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GEOGRAPHICAL PERSPECTIVES ON THE STATE AND PUBLIC SERVICE PROVISION IN NIGERIA

S. I. Okafor

INTRODUCTION

Academic interest in the role of the state in public services provision is well established in human geography as well as in the other social sciences (Pinch, 1989; Johnston, 1989; Weil, *et al*, 1990). Murray Austin, *et al* (1987) define public services as those provided by the public sector while public facilities are the physical structures where these services are produced and made available. From the perspective of the state, it is argued that public services are necessary for the reproduction of labour power. In fact, health care and other social services represent an investment for increasing the productivity of labour. Social programmes are therefore a precondition for economic efficiency. But they are also emancipatory and decommodifying, reducing the dependence of individuals on the cash nexus even as markets have become universal and hegemonic (Esping-Anderson, 1990). Although public sector social services may tend to reflect such principles as retail location and central place theory, their geographical pattern should be governed by equity and welfare considerations - not just considerations of economic efficiency. This is because while most pre-industrial modes of social reproduction are destroyed by the forces of modernization, the market does not provide social protection for the disadvantaged. Yet in the past decade, economic considerations have gained some prominence in the public sector as a result of the restructuring of the welfare state. An important indicator of this restructuring is represented by "...the reductions in the rates of growth of social service expenditures. One policy outcome of these shifts

in public expenditure patterns has been the promotion of private sector involvement" (Laws, 1989:239). The promotion of private sector involvement in social programmes is now an official policy in Nigeria, but the role of the state in public provision remains important.

This paper examines the geographical variations in the provision of public services in Nigeria, using health care services as a case study. The subject is examined within the context of some of the theoretical perspectives that account for the role of the state (and local states) under capitalism. The paper also provides some insight into the probable impact of the restructuring of the welfare state on the spatial pattern of curative health care services. These are subjects of considerable academic and policy interest, especially in Nigeria, which has been implementing a structural adjustment programme under the aegis of the International Monetary Fund (IMF) and the World Bank. The country is, therefore, beginning to encourage increased private sector involvement in the social services sector. The remainder of this paper first reviews briefly the literature on the state and collective consumption. Thereafter, it provides some background information on health care provision in Nigeria before going on to examine the spatial outcome of state policy, and the likely impact of restructuring.

STATE COLLECTIVE CONSUMPTION

State involvement in the provision of public services has a long history in Western Europe from where the concept of the modern nation-state was "exported" to Nigeria and much of the developing world as part of the expansion of European economic, political and cultural influence. State intervention in Nigeria's economy and society was therefore not the result of domestic problems of public health, housing, civil disorder, and social deprivation associated with industrialization and urbanization as was the case in Europe (see Knox, 1984). Notions-about the role of the state were also "imported". A brief discussion of one of the theoretical perspectives that account for the role of the state (as well as local states) in public services provision in the West will shed useful light on the spatial outcome of some aspects of public policy in Nigeria.

The theoretical perspective in question stresses that public services, otherwise referred to as collective consumption (Castells, 1977), are essential for the efficient and profitable functioning of the economy. In this connection, it has been suggested that state intervention in collective consumption is necessitated by the fact that social services are required for the adequate reproduction of labour power, are demanded by the popular masses, and are generally unprofitable in capitalist production (Jackson and Smith, 1984). Social services thus represent a form of state welfare support for the citizens and state support for *the* economic system

by virtually underwriting the cost of reproduction of labour.

This account corresponds with two of the three roles that states perform as a means of containing and regulating the conflicts inherent in capitalism (O'Connor, 1973; Clark and Dear, 1984; Johnston, 1989). One of these two roles is that "the state must secure the conditions of production through the provision of a coordinated infrastructure within which production and exchange can take place... Its role is thus to guarantee the conditions for profit making..." (Johnston 1989: 295). However, the state cannot guarantee even geographical distribution of the conditions for profit making. Rather, it tends to provide these conditions more in response to the needs of capital than to the needs and welfare of the general public, usually as part of regional policy "directed at improvements in the regional conditions of production through investment in infrastructure and social overhead capital..." (Johnston, *et al*, 1994). Peet (1979) puts it rather strongly when he observes that regional policy "is one more way of using public money to enhance the profit-making potential of private industry." It is, therefore, argued in the literature that since the conditions for profit making are unevenly distributed in space, and since the state contributes to bringing these conditions about through the provision of social overhead capital, the state is implicated in the production of spatial disparities in social and economic infrastructure.

