THE POLITICAL ECONOMY OF HEALTH CARE PROBLEMS IN NIGERIA

by

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The economy of Nigeria is based on the capitalist system established by the British colonial government in the early 20th century. Today, the Nigerian economy is sustained by the neo-colonial forces of Europe and America through International agencies and multinational companies such as Lever Brothers, Coca-Cola, World Bank, Barclays Bank International, etc. It is from these organizations and corporations that the domestic capitalist relations of production derive their operative force and support. The institutions and values of the capitalist system now shape the productive process and consequently determine class structure, nature of the state and policy-making and implimentation in Nigeria.

The class structure of a state determines the character of its social services through policy-making and implementation. State organs responsible for the operation of different social services are thereby directly determined by the structure of the political economy of the country in question. That is why it is important to understand the political economy of a country in order to appreciate the nature of its health services. The main health care problems considered here are therefore closely related to the structure of Nigeria's socio-political economy.

I

Class factors and the distribution of health care services

The quality of services rendered to Nigerians in the privileged classes is much better than that of the poor. For instance, one doctor serves only about 400 patients in the former, but 25,000 in the latter category. Life expectancy in Nigeria is 41 years for the poor, but as high as 62 years for the more privileged classes.*

*The statistics in this section are based on estimates calculated using WHO data. It is not possible to obtain vital statistics for such class analysis in Nigeria. For example, if a city (Lagos) with a population of 1 million has 1500 physicians and the rest of the country has 4500, then, the physician-population ration in Lagos will be considerably better than in the ratio for the whole of Nigeria. The ratio for Nigeria is 14,810 patients per physician. But, over half of the 80 million Nigerians in rural areas have no access to physicians.

The structure of the Nigerian health care delivery system provides more and better health care facilities in the cities where the more privileged social class lives, than in the rural areas which are predominantly inhabited by the peasants. Even within the cities, there are hospitals and clinics which are built and reserved for the bourgeois class. For example, the Plateau Hospital in Jos is reserved specifically for senior government bureaucrats, businessmen and professionals such as professors and bankers who are wealthy enough to afford the cost of services it offers. The general hospitals which are built by the government to serve all Nigerians are not nearly as well equipped as the ones reserved for the wealthy. In Nigeria, government general hospitals primarily serve the poor population who can not afford anything better. The general hospitals have fewer physicians and lack essential hospital facilities including even very simple equipment such as drugs, syringes, needles, coolers and beds. O. Okedeji has reported that, even in these general hospitals 'families with elitist connections are served better.'[1]

The health situation in the rural areas where the Nigerian peasants live is even worse than the urban slums. Rural dwellers who constitute 75% of the Nigerian population are served by dispensaries and rural clinics, some of which operate only seasonally, due to lack of drugs or personnel or both. In some states in Nigeria e.g., Sokoto state, clinics are located in villages such as Dancadi and Dingyadi which have no access roads connecting them with the cities. The absence of roads makes it more difficult to get health care equipment to such areas. The Nigerian health care policy is influenced greatly by the bourgeois class. The influence has in effect caused the rural-urban imbalance in health care development and in health services distribution. If the rural areas were inhabited by the bourgeois class, health care services would presumably by equally available to these areas.

a) Fund Misallocation

The Nigerian government blames dearth of capital rather than class factors as the main problem confronting health care in Nigeria. The government's argument is however contrary to the fact and reality of the Nigerian health situation. For example, while some rural areas have only one clinic for every 200 square kms, new government health budgets may provide for specialist hospitals or sophisticated cancer treatment laboratories; even though the main cause of death in Nigeria is from infectious and preventable diseases, and not cancer or other diseases of affluence. The establishment of hospitals for the treatment of diseases such as cancer (which are not even common in Nigeria) is interpreted by the government as a sign of medical and health care development in Nigeria. Maurice King has

noted this problem:

> --- latest operating theatres are built to replace still servicable ones, while most children are still unvaccinated against measles or where rural clinics are still short of syringes -- a thoracic surgeon or a cancer specialist is recruited before an expert on health education. They make lavish provision for the few rather than for the many.[2]

b) Royal Occupation

The production of manpower in Nigeria also reflects the class structure. The British colonial government introduced western medicine in Nigeria as a prestigious bourgeois occupation. The early Nigerian physicians trained by the British government were not arbitrarily chosen but were carefully selected from the families of Kings, Chiefs, and Emirs.* The colonial government used the strategy of training sons of native Chiefs and Kings in order to lobby these native leaders, and have easy penetration and exploitation of the Nigerian colony. The Nigerian physicians who were trained by Christian missionaries, e.g., Dr. Barau Dikko, were also selected from influential families. The Christian missionaries used this strategy to win favours and permission to preach the gospel, especially in Northern Nigeria which already had Islamic religion. Since the early Nigerian physicians all had some kin relations with the political leaders (native Chiefs and Kings), the medical profession emerged more as a powerful political organisation than a medical group. For example, Schram[3] has shown that nine out of 35 Nigerian physicians in the 1950s were full time politicians and 3 consequently became regional governors of Nigeria between 1955-1957. In Nigeria today, the opportunities for medical training are largely available to sons and daughters of influential, wealthy and privileged families, usually residing in the cities.

The production of medical manpower in Nigeria therefore has class implications. This may also explain why Nigerian physicians refuse to practice in the rural areas. They are partly justified because they were born and raised in urban areas, and would not survive life in the rural areas with no pipe-borne water, electricity, markets and schools for their children. The situation may have been different if opportunities for medical training were available to all including children of the peasants, who would perhaps agree to serve in the rural areas after they graduate. But here again the political-economic

*Emirs are Moslem leaders. Emirs are powerful in Northern Nigeria even to date.

structure comes into play. For example, in countries such as Canada where opportunities for medical training are available to even the children of farmers, physicians still refuse to practice in the rural areas because the ideology of capitalism and professionalism are well developed, mitigating against rural practice for reasons related to profits.

c) Mislocation of Schools

Related to the problem of limited opportunites for the children of peasants to have medical education is the absence of primary and secondary schools in the rural areas. The few schools that are in the rural areas are ill-equipped and have no scholarships for children who would want to study medicine. Educated people including school teachers, prefer to stay in the cities, and so the rural inhabitants lack schools, teachers and instructors. The long time required in training a physician also contributes to scare away even the few fortunate children who would otherwise have access to medical training. Children of poor parental background lack a sound financial support that would enable them to spend 6 or 7 years beyond high school in the medical school. The more successful and fortunate children in the rural areas in Nigeria are those with opportunities to obtain a bachelor's degree in the Arts or in the Humanities. Some go on to become midwives and nurses, and are employed by the urban hospitals after graduation. If hospitals were in the rural areas; nurses and midwives, most of whom are originally from the rural areas, may want to practice in the rural hospitals. Schools for nurses and midwives are all in cities.

The inequality in the distribution of health care facilities in Nigeria is therefore a social structural problem. It is the socio-economic structure of Nigeria that determines the production, supply and distribution of health care services. The underdevelopment of the health sector in Nigeria is not merely a factor of poverty as the government suggests, but more of a socio-structural problem as embedded in Western Liberalism and imported into Nigeria. The Western liberal values embodied in the profession of medicine do not favour the introduction of socialized medicine, which may contribute to solving the problem of health care in Nigeria.

Perhaps, the introduction of a carefully planned, classless form of health insurance would be useful in making health care services more available to the Nigerian population. With government subsidized health insurance, all patients will have access to any hospital of their choice. In the present situation, only general hospitals are available to the poor masses. Health insurance will however not solve the problem of rural-urban imbalance, and that is why the solution to the Nigerian

health care problem transcends the health care sector. The problem of social inequality in the provision of schools, water, electricity, roads and markets must be dealt with first, before health care issues can be resolved. Good health means more than the availability of hospitals and dispensaries, it means the total social, psychological and physical well being of individuals.

