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De-constructing inequitable access to health care services in Nigeria

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***Abstract*---**The derogation of erstwhile traditional healthcare services popularized modern healthcare systems which have been adjudged by many Nigerians as profit-making ventures rather than that saving life. Only affluence can afford quality health care in Nigeria. The situation is worst for the majority of women who survive under men. Thus, exploitation and inequitable access to modern health care services stiffened health challenges for many Nigerians especially women. Thus, this study examined ways of deconstructing gender and the capitalist system of health care, a panacea for equitable access to health care services in Nigeria. Weber's social action and rational theory were used for the explanation of variables. Data was generated with the use of questionnaires, case studies, and In-depth and key informant interviews. Data were analyzed using the statistical package for the social sciences. Chi-square and cross-tabulations validated the connectivity between government policies, equitable access to health care services and the health of the masses. The validity and reliability of instruments were ascertained by pilot study (test-retest analysis). Interview and (X^2=16.09; P<0.05) revealed that the irrational and non-affectionate posture of physicians under the modern health care system is more terrifying than sickness and death itself. The modern health care system according to 14.6% of participants is fragmented and inherently is less disorganized

***Keywords*---**Nigeria health care system, capitalist system health care, exploitation, equitable access.

Introduction

According to Kaplan and Porter (2014), the proper goal of any health care delivery system is to improve the value of health services rendered to patients. Thus, the world over, the value of accessing health care delivery services is rated in terms of the cost of procuring health services and final benefits. The socio-economic and political structures in Nigeria place heavy barriers to equitable access to health care services. In Nigeria, the cost of health care is so high that the people prefer to feed themselves with the little money they have rather than seek medication. They manage their health problems as they struggle with their daily needs. The historic access to regulating medicine prices and the perverse practices that evolved in the dispensing and supply of medicine permitted the placement of very high prices for medicines sold by private doctors, clinics, hospitals and vendors. The derogation of the traditional model of health care fueled the inflation of general medical services, this reinforced barriers to wider access to quality health care.

Gradually, while indigenous medicine and its practitioners experienced a decline in patronage because their services were tagged unhygienic and unregulated, patent medicine which gained publicity and acceptance became unaffordable. The epileptic domestication of modern health care services and the derogation of traditional health care regimens and the regulation of what goes on in the health sector by external bodies compounded the health challenges of many Nigerians. The capitalist system of health care which was rationally organized for profiteering further worsened the health routine of Nigerians who prefer to manage their health conditions until the situation degenerates or demobilizes them.

Problem Statement

The derogation of traditional healthcare services popularized modern healthcare systems which have been adjudged by many Nigerians as strategically initiated with the shared purpose of making economic gains as that of saving a life. The introduction of the modern health care system undermined and is diminutive natural methods through which families provided health needs of their members. Only affluence can afford quality health care in Nigeria. Thus, exploitation and inequitable access to modern health care services stiffened the health challenges of many Nigerians. Inequality to access, inappropriate use and allocation of resources for high-cost technology and expertise tell on the functionality of modern health care institutions.

Health care services by the colonialists in Nigeria have not yielded good results. High expenses on health care services render them ineffective. Concerning access, as costs raised for the procurement of healthcare services, the number of people who can afford healthcare services declined. Inequality to access, inappropriate use and allocation of resources for high-cost technology and expertise tell on the functionality of modern health care institutions. These conditions have led to numerous anomalies, diseases and environmental health hazards that are associated with the diminution of the taboos guiding beliefs and practices in Nigeria. According to Millennium Development Goal which advocates rejuvenation of beneficial practices as well as forming collaborative health care systems will

establish one of the positive steps of improving the wellness and peaceful co-existence of the masses

In Nigeria, taking responsibility for the prevention of diseases is considered a secondary issue. Both policymakers and administrators concern themselves with the issue of self-actualization and embezzlement of the fund. This is evidenced in the number of embezzlement of funds that have been earmarked for immunization and sensitization of the public on health issues. Various cases of embezzlement that have been reported over the years are not based on ignorance of the importance of health but greed makes them trivialize the health needs of the people. This interest has led to the subvention of funds allocated to health.

