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ACCESS TO HEALTHCARE AND LABOUR MARKET PARTICIPATION IN NIGERIA

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Abstract :

This study examines the relationship between access to healthcare and labour market participation in Nigeria. Three specific objectives are formulated: to ascertain the extent to which availability of healthcare affects labour market participation in Nigeria; investigate the relationship between healthcare affordability and labour market participation; and to determine the relationship between healthcare acceptability and labour market participation. The study focuses on selected communities in all the five states that make up South East Nigeria. The sample size is 358. The data were collected through structured questionnaire and analyzed using Pearson correlation coefficient. The results reveal that availability of healthcare personnel and facilities has negative correlation and no significant effect on labour market participation, there is significant positive correlation between healthcare affordability and labour market participation and healthcare acceptability correlates positively and significantly with labour market participation. The study concludes that that labour market participation in rural communities in Nigeria is enhanced through healthcare affordability and healthcare acceptability. However, there is still low availability of healthcare personnel and facilities in the rural communities and this is affecting labour market participation. The study recommends that government should build more primary healthcare centers in rural communities, make health insurance scheme enforcement compulsory for all rural residents in Nigeria because when healthcare is available and acceptable, it increases access to healthcare and boosts labour market participation and productivity.

Keywords: *Access to Healthcare, healthcare affordability, healthcare acceptability, Labour Market Participation*

INTRODUCTION

Background to the Study

Nigeria, Africa's most populous country, has faced persistent challenges in the accessibility and quality of healthcare services since gaining independence in 1960. The Nigerian health system has historically been underfunded, centralized, and poorly managed, leading to low health outcomes and inequities in access. In the 1980s, the economic downturn and implementation of Structural Adjustment Programs (SAPs) further weakened public investment in healthcare, shifting the burden to households through out-of-pocket payments (Oladosu, Khai & Asaduzzaman, 2023).

Despite several reform efforts, including the introduction of the National Health Insurance Scheme (NHIS) in 2005, access to healthcare remains unequal and often unaffordable for many Nigerians. Nigeria has numerous healthcare

providers, both in the public and private sectors that offer healthcare services. As of December 2024, Nigeria had a total of 40,399 healthcare facilities located in all 36 states and the Federal Capital Territory. Most of these facilities (85%) were primary healthcare facilities, 14% were secondary healthcare facilities, and only 1% were tertiary healthcare facilities (Ishaq, Mukhtar, Odekunle, 2024). Over 66% of these facilities were owned by the government, specifically the Federal Ministry of Health (Federal Ministry of Health, 2024). According to the World Bank (2022), only about 5% of Nigerians are covered under any form of health insurance, and over 70% of health expenditure is out-of-pocket. This situation disproportionately affects the poor, rural dwellers, and informal workers many of whom lack stable income and social security.

Nigeria's labour market is characterized by a large informal sector, low productivity, high youth unemployment, and gender disparity. According to the National Bureau of Statistics (2023), the informal sector accounts for over 80% of employment. Women, particularly in rural areas, face greater barriers to labour market participation due to childcare responsibilities, poor health services, and cultural constraints.

The interrelationship between health and labour market outcomes is well-documented. Good health is both a driver and an outcome of productive employment. In Nigeria, however, limited access to affordable healthcare can pose serious barrier to labour force engagement. The labour force participation rate in Nigeria stood at approximately 56% in 2022, with higher dropout rates among women and the chronically ill (Kingpriest, Okpanachi & Afolabi, 2025). Health-related work absenteeism and chronic illness reduce productivity and job retention, particularly in the informal sector where there are no sick leave benefits (Fasina & Olafisoye, 2025). Given this assertion, it is pertinent to understudy the nexus between access to healthcare and labour market participation in Nigeria.

Statement of the Problem

There is growing empirical evidence that links healthcare accessibility with labour market outcomes. A resilient and equitable healthcare system contributes to a healthier workforce, enhances productivity, and reduces poverty through improved employability. Adequate healthcare access reduces the time and money spent on illnesses, enhances child survival (leading to greater participation in the workforce). The migration of health professionals from Nigeria prompted by poor working conditions and limited facilities has exacerbated healthcare workforce shortages, limiting healthcare service availability (Oyedokun, Akoki, Adesola & Fatola, 2025). Thus, there is a possible negative feedback loop where poor access to healthcare can impede labour productivity. Thus, the reaction of labour market to changes in healthcare availability, affordability and accessibility in Nigeria remains a problem for research to solve.

