Research Article

# Religion, Economic Inequality And Access To Healthcare In Nigeria: A Socio-Theological Analysis

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**Abstract**

Access to healthcare is a fundamental dimension of human well-being, social justice and national development. Nevertheless, economic inequality continues to determine who receives timely, affordable and adequate medical attention in Nigeria. Religion also occupies a significant position in Nigerian society, influencing moral values, health-seeking behaviour, community relationships and the provision of social services. This paper examined the relationship between religion, economic inequality and access to healthcare in Nigeria from a socio-theological perspective. It adopted a qualitative documentary research method, drawing on relevant scholarly books, peer-reviewed journal articles, healthcare policy documents, legislation and international reports. The analysis explored the social determinants of healthcare access, the effects of poverty and unequal distribution of medical resources, and the roles of Christian, Islamic and other religious institutions in healthcare provision. The major issues examined included out-of-pocket medical expenditure, geographical disparities, inadequate health infrastructure, limited health insurance coverage, religious interpretations of sickness and healing, and the relationship between spiritual care and professional medical treatment. The findings indicated that economic inequality restricts healthcare access by making essential services unaffordable for disadvantaged households and deepening existing inequalities associated with location, gender and social status. Religion was found to have a dual influence: religious institutions can facilitate healthcare through charitable assistance, health education, counselling and community mobilisation, but certain beliefs and practices can also discourage timely medical treatment when spiritual explanations are presented as substitutes for professional healthcare. The paper recommended stronger public investment in healthcare, effective implementation of the National Health Insurance Authority Act, increased collaboration between government and faith-based organisations, and theological education that emphasises human dignity, compassion, justice and responsible healthcare decisions. It further recommended transparent medical assistance programmes, inclusive health education and measures to protect patients from economic and religious discrimination. The paper concluded that equitable healthcare requires an integrated response addressing economic structures, institutional responsibilities and religious values. Such an approach would recognise healthcare not merely as a charitable service but as an essential dimension of human dignity and social justice.

**Keywords:** religion, economic inequality, healthcare access, Nigeria, socio-theological analysis, health justice, faith-based organisations, social determinants of health

## 1. Introduction

Healthcare is indispensable to human survival, social participation and national development. A population's health condition influences educational achievement, economic productivity, family stability and the capacity of individuals to contribute meaningfully to society. However, the availability of healthcare does not necessarily guarantee equal access to it. Where poverty, inadequate public investment, geographical disparities and weak health financing mechanisms prevail, medical services may be more accessible to economically advantaged individuals than to disadvantaged populations. Consequently, healthcare inequality becomes both a public health concern and a question of social justice. In Nigeria, access to adequate healthcare is shaped by a combination of economic, institutional, geographical, cultural and religious factors. Although health facilities operate across different levels of the healthcare system, the capacity to pay for consultations, diagnostic tests, medicines, hospital admissions and transportation remains a significant determinant of whether individuals obtain appropriate treatment. Research on household healthcare expenditure in Nigeria demonstrates that out-of-pocket payments can expose households to catastrophic health expenditure and deepen poverty (Aregbeshola & Khan, 2018). These difficulties are particularly important for people whose livelihoods depend on irregular earnings or informal employment and who lack effective financial protection against illness.

Religion is equally significant in understanding healthcare practices in Nigeria. Religious institutions provide moral guidance, spiritual counselling, material assistance and social support. Christian and Muslim organisations, as well as communities associated with indigenous religious traditions, influence how individuals interpret sickness, suffering, healing and death. Faith-based institutions also participate in health service delivery and community welfare in different African settings (Olivier et al., 2015). Nevertheless, religious beliefs and practices do not always produce identical outcomes. While religious communities can encourage medical treatment, organise health programmes and support vulnerable patients, some interpretations of divine healing, spiritual causation and religious commitment may create difficulties when they discourage professional medical intervention.

The relationship between religion and healthcare therefore cannot be adequately understood without examining the economic and social conditions within which religious beliefs are practised. A poor patient who relies on prayer because professional treatment is unaffordable faces a different situation from a financially secure patient who voluntarily chooses prayer alongside medical care. Similarly, a religious organisation that pays hospital bills can help reduce the consequences of economic inequality without necessarily removing the structural conditions that produced the inequality.

This paper argues that equitable access to healthcare in Nigeria requires an integrated socio-theological approach. Such an approach examines the social distribution of healthcare resources alongside the moral obligations that religious traditions associate with human dignity, compassion, justice and the protection of life. It maintains that neither religious charity nor individual responsibility can substitute for effective public healthcare institutions and fair health financing. Rather, sustainable healthcare justice requires cooperation among government, healthcare professionals, religious institutions, communities and citizens.

## 2. Methodological Approach

The paper adopted a qualitative documentary and interpretive approach. Relevant scholarly literature on health inequality, healthcare financing, religion, social justice and African religious experience was examined alongside Nigerian healthcare policy documents, legislation and reports from international health institutions. The literature included empirical research on healthcare expenditure, conceptual discussions of the social determinants of health and theological works addressing human dignity, solidarity and responsibility towards vulnerable populations.

