Social Justice and the Political Economy of Health Care in Nigeria: Some empirical observations

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This paper evaluates the level of social and/or spatial justice in the Nigerian health sector. It argues that since the steady progress of the Nigerian health sector from a purely capitalist colonial orientation to a more or less indigenous capitalist orientation, the most significant factors responsible for the spatial pattern of health care in the country relate more to the spatial power structure rather than a strict adherence to the principle of social justice through welfare considerations. This argument is adjudged valid, given the empirical instance of health facility distribution vis-à-vis the national population. Using a Gini coefficient, the study evaluates the regional distribution pattern of health care resources in the country and concludes that the observed pattern is an empirical justification of Hart’s inverse care law hypothesis, which states that the availability of medical care varies inversely to the population. The study concludes that except private individuals and communities have direct access to care provision and/or the health care sector is significantly depoliticized, the idea of social or spatial justice may remain only in principle.

Key words: Social justice, political economy, geopolitical zone, health care and Nigeria

Introduction
Health is a major priority in any society. 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 basic necessities, control of assets and the perpetual efforts at building up a reserve against contingencies.

This paper appraises the level of social justice in Nigeria, with regard to the nature of the political economy of health care delivery. There has not been much debate over the inequalities in the global distribution of natural, material, and human resources. The factors that aggravate such inequalities, however, vary from place to place. Such factors, apart from the geographical location, are related to the interest and choice of the administrators of such space between two ends: the well-being of the majority or the advantage of a few.

This paper argues that the Nigerian public health sector has proceeded steadily from a pure capitalist colonial orientation to a more or less indigenous capitalist orientation and that the misconception of the idea of community has led to significant contradictions and conflicts between the public health providers and the people for whom these services are meant. Health care distribution has ‘benefited’ as a result of the characteristic inequalities in service ‘distribution’ in other sectors, such as manufacturing and education, especially in higher institutions of learning. Health care distribution should, however, be guided by the importance of health rather than a mechanical adherence to the concepts of range and threshold, suggesting a definite distance and human population requirements respectively for facility locations.\(^1\) The task of providing health care for Nigerians, therefore, requires a thorough review of the objectives and priorities of the health system.

The remaining part of the paper discusses the idea of welfarism, as it affects health care provision. The emphasis on welfarism encompasses three key issues

\(^1\) The concept of human right that sees every individual as being entitled to a minimum of health care is a fashionable option in social justice argument.
namely, objectives and priority of the health system, the political will of the government, as well as the interest and commitment of the people to the mobilization of health care resources for the common good. It is within these three issues that the real definition of welfare, as it relates to health, is intrinsically located.

First, the paper establishes a conceptual framework for social-spatial justice merely as a theoretical principle and evaluates the Nigerian public health sector since independence. It highlights particular issues in welfare policy making and implementation with emphasis on equity consideration in facility location.

Some Conceptual Clarifications

Welfare approach

The state of things in Nigeria with respect to ‘who gets what where’ may be represented, according to Smith (1986), by extending the abstract formulation of welfare economics, thus providing empirical substance for the abstraction. Within a spatially disaggregated society, the general level of welfare may be represented as:

\[ W = f(S_1, \ldots, S_n) \]  

where \( S \) is the level of living or social well-being in a set of \( n \) territorial division.

In other words, in an absolute sense, welfare is a function of the distribution of ‘good’ and ‘bad’ among groups within a population defined by areas of residence. From equation 1 therefore, social well-being can be described as what the people actually get, that is:

\[ S = f(X_1, \ldots, X_m) \]  

where \( x \) represents the equality of the \( m \) good and bad consumed or experienced.

The same idea could be used to explain the distribution and utilization of a welfare facility, for which the equation will be:

\[ S = f(U_1, \ldots, U_k) \]  

where \( u \) represents the level of well-being, satisfaction or utility of each of the \( k \) population subgroups. In the above equations:

\[ \ldots \text{the terms may be weighed differentially and combined according to any function, to represent the combination of territorial levels of well-being, goods and bads or group well-being that maximizes the objective function.} \] (Smith, 1986)

The spatial context of welfare incorporates the distinguishing factors between societies, including infrastructures and social amenities, as well as their distribution. Welfare, it must be mentioned, is not a directly observable condition like weather. Changes in the welfare trend in a society can, however, be ‘judged’ from time to time by applying appropriate assumptions and following certain rules.

