



HEALTHCARE DELIVERY AND QUALITY OF CARE: A COMPARATIVE ANALYSIS OF PRIVATE AND PUBLIC HOSPITALS IN WUKARI LOCAL GOVERNMENT AREA



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Abstract

Healthcare provision in Nigeria remains a multifaceted challenge, and while researchers have examined the problem from several angles, comparative studies of public and private healthcare delivery specific to Wukari Local Government Area remain limited. The present study was carried out in Wukari Local Government Area of Taraba State, involving 401 adult residents. The study adopted a survey research design and utilised a structured questionnaire for data collection. The collected data were analysed using descriptive statistics, an independent-samples t-test, and multiple regression. The findings indicate a statistically significant difference in the perceived quality of healthcare between users of private healthcare facilities ($M = 2.5027$, $SD = .76125$) and users of public healthcare facilities ($M = 2.2439$, $SD = .97178$); $t(436.70) = 3.523$, $p < .001$. Significant predictors of choosing a public healthcare facility included age, education, socioeconomic income, distance from the healthcare facility, occupation, perceived satisfaction with healthcare services, and public health knowledge, $R^2 = .424$, $F(10, 390) = 28.708$, $p < .001$. The study concludes with policy-relevant recommendations for strengthening public healthcare delivery in the study area.

Keywords: Healthcare access, healthcare quality, healthcare facility, public perception, healthcare choice.

Introduction

Healthcare delivery quality among developing nations has become an area of concern following the continuous failure of health systems in these nations. Although the United Nations, through the Sustainable Development Goals agenda, and the World Health Organisation have provided comprehensive frameworks and indicators for healthcare delivery, many developing nations are yet to maintain reasonable performance (World Health Organisation, 2025). Quality healthcare is the degree to which health services increase the likelihood of desired health outcomes, aligning with current professional knowledge while prioritising the needs and preferences of the patient. This is captured through indicators such as process measures like adherence to clinical guidelines, outcome measures like mortality and readmission rates, and patient-centred measures such as satisfaction and timely access (Jazieh, 2020). Adherence to clinical guidelines in managing population healthcare in developing nations such as Nigeria is inconsistently observed in certain contexts, either due to a lack of proper equipment or a shortage of qualified professionals.

In Nigeria specifically, the shortage of qualified professionals and equipment to handle certain healthcare cases has become routine, driven by the continuous underfunding of public healthcare facilities and the persistent brain-drain of health professionals from the country (Umar, Salihu, & Azuine, 2025; Ajoseh, Langer, Amoniyan, & Uyah, 2024). The consequences of failed clinical procedures, arising from a lack of proper equipment and professionals, are visible in Nigeria's mortality statistics. For instance, as at 2022 Nigeria recorded 60.1 deaths

per 1,000 live births, 107 deaths per 1,000 among children under five, and an overall death rate of 12.43 per 1,000 people (National Demographic and Health Survey, 2022). Other studies place Nigeria among the countries with the highest death rates in the world (Dogbanya, 2025; Ukoji & Ukoji, 2023).

Recurrent readmission for the same ailment has been observed both in urban and rural Nigerian communities, where patients return for treatment, they had previously received. Some studies attribute this to poor treatment procedures at certain health facilities (Kuye & Akinwale, 2021), while others point to inadequate facilities and professionalism in case management (Adesola, Opuni, Idris, Okesanya, Igwe, Abdulazeez, & Lucero-Prisno, 2024). In many cases, patients have lost their lives to treatment errors that were identified too late. In some instances, patients are treated without a proper diagnosis, or with an incorrect diagnosis, resulting in the aggravation of the disease or ailment responsible for their condition.

In many rural Nigerian communities, healthcare providers lack adequate procedures for managing cases, relying instead on informal or assumed knowledge; this increases readmission rates and the persistence of the same ailment over extended periods of treatment. This points to an underlying pattern of crisis in health management within the Nigerian healthcare system, driven by technical errors that characterise healthcare management across developing nations more broadly. Among developing nations such as Nigeria, patient-centred measures in healthcare provision appear to have eluded the population in view of the commercially driven orientation of both public and private healthcare facilities. This is evidenced by widespread dissatisfaction with both public and private healthcare facilities, as well as limited access to healthcare facilities and services (Josiah et al., 2024; Nnadi, Ossai, & Nwokocha, 2024; Jibril et al., 2024). According to some studies, the Nigerian population is among those with severely low access to healthcare globally (Eze, Aniebo, Ilechukwu, & Lawani, 2025; Folorunsho, 2025), a pattern demonstrated in the spatial distribution of healthcare facilities and providers across the nation (Amoah-Nuamah, Agyemang-Duah, Ninorb, & Ekeme, 2023). While a majority of the population lacks access to any type of healthcare facility, whether private or public, Nigeria's doctor-to-patient ratio remains severely below the global standard (Umar, Salihu, & Azuine, 2025).