The other corresponding role is that the state must ensure social integration by ensuring the basic welfare of all, especially that of the exploited groups within society (e.g. labour) who gain least from it and who are therefore most likely to attack the system and harm (if not destroy) it. This role has led to the dramatic expansion of the public economy, especially in Western Europe, as governments have become drawn into the creation of welfare states (Knox and Ag«3W, 1991). The creation of welfare states has led to direct state provision or subsidy of the means of consumption and reproduction — education, health care, housing etc. It is important to note that although theoretically these roles are separable, empirically they are intertwined. For example, education and health care can help secure the conditions of production as well as ensure social integration. As Johnston (1989: 268) observes, a national health service and a free education system may both be presented as gains for the working class. But capital benefits too: it has a healthier and better-educated and, thus, potentially more productive labour force.

The role of local states in the scheme of things has received some attention in the literature. Two viewpoints are particularly apt. One of these is that the local state is an agent or arm of the central state, and that both the local and the central states act in response to the prevailing balance of class forces within society (Knox, 1987). The other is that the local state is a tool of the business elite. Either way, the functions of the

local state clearly indicate that it is the main provider of public goods and services. Saunders (1979) identifies three such functions. The first is the sustenance of private production and capital accumulation by, among other things, investing in "human capital". The second function is the reproduction of labour power through collective consumption, an activity in which the local state plays a dominant role. The third is the maintenance of order and social cohesion by providing welfare programmes and social services, among other things. These functions imply that the activities of local states in the sphere of consumption have implications for¹ the spatial pattern of the provision of public services.

The role of the state (both local and central) in the sphere of consumption has changed somewhat since the mid-1970s, particularly in the advanced capitalist countries (and more recently in the developing countries). This change has had a significant effect on the sphere of social reproduction. Since 1975, the annual growth rates of social expenditures have slowed significantly (Laws, 1989). This shift in expenditure patterns is an indication of the restructuring of the welfare state. Restructuring, in this context, involves a package of policy measures, including measures to promote the use of the private sector in the provision of welfare services, a process referred to as privatization. In the health care sector, privatization rarely entails the sale of entire health programmes to the private sector. Rather, it is more subtle and frequently includes reductions in government regulation, subsidy or provision (Scarpaci, 1991). It is widely agreed that privatization is not simply a shift from state to market provision, but involves many alterations to state intervention such as the expansion of privately provided medical care (Pinch 1989: 53-54).

The role of the state in collective consumption has been affected by the global economic crisis that has characterized the post-1975 period and which has made issues of profitability and economic efficiency important agenda items. As Johnston (1993) has it, by the 1970s and 1980s the welfare state structure was widely seen as a constraint to capitalist progress and a barrier to recovery from the contemporary economic recession. This global crisis has prompted some retrenchment and restructuring on the welfare state side of the public economy (Knox and Agnew, 1991). In Nigeria's health sector, this has witnessed some reductions in the sector's share of federal budget. From 1981 -1985, the average share of the federal budget allocated to the health sector was 3.4 per cent. And in spite of the absolute increase in allocations to the sector from 1986 -1992, the share during this period dropped to 2.2 per cent. In real terms, the drop is even higher, given the depreciation in the value of the Nigerian naira. For example, the real value of the 1990 - 92 allocation is less than 50 per cent of the corresponding level a decade earlier, despite the doubling of the entire budget over the same period. The contemporary

political economy of many states is now characterized by "the dialectical process of creating the welfare state, on the one hand, and implementing privatization, on the other...." (Scarpaci 1991: 1). But on the balance, the post-welfares era is characterized by the glorification of the market (Johnston, 1993). In the new dispensation, the social wage has been drastically reduced, thus, reflecting a redefinition of state responsibility for population welfare.

