Poverty and sickness: The correlation of social inequalities and poor health

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Poverty and Sickness:
The Correlation of Social Inequalities and Poor Health

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Introduction

A Tale from the Village

I grew up in a village in southeastern Nigeria with a population of around 150,000 people. I attended both primary and secondary school in the same village. My parents, uncles, cousins and aunts still live there. In fact, it is the only place I call home. In this village when someone falls sick, it is certain that the entire family, neighbors and relatives around are actively involved in ensuring that the sick person regains his/her health within the quickest time possible. The sickness is seen as a threat to every member of the family as well as the neighbors.

There is a custom of visiting the sick that falls within the unwritten laws of the village. In fact, each family member, relative, and neighbor is expected to visit the sick neighbor first thing in the morning. In a sense, all the adults are supposed to visit the sick person before leaving home for farms, businesses, and other social engagements. And in the house of the sick person during the short visit, there are sometimes conversations on the nature of the sickness: who may have had similar illness in the village, how it was treated and by which healer, doctor or herbal specialist. People are accustomed to offering their time, support, and suggestions on how the sick person can be better cared for with the available resources.

In the same vein, some generous friends, relatives, uncles, brothers and sisters may as well offer financial support to the sick person at the end of their visits. This benevolent gesture implies that the sick person and his/her family need a financial support in caring for the sick person either at home or at the hospital. There is no law that prescribes what should or should not be done when a member of the community falls sick. But everyone seems to understand clearly that sickness dehumanizes the human person and requires a collective effort in restoring the sick person to his/her normal health.

However, if after all the physical (medical) and spiritual care (prayers), the sick person eventually dies, the entire community sees this death as a great communal loss. The whole community mourns the dead. In fact, the custom is that the mourning lasts for eight market days. And during this mourning period no one is expected to go to the farms, business or even plan a trip outside the village. The funeral ceremony is a communal ritual that involves not only the villagers but also the sons and daughters of the dead person who may be residing elsewhere even outside Nigeria. The close relatives of the deceased person are obliged to travel from the city to the village to participate in the funeral ceremony. The above description is not a fairytale; it is still a common practice in my village.

On the contrary, when one moves from these rural communities to cities like Lagos, Enugu, Kano, Abuja, and so on, this social bond seems inexistent with regards to care for the sick. In fact, in most cities across the country, one can live in the same building with other tenants for a year or more without knowing the real names of the persons next door. Human interactions or regular visits with the person living next door, even if he/she is sick, are doubtful. The city life seems to be more focused on the individual than on building social bonds. In other words, the lifestyle in the city is clearly each person to his/her own "tent." The evidence is even more glaring in social institutions like schools, hospitals and government offices. The desire to accomplish individual interest seems to trump almost everything across the country.

The consequence of this unfortunate situation is that no one seems to bother about the neighbor. In fact, I wonder if at all the word "neighbor" should be applied to the kind of frosty and "culture of unconcern" that are on the increase among Nigerians living in the cities. For example, in the Nigerian health care system, doctors, nurses and health care workers treat the patients differently from the practices described above in a village setting. With the current

practices in the Nigerian health care system, the poor and lower income classes suffer unjustly. One may say that the Nigerian health services are comparable with other social utilities like electricity and telephone services. If one is willing to pay more, a better service will be provided.

Hence, the sickness of an individual is seen as a private matter in terms of medical care and financial support. Health care services are commodified. The sick and the poor are clearly at a disadvantage because they lack social and economic means. Clearly, a non-discriminatory care for every human person, which is embedded in our sense of the sacred and the dignity of human person, seems wanting. Thus a commitment to the common good becomes the "way forward."

Flowing from the above social, economic, and political challenges in Nigeria, this thesis argues that every human person deserves adequate basic care. In fact, justice as fairness demands that the poor, the weak, and the sick in our midst should be looked after. First, health care is due because of our shared humanity, sanctity of life and respect for human dignity. Second, health care is a duty because of the interconnectedness of our world and to ensure societal cohesion. But this is done while remaining conscious of our finitude and the scarce resources of our world.

Human and societal needs can neither be collapsed into health needs nor should the fulfillment of individual health need be neglected or relegated a mere private issue. Thus, meeting health needs "fairly" involves not only the provision of medical assistance, but also confronting cultural, religious, political, psychological, social, and economic factors that militate against individual and community's health. In a sense, the various health-related challenges of our world are not likely to be resolved only by channeling our efforts solely to the health institutions. The social determinants of health are just as crippling and dehumanizing as diseases to the human person.

This thesis therefore, seeks to understand the nature of health care inequality in Nigeria. The guiding question that will sustain our enquiry is: What is the health "gradient"[1] and what can be done to either close the gap, or at least reduce the health gradient among social classes? I divided the work into three main chapters.

The first chapter focuses on the cultural and religious values that support individual and community health. This chapter argues that the care for oneself and for the other in the community is an age-old practice among Nigerians and Africans in general. Hence, the chapter affirms the existence of values in our cultures and religious beliefs, which support non-discriminatory health services for all irrespective of gender, social, and economic means.

The second chapter offers an in-depth analysis of the Nigerian health care system. The chapter highlights the growing health inequality between rich and poor Nigerians. In this chapter I assert that the Nigerian health care system favors the rich and the powerful. In fact, I describe the Nigerian health care system as an "inverse care system," because those with the greatest health needs are underserved. I highlighted several elements like individualism, corruption, greed, self-centeredness, and sociopolitical changes in Nigeria as the root causes of this health inequality.

The third chapter focuses on the "way forward" for the Nigerian health care system. In this chapter, I propose a paradigm shift from simply focusing on the "status quo" of providing medical care and support for those with social and economic means, to a consideration of health services as a common good. The chapter recognizes the constraints in the provision of health needs for all due to our scarce resources. However, I affirm that even in the midst of the current scarce resources, basic health services for all Nigerians remain possible. What is required of us (Nigerians) is to re-appropriate the values in our cultures as well as the action of the Good

[1] James F. Keenan, "Developing HIV/AIDS Discourse in Africa and Advancing the Argument for Universal Health Care," in *AIDS 30 Years Down the Line: Faith Based Reflections about the Epidemic in Africa*, ed. Paterne A. Mombe, Agbokhianmeghe E. Orobator, Daniel Vella (Nairobi: Paulines Publication, 2012), 70.

Samaritan who recognized sanctity and dignity in the man who fell into the hands of the robbers by the roadside.

Chapter One

1. Foundational Principles of Health Care

Introduction

In our ever-changing world, individual health is one of the prerequisites and means to attain an enduring human flourishing.[2] "Good health," many would agree, is "wealth," while poor health is a burden as well as an obstacle to meaningful individual and societal cohesion. In many nations of our world, developed and developing countries alike, we have seen a constant trend of correlation between "poverty and sickness" in different degrees. In a few words, people in a lower economic class tend to fall sick more often than those in the middle class; and those in the middle class more often than people in the upper class. This is referred to as the health "gradient," or the effect of social "stratification," which is clearly embedded in the fabric of every society. Wealth is only one, though especially powerful, contributor to social inequality. Other sources become evident when one seeks a deeper understanding of the impact of poverty on human health. There is a noticeable disparity based on social class, gender, and race in relation to health achievement.

In this first chapter I demonstrate that matters of health care have always been an issue of great importance. The chapter focuses on the cultural foundation of health care: the inseparability of caring for oneself, other persons, and society's health. In fact, experience has shown that failing to protect and promote the health of individuals both directly and indirectly affects the normal economic, political, and educational functioning of the entire society. Notably, this foundational principle is embedded in culture and religion, as well as in ethics and justice among the peoples of the world.

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[2] This is a term that will permeate the entire thesis, which is defined "As the gradual, progressive expression and fulfillment of one's potentialities as well as the integration of one's limitations. It concerns, therefore, one's dignity in all its aspects–bodily, psychological, psychic, intellectual, spiritual, emotional and relational." See Andrea Vicini, "The Ethics of Genetic Technology: Knowledge, the Common Good, and Healing. The Case of Human Genome Project" (PhD diss., Boston College, 2000), 266.

Moreover, both individual and public health have become global concerns due to the realization of the ripple effects of one country's crisis in neighboring countries. Hence, the care for oneself, others, and society, which has been an age-old practice in most cultures, cannot be overemphasized. I argue in this chapter that the desire to promote life is deeply embedded in the fabrics of Nigerian societies, cultures, norms, and worship.

1.1. Why Should I Bother?

In a society that is constantly shifting focus to personal interests, it is challenging to offer an honest response to the famous scriptural question "Who is my neighbor?" The challenge lies in the qualification of a neighbor, and also in why anyone should bother about his/her neighbor. A few months ago, I had an insightful conversation with a friend of mine who had just begun his graduate studies in theology. He asked, "what is this whole fuss about public health, and how does this affect one's health in general?" Apparently, he is doing research on the topic and wants clarification on what is at the heart of the topic: public health and how it affects us globally. I chuckled with a smile and said it is all about the interconnectedness of human beings and our environment. In fact, our ethical and environmental consciousness enables us to see the correlation between individual health and public health. Our health consciousness grows more than ever, especially as we realize that relationship with our neighbors as well as our environment is nothing but a "microcosm inside a macrocosm"–the seemingly safe haven of some individuals is now an illusion.

Furthermore, I mentioned to my friend a concrete example on why the public health issue is more than just a "fuss;" the HIV/AIDS and Ebola pandemic in sub-Saharan Africa have had both local and global effects. I noted that at the beginning of HIV/AIDS pandemic decades ago, many commentators and world leaders blamed the spread of the virus on poverty, corruption, and

even promiscuity among the urban poor in developing African nations. And to that effect, little was done to tackle the disease until it spread beyond the borders. But when pandemic reached global proportions, the entire world realized that there was no safe haven for anyone against viral diseases like HIV/AIDS.

In the same vein, at the outbreak of Ebola in West Africa in early 2014, many world leaders and analysts spent months in blame games: on how the Ebola virus spread because indigenous people in the affected area eat monkeys that harbored the virus. Meanwhile, others said that its spread was due to poor medical facilities in the affected countries and lack of social amenities like potable drinking water, proper sewage system, and electricity.

Moreover, the director of the World Health Organization (WHO), Margaret Chan, at the outbreak of the Ebola pandemic, was quoted on social media about her hesitancy in declaring the Ebola crisis in West Africa a global emergency.[3] First, the epidemic was seen as an isolated incidence–a West African problem. Second, the WHO director weighed the impact such declaration will have on the political economy of the affected countries. At the early stage of the crisis she claimed that declaring the Ebola pandemic a global emergency would isolate the affected countries from the rest of the world.

However, I asked my friend, "What is your take on this unfortunate claim attributed to the director of WHO?" His response was that the WHO director missed the bigger picture. The director should know better that when it comes to epidemics, nowhere is safe. In fact, human lives cannot be exchanged with social and economic interests. Notably, events that transpired in West Africa due to slow response by the WHO and international community to the Ebola pandemic showed that prompt response would have saved the "safe" countries the "headaches" that Ebola

[3] http://www.cbsnews.com/news/political-considerations-delayed-who-ebola-response-emails-show/ (accessed 30th March 2015).

brought. The Ebola cases in North America and Europe threw the world leaders and the populace alike into panic. Thus, the realization that the pandemic is not just a West African problem but a world problem, and should be tackled so. Regrettably, the WHO waited nearly one year before declaring the crisis a global emergency in August 2014.[4] The common sense tells us that economy of every nation needs healthy people in order to thrive and develop.

The health of every member of the community is very important because it is the means through which each person can fully participate in the functioning of society. In virtually all cultures and religions, sickness is seen as an abnormality not only as it concerns the individual well-being, but also in the cosmological component of the human environment. On the one hand, in most cultures of Africa, there is a strong belief that the well-being of a person positively impacts the normal functioning of the individual's family, community, and nation at large. On the other hand, illness, which sometimes befalls a member in the community, is seen as an individual, social, and cosmological event that demands the attention of everyone.[5]

In sub-Saharan Africa we find numerous diseases and epidemics like HIV/AIDS, malaria, tuberculosis, and Ebola, which have taken a grueling toll to people and nations in recent times. The most recent crisis is the Ebola pandemic, along with its shocking effects on both human and economic resources of the affected countries like Guinea, Liberia, and Sierra Leone. The reverberating effect of the Ebola pandemic was felt across Africa, because of the consequent restriction of tourism, goods, and services in and out of the affected countries.

Also, the lingering war against Boko Haram, a terrorist group in Northeastern Nigeria, has affected not only lives and property in Nigeria, but equally those of the three neighboring countries: Chad, Cameroon, and Niger. As we face all these unfortunate incidences, it becomes

[4] http://www.bbc.com/news/health-28703853 (accessed 30th March 2015).
[5] Keenan, "Developing HIV/AIDS Discourse in Africa," 73.

more crucial than ever to realize that no man or woman is an island. Hence, the effect of pandemic diseases–e.g., HIV/AIDS and Ebola, and their spread from the Southern hemisphere to the rest of the world–force us to see how the "nose cannot pretend to be indifferent to the tears of the eyes."[6] And this claim ought to permeate the all human cultures.

1.2. Cultural Base of Health Care

In virtually all sub-Saharan Africa countries, including Nigeria, there exist norms and practices that promote individual and communal health. In a typical African society like the Igbo of Nigeria, life is seen as the most precious gift from the creator. It is important to point out from the start that for most languages in sub-Saharan Africa, life and health are expressed almost by the same word. For the Igbo, having good health is synonymous to being alive, which is measured in the relationship with one another.

This belief is manifested in their songs, child's naming, storytelling, and proverbs. Some of the examples include, *Ndu ka-aku:* "life is more precious than wealth," *Chinwendu:* "God owns our life," *Ndubuisi*: "Life is supreme to everything." Hence, any form of illness that hinders individual functioning is seen as an attack, not only on the individual but also on the community and cosmological order. Thus, promoting individual health is tantamount for a society's cohesion.

Furthermore, in Igbo culture, care for one's health or the neighbor's is a moral obligation in order to ensure a humane and peaceful community. In the Igbo language, the *Dibia*—loosely translated as "medicine man" (the healer) is known as one who cares for the sick and assists the community to prevent illness, but the *Dibia* is never seen as one who cures diseases or shortens human mortality. The Igbo people understand death as a natural phenomenon and never as an

[6] This is an Igbo proverb that highlights the interconnectedness among human beings on the one hand and society on the other hand. The Igbos are one of the major ethnic groups in Nigeria numbering over thirty million people. The Igbos are predominantly located in the South East of Nigeria.

absolute moral evil.[7] An attempt to identify a *Dibia* as one who prevents death would be a strange undertaking in the Igbo worldview. There are norms and practices that uphold individual health among the Igbo, but the eventual death of a community member is not blamed on the *Dibia* especially when all necessary efforts were rendered. Thus, a failure to restore the sick person to his/her full health is seen neither as a failure of the *Dibia* nor as an abandonment of their Supreme Being known as *Chukwu*.[8]

Moreover, there exist norms and taboos that enable the individuals to live in harmony with one another and the community. In his famous book *Things Fall Apart*, Chinua Achebe[9] tells a story of *nso-ani* (abomination), which Okonkwo had committed during the Week of Peace. It was a week dedicated to praying to the gods and ancestors to bless the land and people during their new farming season. Hence, no work is done during the Week of Peace, even the dead are not buried but cast into the evil forest during the period. Achebe writes:

> Okonkwo was provoked to justifiable anger by his youngest wife, who went to plait her hair at her friend's house and did not return early enough to cook the afternoon meal. Okonkwo did not know at first that she was not at home. After waiting in vain for her dish he went to her hut to see what she was doing. There was nobody in the hut and the fireplace was cold. "Where is Ojiugo?" He asked his second wife… "She has gone to plait her hair…" And when she returned he beat her very heavily. In his anger he had forgotten that it was the Week of Peace… Before it was dusk Ezeani, who was the priest of the earth goddess, Ani, called on Okonkwo in his obi…"Listen to me" he said when Okonkwo had spoken. "You are not a stranger in Umuofia." You know well as I do that our forefathers ordained that before we plant any crops in the earth we should observe a week in which no man does not say a harsh word to his neighbor… You have committed a great evil… The evil you have done can ruin the whole clan. The earth goddess whom you have insulted may refuse to give increase, and we shall all perish… You will bring to the shrine of Ani tomorrow one she-goat, one hen, a length of cloth and a hundred cowries. He rose and left the hut. Okonkwo did as the priest said.[10]

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[7] Chibueze Udeani, *Inculturation as Dialogue: Igbo Culture and the Message of Christ* (Amsterdam: Rodopi, 2007), 62.
[8] Chukwu is loosely translated as Supreme Being or God among the Igbo.
[9] An Igbo acclaimed author from Nigeria. His first book *Things Fall Apart* was received globally and was translated into over fifty languages.
[10] Chinua Achebe, *Things Fall Apart* (New York: Anchor Books, 1994), 29-31.