Access to quality healthcare facilities and services remains one of the enduring challenges in sub-Saharan African nations such as Nigeria. According to the National Demographic and Health Survey (NDHS, 2022), the majority of the Nigerian population lacks access to healthcare facilities and services, a situation that worsens when disaggregated by rural-urban differences. This is further demonstrated by the rate of out-of-pocket health expenditure among the population: most Nigerians depend on out-of-pocket spending, which unconsciously reflects the scarcity of healthcare facilities, services, and health insurance coverage. Nigeria currently has no comprehensive health insurance scheme for the general population, apart from a few programmes restricted to federal civil servants, which expire upon their retirement (Adekunle & Vincent, 2025).

Studies by Chuke et al. (2022), Okafor et al. (2023), and Okafor (2020) demonstrate underlying loopholes in the Nigerian healthcare system, showing the impact of limited health insurance coverage, restricted access to facilities and services, and shortages of healthcare professionals on overall population health. While researchers have approached the problem of Nigeria's multifaceted healthcare system from several angles, comparative studies of the impact of differences between private and public hospitals on the general health needs of the population remain limited, particularly in north-central Nigeria. In Wukari metropolis specifically, no known study has focused on the comparative analysis of perceived quality of healthcare

services between private and public healthcare providers. In view of this gap, the present study was carried out to comparatively analyse the perceived quality of healthcare provision among the population, with respect to public and private healthcare providers.

Statement of the Problem

Over the years, access to quality healthcare facilities and services across Nigeria and other developing nations has been fraught with challenges relating to the quality of services, affordability, and accessibility in terms of distance, particularly among economically disadvantaged populations. This challenge is compounded by the structure of the available healthcare providers, broadly classified into public and private healthcare providers. While public healthcare providers comprise federal- and state-government-owned institutions, private healthcare providers include mission, privately organised, and individually owned hospitals.

Within these two broad categories of healthcare provision, the population is caught between the challenges of affordability and accessibility, and the pursuit of quality, functional healthcare services. Over time, this divide has shaped differences in choice among the public, informed by the complexity of poverty, public health knowledge, and other factors that characterise the relationship between healthcare providers and the population they serve.

In Nigeria, public health facilities have historically been scarce, and where available, their quality has generally been perceived as poor, while private facilities are perceived as relatively better. However, this remains largely speculative, as there has been limited empirical investigation into the factors responsible for differences in perception and choice between public and private healthcare facilities and services in the country. More specifically, in Wukari Local Government Area, an area characterised by limited healthcare facilities and services, the associated factors responsible for differences in choice of healthcare facilities have yet to be captured through empirical data. Accordingly, the present study addressed the following research questions:

Research Questions

- iii. What are the areas of difference in healthcare provision between private and public healthcare providers, as observed by the residents of Wukari Local Government Area?
- iv. Is there a significant difference between the perceived performance of public and private healthcare providers in Wukari Local Government Area?
- v. What are the predictors of choosing a public healthcare facility among the residents of Wukari Local Government Area?

Objectives of the Study

The general objective of the study is to examine the factors associated with differences in the choice of healthcare facility between private and public providers among the population of Wukari Local Government Area, Taraba State. The specific objectives are to:

1. Ascertain the areas of difference in healthcare provision between private and public healthcare providers, as observed by the residents of Wukari Local Government Area.
2. Examine whether there is a significant difference between the perceived performance of public and private healthcare providers in Wukari Local Government Area.

3. Ascertain the predictors of choosing a public healthcare facility among the residents of Wukari Local Government Area.

Significance of the Study

Healthcare access in Nigeria is surrounded by challenges that researchers from different disciplines have explored from various angles. The present study, adopting a sociological approach, is positioned to surface underexplored factors contributing to the burden of healthcare access among low-income populations in Nigeria. Theoretically, the study contributes to the global debate on the comparative performance of private and public healthcare providers in developing nations. It also brings to this debate the underlying factors that motivate or discourage patronage of public healthcare facilities in Wukari Local Government Area, and how these relate to the broader sustainable development research agenda. Practically, the study offers health policymakers insight into the factors shaping public adoption of government-sponsored healthcare facilities in Wukari Local Government Area, informing policy change and strategies to strengthen public healthcare provision. The study also offers guidance to local and international health-focused organisations operating in developing nations such as Nigeria on strengthening the effectiveness of public healthcare facilities.