A thematic approach guided the analysis. The materials were interpreted under four interconnected themes: economic inequality and healthcare access; religion and health-seeking behaviour; theological principles and healthcare justice; and the responsibilities of government and religious institutions. Particular attention was given to the relationship between household economic circumstances, the organisation of health services and religious responses to sickness.
The analysis was socio-theological rather than exclusively medical or doctrinal. Its sociological dimension examined how poverty, social stratification, institutional arrangements and geographical differences influence access to healthcare. Its theological dimension considered how religious values and teachings can challenge exclusion, encourage compassionate service and establish moral obligations towards disadvantaged people.

The paper is a conceptual and documentary analysis rather than a report of original fieldwork. Accordingly, its findings represent interpretive conclusions drawn from the literature and policy materials considered, rather than statistical estimates generated through new surveys or interviews.

## 3. Economic Inequality and Access to Healthcare in Nigeria

### 3.1 Understanding Economic Inequality in Healthcare

Economic inequality refers to the uneven distribution of income, wealth, productive resources and opportunities among individuals and social groups. In the healthcare sector, it affects people's ability to obtain medical services, maintain good health and protect themselves against the financial consequences of illness. The relationship between economic inequality and health is well established in social determinants research, which demonstrates that health outcomes are shaped not only by medical treatment but also by the social conditions within which people live (Marmot, 2005).

Healthcare inequality becomes particularly serious when access depends substantially on the ability to pay. Individuals with stable incomes, comprehensive insurance and reliable transportation are generally better positioned to obtain

consultations, diagnostic investigations and specialist treatment. Conversely, low-income households may postpone treatment, purchase only part of a prescribed medication or discontinue a recommended course of care because of financial constraints.

These patterns create a cycle in which poverty increases vulnerability to illness, while illness further deepens poverty. A household may lose income when its principal earner becomes sick, incur transport and treatment costs, sell productive assets or borrow money to pay medical bills. Children may also experience interrupted schooling when household resources are redirected towards healthcare expenditure. These consequences demonstrate that poor access to healthcare is not merely a medical problem; it can reproduce social and economic disadvantage across generations.

Deaton (2013) explains that improvements in health and economic prosperity have not been distributed equally across populations. The relationship between wealth and health must therefore be understood through the institutions and social arrangements that determine who benefits from available resources. In Nigeria, the implications are considerable because health-related financial demands can place disproportionate pressure on households with limited savings and insecure livelihoods.

**3.2 Out-of-Pocket Expenditure and Financial Barriers**

Out-of-pocket expenditure occurs when households pay directly for healthcare services without receiving sufficient reimbursement or financial protection through insurance or publicly financed arrangements. Such expenditure can include consultation fees, diagnostic tests, prescription medicines, hospital charges and associated transportation costs. Aregbeshola and Khan (2018) examined out-of-pocket payments and catastrophic health expenditure in Nigeria and demonstrated the importance of healthcare financing in understanding household poverty. Their analysis supports the broader argument that medical expenses can become a mechanism through which households experience or deepen economic deprivation.

The central problem is not simply that healthcare costs money. It is that patients may have to pay when they are least able to do so. Illness is often unpredictable, and emergency treatment may not allow households sufficient time to accumulate savings. When essential services require substantial direct payment, access becomes closely connected to household income rather than medical need.

For people living in poverty, the consequences may include delayed hospital visits, dependence on informal borrowing, reduced food expenditure and recourse to less expensive alternatives that may not provide adequate treatment. Patients may also move between formal facilities, pharmacies, traditional practitioners and religious centres in search of affordable assistance.

These practices should not automatically be interpreted as evidence of ignorance or religious superstition. They may instead reflect responses to financial exclusion and the limited availability of affordable services. Nevertheless, when financial barriers lead patients to delay essential treatment, preventable conditions may become more complicated and expensive to manage.

The expansion of health insurance is therefore essential to improving financial protection. Nigeria's National Health Insurance Authority Act of 2022 provides a legislative framework intended to strengthen health insurance and expand access to healthcare. However, legislation alone cannot guarantee universal access. Effective implementation, public awareness, accessible enrolment procedures, adequate financing and meaningful protection for economically vulnerable households remain crucial.

**3.3 Geographical Inequality and Unequal Distribution of Facilities**

Economic inequality interacts with geographical disparities in the distribution of healthcare services. Urban centres are generally more likely to offer a wider range of hospitals, diagnostic services and specialist practitioners than remote communities with limited infrastructure. However, the degree of disadvantage varies between states, local government areas and individual communities.

For rural households, the effective cost of healthcare includes more than the price charged by a hospital. Transportation,

accommodation, lost working hours and the cost of accompanying a patient may all influence whether treatment is sought. A service that is technically available at a distant hospital may remain practically inaccessible to a family that cannot afford the journey.

The Nigeria Demographic and Health Survey 2018 provides an important national reference for examining differences in healthcare use and health conditions across population groups (National Population Commission [NPC] & ICF, 2019).

Such differences must be interpreted alongside variations in household resources, residence and access to services. Economic and geographical inequalities can also reinforce each other. An economically disadvantaged person living close to a well-equipped hospital may still be unable to afford treatment, while a more affluent person may overcome geographical barriers through private transportation or specialist referrals. This interaction indicates that healthcare inequality cannot be addressed through the construction of facilities alone. It also requires affordable financing, an adequate health workforce, reliable medicines, functioning referral systems and distribution of services according to population needs.

