SOCIAL CLASS AND PREFERENTIAL HEALTHCARE DELIVERY: A STUDY OF HEALTHCARE FACILITIES IN DELTA STATE

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Abstract
This study examined the impact of social class on preferential healthcare delivery in healthcare facilities in Delta State, Nigeria. The study was geographically delimited to Delta State. Two research objectives were established from which two hypotheses were developed. The study was anchored on Max Weber's theory of social stratification. The study is descriptive and a cross-sectional research design was adopted for the study. The structured questionnaire was the main instrument of data collection. The study's population comprised all the people living in Delta State, Nigeria. In line with this, a sample of four hundred (400) respondents was drawn for the study, using the cluster random sampling technique. Then, data were collected from the respondents using 400 copies of questionnaire. The data collected were analyzed with Pearson product moment correlation statistical tool. The analysis revealed that; financial capacity has a significant impact on access to health facilities and the preferential treatment given to patients by healthcare practitioners in healthcare facilities in Delta State. Also, political influence has a significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State. Based on the findings, it was recommended that government should implement a more progressive healthcare financing system that reduces the financial burden on individuals from lower social classes. This could include subsidizing healthcare costs for those with lower incomes or expanding the coverage of social health insurance schemes and there should be a conscious training and sensitization for healthcare professionals, among others.

Keywords: Social Class, Preferential Treatment, Healthcare Delivery, Healthcare Facilities, Financial Capacity and Political Influence

Introduction

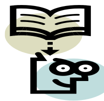
Globally, there exists discriminatory practice in healthcare delivery which stems out of the socio-economic inequalities between individuals across different spheres of endeavor. These discriminatory practices are often found across both the public and private health sectors. It must be stated, however, that discriminatory treatments in the health sector is largely minimal in the more developed countries and prevalent in the less developed countries, like Nigeria (Ogunniyi, Adepoju & Olapade-Ogunwole, 2011). Empirical inquiries from Sub-Saharan African (SSA) countries have unveiled that access to key health services and health outcomes are unevenly distributed across different social groups of the population and that individuals from socioeconomically disadvantaged backgrounds have higher morbidity and mortality rates

and a lower coverage of health services than those from wealthier backgrounds (Ajibola et al., 2018; Akpomuvie, 2007). Socio-economic deprivation and access to healthcare delivery services pose a great challenge to the wellbeing of many in the African continent. This becomes more concerning when considered against the fact that health has a strong influence on people's happiness, earning capacity and productivity; it affects educational performance, determines employment prospects and is fundamental to people's ability to enjoy and appreciate all other aspects of life.

According to Akhtar (1991), staying healthy is an important part of everyone's life, since good health determines how productive a person can be and how much they can participate in daily activities. People with good health are free from disease, and their bodies function efficiently. However, people need guidance on how to stay healthy. Medical professionals provide healthcare delivery, while Scientists conduct research and develop guidelines to help people manage their health. A healthcare delivery system is an provides resources and treatments that help people when they are sick or injured, and helps them stay healthy through preventive care. A healthcare delivery system includes all the institutions, organizations, people and resources that help a particular group of people stay healthy. Despite the prevailing recession, Nigeria is still regarded as Africa's largest economy and one of the fastest-growing in the world. Yet, more than half of the Nigerian population still grapples with extreme poverty, while a small group of elites enjoys ever-growing wealth (Akpomuvie, 2008; Anyanwu, 1997). Although, the gap between the rich and the poor may be a worldwide problem, in Nigeria the scale of inequality is extreme. In one day, the richest Nigerian man (Aliko Dangote) can earn from his wealth 8,000 times more than what the poorest 10% of Nigerians spend on average in one year for their basic consumption.

The Gender in Nigeria Report categorises Nigeria among the 30 most unequal countries in the world. According to World Bank data, in 2009 the poorest half of the population held only 22% of national income. Income inequality, as measured by the Gini Index, increased during the 2000s from 40% in 2003 to 43% in 2009 and has widened even further in the 2020s. The paradox of growth in Nigeria is that as the country gets richer, only a few benefit, and the majority continues to suffer from poverty and deprivation. The disparity is such that the amount of money that the richest Nigerian man can earn annually from his wealth is sufficient to lift 2 million people out of poverty for one year. Just over 15 years into its return to democratic rule, Nigeria is in the curious position of having the world's highest-paid lawmakers preside over some of its poorest people. A Nigerian lawmaker receives an annual salary of about $118,000, equivalent to N37m – and 63 times the country's GDP per capita as at 2013. At the same time, phenomena of economic and social distress such as homelessness in urban slums, high graduate unemployment, malnutrition, maternal mortality and international migration continue to grow.