Furthermore, achieving universal healthcare requires the provision of healthcare to everyone, including those employed in the formal and informal sector (Sychareun, Vongxay, Thammavongsa, & Durham, 2016). Unfortunately, people in the informal sector appear to be mostly excluded from different forms

of social protection including healthcare access as a result of their informality (16). Therefore, addressing this setback requires concerted research into how healthcare access affects labour market participation as this will help to address the problem of uncertainty surrounding access to healthcare and labour market participation in Nigeria. Also, studies linking access to healthcare and labour market participation are very few especially in South East Nigeria. Studies like Oladosu, Khai & Asaduzzaman (2023), Ishaq et al. (2024), Iseghohi (2025) linked access to health to labour productivity from the macro point of view, the micro aspect is largely neglected in recent literature. Thus, taking the South East Nigeria as a case study, this research examines how access to healthcare affects labour market participation with a view to unraveling the nexus and making useful recommendations.

Objectives of the Research

The main objective of this study is to examine the nexus between access to healthcare and labour market participation in Nigeria. Specifically, the study intends to:

1. Ascertain the extent to which availability of healthcare personnel and facilities affects labour market participation in Nigeria;
2. Investigate the relationship between healthcare affordability and labour market participation in Nigeria; and
3. Determine the relationship between healthcare acceptability and labour market participation in Nigeria.

Research Questions

1. To what extent have availability of healthcare personnel and facilities affected labour market participation in Nigeria?
2. What is the relationship between healthcare affordability and labour market participation in Nigeria?
3. What is the relationship between healthcare acceptability and labour market participation in Nigeria?

Research Hypotheses

H_{01}: Availability of healthcare personnel and facilities has not significantly affected labour market participation in Nigeria.

H_{02}: There is no significant relationship between healthcare affordability and labour market participation in Nigeria.

H_{03}: There is no significant relationship between healthcare acceptability and labour market participation in Nigeria.

Scope of the Study

The unit scope of this research is residents of 5 South East States in Nigeria. The variable scope is healthcare personnel and facilities availability, healthcare affordability, healthcare acceptability and labour market participation. The geographic scope is South East Nigeria comprising Abia, Anambra, Ebonyi, Enugu and Imo States.

Significance of the Study

This study will benefit the affected States in South East region of Nigeria because it will measure the extent of impact healthcare access has on labour

market participation. This will help to reformulate existing government policies that will reform healthcare sector in the region.

This research will also benefit the entirety of the country – Nigeria as it will uncover how access to healthcare relates with labour market participation. This appears to be an area in economic research that has remained under-researched and this present study will enable the Nigerian government to borrow from the policy recommendations to revamp the dwindling healthcare sector in Nigeria. This research will benefit the academic community as it will enrich both theoretical and empirical knowledge in this area of study.

Literature Review

Conceptual Literature Review

Availability of Healthcare in Nigeria

Availability simply means the quality of being able to be used or obtained (Eronmhonsele & Erhabor, 2025). Within the context of this research, availability of healthcare refers to the extent to which healthcare services and resources are accessible and obtainable by individuals and communities. It encompasses the presence of facilities, professionals, and technologies needed to provide care. Essentially, Yewande (2025) noted that it is about whether people can get the care they need, when and where they need it. The availability of healthcare personnel and facilities in Nigeria remains a critical determinant of health outcomes and a cornerstone of a healthy workforce.

According to Alubo, Hunduh and Otache (2025), Nigeria's health system suffers from a deeply uneven distribution of professionals, with urban centers hosting the bulk of skilled workers while rural areas remain severely underserved. This disparity has led to higher maternal and child mortality rates in rural regions, where access to skilled birth attendants and basic healthcare services is minimal (Zakariya *et al*., 2025).

Affordability of Healthcare in Nigeria

Affordability of healthcare refers to the degree to which individuals and households can access and pay for necessary medical services without experiencing financial hardship (Ozigbu & Ezekwe, 2025). In this research, affordability is all about ensuring that healthcare costs don't become a barrier to accessing care, especially for those with lower incomes or limited resources. Affordability remains a major impediment to healthcare access in Nigeria, where the healthcare financing system relies heavily on out-of-pocket (OOP) expenditure as stated by Abiodun and Olusegun (2025). This financing model disproportionately affects low-income populations and contributes to healthcare inequity. The World Bank (2024) estimated that over 70% of Nigerians finance their healthcare expenses from personal funds, often leading to catastrophic spending and healthcare avoidance.