### 3.4 Gender, Household Responsibilities and Vulnerability

Gender can influence access to healthcare through differences in income, decision-making authority, family responsibilities and social expectations. Women may face barriers associated with financial dependence, unpaid care work, restricted mobility or the need to obtain permission or financial assistance from other household members. These barriers can be particularly serious when pregnancy-related complications or other urgent medical conditions require timely intervention.

Economic inequality can also affect children, older people and persons with disabilities. Households with limited resources may prioritise the treatment of individuals considered economically indispensable while postponing care for dependants. Such decisions may arise from severe financial constraints rather than an explicit rejection of the value of vulnerable family members.

Religious teachings and institutions can either challenge or reinforce these patterns. Religious communities that affirm the dignity of women, encourage responsible healthcare and provide assistance to vulnerable households may reduce barriers. Conversely, social interpretations that discourage women's independent decision-making or stigmatise certain health conditions may deepen exclusion.

A socio-theological analysis must therefore ask not only whether religious organisations provide healthcare assistance but also who receives that assistance, how beneficiaries are selected and whether existing practices promote equal dignity.

## 4. Religion and Healthcare in the Nigerian Context

### 4.1 Religion as a Source of Meaning and Social Support

Religion influences how people interpret the meaning of illness, suffering, recovery and death. For many Nigerians, sickness is understood through a combination of biological, psychological, social and spiritual explanations. Individuals may seek medical advice while also praying, consulting religious leaders or participating in communal worship.

This combination reflects the social importance of religion in everyday life. African religious traditions often locate human experience within relationships involving family, community, moral responsibility and spiritual meaning (Mbiti, 1990). In contemporary Nigeria, religious communities can therefore function as sources of emotional reassurance, practical support and collective action during periods of illness.

Spiritual support can be important when patients experience pain, uncertainty or fear. Prayer, counselling and pastoral accompaniment may help individuals cope with difficult diagnoses, treatment burdens and bereavement. These forms of support can complement professional healthcare when they respect medical advice and the patient's right to make informed decisions.

The distinction between complementary religious support and the substitution of religious practices for necessary

medical treatment is critical. The former may strengthen patients' emotional and social resources. The latter may create risks if it results in avoidable delays, the rejection of effective treatment or the discontinuation of prescribed medication. The relationship between religion and healthcare should therefore not be reduced to the assumption that religious belief is either beneficial or harmful. Its effects depend on the content of religious teaching, the conduct of religious leaders, patients' circumstances and the quality and affordability of available medical services.

**4.2 Faith-Based Healthcare Institutions and Charitable Assistance**

Faith-based organisations have historically contributed to health service delivery in many African communities. Their contributions may include the operation of hospitals and clinics, provision of community health education, maternal and child health services, support for people affected by infectious diseases and assistance to households facing medical expenses. Research on faith-based healthcare providers in Africa has documented their relevance to the scale, reach, cost and perceived quality of health services (Olivier et al., 2015).

In Nigeria, religious organisations can contribute to healthcare through institutional facilities, charitable programmes, fundraising, patient support and collaboration with health professionals. Their local networks can also help communicate health information to people who may not be reached effectively through formal government channels. Religious leaders often possess substantial community trust. This may allow them to encourage preventive healthcare, promote vaccination, support maternal health programmes, challenge misinformation and refer individuals to qualified practitioners. Religious organisations may be especially useful where community health programmes require cooperation with local leaders and sustained public engagement.

Faith-based assistance can also reduce immediate hardship. A religious community that contributes to a patient's hospital expenses may enable treatment that would otherwise be delayed. Congregational fundraising, welfare programmes and voluntary support networks can help families meet medical costs during emergencies.

Nevertheless, charitable provision has limitations. Assistance may depend on the resources of individual congregations, the generosity of donors or the discretion of religious leaders. Some communities operate well-supported healthcare facilities, while others possess little capacity to provide material assistance. Beneficiaries may also be selected through informal arrangements that are not always transparent.

Furthermore, charity does not necessarily establish an enforceable entitlement to healthcare. A patient who receives assistance through religious generosity may benefit greatly, but another patient facing the same medical need may receive nothing because their congregation lacks resources or does not recognise them as a beneficiary.

For this reason, religious charity should complement rather than replace a publicly accountable healthcare system. Faith-based organisations can make important contributions to service delivery and social support, but the responsibility for ensuring equitable access cannot be transferred entirely to voluntary institutions.

**4.3 Religious Beliefs and Health-Seeking Behaviour**

Religious beliefs may influence when, where and from whom individuals seek healthcare. Some people understand illness primarily through biological processes, while others interpret certain conditions through spiritual explanations involving divine purpose, spiritual attack, moral wrongdoing or supernatural influence. Such interpretations may coexist rather than operate as mutually exclusive explanations.

Kleinman (1988) demonstrates that illness is experienced within cultural and social systems that shape how people understand symptoms, suffering and treatment. This insight is useful in Nigeria, where patients may move between biomedical services and religious settings according to the nature of their condition, personal convictions, community expectations and available resources.

Religious beliefs may positively influence healthcare behaviour when faith leaders encourage individuals to seek professional diagnosis, complete prescribed treatment and adopt preventive practices. Religious teaching can also support healthy behaviour through its emphasis on discipline, care for the body, protection of vulnerable people and responsibility towards family and community.