The underlying moral of this anecdote is that the point of setting aside a Week of Peace was to offer the entire community a decent time to rest. In a sense, it was a self-care approach adopted by the community for people to rest and spend time with their friends and family before the beginning of a new farming season. Obviously, its connection with the earth goddess and ancestors was to encourage respect and instill fear into anyone who might attempt to go against the taboo. The restitution, which the priest charged on Okonkwo, was to ensure total healing among the members of the community, the goddess, and the ancestors.

Moreover, it was feared that the impact of the evil committed by Okonkwo would spread to every member of Umuofia. The well-being of Okonkwo's family as well as the entire village was at stake; hence, the need for reparation. Notably, the ethical implication of this anecdote, which I will take up in detail in the subsequent chapters, is that a sense of a shared humanity and a collective moral obligation are crucial in Nigeria's health care system.[11] Hence, an exclusively market-based approach to health care is counterproductive and at the same time impoverishes those already at the margin of our society.

In the same vein, Laurenti Magesa, a renowned African theologian from Tanzania, reechoed a similar belief in the connectedness between an individual and the community in matters of health. In his book, *What Is Not Sacred?,* Magesa notes, "the art of healing is seen not only in terms of the body, healing the individual body in a mechanistic way, but primarily and holistically in terms of healing the cosmos. The cosmos, the entire social and environmental body that constitutes life and health, is therefore perceived as a person."[12] Arguably, Magesa affirms here an African creed on the interconnectedness that exists between individuals and the created things.

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[11] Michael P. Hornsby-Smith, *An Introduction to Catholic Social Thought* (Cambridge: Cambridge University Press, 2006), 223.
[12] Laurenti Magesa, *What is not Sacred?: African Spirituality* (New York: Orbis Books, 2013), 68.

However, one may wonder whether this notion is shared among the African people and their cultures. Africa is a continent of over one billion people with millions of cultures; differences in norms and practices are very much expected. Nevertheless, there are obvious similarities among cultures, especially in sub-Saharan Africa. In Nigeria alone, with over four hundred ethnic groups including the Igbo, differences in cultures are traceable, but similarities are enormous. Many attribute these similarities in cultures to people's integration into the larger society and because of shared experiences, ranging from wars, pandemic diseases, religious beliefs and various aspects of social change that are frequent across the country.[13]

In general, the meaning of good health among the sub-Saharan Africans, to some extent, is based on normal functioning in relation to others and to the community. Each member of the community prays to be at all times fully alive and active. Magesa captures this notion accurately by using the term "dancing life" in African society. In describing the true meaning of life, Magesa states:

> Life is not a "spectator sport" or something to be experienced by proxy. What is expected for one to grow into Ubuntu[14] in Africa and become fully human is to participate in the dance of life, one's own dance within that of the community. One executes one's dance steps of life by personal involvement, and one is assessed on the basis of performance. The dance of life includes everything that is connected with nurturing life in the world, that is, social institutions, economics and politics, cookery, painting, sculpture, architecture, the art of speech, music, gestures and sense of beauty among others.[15]

Flowing from the above insightful quote, the "dance of life," in my view, is losing its vigor. It is constantly losing its steam as the performance and the rhythm are becoming increasingly individualistic and solitary. And the evidence is the social change in most African countries, Nigeria included, which bombard the people daily with a foreign culture that values more

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[13] Daniel Jordan Smith, *AIDS Doesn't Show Its Face: Inequality, Morality and Social Change in Nigeria* (Chicago: The University of Chicago Press, 2014), 27.
[14] Ubuntu is an African humanism. It is what anchors the "be-ing" of an African in the universe. See Michael Onyebuchi Eze, *Intellectual History in Contemporary South Africa* (New York: Palgrave Macmillan, 2010), 93.
[15] Magesa, *What is not Sacred?,* 69.

individualism over community life and values. One of the reasons for this social change is the social media; even though the social media make the world a global village, an individual often feels disconnected from the concrete community. There are structures in every nook and cranny that force each person to conform to individualism as opposed to the community's ideals.

The analogy of a dance offers an insight for our discussion on public health. Anyone who may have participated in a group dance knows that the focus is on the rhythmic flow of the individual's dance steps, arms, and bodies within the group. The beauty of a group dance comes from the ability of each person involved to perform rhythmically as one body. In other words, the failure of a group dance sometimes comes from the inability of individuals within the group to display skills and uniformity in their performance. In a situation where a dancer or few dancers in the group begin to distinguish themselves from the rest of the group by exhibiting different dance steps, both the dance's rhythm and beauty normally turn awry. The image of the "dance of life" offers us a lens to view the realities of the health care system, in sub-Saharan Africa but more particularly in Nigeria. It captures the need for interdependence between individuals and the community. Hence, it is in the community that individual self-realization takes place, and not in a solitary manner.

In his groundbreaking book *African Religion and Philosophy*, Mbiti affirms:

> In traditional life, the individual does not and cannot exist alone except corporately. He owes this existence to other people, including those of past generations and his contemporaries. He is simply part of the whole. The community must therefore make, create or produce the individual; for the individual depends on the corporate group… when he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not alone but with his kinsmen, his neighbors and his relatives whether dead or living…whatever happens to the individual happens to the whole group, and whatever happens to the whole group happens to the individual. The individual can say, "I am, because we are; and since we are therefore I am." This is the cardinal point in the understanding of the African view of man.[16]

[16] John S. Mbiti, *African Religions and Philosophy* (Oxford: Heinemann, 1969), 106.

Many African authors for decades have considered the correlation between individual and community in the African context.[17] One may argue that Mbiti's position offers leverage to the community, and the individual risks being swallowed up by the community. Mbiti's viewpoint, which resonates with my position in regards to health care, may be rephrased thus: *we are therefore I am, and since I am, therefore we are*. Hence, in advancing the good of the community, the individual's good concomitantly advances precisely because the goods of the community and the goods of the individual are not radically opposed but interwoven. From this viewpoint, it is fair to affirm that the community is a guarantor of one's subjectivity, whereas one guarantees the community's survival by advancing one's constitutive goods, knowing that if the community is threatened, the individual is equally affected.[18] In the anecdote by Achebe that I quoted earlier, the action of Okonkwo is considered a threat to the peace and normal functioning of the community. The goddess priest quickly moved in to correct an anomaly, which threatened both the individual and community's survival.

However, this cultural value prevalent in sub-Saharan Africa is frequently challenged by the growing individualism, greed, and free market economy. Bénézet Bujo, in his book *Ethical Dimensions of Community,* captures this noticeable shift in most African countries. He states: "The nuclear family no longer feels obliged to care for the interest of other members of the extended family. The individual cares mainly for his or her own ego-identity–an attitude that plays an important role for ethical behavior."[19] Bujo argues further that communitarian ethics is indispensable especially with the current pandemic diseases (i.e., HIV/AIDS, Ebola, malaria, and

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[17] Eze, *Intellectual History in Contemporary South Africa,* 95.
[18] Michael O. Eze, "What is African Communitarianism? Against Consensus as a regulative ideal," in *South African Journal of Philosophy,* 27(4)(2008), 108.
[19] Bénézet Bujo, *Ethical Dimension of Community: The African Model and the Dialogue between North and South* (Nairobi: Paulines Publications Africa, 1997), 181.

tuberculosis) ravaging most of sub-Saharan Africa. Bujo's viewpoint resonates with my earlier assertion that individual health is interconnected with public health. The fight against HIV/AIDS and Ebola has enabled us to see how effective community effort could be in promoting individual and public health.

Individualism and health care understood primarily through a market-based economic lens challenge community values. Hence, it is true that African thoughts and actions are deeply determined by the community.[20] Although the effect of social changes is noticeable, people still have a strong desire to reconnect to their kinship and roots. Daniel Jordan Smith, in his recent research on southeastern Nigeria, affirms: "One of the curious aspects of kinship in Nigeria is that its importance appears not to have diminished significantly despite the apparent assault from a changing political economy, urbanization, and people's exposure to global media."[21] The author seems to voice the people's experience that it is in the community that the individual finds his or her fulfillment. This sense of community still remains in most parts of Nigeria.

In the same vein, Bujo reaffirms: "there is interdependency which is based on the fact that all members have the task of mutually increasing the life force. Everybody's behavior and ethical action have consequences for the whole community: the good contributes to the increase of life, while evil destroys or at least reduces life."[22] Bujo's position clearly indicates that the entire community, through communal support and cares, identifies with an individual in his/her misfortune and sickness. Therefore, "health and healing are not individual concerns; they are fundamentally communal in the broad sense of the term, which includes the surrounding physical environment."[23] Magesa's position seems to agree with Bujo's that individual misfortune also

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[20] Ibid., 182.
[21] Smith, *AIDS Doesn't Show Its Face*, 167.
[22] Bujo, *Ethical Dimension of Community,* 182.
[23] Magesa, *What is Not Sacred?*, 68.

affects the community. Hence, Magesa asserts that no individual can enjoy tranquility and happiness in the midst of ill will, misfortunes, and social injustices in the community.[24]

The community model of health care broadens the notions of health and sickness, which ought to be "looked at not only psychosomatically, but have to be seen in their religious and cosmic dimension as well."[25] Hence, diagnosis and healing of one's sickness should go beyond the individual and consider the family as well as one's social and economic relationships. For Bujo, "the doctor or healer has to go beyond mere physiological and individual symptoms, until the proper psychological, moral and socially-conditioned cause is traced and discovered. Here, the patient's family relationships are studied and past conflicts interpreted anew. The sick person's social and economic relationships are thoroughly examined."[26] The communitarian view of illness and healing makes it necessary for the doctor (healer) to adopt a holistic manner in all his/her undertakings. When a child falls sick, the diagnosis covers the health status of the mother (physically, mentally and religiously) as well as the cosmos.[27] There is a belief that the sickness of a child sometimes is linked with the health situation of the mother. There is also a firm belief among Africans that this connectedness that exists between the sick person and his/her immediate community transcends the physiological realm and includes the living dead (ancestors).

Furthermore, the metaphor of a shipwreck is among the numerous metaphors employed by Hans Blumenberg is his writings.[28] He uses this metaphor to contrast how historians no longer perceive themselves as detached spectators, but as part and parcel of the history they retell. In this case I employ this metaphor to contrast an individual that cannot pretend to be isolated from the

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[24] Ibid., 167-168.
[25] Bujo, *Ethical Dimension of Community,* 183.
[26] Ibid., 182.
[27] Ibid., 183.
[28] Hans Blumenberg, *Shipwreck with Spectator: Paradigm of a Metaphor of Experience* (Cambridge, MA: MIT Press, 1997), 2.

reality of his/her community. As Bruno Forte states: "What a beautiful thing it is, when the winds clash over the sea, and the dark vastness of the waters churn beneath, to watch the distant shipwreck from dry land: it is not the other's disaster that brings joy, but the distance that separates you from a similar destiny."[29] The community model of health care in sub-Saharan Africa especially among the Igbo of Nigeria sees the *metaphor of shipwreck* to be at their doorsteps. In a sense, the misfortune of a neighbor is everyone's misfortune.

In most African cultures there seems to be no safe heaven or distance that separates one from his/her neighbor's misfortune. Otherwise, such action contradicts human and social values that recognize the other person as brother or sister. In other words, the African understanding of community and how it impacts the functioning of every life is that everyone is aboard the ship. Thus, in the event of a shipwreck, everyone is in danger and affected. In fact, no one is aloof from the other's disaster; rather, each person works corporately for the full restoration of both the individual and the community. The effect of social change is undeniable in most African societies, but kinship still permeates relationships. Hence, the bond between an individual and the community is deeply rooted not only in the people's culture, but forms part of personal belief and worship.

So far, I have highlighted some of the richness in African cultures and how these values promote individual and public health. It is fair to say that the desire to work cooperatively in order to support and care for others are equally indicative to Africans' beliefs. Through the lens of the culture we see how people live and interact among themselves, but it is through their religion that we see how people live in relation to their creator and their fellow being. I now turn to discuss

[29] Bruno Forte, "A Catholic Perspective," in *Catholic Theological Ethics Past Present and Future: The Trento Conference,* ed. James F. Keenan (New York: Orbis Book, 2011), 11.

how religious belief informs people's desire to uphold both the health of individuals and of the community.

1.3. The Influence of Religious Belief in Health Care

In many African cultures, one can hardly separate the cultural foundation of health care from its historical and religious bases. This is due to the fact that religion, history, and culture are intertwined. What is of historical importance pertains to culture and religion. What is cultural is historical and religious. The religious belief permeates the entirety of life, culture, and history in special ways. The religious foundation of health care springs from the recognition of the "sanctity of life." First, when we speak of sanctity of life, we claim life as sacred. It is a profession of faith in the gift of life that transcends mere reasoning. Second, respect for life hinges on human reasoning and on the dignity of our shared humanity. In fact, with the growing fundamentalism in our world, some people erroneously subscribe to either of the two (faith or reason). Both are complementary, however, and not either/or.

In a sense, the religious desire to care for oneself and others is founded on the awareness "that everyone should treat his existence and that of every other human being with respect. For it belongs to God."[30] With these words, Karl Barth asserts the inherent dignity of human person. In most cultures, especially in sub-Saharan Africa, the care for one's health and that of every other human being falls within the unwritten laws that govern the community. For most Africans, the question why should I care for myself, and the well-being of others, would receive a response like: that's the way it is; our existence transcends us. In other words, it is not subject for debate whether we should care for our lives and the lives of other people. In fact, it would be correct to say that such laws are inscribed in the heart of every human being.

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[30] Karl Barth, "Respect for Life," in *On Moral Medicine: Theological Perspectives in Medical Ethics*, ed. Therese M. Lysaught, Joseph J. Kotva et al. (Grand Rapids, MI: William B. Eerdmans, 2012), 725.

Polycarp Ikuenobe, in his book *Philosophical Perspectives*, argues that this moral sense of the other's welfare is both humanistic and naturalistic from an African worldview.[31] The care for others goes beyond religious belief. This sense of care is enshrined in every person's being. From this standpoint, one can understand the background of the historical development of health care in the past centuries in sub-Saharan Africa.

Nevertheless, the evolution of health care has been one of the outstanding phenomena for the scientific development and human consciousness of our health needs. From the beginning of the first century, the early Christian community lived the gospel by caring for the sick members of their communities. The early missionaries in Nigeria opened churches, schools, and community health centers.

The first Christian missionaries who entered the Nigerian costal area in the mid nineteenth century erected hospitals in Calabar and in Lagos during the 1880s.[32] The desire was to care for the local people who at that time were ravaged by diseases like measles, typhoid, malaria, and cholera. But what appeared complicated regarding the approach used by those missionaries was the inseparability between evangelization and the provision of health care to the indigenous people. In other words, during that period health care was a powerful tool for evangelization especially in the southern part of Nigeria. This explains the high Christian population in the south and the large Muslim population in the north, which seemed impenetrable to Christian missionaries.

However, Christian missionaries played a crucial role in the establishment of the Nigerian health care system, which I will take up in detail in the second chapter. But their approach, which

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[31] Polycarp Ikuenobe, *Philosophical Perspectives on Communalism and Morality in African Tradition* (Oxford: Lexington Books, 2006), 121.
[32] Daniel M.N. McDikkok, *The Nigerian Health System's Debacle and Failure!* (Bloomington, IN: Xlibris Corporation, 2010), 32.

in my view was a form of proselytism, appears insufficient as a model of health care for all irrespective of one's belief, social, and economic statuses. Hence, I turn to another model of health care used by the religious nuns in Europe and North America during the same period of Christian evangelization in Nigeria. These religious women adopted a more holistic approach to health care. From the start, they recognized the inseparability of physical and spiritual needs of sick members of their community. Also, the efforts of these religious women brought us to a level of highly technological health care institutions around the globe.

