

HEALTH INEQUALITY AND PUBLIC POLICY IN NIGERIA: A SOCIOLOGICAL ANALYSIS OF ACCESS TO HEALTHCARE SERVICES

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Abstract

Health inequality has become one of the most enduring social issues facing modern societies, particularly in developing countries. In Nigeria, for instance, access to basic social services has been characterized by deep-seated inequalities along socioeconomic status, geographical location, gender relations, and policy implementation. Although numerous attempts to improve the standard of healthcare delivery have been put in place, such as the National Health Act (2014) and the National Health Insurance Scheme, millions of Nigerians still face serious hurdles when accessing quality healthcare services. This paper seeks to investigate the issue of health inequality in Nigeria from a medical sociological perspective. Specifically, this study seeks to investigate the ways in which public policy and social factors influence healthcare accessibility and utilization. Using existing empirical studies, demographic surveys, and scholarly works, this study seeks to analyze the ways in which poverty, income inequality, geographical inequalities, and gender relations influence healthcare accessibility. This study posits that health inequality in Nigeria cannot be seen as a medical issue; rather, it is a reflection of the inequalities embedded in our social, economic, and political institutions. In addition, this study seeks to evaluate the existing policy interventions and their limitations in addressing inequalities in healthcare accessibility. Finally, the paper stresses on the need for a comprehensive policy approach that incorporates equitable healthcare financing, strengthened primary healthcare systems, and community-centred governance systems to mitigate healthcare inequality in Nigeria.

Keywords: Health inequality, public policy, healthcare access, medical sociology, Nigeria, social determinants of health

1. Introduction

Health is widely regarded as a fundamental component of human well-being and a key indicator of societal development. Access to healthcare, therefore, transcends a purely medical concern and reflects broader social and political dynamics, particularly the distribution of resources and opportunities. Health inequalities—defined as differences in health status and healthcare accessibility among population groups (Adeyanju, Tubeuf, & Ensor, 2017, p. 1111)—remain a central concern for policymakers, sociologists, and health scholars globally. In developing countries, health inequality is closely intertwined with

socioeconomic disparities such as income, education, occupation, gender, and geographic location. Medical sociology emphasises that health outcomes cannot be explained solely by biological factors but must be understood within the context of social structures. Nigeria, with its large population and abundant resources, presents a compelling case, yet continues to experience significant disparities in healthcare access across income groups, regions, and rural–urban divides.

Empirical studies highlight poverty as a major barrier to healthcare utilisation in Nigeria, with low-income households often delaying or foregoing treatment, thereby increasing vulnerability to preventable diseases. This inequality is particularly evident in maternal and child healthcare, where wealthier households utilise services more frequently than poorer ones (Nwosu & Ataguba, 2019, p. 2). Geographic disparities further compound the problem, as urban areas enjoy better healthcare infrastructure and personnel, while rural populations face shortages and long distances to facilities (Okoli et al., 2020, p. 2). Gender dynamics also play a role, with women in some contexts experiencing limited decision-making power and reduced access to care due to financial, cultural, and structural barriers (Ibitoye, 2024, p. 3).

Although the Nigerian government has introduced policies such as the National Health Insurance Scheme, the National Health Act of 2014, and the Basic Health Care Provision Fund, inequalities persist. Scholars argue that these disparities are embedded within broader socioeconomic structures, including income inequality, unemployment, and educational gaps (Iba, 2023, p. 2). Coupled with poor healthcare infrastructure, low insurance coverage, and high out-of-pocket expenditure, these challenges underscore the need for a sociological approach. Accordingly, this study examines the relationship between healthcare inequality and public policy in Nigeria, focusing on key social determinants such as income, geography, and gender to better understand and address disparities in access to healthcare.

2. Conceptual Clarifications

For an understanding of health inequality in Nigeria, it is essential to understand three basic concepts that guide the research and form the basis on which health inequality in Nigeria is analyzed. These three basic concepts are health inequality, public policy in healthcare, and access to healthcare services.