One of the main effects of colonialism in the Third World today is the existence of a social group called the 'indigenous bourgeoisie.' The indigenous bourgeoisie consists of a small, powerful and wealthy clique of natives who had been favoured and trained by the European imperialists. After independence, the scepter of authority was handed over to this powerful native group, which still maintains good economic and political relations with its former colonial masters. These new leaders of the Third World are allied with the metropolitan bourgeoisie in promoting the exploitation of Third World countries through neo-colonial economic links.

The indigenous bourgeoisie are the managers of the state affairs in their various countries within the Third World. They formulate national economic and political policies that benefit the developed countries and their multi-national companies and which also satisfy the economic and social interests of these indigenous bourgeoisie.

The interactional effects of the neo-colonial forces and the interests of the indigenous bourgeoisie are therefore the main obstacles to the development of the Third World, and particularly the development of the health care sector. These interactional effects include the diffusion of entrepreneural values into the Third World countries. For example, the diffusion of professional, scientific medicine to the Third World came along with Western capitalist values. In Western countries such as the USA, doctoring is a form of business enterprise and medical skill a 'commodity' to be sold. In a bid to keep the business of doctoring profitable, physicians employ marketing mechanisms for controlling the production and supply of physicians. By so doing, physicians protect their economic and professional interests at the expense of national health care.

This supports the proposition that the indigenous elite of the Third World who plan the economy and in fact the health care sector are controlled by Western powers. Thus in safeguarding their own interests, the indigenous elite and Western imperialists perpetuate the underdevelopment of health services in Nigeria.

II

The fallacy of 'health by the people'

In 1975 the 29th World Health Assembly officially accepted the concept of primary health care as a World Health policy. According to the WHO, primary health care is a

> practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way and with their full participation. It has social and developmental dimensions and if properly applied, will influence the way in which the rest of the health system functions.[4]

In 1978, the various member governments of the International Conference on Primary Health Care (including Nigeria) identified the following characteristics of primary health care:

(i) A health system that would be patterned after the life-style of the local people to be served.

(ii) Villagers as Primary Health Care Workers, families from the local area and who are also acceptable to the local community.

(iii) Health care offered shall place maximum reliance on available community resources, e.g., community members.

(iv) Primary health workers be trained for a few weeks only in basic hygiene.

(v) Primary health workers be non-salaried workers. The primary health worker should only enjoy dignity and pride presumably associated with serving the community.[5]

Primary health care is therefore health by the people and not health for the people. The central idea of primary health care reflects the understanding that there is not enough money in the countries of the Third World such as Nigeria to consider any other solutions for health care needs, and that community health priorities are more likely to be met if the people themselves both raise and spend the resources required.[6]

The Nigerian government has accepted the idea of primary health care and the Health Ministry has a programme for influencing local communities to provide their own health care i.e.,

the Basic Health Implementation Agency with headquarters in Lagos. This agency will certainly contribute to improving the health of the local or rural communities, if these communities have the resources to provide health care by themselves. But underlying the idea of health by the people are two key issues that must not be overlooked, particularly in the Nigerian situation. These crucial matters are:

1. The issue of social justice.

2. The issue of quality and quantity of rural resources.

It is nothing less than social injustice on the part of the Nigerian leadership if the richer and more privileged bourgeois class living in cities has adequate health care services while the poor masses in the rural areas are asked to provide their own health care services. If any social class was to provide health services for itself in Nigeria, the bourgeois class should be the one, and yet, many wealthy senior government bureaucrats and their families have free medical services.

