Research on Humanities and Social Sciences
ISSN 2222-1719 (Paper) ISSN 2222-2863 (Online)
Vol.3, No.16, 2013

Inequality and Class Difference in Access to Healthcare in Nigeria

Demsy Terwase Audu[1]*; Takim Asu Ojua, PhD[1]; David Gever Ishor, PhD[2] and Christopher Azaager Abari[3].
1. Department of Sociology, University of Calabar, Calabar-Nigeria.
2. Department of Sociology, Federal University Lafia-Nigeria.
3. Department of Sociology, Benue State University, Makurdi-Nigeria.
* E-mail of corresponding author: demsyaudu@gmail.com.

Abstract
The paper examines inequality and social class differences in the provision and access to healthcare in Nigeria. The paper shows that the inequality and class differences in access to health are by and large associated with the erroneous conception of health in terms of its curative potency as against the preventive by the bourgeois class. Furthermore, a large part of the paper concentrates on the discussion of inequality in the provision of health care facilities in Nigeria, while at the time pointing to the regional and rural-urban inequalities and the consequences thereof. The paper concludes that there is a class divide and inequality in the provision and access to healthcare in Nigeria.
Keywords: Inequality, class difference, access, healthcare, Nigeria.

1. Introduction

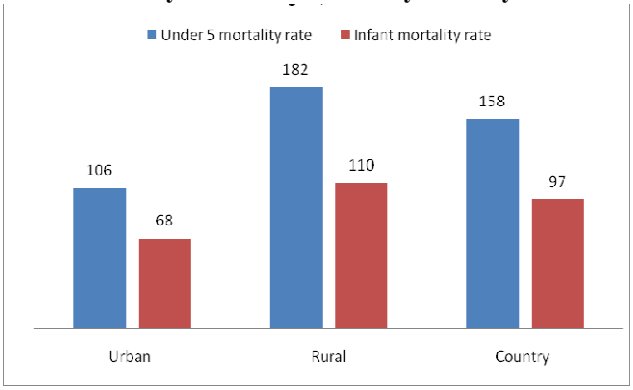
This paper examines social class differences in healthcare provision and access to healthcare in Nigeria. The paper began with the assumption that class is an important point in the discussion of health and illness. The paper is further premise on the viewpoint that even disease is not evenly distributed amongst the population in any given society. Certain people are more prone to sickness and death than others. This indicates that where individuals are situated in the stratification order of society determines the range of conditions that they contend with (Alubo, 2008). Individuals may encounter similar illness but the experiences and manner in which they respond to such illness differ. While some may seek the professional assistance of a physician, others may attempt self-care or dismiss the symptoms as not needing attention. The reason for defining other symptoms as not needing attention is more common among the poor in society. The poor are more likely to under-utilise health services because of the financial cost and or the culture of poverty (Cockerham, 2007).

This means that in order to understand illness and how individuals react and respond to them, such individuals' socio-economic, physical and mental environment that resulted to the pain and illness condition in the first place must be taken into consideration. This is because ill health is often determined by one's relationship to the means of production, with a fundamental division between workers and owners. This view was long pointed out by Engels in his classic work "*The Conditions of the Working Class*", in which he showed the linkages between the Industrial Revolution, the capitalist mode of production and ill-health. Engels clearly showed how disease was triggered via the rapid growth of an alienated, urban dwelling hoi polloi whose lives were typified by a lack of sanitation, hazardous working condition, poor and congested housing, inadequate nutrition, and poverty. Hence, individual's socio-economic status has the most reflective pull on health and illness.

In this paper, we maintain that illness behaviour is shaped by individual's position in the social structure of society. Our argument is anchored on the understanding that health in Nigeria is obscure because of its emphasis on medical cure as a substitute to medical care. Second, there is a huge inequality in healthcare provision amongst class and among geo-political zones in Nigeria. Thirdly, health indicators shows that life expectancy at birth is low, 47 for males and 52 for females, and the probability of under-5s' mortality is 158 per 1,000 live births. Maternal mortality is among the highest in the world at 545 per 100,000. In some states it's as high as 1,500 per 100,000 live births (National Bureau of Statistic, 2011).