2.1 Health Inequality

Health inequality is defined as systematic differences in health status or in the distribution of health resources between different segments of the population. These systematic differences in health are often directly related to social, economic, and political differences in society. According to Margaret Whitehead, “health inequalities are differences in health that are systematic, socially produced, and therefore modifiable through public policy interventions” (Whitehead, 1992, p. 433).

Medical sociologists argue that, in addition to biological and genetic factors, health

inequality is also influenced by social factors that determine people's living environments, their way of living, and their access to healthcare services. According to Michael Marmot, "health inequalities are caused by differences in the distribution of power, income, goods, and services, and in the social circumstances in which people are born, grow, live, work, and age" (Marmot, 2005, p. 1099).

In the context of medical sociology, the issue of health inequality is linked to the social determinants of health. In this respect, the social determinants of health encompass the individual's socioeconomic status, educational level, working conditions, quality of housing, environmental conditions, and access to healthcare facilities.

In the case of Nigeria, the issue of health inequality is reflected in the sphere of maternal and child health. In this respect, the indicators of maternal and child health differ significantly across the population with varying levels of income and geographic location. In this respect, studies that analyzed the data from the national health survey found that "women from richer households were significantly more likely to receive antenatal care and skilled birth attendance compared with their counterparts from poorer households" (Nwosu & Ataguba, 2019, p. 3).

Moreover, the issue of health inequality is not only linked to the unequal distribution of health outcomes but is also associated with the unequal distribution of healthcare resources. In this respect, the unequal distribution of hospitals, medical professionals, and health insurance is reflected in the unequal access to healthcare facilities enjoyed by the population. In this respect, the rural population and the poor population remain disadvantaged.

2.2 Public Policy in Healthcare

Public policy refers to the actions, laws, and institutional frameworks through which governments address social problems, including healthcare. In this context, it encompasses the strategies, regulations, and financing mechanisms used to organise the health sector and ensure access to services. Health policy theorists emphasise that the structure and performance of healthcare systems are largely shaped by governmental decisions. As noted by Walt and Gilson, health policy includes both the formal regulations and the political processes that determine how healthcare resources are distributed across populations (Walt & Gilson, 1994, p. 354). In developing countries, public policy plays a critical role because healthcare systems depend heavily on government funding and regulation. Government decisions influence the availability of facilities, the distribution of healthcare professionals, and the financing mechanisms through which citizens access care. In Nigeria, healthcare policy operates within a decentralised framework involving federal, state, and local governments. The federal government oversees tertiary healthcare and national policy, state governments manage secondary facilities, while local governments are responsible for primary healthcare, which serves as the first point of contact for most citizens (Federal Ministry of Health, 2010, p. 8).

Policy interventions have been introduced to address inequalities in access to healthcare, notably the National Health Insurance Scheme (1999) and the National Health Act of 2014, which established the Basic Health Care Provision Fund to strengthen primary healthcare. However, from a sociological perspective, public policy extends beyond technical administration; it reflects political values and power relations within society. Consequently, the distribution of healthcare resources often mirrors broader social and economic inequalities, thereby reinforcing disparities in access among different population groups.

2.3 Access to Healthcare Services

Access to healthcare refers not merely to the presence of medical facilities but to the ability of individuals and communities to obtain appropriate care within a complex set of conditions. It is a multidimensional concept shaped by structural, economic, and socio-cultural factors. Penchansky and Thomas conceptualise access through five key dimensions: availability, accessibility, accommodation, affordability, and acceptability (Penchansky & Thomas, 1981, p. 128). Availability concerns the adequacy of healthcare resources such as personnel and infrastructure; accessibility relates to the geographical location of services; accommodation addresses how services are organised to meet patients' needs; affordability focuses on the cost of care; and acceptability reflects the cultural and social attitudes that influence healthcare utilisation.