Acceptability of Healthcare in Nigeria

Healthcare acceptability refers to how well a healthcare intervention is considered appropriate and suitable by those delivering or receiving it, based on their anticipated or experienced cognitive and emotional responses (Bucyibaruta *et al*., 2022). The acceptability of healthcare in Nigeria remains a multifaceted

issue influenced by sociocultural, economic, infrastructural, and systemic factors. The relevance of healthcare acceptability to labour market participation lies in whether individuals seek timely care. When services are perceived as unacceptable due to stigma (e.g., HIV, mental illness), poor attitudes of healthcare workers, or religious/cultural misalignment, individuals delay or avoid treatment. This can lead to increased absenteeism from work, reduced job productivity and higher out-of-pocket health costs.

Theoretical Framework

The human capital theory was originally developed by Becker (1964) and Schultz (1961). Human Capital Theory posits that investments in education, training, and health enhance the productivity and economic value of individuals, thereby increasing their ability to participate effectively in the labour market.

Health is considered a core component of human capital. According to this theory, healthier individuals are more likely to be productive, have fewer absences from work, and remain employed for longer periods (Yusuf & Adeyemi, 2022). Access to healthcare facilitates the maintenance and restoration of health, enabling individuals to enter, remain, and advance in the workforce. Conversely, limited access to healthcare can lead to untreated illnesses, reduced physical and cognitive performance, and ultimately labour market exclusion (Grossman, 1972).

This theory is adopted as the theoretical framework of this research and it is predicated on the fact that a healthy population is a productive population. The human capital theory considers health as a human capital stock. Thus, the manner in which individuals allocate their time to labour depends on their access to healthcare. When there is difficulty in accessing healthcare, productivity is bound to decrease because labour market participation rate will decrease due to the time spent seeking for adequate healthcare.

Empirical Literature Review

Studies on availability of healthcare personnel and labour market participation

Adepoju *et al*. (2025) studied the role of community health workers in rural healthcare in Nigeria. Variables used were community health workers' availability, rural healthcare access and employment rate. Data Collection was through review of national CHW deployment and service coverage. The analysis was carried out using Literature review with secondary data synthesis. The study found that community health workers expanded access and employment opportunities, boosting health and productivity in rural areas.

Yusuf and Adeyemi (2022) investigated the relationship between maternal healthcare availability and employment outcomes in Nigeria. Variables used in the study were antenatal care use and postnatal employment. Data were collected from the national Demographic Health Survey (NDHS 2018). The data were analyzed using Propensity Score Matching (PSM). They found that improved access to maternal health increased post-natal labour participation by 13%.

Salami (2021) studied the nexus between informal sector health access and productivity in Nigeria. The variables used were health insurance, productivity

levels. Data were collected from urban household surveys (Lagos & Kano) and analyzed using OLS regression. They found that informal workers with NHIS access were 22%moreproductive.

Adedokun and Okonkwo (2021) studied youth health service access and employment transitions in Nigeria. The study used the following variables: age, illness and employment status. The data were collected from LSMS panel data and analyzed using Probit model. The study found that youth with better healthcare access had smoother transitions into the workforce.

Studies on healthcare affordability and labour market participation

Nwafor (2019) did a study on regional disparities in healthcare affordability and economic productivity in Nigeria. The variables used were state-level health access, health cost and GDP per capita. Data Collection was through NBS state statistics while the data were analyzed using Panel regression. The study found that regions with better health infrastructure with more affordable health care had 18–25% higher labour productivity.

Adebayo and Okeke (2023) examined the impact of out-of-pocket healthcare expenditure on workforce productivity in Nigeria. Variables studied were household healthcare costs and employment status. Data were collected from the Nigeria Living Standards Survey (NLSS) 2018/2019. The data were analyzed using Multivariate logistic regression. The study found that high out-of-pocket (OOP) health expenses are linked to job loss and reduced labour engagement.

El-Yaqub, Tekun and Ismail (2025) studied the impact of Conditional Cash Transfer (CCT) programs on health outcomes and poverty reduction in Nigeria. Variables used were health service utilization, income level, labour market inclusion. Descriptive statistics and regression modeling revealed that the CCT improved healthcare affordability and indirectly supported increased labour participation especially among women.