Due to the fact that economic growth has been creating few opportunities for young people, there have been associated increasing levels of violent crime, as well as religious, inter-ethnic and communal clashes. Poverty and inequality in Nigeria are not due to lack of resources, but to the ill-use and allocation of such resources. Continued widespread corruption and the emergence of the political elite out of touch with the daily struggles of the average Nigerian have conspired to ensure the cost of governance remains astronomical. The cost of governance in Nigeria is without doubt too high; actually it is outrageous, as a consequence, very limited resources are left to provide basic essential services for the wider, growing Nigerian population. An additional problem is weak policy implementation. In fact, over the years a number of policies and programmes have been designed with the purpose of alleviating poverty and



inequality, such as: Rural Basin Development Authority (RBDA), Directorate of Food, Roads and Rural Infrastructure (DFRRI), Rural Electrification Scheme (RES), Agricultural Development Programme (ADP), National Directorate of Employment (NDE) and Better Life for Rural Women. Others were the Family Support Programme (FSP), Rural Banking Scheme (RBS), People's Bank, the National Poverty Eradication Programme (NAPEP) and the Agricultural Credit Guarantee Scheme (ACGS). However, in the majority of cases, these policies and programmes have not been implemented effectively to result in meaningful impact on poverty (Quartz Africa, 2018). There is an urgent need to critically examine the culture of governance and transform the policies and norms that concentrate extreme wealth, privileges and very high incomes in a small percentage of the population at the top, to forestall the self-perpetuating cycle of inequality that subjugates many Nigerians.
Sadly, the challenge of income inequality, as discussed above, creates discriminatory healthcare delivery based on the socio-economic inequalities in the society. This phenomenon is largely domiciled in the Nigerian society. Healthcare was ideally organized to be efficiently delivered at all levels - including in public and healthcare facilities - levels by the Nigerian Government for all individuals in the country. In regards to antinatal care, expectant and nursing mothers usually receive health education and care at private health centres and clinics. In many cases, many child deliveries take place in both public and private clinics, maternity and health centres (Tulchinsky & Varavikova, 2009; Rakich, Longest and Darr, 2018). In spite of the attempt by government to facilitate reformation in the health sector and enhance the health status of her citizens, empirical evidence in Nigeria has revealed that inequalities in healthcare have increased across States; including Delta State (Eke, 2019). Currently, a large proportion of Nigerians encounter barriers to accessing healthcare services in Nigeria, especially in the private sector.

National Population Commission in 2019 reported that over 55% of Nigerians had some financial barriers to accessing health care and over 30% had a physical barrier. In some studies that have been conducted to understand factors driving the differential treatment of patients in regards to inequalities, poverty or financial deficiency has been identified as a major source (Tulchinsky & Varavikova, 2009; Rakich, Longest & Darr, 2018). In Delta State, however, evidence is sparse on the impact of inequalities in access to healthcare by individuals and health outcomes or the treatments that patients receive overtime. In Nigeria generally, the importance of social class to the way that individuals are treated cannot be overstated. The situation of the country creates a huge gap between the rich and the poor, such that the members of the society are able to identify those who are rich and poor and treat them as such. Usually, the rich are respected and treated with honour in all areas of endeavour in the Nigerian society. The reason for which the rich, powerful and high social status individuals are treated respectfully and favourably is because people expect them to return the favour financially or otherwise. In other words, the wealthy are treated favourably because they are in a position to give people financial rewards and social incentives. On the other hand, the poor are treated less favourably in the Nigerian society because people feel that they have very little or nothing to offer, hence they are discriminated against (Adepoju & Olapade-Ogunwole, 2011; Ogbeide & Agu, 2015).