An alternative plan for facility location or closure (e.g., of hospitals) can be judged by the criterion of the equality of distributive benefits (such as access to health care) among the various subdivisions of the population under review. This, however, raises the question of rules guiding distributive justice and the manner in which they are interpreted in the political process.

An examination of the equality of territorial distribution of social facilities involves developing social indicators, which may combine particular elements of social well-being in a composite measure. These elements include income, wealth, employment, quality of environment, health, education, social order (i.e., the absence of crime, deviancy and other threats to social stability and security), etc.

Social and Spatial Justice: Health care perspective

Economic and social development is a fundamental part of the history of mankind. Nigeria is not excluded from the general efforts towards rapid economic development. Consequently, several policies have been put in place to bridge the inequality gap between Nigeria and other countries. The principles behind these efforts constitute what is generally referred to as the concern for social justice in the country’s distributional process. Justice, according to Onokerhoraye (1997), is only
meaningful in relation to two or more persons between whom a transaction or an arrangement may either be considered just or unjust. Justice, however, needs to be balanced by humaneness. The concept of humaneness suggests that a government is not a closed system comprising a series of impersonal processes. It therefore abhors inhuman treatment of any kind. Social justice is the application of the law in a conflict situation with a view to create equity and balance between social cooperation and individual advancement. In other words, if division of labour increases production, the question may be asked: how does government distribute the proceeds from increased production among those who cooperated in the process?

Social justice, according to Harvey (1973), applies to the division of benefits and the allocation of burdens arising out of the process of undertaking just labour. The principle is therefore based on the social and institutional arrangements associated with the activities of production and distribution. The principle of social justice and the issues concerned become, at once, in any society, a fundamental ‘national question’ which calls for an evaluation of the distribution as it applies to individuals, groups, organizations and territories, as well as the mechanisms that are used to accomplish this distribution.

An important ethical question here is: what is ‘just distribution’? This cannot be resolved without making far-reaching moral decisions on some critical areas, such as the moral justification for making legitimate claims upon the product of the society in which he is a member by virtue of residence, occupation or birth. The suggested criteria in the literature include merit, valuation of service, inherent equality and right, need, efforts and sacrifices (Onokerhoray, 1991). These criteria have been a source of controversy within academic and political circles over the years basically because they are mutually exclusive and require relative definitions and interpretations. The criterion of ‘equality’ for example, is politically controversial in view of Aristotle’s position that ‘inequality is generally at the bottom of internal welfare in states, for it is in their striving for what is fair and just that men become divided; (therefore) those who are bent on equality start a revolution if they believe that they, having less, are yet the equals of those who have more’ (Onokerhoray, 1997).

Contemporary political arguments on equality focus, not only on the divergent opinions on the principle, but also on the disagreement on the definition of fairness or justice. The political argument on the principle of equality may endure for a long time, especially with the attempt to distinguish between the criteria for fairness and equality by those opposed to egalitarian policies. Libertarians believe in the operation of a free market for achieving justice. Utilitarians, on the other hand, insist that consideration for the relationship between available resources and the need and interest of the people is crucial for achieving a significant level of justice. The empirical justification of these positions has generated a lot of philosophical controversy.

The current argument may linger in the absence of a stronger alternative position to that of Aristotle on internal welfare. It may, however, be concluded that legitimate agitations by people and interest groups could be a viable means of negotiating and achieving a more vantage position with regards to welfare within a society. The convergence of ideas and people across societies has exposed the fact that social and spatial arrangements are not a natural phenomenon but an essentially human creation. This view is hinged on the idea that man can change and adjust whatever he creates (see Smith, 1994). As such social inequality is indefensible.

‘Spatial justice’ is an important twin concept to the point that the aggregate production output of a society is affected not only by socioeconomic factors like income, but also by location. Spatial geometry is, therefore, a major determinant of the degree of relationship between various phenomena over space (see Raheem, 2000 for empirical evidence). For example, in health care delivery and utilization, distance is more often considered as a cost and, hence, a negative integer. In other words, distance affects movement within a locality. Since movement also involves time, money and energy, it carries with
it the challenge of cost, which is an important element in real income.

The summary of the scholarly positions on the foregoing issue is that the greater the distance between two points, the lower the functional relation of the two points (Joseph and Phillips, 1984; Phillips 1990, Raheem, 1995). This explains the importance of accessibility in the utilization of certain goods and services (including health care) by people resident in different parts of a defined territory. The next section examines health care in Nigeria within the entire framework of the country’s political economy.