HEALTH CARE PROVISION IN NIGERIA

One of the legacies of Nigeria's colonial experience is the large-scale involvement of the Nigerian state in health care provision. In theory, state provision of health care was free for public servants and their family, and subsidized for the rest of the population. But in practice, the services are hardly ever free. Drugs and other medicaments are often in short supply and so patients (including public servants) at times buy them outside the hospital system at market rates. The involvement of the Nigerian state is indicative of a commitment to provide some degree of social protection for the general public even though, initially, this general public largely consisted of the expatriate population and a few Nigerians in the formal sector of the economy, along with their household members. Lucas (1980) notes that the colonial health services assigned priority to the health problems of the Europeans who served in the army, navy and civil services; the crucial issue being the survival of those who maintained a hold on the colonial territory. Since this privileged expatriate and Nigerian population was largely urban-based, it follows that most of health care facilities owned by the public sector were concentrated in the emerging urban centres, particularly those that performed administrative functions, and were, therefore, the abodes of the political and economic elite. There was thus a heavy concentration of services in the capital, Lagos (Lucas 1980).

This concentration is probably the genesis of urban-rural disparities in health care provision in Nigeria, and is quite consistent with the impact of colonialism on the evolution of space economies of most developing countries (Friedman, 1972), indeed, the urban-rural and regional disparities in health care provision are an important colonial legacy. In fact, like some other tropical African cities, Nigerian cities were enclaves and Outposts of the British state. The concentration of social services in urban centres was, therefore, beneficial to the economy of Britain, and not necessarily that of Nigeria. The urban centers were the links to the British economy, and indeed the colonial world economy. And the orientation of urban networks in the colonies was towards exploitation of hinterlands rather than an industry and service-based urban economy

(Knox and Agnew, 1991). In the final analysis, the concentration of public facilities in urban centres provided the infrastructural and welfare support that facilitated the exploitation of Nigeria's natural and human resources to the advantage of the British state and its economic interests. The welfare of the citizens was viewed largely in terms of economic advantages; and even now, the provision of health care and other social services in Nigeria is still partly inspired by economic consideration. For example, the National Rolling Plan for 1992-94, states that "government will continue to earmark substantial financial resources to the (health) sector to enhance the quality of human capital and thus improve national productivity and welfare" (Nigeria, 1992).

Beyond economics, the spatial pattern of the colonial health service also seems to reflect geographical patterns of power and influence. Nowhere is this more clearly illustrated than at the intra-urban scale. An important feature of the spatial structure of many Nigerian cities is the Government Reservation Area (G.R.A). This is especially the case with those cities that were either capitals or provincial headquarters in colonial times and had an expatriate population and a few Nigerian senior public servants. The GRAs were the abodes of the colonial elite, and the priority assigned to the health problems of Europeans by the colonial administration was given spatial expression in the location patterns of some of the earliest government hospitals in Nigeria. The hospitals were located in (or just outside) the Government Reservation Areas (GRAs). Warri, Benin City, Jos, and Ikeja are examples. In some cases, separate hospitals were built for Europeans in the GRAs as in Lagos (Lucas, 1980). This locational pattern, no doubt, conferred unequal advantages on different social classes in some Nigerian cities. Although additional government hospitals have been built in some of these cities, it is doubtful if disadvantaged groups and disadvantaged areas have received any significant benefits (Okafor, 1991). For instance, in Ibadan most of the five government-owned hospitals in the city are located in middle and upper class neighbourhoods. Jericho Nursing Home and Jericho Chest Clinic are located in Jericho Reservation, which is a GRA. A third hospital, Ring Road State Hospital, is located in a relatively new, low-density residential area (see Fig. 1). Although the extent to which the Ibadan situation is typical of Nigerian cities may be contentious, there is some evidence that some cities, especially those that were provincial capitals in colonial times had (and still have) the *big* government hospitals in or near the GRAs (Okafor, 1991). Jos, Warri and Ikeja are cases in point.