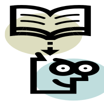
The preferential treatment of individuals based on their social class in Nigeria, permeates all sectors of the economy. This is because money is the major language that many Nigerians understand. In the Educational sector, the rich and their associates are often given preferential treatments; in the legal sector, the rich also gets preferential treatments; even in the religious sector, the rich are highly respected. Although, healthcare is a right of every Nigerian and equal access to healthcare is the propagated belief or ideology in the Nigerian society, the existing

inequalities outside the health sector has infiltrated the fabrics of the healthcare delivery systems in Nigeria. Sometimes, there is the challenge of inaccessibility of healthcare services with hospitals not adequately located in some regions in the country, shortage of healthcare practitioners, lack of fundamental healthcare facilities and equipments, etc. These situations create loopholes in healthcare delivery, which culminate in the difficulties encountered by the economically disadvantaged in the society. Available evidence indicates wide variations in access of the healthcare services by education and household economic resources (Babalola & Fatusi, 2009). Among other factors, unequal opportunities in access to healthcare services and socioeconomic differences continue to remain significant barriers to individuals using health care services in various subgroups in Nigeria (Akpomuvie, 2010; Ikenyei 2017; Ikenyei & Akpotor 2020). In this context, a research on social class and healthcare delivery is necessary in order to understand and monitor socioeconomic inequalities and preferential treatments in various aspects of health in Nigeria. It is against this background that this study was organised.

Statement of the Problem

Contemporarily, the impact of social class on the perception and treatment of individuals in the Nigerian society has become unequivocally lucid. Members of the Nigerian society, no doubt, belong to different social classes, which affects how they view and relate to one another. Generally, there is a distinction between the rich and the poor, the powerful and non-power, and the popular and unknown. These distinctions are not inconsequential in the society, but are significant in determining the treatment people receive from others. More often than not, the rich/powerful/popular in Nigeria are treated with more respect, leniency and courtesy than the poor, un-influential and unpopular. The treatment in question is not just a matter of casual behaviours or actions perpetrated by individuals regularly or occasionally, but also borders on how agencies, organisations and institutions treat individuals based on their social class. Discrepancies or irregularities in the treatment of individuals based on their social class have already been recorded and/or are predominant in the criminal justice system, education sector, employment arrangements, and banking sector (particularly in loan approval), among others (Akpomuvie, 2010; Eke, 2019). Based on the conflict framework of societal organisation, those who have huge finance, education, political influence, and high social status control the society and set up or influence institutions and agencies to work in their favour, sometimes at the detriment of those who do not have. This is why in Delta State, the people with huge finance, education, political influence, and high social status are better treated in society.

Also, people with high social status and wealth have been discovered to gave a high likelihood of visiting orthodox healthcare centres like teaching hospitals. The visitation of such centres is not impulsive but based on certain features of orthodox healthcare centres and what it symbolizes for those visiting (Akiroso, 2007). There is the factor of the quality of services (especially standard equipment) and the organisation of activities in the orthodox health centres. Furthermore, factors like high education, wealth, high power influence, high social status/class, pride and superiority complex also contribute to the preference of orthodox health centres in Delta State. The preferred healthcare facilities for the rich and powerful have often been private hospitals and the poor often opt for public hospitals. However, there is a dearth of research in Delta State about the impact of social class on how individuals or patients are treated in hospitals across the State. This implies that the impact of social class on the treatment of patients in healthcare facilities across Delta State has not been comprehensively investigated. This constitutes the lacuna that this study aims to bridge. It must be stated that such treatments have far reaching consequences on patients within the given context. This is because patients that are treated unfavourably based on their disadvantaged position in the society will suffer



immense negative consequences mentally and physically, and will develop a negative review and perception of the health sector in the State. This is why this study specifically aimed to assess the impact of financial capacity on access to healthcare facilities in Delta State and investigate the effect of political influence on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State.

Research Hypotheses

The following hypotheses were tested in the study:

Ho1: Financial capacity has no significant impact on access to preferential treatment of healthcare practitioners in healthcare facilities in Delta State.

Ho2: Political influence has no significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State.

Review of Relevant Literature

Healthcare Delivery System in Nigeria

Nigeria operates a pluralistic health care delivery system (orthodox and traditional health care delivery systems). Orthodox health care is a Western type of scientific medicine which is made up of hospitals, clinics and primary health centres and it is provided by private and public sectors (Eke, 2019). The traditional healthcare is non-scientific health care that involves use of herbal materials or plant materials as active ingredients to cure ailment. However, the provision of health care in the country remains the functions of the three tiers of government: the federal, state, and local government. The primary health care system is managed by the 25 local government areas (LGAs), with support from the state ministry of health as well as private medical practitioners. The secondary health care system is managed by the ministry of health at the state level (Akpomuvie, 2010; Ikenyei & Lawal 2019; Ikenyei2022). The tertiary primary health care is provided by teaching hospitals and specialist hospitals. The secondary and tertiary levels, also work with voluntary and nongovernmental organizations, as well as private practitioners (Eke, 2019). There are five levels of healthcare system in Nigeria. These are:

- Primary healthcare
- Secondary healthcare
- Tertiary healthcare
- Specialised health care
- Quantinary health care

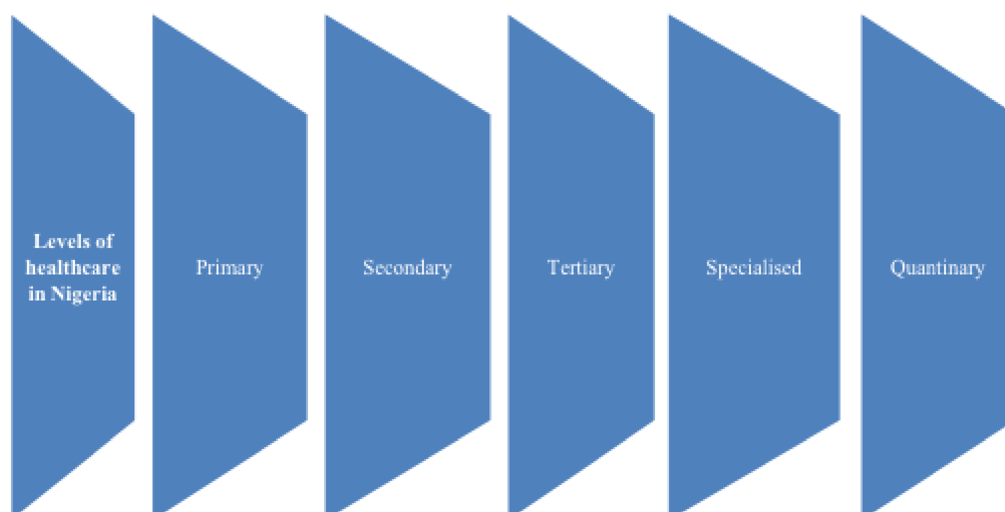


Figure 3: Levels of Healthcare Delivery in Nigeria

Source: Fieldwork, 2023.

The challenge that exists today in Nigeria is to reach the whole population with adequate health care services and to ensure their utilisation (Eke, 2019). The "large government hospitals" which were chosen hitherto for the delivery of health services have failed in the sense that they serve only a small part of the population (Ikenyei 2020 &Ikenyei 2017). Therefore, it has been aptly said that large hospitals are more ivory towers of diseases than centers for the delivery of comprehensive health care services. Raising cost in maintenance of these large hospitals and their failure to meet the total needs of the Nigerian people have led many to seek 'alternative' models of health care delivery with a view to provide health care services that are reasonably inexpensive, and have the basic essentials required by both urban and rural population (Ikenyei 2017). According to Eke (2019), the characteristics of Delta States' health care delivery system is that it is:

a. Predominantly, urban-oriented
b. Mostly curative in nature. Although, health services should cover the full range of preventive, curative and rehabilitative services.
c. Accessible mainly to a small part of the population.

Financial capacity and Access to Healthcare

In a State like Delta and a country like Nigeria where healthcare is not free but usually paid for by citizens, money is therefore the fundamental requirement to access healthcare services. This is why there is a correlation between being financially buoyant and access to healthcare. While government made provisions for access to healthcare constitutionally, in practical, this has not manifested and has resulted in challenges for individuals to gain equitable access to healthcare. Sound health is a fundamental requirement for living a socially and economically productive life. Poor health inflicts great hardships on households, including debilitation, substantial monetary expenditures, loss of labour and sometimes death. The health status of adults affects their ability to work, and thus underpins the welfare of the household, including the children's development (Asenso-Okyere et al., 2011; Ikenyei & Amaechi 2020). However, the health status of individuals cannot be enhanced without access to healthcare. Treatable conditions often go untreated because of lack of access to healthcare. Development in all its forms is only possible when there is access to healthcare service and in turn its effective utilization by individuals. Access to healthcare services is a multidimensional process involving the quality of care, geographical accessibility, availability of the right type of care for those in need, financial accessibility, and acceptability of service (Akpomuvie, 2010; Ikenyei &Efebe2020). The utilization of healthcare services is related to the availability, quality and cost of services, as well as social-economic structure, and personal characteristics of the users (Mbanasor et al., 2013; Ikenyei 2017).