In Nigeria, barriers exist across all these dimensions, significantly limiting access to healthcare. A major challenge is the high level of out-of-pocket expenditure, which accounts for over 70 percent of total healthcare spending, thereby restricting access for many citizens (World Health Organization, 2022, p. 89). Geographic barriers further compound the problem, particularly in rural areas where long distances, poor transportation, and shortages of medical personnel hinder access. Cultural factors also play a critical role, as beliefs and distrust in medical systems can discourage utilisation, while gender norms in some contexts restrict women's autonomy in making healthcare decisions. From a sociological standpoint, therefore, access to healthcare must be understood as the outcome of both structural conditions and cultural dynamics, underscoring the need to address broader social determinants in improving healthcare delivery.

3. Theoretical Framework

To fully grasp the concept of health inequality in Nigeria, a theoretical perspective must be developed to contextualize the concept of health and its outcomes. There are several theoretical perspectives developed by medical sociology to explain the social determinants of disease and its outcomes. This study, therefore, utilized the Social Determinants of Health (SDH) perspective as the dominant theoretical framework, but also drew insights from the works of other classical medical sociologists, namely Talcott Parsons, Michael Marmot, and Paul Farmer. These perspectives, therefore, offer a framework for understanding the social determinants of disease and its outcomes.

3.1 The Social Determinants of Health Framework

The Social Determinants of Health (SDH) model is recognized as being among the most important conceptual models in understanding health inequalities. The model highlights how health outcomes are influenced by the social, economic, and environmental circumstances in which people are born, develop, live, work, and age.

The World Health Organization's Commission on Social Determinants of Health explains that inequalities in health outcomes are caused by differences in the distribution of resources, opportunities, and power in societies (World Health Organization, 2008, p. 1). This affects the living conditions of people in a given society, thus affecting their health outcomes.

Marmot and Wilkinson explain that social factors such as income inequalities, employment conditions, education levels, housing conditions, and social exclusion are among the factors that influence health outcomes in societies (Marmot & Wilkinson, 2006, p. 10). For instance, people living in poor conditions are more likely to be exposed to health risks and are less likely to access health care services.

The SDH framework, therefore, provides a comprehensive approach for analyzing healthcare inequality in Nigeria by highlighting the relationship between socioeconomic structures and health outcomes.

3.2 Talcott Parsons and the Sociological Understanding of Illness

One of the earliest sociological studies of the role of health and illness was by Talcott Parsons, who developed the idea of the "sick role." He suggested that illness or sickness is not just a biological condition but also a social role, and it is subject to cultural norms and expectations (Parsons, 1951, p. 436). According to Parsons, illness or sickness represents a condition wherein individuals in society are exempt from their social roles, but they must desire to get well and seek competent medical assistance to achieve their goal of regaining their health. Thus, the role of medical institutions is to facilitate the process of regaining their social roles by the individuals. Although the theory of Parsons was developed for Western industrial societies, it gives us a good idea of the sociological aspects of access to healthcare. This theory suggests the role of support systems for the provision of medical assistance to individuals.

Parsons' theoretical contribution shows the necessity of institutional structures in supporting healthcare access. When healthcare systems are weak or underfunded, individuals may be unable to perform the socially expected role of seeking medical care, thereby undermining the functioning of the healthcare system.

3.3 Structural Violence and Health Inequality: Paul Farmer's Perspective

Although classical theories of sociology have offered valuable insights into the social aspect of illness, contemporary social scientists have attempted to extend the study of

health inequality by considering structural and political elements. An important theory in this direction has been offered by the theory of structural violence, put forward by medical anthropologist Paul Farmer. The theory of structural violence refers to the social practices that cause harm to particular sections of the population. Farmer, in his theory, defines structural violence as an integral part of the political and economic system that results in inequality in the distribution of resources, including healthcare facilities (Farmer, 2004, p. 307).

Unlike direct forms of violence, structural violence is an indirect practice that imposes limitations on particular sections of the population. Poverty, lack of education, unemployment, and poor healthcare facilities are some of the structural forms of violence that affect health inequality. According to Farmer, structural inequality plays an important role in shaping the pattern of diseases in particular societies. In developing societies, the health inequality of particular sections of the population results from the structural violence that is enforced by the economic and political systems.