1.4. Sister-Nurses and Patient Care in Nineteenth through Twenty-First Centuries

Late nineteenth century Europe and North America saw important developments in the health care sector with more organized nursing care by groups of women religious. This was in response to many calamities, which the world encountered during that period. Some of the calamities like the First World War, the American Civil War, and the need to care for the railroad workers in the new world (North America) made nursing care advance tremendously.[33] It was a period that many would agree shaped the health care sector. Health care gradually became an organized enterprise.

However, the underlying goal of these religious women was to carry out the ministry of the Church, through caring for the sick and providing help for the abandoned and hospitality to the strangers. The focus was to restore dignity to the sick and the abandoned. It was clearly a ministry with not many strings attached in terms of financial, or other religious motives.

Moreover, the primacy they gave to issues of individual and community's health made them unique. The reason is clear: their actions aimed at respecting life, and they desired to uphold human dignity. In a word, the approach of those religious women was both human and Christian.

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[33] Barbra Mann Wall, "A History of Roman Catholic Nursing in the United States," in *Religion, Religious Ethics, and Nursing,* ed. Marsha D. Fowler, Sheryl Reimer-Kirkham et al. (New York: Springer, 2012), 155.

First, it was human because their actions attest that every individual deserves dignity and respect because we are rational beings, created with dignity, and in the image of God. Second, it is Christian because the Catholic nursing tradition springs from the historical Jesus, whose life and action were a manifestation of the unmerited love of God for human beings, especially the poor and the sick: "I came that they might have life, and have it abundantly"(John 10:10b). Thus the issues of individual and community's health were primarily based on people's "need" and not on the "race" or "social and economic status" of a person or a nation.

Historically, the role and uniqueness of religious women in the area of health shows that their vision and strategies provide a wealth of resources for anyone wanting to reduce inequality in health achievement between the poor and the rich. Since the early centuries one may say that the care for the sick has always combined the provision of physical (medical) with spiritual needs. These religious women never made any distinction between the material and spiritual needs of a sick person. Drawing from the history of health care may enable one to grasp fully that when an individual suffers, he/she does not suffer only physically, or psychologically, but also, spiritually, emotionally, economically, racially, and otherwise.

In one of the instructional manuals used by the religious women during the late nineteenth and twentieth centuries, the interconnectedness that exists between the individual's failing health and his/her social context was clearly indicated.[34] An example of such manuals was the one written for the Daughters of Charity and was meant to be always carried by the sisters as they cared for the sick. Wall quotes the manual: "Indeed they were to care for them first because the union between the soul and the body is so close that when the latter is suffering a great deal, the other, attentive to its wants, cannot think anything else."[35] In a sense, the sister-nurses were

[34] Ibid., 158.
[35] Ibid.

instructed to provide care and comfort to the patients' suffering bodies, and at the same time minister to their spiritual needs. And it is through this lens that the "Catholic sisters viewed illness not only in biological terms but also within a spiritual framework."[36] Thus, through the centuries, even with the increase in social changes, it is clear that illness does not cause just physical and spiritual suffering, but unarguably, economic, gender and race based suffering as well. Hence, an individual's health may deteriorate because of his/her low economic status, gender inequality, or ethnic and racial discrimination.

Therefore, holistic care (ethical, medical, sociological and cultural), which is central to my thesis, ought to be aware of the impact of the social context (i.e., economic conditions, education, gender, and race) of every individual and nation. The issues of individual and public health ought not to remain on the level of treatment, but also prevention. When the approach in health care focuses on ethical, medical, sociological, and cultural discourses, it would inevitably spur questions like "why" and "how" do people fall ill? First, this approach offers us reason, to probe the causes of individual and public failing health. Second, it becomes pertinent to put a "cap" where possible on the causative agents of illnesses–"turning off the tap" as opposed to using "mops and containers"–as I will take up subsequently.[37] And this leads us to consider the bases of ethical principles in the field of health care.

1.5. The Emergence of New Questions in Health Care Systems

There is a popular saying that the only thing that is permanent in this world is change. As noted above, from the early century, through the middle ages, individual and society's health were to some extent focused on the needs of an individual and on the interests of the community. What I said above about sub-Saharan Africa supports the idea that both cultural and religious influences

[36] Ibid.,160.
[37] Simmons Ian G., *Changing the Face of the Earth: Culture, Environment and History* (New York: Basil Blackwell, 1989), 334.

of health care are considered acts of self-care and the promotion of public values. Notably, both cultural and religious influences enable us to uphold human dignity. The influences from the culture and religion ensure individuals' cohesion in the community–the common good.

However, if we virtually examine every aspect of human society, social change had its strongest impact on the health care system. One may say that no human institution, especially a healthcare system, was stagnant in terms of advances in science and technology, and the growing individualism in society. In fact, from the end of the twentieth century through the twenty-first century, the world saw huge economic and technological advancements (e.g., empirical knowledge and technical knowhow), which at the same time spurred questions and challenges–e.g., rationing of health care needs, intensive care, and withdrawal of life support–that were never asked or never imagined before.

These centuries brought developed technologies, which transformed the ability of physicians to identify and treat disease. Healthcare practices, which for centuries had little more than love and compassion to help patients, suddenly could boast of X-rays, computerized axial tomography (CT) scans, and magnetic resonance imaging (MRI).[38] With enhanced precision in virtually all medical diagnosis, the difficult questions relating to the causes and cures for some diseases, which for centuries had remained unanswered, could now be regularly addressed.

For Lisa Sanders, "Much of the research of the past few decades has examined which therapy to use and how to use them. Which medication, what dose, for how long? Which procedure? What's the benefit? These are all questions commonly asked and that can now be regularly and reliably answered."[39] In fact, the achievements made in medicine cannot be overemphasized. Experience has shown that the effective therapies we now enjoy in modern

[38] Lisa Sanders, *Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis* (New York: Broadway Books, 2009), xiv.
[39] Ibid., xv.

medicine have saved lives, and continue to improve human lives in many ways. Some diseases and illnesses that were previously considered deadly, because they ravaged human populations, are now treatable.

Moreover, there is a steady growth of epidemiological research in health care. In fact, "doctors and patients have long believed that when people became sick it was because they had disease…relieving sickness involves defeating disease."[40] At the heart of this assertion is the gradual development of medicine in particular and health care in general.

In his book, *The Nature of Healing,* Eric Cassell states: "the history of medicine is the story of gradual unfolding of an understanding of the body and a search for the root of disease."[41] And to say the least, many diseases and illnesses that ordinarily would have been classified as lethal are today either eradicated, or treatable. Examples include syphilis, measles, and cholera, which decades ago were considered as the deadliest illnesses in human society. Nevertheless, this improvement in both medicine and public health presents us with new challenges, especially economic challenges, excruciating absences of justice, gap in human solidarity, and ethical dilemmas.

Furthermore, Cassell reaffirms: "It has been true throughout the history of medicine that as one set of problems was solved another kind was uncovered. The near defeat of infectious disease, the marked increase in the reach and success of surgery, and pharmacologic solutions to many previously stubborn problems have resulted to in large populations of persons living with chronic illness, incapacities, and the afflictions of aging."[42] The emergence of effective medicine as a result of scientific and technological developments opened up new horizons in the field of

[40] Eric J. Cassell, *The Nature of Healing: The Modern Practice of Medicine* (New York: Oxford University Press, 2013), xv.
[41] Ibid., xv.
[42] Ibid., xv-xvi.

health care. Today, as the world looks with gladness at the growth and scientific improvement in health care, one cannot turn a blind eye to the apparent challenges that are evident in various areas. First, these challenges emerge from the limited human resources to procure adequate care. Second, the challenges we face in the health care sector are born out of human self-centeredness–egocentric self-interest. With the increase in social change and rise in capitalism, the notion of common good becomes secondary and sometimes unpopular in human relationships. I will return to this issue in the subsequent chapters.

There is a heightened consciousness as we ask pertinent social justice questions like: who gets what treatment? What are the criteria for the distribution? How long would the treatment last? What is the purpose of embarking on a given medical procedure and why? Critical thought on these social justice questions would enable us to see how far afield we have wandered off the original track that was carefully laid centuries ago by the early Christian community, Catholic religious women, and the community model traceable in African cultures. I will return to this issue in my second chapter on health care system in Nigeria.

1.6. Justice in Health Care

It is due to improved medical practices and its subsequent economic challenges that both ethical and justice questions became inevitable in public health care. The desire to uphold life grows alongside the high cost of medical procurement. In fact, the lives of many have improved as a result of mechanized health care, but many lives have fallen by the wayside, and more are still at the crossroads–especially the poor and marginalized. The questions therefore are: why does it matter to care for oneself, others, and the entire human society in our modern era? Can this be considered as a right? If yes, can this right to health care be placed at the same level as human rights?

Moreover, it is pertinent to note a link between public health and individual rights on the one hand, and ethics and human rights on the other hand. In most societies there are institutions and structures that enable normal functioning and a departure from this normality is tantamount to a human rights violation. When individuals do not have access to potable drinking water or proper ways to discharge human waste, undeniably, there are human rights issues at stake. In fact, every human being has a dignity, not only from a religious perspective, but also according to the Universal Declaration of Human Rights.[43] The dignity of the human person and his/her rights are closely intertwined.

In his book *Just Health Care,* Daniel Norman states that, "preventative health-care institutions can…be viewed as a first defense of the idealization: they act to minimize the likelihood of departures from the normality assumption. Included here are institutions which provide for public health, environmental cleanliness, preventive personal medical services…educational and incentive measure to promote individual responsibility for healthy life style."[44] In fact, a departure from this normality negatively impacts the well-being of individuals. A typical example is a community surrounded by stagnant waters, especially in sub-Saharan Africa, with the consequent high prevalence of malaria.

Similarly, in their book *Is Inequality Bad for Our Health?,* Norman et al. assert: "The goal of public health and medicine is to keep people as close to the idealization of normal functioning as possible under reasonable constraints. Maintaining normal functioning, in turn, makes a limited but significant contribution to protecting the range of opportunities open to individuals."[45] I will return to this assertion in detail in my subsequent chapters, but, as most of the commentators

[43] http://www.un.org/en/documents/udhr/index.shtml#a2 (accessed 11th April 2015).
[44] Daniel Norman, *Just health Care* (Cambridge: Cambridge University Press, 1990), 47.
[45] Daniel Norman, Bruce Kennedy, et al., *Is Inequality Bad for Our Health?* (Boston: Beacon Press, 2000), 17.

affirm, the modern human rights were initially developed outside the health domain; many have tried for decades to articulate them in relation to the normal functioning of every individual.[46]

Historically, the Catholic Church has been guided specifically by the assertion that every human person has a right to basic health care. This belief has constantly been reflected in various official documents and papal encyclicals, e.g., *Pacem in terris*, *Dignitatis humanae*, *Justitia in mundo*, *Salvifici doloris,* and *Evangelium vitae,* etc.[47] These documents and teachings are rooted in the notion that the right to adequate health care "flows from the sanctity of human life and the dignity that belongs to all human persons, who are made in the image of God. Health care is more than a commodity; it is a basic human right, an essential safeguard of human life and dignity."[48] Flowing from this assertion, the right to adequate health care is considered inherent to human dignity. Thus, "people's health care should not depend on where they work, how much their parents earn, or where they live."[49] In other words, because we are human beings and not objects, everyone has a right to basic health care. The desire to attain equitable health care for all remains utopian; hence, basic health care for all seems unrealistic. But this desire entails the necessary health care needs that guarantees human functioning like vaccination, potable drinking water, and low cost treatment plans.

The large gap between theory and practice calls for our attention, especially in the case of the "right to health" discourse. Philip Keane, in his book *Catholicism and Health-Care Justice,* argues that there is no such thing as the "right to health"; rather the concern ought to be

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[46] Jonathan Mann, "Medicine and Public health, Ethics and Human Rights" in *Hastings Center Report*, Vol. 27, No. 3 (May-June 1997), 9.
[47] http://w2.vatican.va/content/vatican/en.html (accessed on 11th April 2015).
[48] Catholic Bishops of the United States, *A Framework for Comprehensive Health Care Reform: Protecting Human Life, Promoting Human Dignity, Pursuing the Common Good* (Washington, DC: United States Catholic Conference, 1993), 1.
[49] Ibid.

on the right to a *reasonable standard* of health care.[50] Of course, Keane's viewpoint is realistic. The underlying factor to this assertion is that first, human health is bound to deteriorate even with the best medical facility in place. Second, health care needs to grow alongside high economic demands.

It is unthinkable for a nation to collapse the entire social needs to the procurement of healthcare needs. The limited available resources in our society inform the claim that what matters is a reasonable standard of health care. But the follow-up question is: what are the defining factors of this standard? Who determines when this so-called standard is attained? I will reflect further on these concerns in the subsequent chapters.

Nevertheless, for Christians, the plight of the poor, the sick, and the oppressed members of the community become the measuring rod, which is central to the New Testament proclamation and teaching of the reign of God. Both ethical and juridical claims push the focus away from simply the treatment of diseases to more inclusive and preventative forms of health care. In cases like malaria and tuberculosis, provision of medication is no longer enough if the individual affected still lives in a poorly ventilated room, clustered environment, or near stagnant waters. Thus, ethical and justice claims are such that "embrace all dimensions of the human person: physical, psychological, social, emotional and spiritual."[51] Hence, central to my thesis, is the idea that ethical and justice claims in health care become humane and holistic–a departure from rationalization and free-market orientation–when we reflect concretely on how the health conditions of some individuals or groups (the well-off) are improving, while the health of the poor is constantly deteriorating.

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[50] Philip S. Keane, *Catholicism and Health-Care Justice: Problems, Potential and Solutions* (New York: Paulist Press, 2002), 11.
[51] Catholic Health Australia, *Code of Ethical Standard: For Catholic Health and Aged Care Services in Australia* (Sydney: Catholic Health Australia, 2001), 3.

The truth of the matter, as I had alluded to earlier, is that something happened within the system, which brought about the inhumane approach in health care. The prevailing "culture of unconcern" means the rich get better while the poor get sicker.[52] Hence, one wonders why malaria and maternal/child mortality are the major causes of death, especially in sub-Saharan Africa. Yet, it is medically proven that malaria is treatable and maternal/child mortality could be reduced to the barest minimal. And this takes us back to the point of departure, namely, why the gradient in health improvement? The gradient in health improvement is not only philosophical speculation; there are verifiable data across sub-Saharan Africa in general, but particularly in Nigeria that confirms the existence of this gradient. The second chapter of this thesis discusses this gradient–the health care inequality in Nigeria.

Conclusion

In this first chapter I have demonstrated how the matters of health care are not only of great importance, but are embedded in the fabric of our societies. The values in our cultures, and religions, as well as justice and ethical approaches serve as foundational principles for promoting life. As a response to the question why does it matter to care for oneself, others, and the public, I argue that "health is wealth," and it is through good health that individual self-realization can take place. In this chapter, I indicated that individual health correlates with public health. Also, I noted the great emphasis on the individual belonging cooperatively to the community, based on interdependence. It means that each person has the task of mutually ensuring human flourishing. Hence, health and healing are not only individual concerns; they are fundamentally communal, especially in sub-Saharan Africa.

[52] Hornsby-Smith, *An Introduction to Catholic Social Thought,* 223.

Finally, the chapter stresses justice and ethical approaches enable us to care for and safeguard individual and public health; yet there is still inequality in achieving basic health needs for all. The second chapter will highlight different factors that contribute to this social inequality and their corresponding impacts on poor individual health.