It would be ideal if the rural people could provide their own health care, but they do not have the necessary resources. The so called primary health worker can treat wounds with iodine and dispense aspirins. He can also organize traditional birth attendants and most importantly he or she can contribute by organizing the community to construct an access road. What else can those health workers do? Preventive health services which should be the main concern at this stage of development will have no place in primary health care if the villagers are to provide their own health services. For instance, the primary health worker himself is uneducated and does not know enough about hygiene and the agents of infection. In this regard, an assistant health officer should be trained. His training should be less (in duration and quality) than that of a general practitioner. If such persons are produced, and the rural areas are improved, health personnel may become sufficient to meet the needs of Nigeria. Mejia has found out that it is cheaper to train low cadre health personnel than training full-fledged doctors. In Thailand, 19 auxiliary health workers are produced at the cost of educating one physician. In East Africa, 20 medical assistants are produced at the cost of educating one physician. In Pakistan, 24 medical assistants, 60 midwives, 60 sanitary inspectors are produced at the cost of educating one physician.

In Nigeria, the Nigerian Medical Association is not in favour of the training of any medical assistants. The president of the Nigerian Medical association and the Chief Medical advisor to the Nigerian Federal Government are both opposed to the idea of producing medical assistants. The chief Medical

advisor clearly stated his opposition:

> ... the money required to establish training facilities for such lower grade personnel might as well be used to expand medical schools.[7]

The president of the Nigerian Medical Association is perhaps more concerned with the potential social status of such medical assistants in the hierarchy of health occupations. He is worried that such medical assistants, if produced, may be as powerful as physicians in the health sector:

> ... very soon such mini-doctors will upgrade themselves and become full-fledged doctors or masquerade as such ...[8]

The Nigerian Medical Association supports the training of village level primary health workers but opposes the training of medical assistants probably because the social distance between the physicians and the village health workers is sufficiently great not to constitute a threat to the medical monopoly of physicians in the business of doctoring. Local health workers and medical assistants might play complementary roles and together improve the health of rural Nigerians. Both are necessary to improve the health care system. Village level health workers might in fact play a more important role if medical assistants are also trained. The so called village workers will have difficulty in dealing with the complexity and red-tape of the Nigerian bureaucracy. The medical assistants will be better educated and qualified than village level health workers to face adequately the cumbersome task of transacting official health business with various government agencies.

The rural community can contribute to changing the health care system, but this contribution will not be in the form envisaged by the government's primary health care scheme. The rural inhabitants are too poor to provide their own health care services. However, Nigeria does in fact possess the resources necessary to provide health care services to all the people at all social strata. For example, Nigeria is two times richer than Tanzania, and yet Tanzania's health services are available to a larger percentage of the population than Nigeria's health services.[9] In 1977 the GNP per capita of Nigeria was U$420 and that of Tanzania was U$190. Tanzania emphasizes preventive health care services and its health care development plans are intrinsically related to the general development of the Tanzanian economy. Health care facilities are provided along with schools, roads, water, food and etc. For example, the present adult literacy rate in Tanzania is 66% and that of Nigeria is about 30%.

About 40% of Tanzanians have access to safe water and only 26% of Nigerians have access to safe water. The comparison between Tanzania and Nigeria shows that even though Nigeria is richer than Tanzania, and has a better physician-population ratio than Tanzania, the health status of an average person in Tanzania is higher than that in Nigeria (see Table 1). This situation may be due to the differences in the health care policies between these two countries. Tanzania tries not only to provide its population with health care facilities, but also other social amenities such as water and agricultural incentives. This leads to higher food production and consequently sufficient calorie supply. Although Nigeria has comparatively more calorie supply to its people than Tanzania, the agricultural land of Tanzania is less fertile; it is rocky and dry. Therefore, it takes more effort in Tanzania to get food crops than in Nigeria. Nigeria on the other hand, takes a different approach, providing sufficient health services only to a small sector of the population residing in cities, while primarily emphasising curative services. For instance, Tanzania voted 1.9% of its health budget on preventive services in 1977 compared to Nigeria's 0.7% for the same purpose, but 99.3% for curative services. Since Nigeria is richer than Tanzania and has more medical facilities (Table 1), policies influencing the management of the health care system must be responsible for Nigeria's lower health status.*