Access to the health care facility by the people is affected by many factors which include environment, finance, lifestyles and life changes. According to Dahlgren (1995) as shown in Fig 1 below, at the centre is the individual, with his or her characteristics such as age, sex, and genetic makeup; these factors are important but cannot be changed. The individual's health is influenced by his or her lifestyle and health behaviour. However, individual lifestyles are influenced by social norms and community networks. These, in turn, are influenced by living and working conditions, education and health care. All these layers of factors are affected by the overall macroeconomic and environmental conditions of society.

Also being gainfully employed and the condition of work also affect access to health care. For instance, some employers offer cheaper health care services by subsidizing health services to their employees. The overall health condition is affected by socioeconomic, cultural and environmental conditions. The socio-economic condition and the prevailing cultural and environmental factors affect health. Therefore, equitable access to health care needs interwoven processes and strategizing to achieve equitable access to health care. While many researchers have examined the modern health care system, few have identified its capitalist tendencies. Thus, this study examined ways of the de-constructing capitalist system of health care, a panacea for equitable access to health care services in Nigeria.

Theoretical Foundation

Structural functionalism and Rational Theory

The study was anchored on Structural Functionalism and Rational Theory. This theory posits that Functionalism entails interaction among various parts within the system. What this means is that social phenomena can be explained in terms of the part they play in the existence and survival of the larger society. Furthermore, there is inter-dependence of various parts within the system. This implies that the function of a part of a system usually affects the system as a whole. There is also the need for the system to maintain equilibrium to survive. This means that the social system tends towards equilibrium. That is, when one variable of the system changes in magnitude or quality, the other variables are subjected to strains and are transformed. As a result, the system changes its pattern of performance and the dysfunctional components are disciplined by a regulatory mechanism and the equilibrium of the system is re-established.

Parsons (1951) popularized the concept of functionalism in sociology. He observed that a social system consists of a plurality of individual actors interacting with each other in a defined and structured manner to meet certain functional prerequisites (Haralambos and Holborn, 1995). Parsons identified adaptation, goal attainment, integration and latency as the four functional prerequisites that are imperative for the survival of any system and the function of any part of the system is its contribution to meeting the functional prerequisite.

Talcott Parson explained the role of structures and their function in the harmonious running of society. He explained how culture and social structure block people from accessing health facilities. This obstruction according to Parson gave rise to rapid disease distribution and a high mortality rate. Following Parson's Analysis, it is obvious that Nigerian policies place economic success at the pinnacle of social desirability. Economic gain rather than the health of the masses is the concern of the government. Health matters are trivialized. Politicizing health policies and appointment of health professionals affect equitable access to health care. Economic gains and advancement of personal profit dominate the interest of those who control the socio-political structures of society. Poverty emanating from the prevailing economic structures subjects the masses to narrow and quack health professionals. The emphasis on attaining equitable health, however, does not match the legitimate available "means" for reaching the desired "goal." This problem is then exacerbated by the socio-structural component, which highlights the structural barriers that limit individuals' access to health facilities. This disjunction between the ideal goals (maintaining health) and the availability of legitimate means to attain such goals (that is, socio-structural limits) puts pressure on the limited modern health facilities. This also is implicated in the frequent patronage enjoyed by traditional health caregivers.

Parson refers to this weakening of cultural means as deviant. The socio-economic and political structures place barriers to equitable health care services. The sole significant question becomes: which of the available health facilities is most efficient in netting the health needs of the people?" There is a need to deconstruct this barrier to enjoy equitable access to health care. Institutionalized health policies and health professional as a result of structural barriers lose their ability to regulate individuals' health

Functionalist theorists emphasize the two concepts of structure and function. Indeed, the model is often called structural functionalism rather than just functionalism. The structures are the various parts of the system. In the case of society, the principal structures usually are considered to be the society's institutions – family, government (executive, legislature and judiciary), health sector, economy, religion and educational system. The analysis focus on the interrelations among these institutions. Each structure and each part within the larger structure are conceived to have a function in assisting society to operate and in preserving its stability.