Eze, Adie and Ineyekineye (2025) carried out a research on strengthening Nigeria's health system for sustainable development. The variables included health financing, system resilience and healthcare access. Thematic content analysis emphasized the need for improved health funding, and rural outreach to boost healthcare affordability and indirectly support workforce productivity.

Studies on healthcare acceptability and labour market participation

Azubuike *et al*. (2025) studied how suburban women in Nigeria accept and embrace birthplace and how it affects their labour market participation. Choice of health facility, distance to care and maternal employment were the variables used. Narrative and thematic analysis found that accepting poor health facilities for healthcare influenced job disruption for women, lowering their labour market participation.

Okonjo and Osei (2020) investigated the relationship between rural acceptability of healthcare facilities and labour migration in Nigeria. The variables used in the study were health center proximity, rate of patronage of healthcare facilities and migration rates. The data were collected through rural health infrastructure survey and Multinomial logistic regression analysis found

that poor rural healthcare access and low acceptability of existing health facilities increased economic migration by 21%.

Fasina and Olafisoye (2025) examined acceptability of healthcare as a measure for productivity in Nigeria. Variables used were number of patients observed, access to health/social amenities and productivity rating scale. Data Collection was through structured questionnaires and the descriptive and inferential statistics found that observed number of patients correlated with increased school absenteeism and reduced child well-being, impacting future labour participation.

Gap in Literature

Given the numerous studies on access to healthcare and labour market participation, none of the reviewed literature addressed access to healthcare from the tripod perspective of availability, affordability and acceptability of healthcare. These represent the three dimensions of access which drives labour market participation. This research serves the purpose of addressing this gap identified.

Again, studies using South East Nigeria as case study are almost non-existent. Concerted effort was made to search for literature from South East Nigeria but the researcher met none. This was addressed as a research gap which this present study intends to fill.

RESEARCH AND METHOD

Research Design

The research design used in this study is descriptive survey research design because it tends to investigate the opinion or other manifestations of a group of people by questioning them. Also, the research design generates data in order to describe how behavior and opinion of a group of people affect a defined outcome.

Population of the Study

The population of this study comprises the residents of each of the States that make up South East Nigeria. The respondents were selected using at random based on their availability as at the time of the research. The population and sample distribution is summarized in Table 3.1 below:

Table 3.1: Population and Sample Size Computation

State	Population of Abia State Based on Population Estimates	Bowley's formula	Sample
Abia	3,727,347	$\frac{3,727,347}{21,955,414} X\ 400$	= 68
Anambra	5,527,809	$\frac{5,527,809}{21,955,414} X\ 400$	= 101
Ebonyi	2,880,383	$\frac{2,880,383}{21,955,414} X\ 400$	= 52
Enugu	4,411,119	$\frac{4,411,119}{21,955,414} X\ 400$	= 80

Imo	5,408,756	$\frac{5,408,756}{21,955,414} X\ 400$	= 99
	21,955,414		**400**

Source: National Population Commission (2024) Population Projection**.**

Note: the sample size of is computed using the Taro Yamane formula as follows:

$= \frac{N}{1 + N(e)^2}$

Where N = the entire population (21,955,414); n = sample size, e = error margin (5%).

$n = \frac{21,955,414}{1+21,955,414(0.05)^2}, n = \frac{21,955,414}{1+54888.535}; \ n = \frac{21,955,414}{54889.535}, n = 400$

Sampling Procedure

This has to do with how the respondents were selected from the sampling unit. The non-probability sampling technique was employed which made the researcher to issue the survey instrument to random residents of the states visited. The respondents comprised those that were present at the healthcare centers as at the time of the researcher's visit. In other words, this study adopted convenience sampling by approaching only residents that were present at healthcare center between the hours of 8am to 4pm on the days of data collection.

Sources of Data Collection

Data for this study were generated from primary sources. Primary data were sourced from respondents' responses using structured questionnaire specifically designed for this study.

Validity of the Instrument

The research instrument (questionnaire) was validated by the supervisor and two research experts in Imo State University Owerri. When they went through the content of the question items in the questionnaire, their corrections were implemented prior to the printing of the final copy of the survey instrument.