However, difficulties may arise where spiritual interpretations are presented as the only legitimate explanation for illness. A person who is told that a medical condition reflects weak faith, demonic activity or divine punishment may experience guilt, fear or pressure to avoid professional treatment. Such risks are particularly concerning when serious conditions require urgent diagnosis or sustained medical management.

The appropriate response is neither to dismiss religious beliefs nor to assume that every religious practice poses a threat to healthcare. Instead, health professionals and religious leaders should develop relationships that respect spiritual identity while clearly communicating the importance of timely, evidence-based medical care.

Religious leaders can explain that prayer and medical treatment need not be mutually exclusive. A patient may receive spiritual encouragement while undergoing surgery, following a prescribed treatment plan or participating in rehabilitation. This approach respects religious commitment without allowing spiritual claims to override medical safety.

**4.4 Religious Networks, Trust and Health Education**

Religious institutions can act as trusted channels for public health education. Churches, mosques and other religious communities often organise regular gatherings through which health information can be shared with large numbers of people. Their established relationships with families may also create opportunities for discussion of sensitive subjects, including mental health, chronic illness, disability and maternal care.

This potential requires responsible communication. Health information distributed through religious networks should be medically accurate, understandable and consistent with the advice of qualified professionals. Religious leaders should avoid making unsupported medical claims or presenting prayer, ritual or faith commitments as guaranteed cures for serious conditions.

Collaboration between religious institutions and healthcare authorities may be especially valuable in communities where distrust of government agencies, misinformation or cultural concerns discourage the use of formal services. Such partnerships can support dialogue, explain available services and encourage people to seek appropriate treatment.

Nevertheless, the use of religious networks must remain inclusive. Healthcare information and assistance should not be restricted to members of a particular denomination or faith. People who belong to minority religions, indigenous religious communities or no religious tradition should be able to access public health services without discrimination or pressure to participate in religious activities.

The contribution of religion to healthcare is strongest when community trust is translated into accurate information, timely referral, compassionate support and respect for the dignity and freedom of every patient.

**5. A Socio-Theological Interpretation of Healthcare Inequality**

A socio-theological analysis brings social explanations of inequality into conversation with religious teachings about human worth, justice and moral responsibility. It recognises that healthcare access involves both material resources and ethical questions concerning how a society treats its members.

The social dimension asks why some people can obtain treatment while others cannot. The theological dimension asks whether the resulting inequalities are consistent with religious commitments to compassion, justice and the protection of human life. Bringing the two perspectives together makes it possible to evaluate healthcare inequality as more than an unfortunate difference in individual circumstances.

**5.1 Human Dignity and the Value of Life**

Human dignity is a central principle in Christian theological ethics and is also reflected in wider religious and moral traditions. Within Christianity, the belief that human beings possess inherent worth provides a basis for treating each person with respect irrespective of wealth, social position, ethnicity, gender or religious affiliation.

This principle has practical implications for healthcare. A person's financial capacity should not determine whether their suffering is acknowledged or whether they are considered worthy of treatment. Although healthcare systems must allocate limited resources, allocation decisions should be guided by medical need, fairness and defensible public

priorities rather than by assumptions that wealthier individuals have greater human worth.

The Christian ethical understanding of care for the sick appears prominently in the parable of the Good Samaritan (Luke 10:25–37). The narrative challenges indifference to suffering and presents compassionate action as a responsibility that crosses social and communal boundaries. Its relevance to healthcare inequality lies in the insistence that the needs of a vulnerable person should elicit practical assistance rather than exclusion.

Orobator (2008), in his exploration of African Christian theological reflection, emphasises the importance of interpreting Christian faith in relation to African social and communal realities. Applied to healthcare, this perspective encourages a theology that addresses actual experiences of suffering, exclusion and vulnerability rather than remaining limited to abstract moral declarations.

Human dignity also has implications for how patients are treated within religious healthcare institutions. A patient should not be denied necessary treatment because of religious affiliation, poverty, disability or inability to participate in religious activities. Compassionate healthcare requires respect for the person as a person, not merely as a potential recipient of charity or a member of a religious community.

**5.2 Social Justice and the Preferential Concern for the Poor**

Social justice concerns the fairness of the arrangements through which societies distribute opportunities, responsibilities and essential resources. In healthcare, it requires attention to the needs of those whose circumstances make them especially vulnerable to illness or exclusion.

Farmer (2004) uses the concept of structural violence to explain how political, economic and social arrangements can systematically expose some populations to preventable suffering. His analysis is relevant to healthcare inequality because harm can arise not only through direct acts of violence but also through institutions and arrangements that repeatedly disadvantage particular groups.

When people cannot obtain necessary healthcare because they lack money, live far from adequate facilities or have no meaningful financial protection, the resulting disadvantage cannot always be explained by personal choices. It may also reflect structural conditions over which individuals have limited control.

A theological concern for the poor challenges religious communities to recognise these structural dimensions of suffering. Providing food, paying hospital bills and visiting sick people are important expressions of compassion. However, a more comprehensive response also asks why people repeatedly face the same financial barriers and what institutional changes could reduce their exposure to preventable hardship.

Francis (2020), in *Fratelli Tutti*, emphasises fraternity, social friendship and concern for people who are marginalised. Applied to healthcare, this perspective supports social arrangements that recognise the interdependence of human beings and reject indifference to preventable suffering.