In the traditional system, patients enjoyed the company and narration of stories from their relatives. In the modern system, the administration of drugs is strictly between the physician and the ailing patient. The strengths that come from

friends and family under the traditional systems of health care are lost to the unfriendly posture that often exists between patients and modern physicians. This has often claimed more lives than the ailment itself. Most patients who did not anticipate spending the number of days they spent in the hospital became abandoned on a hospital bed by relatives as a result of their inability to settle hospital bills. Such patients are made to evacuate from hospital beds to avoid further accumulation of hospital bills. In this instance, we find patients who litter the corridors and the floors at the hospital across all levels awaiting bail from the hospital management as a debtor. Because these patients cannot afford good food, they rely on hospitality from sympathizers to survive while they struggle towards settling their bills. This situation discourages average persons in Nigeria from going to the hospital even when there are systems of illness. Although there is subsidization in the cost of health care by some institutions for their staff especially those under the national health insurance scheme (NHIS). Following emergent health policies by the government, the gap between those who have means of accessing health and those who have not widens. The need to destroy the capitalist orientation of providing health care services becomes imperative which makes this theory appropriate for the study.

Tools and Methods

The study explored descriptively with the adoption of a cross-sectional research design, the ways of the de-constructing capitalist system of health care in Nigeria. The adoption of a cross-sectional research design was based on the fact that information was elicited from sets of respondents who possessed heterogeneous but closely related socio-demographic characteristics at a point in time.

Study Area

The study was conducted among selected communities that make up the 6 Geopolitical zones in Nigeria. The Geopolitical zones include; North Central, North East, North West, South East, South-South and South West. For convenience's sake, the following states from each of the Geo-political zones were co-opted. Kogi from North central, Adamawa from North East, Zamfara from North West, Enugu from South East, Delta from South-South, Oyo from South West. The choice of the study areas is rooted in problematic methods of health care which typified other communal communities in Nigeria. This modern health care is derogated for it has been identified as inefficient and insufficient in catering for the health of the masses. The states are surrounded by thick forests and heavy vegetation. The Geopolitical Zones in Nigeria were created during the regime of President Ibrahim Badamisi Babangida. The Geopolitical zones are currently 6, with each containing a set of people with similar cultures belonging to the same ethnic group. Virtually the people in the regions are predominantly farmers and artisans. They have a forest which is rich with shallow roots and plants that harbour and provide feed for fish as a fishery hub. It is home to industries that manufacture rubber, palm oil and timber. They have forests rich in herbs and are dominated by cosmopolitan health care methods

Study Population

The population of the study included: a) household heads, b) Migrants c) Traditional Medicine Practitioners d) modern health workers and e) government officials and f) Chiefs. The inclusion criteria for participants were predicated on age and voluntarism. Those who are age 40 and above were selected for sampling. This age range is significant enough for an individual to build a home where they are individually charged with certain responsibilities that equipped them with important and relevant information on the diminution of the traditional health care system and the implication of government policies and the activities of modern health care providers.

Sampling Procedure and Sample Size

Multi-stage sampling techniques which utilized both Probability and Non-probability sampling methods were adopted in the sample selection of the communities, hospitals, traditional practitioners and other significant respondents. First stage: stratified sampling technique was utilized for the grouping of the communities. Second stage: Using a simple random sampling method, five clans each were selected from the main communities. The Six Geopolitical zones were chosen as the study location because of the derogation of traditional methods of health care and the predominance of inefficient and insufficient modern healthcare facilities. Random selection was used in co-opting 425 participants that were involved in the study. The Snowball method was used to select traditional medicine practitioners and Chiefs.

Methods of data collection

For quantitative and qualitative methods of data collection, the consents of significant persons were sorted. Other two research assistants who were made to understand the focus of the study were carefully trained in the process of data collection. Semi-structured questionnaires were administered to 425 participants which ran across the 25 sub-communities selected. A total of 25 questionnaires were administered to participants in each community that cut across the six states selected from the Geopolitical zones. The determination of the sample size apportioned to each community was derived by dividing the total number of participants sampled which is 425 by the total number of the state selected which is 6. While traditionalists were snowballed, household heads were randomized. Quantitative data aided a detailed and robust discussion of findings. In-depth and key informant interviews were conducted solely by the researcher. The questionnaire was administered by all the resource persons, that is the researcher and the two other assistants that were recruited.