Nigeria has a large number of children under the age of five suffering from severe to moderate malnutrition, with an estimated 43 per cent of children suffering stunted growth. Furthermore, there is growing problem of HIV/AIDS as well as a significant rise of other non-communicable diseases. The adult HIV rate was 4.1 per cent adults in 2012. In the same, there were 217,148 deaths from AIDS (National Agency for the Control of AIDS, 2012). Coupled with this is the lack of a structured healthcare system and the issue of medical brain drain which sees many of the country's top brains move abroad in search of higher income and better lives for themselves and their families – this has contributed to a dearth of trained human resources. In such circumstances, it is the poor and socially disadvantaged that bear the brunt of Nigeria's iniquitous health system. At least 70 to 75 percent of health expenditure comes from out of pocket expenses. The wealthy and middle classes either have access to private or insurance based healthcare access, or will travel overseas to access it.

Figure 1. Under -5 mortality and infant mortality rates by urban and rural areas



Source: National Bureau of Statistic, 2011.

Moreover, human development index puts Nigeria at an abysmal state. Nigeria is in the 153rd position according to the ranking, thereby categorising it under countries described as having a low human development indices. Despite being described as the giant of Africa and the 6th largest oil producer in the world, Nigeria's human development index was ranked behind Namibia (which had a medium human development index) Congo (with long years of ethnic conflicts), Kenya, Angola and Cameroun (UNDP, 2013).

2. The Conception of Health in Nigeria

The importance attached to health in Nigeria is overwhelming as indicated by various dictum: "Health is wealth"; "A healthy nation is a wealthy nation", etc (Alubo, 2010). Alubo further stated that this importance is also reproduced in the way people greet themselves and in the annual budgets of both the state and federal government. The proper functioning of a society depends largely on how healthy its members are; a major social concern. In all historical epochs, human societies have evolved institutions, which provide health and medical services for the prevention and treatment of diseases whenever sickness occurs. All these are geared towards the promotion of overall health and well being of citizens.

This ability by human society to evolve mechanisms for the treatment of illness differs from one society to the other and from a particular historical epoch to the next. Several factors accounts for these variations, but one factor remain distinct; the definition associated with what constitutes and causes disease and illness among individuals' or groups. The allocation and management of health resources largely depends on the definition a society attributes to the concept of health, illness and diseases. Prior to colonialism, Nigeria had its definition and conception of health which was altered through the process of colonization. This form of medicine that was introduced into Nigeria was yet to reach its advanced stage when Nigeria gained her independence from Britain (Ityavyar, 1988).

The dominant explanation of this new form of medicine was anchored on the germ theory of disease causation. Hence, sickness is attributed to pathogenic micro organisms of which diagnosis largely, consist of identifying the disease agent and its further removal through surgical remedy or cure. With this conception in mind, the human body became an object of study and observation in order that physiological processes could be demystified and brought under medical control (Cockerham, 2007). As a result, disease was no longer considered an entity outside the boundaries of knowledge, but an object to be studied, confronted and control scientifically. This conception of medicine, obscure the origins of suffering and prevent people from understanding the sources of poverty and disease. This was the case with developed economies, in that the modernisation of medicine and healthcare delivery served the purpose of the upper class by creating a huge market for their manufactured drugs and hospital equipment. Moreover, this path to the modernization of healthcare development seemed replicated among underdeveloped countries of the world. As Mburu pointed out:

> The poorer ... countries have tended to copy both the philosophy and development priorities of the developed world, even though their problems and population structures are different. In following the health delivery trends of the technologically sophisticated societies, African countries have so far failed to make their health system effective, let alone efficient. Clearly, the system does not fit the population (quoted in Alubo, 2010).

The explosion of scientific knowledge and the sophistication and complex medical diagnosis and treatment that further ensued reached the status of determinants of diagnosis rather than aids. Increasing public demand for medical services brought about an increase in the cost of health care, the expansion of service delivery and the movement from treating patients in hospitals. Thus, treatment is more directed towards the scientifically defined symptoms rather than the person as a whole. Consequently, patients are simply discharged as 'cured' because their blood pressures are defined as being within 'normal' limits, despite the fact that they still complain of the

feelings of illness that first took them to the doctor in the first place. This mechanistic nature is associated with illness in the modern world, even when cure seem impossible, doctors are willing to keep the person in the hospital simply because of the economic gain they derive from the person's presence in the hospital.

