

# The Dilemma of Equity and Social Exclusion in Health Care Delivery Services in Nigeria

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## *Abstract*

*Health is a fundamental human right and the attainment of the highest possible level of health is a most important worldwide social goal. The provision of quality, accessible and affordable healthcare therefore remains an important issue globally. However, there is no denying in the fact, that Nigeria's healthcare index is very poor, and that the people are suffering as the healthcare policies and programmes in the country are implemented in a way that those at the lower socio-economic strata of society suffer exclusion. Consequently, the healthcare delivery system in Nigeria is largely hinged on individual's ability to pay rather than on needs. This article argues that Nigeria's national health care delivery indices can only be improved if services are available, accessible and affordable.*

**Keywords:** health, equity, human rights, health care, social exclusion

## **Introduction**

According to the World Health Organization [WHO] (1946), health is “a state of complete physical, social and mental wellbeing and not just the absence of disease and infirmity.” The centrality of health to national development is very clear, as improving health status and increasing life expectancy contribute to long-term economic development. Upon this reality, Alubo (2012) submits that health is a much-valued concept, eulogized in Nigeria variously as being wealth, and a healthy nation is a wealthy nation. He explains further that Nigeria's appreciation for health is seen from common daily greetings between neighbours across different cultures. Often, the daily greetings are occasions to ask after the health of family members of both parties.

Reiterating the importance of health in human societies, Rice and Smith (2001) stress that among the many objectives set for health care systems by policy makers, the pursuit of concepts such as equal access to health care, or equal health outcomes, frequently play an important role. The prominence of such objectives suggests that a concern with equity is an important element of the ethical bases underlying the design of health care systems. Access to health care provision in many societies, however, is often as challenging as the struggle for subsistence. This is so because of the constant struggle for necessities, control of assets and the perpetual efforts at building up a reverse against contingencies (Raheem, 2006). Equally crucial is the health outcomes. By outcomes, it means usual indices (such as infant and maternal mortality, life

expectancy, etc) among the population. Regardless of which aspect of health inequality is the focus of concern, there is growing international recognition that health and well-being are the products of many, factors and that a sophisticated understanding of the social determinants of health is essential for the development of public health policy.

Alubo (2012) argues that health is fundamentally rooted in the structures of power, privileges and what people have access to, as well as what they need but do without. Thus, the human right to health care is clearly linked to the rights to life and non-political freedom. Health care is either life preserving or serves to alleviate or eliminate sickness or suffering, which are barriers to our ability to develop fully as human beings.

This article argues on the premise that health care provisions and services in Nigeria are not based on the needs of consumers, rather, they are based on consumer's ability to pay. In other words, the issues of equity and social inclusion principles are not watchwords in the provision of health care services to the poor populace across the country. This has further led to denial of majority in terms of affordability and accessibility to quality health care services. The problem is further compounded with massive unemployment in the country, which has exposed the larger members of the population to various health risks and challenges. It is further stress that social inequalities among Nigerians lead to unequal health outcomes. It is also argue that health institutions, and in particular; the method of health financing in the country, could feed inequality back into the social space and exacerbate the existing inequalities and impede the social capacity to care.

Based on the premise above, the article is divided into five sections. Following immediately is the platform and objectives for health equity and right to health in Nigeria; the third section examines the theoretical explanations of inequality and social exclusion in Nigerian health sector. In addition, section four discusses meanings and manifestations of inequalities and social exclusion in health care services in Nigeria; while the last section is the conclusion; towards agenda for health equity and social inclusion in Nigeria.

### **Platform and Objectives for Health Equity and Rights to Health in Nigeria**

The Universal Declaration of Human Rights [UDHR] (1948) states that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services' (Art 25.1). The UDHR states that:

*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.*

The World Health Organization, in its Constitution, also attests to a right to the “highest attainable standard” of health. At the most basic level, “right” means that government guarantees something to everyone. Thus, the right to health is a right to an *effective and integrated health system*, encompassing healthcare and the underlying *determinants of health*, which is responsive to national and local priorities, and accessible to all’ (United Nations, 2006: 7).