**Health Care and Nigeria’s Political Economy**

The advent of colonialism in the geographical area now known as Nigeria is not only a watershed in the area’s socioeconomic history and the etiology of diseases but it has also had a strong and lingering influence on the manner of locating facilities. The prevailing mode of production in the area (now Nigeria) can best be described as pre-capitalist. Within this system of production, Mabogunje (1995) contends that kinship relation was the dominant factor for articulating and coordinating all societal activities.

Kinship determined individuals’ access to the various factors of production, notably land, labour, credit and enterprise. For instance, living in a certain location, taking up a certain occupation, owning land, labour and skills were functions of an individual’s kinship relations. It is therefore easy to appreciate that the health status of such an individual depended to a large extent, on his kinship relationship so far as this determined his nutritional status through the extent of family labour and land. The distribution of what then could be called health and other facilities probably followed a similar pattern.

One of the most important missions of colonialism in Africa was to terminate the existing mode of production and replace it with proper methods of business transaction with money as the medium of exchange. The colonial mission in Nigeria, as in other African countries, was to penetrate and transform the existing pre-capitalist economies and integrate them into the global capitalist market. This, to a large extent, was achieved.

Thereafter, distribution of resources became less dependent on kinship relation and more on the power relation between the ‘haves’ and ‘have nots’, measured in terms of the pound and, later, the naira.

A major characteristic of capitalism is that the all of a society's available resources – labour, land, capital and entrepreneurship – must be brought into a free market and given price tags like commodities (Polanyi, 1975). Resource commoditizing individualizes the ownership of such resources. Consequently, the trademark of capitalism is the evident change in the geography of a country. For instance, agriculture, export, mining and transportation activities change the environmental conditions in a country over time. Such environmental changes have led to increased rural-urban migration of labour. This in turn has put so much pressure on the few available infrastructural facilities in urban areas, which has resulted, inter alia, in poor environmental sanitation. Also, the rural areas have lost a significant portion of the economically-active population, a situation which has had grave consequences for family life, social cohesion, economic vitality as well as disease and environmental control.

Thus, in Nigeria and other African countries, the exposure to free market forces, with its emphasis on money as the means of transaction, seriously undermined the integrity of the social life to which the population was accustomed. Extensive mobility, which has characterized the Nigerian economic landscape, changed the epidemiological pattern of diseases over large areas. Polanyi (1957) rightly observed that as a feature of capitalism, free market forces, if allowed to operate unrestrained, have the tendency to undermine relationships in the social arena. Consequently, as a society becomes increasingly capitalist, it also tends to evolve certain institutional mechanisms to counterbalance the operations of the free market and ensure the welfare of the citizens. Among these institutional mechanisms are trade unionism, factory regulations and legal contract. The collective cost of establishing these mechanisms is referred to as the social cost of production. According to Friedman (1985), this refers to the cost of making working conditions healthy, the
cost of feeding workers and their families, of maintaining retired workers, and of controlling or containing the environmental effects of the production process.

The social costs of production thus enable us to better appreciate the relationship between health issues, the prevailing mode of production and the adequacy of state policies in establishing the necessary institutional protection against the consequences of the unrestrained operation of free market forces.

In a full capitalist system, these costs are usually borne by the state, corporate capital, consumers and, to some extent, and workers themselves, through contributions to social security schemes. Sometimes, the costs are paid through health insurance schemes, and might be subsidized by employers, the state or by the sick; often, they cover all members of the family. Thus, in a capitalist society, or a pseudo-capitalist one like Nigeria, a system of individualized health care provided by priced professionalized services are deemed effective and efficient only within the context of the social relation of capitalist production in which everything is commoditized and monetized – an economy where the locus of computation of the social cost of production is indeterminate.

This indeterminacy is the major problem of health administration and health care delivery in most African countries, including Nigeria. Hence, it is easy to see why the resolution of the health crisis in Nigeria is only possible in the context of a development strategy that moves her towards completing the transition to a full free-market economy. The possibility of such a development strategy is entailed in the focus on the community as an institution.