This uncertainty in the medical context has consequences for the increasing cost of medical services. For this reason, Mechanic argued, there is a professional norm to treat the patient without regard to the patient's ability to pay. Physicians therefore take actions in the interests of their clients without significant consideration of the cost or long-term economic consequences of medical treatment. And in the long-run patients are taken hostage in hospitals because of their inability to settle their bills.

Importantly also is the issue of cure and care, with the former given more attention in terms of investment. This, Alubo argued is a deliberate ideological strategy of the capitalist system. In the same vein Navarro and others (quoted in Alubo, 2010) long argued that the capitalist system reduces the problems of political and economic origins to medical problems... this they do in order to make people believe that structural problems can be resolved through the individualist approach of modern medicine. Thereby diverting people's attention from the poverty and deprivation state in which the capitalist system has put them in the first place. This modern capitalist inverted manner and nature in which health is conceived particularly by the ruling elites goes a long way in influencing the inequality associated with healthcare provision in Nigeria, to which we now turn.

3. Inequality in Healthcare Provision and Access

The system of health care delivery in Nigeria seems complex. The complexity is evidence in the disparity in which healthcare facilities are provided by the government. With a so-called public funded system of healthcare, one should expect the availability and free at the point of use, but this is not the case in reality. Furthermore, irrespective of the problem of provision the situation with regard to access is further complicated by the fact that majority of Nigerians including the poor pay for healthcare from their private pockets. But before we continue, let us understand how the healthcare system in Nigeria functions.

In Nigeria, there exist different types of facilities, levels, providers and the types and ways through which services are provided. But, one of the major problem associated with the Nigerian health system is her health financing. For example, the World Health Organisation (2011) sees health financial as concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively in the health system. Hence, the system is expected to be structured in a way that even the poorest in the remote villages should be able to receive needed care without worrying about the cost, which is the hallmark of an equitable and fair health system (Shobiye, 2012). It is also important to state that utilization of healthcare is not the same thing as access. Access is a complex (and contested) concept (Culley, 2009), which entails need, demand and supply. Hence, an equitable service requires the provision of equal access for equal need (Aspinall and Jacobson, 2004). Evidence on class differences in 'need' for healthcare services (considered as prevalence), as we have seen, is unclear. The evidence on supply of healthcare facilities certainly suggests restricted access to many forms of services in government owned hospitals, although the 'supply' in the independent sector is abundant and instantly available for those who can afford it.

Healthcare in Nigeria is paid for through different mechanisms – allocation from government's budget; through out-of-pocket payments; via health insurance (social and private) and through external funding. In Nigeria, majority of health care is privately financed. Private expenditure on health as a percentage of total health expenditure was 63.3% (WHO, 2011); that is about two-thirds of the total amount spent on health care. And out of this, prepayment through private health insurance plans is only 3.1% and a huge 95.4% is paid out-of-pocket (Shobiye, 2012). This means that at the time of access a large percentage of Nigeria including the poor pay for health care out of their pockets. Hence, as Ityavyar argued:

> In the capitalist philosophy, public goods (*healthcare*) are implicitly dictated by the market, i.e. price determination. Access to any service such as health, education, transport etc, is strictly based on ability to pay. In the first place, supply of any service comes from owners of the means of production who accumulate and sell in order to maximise profit (Ityavyar, 1988:1224, emphasis mine).

Our position here is that this out-of-pocket payment for healthcare services put majority of Nigerians in a great deal of financial risk and further restricts their direct access to healthcare when needed. Majority are compelled to sell their personal possessions and effects and are further indebted in their search for health. Consequently, this private out-of-pocket payment has created a barrier for many and is therefore not equitable in providing care to all Nigerians, thus inequality. As a result, Ityavyar argued that:

> As its prominent feature, social inequality is but another expression of class configuration engendered by capitalism. Unequal access to social services only reveals the fundamental contradictory logic of capitalism... for the poor majority have no access to the means of production and service that is founded on the logic of profit... the fundamental basis of social

inequality (Ityavyar, 1988:1224).