Chapter two

2. The Nigerian Health Care System

Introduction

Nigeria has a population of over 170 million people with a very low life expectancy below 60 years.[53] The Nigerian health care system has three different tiers: federal, state, and local levels. The federal government controls the health care system. The resources from the federal government are distributed to the state and local governments, hospitals, and primary health centers respectively. However, the private organizations in the past two decades have been important stakeholders in the health sector. Many Nigerians are gradually being introduced to the need for health insurance. People no longer perceive insurance companies as agents of fraudsters. There is a gradual improvement in the quality of health care, even though the problem is its accessibility to a few people. Many people are still left out from the mainstream of health care.

Nigeria is endowed with both human and cultural values. One of these values is that each person strives to uphold the well-being of the individual and the community. However, one would expect that these cultural values do not remain on the social level, but also permeate both the nation's economic and political systems. On the contrary, the situation in the Nigerian health care system is concerning. This situation forces one to agree that things are not right within the system. In fact, the current health care system in Nigeria shows that there is a cultural disconnect between individual and community values. The discrepancy lies in how the health care system was operated during the colonial era and due to greed and corruption in the system since the country's independence in 1960.

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[53] Federal Republic of Nigeria, *Nigeria Demographic Health Survey, 2013* (Abuja: National Population Commission, June 2014, (Accessed 26th March 2015), 3. http://dhsprogram.com/pubs/pdf/FR293/FR293.pdf.

Notably, many would agree that the health of a nation is manifested in its citizens' health. Ironically, Nigeria is regarded as the giant of Africa in terms of its economic and human resources. But this high rating does not reflect in Nigerians' health improvement. Thus the Nigerian health care system is a clear contradiction because wealth makes a difference in accessing health care services. And this spurs discussion on the issues of social and economic inequalities. Social and economic inequalities put the healthy and the powerful in advantageous positions, while the rest of the population suffers, especially the poor.

In this chapter, I discuss the growing health inequality between rich and poor Nigerians. The growing level of health inequality, which retraces its origin to the colonial period, is alarming. The current Nigerian care health system still manifests in different ways some colonial ideologies that reserved health care services for the colonial masters and their allies.[54] The Nigerian health care system one would think is supposed to serve all Nigerians, the poor, the middle and upper classes.

Moreover, in addition this chapter discusses some of the government policies and regulations that are clearly a derailment from the community model rooted in the culture. I argue that the Nigerian health care system shows a clear discrepancy between the values in our culture and the current praxis. The nature of the Nigerian health care system is better described as an inverse care system: a situation where "the availability of good medical care tends to vary inversely with the need for it in the population served."[55] And the reason for this unfortunate reality is because the procurement of health care services depends heavily on market forces.

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[54] Olugbemi Moloye, *Medical Pluralism in Nigeria: Understanding the Efficiency of Traditional Care, Addressing healthcare Issues Nationwide Making Sense of Nigerian Preventive and Curative Healt*h (Tallahassee: Sokhe Chapke Publishing, 2014), 1.
[55] Tudor H. Julian, "The Inverse Care Law," in *The Lancet*, 297, No. 7696 (1971), 405-412.

Health care services are market oriented, or as many Nigerians fondly refer to the system: pay-as-you-go.

Therefore, this chapter identifies among other things some of the policies and praxes that enforce health inequalities in Nigeria. The goal, which inspires this chapter, will be to appropriate some of these identifiable values in our cultures and religions. In my view, some of these values will serve as tools for tackling the health care inequalities, which clearly inhibit a normal flourishing of the poor and lower income classes.

2.1. The Development of the Nigerian Health Care System

The Nigerian health care system owes its development to different historical events, which date as far back as the early 1470s. The early fifteenth century marked the arrival of the early explorer into Benin and Warri kingdom.[56] It was the first time the local people were exposed to modern medicine. The region experienced another major contact with the West at the beginning of nineteenth century: the arrival of Portuguese, Spaniards, Danish, French, and British traders who would eventually became slave masters. It was a period characterized by slave trade to the Americas via Europe.[57]

The southern part of Nigeria has a high prevalence of malaria, typhoid, and cholera. These Europeans found the area extremely dangerous due to diseases. Hence, they carried medical personnel and supplies aboard the ships for treating their crews, staff, and slaves.[58] A few years into this transatlantic slave trade, the British Parliament, through the support of William Wilberforce, required simple treatments for the entire Delta region in the form of vaccination programs for slaves and accessible coastal towns. The erection of hospitals (i.e., primary health care centers) occurred through the efforts of the early Christian missionaries in collaboration with

[56] McDikkok, *The Nigerian Health System's Debacle,* 31.
[57] Ibid.
[58] Ibid.

the colonial regime. The first of these hospitals was established in Abeokuta in the 1860s; Lagos and Calabar followed in 1888 while hospitals in the northern Nigeria were built decades later because of the strong Islamic influence in the region.[59]

In the same vein, the early missionaries worked closely with the colonial government. Medical care and other health services were primarily for the military, their allies, and the elites in the society. The health needs of common people (the have-nots) were secondary. The missionaries, on one hand, provided the local people with health care services as a means of bringing them into the new Christian faith. On the other hand, the colonial regime used health care services as a tool for colonial conquest and control. From both angles, health care services were tied to either spiritual or political purposes. Individual health care needs depended on either personal worth (social and economic) or a higher goal (spiritual).

Unfortunately, this practice would gradually permeate what became the Nigerian health care system. At the nation's independence in 1960, there were many hospitals and medical schools across Nigeria, both governmental and missionary. In the 1960s, Nigeria had over sixty government nursing and midwifery schools, one college of medicine in Ibadan, and two schools of pharmacy (one in Lagos and the other in Zaria).[60] It was the beginning of a new wave in the health care system in Nigeria. And this takes us to the issue of distribution of health services in Nigeria, which is the hallmark of health inequality in the country.

2.2. Distribution of Health Services in Nigeria

The Nigerian health care system is modeled after the British health system, a system that operates in different tiers: federal (tertiary), state, and local. The similarity, however, lies only on their formation (model) and neither on the nature of services nor on the efficiency of the system.

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[59] Ibid., 32.
[60] Ibid., 75.

Britain operates a socialized health care system: health services being provided for all citizens with no extra cost but through taxpayers' money; most Nigerians pay out of their pockets.[61] However, the 2014 National Health Bill (NHB), which I will discuss shortly, brings a new hope to many Nigerians–especially for poor and lower income families.

These three levels in the provision of health services in Nigeria are unique in their functions. The health care system is decentralized in order to facilitate the efficient distribution of health services to the people especially those in rural areas. At the federal level, the Federal Ministry of Health (FMOH) is responsible for technical support, enacting policies concerning the overall health system at both national and inter-national levels.[62] In other words, the FMOH funds the tertiary health system like the university teaching hospitals across the six geopolitical zones in the country.

The State Ministries of Health (SMOH) take charge of secondary hospitals in each of the thirty-six states of the Federation. The SMOH receive the annual health allocation from the FMOH, which is used to fund, regulate, and provide human and technical support for local health services (Primary Health Centre, PHC). And finally, the local government is directly responsible for health services, which are organized within the wards, towns, and autonomous communities.[63]

The distribution of health services involves delivering the basic health services to those with greatest needs. And this process includes ensuring that human and material resources that support health are properly managed and made accessible to people that need them most. Hence, the citizens judge the efficiency of a health sector based on the accessibility of these health care needs. The efficiency or inefficiency of the health care system can as well be understood in light

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[61] Ibid.
[62] http://www.who.int/pmnch/countries/nigeria-plan-chapter-3 (accessed 20th February, 2015), 21-30.
[63] In Nigeria there are 36 independent states, and 774 local governments areas. The local government area is comparable with districts, or counties in other countries. Most local governments in Nigeria have population of about 1-4 million people unlike districts, which generally have population of 300,000 or less.

of just and unjust practices in the sector. The distribution of health services is considered as just and efficient when the health needs of the citizens are regularly met with reduced disparity and the opposite are defined as unjust health care systems. Unfortunately, the Nigerian health care system falls short of these attributes of efficiency or just health care system. And one of the reasons is the disparity in the distribution of health care needs.

The distribution of health services is a major challenge in the Nigerian health care system. Oftentimes, the majority of Nigerians, especially those at the margins, do not have access to even basic health services. As I alluded to earlier, new hope was rekindled in the long awaited NHB that was signed into law last November 2014. This is a noteworthy development because Nigeria has been without a health bill for decades. The bill outlines the category of people who are eligible for free health services and states that the national health system should "provide for persons living in Nigeria the best possible health services within the limits of available resources."[64] The bill asserts that there are categories of persons that may be eligible for exemption from payment for health care services at public health establishments. And these people include vulnerable groups such as women, children, older persons and persons, with disabilities.[65]

However, in virtually all three-tiers health care sectors in Nigeria, the ideal has always been embellished nicely with words, but our problem as a country lies in praxes–namely in implementations. The reality on the ground, for instance in most public hospitals, differs woefully from the ideal. The distribution of health services in Nigeria is such that those who need them hardly receive anything. It is better described as "inverse health care."

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[64] The Senate Federal Republic of Nigeria, *National Health Bill*, 2014 (Abuja: Federal Capital Territory, 2014), subsections 1(1c).
[65] Ibid., subsection 3, (1d).

2.3. Inverse Care System in Nigeria

The decentralization of health care services in Nigeria aims at facilitating the efficient distribution of health needs to all citizens irrespective of their state, local government, towns or village. The three-tiers health care system with tertiary, secondary, and local health care centers was meant to ensure that people in the rural areas as well as those in the urban areas were duly served by addressing their basic health needs. In fact, this approach was in line with the commitment of the Nigerian federal government to provide health to all Nigerians before 2000. Many would agree that this was a reiteration of the Alma-Ata Declaration of 1978.[66] But unfortunately, "Health for all in the Year 2000" has come and gone, and the social and human conditions of most Nigerians deteriorate daily, especially in the case of the poor and lower income classes.

The health inequality that exists between the higher social classes and the lower social classes is disturbing. Hence, the federal government's commitment to provide adequate health care to all Nigerians remains elusive due to "basic infrastructural inadequacies, policy malfeasance to the nation's health personnel brain drain… inadequate distribution of manpower resources within and between states."[67] I agree with Moloye that the problems of the Nigerian health care system are multifaceted and each negatively impacts citizens' health improvement. Nevertheless, my experience is that inequitable distribution of the available health care services remains a major problem.

I would imagine that the likely questions that lie in the mind of everyone at this stage could be: why can't a country like Nigeria, among the top ten oil producing nations, boast of basic

[66] In 1978, the World Health Organization declared the importance of primary health care in ensuring improved health for all citizens of the world. This declaration anticipated various stages of implementation in which the final stage was to be attained by year 2000.
[67] Moloye, *Medical Pluralism in Nigeria,* 3.

health infrastructure for its citizens? Why is there brain drain in the country? Why is there inequitable distribution of health care needs? Why do the health conditions of the poor and lower income classes continue to deteriorate? The whys can go on and on, but the root causes of Nigeria's health care problem as well as other social inadequacies are primarily corruption, greed, nepotism, egocentric self-interest, and lack of social and political will to effect positive change.

The issues of illiteracy and some cultural beliefs, especially in the rural areas, also contribute to the problem, though very insignificantly in the past decade. The situation in Nigeria since the late 1980s to date shows that the number of Nigerians with university degrees has increased exponentially. In fact, most families now have first time university graduates, which was not the case three decades ago. These young graduates influence their illiterate parents as well as their relations in seeking modern medicine as opposed to traditional medicine and rituals. Also, this trend had led to a reduced superstitious belief in the case of deadly diseases, which used to be very common among Nigerians.

However, corruption and nepotism seem to be the two main clogs in the pipes of the Nigerian health sector. In fact, it is very common among political leaders that when an action or a decision has no direct or indirect positive impact on one's personal interests, state, town, or people, it is not worth undertaking. This issue is worrisome especially because it affects general health improvements. But without making a blanket judgment on all Nigerians, I will use a specific work experience in one of the Nigerian University hospitals to highlight this trend.

2.4. Public Hospital in Nigeria

The term public hospital spurs in us the idea of the existence of private hospitals. As noted, the Nigerian government oversees the affairs of public hospitals, while individuals and religious organizations are the key players in private hospitals. The public hospitals are supposed

to provide for all Nigerians their basic health needs. But unfortunately, at this point in Nigerian public hospitals, who gets health care services depends on one's social, economic, and political status. As noted earlier, some of these trends can be traced back to the colonial era when health care services were reserved for a few people.

However, over five decades after Nigerian independence, the same utilitarian and libertarian approaches to health care services still regulate the Nigerian health care system. Health services are readily available for the rich and the powerful. This inequality negates what health care stands for as a means of ensuring human flourishing.

From 2008 to 2010 I worked as a chaplain at the Lagos University Teaching Hospital (LUTH). The hospital is classified among the top three Nigerian hospitals. As a teaching hospital, it is the hub of all medical research, cancer treatments, dialyses, and high-level surgeries. But the facility does not cater to the health needs of the poor and lower income classes due to the way the institution is compartmentalized.

Compartmentalization occurs in virtually all government hospitals in Nigeria by dividing a hospital into different sections, units or wards. Ordinarily, this division, even in the developed countries, is based on the kind of disease or sickness that one has. In LUTH, the case is different because the compartmentalization is not only based on the nature of diseases or sicknesses, but also on social and economic classes. This may sound strange but the reality on the ground is that if a patient is willing to pay an extra fee, he/she will be admitted into a private room with fairly all facilities in place. Also, if the patient belongs to the elite class (e.g., the top government officials and business moguls), he/she is much more likely to be admitted into the elite ward. Of course, the medical bills for these privates or elites wards are over ten times higher than in regular wards.

As one would expect, this kind of ward assures efficient medical personnel and round-the-clock health services.

During my work experience at LUTH, I was exposed to the internal operations of the institution. The hospital is housed in a big complex with over four hundred and fifty beds including Intensive Care Units (ICUs). The hospital building has eight different floors. The first to the seventh floor are known as the regular patients' wards opened to the public: ordinary people, nursing mothers, children, cancer patients, HIV/AIDS patients, etc. The last floor, which is referred to as E-8, or the elites ward, is spaciously furnished to suit the taste of people in middle and higher income classes.

The idea of this elite wing in Nigerian health care institutions is not just to provide privacy to the patient or protection from infectious diseases. It is rather to ensure that a patient is well-cared for by the best medical personnel. But what I found most surprising and mind-boggling in this "hospital in a hospital" is that the health services that over ninety percent of Nigerians receive in the regular wards, are shabby, inhumane, and totally unacceptable for the twenty-first century. The rationing of medical needs as well as inadequate medical supplies like drugs, protective gowns, hand gloves, electricity, and water are some concrete examples of this phenomenon. The rationing involves weighing options on which patient gets what medical treatment and for how long. In most cases, the financial status of a patient is what determines who gets what care.

Moreover, because of this kind of compartmentalization, oftentimes basic utilities like water and electricity can be off for days in the regular wards (from the first to the seventh floors). But, in the elite ward, there is uninterrupted water and power with air conditioners blowing in full capacity along the hallways and in the patients' rooms. Also, in the regular wards the ratio of nurse to patients is 1:20, while in the elite wards is 1:5. One can imagine the kind of services the

patient will receive in these regular wards. Some of the regular wards are often regarded as "death zones," because medical personnel seem overwhelmed and clearly unable to care as much as they should, due to their workload and infrastructural inadequacies.

On the contrary, in the elite ward, some of the benefits include proper medical care and a prompt visit by an experienced consultant on a daily basis. Also, the waiting time for patients in the elite wards to have access to dialysis, x-ray or radiotherapy is just a click of the mouse. Priority is given to them to use these facilities, and even to be transported through the elevators powered by generators when the rest of the hospital is without electricity for days. What causes this heart-wrenching situation is that these men and women can pay for their services. How did we get here as a nation? The growing health inequality in Nigeria is the epitome of libertarianism in health care: if one can afford it, he/she is free to use the service unhindered even to the detriment of others in dire needs.