Reliability of the Instrument

The Cronbach Alpha coefficient was used in ascertaining the reliability of the instrument. The Cronbach Alpha has a benchmark of 0.70 which means that any computed Cronbach alpha coefficient is considered satisfactory if it falls within the range of 0.70 and 0.80. The reliability coefficient obtained from each of the questionnaire item groupings were 0.791, 0.752, 0.698 and 0.773 which confirmed their reliability for the research (See Appendix).

Method of Data Analysis

The data analysis method is both Descriptive and Inferential. The Descriptive aspect of the analysis uses weighted percentage analysis and weighted mean to describe the questions and make deductions. Additionally, deductions are made based on the outcome of the mean value.

For the inferential statistics, the Pearson correlation analysis and t-test of significance of the Pearson r is adopted. The Pearson correlation tests the degree of relationship between access to healthcare variables and labour market participation. The degree of relationship is further tested for statistical

significance using the t-test.

Decision Rule:

This study will base its strength of rejecting the null hypothesis (H0) on the premise below:

Reject H_0 and accept H_1 if *p-value* of t-statistic is less than 0.05

The computations were done using the Statistical Package for Social Sciences (SPSS) software.

Data Presentation, Analysis And Discussion Of Results

Data Presentation

The total sample of 204 was proportionately distributed to the residents of the selected communities but 158 were returned thereby making the working sample to be 158. This is represented in Fig. 4.1 below:

Table. 4.1: Questionnaire Distribution and Return Rate

State	Number Distributed	Number Returned	Response Rate
Abia	68	50	74%
Anambra	101	95	94%
Ebonyi	52	48	91%
Enugu	80	74	92%
Imo	99	91	92%
Total	**400**	**358**	**90%**

Source: Field Survey (2025)

According to Table 4.1, the highest response rate recorded was from Anambra State with 94% followed by Enugu and Imo States with 92% each. Ebonyi State had 91% response rate while the least response rate was from Abia State with 74%. In total, 358 questionnaires were returned and duly completed out of 400 distributed and this gave a total response rate of 90%.

Table 4.1: Demographic Distribution

S/N	Variable	Options	Frequency (n = 358)	Percentage %
1.	**Gender**	Male	251	70.1
		Female	107	29.9
		Total	***358***	
2.	**Age Group**	Below 30 years	79	22.1
		31 – 40 years	196	54.7
		Above 40 years	83	23.2
		Total	***358***	
3.	**Level of Education**	No Formal Education	15	4.2
		FSLC	89	24.9

		WAEC/OND	70	19.6
		First Degree/HND	160	44.7
		Post-graduate	24	6.7
		Total	***358***	
4.	**Marital Status**	Single	145	40.5
		Married	213	59.5
		Total	***358***	
5.	**Occupation**	Trader	118	33.0
		Civil Servant	133	37.2
		Student	48	13.4
		Unemployed	59	16.5
		Total	***358***	

Source: Field Survey (2025)

The data summarized in Table 4.1 shows that there are more female participants in the study than male participants. Female respondents make up 70.1% of the total respondents (251 out of 358 respondents) while male respondents make up the remaining 29.9% (107 out of 358 respondents. The respondents are majorly in the age category of 31 years to 40 years and have adequate level of education with 44.7% of them being first degree holders. While 59.5% are married, majority (37.2%) are civil servants while 33% are traders.

Table 4.2: Responses on Availability of Healthcare Personnel and Facilities

Code	Availability	SA	A	D	SD	Mean	Remark
AV1.	The number of doctors and nurses and other healthcare professionals is adequate.	14 (3.9)	13 (3.6)	224 (62.6)	107 (29.9)	1.82	Negative
AV2.	The number of hospital beds is appropriate.	37 (10.3)	36 (10.1)	129 (36.0)	156 (43.6)	1.87	Negative
AV3.	The distance to the nearest healthcare facility is short.	5 (1.4)	161 (45.0)	103 (28.8)	89 (24.9)	2.23	Negative

Source: Survey Data (*Results were extracted from SPSS output, percentage figures are in parenthesis*)

Table 4.2 indicates that all the question items have negative mean values thus giving the impression that the respondents strongly disagreed to the statements on availability of healthcare personnel and facilities in their rural communities. Individual analysis of the responses shows that the number of doctors and nurses and other healthcare professionals is inadequate (mean = 1.82), the number of hospital beds is not appropriate (mean = 1.87), and that the distance to the nearest healthcare facility is not short (mean = 2.23).