From the foregoing there, it can be deduced that inequality in access to health services in Nigeria tend to assume that everyone has an occupation, whereas increase in unemployment and early retirement seems to be the case in Nigeria and hence an increasing number of men and married women who do not have a paid job and thus the necessity to consider to which occupational class they should be assigned. Similarly, despite the growth and expansion witnessed over the years in Nigeria, structural changes and the inequalities associated with healthcare of the colonial period have remained unaltered even though more hospitals and trained manpower seem available. This private driven idiosyncrasy of the bourgeois class and out-of-pocket payment for healthcare services in Nigeria was further compounded with the overture of Structural Adjustment Program (SAP), thereby locating healthcare under the capitalist ideological frame of profit accumulation. This explains why most of the modern hospitals only spread in areas of anticipated high profit and thus, the urban – rural and geopolitical disparity in the distribution of healthcare facilities.

Table 1. Distribution of healthcare facilities by tiers in Nigeria's Geopolitical Zones in 1999.

Geo-political zones	Primary			Secondary			Tertiary		
	Private	Public	Total	Private	Public	Total	Private	Public	Total
South-West	1,290	1,848	3,138	191	253	444	0	6	6
South-East +	1,195	617	1,812	515	36	551	0	6	6
South-South ++	680	1,259	1,939	490	145	635	0	7	7
North-Central	1,882	3,099	4,981	195	209	404	1	3	4
North-East	333	2,126	2,459	20	80	100	0	2	2
North-West +++	364	3,235	3,599	37	104	141	0	4	4
Total	**5,744**	**12,184**	**17,928**	**1,448**	**827**	**2,275**	**1**	**28**	**29**

Source: (National Health Management Information System, in Erinosho, 2005)

\+ Excluding data for Anambra and Ebonyi States.

++ Excluding data for Cross River state.

+++ Excluding data for Kebbi state.

From the above figures, States in Nigeria with urban status like Lagos, Abuja etc enjoy more patronage than those with rural status like Jigawa state. Consequently, all the private hospitals are located in urban centres where anticipated profit accumulation is the basic aim for establishment from the first instance. For example, the South-West that have a more urban outlook than rural has more general hospitals. Furthermore, tertiary hospitals are located more in the South-West, South-East and South-South also with a more urban than rural settlements. This urban – rural and geopolitical zone dichotomy is a capitalist ideology of demand and supply with profit accumulation as the base and therefore has tremendous influence on the structural distribution of health care facilities.

The result of health inequality (table 1) indicates that health inequality is prevalent in the Northern region of Nigeria. Statistics indicates that households in the North have the highest incidence of poverty, since most of the poorest states are in this region. This therefore means that the amount of resources that can be spent on accessing health care service delivery centres is limited. Hence, healthcare provision in Nigeria is aimed at serving only those who can pay for the services as is the case in advanced economies where the forces of demand and supply are given a free rein, and the government interfering minimally by simply providing the policy thrust.

Table 2. Hospital beds by types of hospital [1990].

Type of Hospital	No of Bed	Proportion (%)
General Hospital	56,688	53.0
Maternity	20,370	19.0
Teaching	7,130	6.7
Orthopaedics	733	0.7
Others 2	22,025	0.6
Total	**106,946**	**100.0**

Sources: Adebanjo and Oladeji, 2006.

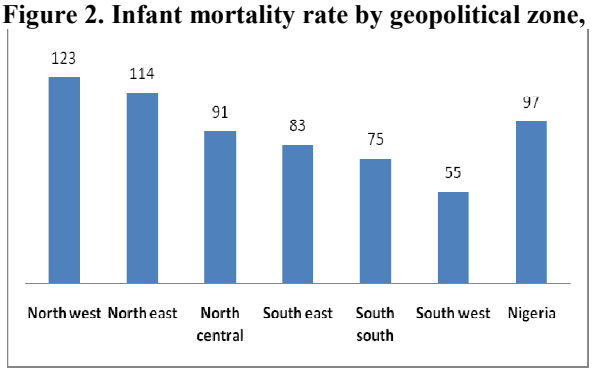
Table 3. Key health personnel in Nigeria in 2002.

S/N	Health Personnel	Number	Percentage
1	Physicians	34,923	9.40
2	Nurses and Midwives	210,306	56.60
3	Dentists and Technicians	2,482	0.67
4	Pharmacists and Technicians	6,344	1.70
5	Environmental and Public Health Workers	n.a.	n.a.
6	Laboratory Technicians	690	0.16
7	Other Health Workers	1,220	0.33
8	Community Health workers	115,761	31.14
9	Health Management and Support	n.a.	n.a.
Total		**371,726**	**100.00**

Source: World Health Organisation (WHO), 2006.