Method of Data Analysis

The quantitative data were analyzed with the use of Statistical Package for Social Sciences (SPSS) Version 15. Analysis was categorized into three levels. The univariate analysis described vividly the statistical relevance of the frequency distribution of participants according to their socio-demographic characteristics. Bivariate analysis with the use of the chi-square test was adopted to show the

connectivity between modern health care services, exploitation of government policies, inequity in accessing health services under modern plate form of health services, their level of wellness and welfare of the people in Nigeria. The correlation details the relationship that exists between the government, the exploiters and the community. Thematic extractions method was used in the analysis of qualitative data which were transcribed verbatim and related accordingly. Deductive extractions of information group themes from the interviews based on the objectives of the study

Data Presentation and Discussion

This section discussed the findings, while section one detailed the demographic characteristic of the research population, subsequent sections discussed the subject of the problem for this research.

Table 1. Showing Socio-Demographic Characteristics of Respondents

S/N	Variables	Frequency	Percentage (%)
1.	Age		
	40-50	181	42.6
	51-60	123	28.9
	61-70	53	12.5
	71-80	34	10.4
	81- above	24	5.6
2.	Gender		
	Male	215	50.6
	Female	210	49.4
3.	Religion		
	Christianity	258	60.7
	Muslim	62	14.6
	Traditional	76	17.8
	Atheist	-	-
	Others	29	6.9
4.	Education		
	Pri sch	126	29.6
	Secondary Sch	91	21.4
	BSc	104	24.5
	Higher Degrees	92	21.7
	Others	12	2.8
5.	Marital Status		
	Single	131	30.8
	Married	207	48.7
	Divorced	15	3.5
	Separated	26	6.2
	Cohabiting	46	10.8
6.	Occupation		
	Farmer	129	30.4
	Business	77	18.1
	Civil Servant	173	40.7
	Native Doctor	16	3.7

	Others	30	7.1
7	Income Level		
	10-44	68	16
	45-74	154	36.2
	75-104	122	28.7
	105-134	46	10.8
	135-above	35	8.3
	Total	425	100

The age distribution of participants are 42.6% fell between the age of 40 to50, a total of 28.9% were within the age range of 51 to 60, while those who were aged between 61 to 70 were 12.5%, 10.4% participants were 71 to 80 and those who are 81- above were 5.6%. A larger percentage of the participants fell between age 40 and 50 because a larger percentage of the population fall between these ages. Also, those within this age were readily accessible, unlike others who are unreachable due to their engagement in activities that restrict them in an unreachable environment for the researcher. A total of
50.6% of participants were males and 49.4% were females.

A total of 60.7% and 14.6% of the participants are Christians and Muslims respectively. While traditional adherents are 17.8%, no participant was an Atheist. The category of participants who fell under others was 6.9%. A total of 29.2% of participants had Primary school certificates. Secondary School leavers were 21.4%. BSc holders were 24.5%, while higher degree holders are 21.7%, a category which fell under others was 2.8%. Those who were single at the time of the survey were 30.8%. While 48.7%, 3.5% and 6.1% are married, divorced or separated, a total of 10.8% were cohabiting.

Participants who are farmers were 30.4%, 18.1% were business-oriented, 40.7%were civil servants and 3.7 are native healers, the category of participants who signified their occupation as others were 7.1%. Participants whose income falls within #10-44 were 16%, a total of 36.2% earns between # 45-74 naira as income, 28.7% earns #75-104, 10.8% earns #105-134 and 8.3% earns #135-above.

From the demographic characteristics of participants, it was evidenced that a larger percentage of the population are youths. Poor conditions of livelihood and lack of security increased the mortality rate for the aged. Previously majority enjoyed long life because of the enabling environment. The above deduction is further clarified by the level of income received by different individuals whose salaries cannot cover the necessary expenses for their upkeep and those of their dependents. Despite that, a larger percentage signified married, the majority in its actual sense is cohabiting because the necessary social rites which legalise marriage were not performed.