Table 4.3: Responses on Healthcare Affordability

Code	Affordability	SA	A	D	SD	Mean	Remark
AF1.	The health insurance coverage has helped me to ease the cost of healthcare.	35 (9.8)	28 (7.8)	127 (35.5)	168 (46.9)	1.80	Negative
AF2.	I can comfortably pay for my healthcare from my earnings.	17 (4.7)	22 (6.1)	138 (38.5)	181 (50.6)	1.65	Negative
AF3.	Price of healthcare is subsidized through health insurance.	131 (36.6)	155 (43.3)	57 (15.9)	15 (4.2)	3.12	Positive

Source: Survey Data (*Results were extracted from SPSS output, percentage figures are in parenthesis*)

Table 4.3 shows that majority of the respondents representing a combined 35.5% disagreed that health insurance coverage has helped them to ease the cost of healthcare. This also reflects in the negative mean score of 1.80 which is below the 2.5 criterion mean. Also, 50.6% strongly disagreed that they can comfortably pay for healthcare from their earnings (mean = 1.65). About 43.3% of the respondents were in agreement that price of healthcare is subsidized through health insurance (mean = 3.12).

Table 4.4: Responses on Healthcare Acceptability

Code	Acceptability	SA	A	D	SD	Mean	Remark
AC1.	I am satisfied with healthcare services in my area.	28 (7.8)	21 (5.9)	208 (58.1)	101 (28.2)	1.93	Negative
AC2.	I can communicate very well with the healthcare providers in my area.	108 (30.2)	236 (65.9)	14 (3.9)	0 (0.0)	3.26	Positive
AC3.	The healthcare practices in my area are appropriate for my culture.	186 (52.0)	149 (41.6)	12 (3.4)	11 (3.1)	3.42	Positive

Source: Survey Data (Results were extracted from SPSS output, percentage figures are in parenthesis)

Responses on healthcare acceptability are summarized in Table 4.4. The responses show that 58.1% of the respondents disagreed that they are satisfied with healthcare services in their area. In other words, majority of the respondents are not satisfied with the healthcare services in their area. The mean value of 1.93 proves this assertion. Furthermore, 65.9% agreed that they can communicate very well with the healthcare providers in their area (mean = 3.26), while 52% of the respondents strongly agreed that the healthcare practices in their area are appropriate for their culture (mean = 3.42).

Table 4.5: Responses on Labour Market Participation

Code	Labour Market Participation	SA	A	D	SD	Mean	Remark
LMP1.	My current employment does not stop me from seeking quality healthcare.	152 (42.5)	140 (39.1)	20 (5.6)	46 (12.8)	3.11	Positive
LMP2.	I face some health challenges in the discharge of my duties at my work place.	147 (41.1)	145 (40.5)	24 (6.7)	42 (11.7)	3.11	Positive
LMP3.	I participate in trainings and update courses.	81 (22.6)	50 (14.0)	73 (20.4)	154 (43.0)	2.16	Negative
LMP4.	I aspire to reach the highest level in my career.	151 (42.2)	147 (41.1)	19 (5.3)	41 (11.5)	3.14	Positive
LMP5.	The number of persons employed in my community is declining as a result of poor health safety practices.	187 (52.2)	96 (26.8)	43 (12.0)	32 (8.9)	3.22	Positive
LMP6.	There is decline in available labour in my community.	162 (45.3)	180 (50.3)	5 (1.4)	11 (3.1)	3.38	Positive

Source: Survey Data (*Results were extracted from SPSS output, percentage figures are in parenthesis*)

As evidenced in Table 4.5, while 42.5% of the respondents strongly agreed that their current employment does not stop them from seeking quality healthcare, 5.6% disagreed to this assertion. Thus, the resulting mean score of 3.11 is on the positive side which implies that the respondents agreed to the statement. Furthermore, they strongly agreed that there is decline in available labour in their community (mean = 3.38). However, very few of the respondents participate in trainings and update courses.

Test of Hypotheses

The hypotheses are tested using the probability value of the t-statistics from the multiple regression analysis. The *p-value* of the t-statistic shows the overall significance or otherwise of the variables. The null hypothesis will be rejected if the *p-value* is less than 0.05 critical value i.e. reject null if *p-value* < 0.05, otherwise, accept null.

Test of Hypothesis One:

H_{01}: Availability of healthcare personnel and facilities has not significantly affected labour market participation in Nigeria.