From the above table 2, it can be seen that the bed-population ratio is abysmal in that the available bed space in all the general hospital cannot serve the urban population alone let alone the majority who are resident in rural communities. Also, the doctors-patient ratio is very poor in that as at 1999 there were only two (2) physicians available to service the public hospitals and attend to patients. This calculation does not include the private primary, secondary and tertiary hospitals in Nigeria. Furthermore, the inclination of recent shows that apart from primary health workers and in some cases nurses and midwives who may likely work in the rural areas and partly in general hospitals, majority of physicians prefer to work mainly in the urban centres where there is the available of most of the social amenities.

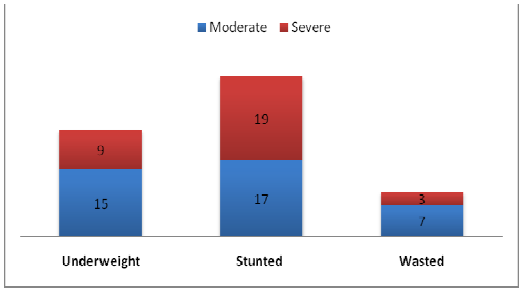
Figure 2. Infant mortality rate by geopolitical zone, 2011.



Source: National Bureau of Statistic, 2011.

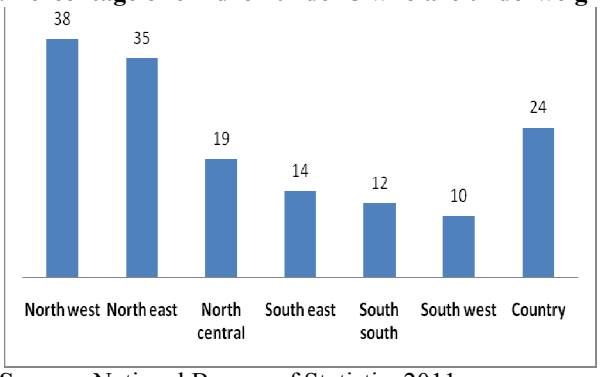
It is therefore not surprising that infant mortality across the six (6) geopolitical zones show obviously this inequality in health as infant and under-5 mortality rates are lowest in the South-West zone with 55 per thousand live births respectively while for North West, rates are 123 per thousand live births (Fig. 2). Furthermore, the key indicators for monitoring the nutritional status of a child under 5 are underweight, stunting and wasting (Fig 3 and 4). In Nigeria, 24 percent of children under 5 are underweight (9 percent severely), 36 percent are stunted (19 percent severely) and 10 percent are wasted (3 percent severely). Malnutrition rates in the North West and East regions are higher than in the South (Fig 4). Children in rural areas are more likely to have nutritional deficiencies than those in urban areas with 19 percent underweight as against 31 percent.

Figure 3. Percentage of children under 5 who are underweight, stunted, and wasted, Nigeria, 2011.



Source: National Bureau of Statistic, 2011.

Figure 4. Percentage of children under 5 who are underweight, by Geo-political zone, Nigeria, 2011.



Source: National Bureau of Statistic, 2011.

These inequalities in health care provision in rural-urban areas and as reflected in the various geo-political zones as can be seen in the chart above arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. This conditions are shaped by political, social and economic forces (Graham, 2007), and in that way undermines the overall health interest of the common people. Little wonder, emphasis is always on the curative than preventive healthcare as earlier mentioned elsewhere. This is because the curative serves the elite, whereas the preventive serves the poor (Erinosho, 2006).

4. Conclusion and Recommendations

Understanding differences in access to healthcare is highly complex. This is because services can be needed, but neither demanded nor supplied; they can be both needed and demanded but not supplied and they may be both needed and supplied, but not demanded (Smaje and Field, 1997). In Nigeria, the evidence suggests that healthcare is limited in rural and semi-urban slums where majority of the poor who cannot pay for capitalist modern healthcare resides. The limited availability of health care facilities in such areas hinders people in the lower strata of society from seeking medical care. Hence, this group of persons have been forced to contend with higher morbidity and mortality rates of almost every disease or illness. Beside, individuals' ability to access healthcare in Nigeria is correlated with such individuals' ability to pay for such services. Furthermore, the distribution of healthcare infrastructure is highly urban particularly in major cities of Nigeria where residents have the ability to pay for the services. This is evident in the way and manner health care facilities are distributed on the basis of urban and geo-political zones within the country and a flare for curative rather than preventive. Furthermore, inequalities in health stem from the conditions of life in which people are placed under and this further affect people's ability to respond to illness. This conditions in which individuals are placed are further shaped by political, social, and economic structures.