On a different note, I have always thought that compartmentalization of Nigerian public hospitals based on individual social and economic statuses are the same everywhere in the world. But unfortunately, the Nigerian health care system is infamous in every angle. My three-month internship at the Saint Louis University Hospital (SLUH), Missouri, enabled me to experience what patient care entails in that institution. I discovered how each individual's health needs matter to the medical personnel. The hospital is compartmentalized based on the degree and nature of patients' diseases and sicknesses and never on the worth or amount an individual is willing to pay. Hence, health services are distributed equally based on individual needs. Of course this assertion excludes those who may seek advanced health services elsewhere even without going to the hospital. One may compare Nigeria with the US. Both are twenty-first century societies and, as

long as we could avoid self-centeredness and corruption in our system, Nigeria is endowed with the human and natural resources to provide basic health care services to all its citizens.

The most disturbing aspect of the Nigerian health care system is not just that the poor and lower income classes are not duly served in our public hospitals, but the growing culture of unconcern that is becoming a norm within the hospital community. Both the authorities and some of the medical personnel appear unconcerned by the situation. Oftentimes, patients are referred to different private laboratories for scan, x-ray, ultrasound tests and so on, either because the facility in LUTH has broken down or due to power outages in the hospital. A desperate patient will have no time to waste and must seek an alternative. But it is hard to believe that the same medical personnel in the public hospitals serve in most of the private hospitals and laboratories all over the cities. In fact, some of the medical personnel lack passion to work in the public hospitals. Most doctors and nurses in Nigeria regularly complain of poor working conditions, and these are genuine concerns. Hence, private hospitals become the alternative for one wishing to get better health services as long as he/she is willing to pay exorbitantly.

In the same vein, over eighty percent of middle and upper class people who enjoy first class care in our public hospitals do so through public funds. In the new NHB, which I mentioned earlier, it is stated that no individual should use government funds to procure medical care home or abroad. In particular,

> Without prejudice to the right of any Nigerian to seek medical check-up, investigation or treatment anywhere within and outside Nigeria, no public officer of the government of the Federation or any part thereof shall be sponsored for medical check-up, investigation or treatment abroad at public expense except in exceptional cases on the recommendation and referral by the medical board and which recommendation or referral shall be duly approved by the minister or the commissioner of health of the state as the case may be.[68]

[68] *National Health Bill*, 2014, subsections 46.

Although the NHB has just been signed into law, the common practice has been the contrary. Public officers are regularly seen lavishing public resources both locally and abroad and even sometimes engage in non-beneficial treatment just because he/she can pay for something like cosmetic surgery and aggressive cancer treatment.

During my work at LUTH I encountered a terminally ill patient. He was a stage four-cancer patient. The man was in his mid-fifties and worked at the time as a top government official. His name was Mr. Igwe (pseudonym for confidential purpose). Due to his social status, undergoing medical processes like biopsy tests, radiotherapy, and chemotherapy were swift since he was admitted at the elite ward. He is among the small percentage of Nigerians that enjoy the employer-based health insurance that is, a co-payment system between the employer (the government) and the employee. As indicated in Igwe's medical record, the insurance company pays half, while he pays the other half of the medical bills.

However, as days went by, his case deteriorated because the cancer continued to spread. Based on the medical results, his physicians knew that the end was near, and any aggressive treatment would be futile. From the medical viewpoint, all he needed most at that point was palliative care together with love and support from the people around him. The patient's wife and his children were briefed on the diagnosis, though not with details so as not to hurt their feelings. The medical secrecy and confidentiality assume different forms in most Nigerian hospitals compared to international standards. Sometimes patients and patients' families are not properly informed of the nature of their diseases or sicknesses. Some of the doctors do claim that these patients may not fully understand medical details and sometimes patients are devastated when told of the gravity of their sicknesses.

Nevertheless, Igwe's family was resolute that the spread of the cancer could be contained. But to the contrary, everyone saw hope of life disappearing from Igwe as the clock was ticking. Everyone agrees that death is inevitable, but it is very hard to embrace it especially when one feels there are still more reasons to keep the treatment going. Facing death is much easier for the poor; they accept more willingly their fate and the inevitability of death than those in the upper class, especially with all the medical possibilities that are available today. It seems there is always room to try further and harder when the medical and economic means are available.

After two weeks of seemingly futile treatment, Igwe's family in protest sought him to be discharged and transferred to a cancer specialized hospital in India. They claimed that better medical facilities in India, aggressive chemotherapy, and other treatments would cure the cancer. His physicians knew fully well the futility of this request to transfer the patient to India. But in order to respect the autonomy of the patient and his family, the physicians did not dissuade the family from seeking medical care abroad.

In a hospital without well-organized social workers or an ethics committee, the local chaplain becomes the only reliable bridge between the hospital community and the patient. A brief conversation with the physicians confirmed that the aggressive treatment lacked any potential benefit; instead, the patient needed palliative care. I had a long conversation with Igwe's family regarding the prognosis and futility of all further aggressive treatments. At the end, it became obvious that the family was poised to go to any length in order to ensure that Igwe was treated. And this is exactly what I found puzzling in Igwe's case because almost all family members believed that as long as they could pay they should pursue aggressive medical procedure even with a very slim or inexistent chance that the patient will heal or survive longer.

In sum, Igwe's family never heeded any of the advice or medical opinions against seeking aggressive treatment abroad. They obtained the medical clearance from the hospital and a day later they took off to India. Unfortunately, as the event turned out, Mr. Igwe died at the airport, shortly after they landed in India. To say the least, one can imagine the suffering that followed the inevitable return trip to Nigeria, as well as the expenses involved.

The bottom line here concerns ethical consciousness. This heart-wrenching story shows how the use of limited human resources for a clearly non-beneficial treatment is supposedly justified, on the one hand, because the insurance company is paying and, on the other hand, because the individual is a top government official. There were many poor people in the same hospital. They died simply because of insufficient oxygen cylinders in the hospital wards. There were also those who died waiting to be taken to the dialysis machine or to receive a full dosage of malaria tablets, which never happened. In contrast, there were many extra oxygen cylinders put on the reserve section in the elite wards.

2.5. Not All Bad News… If It Affects the Majority

The current situation of the Nigerian health care system highlights a further trend. Both the authorities and the medical personnel are known to be proactive only when the health situation affects the majority. And then serious strategies are employed and most often the situation is properly handled. Take for instance the issue of polio in the northern Nigeria, and the recent Ebola pandemic, which was introduced into Nigeria by a Liberian man who flew into Lagos. It is worth considering how polio has been tackled during the past decades in Nigeria.[69] At some point it was declared a national issue that needed an urgent response by the government, NGOs, and

[69] Elisha P. Renne, *The Politics of Polio in Northern Nigeria* (Bloomington, IN: Indiana University Press, 2010), 83.

citizens alike. Currently, Nigeria is into its second year without any new or active polio case. We hope this remains effective for a long time.

There are several lessons we can draw from Nigerian campaign against polio. First, the government declared the polio virus as a national emergency that required both human and medical resources to be put together for its eradication. The situation was never seen as a regional problem (northerners or southerners) alone, but rather a national health crisis. Second, the treatment has been available for everyone, especially children, in northern Nigeria where polio is most prevalent. As part of the polio eradication campaign, "health workers go house-to-house, providing polio vaccines, Vitamin A drops, deworming medicines, and insecticides-treated bed nets to protect against malaria-carrying mosquitos."[70] The treatment is not sectarian, even though some Muslims resisted the program at the beginning, but every child is vaccinated free of charge, rich and poor alike. The government, medical personnel, and common Nigerians saw the campaign and the current result as a testimony of a just health care–the common good in its entirety.

Similarly, the Ebola virus in Lagos and Port Harcourt was urgently contained with the best medical response one can imagine even for developed countries. It was even more aggressive than in the case of polio. The federal government declared the Ebola pandemic a national emergency, and all hands were on deck throughout the pandemic period. Nigeria became the first country in West Africa to be declared an Ebola-free nation.

These two cases (Ebola and Polio) may sound like a tale of the moonlight, but my point, on one hand, is that Nigeria is capable of providing not just basic health care services to every Nigerian, but a high quality free medical care to everyone in need. On the other hand, one

[70] Ibid., 2.

wonders why this kind of zeal and unity that was shown during the crisis situation cannot be put together in tackling malaria as well as maternal and child mortalities in Nigeria. The reason seems to be that these health conditions affect just a group and the majority of them are poor and from lower income classes.

2.6. Primary Health Care Centers: Situation from the Grassroots

Based on the World Health record, the general health of Nigerians has a low rating. In the 2005 report from FMOH and Work Bank, "One in every ten children dies before his first birthday and one in every five before his fifth."[71] Within a decade since the publication of this report, there has been a slight improvement, but the overall outcomes are low when compared to other countries in sub-Saharan Africa.

It is from this standpoint that one could get a better view on the situation of people living in rural areas. In the three-tier health care system in Nigeria, which I highlighted above, the local government oversees the affairs of Primary Health Care (PHC) centers in all 774 local government areas in the country. The rationale for this decentralization is to "democratize access to health care service for all Nigerians irrespective of their social position or residential habitation."[72] It is a brilliant idea. Health services are hereby brought to the doorsteps of people living in the rural areas. Hence, the PHC service scheme in Nigeria was primarily "designed as a system that would function within a hierarchy of facilities which involved a health team approach, whose activities would be mobile and community oriented."[73] For one familiar with Nigeria's terrain, the people in the rural areas tend to get sick more frequently due to poor sanitation, lack of potable drinking water, environmental pollution, and high fertility rates. The obvious health

[71] World Bank Working Paper No. 187, *Improving Primary Health Care Delivery in Nigeria: Evidence from Four States* (Washington DC: The World Bank, 2010), 7.
[72] Moloye, *Medical Pluralism in Nigeria*, 18.
[73] Ibid.

consequences include typhoid, cholera, malaria, and high maternal and child mortality rates. At present, Nigeria is among the countries with high death-rates resulting from malaria and maternal and child mortality.[74]

As I noted earlier, the condition of the poor and lower income classes is unacceptable because communicable diseases like malaria, pneumonia, and diarrhea are often linked with malnutrition.[75] No doubt this fact sends cold to the spine: a country which ranks among the top ten oil nations will let its citizens face malnutrition. On the effects of these communicable diseases, the same report notes that, "these diseases can be prevented or treated at a very low cost, but the coverage of many of the health interventions needed to prevent and treat them is very low."[76] I agree with the report that basic health interventions as well as a political will to effect change are lacking.

My experience in LUTH is that most of these deaths–maternal mortality as well as some neonatal deaths–are peculiar to the poor and lower income classes. It is not that parents are careless or ignorant of their health needs, but that they lack the economic means, and the structure favors the affluent group. In 2003, the Nigerian Demographic Health Survey (NDHS) shows "that only 1 percent of children under five slept under an insecticide treated bed net; only 17 percent of children six month of age or younger were exclusively breastfed; only 34 percent of children under five received a vitamin A supplement; and only 13 percent of one year olds were fully immunized."[77] In the last decade, there is a slight improvement but much is still expected.

Notably, the under-5 mortality rate decreased from 201 deaths per 1,000 live births in 2003 NDHS to 128 deaths per 1,000 live births in 2013. This implies that during this period one

[74] Ibid., 17.
[75] World Bank Working Paper No.187, 7.
[76] Ibid.
[77] Ibid.

in every eight children born in Nigeria died before reaching the fifth birthday.[78] These figures are just the tip of the iceberg because most rural areas in Nigeria have no medical data. Statistical data from rural areas are inaccessible and they have higher health needs. But unfortunately, these areas have the least medical personnel and equipment.

As a young child I grew up in a village with over 150,000 thousand people, and all depended on one PHC center. It is located about 8km away from home. And for some people the distance is even farther, but everyone had to make his/her way to the center for every sickness and maternity/neonatal care. The infrastructural inadequacies, poor staffing, and inadequate drug supply confront PHC centers in most towns and villages across the country. It is becoming a common practice that most young medical personnel who graduate from the university aspire only to work in the urban areas or private sectors. The reasons include higher remuneration and access to fairly well-functioning equipment in the urban areas and private sectors. In fact, choosing to work in PHC centers across the country is basically to work in an environment devoid of medical advancement and training, unlike hospitals in the urban areas.

In sum, some medical personnel would want to serve the people in the rural areas if there were basic infrastructures and essential medical supplies. But the experience has shown that most PHC centers are neither cost-effective nor self-sustainable if they were to depend solely on what the people in the rural area can afford to pay.[79] This is where government funding and genuine medical subsidies become crucial. The exclusively market-oriented payment of medical care has never been favored anywhere in the world. Health needs should be seen differently than other social commodities.

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[78] Federal Republic of Nigeria, *Nigeria Demographic Health Survey, 2013,* 117-118.
[79] McDikkok, *The Nigerian Health System's Debacle,* 159.

Conclusion

In this chapter I highlighted different human, structural, and political backgrounds to health inequality in Nigeria. I noted that health care inequality among Nigerians is an age-old problem. The origin is partly associated to the periods of slavery and colonization of the nation, and partly to the greed and corruption in the system. Delivering health services to the indigenous people was used as a means to attain religious, utilitarian, and political purposes. Other nations and ethnic groups shared this experience during those dark periods in African history. Since the independence in 1960, we have seen steady improvement in the Nigerian health care system but regrettably, it still favors only a few, the majority of whom are in middle and higher income classes.

This chapter also indicated that the growing health care inequality is rooted in corrupt practices among government officials. I also noted that both market-base and libertarianism in health care threaten the true sense of basic health care for all. The chapter also highlighted the worrisome trend of a culture of unconcern among the authorities as well as medical personnel. It is not surprising to note that in all the top five Nigerian medical schools, social ethics and bioethics courses are not core courses in their curriculum. Some of the medical students that I encountered while in LUTH testified that social ethics and bioethics are basically treated as selected topics or sub-topics. One wonders how this segment of young doctors, nurses, and health workers who graduate from our institutions would not consider their roles in society at the level of an engineer or lawyer. I will return to this issue in detail in the next chapter.

Addressing health care inequality requires going beyond the usual short-term measures. Otherwise, government and individual efforts will amount to simply perpetuating a vicious circle where the rich get better health services and the poor rely on fate. Because of the issues raised in

this chapter, to tackle health care inequality in Nigeria, the social determinants of health need to be addressed. We equally need to reinvigorate "civic generosity" in our cultures and beliefs. This reflection forms the main focus of the next chapter, where I will stress that reducing the gap between the health achievement of the wealthy and the poor is possible. Our experiences in the campaign against polio and the recent Ebola pandemic attest to the claim that Nigeria has all it takes to provide not just the basic health services but also quality health care to every Nigerian.

Chapter Three

3. The Way Forward: Just Health Care in the Midst of Scarcity

Introduction

At this point in my thesis, two things are gradually becoming clearer: first, Nigerians, just like every group of people in our world, have values in their cultures. And these values are specifically community oriented. The potency of these values depends on how they support lives and human flourishing in the community. Second, there is an indication that something turned awry along the line especially during and even after the colonial period in Nigeria. Hence, these values, though not totally lost, are muddled by self-centeredness and egocentric self-interest. In effect, today's common practices among Nigerians show that high emphasis is put on individual achievement with less focus on social bonds. The slogan seems to be: "Each person to his/her own tent"(2 Samuel 20:1b). The sense of common good seems to decrease daily in proportion to the extent that it concerns health care. There is a dearth of communitarian ethos, which has been the essential element in our cultures.

In this third chapter, after our consideration of the cultural values and the numerous challenges facing the Nigerian health care system, the questions therefore are: Can health services be fairly distributed especially to the poor and lower income classes in Nigeria? What is/are the possible framework(s) that could guide effective provision for basic health care services to those with greatest needs–people at the margins in our country? And lastly, what makes the provision of basic health care needs different from other social services in Nigeria? In other words, why is it that health care policies cannot and should not adopt market dynamics? Hence, the market notion that focuses on the survival of the fittest is considered both inhuman and incompatible with the

health care system. The obvious reason for this claim is that this notion denigrates human dignity. Market based health care is in effect an assault on the values of the common good.

This third chapter is divided into two sections. The first section focuses on objective and subjective criteria in the provision of basic health care needs. From the objective standpoint, I discuss different external measures necessary to ensure human flourishing. In other words, the focus is on capability principles that can enhance individual, social, and economic developments. These capability principles are discussed in relation to their impact on Nigerians' health improvement. The subjective criterion focuses specifically on individual self-affirmation. I highlight different ways in which those at the margins of our society can regain their "agency," "self-worth," and "personhood." It is arguable that poverty dehumanizes human persons just as some charitable acts may force an individual or a group of people to remain perpetually dependent on others. A master-servant relationship in health services is not liberating. It perpetuates injustice and makes it appear to be a norm in the society.