In developing countries, the under-utilization of the health services in public sector has been a universal phenomenon. The state of the Nigerian health system is dysfunctional and grossly under-funded with a per capita expenditure of US$ 9.44 (World Bank, 2020). As a result, Nigeria still has one of the worst health indices in the world and sadly accounts for 10 percent of the world's maternal deaths. The National health management information system is weak, without an integrated system for disease surveillance, prevention and management. Research also indicates that there are high rates of absenteeism (about 40%) among medical doctors, especially in rural areas (Hamid et al., 2005; Ikenyei 2023). It must be stated that the inequalities in access to health facilities are the challenges of rural populace. According to the Federal Ministry of Health (2008), the total shares of public ownership in 2004 on health

facilities were 14,607 while the private sector accounted for 9,029 in Nigeria. Consequently, various Nigerian governments have made numerous great efforts toward the provision of healthcare facilities to its populace. Notable among these efforts were the expansion of medical education, improvement of public health care systems, provision of primary health care (PHC) in many rural areas.

However, overt attention has not been paid to equity in the planning and distribution of health care facilities over the years in the country. Public and private healthcare facilities are sparsely provided in many rural areas within the country. Such regions with difficult terrain and physical environment are often neglected (Onokerhoraye, 2019). This makes the distance between the rural dwellers and the healthcare center far apart, given the transportation problems experienced in these areas, and its attendant cost. Many rural areas do not have clinics; the sick must be carried on the backs of young men or on bicycles to the nearest clinic. Moreover, clinics in rural areas often lack adequate equipment or trained health personnel, and require payment before providing services. In the absence of health insurance, poor people are often unable to afford healthcare of any kind. Healthcare access and utilization are of major interest to development, because they are vital elements of wellbeing and components of human capital (Brown & Ogbonna, 2018). In rural areas, where physical jobs tend to be more abundant, healthcare access and utilization stand to be more important than education in determining labour productivity. Furthermore, every individual sees good health as a need; this makes healthcare utilization an economic good. Good health is a need for all and the choice of a particular healthcare system respond to the laws of demand and supply, the demand for health care is a derived demand. Health care is not demanded for itself but for the advantages that can be derived from being healthy (Jehoel-Gijsbers & Vrooman, 2007).

Many low-income countries, Nigeria inclusive, have not been able to meet the basic healthcare needs of their people, especially those in the rural areas. In Nigeria, there has been a growing recognition of the challenge of rural people's health issues and the need for it to be addressed (Okoli, 2020). There is a huge shortage of qualified practitioners in the rural areas. Accessing health care in rural areas is confounded by problems such as insufficient health infrastructure, the presence of chronic diseases and disabilities, socioeconomic and physical barriers (Ricketts, 2019). Poverty and access to healthcare services are major development problems in Africa particularly in Nigeria. Health is central to community well-being as well as to personal welfare.

Political Influence and the Behaviour of Healthcare Practitioners

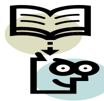
In Delta State and Nigeria in general, political influence is tantamount to financial capacity. This is because of the huge amount of money at the disposal of politicians across the country. This creates an avenue for politicians to gain access to many services and afford a wide variety of things. Apart from the financial benefits associated with politics, there are also the issues of prestige and popularity that comes with it (Kennedy, 2019; Ikenyei and Nwankwo 2018). These factors provide an advantage to the politically influential individuals in access to job opportunities, educational openings, allocation of resources and healthcare. Generally, those that are politically influential can access healthcare facilities in Delta State and other States in Nigeria. Since the cost of getting treatment from healthcare facilities is more expensive than public hospitals, the politicians find it easier to access hospital facilities than those who are poor. Similarly, there are also situations in which even if both those with political influence and those without political influence access similar political facilities, the politically influential are able to get the top quality facilities.

Apart from the quality of facilities, it is also glaring that people with political influence are more likely to be treated favourably than those without. In hospitals, people with political influence are often treated with respect and attended to swiftly due their position in the society. In every society, there are individuals with very high social status and enjoy a high level of respect from society. Social status refers to the honor or prestige attached to one's position in society. It may also refer to a rank or position that one holds in a group, such as son or daughter, playmate, pupil, etc. One's social status is determined in different ways. One can earn his or her social status by his or her own achievements; this is known as achieved status. Alternatively, one can inherit his or her position on the social hierarchy; this is known as ascribed status. An ascribed status can also be defined as one that is fixed for an individual at birth, like sex, race, and socioeconomic background. Social status is most often understood as a melding of the two types of status, with ascribed status influencing achieved status. For example, a baby born into a high-income household has his family's high socioeconomic status as an achieved status and is more likely to be exposed to resources like a familial emphasis on education that will make it more likely for him or her to get into an elite university. Admission, therefore, is an achieved status that was heavily influenced by resources made available by the person's ascribed status (Lucas & Gilles, 2014; Frenk, 2010).