Interview and (X^2=16.09; P<0.05) revealed that the irrational and non-affectionate posture of physicians under the modern health care system is more terrifying than sickness and death itself. The capitalist succeeded in luring the Nigerian government in furthering the enactment of policies that support their capitalist intent. In western countries, the social benefits of health expenditure are well

valued. As the state spends on the maintenance of health, more lives are saved, and their input is made manifest. Nigerians in their naïve state believe that financing the health care system is a secondary venture.

The capitalist healthcare system and its doctrines provided a basis for the subversion of the indigenous healthcare methods. The traditional methods of health care were submerged with the introduction of modern health care services. Since there is a campaign for privatization and opportunities for equal plate form for all players in the Nigerian industry, there is a need to revive and reinvigorate traditional systems of health care. According to responses, a total of 47% of participants who engage in traditional health care provisioning are illiterate. They lack back educational qualifications which can empower them to compete favourably with modern health care practitioners. Therefore there is a need to provide an equal chance for the education of adults who engage in traditional health care provisioning.

Although modern health care delivery offers many benefits and has been useful in the prevention and cure of diverse ailments for the masses, they have their weakness which make health care services unwelcoming to the masses. Government spending on health is essential to boast equitable accessibility and sustainability of health care services. This will help people who would otherwise be without health care due to a lack of adequate cash and awareness. Nigerians prefer to manage their health condition because of the poor awareness of the importance of regular checks up and proper health care routines. Below are the weakness listed by participants.

Table 2. Weaknesses of Modern Health Care System in Nigeria

S.N	Responses	Frequencies	Percentage (%)
1	Disorganization and fragmented services	35	8.3
2	Discrimination in health care	34	8
3	The migratory problem of professionals	58	13.6
4	Low morale among health workers	53	12.5
5	Poor regulation of prices	54	12.7
6	Poor infrastructure	57	13.6
7	Exploitation	60	14.12
8	Poor remuneration	17	3.88
9	Politics	27	6.3
10	Corruption	30	7
	Total	425	100

The modern health care system according to (8.3%) of respondents is fragmented and one of the inherent problems of fragmentation is disorganization. This fragmentation gave birth to disorganization in a rendition of health care services. Numerous independent units are involved in treating a patient's conditions. It is evidenced that across different regime, administrators politicizes the domiciliation of health care delivery infrastructures. The indigenous health care services are community-based. The indigenous method of health care hardly gave little chance for the fragmentation of health care services. This is because different

practitioners who offer diverse services are found within the same locality (community). Significantly, as a traditional practitioners, they are skilled in many areas of health care services. For example, a bone setter is equally skilled in divination-diagnosis; s/he handles psychiatric problems, treats infertility, attendant to expectant mothers and hernia problems.

One other weakness of the modern health care system according to (15%) of participants is that it is discriminatory. The capitalist system of health care which is largely built on profiteering favoured the wealthy. This is exemplified by hospitalizing the rich in an intensive care unit while the poor patient who needs intensive care is left in the general wards. Some of them who need intensive care but are denied are left to suffer and in most cases, they die. Lack of adequate attention and care which the poor need while they are in critical conditions accounts for many deaths. In most cases, patients who cannot afford hospital bills are ejected from the hospital beds. They are detained and are left to survive on charity while in detention. They are detained to sleep in the corridors of the hospitals until their bills are settled. The situation is worst for patients who cannot afford the initial deposit before the commencement of treatment. Equity in the utilization of health services is hampered by the high cost. Equity of access to health care depends on who has access to socio-economic and political power. Another problem of the modern health care system is informal payments. Efficiency is influenced largely by the extent of pooling and the methods of payment. Depending on the extent of decentralization and fragmentation in the system, payment modalities and associated decisions affect different units in the hospital

Although most health care costs are fixed, a total of (12.7%) of participants advanced that poor regulation of prices is prominent in modern healthcare services. The lack of standardization stems from the artisanal nature of medical care in Nigeria. Across the different levels of health care systems, the same drugs and ailments go for different billings or prices. Also, the cost of health care services depends on the expertise of the medical personnel. It is widely believed that physicians whose health services are effective have higher patronage. The high patronage influences their charges in the provision of health care. The capitalist orientation of health care determines how and when patients are admitted to the hospital and how and the condition under which they are discharged. Too often, high cost and the rational procedures associated with different departments in hospitals and clinics are the basic reason for compounded health problems which patients nurse until they degenerate into a critical stage that their illness becomes a tedious task to handle by modern health care delivery