Ataguba and Akazili (2010) further reported that the 58th World Health Assembly held in Geneva, Switzerland on May 16-25, 2005, draw the attention of developed and developing countries towards ensuring universal access and coverage in health services provision. In recognition of the importance of universal coverage and equity in health services provision, the WHO proposed at the 2010 World Health Assembly issues that will address financing of health in enhancing universal coverage.

Appreciating the importance of health, National Health Policy targeted at achieving health for all Nigerians was promulgated in 1988. Its objective was to provide the population with access to Primary Health Care (PHC) as well as to secondary and tertiary care through a functional referral system. The policy regarded PHC as the key to attaining the goal of health for all the people in Nigeria. Essentially, PHC services include health education, adequate nutrition, safe water and sanitation, reproductive health, including family planning. Others are immunization against six major childhood diseases (diphtheria, tetanus, pertussis, measles, poliomyelitis, tuberculosis and hepatitis B) and provision of essential drugs and disease control (Adegboyega, 2012).

There was a comprehensive review of the 1988 policy into a new policy tagged the *Revised National Health Policy*, launched in 2004. The overall objective of the policy is to strengthen the national health system in order to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians and facilitate the achievement of the health-related MDGs (Federal Republic of Nigeria, 2004). The revised policy also regards PHC as the framework to achieve improved health for all in Nigeria.

In spite of the laudable health objectives contained in the policies and initiatives, the performance of Nigeria on essential health indicators and PHC services, which is adjudged the key to the attainment of the “health for all” policy objectives has not been satisfactory. Available statistics indicate that Nigeria has some of the worst indicators of maternal health in the developing world. For instance, 62% of births in Nigeria occur at home. A skilled health worker assisted only 39% of births and 56% of women would not receive any postnatal care (NPC & ICF Macro, 2009). An estimated 50,000 Nigerian women die each year from complications associated with pregnancy and childbirth, thus accounting for 10% of global estimates of maternal deaths. Twenty percent (20%) of global estimates of abortion-related deaths and 40% of obstetric fistulas occur in Nigeria (Health Reform Foundation, 2006).

### **Theoretical Explanations of inequality and social exclusion in Nigeria Health Sector**

This section examines the impact of theory in the effective analysis of the topic under review. This is done to properly situate the nexus between inequality and social exclusion as prevalent in the country and their impacts on health care delivery service in Nigeria. In this regard, this paper adopts social exclusion theory to provide a sociological explanation to the subject matter.

The social exclusion theory builds on the evidence that the causes of poverty and inequality are embedded in the structures of social systems and relationships – in exclusionary process – and not in individual inadequacies (Social Exclusion knowledge (SEKN, 2008). In the light of this, Sen (2000) argues that social exclusion's emphasis on relational features in the deprivation of capability is of particular value, as this highlights the relationship between poverty and inequalities in societies.

SEKN (2008) defines social exclusion in the following ways:

*Exclusion consists in the dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions-economic, political, social and cultural and at different levels including individual, household, group, community, country and global levels.*

According to SEKN (2008), social exclusion processes result in a continuum of inclusion/exclusion characterized by inequalities in:

1. Access to resources (means that can be used to meet human needs).
2. Capabilities (the relative power people have to utilize the resources available to them).
3. Rights.

This continuum results in health inequalities. Social exclusion influences health directly, through its manifestations in the health system, and indirectly, by affecting economic and other social inequalities that influence health. These inequalities contribute to social exclusion process, creating a vicious circle.

Social exclusion can be a useful concept for exploring why certain population groups may be more at risk of poverty and associated health inequities. World Bank studies for Eastern Europe and Central Asia, cited in Alam, et al. (2005), found that when looking beyond national averages, certain characteristics can raise poverty risk above average. These include being young, living in a rural area, being unemployed and having low levels of education (Eurostart, 2010). There is also evidence that certain social groups suffer considerably higher rates of poverty. These include the refugees and internally displaced persons and disabled and institutionalized people (Alam, et al., 2005). These 'vulnerable groups' are more exposed to adverse living conditions that result in health inequities. Many of these groups are identified as

suffering a markedly greater burden of mortality and disease (European Commission, 2009).