The regressive patterns of health care in Nigeria and the consequent inequitable geographical access to health care services have a fairly long history, dating from colonial times. It is partly a result of the role of the state which strays from a neutral position because dominant **or** class

interests tend to be favoured in the allocation and distribution of resources. The state reflects these power groups in deciding who gets what and where (Phillips, 1990). Rural deprivation in Nigeria is a manifestation of this tendency. The constraints of rural spatial structure notwithstanding, rural deprivation in the country is basically a function of the "powerlessness" of rural inhabitants. Otherwise, a situation in which "...more than 75 per cent of all available major health manpower and facilities in the country are still concentrated in the urban areas which account for about 30 per cent of the country's population" (Nigeria, 1990: 233) would be hard to rationalize.

It is important to note that there has been a policy shift in favour of primary health care (PHC) as part of Nigeria's macroeconomic adjustment programme. Since rural health care services are mainly of the PHC type, the logic is that rural areas will benefit from this new emphasis. However, from some of the evidence available, government expenditure on PHC remains substantially lower than expenditure on hospital services. For example, between 1986 and 1991 capital expenditure on PHC by the Federal Government averaged N35.6m per year as against N156.5m for hospital services (World Bank, 1994). Given the urban bias in the distribution of hospital facilities, it is doubtful if urban-rural disparities have changed significantly in favour of rural areas.

At the regional scale, the spatial pattern of provision seems to suggest that the significance of public services for the efficient and profitable functioning of the economy translates in practice into the concentration of services in economically advantaged areas. This phenomenon is not limited to privately-owned health care facilities, the location of which is governed by economic considerations. Regional variations in the availability of health care services is of some concern to the Nigerian government.

REGIONAL PATTERN OF PROVISION

Nigeria is a federal state with three tiers of government; and health care provision is a shared responsibility among all levels of government. In practice, however, the central government concentrates on tertiary health care, the state governments on secondary health care, and the local governments on primary health care. Most health care delivery systems worldwide have a three-tier hierarchical structure. At the top of the hierarchy are the tertiary facilities (e.g. teaching hospitals) which offer an intermediate level of health care services and refer the complicated or difficult cases to the tertiary facilities. At the bottom of the hierarchy are the primary health care facilities (eg, dispensaries, health posts, etc.) which handle common day-to-day problems and refer the more serious cases to the secondary tiers. Thus, tertiary, secondary and primary health care facilities offer

tertiary, secondary and primary health care services, respectively. Nigeria's federal system has implications for the impact of decentralization on the spatial structure of health care services, and on spatial development generally, given the leading role of both the central state and local states in health care provision. This is because resource bases and priorities vary across the federation's states and local governments.

The dominant role of the state in this regard is clearly evident from the very limited data available. For example, in what used to be Bendel State, approximately 87 per cent of the medical doctors worked in the public sector in the early 1980s. In fact, about 85 per cent of all medical and health personnel in the state were employed in government hospitals. At the national level, the ownership of health care facilities and beds also reveals this degree of state involvement in health care provision. Again, from the limited data available, approximately 81 per cent of all categories of health care facilities and 72 per cent of all health facility beds were owned by the public sector up till 1986. The central government, the state governments and the local governments respectively account for 16 per cent, 46 per cent and 10 per cent of the public sector beds, indicating the significance of local states in health care delivery. Because of its dominant role, the actual location decisions of the state (as opposed to stated location policies) are important in shaping the geographical pattern of health care facilities in Nigeria. The geographical pattern of facilities is a good indicator of the spatial outcome of location decisions.

The distribution of health facility beds in Nigeria is set out in Table 1. The table reveals one of the dichotomies in Nigeria's space economy some of which correspond with regional differences in economic development. Health care facility beds are concentrated in the southern zones (southeast and southwest) which account for about 63 per cent of all hospital beds but only 47 per cent of population. Approximately 55 percent of government beds and about 84 per cent of non-government beds are in the south. These data reveal varying levels of regional disparity in the distribution of health facility beds in the country. However, the disparity is far more pronounced for non-government beds than for government beds. The data also support the contention that the private market can exacerbate regional disparities in health care provision. In fact, the north-south dichotomy is due largely to the concentration of non-government beds in the southern zones.