Tanzania uses village level health workers, but in between the village health workers and the physicians are medical assistants. The medical assistants receive a shorter period of training than full-fledged physicians, but are capable of adequately providing rural health care services which physicians have neglected. The Nigerian government should maximise its efforts to provide health for the people because health by the people is not a realistic approach to solving the problem of health care especially in a country where the rural inhabitants are critically impoverished. In Tanzania the major effort to solve health care problems started with a change in political philosophy and political goals. Perhaps Nigeria may reconsider

*Some scholars may argue that ethnic differences and nepotism contribute to health care underdevelopment in Nigeria. But the effects of ethnic favouritism alone would not have created a major difference in the distribution of health care facilities. For example, even within the states that comprise one ethnic groups such as Hausa, Yorubas and Ibos, health services are underdeveloped. In these states, ethnic factors are not responsible for the allocation and distribution of health facilities since all the inhabitants are of the same ethnic group. It should also be noted that Tanzania as well as Nigeria have many ethnic groups, and so both of them are exposed to the evils of tribalism.

TABLE 1

A COMPARISON OF HEALTH STATUS MEASURES IN TANZANIA AND NIGERIA

	Tanzania	Nigeria
GNP per capita in U$	190	420
Crude birth rate/1000	48	50
Crude death rate/1000	16	18
Infant mortality rate/1000	--	163
Life expectancy at birth	51	48
*Adult literacy	66	30
**Population-per physician	18,490	14,810
Daily calorie supply as % of requirements	86	88
% of expenditure on health	07	--
Preventive health as % of total health budget	1.9	0.7

Data not available

* Refers to 1974 Statistics

**Refers to 1976 Statistics

All others 1977 estimates.

SOURCE: Health Sector Policy Paper op. cit., p. 71-72.

its political ideology as a realistic starting point for a substantial change in the health care system. A change in the health care system may be far-fetched unless the political leaders of Nigeria begin to perceive health care as a basic necessity rather than a mere commodity to be sold for economic gain.

III

The commodification of health

To Freidson, the foundation on which the analysis of a profession must be based is its relation to the ultimate power and authority in the modern society (the state). It is from the state that the medical profession obtains its power and legally supported monopoly over health practice.

> this monopoly operates through a system of licencing ... it is the state that grants this monopoly the exact form of which varies widely throughout the world.[10]

In Nigeria, as in other countries such as Canada and USA, the medical association has a monopoly over the practice of medicine. This monopoly is granted and protected by the state. The relationship between the state and the medical profession in Nigeria as in other countries is cordial and complementary. Freidson and Krause[11] have indicated that there is a cordial relationship between the medical profession and the state in the USA. Navarro[12] notes the same kind of relationship in the USA and in Latin American countries such as Chile and Argentina. Twumasi has shown the same pattern of state-medical professional relations in Ghana[13] and Medvevdev and Medvevdev[14] show that the state and the medical profession enjoy a good relation in the Soviet Union. The good relations between the state and the medical profession in many countries of the world show the political character of the medical profession. Freidson has also noted that

> the foundation of medicine's control over its work is clearly political (and economic) in character involving the aid of the state in establishing and maintaining the professional pre-eminence ... the occupation itself has formal representatives, organizational or individual attempt to direct the efforts of the state towards policies desired by the occupational group.[15]

The relationship between the state and the medical profession in Nigeria can be identified both formally and informally. Formally, the Nigerian Medical Association has representatives

on the National Health Council (the highest health policy-making body in Nigeria) and the Federal government calls on the Nigerian Medical Association from time to time for expert advice on health care matters, e.g., in determining the potential use of traditional medicine and healers in the health care system. Informally, the medical association influences health policies through its members in the Senate, State Assembly and those physicians in other positions of power such as governors and ministers.

The relationship between the state and the medical profession is cordial and complementary because each side obtains some benefits from the relationship. For example, health care policies in Nigeria are designed to favour the more privileged social class in which members of the state belong.