Theoretical Framework: Health Belief Model

The study was guided by the Health Belief Model (HBM), developed by Rosenstock (1974). While the model is grounded in behavioural theory, its central concern is the relationship between human behaviour and clinical outcomes; it was developed to address the socio-medical dimensions of human experience.

As its name implies, the HBM is concerned with how individuals, and possibly groups, perceive health issues along a spectrum from negative to positive (Seth, 2005). The negative pole relates to an individual's understanding of the magnitude of a health situation, usually a disease, and its implications for the person affected; this understanding spurs action toward the situation to the extent the individual is able. The positive pole relates to an individual's understanding of the benefits of taking action on a given health issue. When an individual is convinced of the benefits of acting against an undesirable health issue, they are more likely to act (Seth & Noar, 2005; Rosenstock, 1974).

According to Rosenstock, perceived threat from a disease is classified into perceived susceptibility to, and severity of, the disease in question, while perceived benefits and barriers significantly affect the likelihood of taking action (Janz & Becker, 1984). While perceived susceptibility and severity place an individual on the path toward considering action, perceived benefits and possible barriers to action serve as motivators (or deterrents) to acting (Seth, 2005). The HBM also acknowledges socio-environmental factors, captured as cues to action and demographic factors: cues include environmental stimuli such as public media and enlightenment from peers, while demographic factors include race, ethnicity, age, and related variables (Rimer, 1997; Rosenstock, 1988).

In relation to the choice of healthcare provider, health-seeking behaviour and awareness of institutional performance inform the extent to which individuals and groups decide where to seek healthcare when in need. The HBM suggests that engagement with a healthcare institution is shaped by belief in the satisfaction obtainable from its services relative to alternatives. As people are motivated to seek healthcare, they are equally motivated to seek reliable and accessible institutions that can meet their needs, giving rise to varied choices between public and private healthcare facilities.

Methodology

The study applied a cross-sectional survey design for population and data management, involving the selection of a subset of the population representative of the entire population using a probability sampling method. The cross-sectional survey applied was descriptive and observational, involving data collection from a representative subset of the population at one point in time, with the aim of providing data representative of the entire population under study. The application of the cross-sectional survey design was anchored on the study's aim of capturing comparative information on healthcare provision by public and private healthcare facilities among the residents of Wukari Local Government Area.

The study was carried out in Wukari Local Government Area, situated in Taraba State, North-East geopolitical zone of Nigeria. The headquarters of the LGA is the town of Wukari, and the LGA shares boundaries with parts of Nasarawa State. Towns and villages that make up Wukari LGA include, among others, Wukari, Auyi, Rafin Kada, Chonku, Gidan Idi, Arufu, Bantaje, and Kuyu.

The estimated population of Wukari LGA is put at 269,031 inhabitants, with the area predominantly inhabited by members of the Jukun ethnic group (NPC, 2006). According to the 2024/2025 population projection for Wukari LGA, approximately 292,231 people live in the LGA. The adult population, which is the target population for the present study, is estimated at 121,012. The study therefore relied on the adult population of the LGA to develop the sampling frame and sample size and is limited to the adult population living in Wukari LGA.

The sample size for this study was statistically determined using the Taro Yamane (1967) formula, based on the adult population of Wukari LGA. The Taro Yamane formula is given as:

$$n = N / [1 + N(e)^2]$$

Where n = sample size; N = the finite population; e = level of significance (margin of error).

$n = 121,012 / [1 + 121,012(0.005)^2] = 121,012 / [1 + 121,012(0.0025)] = 121,012 / 302.53 \approx 401$. The sample size for this study was therefore 401 respondents.

Given the study's interest in the adult population of Wukari LGA, sampling units were selected from streets and outlets across the LGA using a multistage sampling technique for more comprehensive representation of the target population (Pandey & Pandey, 2015). At the first stage, 10 communities were selected by simple random sampling (balloting). From these 10 communities, 40 wards/villages were randomly selected by balloting. Households within each selected ward/village were then arranged for random selection; in residential areas with unique settlement patterns, a modified simple random sampling procedure was applied. This procedure led to the selection of compounds from which respondents were drawn, with 10 households randomly selected within each selected compound. The study applied availability sampling to select respondents from each selected household for questionnaire administration. In total, 10 communities were selected, from which 40 wards/villages and 401 households were selected, yielding 401 respondents.