Based on the foregoing therefore, it is important for the government the primary prevention of disease in addition to those approaches that merely focus on treatment of the sick. Such preventive approaches must involve community and environmental interventions rather than one-to-one preventive encounters. Hence, the liberal class must pay increasing attention to the role of political, social and economic structures that influences the provision and access to healthcare, as espouse by Marx in the distribution of resources in the society and further enlighten the masses to challenge this inequality through mass protests. Furthermore, a new health strategy to break the cycle of ill-health due to poverty and deprivation must be put in place by the Nigerian government. National health financing systems need to be pro-poor if healthcare targets are to be met. Hence, as Bennett and Gilson (2001) stated, such systems should therefore incorporate three important dimensions: they should ensure that contributions to costs of healthcare are in proportion to different households' ability to pay; protect the poor from financial shocks associated with severe illness; and enhance the accessibility of services to the poor.

References

Adebanjo, A.A. and Oladeji, S.I. (2006), "Health Human Capital Condition: Analysis of the Determinants in Nigeria', in Falola et al., (eds.) *Traditional and Modern Health Systems in Nigeria*. Trenton and Asmara: Africa World Press.

Alubo, S.O. (2008), "Ontological Response to Illness in Africa". *Jos Journal of Social Issues*, 6, 1-23.

Alubo, S.O. (2010), "In Sickness and in Health: Issues in the Sociology of Health in Nigeria". *University of Jos Inaugural Lecture Series*, 41, March 19, 2010.

Aspinall, P. and Jacobson, B. (2004), *Ethnic Disparities in Health and Healthcare*. London: Department of Health,

Bennett, S. and Gilson, L. (2001), *Health Financing: Designing and Implementing Pro-Poor Policies*. London: DFID Health Systems Resource Centre.
Cockerham, W.C. (2007), *Medical Sociology* (10th edition). New Jersey: Pearson.
Culley, L. (2009), "Dominant narratives and excluded voices: Research on ethnic differences in access to assisted conception in more developed societies. In Culley, L. Et al., (eds), Marginalized reproduction: Ethnicity, infertility and reproductive technologies. London: Earthscan.
Erinosho, O.A. (2005), *Sociology for Medical, Nursing and Allied Professions in Nigeria*. Abuja and Ijebu-Ode: Bulwark Consult.
Erinosho, O.A. (2006), *Health Sociology for Universities, Colleges and Health Related Institutions*. Abuja: Bulwark Consult.
Graham, H. (2007), *Unequal Lives: Health and Socio-Economic Inequalities*. New York: Open University Press.
Ityavyar, D.A. (1988), "Health Services Inequalities in Nigeria", *Soc Sci. Med.* 27(11): 1223-35.
Leonard, K.L. & Leonard, D.K. (2004), "The Political Economy of Improving Health Care for the Poor in Rural Africa: Institutional Solutions to the Principal-Agent Problem". (Online) 14th January 2010. Available from: http://www.highbeam.com/doc/1G1118034882.html**.**
National Agency for the Control of AIDS (2012), *Global AIDS Response Country Progress Report – Nigeria*. Abuja: FG Printers
National Bureau of Statistic (2011), *Nigeria Multiple Indicator Cluster Survey 2011Summary Report.* ABUJA: FG Printers
Shobiye, H. (2012), Paying For Health in Nigeria Part One. (Online) 29th August, 2013. Available from: http://nigerianstalk.org/2012/05/07/paying-for-health-in-nigeria-part-1/.
Smaje, C. and Field, D. (1997), "Absent minorities? Ethnicity and the use of palliative care services", in Field et al., (eds) *Death, gender and ethnicity*. London: Routledge.
UNDP (2013), *Human Development Report 2013*. New York: UNDP.
WHO (2006), *Country Health System Fact Sheet (Nigeria).* Geneva: WHO.
WHO (2011), *World Health Statistics 2011*. Geneva: WHO.