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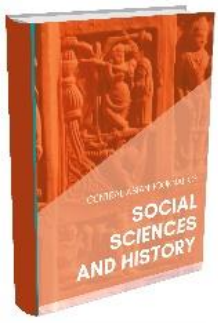

The Poor and Access to Health Care Services in Selected Local Government Areas of Rivers State

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Abstract:
This study examines poverty and access to healthcare services. Anchored on the structural theory of poverty, the study argues that widespread poverty in Rivers State is caused by economic, political and social distortions or discrimination and thus perpetuates the people's inability to have access to maximum healthcare services. Data for this correlation-based study were generated through an 18-item structured questionnaire administered to six hundred and fifty-eight (658) randomly and purposively selected respondents from Etche, Obio-Akpor, Asari-Toru, Akuku-Toru, Andoni and Eleme Local Government Areas. Two hypotheses were tested in the study using Spearman rho correlation coefficient. The first hypothesis stated that unemployment is negatively correlated with access to health care services. The second hypothesis states that low income is negatively correlated with access to healthcare services. All the hypotheses were retained because of the variable of poverty, unemployment and low income.

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Because of these, most of the people find it difficult to access orthodox healthcare services. Sustainable poverty alleviation options which could increase employment opportunities and increased industrialization were recommended as appropriate options for tackling widespread poverty and ensuring access to quality healthcare services.

Introduction

Poverty and access to health care services are major development problems in Africa, particularly in Nigeria. Health is central to community well-being as well as to personal welfare. According to Knox (1979), it has a strong influence on peoples earning capacity and productivity; it affects educational performance (and thus determines employment prospects); and it is fundamental to people's ability to enjoy and appreciate all other aspects of life. Health has also been shown to explain in statistical terms at least, a large proportion of the variation between people in their overall happiness or perceived well-being. Reports of studies conducted in Britain, the United States and other Western societies indicate that health and provision of health care facilities are consistently valued higher than any other aspect of well-being including housing, money income, social statues, education, family life and leisure (Abrams, 1976). The case is different in developing societies, which is characterized with poor or low availability of health care services. Nigeria, Africa's most populous country, is known for its widespread poverty and poor health care conditions. The World Bank report has it that more than 70% of Nigerians live on less than US $1 per day, and this impairs their ability to afford health care. Poverty and corruption, demographic pressures, cultural attitudes and practices, gender inequalities and insufficient investment in public health care are some of the barriers to effective control and treatment of diseases such as hypertension and cholera in most Nigerian adults affected by the disease (Adebisi and Samali 2013).

Socioeconomic promoters of diseases and ill-health in Nigeria have been identified to include poverty, inadequate financing of the health sector education, inadequate health workers, poor laboratory support, political instability and corruption existing in many parts of Nigeria (Cooper, Rotimi, Kaufman, Muna, and Mensah, 1998; Kadiri, 2005; Seedat, 2007). Poverty is at the center of all these factors. Thus, as Salako (2003) has observed, there is a nexus between poverty, socio-economic conditions and diseases. The socio-economic determinants can be classified in terms of hunger, lack of water, lack of energy, poor sanitation and poor housing conditions (Deepa, 2001).

The National Bureau of Statistics (2005) has reported that there is marked deterioration in the quality of life of Nigerians over the years since independence, resulting in the steady increase in the number of Nigerians caught below the poverty line. According to Garcia, Kohl, Ruengsorn and Zislin (2006), Nigeria's main challenges include reducing poverty, diversifying its economy from oil and gas sector towards more labour intensive sectors, and improving health and education. The oil has increased economic volatility and inflation while those living in poverty are most vulnerable to volatility and inflation. In addition, instability of government revenues and a crowding out of agriculture (which provides the source of income to the poor) have made the situation worsen. The oil industry has failed to employ a sizeable number of unskilled workers, thereby contributing little to poverty reduction in the Nigerian society.

It is against this backdrop that this study examined the consequences of poverty on access to healthcare services by Nigerian citizens in Rivers State. In particular, the study was carried out in Etche, Obio-Akpor, Asari-Toru, Akuku-Toru, and Eleme local government areas of Rivers State.

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Aims and Objectives of the study

This study examines poverty and access to healthcare services in Rivers State, Nigeria. Specifically, the study:

a. Examines the relationship between poverty and access to healthcare services.

b. Investigates the relationship between unemployment and access to healthcare services.

c. Ascertains the relationship between low income and access to healthcare services.

Research Questions

The following questions guided the study:

a. What is the relationship between poverty and access to healthcare services?

b. What is the relationship between unemployment and access to healthcare services?

c. What is the relationship between low income and access to healthcare services?