The theory argues further that increased unemployment leads to a drop in income for many households, exposing them to poverty and increased debt. With the number of unemployment rising and the number of job vacancies falling, competition for jobs have increased. The rise in unemployment has direct and indirect effects on the health of workers (Benach, 2010). Anxiety from unemployment can also lead to mental health problems and coping strategies with diverse health consequences. For example, Popov (2009) submits that unemployment-related stress was the main factor behind the adult male mortality crisis in the Russian Federation during the transition. Layoffs are associated with a higher risk of heart attacks and other stress-related illness in the short term. In the long term, the mortality rate of laid-off workers is higher than that of comparable workers who kept their jobs (IMF/ILO, 2010).

Relating the arguments above to the health services discourse in Nigeria, it is worthy of note that the prevalence of abject poverty among the larger population coupled with massive youth employment exposed the poor masses to health crises and by extension social exclusion. In Nigeria today, the health care system does not provide better opportunity and platform for people at the lower strata (the poor, unemployed and rural dwellers) to access effective and qualitative health care services. The problems of poverty and chronic unemployment in the country have made it very difficult for common person to enjoy good living conditions such as better housing, balanced diet and health education towards healthy living. The 2008 Nigeria Demographic and Health Survey as reported by NPC and ICF Macro (2009) indicates that the percentage of the population living in the bottom 20% of the wealth index ranges from 5.2 in all three southern zones to 20.6% in the North-Central, 31.9 in North-West, and 47.4% in North-East. The percentage of the population in the wealthiest quintile is 32% in the South, 13.8% in North-Central, 7.6 in North-West, and 3.2% in North-East.

### **Meanings and Manifestations of Inequalities and Social Exclusion in Health Care Services in Nigeria**

Health inequality designates differences, variations, and disparities in the health achievements of individuals and groups. Asada (2010) defines health inequalities as summary measures of the population's health associated with individual- or group-specific attributes (e.g., income, education, or race/ethnicity). The root causes of inequalities in health are the complex interaction between personal, social, economic and environmental factors (Marmot and Wilkinson, 1999). Health inequalities are a kind of social inequality. Social inequalities are also seen in areas such as employment and work conditions, education, and access to social protection, housing and participation. Inequalities tend to reproduce themselves over time and across generations, creating inequality traps (World Bank, 2005).

The extent of health inequalities is typically proportionate to the level of disadvantage, with populations experiencing poverty and social exclusion having fewer opportunities for health than those in more privileged positions. Health is socially determined. The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. The distribution of power, money and resources at global, national and local levels, which are themselves influenced by policy choices (WHO, 2009), shape these circumstances. Many health researchers regard social position as the fundamental cause of health. This is because it is the pivotal link in the causal chain through which social determinants connect up to influence people's health. Importantly, Mackintosh (2006) argues that health system can feed into and reinforce existing social and health inequalities. Therefore, health inequalities in Nigeria manifest among the poor, the unemployed, and people living in rural areas where health facilities are either unavailable or not functioning, among others.

Advancing the discussions on health inequalities in Nigeria, Olaniyan and Lawanson (2010) observed that there are severe budgetary constraints and uneven distribution of resources among the urban and rural areas with the rural areas mostly affected by inequitable budgetary health expenditure allocation. According to Ichoku and Fonta (2009), Nigeria's health financial arrangement has shifted from health provisioning by government as a normal good towards a competitive market where greater proportion of health services are provided by ability to pay through out of pocket expenses (often referred to as user fee). Furthermore, excessive reliance on the ability to pay through Out-of-pocket payment (OOP) reduces health care consumption, exacerbates the inequitable access to quality care, and exposes households to the financial risk of expensive illness (Onwujekwe *et al.*, 2010; FMOH, 2004).