The Gini Coefficient,² which is a good measure of overall equality or inequality of a distribution in a spatial system, was computed for each category of hospital beds. The indices are 20.5 for government beds, 44 for non-government beds, and 20.7 for all beds. These indices clearly reveal the comparatively high level of localization of non-government beds. But government beds are also localized in their geographical distribution

(even though to a lesser degree), indicating that the location decisions of the central state and local states are not necessarily equitable in their outcome. Indeed, of the three levels of government in Nigeria, the distribution of federal government beds is the most lopsided, with a coefficient 37 as against 20 for state government beds. The federal government beds are concentrated in Lagos State (17.9 per cent), Kaduna State (13.0 per cent), Oyo State (10.4 per cent) and Anambra State (9.6 per cent). These four states thus account for over half of all central government beds in the country.

Lagos metropolis (in Lagos State) is the nerve centre of Nigeria's economy and, until recently, was Nigeria's capital city. It is an important industrial, commercial and service centre. Kaduna in Kaduna State, Ibadan in Oyo State and Enugu in what used to be Anambra State were also important regional centres and second-tier capital cities when Nigeria was a federation of three regions — Northern Region, Western Region and Eastern Region. They were important administrative and commercial centres and have since remained so. The states of which they are capitals are also relatively important in manufacturing. The four states in question, namely Lagos, Kaduna, Oyo and Anambra, contain the largest teaching hospitals in the country, all of which are federal government-owned. If we add the oil-producing states of Edo, Delta and Rivers, it will be the case that six states (five of which are in the south) with a combined population of 34 per cent of Nigeria's total population account for 63 per cent of all federal government beds.

The existing regional differences in the availability of hospital beds and other health care resources (Okafor, 1987) generally reflect regional differences in economic development in Nigeria. Given the importance of considerations of profitability in the location decisions of private providers, a regressive impact of increased private sector involvement in health care delivery is the predictable outcome. The association between levels of health care provision and levels of economic development is born out by several studies. Using the size of internally generated revenue per state as an indicator of the level of economic activity and general level of development, it was found that internal state revenues are higher in states with sizeable urban population ($r = 0.62$) (Okafor, 1989). The size of tonally generated revenue depends on the level of economic development of the states because of the abundance of taxable assets and resources within the states. The same study further noted that the regional pattern of some health care resources is strongly associated with internal late revenue (doctors: $r = 0.93$; hospital beds: $r = 0.87$). Hence, internal state revenue and urbanization are particularly important in explaining the regional patterns of hospital facilities, especially doctors and hospital beds.

Fig 1:

Spatial Pattern of Hospitals and Residential Zones in Ibadan

Table 1:
Percentage Distribution of Health Facility Beds in Nigeria (1986)

<i>Regions States</i>	<i>Govt. Beds</i>	<i>Non-Govt. Beds</i>	<i>All Beds</i>	<i>Total Population</i>
S.E.				
Anambra	6.6	16.3	9.4	6.39
Cross River	4.2	13.6	6.9	6.15
Imo	4.4	12.4	6.7	6.88
Rivers	4.9	00.7	3.7	2.89
S.W.				
Bendel	8.4	10.9	9.1	4.32
Lagos	6.4	4.9	6.0	2.53
Ogun	5.7	5.4	5.6	3.16
Ondo	7.5	9.8	8.2	4.91
Oyo	6.2	8.7	6.9	9.33
N.W.				
Kaduna	8.8	3.0	7.1	7.20
Kwara	5.0	5.8	5.2	3.33
Niger	2.2	0.1	1.6	1.92
Sokoto	3.9	0.0	2.8	8.57
X.E.				
Bauchi	3.7	0.2	2.7	4.27
Benue	2.8	6.5	3.9	4.26
Borno	4.0	0.1	2.9	5.27
Gongola	4.3	0.2	3.2	4.65
Kano	5.5	4.3	4.3	10.42
Plateau	4.8	0.2	3.5	3.56
FCT	0.4	0.0	0.3	0.24,

Note: FCT = Federal Capital Territory

Source: Medical Statistics Division, Federal Ministry of Health, Lagos.