Research Hypotheses

a. There is no significant relationship between unemployment and access to healthcare services.

b. There is no significant relationship between low income and access to healthcare.

Conceptual Issues

Poverty Explained

Poverty is a global phenomenon, but arriving at a single definition and measurement of poverty has been a herculean task due to a number of factors (Anyawu, 1997; Kotler, Roberto, & Leisner, 2006). Poverty has been variously defined by various scholars, especially in social sciences, development studies, and humanities. Khanker and Haughton (2009) see poverty as well known pronounced denial of means of livelihood such as basic necessities like food, housing, drinkable water, clothes, access to good education, health services, jobs which are very vital in enhancing human capital and social wellbeing. Galbraith (1969) stressed that people are poverty-stricken when their incomes, even if adequate for survival, fall radically behind that of the community; they are degrades, for in the literal sense, they live outside the grades or categories which the community regards as acceptable.

The Central Bank of Nigeria (1999:1) has defined poverty as 'a state where an individual is not able to cater adequately for his or her basic needs of foods, clothing and shelter; is unable to meet social and economic obligations, lacks gainful employment, skills, assets and self-esteem; and has limited access to social and economic infrastructure such as education, health, portable water, sanitation and consequently has limited chance of advancing his or her welfare to the limit of his or her capabilities'.

Nwoabi (2003) identifies the dimensions highlighted by poor people to include lack of income and assets to attain basic necessities (food, shelter, clothing and acceptable levels of health and education), sense of voice-less-ness and powerlessness in the institutions of the state and society; and vulnerability to adverse shocks. Akpomuvie (2010) notes that poverty may be categorized along five dimensions of deprivation; personal and physical deprivation (deprivation experienced in health, nutrition, literacy, educational disability and lack of self-confidence), economic deprivation (lack of access to property, income, assets, factors of production and finance, or the denial of access to the basic necessities of

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human existence); social deprivation (this involves the barriers to full participation in social, political and economic life; people may be deprived of their human right because of personal and economic deprivations); cultural deprivation (people are deprived in terms of values, beliefs, attitudes, knowledge, information and orientation, and thus are not able to take advantage of economic and political opportunities): and political deprivation (lack of political voice and power).

Currently, poverty is increasingly recognized as a multidimensional phenomenon, which involve, for instance, lack of access to education, healthcare and infrastructural facilities; the denial of opportunities and choices to take independent decisions and to command respect of others; even remoteness to political power. Ucha (2010) has identified unemployment, especially among young graduates; corruption, especially among political office holders; non-diversification of the economy; income inequality; laziness, especially among those who come from wealthy households; and a poor education system as key factors that contribute to poverty in Nigeria. As a major socio-economic problem, poverty has posed a serious challenge the world over, especially in developing countries (Islam, 2004). Poverty is a humiliating and dehumanizing experience. Thus Ukpong (1996, cited in Obadan, 1996) pushed for urgent actions towards its eradication and control. However, scholars (Repnik, 1994; Robb, 2000) are of the view that poverty cannot be eradicated but rather alleviated.

Health and Healthcare System Explained

Health, according to World Health Organization (WHO, 2000), is a state of complete physical, mental and social well-being and not merely the absence of disease or infinity. The definition is vast and complex, therefore not practicable under the subject matter. Disease designated altered bodily state or processes that deviates from norms established by biomedical science. Disease is that alteration of living cells or tissues that jeopardizes survival in the environment. Illness treatment is determined by its cause and the cause determines the pathway to health care delivery (Owumi, 1996).

Ill-health refers to a bodily or mental start is deemed undesirable. As a result, intervention to ameliorate or remedy that condition can be sought and justified. Illness behavior is people's willingness to use health services, their access to services, their perception of their illness (Marshall, 1994). Health behaviour refers to efforts made to relieve one of the associated discomfort and pained experienced. In fact, it refers to any activity undertaken by a person who believes to be healthy to prevent a disease, such as having routine checkups, immunization, and vaccination. The utilization of Health care service is determined by culture (Rumun, 2014).

Health is a major component of a nation's socio-economic development. Good health does not only contribute to better quality of life but it also essential for a virile labour force for the creation and maintenance of a nation's wealth. The importance attached to the health of a people and level of economic wellbeing necessitates the commitment of governments worldwide to health care issues. Poverty has an inverse relationship with health and health care. The two socio-economic phenomena are therefore very crucial determinants of the wellbeing and survival of man in his ecological niche (Akpomuvie 2010).