In the case of Nigeria, for instance, the structural violence can be seen with regard to the unequal distribution of healthcare facilities. The rural population mostly lacks access to healthcare facilities, while the urban population has access to a majority of the medical infrastructure. Such a difference in the distribution of healthcare facilities acts as a form of structural violence against the rural population. In addition, the high cost of healthcare facilities in Nigeria acts as another form of structural violence. The people are mostly forced to pay for the healthcare facilities, which results in a number of people avoiding healthcare services due to the high costs.

The concept of structural violence developed by Farmer can be seen as an effective tool for understanding the inequalities that exist with regard to healthcare facilities.

.4. Structure of the Nigerian Healthcare System

Nigeria operates a three-tier healthcare system comprising primary, secondary, and tertiary levels, each managed by different tiers of government and designed to perform distinct but complementary roles. Primary healthcare (PHC), overseen by local governments, forms the foundation of service delivery and provides essential services such as immunisation, maternal and child healthcare, health education, and treatment of common illnesses. It is intended to serve as the first point of contact between citizens and the healthcare system (Federal Ministry of Health, 2010, p. 7). Secondary healthcare, managed by state governments, includes general hospitals and specialised facilities that offer more advanced diagnostic and treatment services, often receiving referrals from PHC centres.

At the apex is the tertiary healthcare system, controlled by the federal government and comprising teaching hospitals, federal medical centres, and specialised institutions that provide advanced medical care, research, and professional training. Despite this structured arrangement, coordination among the three tiers remains weak, resulting in inefficiencies in service delivery. The fragmentation of responsibilities across federal, state, and local

governments has been identified as a major challenge, often creating gaps in healthcare provision and limiting the effectiveness of the system (Aregbeshola & Khan, 2018, p. 2).

4.1 Historical Development of Healthcare in Nigeria

The development of modern healthcare institutions in Nigeria can be traced back to the colonial period. During the late nineteenth and early twentieth centuries, colonial authorities established medical facilities primarily to serve colonial administrators and European traders. Indigenous populations often had limited access to these services. Following Nigeria's independence in 1960, the government began expanding healthcare infrastructure to serve the broader population. However, rapid population growth and economic challenges significantly constrained the capacity of the healthcare system. The Alma-Ata Declaration of 1978, which emphasized primary healthcare as the cornerstone of global health systems, influenced Nigeria's adoption of primary healthcare as the central strategy for healthcare delivery. This led to the establishment of numerous primary healthcare centers across the country during the 1980s. Nevertheless, economic downturns during the Structural Adjustment Program (SAP) era in the 1980s and 1990s weakened Nigeria's healthcare system due to reduced government spending on social services. As a result, many healthcare facilities deteriorated, and shortages of medical personnel became widespread. Today, Nigeria continues to face the long-term consequences of these historical developments, particularly in the form of weak infrastructure and limited healthcare funding.

4.2 Healthcare Financing in Nigeria

One of the most significant challenges confronting the Nigerian healthcare system is inadequate financing. Healthcare funding in Nigeria is derived from several sources, including government expenditure, private sector investment, donor funding, and out-of-pocket payments by households.

However, the Nigerian healthcare system is heavily reliant on out-of-pocket expenditure, which places a substantial financial burden on individuals and families. According to the World Health Organization, out-of-pocket payments accounted for approximately 74 percent of total health expenditure in Nigeria in recent years (World Health Organization, 2022, p. 86).

Heavy reliance on out-of-pocket payments has serious implications for healthcare access, particularly among low-income populations. When healthcare costs are high, individuals may delay seeking treatment or avoid medical care altogether, thereby worsening health outcomes.

To address this challenge, the Nigerian government established the National Health Insurance Scheme (NHIS) in 1999 with the aim of improving financial access to healthcare services. The NHIS was designed to provide health insurance coverage for both formal and informal sector workers. Despite these efforts, health insurance coverage remains limited. Studies estimate that less than 10 percent of Nigeria's population is currently covered by health insurance, leaving the majority of citizens dependent on out-of-pocket payments for

healthcare services (Aregbeshola & Khan, 2018, p. 3).

