Abiso, M. A., & Ilori, T. (2024). The role of community health workers in hypertension management in Nigeria. *BMC Primary Care*, 25, 266.
- Sharma, R., Nachum, S., Davidson, K. W., & Nochomovitz, M. (2021). It's not just burnout: COVID-19 and the importance of supporting health care workforce well-being. *Journal of General Internal Medicine*, 36(4), 1117–1119.
- Uzochukwu, B. S. C., Onwujekwe, O. E., Mbachu, C. O., Okeke, C. C., Molyneux, S., & Gilson, L. (2019). Accountability mechanisms for implementing primary health care under decentralisation: A comparative analysis in Nigeria. *Health Policy and Planning*, 34(8), 1–12. <https://doi.org/10.1093/heapol/czz087>
- Uzochukwu, B., Onwujekwe, O., Mbachu, C., Okeke, C., Molyneux, S., Gilson, L., & Ezumah, N. (2022). Accountability mechanisms in primary healthcare systems in Nigeria. *Health Research Policy and Systems*, 20(1), 65.
- World Health Organization & UNICEF. (2023). *Primary health care operational framework: Monitoring indicators and implementation guidance*. WHO
- World Health Organization. (2022). *Primary health care measurement framework and indicators: Monitoring health systems through a primary health care lens*. WHO.
- Yisa, S. S., Oggunniyi, T. J., & Dine, R. D. (2025). Strengthening primary health care in Nigeria: a means to achieve universal health coverage. *BMJ global health*, 10(10), e018486. <https://doi.org/10.1136/bmjgh-2024-018486>