It is the relative rank that an individual holds, with attendant rights, duties, and lifestyle, in a social hierarchy based upon honour or prestige. Status may be ascribed, that is, assigned to individuals at birth without reference to any innate abilities, or achieved, requiring special qualities and gained through competition and individual effort. Ascribed status is typically based on sex, age, race, family relationships, or birth, while achieved status may be based on education, occupation, marital status, accomplishments, or other factors. The word status implies social stratification on a vertical scale. People may be said to occupy high positions when they are able to control, by order or by influence, other people's conduct; when they derive prestige from holding important offices; or when their conduct is esteemed by others. Relative status is a major factor in determining the way people behave toward each other. Having high social status can impact how an individual is treated in healthcare facilities due to the fact that people with high social standing are usually treated more favourably in the society. The treatment of the hospital officials towards men of high standing in the society is usually based on respect and regards.

Theoretical Framework: Max Weber's Theory of Social Stratification

Max Weber (1864 - 1920) developed this theory in his posthumous essay, *Wirtschaft und Gesellschaft* (Class, Status and Party). The theory presents a three-component framework of stratification. In his analysis of stratification system Weber adopted Marxian analysis. But he modified and elaborated it. Like Marx, Weber sees class in economic terms. He argues that class develops in market economies in which individual compete for economic gain. He defines class as a "group of individuals who share a similar position in market economy and by virtue of that fact receives similar economic rewards". Thus, in Weber's terminology, a person's "class situation" is his "market situation". Those who share a similar class situation also share similar life chances and get equal treatment from the public. Weber argues that the major class division is between those who own the forces of production and those who do not. Thus, those who have substantial property holdings will receive the highest economic rewards and enjoy superior life chances. According to Weber class divisions originates not only from control or lack of control of means of production, but also from economic differences which have nothing directly to do with property. Such resources include skill and credentials or qualifications which affect the types of jobs people are able to get. Weber believed that an individual's "market- positions" strongly influences his or her overall preferences, treatment and life



chances. Weber argued that there are four major classes in the modern capitalist society. They are upper class, white-collar workers, petty-bourgeoisie and manual working class.

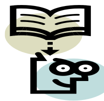
According to Weber class forms one possible basis for group formation, collective action and the acquisition of political power. Weber argued that there are other bases for these activities. A particular group forms because their members share a similar status situation. Class refers to unequal distribution of economic rewards stats refers to the unequal distributions of social honour. A status groups is made up of individuals who are awarded a similar amount of social honour and therefore share the same status situation. They share a similar life style, identity with and feel they belong to their status group and often place restrictions on the ways in which outsiders may interacts with them. Weber's observation on status groups are important since they suggest that in certain situations status rather than class provides the basis for the formation of social groups whose members perceive common interests and a group identity. This shared status also affects the way people treat them. For Weber, therefore, wealth, political influence and status affect the lifestyle of individuals and the treatment that they get from others. The allocation of social status through relationship to the means of production and the consequences of their activities creates socio-economic inequalities that affect how individuals are treated in the society. Although, the elite who occupy the upper echelons are favourably treated in the society, those who find themselves at the lower echelons of the society suffer immensely from this arrangement and are treated highly unfavourably. The preferential treatment of patients during healthcare delivery across private hospitals in Delta State is therefore a product of the overarching class structure and inequalities created by the ruling class in the society. In line with this, the poor find it more difficult to access or enjoy healthcare delivery compared to the rich. This study was anchored on this theory because it comprehensively covers the variables of interest to the research. The theory clearly explains the key elements of stratification and elucidates how class, wealth, status, and politics affect people's life choices/preferences and how they are perceived and treated by others in society. Based on this theory, it becomes obvious that the rich and the poor are treated differently in health facilities across Delta State.