The importance of the national system of cities in public service provisions was emphasized by Mabogunje (1974:29), who observed that:

whether we think of welfare services or employment opportunities, the urban system in Nigeria today is already proving inadequate as a means of achieving the type of social order that the country desires. Instead of broadening the access of individuals to national resources, the position has become one of restriction through the concentration of facilities and opportunities... giving rise to social and territorial inequalities.

Regional variations in health care provision thus reflect to some degree regional variations in levels of urbanization and development because urban centres are the nerve centres of the economy. These variations therefore suggest that the state seems to operate in a manner that secures the conditions of production in advantaged areas.

In other words, health care services (as well as other public services) which contribute to the social wage seem to be concentrated in economically advantaged areas, despite territorial decentralization and state intervention. Based on a variety of development indicators, the southern zones are generally more developed than the northern zones (PAI, 1990). For example, between 1964 and 1989, the average shares of industries , (based on number of industrial establishments) were 22.5 per cent for the north and 77.5 per cent for the south. The regressive spatial pattern of health care provision' is by no means limited to Third World countries. As Scarpaci (1991: 17) observes, states intervention in Britain has, not been entirely successful in eradicating misdistribution problems as more powerful and culturally advantaged areas continue to attract personnel.

CONCLUSION AND DISCUSSION

Does the spatial structure of Nigeria's public environment make any sense, characterized as it is by spatial disparities despite state intervention? This question points up the central concern of this paper, and it is clear from our discussion that spatial disparities and the role of the state in their production seem to be consistent with the role and behaviour of the state under capitalism. These disparities in health care provision in Nigeria result from a combination of factors. These include colonial legacy and geographical differences in economic development. The latter factor mirrors spatial variations in levels of urbanization and internal state revenue, and suggests that some of the inequality is due to the fact that this level of spending is determined in part by local states, and that their budgets reflect variations in economic development For the central state,

the accent is clearly on the economically advanced areas. All of these seem to boil down to the fact that the level of health care provision by both the state and the private market seems to suggest that the political and economic systems work in concert to enhance the position of economically advanced areas. *The* association between the level of development and level of health care provision implies that the level of development attracts or enables state and private sector investment in an important social infrastructure; or conversely, that investment in social infrastructure attracts or enables development. Either way, the role of the state can hardly be one that ensures the basic welfare of all, given the spatial inequalities in the distribution of public sector health care facilities; a pattern that is also true of facilities owned by local states (Okafor, 1982). This being the case, the contention gains some credence that in providing infrastructure the Nigerian state is more concerned with securing the conditions of production.

It can be argued that the outcome of state intervention in the social sector is not, in fact, qualitatively different from that of the private sector, and that geographical maldistribution results from the actions of both the state and the private market. However, the retreat of the state and the ascendance of the private market will clearly exacerbate a maldistribution problem that is already in existence. This will be more so because health care services are currently not universally available — only about one-third of health care facilities are in rural areas which account for two-thirds of the country's population. In these circumstances, the retreat of the state can only make geographical patterns of provision a lot more regressive. Because the maldistribution problem also affects public sector facilities, the state in Nigeria, like states elsewhere, is implicated in the production and reproduction of the social (and other) dimensions of uneven development in the country. Thus, state intervention does not necessarily promote an equitable spatial order. This is in spite of the fact that the distribution of government hospital beds (with a Gini Coefficient of 20.5) is less inequitable than the distribution of non-government beds (with a coefficient of 44.0).

END-NOTES

1. It should be borne in mind that the provision of some services (e.g. defence was a common feature of some pre-industrial states).
2. The Gini Coefficient is defined as follows:

$$G = 1/2 \sum_{i=1}^n X_i - Y_i$$

Where X_i = the proportion of health facility beds in Nigeria located in state i ,

Y_i = the proportion of Nigeria's total population in state i .

The coefficient ranges from 0 to 100, the former indicating a perfectly equal distribution and the latter, maximum inequality in distribution.

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