The modern health care delivery system typified the exploitation of patients by a physician. The use of shared staff, space and equipment influenced the high cost of health care. This corresponds to the findings of Kaplan and Porter (2014). According to (18.1%) of participants; the sick became the object of exploitation in the course of seeking wellness under modern health care services. This is exemplified by health officials who exploit patients as they dispense personal drugs to helpless patients at a higher rate than the normal price. They buy tissue paper and Dettol before they are attended to. In most cases, the drugs of a patient

are used to treat another patient. With permission, while sometimes without permission. Also, respondents revealed that poor remuneration makes the modern health care system problematic. The defenceless patients are exposed to obeying modern ideologies and interests of imperialist masters. Respondents are of the view that the imperialist initiatives are more concerned with exploiting the people than that improving their welfare. According to Porter (2015), health care provisions are to be made a not-for-profit and publically traded health care system for the common man to afford health care services. According to (6.3%) of respondents, the modern health system is highly politicized. To establish health facilities, politics is involved. Also, the appointment of health professionals and administrators according to 8% of respondents is highly politicized. The problem according to (7%) of respondents is compounded by corruption. To import drugs or set up health infrastructure, Nigerians want kickbacks before granting permission for the importation of drugs or erection of health structures. This affects the prices of drugs and the availability of health structures/drugs.

The commitment to health is not human-oriented per se, but profit-oriented. The complex system and the high charges reflect the exploitation of patients. Hospitals' overhead cost is expensive; this is displayed by the hospital rules which demand initial deposits before the commencement of treatment. This has caused the death of 20% of patients who should have survived their illness if treatment had commenced immediately. The imperialist's exploitative motives led to the formulation of rational rules which distance the hospital and its staff from their relationship. Practitioners became irrational to relations and are made to display unaffectionate behaviours. The professional ethics and the rational norms override the affectionate nature of indigenous people and the life of their relations with those who have now become their patients. Respondents appealed to the need to strengthen the health care financing, reconfigure the continuum of care, improve the quality of health services, link with the community, and advance public health than profit-making. The impersonal rational method has been adopted and adhered to rigidly in Nigerians because many have abused the opportunity.

Lack of infrastructure according to (13.4%) of respondents is one of the weaknesses of the modern health care system. According to (78.9%) of respondents, there is insufficient infrastructure and Nigerians lack a maintenance culture. The decay and the dilapidated infrastructures add to the challenges of meeting the health needs of Nigerians. This problem arises from the low value attached to health in Nigeria. Also, poor maintenance culture further complicates the efficiency of available infrastructure. This problem applies to the mother country where these care systems originated from. Health professionals need functional equipment and a conducive environment to provide good quality health care. Health professionals and managers need adequate tools to deliver appropriate services. This implies that the need for replacement of obsolete facilities and equipment, new training programmes, and clear standard-setting with access to monitoring and feedback and the wherewithal to take steps to enhance performance is paramount. These needs are of course linked with the efforts to improve the quality continuum of care.

According to (12.5%) of participants, the challenges inherent in the modern health care system in Nigeria induce low morale for health workers. Poor remuneration and dilapidated equipment psychologically demoralize health personnel. Loss of motivation and satisfaction for health practitioners affects the care services given to patients. This problem influences every activity that goes on in the life of a practitioner and the institution under which they have been engaged.

One of the greatest weaknesses of modern health care in Nigeria is the migration of health personnel. Because the economy is not prepared to leave up to standards like what is obtainable in foreign countries, health personnel after long periods of study prefer to travel abroad where their services will be appreciated and well-compensated. According to (13.6%), of participants, there is high migration of health professionals. The drudgery and dissatisfaction that emerge out of the poor infrastructure, poor appreciation and poor remunerations account for the migration of skilled personnel to where they can get a good offer for the services they render. Hospitals are undermined and are diminutive to natural methods through which families provided health needs of their members. The devaluation in the meaning and efficacy of family means of maintaining health led to the worst condition of health in the community.