Contributing to health inequity discourse, Alubo (2012) argues that access to medical care in Nigeria is a class issue. While some can afford the best centres' within Nigeria, including elaborate private hospitals, many more can only afford General Hospitals. Others attend the informal medical sources. These combined sources according to Alubo (2012) apparently add up to 54% of Nigerians recorded as accessing medical care. These arguments corroborate the 2005 reports of the Federal Ministry of Health (FMOH) where it was estimated that 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. It was reported that 38% of these facilities are owned by the private sector, which provides 60% of health care in the country (FMOH, 2005).

Abayomi (2009) further argues that medical treatment is being received in archaic and underfunded hospital infrastructural system where health care personnel work under a prehistoric hospital conditions coupled with lack of proper diagnostic facilities. Report from the WHO (2002) also indicates that most health facilities in Nigeria are poorly equipped and lack essential supplies

and staff, while over one-third of rural health facilities lack electricity. The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage is 23% (NPC & ICF Macro, 2009); only 12% of under-fives sleep under insecticide treated nets (ITNs); 20% of children in urban areas and 14% resident in rural areas with fever are appropriately treated with anti-malaria drugs; contraceptive prevalence rate is 15% and only 39% of women deliver under the supervision of skilled attendants.

There is a growing concern about the economic impact of health care expenditure on households who face illness, particularly in areas where pre-payment mechanisms do not exist and households have to make out of pocket expenditures to use health services. In Nigeria, private expenditure accounts for almost 70% of total expenditure on health of which 90% is out-of-pocket (WHO, 2004). This high level of out-of-pocket expenditure implies that health care can place a significant financial burden on households. Payment for health care is said to be catastrophic when it exceeds a defined level of household income and leads the household to sacrifice consumption of other items that are necessary for their well-being such as shelter or education. For households living close to the poverty line, even low levels of expenditure on health care may be sufficient to tip them into poverty. Based on this premise, WHO Commission on Social Determinants of Health (CREHS) (2010) set the threshold level for catastrophic expenditure ranging from 5% to 40% of total household expenditure that is spent on health. For any given threshold, the study buttressed that we would expect a higher proportion of households in the poorest quintiles to experience catastrophe. On this basis, out-of-pocket health expenditure is seen as a social exclusion especially in Nigeria where the larger percent of the population are living below the poverty line. This in the end enhances health inequity among the larger populace.

Expanding discussion on the subject matter is the intimation of most researchers that the rural areas have several problems. The critical setback to development in Nigeria is the lack of proper and adequate attention to the difficulties faced by the rural regions. Based on this premise, Jegede (2002) observed that the few available health facilities in Nigeria are concentrated in the urban areas at the neglect of rural areas. As a result, the lower class people have no access to qualified physicians, hence the patronage of quack doctors, herbalists and spiritual homes. A cross-sectional survey of health facilities in Shagamu Local Government Area in South West Nigeria by Adelaja (2012) cited in Prata *et al.* (2012), it was found that 67% of the 300 women studied delivered at home, and the majority utilized unskilled attendants. In the study, 86% of all home deliveries used unhygienic surfaces, and most utilized unclean kitchen equipment (such as knives, scissors) for cord cutting, with higher risk of infection for both mother and child.

The above scenarios are indications of health dilemmas (health inequality, social exclusion) and challenges facing large numbers of the Nigerian populace.

**Conclusion: Towards the Agenda for Health Equity and Social Inclusion in Nigeria**

The human development paradigm refers to people's denial of choices and opportunities to lead a life one finds worth living - one that includes material well-being (such as income, education, health and safe water) as well as opportunities to enjoy dignity, self-respect and other basic rights (UNDP, 2007). The Human Development Index (HDI) is a summary measure of average achievements in a country of three basic dimensions of human development: a long and healthy life, knowledge, and a decent standard of living (UNDP, 2008).