4.4 Healthcare Workforce and the Brain Drain Phenomenon

Another critical challenge within the Nigerian healthcare system is the shortage of medical professionals. Although Nigeria produces a significant number of healthcare workers through its universities and medical training institutions, many of these professionals migrate abroad in search of better working conditions and higher salaries. This phenomenon, commonly referred to as medical brain drain, has significantly weakened Nigeria's healthcare workforce. According to the World Health Organization, Nigeria has approximately 4 doctors per 10,000 population, which falls far below the recommended global threshold for adequate healthcare service delivery (World Health Organization, 2022, p. 92). The migration of healthcare professionals to countries such as the United Kingdom, Canada, and the United States has intensified in recent years due to poor working conditions, inadequate remuneration, and limited career opportunities within Nigeria's healthcare system. The shortage of healthcare workers disproportionately affects rural communities, where medical professionals are often reluctant to work due to poor infrastructure and limited professional opportunities. As a result, rural populations frequently rely on poorly equipped health facilities or informal healthcare providers.

4.5 Infrastructure and Regional Disparities in Healthcare Facilities

Healthcare infrastructure in Nigeria is unevenly distributed across regions. Urban areas generally have greater concentrations of hospitals, medical equipment, and healthcare professionals, while rural communities often lack basic healthcare facilities. According to the National Bureau of Statistics, healthcare facilities are significantly concentrated in southern urban regions such as Lagos and Abuja, whereas many rural communities in northern Nigeria have limited access to functional health centers (National Bureau of Statistics, 2022, p. 34). The uneven distribution of healthcare facilities contributes to significant disparities in health outcomes across different regions of the country. For example, maternal mortality rates and infant mortality rates are generally higher in rural areas where access to skilled healthcare providers is limited. In addition to geographic disparities, infrastructural deficiencies such as unreliable electricity supply, inadequate medical equipment, and poor facility maintenance further undermine the quality of healthcare services in many Nigerian hospitals. These infrastructural challenges often compel wealthier Nigerians to seek medical treatment abroad—a phenomenon commonly referred to as medical tourism—while poorer citizens are left with limited healthcare options within the country.

4.6 Implications for Healthcare Inequality

The structural characteristics of Nigeria's healthcare system have profound implications for health inequality. Weak institutional coordination, inadequate funding, shortages of medical personnel, and uneven distribution of healthcare infrastructure collectively create barriers to healthcare access for large segments of the population. From a sociological

perspective, these structural deficiencies reinforce existing socioeconomic inequalities by disproportionately affecting low-income households and rural communities. As a result, health outcomes in Nigeria often reflect broader patterns of social inequality within the society. Addressing these systemic challenges requires comprehensive policy reforms that prioritize equitable distribution of healthcare resources, expansion of health insurance coverage, and improved governance within the healthcare sector.

5. Integrated Analysis, Policy Implications, and Recommendations

The preceding sections of this study have examined health inequality in Nigeria from multiple perspectives. Section One introduced the broader problem of unequal healthcare access and situated the discussion within the Nigerian context. Section Two clarified the conceptual foundations of health inequality, public policy, and healthcare accessibility. Section Three established the theoretical framework using the Social Determinants of Health approach, Parsons' sociological analysis of illness, and Farmer's structural violence perspective. Section Four provided a contextual overview of the Nigerian healthcare system, highlighting its institutional structure, financing mechanisms, workforce challenges, and infrastructural limitations. This final section integrates these strands of analysis in order to provide a comprehensive understanding of the relationship between health inequality and public policy in Nigeria. It also identifies the policy implications of the study and proposes recommendations for addressing healthcare disparities within the country.