Methodology

This study adopted the cross-sectional research design. The population of the study comprises all the inhabitants of Delta State. The 2022 projected population of Delta State, according to the National Population Commission, is 5,636,145 (NPC, 2020). This study used the random cluster sampling technique. The sampling technique was applied through a multi-stage procedure. First, Delta State was divided according to her three senatorial zones (Delta North, Delta Central and Delta South). From the three senatorial districts, the researcher randomly selected two Local Government Areas each. This made it Six Local Government Areas. They were Ethiope East and Ughelli North L.G.As (Delta Central), Oshimili South and Ukwuani L.G.As (Delta North), and Isoko North and Warri South (Delta South). The reason for utilising this sampling technique was to ensure that the sample is representative of the various Senatorial Districts in the State. Lastly, in each of the Local Government Area, 2 communities were randomly selected. The selection process is shown in **Table 3.1.**

Table 3.1: Sample Selection

S/N	Senatorial Districts	L.G.A	Communities	Sample Size
		Ethiope	Sapele	34
		West	Oghara	33
1	Delta Central	Udu	Otor-Udu	33



			Ovwian	34
		Oshimili	Asaba	34
		South	Okwe	33
2	Delta North		Obiaruku	33
		Ukwuani	Umutu	33o
		Isoko	Emevor	33
		North	Ozoro	33
3	Delta South	Warri	Edjeba	33
		South	Okere	34
Total		**6 L.G.As**	**12 Communities**	**400**

Author, 2023

The primary instrument of data collection that was adopted for the study is the structured questionnaire. The study adopted the structured questionnaire as the instrument of data collection because of its quantitative nature. The researcher carefully designed a structured questionnaire to collect data from the respondents regarding the subject of the study.The researcher used face and content validity to ensure the validity of the research instrument. In this regard, the Project Supervisor suggested some changes to the instrument, and the changes were well considered and incorporated in the final version of the questionnaire, hence the validity of the instrument. The Pearson product moment correlation statistical tool was used to test the formulated hypotheses.

Results

Hypothesis 1: Financial capacity has no significant impact on access to preferential treatment of healthcare practitioners in healthcare facilities in Delta State

Table 2: Correlation Test for Hypothesis I

		Financial Capacity	Preferential Treatment
Financial Capacity	Pearson Correlation	1	.632**
	Sig. (2-tailed)		.000
	N	392	392
Preferential Treatment	Pearson Correlation	.632**	1
	Sig. (2-tailed)	.000	
	N	392	392

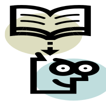
**. Correlation is significant at the 0.01 level (2-tailed).

SPSS, 2023

From the above computation, it can be seen that the r= .632 and the probability (significance) value based on the 2-tailed test is >0.000. This shows that there is a positive correlation between financial capacity and preferential treatment of healthcare practitioners. It must be stated also that the observed correlation is statistically significant. Therefore, we reject the initially formulated hypothesis and state that financial capacity has a significant impact on access to preferential treatment of healthcare practitioners in healthcare facilities in Delta State.

Hypothesis 2: Political influence has no significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State

Table 3: Correlation Test for Hypothesis II



		Political Influence	Behaviour of Practitioners
Political Influence	Pearson Correlation	1	.263**
	Sig. (2-tailed)		.000
	N	392	392
Behaviour of Practitioners	Pearson Correlation	.263**	1
	Sig. (2-tailed)	.000	
	N	392	392

**. Correlation is significant at the 0.01 level (2-tailed).

SPSS, 2023

From the above computation, it can be seen that r= .263 and the probability (significance) value based on the 2-tailed test is >0.000. This shows that there is a positive correlation between political influence and the behaviour of healthcare practitioners. It must be stated also that the observed correlation is statistically significant. Therefore, we reject the initially formulated hypothesis and state that political influence has a significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State.

Discussion of Findings

The main objective of the study was to examine the impact of social class on preferential healthcare delivery in healthcare facilities in Delta State, Nigeria. In line with this, data collected through a structured questionnaire were analysed. The analysis produced several results which were discussed herewith.