Instrument of Data Collection

A researcher-developed questionnaire, face- and content-validated by the project supervisor and three other lecturers in the Department of Sociology/Anthropology, was used for the study. Unsatisfactory items were restructured or deleted, and these modifications were reflected in the final instrument.

The study adopted a quantitative approach, using a structured questionnaire containing both structured and fixed-option questions on the issues raised in the study, enabling the direct testing of relationships between the study's key variables.

Three (3) undergraduate students from Federal University Wukari were recruited and trained as research assistants for the data collection exercise, covering the nature and aim of the study as well as the technical structure of the questionnaire. The three research assistants helped administer the instrument to respondents across the communities and wards/villages selected for the study. The questionnaire was distributed during evening hours at the chosen residences to improve access to respondents.

Data Analysis

The study applied a quantitative method of data analysis. The Statistical Package for the Social Sciences (SPSS version 23) was used to capture the data collected. Descriptive statistics, including frequency distribution tables and percentages, were used to analyse responses to the questionnaire items. An independent-samples t-test and multiple regression analysis were used to examine relationships between socio-demographic variables and performance indicators of public and private healthcare providers in Wukari Local Government Area.

Presentation of Study Findings

This section presents the study's findings and their analysis.

Table 1: Socio-Demographic Characteristics of Respondents

Variable	Category	Frequency (%)
Gender	Male	241 (60.1%)
	Female	160 (39.9%)
Age	18–28	60 (15.0%)
	29–39	40 (10.0%)
	40–50	221 (55.1%)
	51–61	60 (15.0%)
	62 and above	20 (5.0%)
Religion	Christianity	261 (65.1%)
	Islam	120 (29.9%)
	African Traditional Religion	20 (5.0%)
Occupation	Self-employed	180 (44.9%)
	Trader/artisan	60 (15.0%)
	Civil servant	161 (40.1%)
Education	Primary	40 (10.0%)
	Secondary	280 (69.8%)
	Higher institution	81 (20.2%)

Note: n = 401 for each variable. Source: Field Survey, 2026

Table 1 shows that a majority of respondents (60.1%) are male; the largest age group (55.1%) falls within 40–50 years; a majority (65.1%) are Christian; the largest occupational group (44.9%) is self-employed; and a majority (69.8%) have secondary education as their highest qualification.

Table 2: Distribution of Respondents by Distance from the Nearest Healthcare Facility

Distance	Frequency (%)
Less than 1 kilometre	100 (24.9%)
1–2 kilometres	40 (10.0%)
5 kilometres and more	261 (65.1%)
Total	401 (100.0%)

Source: Field Survey, 2026

Table 2 shows that a majority of respondents (65.1%) have their nearest healthcare facility at a distance of 5 kilometres or more, 24.9% have their nearest facility within 1 kilometre, and 10.0% have their nearest facility between 1 and 2 kilometres.

Table 3: Distribution of Respondents by Perceived Satisfaction with Healthcare Services

Response	Frequency (%)
Dissatisfied	100 (24.9%)
Neutral	141 (35.2%)
Satisfied	160 (39.9%)
Total	401 (100.0%)

Source: Field Survey, 2026

Table 3 shows that a majority of respondents (39.9%) reported being satisfied with the healthcare services received, 35.2% were neutral, and 24.9% reported dissatisfaction.

Table 4: Distribution of Respondents by Perceived Quality of Healthcare Facilities

Response	Frequency (%)
Not good at all	101 (25.2%)
Somehow good, with reservations	180 (44.9%)
Fairly good and encouraging	100 (24.9%)
Very good and satisfactory	20 (5.0%)
Total	401 (100.0%)

Source: Field Survey, 2026

Table 4 shows that a majority of respondents (44.9%) rated the quality of healthcare services as somehow good, with reservations; 25.2% rated it as not good at all; 24.9% rated it as fairly good and encouraging; and 5.0% rated it as very good and satisfactory.

Table 5: Distribution of Respondents by Public Health Knowledge

Response	Frequency (%)
Not at all	101 (25.2%)
Partially aware	180 (44.9%)
Fairly good	100 (24.9%)
Very good	20 (5.0%)
Total	401 (100.0%)

Source: Field Survey, 2026

Table 5 shows that a majority of respondents (44.9%) are partially aware of public health matters, 25.2% report no awareness, 24.9% report fair awareness, and 5.0% report a high level of public health knowledge.