Table 4.6: Pearson Correlation Result for Hypothesis One

Variables	Pearson *r*	Mean ($\bar{X}$)	t	*p-value*	Remark
Labour Market		16.83			

	-0.126		-1.586	0.746	Negative and insignificant correlation
Availability		6.26			

Source: *Extracted from SPSS Result*

Table 4.6 shows that availability of healthcare has a negative correlation coefficient of -0.126 which implies that availability of healthcare correlates negatively with labour market participation. Thus, availability of healthcare has a decreasing effect on labour market participation. In the hypothesis test, it is observed that the probability value of 0.746 is greater than 0.05 critical value. Thus, the null hypothesis is accepted and the study concludes that availability of healthcare personnel and facilities has not significantly affected labour market participation in Nigeria.

Test of Hypothesis Two:

H_{02}: There is no significant relationship between healthcare affordability and labour market participation in Nigeria.

Table 4.7: Pearson Correlation Result for Hypothesis Two

Variables	**Pearson *r***	**Mean ($\bar{X}$)**	**t**	***p-value***	**Remark**
Labour Market		16.83			
	0.693		12.006	0.049	Positive and significant correlation
Affordability		7.37			

Source: *Extracted from SPSS Result*

The null hypothesis is rejected since the *p-value* of the t-statistic 0.049 is less than 0.05 critical value. Therefore, the conclusion is that there is significant relationship between healthcare affordability and labour market participation in Nigeria. The correlation coefficient of customer trust is 0.693 and this is a positive coefficient. It implies that healthcare affordability correlates positively with labour market participation. Therefore, increased healthcare affordability exerts positive effect on labour market participation and the increase is significant.

Test of Hypothesis Three:

H_{03}: There is no significant relationship between healthcare acceptability and labour market participation in Nigeria**.**

Table 4.8: Pearson Correlation Result for Hypothesis Three

Variables	**Pearson *r***	**Mean ($\bar{X}$)**	**t**	***p-value***	**Remark**
Labour Market		16.83			
	0.714		12.737	0.024	Positive and significant relationship
Acceptability		8.98			

Source: *Extracted from SPSS Result*

The null hypothesis is rejected since the *p-value* of the t-statistic 0.024 is less than 0.05 critical value. Therefore, the conclusion is that there is significant relationship between healthcare acceptability and labour market participation in Nigeria. The correlation coefficient of healthcare acceptability is 0.714 and this is a positive coefficient. It implies that healthcare acceptability correlates positively with labour market participation. Therefore, increase in healthcare acceptability also increases labour market participation and the increase is significant.

FINDINGS AND DISCUSSION

The study set out to achieve the main objective of investigating the relationship between access to healthcare and labour market participation in Nigeria. Five States in South East Nigeria were selected for the study and they include Abia, Anambra, Ebonyi, Enugu and Imo State. Analysis using sample of 358 residents of these communities gave rise to interesting findings which are discussed based on the specific objectives of the study:

Objective 1 – Ascertain the extent to which availability of healthcare personnel and facilities affects labour market participation in Nigeria;

The first objective focused on investigating the correlation between availability of healthcare personnel and labour market participation in Nigeria. The respondents opined that the number of doctors and nurses and other healthcare professionals is not adequate also noting that the number of hospital beds is insufficient while the distance to healthcare facility is very far. These individual responses give us a hint on the relationship between availability of healthcare personnel and facilities affects labour market participation.

The analysis of the hypothesis showed that the null hypothesis was accepted (*p-value = 0.*746) and the study concluded that availability of healthcare personnel and facilities has not significantly affected labour market participation in Nigeria. The correlation coefficient was also negative which meant that availability of healthcare decreases labour market participation in Nigeria with no significant relationship existing between the two constructs. This finding did not agree with the finding made in the work of Adepoju *et al*. (2025), Yusuf and Adeyemi (2022) which found that access to community health workers expanded employment opportunities, boosting health and productivity in rural areas. Also, Adedokun and Okonkwo (2021), Nwafor (2019) found that youth with better healthcare access had smoother transitions into the workforce. Thus the reason for the negative and insignificant effect of healthcare availability on labour market participation as against the positive effect found by other studies may be due to the use of sample that have different characteristics and the focus on the rural communities in South East Nigeria.

Objective 2 – Investigate the relationship between healthcare affordability and labour market participation in Nigeria.