The second section focuses on the common good in health care. This part responds to my guiding question posed at the beginning: Why should I bother about my health and that of my neighbor's? The notion of the common good encourages us to undertake the issues of health care not just as an individual good but also as a societal good. The challenge, however, has been how to persuade one to treat others in a manner devoid of egocentric self-centeredness even in the midst of scarcity. Hence, I propose collective moral obligation and civic generosity as two ways we can ensure that an individual's well-being or misfortune ceases to be only a private concern, but also they become a society's joy or sorrow. Notably, this proposal is founded not only in a communitarian ethos–solidarity–but also in a belief that we are brothers and sisters, created in the image and likeness of God.

Section One
3.1. Objective and Subjective Criteria for Basic Health Care

One of the fundamental questions in this thesis is why the middle and high-income classes get better health services than poor and lower income classes. The existence of a health gradient between the rich and the poor in sub-Saharan Africa, especially in Nigeria, calls for reconsideration in individual and communal attitudes as well as political agendas and policies. In Nigeria, it is increasingly obvious that an individual's health depends directly on one's social and economic status. Hence, we need to consider the root cause of this trend, which lies mainly outside the health care system. This cause is referred to as the social determinants of health. These determinants are clearly external to an individual or a group, and may impact directly or indirectly health improvement or deterioration depending on the circumstances. Some of these social determinants of health include the following: education, unemployment, ethnic/racial inequalities, poverty, gender inequality, social exclusion, corruption, and war.

The situation in the Nigerian health system shows that the gap between the rich and lower income classes will continue to widen if these social determinants of health are not addressed. As I earlier alluded to in the previous chapters, the Nigerian health care system is founded on the neo-liberal and market ideology that perpetuates health inequality. As such, an individual is free to seek non-beneficial health services even to the detriment of others because he/she has the social and economic means to do so.

In their various documents, the Nigerian Bishops Conference had shown their support and care for the poor and the marginalized especially in the North Eastern part of the country. In the last three years, thousands of people have been killed and over a million people displaced from their homes due to the Boko Haram terrorist attacks. Also, the Ebola virus in Lagos and Port Harcourt steered the Bishops into adopting some preventative measures within the local churches.

The Bishops thought that the respect and dignity of the human person remain paramount and cannot be exchanged with any political interest or sectarian ideology of any kind.[80]

In the same vein, as the US Catholic Bishops remind us, to tackle the root causes of health inequality requires that both individual and government decisions regarding health care "must be judged in light of what they do *for* the poor, what they do *to* the poor and what they enable the poor to do *for themselves*."[81] The US Catholic Bishops are emphatic that the measuring rod of every decision by an individual or government ought to be the impact it makes *for* and *to* the poor. It is true that the context of this statement was economic justice in US, but as seen so far, both economic and health inequalities are intertwined and correlate in various ways. And the condition of the poor and lower incomes classes raises social justice questions all over the world.

However, globally the common approach to define the economic status has always been to measure and determine a country's growth and improvement based on Gross Domestic Product (GDP) or Gross National Product (GNP), while little is said on how this growth translates concretely in the lives of common people, especially the poor. Thus, it is necessary to change this approach and tackle not just the symptoms but also the root cause of the problem. This claim is inspired by an anecdote about an eighteenth-century protopsychiatrist. He developed an infallible method of distinguishing the sane from the insane. The story tells that the protopsychiatrist locked those to be diagnosed in a room with water taps on one side and a supply of mops and buckets on the other. He then turned on the taps and watched: those that he considered mad ran for mops and buckets; the sane walked over and turned off the taps.[82]

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[80] Catholic Bishops Conference of Nigeria, "The Lord Comforts His People!" (Effuru, Delta State: Diocesan Conference Centre, September 11-19, 2014, accessed 12th April 2015, http://www.cbcn-ng.org/articledetail.php?tab=15).
[81] Catholic Bishops of the United States, *Economic Justice for All: Pastoral Letter on Catholic Social Teaching and the U.S. Economy* (Washington, DC: United States Catholic Conference of Bishops, 2009), 24.
[82] Ian, *Changing the Face of the Earth*, 334.

A close look at the Nigerian health care system reveals that the solution to health inequality requires that we draw from our human, cultural, and religious values. As such, tackling health care inequality cannot remain on the level of free choice or market dynamics but instead on "prediction and prevention." So in this section I will highlight the impact of unemployment and poverty on the citizens' health. I will proceed to reflect as well on the education and health inequality in Nigeria. And finally I will consider, gender and health inequality.

3.2. Unemployment and Poverty

Among other factors, unemployment and poverty are foundational to the growing social and economic inequality in Nigeria. This trend, however, has a direct impact on individual and public health as indicated in the chapter two. The irony is that the country's GDP is growing exponentially, but this growth is not reflected in the lives of common people. Poverty limits a person's health care choices and most often is caused by an inequitable distribution of the nation's wealth. The unemployment rate is high and sometimes only flexible and low-pay jobs are available.

In the recent World Bank report on the Nigerian economic situation released in July 2014, the national poverty rate remains at 35.2%. However, in the rural areas poverty rate is much higher as it stands at 46.3%. The urban areas have relative lower poverty rate of 15.8%. Notably, the poverty rate of people in the Southern part of Nigeria is lower compare to those in the Northern part of the country. In the South West, the lowest poverty rate stands at 16% in 2012-2013, while an estimated 50.2% of the population lives below the poverty line in the North East.[83]

Moreover, in most rural areas across Nigeria when someone falls ill because of malaria or suffers minor kneel or ankle injury, the option to seek medical attention in the hospital is rarely a

[83] The World Bank, "Nigeria Economic Report," No. 2, July, 2014 (http://www.worldbank.org/en/country/nigeria, accessed on 13th April, 2015), 17-18.

first choice because of the cost. This practice cannot be interpreted as being carefree about one's health needs; rather, it is primarily because of financial incapability. The government policies that aim to tackle the growing disparity in the provision of health care services between the rich and the lower income classes remain ineffective if the issue of unemployment is not addressed. The literacy rate in Nigeria is over 60%, though a higher rate is still desirable. Nigeria is among the countries in sub-Saharan Africa with a high population of young university graduates. But the majority of these young men and women are without decent jobs after graduation. The World Bank report in 2013 puts the unemployment rate in Nigeria at 7.5% of the total labor force.[84] For an individual the likely consequence of remaining unemployed for long is poor health condition.

In the encyclical *Laborem Exercens*, John Paul II states: "man's life is built up every day from work, from work it derives its specific dignity, but at the same time work contains the unceasing measure of human toil and suffering, and also of the harm and injustice which penetrate deeply into social life within individual nations and on the international level."[85] From John Paul's standpoint, it is unequivocal that everything about a man and a woman revolves around his/her work. In fact, work does not only determine one's social stratification but also dignifies and humanizes a man or a woman in society.

Notably, when one is capable and willing to work but cannot find a job, the individual experiences full deprivation and desperation. For a young man or a woman, it is dehumanizing not to find a decent job in order to lead his/her life. The choice in life becomes limited and sometimes nonexistent when it comes to health care needs. Therefore, the first step in tackling health inequality is to address the social conditions and policies that put most Nigerians out of

[84] http://worldbank.org/all?qterm=unemployment+rate+in+Nigeria#. Accessed 17th April 2015.
[85] John Paul II, *On Human Work: Laborem Exercens* (14 September, 1981), #1. Accessed 12th February 2015, www.vatican.va.

work. And this includes creating new jobs and empowering small-scale traders. There is need to uplift people out of poverty through job creations in Nigeria.

Moreover, confusion always arises when an attempt is made to define who is poor and what is poverty. Poverty as a social phenomenon is relative to place, situation and person, but this is not to say that we cannot come up with a way of judging who is actually poor, especially with the increasing health gradient in Nigeria. Thus, the poor are individuals or families whose incomes are unable to provide them with the basic needs of life. Using the "deprivation measurement," it will be fair to say that the poor are individuals or families that are deprived–mildly, moderately, or severely–of food, clean drinking water, sanitation facilities, health care needs, shelter, education, information and access to services.

The unfortunate reality of our contemporary society is that one's voice, life decisions, and choices are largely controlled by the social and economic ability. It is from this awareness that John Paul II in the same encyclical *Laborem Exercens* affirms:

> Human work is a key, probably *the essential key*, to the whole social question, if we try to see that question really from the point of view of man's good. And if the solution–or rather the gradual solution–of the social question, which keeps coming up and becomes ever more complex, must be sought in the direction of "making life more human," then the key, namely human work, acquires fundamental and decisive importance.[86]

Human work is clearly defined as a determinant of human and social development. Central to this encyclical is that human work determines what kind of family one may have, his/her health status within a period of time, and the individual's cultural and moral development. It is through human work that an individual or group will stand in communion with others in pursuit of their social needs and fulfillments.

[86] Ibid., #3.

Health care needs are clearly different from other social needs. Government policies and decisions must be tailored toward providing means for individual and group flourishing. In his book, *An Introduction to Catholic Social Thought*, Michael Hornsby-Smith captures this thought as he states: "The fact is that some policy choices are more likely to reduce the different dimensions of inequality and are, therefore, more likely to enhance the capability of realizing fully each individual's equal dignity and favor the values of social justice and equality of substantives citizenship in terms of civil or legal, political, and social and cultural rights."[87] I share the author's view that some government policies will positively impact citizens' health than others. In the context of the Nigerian health care system, it is crucial to enact policies that support developments in rural areas. In fact, such developments will provide opportunities for local people and also reduce the mass flow of youths from rural to urban areas. Consequently, some doctors, nurses, and health workers will be able to serve the people at the Primary Health Centers unhindered.

The health care system is not a platform for competition where one strives to outperform the other. In fact, people should be given options to choose. Sometimes people are clearly excluded socially because they either lack the means or due to structural injustices that favor only a few. In a sense, unemployment, which brings with it poverty and deteriorating health conditions, is seen as an attack on human flourishing. It reduces human "capability and functioning."

In his book *Inequality Reexamined*, Amartya Sen defines capability as "primarily a reflection of the freedom to achieve valuable functionings. It concentrates directly on freedom as such rather than on the means to achieve freedom, and it identifies the real alternative we have.

[87] Hornsby-Smith, *An Introduction to Catholic Social Thought,* 220.

Insofar as functionings are constitutive of well-being, capability represents a person's freedom to achieve well-being."[88] Sen makes an important point because the experience of most poor and lower income classes in Nigeria is that people do not have the freedom to obtain their basic health needs. The scope of capability goes beyond just the means to achieve freedom or, in this case, basic health care. It encompasses both the basic social needs of an individual and also the optimal conditions necessary to function physically, mentally, emotionally, socially, and spiritually unhindered. It is from this viewpoint that most people agree that poverty is a deprivation of these basic human capabilities.

Furthermore, in his book *Development as Freedom* Sen notes: "Poverty must be seen as the deprivation of basic capabilities rather than merely as lowness of income, which is the standard criterion of identification of poverty."[89] Hence, we get a better understanding of the lingering issue of health inequality when unemployment and poverty are viewed from the angle of capabilities deprivation. The situation in Nigeria has shown that inadequate income is a strong indicator as well as a condition for an impoverished life. But what is most concerning is the limited choice the poor and lower income classes have.

Sen argues further that income poverty and capability deprivation are not the same thing. For him income poverty focuses on the *means*, while capability deprivation draws our attention to human ability—freedom—to satisfy the *ends,* which forms our goals as created beings. Sen clarifies: "What the capability perspective does in poverty analysis is to enhance the understanding of the nature and causes of poverty and deprivation by shifting primary attention away from *means*…to *ends* that people have reason to pursue, and, correspondingly, to the

[88] Amartya Sen, *Inequality Reexamined* (Cambridge, MA: Harvard University Press, 1995), 49.
[89] Amartya Sen, *Development as Freedom* (New York: Anchor Books, 1999), 87.

freedoms to be able to satisfy these ends."[90] Taking Sen's viewpoint as a stepping-stone, it is clear that an individual's poor health is a form of capability deprivation. It is a situation where one clearly lacks the freedom to choose, and for some there is nothing to even choose from. The individual remains unable to enjoy basic social needs like health care and education, which are understood here as part of the human ends.

The perspective of capability deprivation sheds light on one of the underlying questions of this thesis by focusing on why the poor and lower incomes classes are clearly at a disadvantage in terms of their health needs across Nigeria. The fact is that most people are not only economically impoverished but also lack the freedom to choose rightly when it comes to their health needs. One may add that there is no option in the first place for most people, especially in rural areas. The imaginary chasm is dug to separate the upper class from the poor and lower income classes beginning with the options and choices people have and can freely make. Sen reaffirms: "It is not only the case that, say, better basic education and health care improve the quality of life directly; they also increase a person's ability to earn an income and be free of income-poverty as well. The more inclusive the reach of basic education and health care, the more likely it is that even the potentially poor would have a better chance of overcoming penury."[91] The need for a more inclusive social condition, especially in the health care system, demands expansion of human capabilities and freedoms. Sen argues that it is foundational to understand poverty and deprivation in relation to the lives people can actually lead and the freedoms these men, women and children actually have.[92]

Notably, Sen's approach that links capability and functioning with human's health and well-being makes one believe that health cannot be viewed the same way as other social values.

[90] Ibid., 90.
[91] Ibid.
[92] Ibid., 92.

Health clearly possesses two values: intrinsic and instrumental values. Jacquineau Azetsop in his book *Structural Violence*, commenting on Sen's capability approach, states: "Sen's capability approach gives a special importance to health due to its intrinsic value as an important basic capability and to its instrumental value with regard to functioning."[93] Azetsop agrees with Sen's approach, which widens our understanding of health as both the "means" and the "ends" for human flourishing. The challenge therefore is to avoid separating one from the other or prioritize one against the other. Azetsop makes an important remark that good health goes beyond the realm of health care and, at the same time, the promotion of health requires more than equal access to health-care infrastructures.[94] The truth of the matter is that the situation of unemployment and poverty leaves most poor and lower income classes incapable of enjoying basic health services even when they appears to be available.

Paul Farmer,[95] in most of his decades of work and writing, has been an ardent supporter of holistic human care that goes beyond simply ensuring access to health care facilities. Farmer has recognized from the early stage of his career the correlation between social and economic inequality and poor health of those living at the margins of our society. This wholesome vision of human flourishing permeates the mission statement of Partners in Health (PIH), a group founded by Farmer and his co-medical experts in 1987. The PIH mission statement states: "… We are dedicated to providing the highest level of clinical care possible while alleviating the crushing social and economic burden of poverty that creates obstacles to health. At its root, our mission is

[93] Jacquineau Azetsop, *Structural Violence, Population Health and Health Equity: Preferential Option for the Poor and the Bioethics Health Equity in sub-Saharan Africa* (Dudweiler Landstr: VDM Verlag Dr. Muller, 2010), 107.
[94] Ibid.
[95] An influential cross-border doctor, anthropologist, and professor at Harvard Medical School.

both medical and moral. It is based on solidarity, rather than charity alone."[96] It is fair to describe this quote from the PIH's mission statement as both holistic and human in relation to social justice in health care. The goal is clearly founded on the desire not only to reduce health inequality, but also to create conditions that uplift the poor and the marginalized from deteriorating health situations. Hence, their mission is not just charity, or simply offering of benevolent support to those who are sick or suffer and who need our help. Rather, the work of Farmer and his group is both "medical and moral" and, above all, rooted in pragmatic solidarity.[97] In a sense, PIH appropriates a solidarity that sees no dichotomy between one's social and economic rights. The group champions health care services that uplift an individual from deteriorating health conditions.