The concern for disadvantaged populations should not be understood as an argument for ignoring the needs of other patients. Rather, it requires recognising that equal human worth sometimes demands additional support for individuals facing greater barriers. Subsidies for low-income households, accessible rural services and protection for vulnerable patients are consistent with a conception of justice that responds to differences in need and capacity.

**5.3 Compassion, Solidarity and Collective Responsibility**

Compassion is a willingness to recognise another person's suffering and respond to it. Solidarity goes further by recognising shared responsibility for addressing the conditions that expose people to avoidable hardship.

Religious traditions can encourage solidarity through mutual aid, communal giving, hospitality and organised assistance. Christian congregations may establish welfare programmes and medical support funds, while Muslim communities may use charitable practices, including zakat, to assist eligible people experiencing hardship. Other religious communities may express solidarity through their own charitable and communal traditions.

These practices can provide important resources where public support is insufficient. However, their effectiveness depends on how they are organised, how funds are managed and whether assistance reaches those with the greatest needs.

A solidarity-based response to healthcare inequality should therefore include both immediate assistance and longer-term action. Immediate assistance helps patients pay for treatment or obtain medicines. Longer-term action includes health education, preventive programmes, advocacy for fair financing, support for community health workers and partnerships that strengthen local health services.

Sen's (1999) capability approach offers a useful complementary perspective. Development, in his account, involves expanding people's substantive freedoms and opportunities to live lives they have reason to value. Healthcare is important because illness can undermine the ability to learn, work, participate in community life and exercise other freedoms. From this perspective, healthcare exclusion reduces human capabilities and constrains meaningful participation in society.

Religious solidarity becomes more transformative when it helps people access healthcare while also supporting social arrangements that protect their capacity to live healthy and dignified lives.

### 5.4 The Body, Health and Moral Responsibility

Religious views of the body can influence attitudes towards prevention, treatment and personal responsibility. In Christian contexts, the body is frequently discussed in relation to stewardship, care and responsibility rather than simple possession. These ideas can encourage individuals to seek appropriate treatment, avoid preventable harm and care for people who cannot adequately care for themselves.

However, moral responsibility should not be confused with blaming people for their illnesses. Individuals' health outcomes are influenced by conditions that may lie beyond their control, including poverty, environmental exposure, unsafe working conditions and limited access to healthcare. The social determinants of health approach demonstrates why health cannot be explained entirely through personal behaviour (World Health Organization [WHO], 2008).

A theology of stewardship should consequently recognise both personal and collective responsibilities. Individuals may have responsibilities to seek appropriate care when possible, but governments also have responsibilities to develop healthcare systems that people can realistically access. Employers, communities and religious institutions likewise have obligations within their respective capacities.

This distinction is important because patients living in poverty should not be morally condemned for failing to obtain services they cannot afford. Rather, responsible health ethics should encourage informed choices while acknowledging the structural barriers that restrict those choices.

## 6. Challenges at the Intersection of Religion, Inequality and Healthcare

### 6.1 Poverty and the Limitations of Religious Charity

One significant challenge is the gap between the scale of healthcare needs and the resources available to religious organisations. Religious communities may wish to assist members who require treatment, but their resources are often limited and must be distributed among competing needs, including education, food assistance, housing and other welfare activities.

Where healthcare expenses are high, individual congregations may be unable to provide sustained assistance. A religious organisation may pay for an initial consultation but lack the resources to support prolonged hospitalisation, surgery or continuing treatment. Patients with chronic illnesses may need assistance over many months or years, making reliance on occasional charitable contributions particularly uncertain.

This limitation demonstrates why charitable assistance cannot serve as the principal foundation for equitable healthcare. Religious organisations can provide essential support, but lasting financial protection requires dependable healthcare financing and institutions with the capacity to serve populations according to need.

**6.2 Prosperity Teachings and the Risk of Victim-Blaming**

Another challenge arises when religious messages connect material success or physical healing too closely with the strength of a person's faith. Some forms of religious teaching may encourage the expectation that prayer or spiritual commitment should produce immediate healing or that continued illness reflects personal spiritual failure.

It would be inaccurate to attribute these attitudes to all Pentecostal, evangelical, Islamic or other religious communities. Religious traditions are internally diverse, and many religious leaders actively encourage medical treatment. Nevertheless, where such interpretations occur, they can create distress for patients and contribute to delayed healthcare.

A patient who remains ill after prayer may experience shame, guilt or fear of being judged by the religious community. Families may also be encouraged to continue spiritual interventions despite the need for urgent professional care. These risks are especially serious when they affect children, individuals who cannot make decisions independently or patients experiencing conditions that require immediate treatment.

Religious leaders and theological educators should therefore distinguish spiritual encouragement from unsupported promises of cure. They can affirm the importance of prayer while making clear that illness does not automatically indicate moral failure or insufficient faith. They should also encourage timely consultation with qualified healthcare professionals.

**6.3 Weak Coordination Between Religious and Formal Healthcare Systems**

Religious healthcare programmes and formal health services may operate without adequate coordination. Where communication is limited, religious institutions may lack access to reliable public health information, while government programmes may fail to use the community relationships that religious leaders have established.

The consequences include missed opportunities for referral, duplicated activities and inconsistent messages about health conditions and treatment. A religious community may organise an awareness programme but lack a clear process for connecting participants with nearby clinics. Alternatively, public health authorities may develop community programmes without consulting trusted local leaders.