The second objective sought to investigate the extent to which affordability of healthcare affects labour market participation in Nigeria. The respondents as earlier discussed disagreed that health insurance coverage has helped them to ease the cost of healthcare. They also opined that they cannot comfortably pay

for healthcare from their earnings but they agreed that price of healthcare is subsidized through health insurance. Thus, the individual repsonses implies that only health insurance subsidizes healthcare cost for the residents. Out-of-pocket healthcare expenditure for them is not affordable due to their low remuneration but the health insurance coverage is still very low amongst the residents as seen in their responses.

The hypothesis test confirmed that there is significant positive relationship between healthcare affordability and labour market participation in Nigeria. This implies that healthcare affordability correlates positively with labour market participation. Therefore, increased healthcare affordability translates to positive labour market participation and the increase is significant. Further implication of this finding is that an accessible healthcare is an affordable healthcare and when residents can afford healthcare, it boosts their participation in labour force because there will be low number of sick leaves and absent employees. Thus, manpower will be adequately utilized for production purposes thus enhancing productivity. This corroborates the findings of Salami (2021) where-in they stated that informal workers with NHIS access were 22% more productive. Also, Adebayo and Okeke (2023) noted that high out-of-pocket (OOP) health expenses are linked to job loss and reduced labour engagement while low out-of-pocket health expenses increases labour engagement.

Objective 3 – Determine the relationship between healthcare acceptability and labour market participation in Nigeria.

The responses to the research questions on healthcare acceptability were rather split between positive and negative responses. Based on the respondents' individual opinion, they opined that they are not satisfied with healthcare services in their area but that majority of them can communicate very well with the healthcare providers in their area. They also agreed that healthcare practices in their area are appropriate for their culture. Thus, there was no cultural impediment to their access to healthcare in their communities.

In terms of the relationship with labour market participation, the hypothesis test revealed that there is significant relationship between healthcare acceptability and labour market participation in Nigeria. Healthcare acceptability correlated positively with labour market participation meaning that increase in healthcare acceptability also increases labour market participation and the increase is significant. Eze, Adie and Ineyekineye (2025) advocated for improved healthcare acceptability through a system of decentralized access to healthcare as well as adequate funding. Other studies hinted on the relevance of healthcare acceptability in boosting labour participation (El-Yaqub, Tekun & Ismail, 2025; Kingpriest *et al*., 2025). Therefore, when the healthcare service is accessible and the practices are accepted by the people, it reduces economic migration and boosts local labour participation and productivity as was the case in this research.

CONCLUSION AND RECOMMENDATIONS

Summary of Findings

The findings made in this study are summarized underneath as follows:

1. Availability of healthcare personnel and facilities had negative correlation (r = -0.126) and no significant effect on labour market participation in Nigeria (p=*0.746*).
2. There was significant positive correlation between healthcare affordability and labour market participation in Nigeria (r = 0.693; p=0.049).
3. Healthcare acceptability correlated positively and significantly with labour market participation in Nigeria (r = 0.714; p=0.024).

Conclusion

The conclusion from the study is that labour market participation in rural communities in Nigeria is enhanced through healthcare affordability and healthcare acceptability. Thus, in order to confirm that access to healthcare is adequate, it must be affordable and acceptable by the residents and this is the case for the residents of rural communities in South East Nigeria that were studied. However, there is still low availability of healthcare personnel and facilities in the rural communities and this is affecting labour market participation because the residents have to travel far distance in order to access quality healthcare. This situation is reducing their participation in labour market and decreasing their man-hour and productivity. In other words, the available healthcare in the rural communities is affordable and acceptable but not adequately available, and this has adverse effect on labour market participation.

Recommendations

The study recommends as follows:

1. Government should build more primary healthcare centers in rural communities and equip them in order to make them available for use by local residents. The time spent in looking for healthcare can be reduced when healthcare facilities are made available in every rural community in Nigeria thus boosting labour productivity..
2. The affordability of healthcare should be strengthened by making health insurance scheme compulsory for all rural residents in Nigeria. This should also be enforced as most rural residents do not know is usefulness in reducing health care cost. An affordable healthcare increases the health status of the people thus boosting health capital and productivity of labour.
3. Healthcare practices are acceptable by the people and this should be further encouraged by healthcare workers. When healthcare is available and acceptable, it increases access to healthcare and boosts labour market participation and productivity.

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