The medical profession, on the other hand, exploits the good relations with the state to protect its economic and political interests, e.g., determination of the working condition of physicians in the public sector and protection of the association's monopoly and other interests which together make the medical profession a very powerful occupation in and outside the health sector. Implicitly, the health needs of the general population are considered only after the various private interests of the state and the medical association have been satisfied.

The fundamental ideology of the modern medical profession in Nigeria is implicitly opposed to the rapid development of health care services for all the population. The beliefs, values, norms and symbols of the medical profession correspond to the very basic tenants of capitalism. For example, capitalism allows but a minimum government intervention in business, because maximization of profits is its main value and belief. Capitalism also fosters monopoly control of business. In Nigeria doctoring has very clearly emerged as a form of business enterprise acquiring all the characteristics of capitalism. For example, doctoring does not want any government intervention in its business and that is why the good relations between the state and the medical profession are essential in protecting the latter's economic interests. The medical profession also wants an unshakable monopoly in the practice of medicine. This explains why traditional medicine is not officially recognised and healers are not licenced to practice in spite of the mounting pressure put on the government by both the traditional healers and their clients. The Nigerian physician sees his medical skills as a valuable commodity and seeks to place his skills where there are good markets. The peasants in the rural areas lack the wealth required to buy expensive commodities such as the doctor's medical skills, and the doctor on the other hand does not want to practice in the rural areas where

the market for his skills is presumably unprofitable.

Like capitalism, the medical profession requires freedom to control its work and to determine how economic, political and legal power affects medical practice. The medical profession is very influential in directing Nigerian health care policy towards curative services rather than preventive care. Preventive medicine is not economically rewarding to physicians because the elimination of disease would critically reduce the high demand for physicians. The ultimate desire of the physician appears to be making as much profit as possible from his medical skills. The growing desire of physicians in Nigeria to set up their private clinics and hospitals also stems from the same fact that the Nigerian society has a constant supply of sick persons. The agents of the diseases are never destroyed and so in spite of the many private clinics and hospitals in the cities, physicians still have an overwhelming number of customers. The great desire for profit pushed almost all physicians in Nigeria before 1975 to set up their private hospitals and clinics. Government hospitals at this time ran out of physicians because government salary was not as handsome as the income accruing from private practice. It was at this time that the traditional good relations between the state and the medical profession was strained. The government, in order to retain physicians in the general hospitals, enacted a decree which required five years of compulsory medical practice in a government hospital clinic or in a mission hospital by graduating physicians before they may be free to set up their own private hospitals and clinics. In a recent study, Pearce noted that 'the Nigerian Medical Association is still fighting to have the decree repealed.'[16]

The enactment of a decree to regulate medical practice in Nigeria in 1975 in effect shows that the Nigerian government can control the medical profession if it wants to do so. For instance, the problem of a shortage of doctors in the Nigerian health care system seems to be a carefully worked out strategy by the medical association, which is supported by the state bureaucracy in order to control the production and supply of physicians. This argument is plausible because both the Nigerian Medical Association and the Federal Government are aware of the shortage of health personnel, especially doctors, and yet the Nigerian medical schools are not expanded to meet this need. In the 1967/70 school session, 1357 qualified candidates applied for admission to the University of Ibadan Medical school and only 108 were admitted. In the 1971/72 session, 1200 candidates applied, and only 150 were admitted.[17]

The excuse given for not expanding the medical schools is always the same: lack of capital. However, if Nigeria has a problem, it is the problem of misuse rather than lack of capital.