The healthcare system is intended to deliver the healthcare services. It constitutes the management sector and involves organizational matters and the totality of resources a population or community distributes in the organization and delivery of healthcare services. Healthcare can be described as a response to equilibrium. In other words, when there is an alteration in a system, those devices used to ensure equilibrium is healthcare (Jegede, 2006). The medical system of a given state, community or nation refers to the available health care facilities in place for the management of health problems. The

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existing health care system is defined by the culture and belief of the members of the community (Owumi, 1996).

Healthcare is the prevention, treatment and management of illness as well as the prevention of mental and physical wellbeing of man through the services offered by the health workers such as: Medical Doctors, Nurses, Paramedic staff etc. According to the World Health Organization (2000), healthcare embraces all the goods and services designed to promote health, including preventive, curative and palliative intervention, whether directed to individuals or to populations. In Public Health Economics, health is treated as a 'special goods" and its distribution, as argued, should not be determined by the levels of the people's income.

Major factors that affect the overall contribution of the health system to economic growth and development in Nigeria have been enumerated by Obansa and Orimisan (2013) to include inter alia; lack of consumer awareness and participation, inadequate laboratory facilities, lack of basic infrastructure and equipment, poor human resource management, poor remunerator and motivation, lack of fair and sustainable health care financing, unequal and unjust economic and political relations between Nigeria and advanced countries, the neo-liberal economic policies of the Nigerian state, pervasive corruption, very low government spending on health, high out-of-pocket expenditure on health, absence of integrated system for disease prevention, surveillance and treatment.

Theoretical Framework

This study is anchored on the structural theory of poverty. In simple terms, supporters of the structural school are of the opinion that poverty is caused by economic, political, and social distortions or discrimination. The idea that poverty is caused by economic, political and social distortions or discriminations lends itself to the progressive social theory. The progressive social theorists do no look at the individual as a source of poverty, but to the economics, political, and social system which causes people to have limited opportunities and resources with which to achieve income and wellbeing. The 19th century social intellectuals developed a full attack on the individual theory of poverty by exploring how social and economic systems overrode and created individual poverty situations. For example, Marx showed how the economic system of capitalism created the 'reserve army of the unemployed' as a conscientious strategy to keep wages low. Later Durkheim showed that even the most personal of actions (suicide) was in fact mediated by social systems. Discrimination was separated from skill in one after another area, defining opportunity as socially mediated. Taken to an extreme, radical thinkers argued that the system was flawed and should be radically transformed (Bradshaw, 2006).

Larger economic and social structures have been found to account for poverty. Perspectives regarding structural factors argue that capitalism creates conditions that promote poverty. Beeghley (2000) noted the effect of economic structure stating that irrespective of individual effort (hard work, skill); the structure of the United States economy ensures that millions of people are poor. Specifically, the Davis and Moores' functionalist theory, labour market theories, and the social exclusion perspective threw more light on the structural causes of poverty. The functionalist theory of social stratification argues that poverty is an important social, economic and political function for society in general, and for the middle and wealthy classes in particular (Davis & Moores, 1945).

Elimination of structural barriers to better jobs through education and training have been the focus of extensive manpower training and other programs, generating substantial numbers of successes but also

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perceived failures. However, in spite of perceived importance of education, funding per student in less advantaged areas lags that which is spent on richer students, teachers are less adequately trained, books are often out of date or in limited supply, amenities are few, and the culture of learning is under siege. This systemic failure of the schools is thus thought to be the reason poor people have low achievement, poor rates of graduation, and few pursue higher education (Chubb and Moe, 1996).

Since the theory identifies the problem of poverty to be in the system rather than in the poor themselves, a community development response must be to change the system in order to give the poor a place in society. Systemic changes should target how one can get more jobs, improve schooling for the poor, equalize income distributions, remove discrimination bias from housing, banking, education, and employment, and assure equal political participation by poor persons. Changing the system can take place at three levels. From a grassroots level, social movements can exert pressures on vulnerable parts of the system to force desired change. Rank (2004) argues that change could be mobilized to support better jobs for the poor and a more effective system since as the subtitle of his book states, 'American Poverty affects us all'.