Table 6: Distribution of Respondents by Likelihood of Choosing a Public Healthcare Facility over a Private One

Response	Frequency (%)
Strongly disagree	60 (15.0%)
Disagree	40 (10.0%)
Undecided	221 (55.1%)
Agree	60 (15.0%)
Strongly agree	20 (5.0%)
Total	401 (100.0%)

Source: Field Survey, 2026

Table 6 shows that a majority of respondents (55.1%) are undecided as to whether they would choose a public healthcare facility over a private one when ill, 15.0% agree they would choose a public facility, another 15.0% strongly disagree, 10.0% disagree, and 5.0% strongly agree.

Table 7: Independent-Samples t-Test on Perceived Performance of Public and Private Healthcare Providers

	F (Levene's)	Sig.	t	df	Sig. (2-tailed)	Mean Diff.
Equal variances assumed	107.677	< .001	3.699	616	< .001	.25879
Equal variances not assumed	—	—	3.523	436.70	< .001	.25879

Source: Field Survey, 2026

An independent-samples t-test was conducted to compare mean perception scores between users of public and private healthcare in Wukari Local Government Area. The results show a statistically significant difference in perceived healthcare quality between users of private healthcare facilities ($M = 2.5027$, $SD = .76125$) and users of public healthcare facilities ($M = 2.2439$, $SD = .97178$); $t(436.70) = 3.523$, $p < .001$. The null hypothesis of no significant difference between the perceived performance of public and private healthcare providers in Wukari Local Government Area is therefore rejected, indicating a statistically significant difference between the two groups.

Table 8: Regression Coefficients for Predictors of Choosing a Public Healthcare Facility

Predictor	B	Std. Error	Beta	t	Sig.
(Constant)	.449	.308		1.458	.145
Gender	-.114	.092	-.057	-1.234	.218
Age	.323	.064	.238	5.072	< .001
Education	-.027	.053	-.028	-.521	.003
Religion	.065	.059	.039	1.102	.271
Socioeconomic income	-.487	.054	-.462	-8.955	< .001
Distance from nearest hospital	.353	.052	.241	6.813	< .001
Occupation	-.081	.045	-.071	-1.811	.001
Access to healthcare information	.048	.049	.039	.980	.327
Perceived satisfaction with services	.085	.051	.073	1.670	.001
Public health knowledge	.536	.043	.472	12.603	< .001

Dependent variable: Public healthcare facility as a choice among residents of Wukari Local Government Area. Source: Field Survey, 2026

$R^2 = .424$ (42.4%), Adjusted $R^2 = .409$ (40.9%). Note: The original SPSS ANOVA output (Sum of Squares and Mean Square values) for this regression model could not be recovered, as the underlying dataset was subsequently lost. $F(10, 390)$ was therefore recalculated from R^2 using the standard identity $F = [R^2/df1] / [(1 - R^2)/df2]$, yielding $F(10, 390) = 28.708$, $p < .001$, which is internally consistent with the reported R^2 and Adjusted R^2 above. The full ANOVA summary table (Sum of Squares, Mean Square) is omitted accordingly.

Based on the standardised Beta coefficients and their associated significance levels, the statistically significant positive predictors ($p < .05$) of choosing a public healthcare facility are age, distance from the nearest hospital, perceived satisfaction with healthcare services, and public health knowledge. The statistically significant negative predictors are education, socioeconomic income, and occupation. Gender ($p = .218$), religion ($p = .271$), and access to healthcare information ($p = .327$) were not statistically significant predictors in this model.

Discussion of Findings

Healthcare provision in developing nations, including in sub-Saharan Africa, remains a challenge in which both public and private sectors bear responsibility for gaps in quality. However, amid growing demand and shifting expectations, competition between public and private healthcare facilities appears to be intensifying as both strive to meet population needs. Despite continuing debate about government provision of healthcare, underlying issues remain in the public's patronage of public healthcare facilities relative to private ones. The present study examined this concern through a comparative assessment of public and private healthcare patronage in Wukari Local Government Area, focusing on the areas of difference in healthcare provision observed by residents.