The Nigerian government has other priorities. For instance, between October 1979 and July 1982, the Federal and the state governments sponsored overseas tours for over 500 legislators, ministers and senators. In 1979 almost all the members of the Nigerian senate were sponsored on a tour of the American continent under the veil of studying the machinery of democracy. A conservative estimate places the amount wasted in this manner at U$ 3.5 million. This amount alone is large enough to start a medical school. Corruption has also affected national health care development. For example U$ 4.2 billion of the government money was recently stolen by a Nigerian official from the government account. Half of the national budget in some departments such as the health department is misappropriated.*

IV

Health and Culture: In defence of traditional medicine

Culture refers to the tradition of a people - a set of everyday behaviour or way of life of a people who have settled in one place for a long time and who share common beliefs, customs, and traditions. Several studies such as those of Suchman, Mechanic, Zola and Segall[18] have shown a relationship between culture and health behaviour, reactions to pain, perceptions of causal factors and ideas about prevention and cure. Culture influences the medical system one uses for a given illness. For example, culture influences a Nigerian patient to see a traditional healer for illnesses such as jaundice and ailments caused by bewitchment, and to see a modern doctor when taken ill by diseases such as gonorrhoea.

Every medical system has its own pattern of consumption. The pattern of consumption is often based on the cultural understanding of disease and its cause. For example, a traditional healer treats headaches by either touching the victim's head or applying medicine on the victim's head. A Western trained physician understands the cause of headaches to be not necessarily located around the head and so gives drugs to a headache victim. The healing practice is therefore based on the understanding of the cause. Though the modern doctor's

*The data here are based on a very careful estimation. Every month Nigeria sends 5-10 senators and legislators to Europe and America to observe the working of democracy. This is obviously wasteful. Corruption and embezzlement of government funds are profitable business to bureaucrats in Nigeria because civil servants who embezzle government money do not repay it even when they are convicted. They are only dismissed from the service without the usual retirement benefits. Corruption is difficult to document but its presence in the Nigerian bureaucracy is obvious.

drugs go into the stomach, the aim is to heal the headache. The traditional healer applies his medicine directly to the affected part of the body. In both cases the patient recovers.

According to Suchman, the understanding of a people's culture is necessary before any health care policy formulations for such a people can be successful. He notes that:

> many health care programmes have failed because they did not recognise and accept the cultural definition of psychosocial environment in which they had to work.[19]

Suchman's argument becomes even more plausible in a situation where a highly scientific and bureaucratic system of medical care is forced upon urban and rural slums where customs are not congruent with what is offered. For example, health planning in Nigeria does not take cognizance of the cultural factors. Health planners also make the mistake of thinking that the people need only modern health care facilities, and not traditional medical care. The failure of the Nigerian health system is partly due to the blatant neglect of cultural factors involved in the delivery of health care. There are cases in the Northern states of Nigeria, e.g., Sokoto and Niger where sophisticated health care has been planned for people who continue to have a great attachment to traditional medicine. That is the reason why health education, modern medicine, and traditional medicine all must come together in order to build a healthy Nigerian society.

Margaret Mead[20] in her book Culture and Health has noted that, traditional medicine is acceptable particularly in the treatment of native diseases. Natives of India and Africa identify three groups of diseases. The first group comprises everyday diseases. Everyday diseases are caused by over-eating, eating bad food, and over-working. These ailments are usually not serious, they can be treated by drinking warm water or having a hot bath and adequate rest. The second group comprises native diseases which are presumably caused by the native devils, witches and other supernatural forces. Diseases in this group are not usually taken to the hospital. According to the natives, only traditional healers deal adequately with such diseases. In most cases diseases in this group are long term, incapacitating types such as mental illness. The third category of diseases identified by the Indians and Africans in Mead's study are 'foreign diseases.' According to them, foreign diseases are those imported from the Western World, e.g., gonorrhoea and syphilis. The natives claim that traditional medicine heals foreign diseases too, but western medicine treats them better and faster than traditional healers.

This typology of diseases was also found in Nigeria in a study in Mkar Benue state.[21] The natives are not foolish. They know what to do in every illness situation. They know which diseases to take to the modern doctor and which to the traditional healer. They selectively use the type of care that their culture permits and that which gives them social and psychological satisfaction. The Nigerian people, including those in the rural areas, like and use Western medicine but do not want to throw away traditional medicine in favour of modern medicine. To them, that would be throwing away the baby with the bathwater. They need traditional as well as modern medicine, and they should not be blamed for this because traditional medicine and the culture of the native people can not be separated.