Methodology

This study, based on correlational survey design, was carried out in six local government areas (two for each senatorial zone) in Rivers State, Nigeria. These include Etche, Obio-Akpor, Asari-Toru, Akuku-Toru, Andoni and Eleme local government areas. Data for the study were generated through a structured questionnaire administered to six hundred and fifty-eight (658) respondents who were purposively and randomly selected. These were adults aged 18 years and above. 121 (18.4%) of the respondents reside in Obio-Akpor Local Government Area, 115 (17.5%) of the respondents reside in Eleme Local Government Area, 110 (16.7%) of the respondents reside in Etche Local Government Area, 109 (16.6%) of the respondents reside in Akuku-Toru Local Government Area, 102 (15.5%) of the respondents reside in Andoni Local Government Area, and 103 (15.3%) of the respondents reside in Asari-Toru Local Government Area. 360 (54.7%) of the respondents were females while 298 (45.3%) were male. 316 respondents (48.0%) were aged 18-37 years, 267 (40.6%) were aged 38-57 years, and 75 (11.4%) were aged 58 and above years. 487 (74.0%) of the respondents were married, 82 (12.5%) were single, 38 (5.8%) were divorced, 26 (4.0%) were separated, and 25 (3.8%) were widowed.

251 (38.1%) of the respondents had primary school education, 230 (35.0%) had secondary education, and 177 (26.9%) had tertiary education. 528 (80.2%) were Christians, 96 (14.6%) were members of Traditional Religion, and only 34 (5.2%) were members of Islamic religion. 379 (57.6%) were employed, whereas 279 (42.4%) were unemployed. 334 (50.8%) did not earn any monthly income; 189 (28.7%) earned N,50,000 – N99,000; 124 (18.8%) earned less than N50,000; and only 11 (1.7%) earned N100,000 and above.

Descriptive statistic (frequency and percentages) and inferential statistics (Spearman rank-order correlation coefficient, abbreviated as Spearman rho) were used to analyze the results and hypotheses of this study. Descriptive statistics describe the phenomena of interest. They include the analysis of data using frequencies, dispersions of dependent and independent variables and measures of central tendency and variability and to obtain a feel for the data. As noted by Sekaran, (2003), inferential statistics is employed when generalizations from a sample to the population are made.

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Results and Discussion

Respondent's opinion concerning unemployment and access to healthcare services

Table 1: Unemployment is a barrier to accessing healthcare

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	6	0.9	0.9	0.9
	Agree	561	85.5	85.3	86.2
	Strongly Agree	91	13.8	13.8	100.0
	Total	658	100.0	100.0	

Source: Researcher's Field Survey, 2019

Table 1 shows that 85.3% of the respondents respectively agreed and strongly agreed that unemployment is a barrier to accessing healthcare. In all, 99.1% of the respondents accepted that unemployment is a barrier to access healthcare. However, only 0.9% of the respondents accepted that unemployment is not a barrier to accessing healthcare.

Respondent's opinion on the unemployed and access to healthcare services

Table 2: The unemployed find it difficult to access healthcare services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	547	83.1	83.1	83.1
	Strongly Agree	111	16.9	16.9	100.0
	Total	658	100.0	100.0	

Source: Researcher's Field Survey, 2019

As shown in Table 2, 83.1% of the respondents agree that the unemployed find it difficult to access healthcare services. 16.9% strongly agreed that the unemployed find it difficult to access healthcare services. In all, all respondents agreed that the unemployed find it difficult to access healthcare services.

Respondent's opinion concerning low income and access to health care services

Table 3: Having low income is a barrier to access to healthcare services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Disagree	2	.3	.3	.3
	Agree	541	82.2	82.2	82.5
	Strongly Agree	115	17.5	17.5	100.0
	Total	658	100.0	100.0	

Source: Researcher's Field Survey, 2019

Table 3 reveals that 82.2% and 17.5% of the respondents respectively agreed and strongly agreed that having low income is a barrier to access to healthcare services. In all, 99.7% of the respondents accepted that having low income is a barrier to access to healthcare services. However, only 0.3% of the respondents did not agree that having low income is a barrier to access to healthcare services.

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Respondents opinion on how income earners and access to healthcare services

Table 4: Low income earners find it difficult to access healthcare services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	550	83.6	83.6	83.6
	Strongly Agree	108	16.4	16.4	100.0
	Total	658	100.0	100.0	

Source: Researcher's Field Survey, 2019

Table 4 shows that 83.5% of the respondents agreed that low income earners find it difficult to access healthcare services and 16.4% of the respondents strongly agreed that low income earners find it difficult to access healthcare services. This clearly shows that all the respondents accepted that low income earners find it difficult to access healthcare services.

Testing of Hypotheses 1

H_{o1}: Unemployment is negatively correlated with access to healthcare services in Rivers State.

The relationship between unemployment and access to healthcare services was investigated using the spearman rho correlation coefficient based on data generated in the unemployment scale and in Healthcare services Scale.