The findings show that a majority of respondents (65.1%) have their nearest healthcare facility at a distance of 5 kilometres or more, while 24.9% have a facility within 1 kilometre and 10.0% within 1–2 kilometres. This suggests that the spatial distribution of government healthcare facilities is insufficient, consistent with other studies (Amoah-Nuamah, Agyemang-Duah, Ninorb, & Ekeme, 2023), and is likely affecting public perception and use of public healthcare facilities relative to private ones. A majority of respondents (39.9%) reported being satisfied with the healthcare services received, while 35.2% were neutral. Although the data do not identify which specific facility type respondents were referring to, earlier studies (Basu, Andrews, Kishore, Panjabi, & Stuckler, 2012) found greater public support for private healthcare facilities on account of perceived service quality, suggesting that residents of Wukari Local Government Area may similarly be more favourably disposed toward private providers.

A majority of respondents (44.9%) rated the quality of healthcare services as somehow good, with reservations, while 25.2% rated it as not good at all, 24.9% as fairly good and encouraging, and 5.0% as very good and satisfactory. Quality healthcare, according to the World Health Organisation (2025), is the degree to which health services increase the likelihood of desired outcomes, aligning with current professional knowledge while prioritising patient needs and preferences, captured through process measures such as adherence to clinical guidelines, outcome measures such as mortality and readmission rates, and patient-centred measures such as satisfaction and timely access. Consistent with the Health Belief Model's emphasis on perceived barriers and perceived quality as drivers of health-related choices, the relatively guarded ratings recorded among respondents in Wukari Local Government Area suggest that perceived quality is not yet a strong enough motivator to shift preference decisively toward either provider type.

The study also examined whether there is a difference in the perceived performance of public and private healthcare providers, tested using an independent-samples t-test. The results show a statistically significant difference in perceived healthcare quality between users of private healthcare facilities ($M = 2.5027$, $SD = .76125$) and users of public healthcare facilities ($M = 2.2439$, $SD = .97178$); $t(436.70) = 3.523$, $p < .001$, leading to rejection of the null hypothesis that there is no significant difference between the perceived performance of public and private healthcare providers in Wukari Local Government Area. This finding is consistent with other studies (Bawuah, Appleton, & Li, 2024; Valls Martínez, Ramírez-Orellana, & Grasso, 2021), which similarly found that users of private and public healthcare facilities differ in their perceptions of healthcare quality and performance.

Finally, the study examined the predictors of choosing a public healthcare facility. As shown in Table 8, the statistically significant positive predictors were age, distance from the nearest hospital, perceived satisfaction with healthcare services, and public health knowledge, while the statistically significant negative predictors were education, socioeconomic income, and occupation. Age as a positive predictor of choosing public healthcare facilities may reflect the fact that older residents are generally more attuned to government-run services than younger residents. Distance from the nearest facility also plays a role: in emergency-driven healthcare-seeking behaviour, which characterises much of healthcare use in this context, the nearest facility often becomes the default choice regardless of ownership type, consistent with other studies. Similarly, when a facility's services are perceived as effective and responsive to patients' needs, it becomes the preferred choice, which helps explain perceived satisfaction and public health knowledge as positive predictors. Conversely, education and socioeconomic income as negative predictors suggest that greater health literacy and greater financial capacity are associated with a preference for private, rather than public, healthcare facilities, consistent with the Health Belief Model's proposition that perceived benefits and reduced perceived barriers (in this case, the financial and informational capacity to access private care) shape health-related choices.

Conclusion and Recommendations

Healthcare provision in Nigeria is generally perceived as poor, though the growing role of the private sector has emerged as a source of competition that is shaping public choice between provider types. In Wukari Local Government Area, the findings point to a statistically significant difference in the perceived quality of public and private healthcare facilities, with that choice further shaped by perceived quality of services, distance from healthcare facilities, education, socioeconomic income, occupation, and public health knowledge. These findings suggest that closing the perception and performance gap between public and private healthcare facilities in Wukari Local Government Area will require deliberate policy attention rather than reliance on competitive pressure alone.

Based on the findings, the study recommends the following:

1. Policy implications: government health authorities in Wukari Local Government Area should prioritise reducing the distance between residents and the nearest public healthcare facility, given its role as a significant predictor of facility choice.
2. Practice implications: public healthcare facilities should invest in visible, patient-centred quality improvements, since perceived satisfaction and perceived quality were closely linked to facility preference in this study.
3. Public health knowledge: given that public health knowledge was a significant positive predictor of choosing public healthcare facilities, community-level health education campaigns may help improve the standing of public healthcare providers among the population.

4. Future research: subsequent studies should collect data using instruments with validated Likert-scale items and should reconcile facility-level and respondent-level sample sizes in advance of analysis, to avoid the discrepancies between reported N and test-specific df encountered in this manuscript.

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