Birchman has warned that physicians should not focus on objectively measurable parameters in evaluating traditional medicine because traditional healers do not primarily treat disease but sick people. There is usually a connection between health and harmony in the traditional medical system which is understood in cultural terms and social relationships. For example, Lambo relates the story of an African bureaucrat who fell sick a week after he was promoted to a higher rank by the government. The timing of his sickness and his promotion left the victim no further doubts that he was bewitched by his enemies who were jealous of his promotion. As an educated person living in the city this bureaucrat considered it more fashionable to visit a hospital though in the back of his mind he knew that bewitchment was best cured by a traditional healer. Several visits to specialists in Western medicine did not help his situation. It was not until he visited a traditional healer that he was cured. The traditional healer made sacrifices and destroyed the power of bewitchment that was haunting him. The story helps to relate explicitly, the use of traditional healers in the Nigerian society.

If Nigeria produced one physician for every household, the Nigerian people would still need the services of traditional healers. Traditional medicine is intricately related to the people's culture, and this indicates the necessity for the Nigerian government to defend and promote the use of traditional medicine in the Nigerian society. Giving official recognition to traditional medical institutions through legislation may be a desirable starting point towards their official recognition. Traditional healers should be licenced to practice in public. Nigerian scholars and those especially in the disciplines of anthropology and sociology should be eager and willing to conduct research that will enlighten health planners on the dynamics of culture and its impact on illness behaviour. Physicians should also be given more education in this aspect of social science. This may instill a sense of respect for traditional

medicine, which is regrettably lacking in their present training. Physicians should be able to learn and appreciate the fact that traditional medicine provides curative and preventive services. Preventive services for ailments such as psychiatric traumas are provided by traditional healers in forms of medicines for love marriage, riches, good farms, and medicines to find jobs. These may be scientifically unproven, but the traditional healing ideology serves a purpose and brings satisfaction to those that use traditional medicine. This is because the traditional medical ideology brings the totality of the patient's social and cultural environment into the context of therapy.

In conclusion, it should be emphasized that the proposition that the indigenous bourgeoisie in the Third World and especially in Nigeria are obstacles to the development of health care services is very plausible. The medical profession in countries of the Third World may also be blamed for turning health care into a money making venture as has been shown in this thesis. Although the profession of medicine parades itself as a humanitarian occupation, available evidence does not support such an assertion. As long as medical skill remains a commodity to be sold for money, the medical profession will never be a truly humanitarian occupation. As long as the working class lacks the wealth to buy the doctors' services, adequate health care services will continue to be unavailable. The contribution of the science of medicine to the well being of modern society is very precious; however, the commodification of health and the current wave of medicalization of society by the medical profession are likely to cast a pall on all that medicine has to offer to the modern world.

The provision of modern health care services to the Nigerian people together with traditional medicine is very desirable because it will enable even the poor masses of Nigeria to choose, from the available health services, those most relevant for a given sickness. The culture of the Nigerian people allows a division of diseases into "native" and "foreign" diseases and so they need two medical systems with modern medicine concentrating on 'foreign diseases' and traditional medicine concentrating on 'native diseases.'

But the real solution to the health care problems in Nigeria presupposes and calls for substantial changes in the structure of the socio-political economy of the country. In the long run, this is the only guarantee for good health services for the totality of the Nigerian people.

NOTES

1. Olu Okedeji, in Akinkugbe ed., Priorities in National Health Planning, p. 115.

2. Maurice King: Medical Care in Developing Countries, p. 1-11.

3. Ralph Schram: "History of Nigerian Health Services." Ibadan: Ibadan University Press, 1971, p. 205.

4. Primary Health Care - "Joint Report," p. 8.

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