Table 5: Spearman rho correlation analysis of the relationship between Low income and Healthcare Services in Rivers State, Nigeria

			Unemployment	Healthcare Practices
Spearman's rho	Unemployment	Correlation Coefficient	1.000	.-003
		Sig. (2-tailed)	.	.942
		N	658	658
	Healthcare Practices	Correlation Coefficient	-.003	1.000
		Sig. (2-tailed)	.942	.
		N	658	658

Decision: the test shows that the correlation is significant at 0.05 level (2-tailed). This simply means that the hypothesis of relationship between unemployment and healthcare services is statistically significant in this study. It shows that unemployment is negatively correlated with access to healthcare. This means that the more people are unemployed, the less the people have access to healthcare services in Rivers State, Nigeria.

Testing of Hypotheses 2

H_{02}: Low income is negatively correlated with access to healthcare services in Rivers State.

The spearman rho correlation technique was used to test the above hypothesis based on data generated in the low income scale and in Healthcare Services Scale.

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Table 6: Spearman rho correlation analysis of the relationship between Low income and Healthcare Services in Rivers State, Nigeria

			Low income	Healthcare Practices
Spearman's rho	Unemployment	Correlation Coefficient	1.000	.-054
		Sig. (2-tailed)	.	.169
		N	658	658
	Healthcare Practices	Correlation Coefficient	-.054	1.000
		Sig. (2-tailed)	.169	.
		N	658	658

Decision: The test shows that the correlation is not significant at 0.05 (2-tailed). This simply means that the hypothesis of relationship between low income and access to healthcare services is not statistically significant in this study. Also, it shows that low income is negatively correlated with access to healthcare services. This means that the more low income increases, the less people increase their access to healthcare services. In the final analysis, a correlation coefficient of -.054, as seen in the relationship between low income and access to healthcare services, indicate a strong negative linear correlation or relationship.

Conclusion and Recommendations

This study examined the relationship between poverty and access to healthcare practices in Rivers State, Nigeria. Results of the study show that the people are largely poor; are unemployed, have menial jobs, and earn low income. As a result, most of the people find it difficult to access orthodox healthcare services. It is therefore necessary for appropriate remedial responses for tackling poverty and unemployment and their concomitant outcomes to be made a priority or undertaken by the governments at all levels and other development partners. It is ironical that Rivers State houses abundant deposits of crude oil which is the base of the country's treasury and yet majority of its people are swimming in poverty and lack.

In line with the study's findings, three strategic options are considered as remedies to stem the tide of poverty and ensure maximum access to healthcare services particularly in Rivers State and generally in Nigeria. The first strategic option is poverty alleviation. Poverty alleviation aims at improving the living conditions of the poor, that is, increasing their access to the basic needs of life and enhancing their ability to meet social, political and economic obligations. The poverty level of people of Rivers State is too high, though the state is an oil State. Poverty cannot be completely eradicated in any society, but its rate or magnitude can be drastically reduced or alleviated. In all, poverty alleviation targets in Rivers State should be inclusive and dependent on the needs of the people (people-oriented).

Eminue (2005) has succinctly identified the problems of poverty alleviation programmes to include lack of proper focus; inadequate coordination; political instability; unwieldy and expansive scope; lack of executive capacity; corruption and mismanagement; "top-down" rather than "bottom-up" approach; duplication of implementation agencies; micro-credit problems; absence of cost effectiveness in some poverty alleviation programmes; high administrative cost; inadequate funding; slow economic growth or infrastructural inadequacies and macroeconomics and sectoral problems such as inflation, unemployment, and lack of modern technology among others. Tackling these problems in effective manner will ensure the capability of poverty alleviation programmes to drastically reduce poverty to

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the barest minimum.

Secondly, increased employment opportunities or strategies constitute a sure strategy for combating widespread poverty. One simple truth lies behind different approaches to the explanation of poverty: the poor because they do not have good jobs. As noted by Brinkerhoff and White (1988), the crux of poverty is lack of jobs that provide steady work at a decent wage; a wage that would enable people to support themselves and their families. Poverty reflects glaring defects in the economy because it manifests itself in the forms of mass penury, mass unemployment, poor welfare services and increased dependency among other things. The failure of the Nigerian government to provide adequate employment opportunities for its citizens has continued to promote low human capital development and increased poverty.

Finally, increased industrialization is a sure key to responsive poverty alleviation; In fact, increased unemployment in the Nigerian society can be effectively combated or drastically reduced through increased industrialization. Industries are established to employ people (labour) to manufacture consumable commodities. Employment in industries offers people the opportunity to live above poverty level and improve their living standards generally. Therefore, government and other development partners should make widespread industrialization a priority.

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