Coordination must not mean that religious organisations replace medical professionals or that health policy becomes dependent on religious approval. Instead, cooperation should be based on clearly defined responsibilities. Religious leaders can provide information, encouragement and social support, while qualified health professionals remain responsible for diagnosis, treatment and clinical guidance.

Formal referral arrangements, periodic training, shared health education activities and communication with local health authorities can strengthen cooperation while protecting professional standards.

**6.4 Stigma and Discrimination**

Stigma constitutes an additional barrier to healthcare access. People who live with mental health conditions, HIV, infertility, disability or illnesses associated with social misunderstanding may experience rejection, blame or pressure to conceal their conditions.

Religious communities can play a constructive role by promoting compassion and challenging discriminatory attitudes. Their moral influence may encourage families to support affected members and help communities recognise that illness does not remove a person's dignity.

However, when a health condition is presented as evidence of immoral conduct or spiritual failure, religious authority can unintentionally reinforce stigma. Patients may avoid seeking treatment because they fear public exposure or condemnation.

Religious education should therefore emphasise confidentiality, respect and non-discrimination. Health conditions should be discussed responsibly, with a distinction between moral reflection and the attribution of unsupported blame to individuals. Public health programmes should also protect patients' privacy and ensure that assistance is not

conditional on disclosing unnecessary personal information.

**6.5 Institutional Weakness and Inadequate Health Financing**

Religious institutions operate within the wider conditions of the Nigerian healthcare system. Where public facilities lack medicines, staff or functioning equipment, patients may depend more heavily on private facilities, family support and charitable assistance. These alternatives may be unaffordable for low-income households.

The World Health Organization and World Bank (2023) global monitoring report on universal health coverage highlights the continuing international difficulty of ensuring access to essential services without financial hardship. The report reinforces the importance of health systems that provide necessary services while protecting households from excessive healthcare costs.

Nigeria's National Health Insurance Authority Act of 2022 represents an important institutional framework for strengthening insurance-based healthcare financing. Nevertheless, the practical effectiveness of health insurance depends on implementation, enrolment, service availability, administrative capacity and sufficient financial resources.

A religiously motivated response cannot resolve these institutional challenges independently. Religious leaders may advocate reform, educate communities and assist vulnerable households, but responsibility for health policy, resource allocation, service regulation and public accountability remains with the appropriate public institutions.

**6.6 Pluralism and Unequal Access to Religious Assistance**

Nigeria's religious diversity requires an inclusive approach to faith-based healthcare partnerships. Religious institutions differ in financial resources, organisational capacity, geographical reach and access to medical professionals. Some operate established health facilities, while others depend primarily on volunteer support.

Consequently, the availability of religious assistance may differ substantially between communities. An individual who belongs to a well-resourced religious organisation may obtain help with hospital expenses, while someone outside that network may be unable to secure equivalent assistance.

Public healthcare should not reproduce these inequalities by making access dependent on religious affiliation. Cooperation with faith-based organisations must therefore preserve equal access for people of different beliefs and those who do not identify with a religious tradition.

This requirement does not diminish religion's contribution to healthcare. Rather, it ensures that religious participation strengthens public welfare without turning religious membership into a condition for receiving essential services.

## 7. Recommendations

The findings of this paper demonstrate that the relationship between religion, economic inequality and healthcare access in Nigeria requires practical interventions at governmental, institutional, community and theological levels. The following recommendations are proposed to promote equitable healthcare and strengthen the positive contributions of religious institutions.

**7.1 Strengthening Public Investment in Healthcare**

The Nigerian government at the federal, state and local levels should increase and sustain investment in healthcare infrastructure, primary healthcare centres, essential medicines, medical personnel, diagnostic facilities and referral services. Greater attention should be directed towards economically disadvantaged and underserved communities, where poverty and inadequate facilities combine to restrict access.

Investment should be guided by population needs and measurable service gaps rather than political considerations alone. Improving the distribution of qualified medical personnel and essential services would reduce the need for vulnerable patients to travel long distances or depend exclusively on costly private facilities.

**7.2 Improving Health Insurance and Financial Protection**

The government should strengthen implementation of the National Health Insurance Authority Act of 2022 to improve access to affordable health insurance, especially among low-income households, informal-sector workers and other vulnerable groups.

Enrolment procedures should be accessible, public awareness should be increased, and appropriate mechanisms should protect people who cannot afford regular contributions. Health insurance programmes should also provide meaningful access to essential services, with effective oversight to ensure that covered patients can obtain the care for which they are eligible.

These measures would reduce dependence on out-of-pocket expenditure and limit the risk that illness pushes already disadvantaged households further into poverty.

**7.3 Formalising Partnerships Between Government and Faith-Based Organisations**

Government health agencies should establish structured partnerships with Christian, Muslim and other religious organisations willing and able to contribute to healthcare delivery. These partnerships could include preventive health education, maternal and child health programmes, screening initiatives, mental health awareness, patient referral and assistance for vulnerable households. Agreements should specify responsibilities, professional standards, referral procedures and accountability mechanisms. Participating religious institutions should work with qualified healthcare professionals and refer patients to appropriate facilities when medical diagnosis or treatment is required. Such partnerships should be inclusive and non-discriminatory. No patient should be denied public healthcare or made to participate in religious activities because of their beliefs or lack of religious affiliation.