The introduction of health care technology and services from a developed country to Nigeria has shown less satisfactory results. Canadian Institute for advanced research (CIAR) believed that individual determinants of health do not act in isolation. Adoption and rejuvenation of beneficial beliefs and practices which are reflected in lifestyles, social and physical environments will lead to more advancement in peace and wellness than that spending a huge amount on a sophisticated health care delivery system.

To De-construct the capitalist system of health care for equitable access to health, the following should be considered for implementation:

a. The socio-economic structures should prioritize health. By so doing, politics in the allocation and appointment of health professionals and health structures should be downplayed.
b. Embark on research to find ways of restructuring health care services and improving the level of awareness on the importance of maintaining good health regularly. The outcome of the research should intimate policymakers on how to deregulate the capitalist ideas of health care provisioning in Nigeria at large.
c. Decentralization of management, liberalization of both traditional and modern health care systems and subsidization of reimbursement in payment mechanisms should be pursued as the key strategies in delivering better health care and good performance of modern health care delivery system for the good of the public.
d. The government should devise cost-cutting steps that can reduce health care costs which are capable of discouraging the common man from accessing modern health care.
e. Major players in health care delivery organizations should devise cost-effective methods of treating patients at the barest cost to enhance equitable access to health care.

f. Build collaboration and alliances that can foster health care structures. These alliances and collaborative gestures should be advanced within and across the border.
g. The entrenchment of traditional aspects of health care service into the modern healthcare system.
h. Make health care provisioning a nonprofit organization.
i. Policy formulation should be locally determined and they should be made to reflect the people's desire and choice of health care that is conducive and accessible in terms of cost and proximity.
j. Encourage tax support health care system
k. Restoration of indigenous working systems of beliefs is paramount to livelihoods-wellness.

Observed Perspectives

The capitalist system of health care which offers comprehensive health care services, they are found to have the following weakness in its healthcare delivery services; disorganization and fragmented services, discrimination in health care, the migratory plague of professionals, low morale among health worker, poor regulation of prices, poor infrastructure, exploitation and politics

The traditional health care services though have some weaknesses were more accessible and practicable to preliterate people than the modern health services. To seek health one must book an appointment with a physician. The sick must take bed rest according to Parson. But in the traditional health care system, patients embark on preventive care at will when they feel symptoms of the ailment. They also take limited bed rest, unlike modern care where patients are bedridden to obtain effective treatment.

Some of the ways forward are listed as building collaborative alliances that can foster health care structures. These alliances and collaborative gestures should be advanced within and across the border.

- Privatizing and granting free access to the healthcare system will cut down the cost of health care and it will enhance service delivery in health care services by practitioners.
- The entrenchment of traditional aspects of health care service into the modern healthcare system.
- Make health care provisioning a nonprofit organization.
- Policy formulation should be locally determined and they should be made to reflect the people's desire and choice of health care that is conducive and accessible in terms of cost and proximity.
- It is imperative to train Nigerian consultants and improves their condition of service.
- Build on transitional leadership roles that encourage the mentoring that can lead to advancement in health care practices.

Conclusion and Recommendations

Although exponents of the modern health care delivery system faulted traditional health care from the start due to dosage and efficacy, high cost, non-amortized health expenses and the bureaucratic bottlenecks make modern health care less attractive to many. Over 80% of the African population patronizes traditional medicine. The de-constructing capitalist system of health care system becomes imperative in the present time due to numerous health problems which people manage as a result of the high cost of health care among other factors militating against access to modern health care services.

The modern health care delivery system is a capitalist venture which is more interested in profit maximization rather than that saving life. The derogation of the traditional method of health care was strategies to de-popularize it thus creating a large market for the modern health care system. There is a need to make the health care system a salvaging venture for the common man rather than a profiteering venture. Health policies should be domesticated and the people involved should be consulted before policies are formulated.

Respondents advanced the need of improving hospital performance and restructure of health care delivery system. Also strengthening the interface between primary care and secondary and tertiary care was strongly advised and lastly strengthening and modernization of primary health care centres is necessary. Health care in Nigeria should imbibe these four strategies of improving health care to de-capitalize the present structures that discourage or rather frustrate people's efforts of seeking health care services.

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