Spatial Justice in the Nigerian Health Sector: An empirical instance

Public policies on health care provision in Nigeria address the distribution question, but only at the gross or regional level. Explicit recognition is given to urban and urban/rural communities and the inequalities in health care provision between them. In fact, neither community (urban or rural) is differentiated in terms of the social structures which influence access to health care services. Consequently, the distributive consequence of location is neither explicitly nor adequately addressed in the provision of health care services. Okafor (1991) noted that 'government policy statement on health care provision betrays its conceptualization of the issues of distribution'. More often, health care is conceptualized from the perspective of the economic benefits of a healthy populace and an acknowledgement of the need to make services accessible to the general population (FMED, 1975). Social imbalances are underplayed for geographical equity, as noted in the Third National Development Plan (1975-1980) (Federal Ministry of Economic Development, 1975).

Even then, a typical distributional pattern of health facilities in Nigeria simply validates the above perspective. In 1999 for instance, out of the 897 government hospitals in the country, 75 per cent (or 673 hospitals) were located in the southern geopolitical zones, while only 24.48 per cent (224) were located in the north. Pathetically, the north 'houses' about 52.9 per cent of the population, while the south has only about 46.6 per cent (see table 1) (FOS, 1996). This presents a perfect empirical justification of Hart's inverse care law hypothesis. Knox (1979) explained that the inverse care law relates to the regressive spatial pattern of health care provision 'with the availability of good medical care varying inversely with the population'(Hart, 1971). The regional localization coefficients also vary. A coefficient of localization is a form of Gini coefficient describing 'the regional contraction (inequality) of health care resources over time' (Joseph and Phillips, 1984); it is expressed as:

\[
s_c = \frac{1}{2}\sum \left( \frac{G_p^x - P_i^x}{\Sigma G_p / \Sigma P_i} \right)
\]

where:

- \(G_p^x\) = number of units of health resources in region \(x\); (no. of hospitals, in this case)
- \(P_i^x\) = population of region \(x\)
Table 1. Geopolitical zones in Nigeria and their coefficients of localization of health care (1999)

<table>
<thead>
<tr>
<th>Geopolitical zone*</th>
<th>Population (%) in bracket</th>
<th>No. of govt hosp. (%) in bracket</th>
<th>Coeff. of localization (U)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North central</td>
<td>16.15 (18.3)</td>
<td>114(12.7)</td>
<td>0.03</td>
</tr>
<tr>
<td>Northwest</td>
<td>18.77 (21.2)</td>
<td>62(6.9)</td>
<td>0.007</td>
</tr>
<tr>
<td>Northeast</td>
<td>11.89 (19.9)</td>
<td>47(5.2)</td>
<td>0.04</td>
</tr>
<tr>
<td>Southwest</td>
<td>17.57 (19.9)</td>
<td>286(31.9)</td>
<td>0.07</td>
</tr>
<tr>
<td>Southeast</td>
<td>10.60 (12.08)</td>
<td>161(17.9)</td>
<td>0.03</td>
</tr>
<tr>
<td>South south</td>
<td>12.91 (14.6)</td>
<td>226(25.20)</td>
<td>0.05</td>
</tr>
<tr>
<td>FCT</td>
<td>037 (0.4)</td>
<td>1(0.1)</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>88.5</td>
<td>897</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Author's computation from Annual Abstract of Statistics (Federal Office of Statistics, 1995)

A coefficient value of 0.0 indicates that resources are distributed across the regions proportionally to their populations. Values between 0.01 and 0.1 reflect increasing levels of localization. With this definition, two forms of localization can be identified. First, there is a negative ‘localization’, which depicts a situation where resources are located where the population is not much. This is the situation in the northwestern geopolitical zone, which has about 21.2 per cent of the national population, but 6.9 per cent of government hospitals. Second, there is the positive localization, which usually favours a population. This is the case in the southwestern zone, which has 19.9 per cent of the population, but close to 32 per cent of the total health resources (government hospitals). The coefficient of localization ($CL^2$) in both cases is 0.07 – although, one is a negative integer while the other is positive (see table 1).

Several factors determine the distribution pattern of health institutions even from the government’s point of view. Among these are population size, urbanization level, revenue base, colonial influence and spatial distribution of political power. Okafor (1989) noted that because these variables differ in their levels of occurrence, the resultant distribution of health facilities also varies accordingly. From table 1, if population is a primary determinant of needs and, therefore, an important criterion for the spatial allocation of public goods and services, including health care resources in a region, then the location of less than 7 per cent of health facilities where more than 21 per cent of the population is located cannot be said to be based on population and/or need criteria.