**7.4 Integrating Healthcare Ethics into Theological Education**

Theological institutions, seminaries, religious education departments and leadership training programmes should incorporate healthcare ethics, social justice and responsible health communication into their teaching. Religious leaders should be equipped to explain that prayer, pastoral counselling and spiritual encouragement can complement professional medical treatment. They should discourage interpretations that automatically associate illness with weak faith, immoral behaviour or spiritual failure. Theological education should also encourage reflection on the social causes of healthcare inequality, including poverty, inadequate public services and financial exclusion. This would help religious leaders move beyond individual charitable responses towards sustained engagement with the wider conditions affecting human health.

**7.5 Establishing Transparent Religious Medical Assistance Programmes**

Religious organisations should create transparent and accountable procedures for providing medical assistance to individuals and households experiencing financial hardship. Where resources permit, they should establish designated medical assistance funds, partner with healthcare facilities or organise collaborative welfare programmes. Beneficiaries should be selected according to clear criteria, including financial vulnerability, medical urgency and the nature of the treatment required. Assistance should not depend on a person's religious affiliation, ethnicity, gender or participation in worship. Religious institutions should also protect patient confidentiality and maintain reasonable financial records to ensure that available resources are managed responsibly and directed towards those most in need.

**7.6 Expanding Community Health Education**

Religious organisations should collaborate with healthcare professionals and public health authorities to provide medically accurate information on preventive healthcare, vaccination, maternal health, mental health, chronic diseases and medication adherence. Religious leaders should be encouraged to direct individuals to qualified medical practitioners when symptoms require professional assessment. Public health programmes should provide appropriate training and accessible information that enable religious leaders to communicate responsibly about health matters. This approach would utilise the trust that religious institutions often enjoy within their communities while reducing the risk of misinformation and delays in obtaining treatment.

**7.7 Protecting Patients from Stigma and Discrimination**

Religious institutions and healthcare providers should actively discourage practices that shame, stigmatise or discriminate against people because of illness, disability, poverty or religious identity. Religious teaching should

emphasise the dignity of every person and the responsibility to offer compassionate support to those experiencing sickness. Healthcare providers should protect patient confidentiality, respect informed consent and ensure that services are delivered without religious coercion. Particular attention should be given to people living with mental health conditions, HIV and other illnesses that may attract misunderstanding or social exclusion. Public education should challenge harmful stereotypes and encourage supportive relationships among families, religious communities and healthcare professionals.

**7.8 Promoting Healthcare Research and Policy Evaluation**

Universities, research institutions, public health agencies and religious organisations should support further research on the relationship between religious beliefs, household income and healthcare-seeking behaviour in Nigeria. Future empirical studies should examine how financial constraints influence patients' choices between formal healthcare and alternative sources of assistance. Research should also assess the effectiveness of religious medical assistance programmes, community health education and government partnerships with faith-based organisations. Evidence from such studies could inform policy design, programme evaluation and the allocation of healthcare resources. It would also help distinguish between religious practices that support appropriate healthcare and those that may contribute to delays or exclusion.

**7.9 Encouraging Religious Advocacy for Healthcare Justice**

Religious leaders and organisations should use their community influence to promote public accountability, equitable health financing and improved access to essential services. Their advocacy should be evidence-informed and directed towards practical improvements in the healthcare system. Religious social action should combine immediate assistance to patients with sustained efforts to address the structural conditions that make healthcare inaccessible. Paying a patient's hospital bill may relieve immediate suffering, but advocating for affordable services and stronger financial protection can help prevent similar hardship among a wider population.

**7.10 Ensuring Accountability and Monitoring Implementation**

Government agencies, healthcare institutions and participating religious organisations should establish clear mechanisms for monitoring healthcare interventions and evaluating their outcomes. Relevant indicators could include the number of vulnerable households enrolled in health insurance, access to essential medicines, availability of primary healthcare services, use of formal referral systems, reach of community health education programmes and the distribution of medical assistance among disadvantaged groups. Regular evaluation would help identify gaps, improve the management of resources and ensure that interventions benefit those facing the greatest barriers to healthcare. Accountability should remain consistent with privacy protections, professional standards and the rights of patients.

## 8. Discussion

The relationship between religion, economic inequality and healthcare access in Nigeria reveals the importance of addressing both material deprivation and the moral responsibilities of institutions. Economic inequality limits healthcare access by distributing the capacity to obtain treatment unevenly. Direct healthcare payments, inadequate financial protection and geographical barriers can prevent people from receiving the care they need, even when their conditions are medically treatable. Religion enters this relationship through its influence on personal meaning, community relationships, health-seeking behaviour and social action. Religious institutions can provide practical assistance and mobilise communities in ways that strengthen access to healthcare. Their moral authority may also help challenge stigma and encourage public concern for vulnerable groups. At the same time, religion's contribution depends on how it is interpreted and practised. Where religious beliefs encourage patients to seek appropriate care and provide support during treatment, religion may strengthen health outcomes indirectly through emotional reassurance, social support and practical assistance. Where religious claims discourage professional treatment or blame patients for their illnesses, they can increase vulnerability. The paper's socio-theological argument is that these outcomes cannot be understood separately from the wider political and economic environment. A patient who turns to prayer because medical services are unaffordable is not facing the same problem as a patient who has access to appropriate care but chooses not to use it. Financial exclusion and religious belief may interact, and a credible analysis must recognise that distinction.