The data analysis revealed that financial capacity has a significant impact on access to preferential treatment of healthcare practitioners in healthcare facilities in Delta State. From the computation, it was seen that the r= .632 and the probability (significance) value based on the 2-tailed test is >0.000. This shows that there is a positive correlation between financial capacity and preferential treatment of healthcare practitioners. It must be stated also that the observed correlation is statistically significant. Therefore, we reject the initially formulated hypothesis and state that financial capacity has a significant impact on access to preferential treatment of healthcare practitioners in healthcare facilities in Delta State. It must be stated that wealthy patients are more likely to get preferential care from healthcare workers. Also, the acquisition of hospital cards and folder in healthcare facilities is easier for the financially buoyant. Similarly, wealthy patients are more likely to get the best available doctors or nurses The rich can easily access good healthcare facilities. Furthermore, there the bills associated with healthcare facilities across Delta State is often challenging for the poor and are mainly easy for the rich to afford. This is in line with the findings of Ricketts (2019) and Okoli (2020), who submitted that income level is important at the lower end of the socio-economic scale as well as in the rural areas where personal health can be shown to be an important component in localized cycles of poverty and deprivation. The growing incidence and the dynamics of poverty in Nigeria have stratified and polarized Nigerian society between the haves and the have-nots, between the influential and the non-influential, between the educated and the uneducated in terms of their access to the basic things of life which health care is one. Hence, those with low financial capacity are unable to access quality healthcare.

Also, the data analysis revealed that political influence has a significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State. From the computation, it was seen that r= .263 and the probability (significance) value based on the 2-tailed test is >0.000. This shows that there is a positive correlation between political influence and the behaviour of healthcare practitioners. It must be stated also that the observed correlation is statistically significant. Therefore, the initially formulated hypothesis was rejected and it was concluded that political influence has a significant effect on the behaviour of healthcare practitioners towards patients in healthcare facilities in Delta State. Hence, politically influential patients are given very good reception. The acquisition of hospital cards and folders by politically influential patients is very rapid. Politically influential patients are often made to see the doctor or nurse as soon as possible. People without any political influence often experience delays in regards to see the doctor or nurse. Doctors or nurses are often very polite and nice to the politically influential patients in healthcare facilities across Delta State.

Conclusion and Recommendations

Contemporarily, the impact of social class on the perception and treatment of individuals in the Nigerian society has become unequivocally lucid. Members of the Nigerian society, no doubt, belong to different social classes, which affects how they view and relate to one another. Generally, there is a distinction between the rich and the poor, the powerful and non-power, and the popular and unknown. These distinctions are not inconsequential in the society, but are significant in determining the treatment people receive from others. More often than not, the rich/powerful/popular in Nigeria is treated with more respect, leniency and courtesy than the poor, un-influential and unpopular. The treatment in question is not just a matter of casual behaviours or actions perpetrated by individuals regularly or occasionally, but also borders on how agencies, organisations and institutions treat individuals based on their social class. Discrepancies or irregularities in the treatment of individuals based on their social class have already been recorded and/or are predominant in the criminal justice system, education sector, employment arrangements, and banking sector (particularly in loan approval), among others. Based on the conflict framework of societal organisation, those who have huge finance, education, political influence, and high social status control the society and set up or influence institutions and agencies to work in their favour, sometimes at the detriment of those who do not have. This is why in Delta State, the people with huge finance, education, political influence, and high social status are better treated in society. Thus, in Delta State, people with different financial capacities, political influence, social status, and education make different choices regarding the use of healthcare facilities. Some people in Delta State mainly visit unorthodox healthcare centres and some others prefer orthodox healthcare centres. There are different attributable reasons why people visit unorthodox healthcare centres across the state. Sometimes, low education and awareness has a major impact on the decision to visit such centres. These inequalities, especially income inequality, creates an imbalance in how people are treated in the society. This implies that people are treated differently based on the social class that they belong. Preferential treatment is often given to people from the middle and upper classes in Delta State and Nigeria at large. Since, the health sector is also influenced by the stratification of society, patients are also treated on the basis of their social class. This is because social class serves as a basis for evaluation and assessment of individuals in the society. On the basis of this, there is preferential healthcare delivery based on the classes of the patients in hospitals. The preferential treatment is often favourable to those with higher social classes, statuses, wealth and education. Based on the findings of this study, the following recommendations were made:

1. The government should implement a more progressive healthcare financing system that reduces the financial burden on individuals from lower social classes. This could include subsidizing healthcare costs for those with lower incomes or expanding the coverage of social health insurance schemes.
2. There should be a conscious training and sensitisation for healthcare professionals. This should involve conducting training and sensitisation programs for healthcare professionals to ensure that they are aware of the importance of treating all patients equally, regardless of their social class. This includes addressing unconscious biases and providing cultural competency training.
3. Management of healthcare facilities should enforce effective regulation and oversight by strengthening regulatory mechanisms to monitor and enforce healthcare standards across both public and private healthcare facilities. Regular inspections, audits, and penalties for non-compliance can help ensure that all facilities provide equal access to quality healthcare services.

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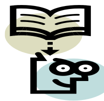

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