In Nigeria, where welfare considerations play a relatively insignificant role in the determination of ‘who gets what’, some ‘surrogate’ factors for welfare issues are usually considered. In this regard, the revenue base of individual spatial units (states or local government areas) is one of the most relevant factors. States in Nigeria are the main providers of public services, including health care. The revenue base of these states is, therefore, important in explaining the spatial disparities in health care provision. This is because wealthy states are able to provide high-quality services, whereas poor states provide limited and low-quality services (Okafor, 1989). Although, states and local government areas in Nigeria derive their revenue from a variety of taxes and statutory federal allocations, the revenue is distributed, not equally, but according to a complicated sharing formula.

Perhaps the most important factor in the spatial distribution of benefits and/or ‘disbenefits’ in Nigeria is the spatial pattern of political power per unit of time. Friedmann (1972) observed that in the initial phase of development, power is concentrated in the capital cities and, to a lesser extent, in the provincial headquarters. This initial distribution of power tends to influence the subsequent evaluation of the space economy. In other words, the concentration of wealth in urban centres in Nigeria makes them the loci of economic and political power as well as the bases for the elites. This is because location and allocation decisions favour people and places with the power to influence the process (Smith, 1977; Knox, 1982).

A locational irony, however, exists in Nigeria, with the bulk of government health resources located in a region which had held political power for a relatively short period of time. The north has held political power for over 30 years out of the nation’s
44 years of independence (as at 2004). It, however, has only 24.8 per cent of the total number of government hospitals, although it held more than 50 per cent of key political positions in the country for more than three decades. On the other hand, the south has 75.2 per cent of health resources, despite the fact that it has had less access to key political positions since independence. Efforts at finding an answer to the puzzle in the facility distribution method in Nigeria is fast looking away from the mundane issue of power relations, as indicated above, to the influence of the geography of common resources.

As explained earlier, the distribution of urban centres and revenue bases are the most likely factors that determine the spatial pattern of health resource distribution. The states in southern Nigeria are relatively more urbanized, with stronger economic bases, compared to the scattered and thinly populated (when compared in terms of density) vast savanna lands of the north which is economically less buoyant.

In Nigeria therefore, it can be argued that the most important factors are community participation and the path of development followed by individual states. In health care provision, societies differentiate between people and places in the allocation of resources but it is the equity principle that is generally used to uphold the legitimacy of this differentiation, particularly when the Nigerian health policy is built around the principle of ‘a just and egalitarian society where equality of opportunity is ensured for all citizens’ (Federal Ministry of Health, 1988). The above analysis shows that even when social and spatial justice is conveniently touted as a guiding principle in facility distribution, the pattern of care provision can be explained by many other factors, to the extent that it is not impossible to indict administrators and decision-makers of ‘pork-barrelism’ – a decision motivated solely by the desire to gain political goodwill and alienate the minority (Johnston, 1986). Pork-barrelism is personified in different nomenclatures in Nigeria’s political and economic arena, the commonest of which are the quota system, federal character and zoning. The result of these economic and political manipulations determines the nature of the space economy. Moreover, the distribution of resources in health care is similar to what obtains in other areas where decisions are based on some complicated formula of derivative and resource control.

Summary and Conclusion
The foregoing analysis shows that the distribution formula in health care provision, as in any other locational decisions, is not based on the factor of social justice as the Nigerian government attempts to do. Rather it has shown that certain factors interact to produce a given distributional pattern of care provision, among which are the spatial patterns of political power, community effort and participation, the revenue base of lesser spatial units and, perhaps, a degree of welfare considerations (social justice) by the national government.

In conclusion, it should be mentioned that in a federation like Nigeria, where some degree of decentralized control of development exists, it is doubtful whether social justice would not remain in principle. Decentralized control has the advantage of ensuring that the levels of provision are sensitive to local variations in need. The existing disparities in care provision between states, however, might be unavoidable due to the different revenue bases, levels of urbanization, and so on. A significant mismatch may therefore exist in the spatial pattern of health care provision and the spatial distribution of the population as a vindication of the fact that health care distribution is multi-factorial.

By implication, access to health care is a question of location, which means, therefore, that the variations in access over space may continue to foreclose the possibility of achieving equal opportunity and egalitarianism in the society. The resolution of the last position is a typical national question requiring an amalgam of ideas and sincere deliberations. There is a need to consider other strategies which Nigeria can adopt to give every Nigerian access to basic health care within a reasonable distance, without jeopardizing other entrenched principles of derivation, such as the quota system and resource control.
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References


Biographical Note
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