The capability approach articulated by Sen (1999) offers a useful way to understand this relationship. Access to healthcare contributes to people's capacity to live healthy lives, work, learn and participate in society. When economic

circumstances prevent individuals from obtaining necessary treatment, their substantive freedoms are reduced. Healthcare inequality consequently undermines not only bodily well-being but also broader human development. Theological ethics adds another dimension by questioning the moral acceptability of arrangements that leave vulnerable people unable to obtain essential treatment. If human dignity, compassion and solidarity are taken seriously, religious institutions have reason to support practical assistance and reforms that reduce unjust barriers to healthcare.
However, religious solidarity cannot be the sole solution. Its reach depends on available resources, organisational capacity and voluntary participation. A comprehensive response requires functioning public healthcare institutions, effective financing and accountable regulation. Religious organisations can strengthen these arrangements through service provision, health education and advocacy, but they cannot independently guarantee equitable access for an entire population. The analysis therefore supports a complementary model in which government bears its public responsibilities, healthcare professionals provide competent clinical services, religious institutions contribute ethical leadership and community support, and citizens are equipped to make informed healthcare decisions. Such a model treats religious involvement as a valuable resource within a broader system of public responsibility rather than as an alternative to that system.

The recommendations outlined above follow from this integrated understanding. Stronger public financing and health insurance would address economic barriers; collaboration with religious organisations would improve community engagement; theological education would encourage responsible health-seeking behaviour; and transparent assistance programmes would strengthen the delivery of charitable support. Research and monitoring would help determine whether these interventions are achieving meaningful improvements. Ultimately, healthcare justice requires the alignment of ethical commitments with effective institutions. Religious values can motivate solidarity and compassion, but their contribution becomes more sustainable when translated into practical action, accountable partnerships and support for policies that protect all members of society.

## 9. Conclusion

Religion, economic inequality and access to healthcare are closely interconnected in Nigeria. Economic inequality restricts access to essential medical services by limiting households' ability to pay for treatment, obtain insurance and overcome geographical barriers. Religion influences how people understand illness, where they seek assistance and how communities respond to suffering. It can promote healthcare access through charitable support, social solidarity, health education and moral advocacy, but it may also create difficulties where religious interpretations discourage appropriate medical treatment or reinforce stigma.

This paper has argued that a socio-theological approach provides a useful framework for understanding these relationships. The social dimension identifies the structural conditions that produce unequal healthcare opportunities, while the theological dimension evaluates these conditions in light of human dignity, justice, compassion and collective responsibility. The central implication is that healthcare should not be treated merely as a commodity available to those who can afford it or as a charitable benefit dependent on religious generosity. It is an essential component of human well-being that requires effective public institutions, equitable financing and protection for vulnerable populations. Religious organisations can make important contributions by providing practical support, promoting medically responsible teaching and advocating for fairer healthcare arrangements.

The paper therefore concludes that reducing healthcare inequality in Nigeria requires sustained cooperation between government, religious institutions, healthcare professionals and communities. Implementing the recommendations outlined above would help address financial barriers, improve health education, promote responsible religious engagement and strengthen protections for disadvantaged patients. Such cooperation can contribute to a healthcare system in which access to treatment is determined more fairly by human need than by economic privilege or religious affiliation.

## References


1. Aregbeshola, B. S., & Khan, S. M. (2018). Out-of-pocket payments, catastrophic health expenditure and poverty among households in Nigeria 2010. *International Journal of Health Policy and Management, 7*(9), 798–806. https://doi.org/10.15171/ijhpm.2018.19
2. Deaton, A. (2013). *The great escape: Health, wealth, and the origins of inequality*. Princeton University Press.

3. Farmer, P. (2004). An anthropology of structural violence. *Current Anthropology, 45*(3), 305–325. https://doi.org/10.1086/382250
4. Francis. (2020). *Fratelli tutti: On fraternity and social friendship*. Libreria Editrice Vaticana.
5. Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic Books.
6. Marmot, M. (2005). Social determinants of health inequalities. *The Lancet, 365*(9464), 1099–1104. https://doi.org/10.1016/S0140-6736(05)71146-6
7. Mbiti, J. S. (1990). *African religions and philosophy* (2nd ed.). Heinemann.
8. National Health Insurance Authority Act, 2022 (Nigeria).
9. National Population Commission (NPC) [Nigeria], & ICF. (2019). *Nigeria demographic and health survey 2018*. NPC and ICF.
10. Olivier, J., Tsimpo, C., Gemignani, R., Shojo, M., Coulombe, H., Dimmock, F., Nguyen, M. C., Hines, H., Mills, E. J., Dieleman, J. L., Haakenstad, A., & Wodon, Q. (2015). Understanding the roles of faith-based health-care providers in Africa: Review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *The Lancet, 386*(10005), 1765–1775. https://doi.org/10.1016/S0140-6736(15)60251-3
11. Orobator, A. E. (2008). *Theology brewed in an African pot*. Orbis Books.
12. Sen, A. (1999). *Development as freedom*. Alfred A. Knopf.
13. World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. World Health Organization.
14. World Health Organization, & World Bank. (2023). *Tracking universal health coverage: 2023 global monitoring report*. World Health Organization.