In the same vein, in his work across many continents (i.e., Africa, Asia, North America, and Latin America) Farmer asserts that unemployment and poverty are the key factors that contribute to the deteriorating health of the poor in our society. During his work in Haiti, Farmer noted that tackling unemployment and poverty was the first step in addressing the alarming health care inequality in the country. He noted that often the poor and the people in lower income classes tended not to enjoy health services even when they were available. Hence as a result of this, patients were wrongly labeled as "noncompliant." Farmer challenged this assumption based on his experience in Haiti and Rwanda. Farmer notes:

> Doctors may instruct their patient to eat well. But the patients will "refuse" if they have no food. They may be told to sleep in an open room and away from others, and here again they will be "noncompliant" if they do not expand and remodel their miserable huts. They

[96] Paul Farmer, "Reimagining Accompaniment: A Doctor's Tribute to Gustavo Gutierrez," *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutierrez,* ed. Michael Griffin and Jennie Weiss Block (New York: Orbits Books, 2013), 21.
[97] Paul Farmer, "Rethinking Health and Human Rights: Time for a Paradigm Shift," in *Partner to the Poor: A Paul Farmer Reader,* ed. Haun Saussy (Berkeley, CA: University of California Press, 2010), 483.

> may be instructed to go to hospital. But if the care must be paid for in cash, as is the case throughout Haiti, and the patients have no cash, they will be deemed "grossly negligent."[98]

Farmer captures clearly that equal access to health care is important but is not exhaustive to the solution of widening health inequality between the rich and the poor. There is a need to match medical care with the provision of other essential social needs like food, employment, shelter, and potable drinking water. But more specifically, the dignity of the human person requires that one should enjoy freedom to develop and to attain human flourishing. As the PIH mission statement puts clearly, the health care approach ought to be both "medical and moral" in order to reduce the existing health gradient. Hence, tackling unemployment and poverty will ensure that the poor and lower income classes regain their freedom and agency to flourish with dignity.

3.3. Education and Health Inequality

A brief discourse on the issue of education in Nigeria is required regarding both how the achievement gap relates to one's social stratification and the impact in integral human formation. The situation in Nigeria shows that even in a normal condition with equal access to necessary social needs, the educated people tend to have better health condition than the uneducated. The gap between the educated and the uneducated is not only observed within social circles, but also intellectually and sometimes morally. In effect, the health conditions of the educated people are at a clear advantage.

The education sector in Nigeria operates in two different forms: public and private institutions. The regional and local governments directly control the affairs of the public institutions while private and religious organizations run the private institutions. It is common that private institutions require high tuition, unlike the public institutions. To attend a public school in

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[98] Paul Farmer, *Pathologies of Power: Health, Human Rights, and the New War on the Poor* (Berkeley, CA: University of California Press, 2005), 151.

Nigeria is less expensive and the enrollment is based on academic merit. But the people from the upper social class prefer private institutions because of the better infrastructure in place in those schools.

However, the achievement gap begins from the early stage in school where the children from rich families and those from poor families are separated based on their financial statuses and academic performances. Diane Ravitch, in her book *Reign of Error,* captures this unfortunate reality thus:

> Achievement gap begins long before children start kindergarten. On the first day of school, some children have had better medical care than others; are better nourished than others; are likelier to have a larger vocabulary because of having a parent who is college educated; are likelier to have books and computers in the home; and are likelier to live in sound housing in a safe neighborhood. The children at the wrong end of the gap are likelier to attend schools in overcrowded classrooms with inadequate resources and inexperienced teachers, as compared with the children at the advantaged end of the gap, whose schools are likelier to have small classes, experienced teachers, a full curriculum, laptops, libraries, playing field and a full of stuff.[99]

Ravitch's observation shows that the education achievement gap begins even before a child steps into elementary school. Some children arrive at the school on the first day with a better medical care than others. In fact, in Nigeria, some of these poor and lower income children are totally ignorant of their health condition (e.g., short-or-long sightedness). Education is considered not only as a means of ensuring social and economic strength, but also a way to raise one's intellectual and moral capability.

The education achievement gap in Nigeria contributes to the health inequality between the poor and the rich. A long-term measure will require not only transforming the structures and changing the policies that advantage only a few, but also a review of our schools' curricula. This may appear very ambitious, but it is worrisome that the quality of education in Nigeria alienates

[99] Diane Ravitch, *Reign of Error: The Hoax of the Privatization Movement and the Danger to America's Public Schools* (New York: Vintage Books, 2014), 59.

us from some of our cultural and religious values. There is a gap between our cultural and religious values on one side, and the kind of education we receive in our institutions on the other.

The ethnography of Nigeria shows that it has strong cultural and religious values. But what remains incomprehensible is why "civic generosity" is lacking in our public arenas, specifically in the health care system. There is a dearth of altruistic human relationships when it comes to the distribution of social needs, like health care services. As elementary and high school students, we were taught many civic values in social studies. It was true then and now, even though the social studies course does not form part of the core courses in the schools' curricula. Yet the knowledge from this course remains immeasurable despite the less attention given it than the so-called core courses.

However, with the current social and cultural changes in the country due to a changing political economy, urbanization, and people's exposure to the social media, our high schools and colleges need more than a social studies course.[100] As I noted at the end of the second chapter, the courses in social ethics and bioethics should not be limited to medical schools. The Nigerian health care situation requires that ethical courses be introduced into our high schools' curricula. Moreover, usual medical ethics courses done during medical studies seem insufficient for preparing the doctors, nurses, and health care workers that the Nigerian health care system ardently desires.

The training of our medical students as well as our health care workers requires not only acquisition of technical know-how but also conscience formation. As such, in light of these excruciating ethical challenges in our health care system, doctors, nurses, and health care workers

[100] Smith, *Aids Doesn't Show Its Face*, 167.

will begin to perceive their roles differently. In fact, they will begin to understand their role differently from an engineer or businessperson.

The study of social ethics and bioethics in our high schools will serve as a tool for reintegrating our cultural values with our modern education. Namely, cultural values need to be devoid of egocentric self-interest but embedded in collective moral obligation. It is through this collective moral obligation that individual self-worth or agency will come fully into the light in society. Undoubtedly, there is always need for medical aid, financial support, access to social needs, and education for all through the help of the government or through the benevolence of the rich. I will return to this later on, but, as noted before, I find holes in acts of charity that fail to uplift the poor from their inhumane situation. Our education and religious beliefs should enable us to appropriate the existing cultural values without annihilating us. Our education should enable us to purify norms and beliefs that hinder human flourishing.

3.4. Gender and Health Inequality

Gender inequality is another serious issue in the area of health care. Culturally, the gender gap between men and women is an age-long issue that cuts across social, political, and economic relationships among people. Women clearly occupy an inferior position in the Nigerian society. Men typically have greater economic power, better jobs, more education, political clout, and fewer social restrictions. The fallout of this situation is that women are less likely to have voice in social and political decisions that affect their health.

In the Nigeria Demographic Health Survey released in June 2014, there are differences in educational attainment according to gender. The report shows that the majority of Nigerians have attained some education: primary and secondary school certificates, but some have university degrees. The differences based on the gender reveal that 70% of males age 6 and over have ever

attended school, as compared with 58% of females. On one hand, only 8% of females in the wealthiest household have no education, as compared with 81% in the poorest households. On the other hand, only 5% males in the wealthiest households have no education, compared with 71% in the poorest households. In sum, the data shows the median number of years of educational attainment in Nigeria between males and females as 4.7 years and 1.7 years respectively.[101]

However, the HIV/AIDS pandemic in sub-Saharan Africa affected more women than men due to several social and cultural reasons. In fact, some of these reasons were considered to depend on biological differences, and some claim men are more biologically able than women to fight viral diseases like AIDS. Without venturing into any of these debates, there is a clear indication of some elements in our cultures that subjugate women in various ways.

Smith, writing about women's situation in Nigeria, notes: "In southeastern Nigeria, it is a relatively recent idea that socially acceptable trajectories for success for women include education, employment, and other means of income generation beyond traditional occupations of farming and local rural trade."[102] Smith makes an accurate observation on the changing trends among the people of southeastern Nigeria. Although things are improving gradually, culturally women are seen as helpers whose primary role is to raise children. In fact, the woman's role is still perceived as taking care of house chores as opposed to being among the principal actors with men in the society.

In the same vein, the right of inheritance in Nigeria is still exclusively reserved for men. And this calls for a critical reflection and concrete changes if the condition of women is to improve meaningfully. Nigeria is a patrilineal society, which puts men ahead in almost everything while women remain on the "sidewalk." In my view, addressing some economic and cultural

[101] Federal Republic of Nigeria, *Nigeria Demographic Health Survey, 2013*, 25.
[102] Smith, *Aids Doesn't Show Its Face*, 57.

taboos that subjugate women in our country will not only enable women to regain their agency, but also improve the health of their children and their families in general. The high maternal and child mortality rate in Nigeria cannot be tackled only by medical care if women do not actively participate in decisions that affect them. A typical case in point is family planning among Nigerians. It is almost a given that women's health concerns or interests do not matter in deciding the number of children to bear. The culture places men above women when it comes to deciding the size of the family even to the detriment of woman's health. This inhuman treatment is more pronounced among uneducated couples and the poor in the rural areas.

In sum, dismantling social constructs, economic oppression, and taboos directed against women will ensure not only improved women's health, but also the health of their children. The health needs of women should not be perceived as an afterthought in our society. The respect for life and dignity of the human person obliges everyone not to see women as second-class citizens that are easily sidelined.[103] Women's improved health benefits not just their families but also the entire society. The health improvement of women is grouped among society's good especially when we reflect on child's health.

Section Two

3.5. The Notion of the Common Good

The progression of this thesis up to this stage has brought two things to bare: first, the degree of the health gradient between the wealthy upper class and the poor and lower income classes in Nigeria; second, the importance of a paradigm shift, which includes a change in health care approaches that have commodified health care needs. The paradigm shift implies also an attitudinal change from a culture of unconcern to one of a collective moral responsibility. Hence,

[103] Helen Alvare, "A More Perfect Union," *America* (December, 22-29, 2014), 12.

it is imperative now than ever that the basic minimum health services should be made accessible to those with greatest needs.

However, the question that remains to be answered is: Why should anyone—the rich, leaders, and policymakers—abide by this unwritten universal law of caring for others? The goal of this last section therefore is to respond not only through philosophical reasoning, but also through a valorization of cultural and religious beliefs. And fundamental to this claim is the awareness that every human person is created as a true image of God.

Notably, this section is inspired by the story retold by Farid Esack in his book *On Being a Muslim,* Esack writes:

> The story is told of a rabbi whose disciples were debating the question of when precisely "daylight" commenced. The one ventured the proposal: "It is when one can see the difference between a sheep and a goat at a distance." Another suggested: "It is when you can see the difference between a fig tree and an olive tree at a distance." And so it went on. When they eventually asked the rabbi for his view, he said: "When one human being looks into the face of another and says: 'This is my sister' or 'this is my brother' then the night is over and the day has begun."[104]

When viewed in light of the Nigerian health care system, both the moral and ethical undertone of this anecdote is that health services should be available to everyone because we are creatures of God. Health care services cannot and should never be put on the market for sale to the highest bidder. Hence the rabbi seems to be saying to Nigerians that basic health care for all is attainable only when we–as Nigerians, individuals and policymakers–become aware of our shared humanity, our deeper connection to one another, and the interconnectedness of human persons irrespective of social and economic statuses.[105]

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[104] Farid Esack, *On Being a Muslim: Finding a Religious Path in the World Today* (Oxford: Oneworld, 1999), 137.
[105] Danny Fisher, "May you Always Be a Student," in *The Arts of Contemplative Care: Pioneering Voices in Buddhist Chaplaincy and Pastoral work*, ed., Cheryl A. Giles and WiIla B. Miller (Boston, MA: Wisdom Publications, 2012), 182.

Similarly, the above inspiring words from the rabbi force us to consider the two lingering conundrums in health care: first, the pretention of health as a right; second, the demand for equality in accessing health care needs. With a better understanding of what holds us together– i.e., human dignity–both arguments cannot easily hold in the health care system, at least not without a huge cost and sacrifices. First, health is not a right as already indicated; and, second, equality is unrealistic. To envision equality is to imagine an ideal world, which remains unattainable. Hence, the notion of common good enables us to respond to what matters for one another. The first step will be to dismantle structures that render a group incapable of flourishing. Also, appropriating the notion of common good will ensure everyone gets a minimal access to basic health care services. In fact, central to this claim is: first, we are finite beings, and even with the finest medical resources, our health can still fail. Second, we live in a world of limited resources, and only the basic minimum can be guaranteed to some people.

3.6. The Common Good in Catholic Ethics

The Second Vatican Council's Pastoral Constitution on the Church in the Modern World (*Gaudium et spes, GS*) offers extensive teaching on the notion of common good. The council defines common good as "the sum of those conditions of social life which allow social groups and their individual members relatively thorough and ready access to their own fulfillment."[106] These social conditions are clearly located in the community and each individual attains his/her flourishing cooperatively. GS recognizes the human person as naturally a social being who is always in need of others for his/her normal flourishing and who contributes to the flourishing of others. The Council fathers wrote:

> Man's social nature makes it evident that the progress of the human person and the advance of society itself hinge on one another. For the beginning, the subject and the goal

[106] Second Vatican Council, *Pastoral Constitution on the Church in the Modern World: Gaudium et spes* (December 7, 1965), #26. Accessed 15th February 2015, www.vatican.va.

> of all social institutions is and must be the human person, which for its part and by its very nature stands completely in need of social life. Since this social life is not something added on to man, through his dealings with others, through reciprocal duties, and through fraternal dialogue he develops all his gifts and is able to rise to his destiny.[107]

The social aspect of the human person is not foreign but fundamental to individual self-realization. It is through the interdependence between individuals and society that everyone attains his/her ultimate goal, especially the weakest in the society. The notion of common good ought to invigorate in every man and woman the virtue of solidarity that enables us to transcend individualistic morality and egocentric self-interests.

Moreover, while commenting on GS, David Hollenbach notes that the notion of common good "calls for an ethic that stresses active solidarity and enables all persons to participate in the life of the human community in ways that benefits their dignity."[108] Active solidarity is an essential term because it rejects any form of passivity or culture of unconcern; rather every individual is committed to uphold the values and inherent dignity present in the other.

John Paul II reasserts a similar point regarding solidarity in the encyclical *Sollicitudo Rei Socialis*: "This then is not a feeling of vague compassion or shallow distress at the misfortunes of so many people, both near and far. On the contrary, it is a firm and persevering determination to commit oneself to the common good; that is to say to the good of all and of each individual, because we are all really responsible for all."[109] John Paul II stresses the importance of solidarity as a virtue that is not restricted to a particular religion. From his viewpoint even a nonbeliever is capable of committing him or herself to the norms of social justice and the common good. And this is concretely where a light could shine for Nigerians and on the Nigerian health care system.

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[107] Ibid., 25.
[108] David Hollenbach, "Commentary on *Gaudium et spes* (Pastoral Constitution on the Church in the Modern World)" in *Modern Catholic Social Teaching: Commentaries and Interpretations,* ed. Kenneth R. Himes (Washington, DC: Georgetown University Press, 2011), 280.
[109] John Paul II, *On Social Concern: Sollicitudo Rei Socialis* (December 30, 1987), 38, accessed 20th march 2015, www.vatican.va.

As noted, it is a system that has up until now valorized market dynamics that favor only a few people in the upper class, while the poor and lower income classes are literally nonmembers.

3.7. The Fundamental Principle of the Common Good

Two fundamental principles safeguard health care as a common good: first, the respect of sanctity of life, which we derive from our awareness of the inherent dignity that every individual possesses; second, the experience of Christ who first journeyed on this path of mercy and cared for those in greatest need. In other words, for Christians, to seek the well-being of the individual and of the community springs from an unreserved sense of solidarity as a virtue and understanding of the human person as a true image of God. It equally hinges on our faith in Christ who first loved us irrespective of our social, moral, and economic statuses.

In his article on "Suffering, the Body, and Christianity," James Keenan captures it thus: "By looking at ourselves in God's image: therein we derive the notion of sanctity of life…looking at ourselves as called to imitate Christ: therein we derive the practice of mercy…we are called to respond to those who suffer and fear the loss of their integrated selves by assuring them that we shall always treat them as they are, subject and fellow citizens of the kingdom of God."[110] Certainly, the persisting night of the Nigerian health care system will be over and a new day will dawn when every Nigerian sees each other as true citizens of God's kingdom. If the well-being of an individual is given equal importance as the good of the others in the community, everyone will rise to challenge the unjust distribution of health services as a deprivation of the common good.