5.1 Synthesis of Key Findings

A central argument of this study is that health inequality in Nigeria is rooted more in structural and institutional conditions than in purely biological factors. The Social Determinants of Health framework highlights how socioeconomic conditions—such as income, education, employment, and living environments—shape health outcomes, and in Nigeria these determinants are unevenly distributed. Income inequality is particularly significant, as a large proportion of the population lives below the poverty line and lacks the financial means to access care. Given the heavy reliance on out-of-pocket payments, many households delay or avoid treatment altogether. The World Bank identifies such payments as a major barrier to healthcare access in low- and middle-income countries, including Nigeria (World Bank, 2021, p. 54).

Geographic and gender disparities further deepen these inequalities. Healthcare infrastructure and personnel are concentrated in urban centres, while rural communities face severe shortages, resulting in reduced access to essential services. Evidence from the Nigerian Demographic and Health Survey indicates that rural women are significantly less likely to receive skilled birth attendance compared to their urban counterparts (National Population Commission & ICF, 2019, p. 269). Gender norms also restrict women's autonomy and access to care in many communities. Additionally, weaknesses in policy implementation—despite initiatives such as the National Health Insurance Scheme and the National Health Act—limit the effectiveness of interventions due to poor funding, weak

institutions, and governance challenges. These conditions reflect what Paul Farmer describes as structural violence, where systemic inequalities disproportionately expose poor, rural, and marginalised populations to health risks.

5.2 Policy Implications

The findings of this study underscore critical implications for healthcare policy in Nigeria. Addressing healthcare inequality requires more than medical interventions; it demands the integration of health policy with broader social policies aimed at reducing poverty, improving education, and fostering economic development. Strengthening primary healthcare is equally vital, as these facilities serve as the first point of contact for most citizens, especially in rural areas, yet many remain under-resourced in terms of equipment, personnel, and infrastructure. Expanding health insurance coverage is also essential, given the limited reach of the National Health Insurance Scheme, which leaves many Nigerians exposed to high out-of-pocket costs—particularly those in the informal sector and low-income groups. Furthermore, tackling the shortage of healthcare professionals is crucial, as the migration of skilled workers continues to weaken service delivery; improving working conditions, remuneration, and career prospects would help mitigate this challenge and enhance overall system effectiveness.

5.3 Recommendations

Based on the analysis presented in this study, several recommendations can be proposed to address healthcare inequality in Nigeria.

1. Expansion of Universal Health Coverage

The Nigerian government should prioritize the expansion of universal health coverage through the strengthening of the National Health Insurance Scheme. Efforts should be made to incorporate informal sector workers, rural populations, and low-income households into health insurance programs.

2. Increased Government Funding for Healthcare

Nigeria's public health expenditure remains relatively low compared with international standards. Increasing government investment in healthcare infrastructure, medical equipment, and healthcare workforce development is essential for improving healthcare accessibility.

3. Strengthening Primary Healthcare Systems

Greater emphasis should be placed on strengthening primary healthcare centers, particularly in rural communities. This includes improving facility infrastructure, ensuring the availability of essential medicines, and deploying trained healthcare professionals to underserved areas.

4. Addressing Healthcare Workforce Migration

Policies should be implemented to improve the working conditions of healthcare professionals in Nigeria. Competitive salaries, improved hospital facilities, and opportunities for professional development could help reduce the migration of medical

professionals abroad.

5. Integrating Health Policy with Social Development Policies

Because health inequality is closely linked to broader social determinants, healthcare reforms must be integrated with policies aimed at reducing poverty, improving education, and promoting rural development.

5.4 Conclusion

The purpose of this study has been to explore the inequality of health in Nigeria from a sociological perspective, focusing specifically on the relationship between public policy and access to healthcare. As the analysis shows, inequality of access to healthcare is deeply rooted in the social and economic structures of the country. While the government of Nigeria has put several policy initiatives in place to ensure the improvement of accessibility to healthcare, the structural problems remain a challenge to the effectiveness of these policies. Therefore, to solve the inequality of access to healthcare, there needs to be a holistic approach to the improvement of the healthcare system and social and economic development. Ultimately, to solve the inequality of access to healthcare, there needs to be a commitment to the improvement of the system, more investments by the government, and a commitment to social justice.

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