It is worthy of note therefore that the citizens right to health is a fundamental pillar of efforts to improve the health of populations experiencing poverty and social exclusion. This right is further expatiated in Article 12 of the International Covenant on Economic, Social and Cultural Rights. It is indicated in the said article that the right to health embraces social factors that promote conditions in which people can lead a healthy life. This includes right to food and nutrition, housing, access to safe and portable water and adequate sanitation, safe and healthy working conditions and a healthy environment (United Nations Economic and Social Council [ECOSOC], 2000). Furthermore, the World Health Organization (2008a) sets out the following four criteria by which to evaluate the right to health;

- a. Functioning public health and health facilities, goods, services and programmes have to be available in sufficient quantity.
- b. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of state party. Accessibility has four overlapping dimensions:
  1. Non-discrimination
  2. Physical accessibility
  3. Economic accessibility (affordability)
  4. Information affordability.
- c. All health facilities, goods and services must be acceptable to users in terms of being respectful of medical ethics, culturally appropriate and sensitive to gender and life cycle requirements, and designed to improve the health status of those concerned.
- d. Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

The primary health care approach, as highlighted by World Health Assembly resolution, is essential for addressing the relationship between poverty, social exclusion and health. The values and principles of primary



health care are equity, solidarity, and social justice, universal access to services, multi-sectoral action, decentralization and community participation. Local health services, which provide the first point of contact with the health system, are especially important for meeting the needs of disadvantaged populations.

In line with the premise above, Horváth *et al.* (2010) submit that the health sector has an important contribution to make to societal development. Therefore, in the process of making updates, Nigerian governments should weigh the short-term costs and benefits (such as savings on social programmes) against long-term ones (eroding the human capital base for human development, for instance). This article concludes that all efforts must be embraced to minimize all the structures and barriers against health equity and social inclusion among Nigerians.

In view of the various factors contributing to health inequality in Nigeria coupled with its potential danger on the socio-economic development of the country, the paper recommends the following:

- a. Government at all levels as a matter of urgency address all form inequalities that contribute to poor health outcomes and utilization among the population. Equity in utilization means that health services and resources should be used according to need, not by people's ability to pay (WHO, 2008a). Poorer people can be disproportionately restricted from using services because of their cost. When this occurs, both utilization and out-of-pocket payments by richer people comprise a greater share of the total. In this case, household survey data on health spending will appear to be more equitable than if the poor and the rich used the services equally and paid the same amounts (WHO, 2008b). Therefore, it is recommended that government at all levels in Nigeria should demonstrate good governance coupled with transparency, accountability and inclusiveness in the management of health resources.
- b. In Nigeria, the existing health insurance (NHIS) is discriminatory and exclusive in nature. Therefore, there is need for alternative health care financing especially for the poor, the unemployed and those at the informal sector. This will enhance better health to these categories of people in the country. Health systems can advocate for protecting population health by investing in policies and practices that keep people employed help those who become unemployed to cope with the negative effects, and get unemployed people back into work as soon as possible.
- c. Health stewardship is also required for effective functioning of sector in Nigeria. Health systems formulate strategic policy direction, oversee regulation and its implementation, provide intelligence to ensure accountability and transparency and align development assistance with national priorities through the stewardship function. In all of these tasks,

health equity should be a core consideration. Particularly relevant to improving the health of populations experiencing poverty and social exclusion, stewardship also involves engaging other sectors that influence health by using evidence on the links between social, economic and environmental determinants and health.

- d. Effective provision of health campaigns and education for every Nigerian will go a long way in promoting equity in the delivery of health care services in the country. The role of mass media and civil societies will help in achieving this, as it will sensitize the public on the need for government to cater for their health demands.
- e. If health care services delivery is to be more equitable in Nigeria, this article stressed that leaders and health care providers need to embrace the basic principle of ensuring the 'empowerment of poor clients to have a more central role in health system design and operation.' Thus, equity in health systems is premised on both technical adequacies (e.g. the objective comparability of needs and services) and socio-moral perspectives (e.g. the opportunity to access services and the consequences for consumers of the services).

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