[110] James F. Keenan, "Suffering, the Body, and Christianity: The Early Christians lived the Theological Basis of Catholic Health Care," in *On Moral Medicine*, 754.

The Catholic Bishops' Conference of England and Wales reechoes that every human person possesses a basic dignity that comes from God. In their view, the real test of every human institution becomes how its policy enhances or diminishes this inherent dignity. They state:

> We believe each person possesses a basic dignity that comes from God, not from any human quality or accomplishment, not from race or gender, age or economic status. The test therefore of every institution or policy is whether it enhances or threatens human dignity and indeed human life itself. Policies, which treat people as only economic units, or policies which reduce people to a passive state of dependency on welfare, do not do justice to the dignity of the human person.[111]

The dignity of the human person transcends social and economic worth. It is therefore a common good when the dignity of every individual is accorded equal respect irrespective of one's social and economic status.

The notion of the common good arguably is authoritative in Catholic teaching and in Scripture. But it also serves as a signpost and a way forward for ensuring human flourishing. The idea of common good specifically offers to health care a better approach for tackling the gap between the rich and the poor. It is true that the equal access or egalitarian approach to health care services remains an ideal, but what matters is how each person can access the basic minimum. Hence, a true community where every human person flourishes will exhibit three main characteristics: interdependence, solidarity, and participation of everyone in the community values. As such, the notion of common good will oppose the prevailing "culture of unconcern," or the "global indifference" as Pope Francis recently affirmed in some of his teachings.

3.8. The Common Good and the Culture of Unconcern

Pope Francis recently highlighted the prevailing global indifference that is increasing in our world. He describes this new trend as: "The culture of comfort, which makes us think only of

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[111] Catholic Bishops Conference of England and Wales, *The Common Good and Catholic Church's Social Teaching: A Statement of Catholic Bishops' Conference of England and Wales* (Westminster: Catholic Conference of England and Wales, 1996), 13.

ourselves, makes us insensitive to the cries of other people, makes us live in soap bubbles which, however lovely, are insubstantial; they offer a fleeting and empty illusion which results in indifference to others; indeed it even leads to the globalization of indifference."[112] These attitudes are noticeable both in our social and political arenas. The rich people appear unscathed in the face of others' hardship, sufferings, and deaths.

However, the fluidity of this seemingly safe haven of the rich is what Pope Francis describes as living in the "soap bubbles," however comforting they may appear are only so for a very short period. Pope Francis reiterated this position in his 2015 Lenten Message as he called for all the people of good will to confront this selfish attitude of global indifference.[113] In his view, global indifference had made the hearts of our leaders, policymakers, medical doctors, and nurses grow cold in the face of others' sufferings and pains. Thus, imbibing the idea of common good frees the rich and the entirety of society from this indifference and makes us wary of the comfort of living in the "soap bubbles."

The culture of unconcern is indeed troubling especially in our inability to unravel totally its source. In my view it is partly due to social change and partly due to human degradation. In any case, it is clearly in opposition to the African sense of a community. The first chapter of this thesis highlighted some cultural values and their impact in ensuring individual cohesion in the community. It was noted that what binds individuals together in the community is a sense of common goal. Each individual was responsible not only for him/herself but also for the well-being of others in the community. This interdependence among members permeates all the fabric of our society. Hence, the action of Okonkwo as noted above was considered dangerous because it threatened the corporate existence of the entire Umuofia community. The respect for a

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[112] Francis, "Homily at Mass in Lampedusa, July 2013," (www. vatican.va, accessed 12th April 2015).
[113] Francis, "Make Your Heart Firm: Message for Lent 2015,"(www. vatican.va, accessed 17th April 2015), 3.

collective moral obligation compelled Okonkwo to see his action not as exclusively private, but also as inimical to their corporate existence and the community's peace.

Therefore, the way forward is to eliminate the culture of unconcern in our social and political economy, to strengthen our collective moral responsibility, and to understand the virtue of justice as directed to the common good.[114] The growing health inequality is not only an indication that individual interests overshadow love and care for those at the margins, but it even appears as an adopted norm. And this is why the prevailing culture of unconcern is seen as a departure from the fundamental values of a community. The culture of unconcern glorifies one's social and economic statuses even when the source of one's achievement is dubious. Thus another's misfortune is easily considered as that person's fate.

In the same vein, the compartmentalization of Nigerian public hospitals based on patients' social and economic statuses legalizes this culture of unconcern–the *laissez faire* attitude. The rationale remains elusive as to why taxpayers' money is unjustly reserved for those in middle and upper classes. This practice remains a justice issue not only when seen through the lenses of a civilized society, but also through our cultures because it dehumanizes the poor. The aforementioned "inverse care law" in Nigerian health care system should be exchanged with and "purified" by the preferential option for the poor: a humanistic approach that will ensure that those with the greatest needs are cared for.

The virtue of solidarity rooted in compassion and love seems expedient for the entire social, economic, and political spheres of our country. In fact, one wonders if the rich and those in public authorities lose their true sense of compassionate love and solidarity the moment they ascend to power. One of the examples includes the story I highlighted above in chapter two about

[114] Neil Messer, *Respecting Life: Theology and Bioethics*, (London: SCM Press, 2011), 199.

the "carefree attitudes" of our public officers in the discharge of their duties. Another example is the action of the Nigerian president during the recent terrorist attack in Nnyanya, near Abuja, Central Nigeria. The president visited the scene shortly after the attack that killed over 72 people with hundreds injured. He was there to console the victims and to promise unwavering efforts of the federal government to bring the perpetrators of the attack to justice and to free the entire nation from any reoccurrence of such a barbaric attack.

Nevertheless, the president left the scene headed straight to Kano in the northeast of Nigeria to attend a political rally. From the event, the president was seen on television in a celebrative mood with other politicians. As expected, the president's action spurred rage and anger for his lack of respect for those who had just died in the attack and the hundreds of others in critical condition. This event may be regarded as an isolated incident, but it speaks volumes regarding the new trend of the culture of unconcern in the Nigerian social and political system.

One thing is clear at this point—that such actions by the public leaders are considered outrageous, whether from the viewpoint of Christians, Muslims, African traditional believers in Nigeria, and even nonbelievers. There is an inherent sense of the sacred in every human person when we reflect consciously on the pains and sufferings of others. Hence, human virtues of compassionate love, solidarity, charity, and mercy are not foreign to Nigerian cultures.

However, I also recognize the potential danger of attempting to practice the virtue of compassionate love in a secular public arena like the Nigerian health care system. Of course the language of the public is based on power: one who has money should be free to spend it at will for the procurement of health and other social services. But as noted by Neil Messer in his book *Respecting Life*, "to maintain too sharp a distinction between love and justice can itself be

problematic."[115] In a humane society, there should be no separation between justice and the other virtues. Many agree with Thomas Aquinas' assertion that "all virtues are oriented to the promotion of justice."[116] The importance of these human virtues cannot be overemphasized in addressing health care inequality. Therefore, the society's liberal attitude, market dynamics, and power issues require the virtues of love and solidarity so as to prevent social distortion and degeneration.[117]

3.9. The Common Good and the Image of the Good Samaritan

Allen Verhey, in his book *Reading the Bible in the Strange World of Medicine*, offers us a critical analysis on the story of the Good Samaritan (Luke 10:25-37). He begins by questioning the validity of the Good Samaritan as an image of care for the sick and the abandoned. Verhey wonders if Christians, health care workers, and all the people of good will continue to tell this parable of the Good Samaritan while at the same time acknowledging the limits of our scarce resources. He states: "Can we live this story we love to tell–as citizens, as physicians, as churches–and recognize scarcity? Can we still be Good Samaritan–or Fair Samaritan–in the midst of tragic choices imposed by scarcity?"[118] Verhey places the compassionate heart of the Good Samaritan side by side with our modern reality of limited health care resources. And at once we see the challenges confronting the Good Samaritan as a contemporary image of care for those who are sick.

Verhey widens our imagination as he wonders what the Samaritan would have done if he had encountered another neighbor on the way side on his arrival at the inn to pay the bill for the first wounded traveler. Verhey writes: "Would he do the same for this second neighbor? Suppose

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[115] Ibid., 207.
[116] Vicini, "The Ethics of Genetic Technology," 284.
[117] See Messer, *Respecting Life*, 207.
[118] Allen Verhey, *Reading the Bible in the Strange World of Medicine* (Cambridge, UK: William B. Eerdmans, 2003), 361.

he encountered not just one other but more than his donkey could bear, more than his purse could afford, more than even the most hospitable innkeeper could receive. What would he do then? And could he then still be the Good Samaritan?"[119] And central to these questions is whether we can continue to tell the story of the Good Samaritan and accept the idea that it speaks to health care. To respond either yes or no to these questions requires an in-depth analysis of the story's different facets.

Verhey offers three things to consider before a meaningful response could be attempted for arguing the validity of the Good Samaritan parable in our current health care system. First, we need to recognize the limitedness of health care resources (by acknowledging scarcity). Needless to say, no human society will collapse the entire social needs of its citizens into health care needs. For Verhey, "There are, after all, other things that a decent society should value besides health: education, human services for the poor and elderly, a clean environment and the list goes on."[120] The scarcity of virtually all human and natural resources obliges us to make not-so-easy decisions on the allocation and distribution of health care services.

Second, we need to recognize the sanctity of life of every human person, far and near, friends and enemies, brothers and sisters (by acknowledging sanctity). As the narrative of the Good Samaritan unfolded, it was clear that it did not matter to the Samaritan whether the wounded man was his friend or foe, or whether both of them shared the same religious belief or were at loggerheads with each other. Verhey states: "What mattered was the hurt, the pain, the need of one who was, after all, like him, the object of God's unbounded love. And that unbounded love conferred upon the wounded man a *sanctity* that in turn evoked the limitless care of the

[119] Ibid.
[120] Ibid., 362.

Samaritan."[121] The sense of sanctity is what prompts the Samaritan, our modern doctors, nurses, and health care workers to bandage the wounded and console the dying.

Third, we need to recognize our finitude; we are created beings and not immortals (by acknowledging tragedy). Verhey affirms: "Tragic choices are always a consequence of our finitude, of the fact that we are not gods, that our mortality is indefeasible, and that our resources, while considerable, are still finite…medicine and medical technology do not and cannot provide an escape either from our mortality of from the finitude of our resources."[122] Verhey's position reaffirms the earlier discourse on why we cannot talk of a right to health, but rather a right to basic health care. Our finitude challenges any attempt to conceive health as a right, because even with the best medical service in our disposal, our health can still deteriorate.

Therefore, in response to the question if we can still be Samaritans, Verhey answers: "Yes, we can–but to be 'good' the contemporary Samaritan will require virtues besides compassion."[123] Notably, Verhey's assertion is line with the central theme of this thesis. I consider it as the kernel of the entire work, which I propose in terms of the "way forward:" compassion is necessary but not enough to address the challenges facing the Nigerian health care system. Verhey concludes that contemporary Samaritans ought to possess three virtues: truthfulness, humility, and gratitude.[124] These three virtues spring out of the knowledge of scarcity, sanctity, and tragic choices surrounding health care.

Finally, the virtue of truthfulness disposes us to the reality of our world with limited resources. The virtue of humility is our readiness to acknowledge our finitude; we are not gods, but simply mortals. The virtue of gratitude comes into play when we combine truthfulness and

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[121] Ibid., 364.
[122] Ibid., 365.
[123] Ibid., 369.
[124] Ibid.

humility. In a sense, the result ought to be thankfulness for the opportunities within our limitedness. Hence, Verhey affirms: "Truthfulness and humility will prevent us from the hubris of thinking we have the opportunity to usher in a new heaven and a new earth or the opportunity to win some technological triumph over mortality and the human vulnerability to suffering."[125] The "way forward" in the Nigerian health care system is: the commitment to these human virtues which will enable doctors, nurses, health care workers and our policymakers to realize that within our limits as creatures of God, we are required to ease the pains and sufferings of others, especially the poor and the sick. Hence, in the midst of scarcity, the virtue of justice[126] becomes the essential tool for contemporary Samaritans especially Nigerians who truly desire the common good.

Conclusion

So far I have stressed in this chapter, that the growing health inequality in the Nigerian health care system can be reduced. The provision of basic health care services for all Nigerians can only be possible when individuals, groups, policymakers, and leaders become more conscious of our shared humanity and the dignity of every human person. As such, the re-appropriation of human virtues of solidarity, compassionate love, charity and mercy become the "way forward" in view of the common good.

[125] Ibid.
[126] Ibid.

Conclusion

The Essential Elements

People are known for their cultures: how they welcome new life into their community during birth, how lives are supported and cared for through human relationships, and, finally, how human finitude is received at death. So, one's birth, relationships, and the inevitable death are three crucial elements in every human society. The progress of every society depends on how these three elements are perceived and handled by its citizens. Structures and policies are supposed to ensure that each of these elements takes its full course. It is only then that we can talk of human flourishing in the community.

With its diverse cultures, Nigeria faces challenges due to social, economic, and political changes. The traditional values, which once held people together, are constantly being bombarded by modern ideas, corrupt practices, greed, and technological and social changes that put more emphasis on individual accomplishment. The social bonds that hold people together in the community get weaker each day as individuals strive to appropriate their own self-interests. The insight from Chinua Achebe's book *Things Fall Apart* seems prophetic to the current Nigerian health care system: the people abandoned their values for unfamiliar foreign cultures. They are no longer rooted in their cultures. But at the same time cannot properly adapt to the new cultures. The collaborative spirit among individuals striving for the common good seems very unpopular across the country. In effect, the slogan appears to be: each person to his/her own tent. Thus, the strong and the powerful survive while the weak fall off the path and are trampled upon.

In this work, moved by the understanding of these social changes, I undertake a triadic reflection on where we are coming from as Nigerians, where we are currently, and where we need to be in terms of providing basic health care for all citizens irrespective of one's social, economic

and political status. And clearly the evidence of where we are coming from as a nation shows that the common people deserve better care than the current health care services are providing to them. There are values in our cultures that had always safeguarded the community from individualism and human degradation. Some of these values include: the notion of the sacred, the understanding of human person as creature of God, the idea of the common good, and the interdependent nature of human beings.

The health care inequality in Nigeria is increasingly worrisome but all hope is not lost. And this act of hope resonates with Alasdair Macintyre's assertion in his book *After Virtue*. He notes: "the language and the appearance of morality persist even though the integral substance of morality has to a large degree been fragmented and then in part destroyed."[127] In a sense, Nigerians have the potential to steer this ship (health improvement) out to a safe ground. And this will be out of the growing inequality in the Nigerian health care system.

The way forward begins with a conscientious effort by every Nigerian to recover those eroding values in our cultures that support the common good. The second step is to purify and transform some of the norms, practices, policies, and structures in our country that currently hinder the human flourishing of every Nigerian. There is no doubt a genuine change will start from the training of our doctors, nurses, health care workers, and policymakers. The incorporation of social ethics and bioethics in the schools' curricula is crucial. There is a common saying that the study of humanity makes us more humane–"humanity humanizes." Our education ought to widen our respect for human life, the dignity of every individual, and the interdependence that exists among people as enshrined in our cultures and beliefs.

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[127] Alasdair Macintyre, *After Virtue: A Study in Moral Theory* (Notre Dame, IN: University of Notre Dame Press, 1981), 5.

Flowing from the above realizations, I will say that the human virtues of solidarity, compassionate love, and justice will continue to find home in our cultures. Both religious virtues and cultural values converge in promoting the common good. Hence, the virtues of solidarity, love and justice have no border or restriction. So, if received, these virtues will increasingly enlighten some of our closed cultures that degrade human person especially the women and the poor. As such, we will become more conscious that the sanctity that each individual possesses must be recognized and cared for irrespective of one's race, ethnicity, social, political and economic background. The task, therefore, is to make this wholesome vision the norm for Nigerians and the Nigerian health care system in particular. Hence, every Nigerian will receive health care services, not because he/she possesses requisite social and economic means, but because he/she has inherent dignity as a creature of God.

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