

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

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ABSTRACT - Although the extent to which human capital, economic policies and physical infrastructure contribute towards economic development continues to generate intense debate in development studies, there is a consensus that the human capital and the factors (including health care) that it (human capital) plays very significant roles in achieving sustainable development including economic, social and environmental aspects. Sadly, health care quality, as one of the essential components of life quality of most urban centres in developing countries (DCs), remains largely unknown. This paper analyses healthcare (including health institutions and professionals) available in Calabar city in southeastern Nigeria. Despite the recent emphasis of Cross River State Government on developing the local-regional and global preferred tourism destination in Calabar city, for over a decade (since 1999 to the present) as frequently and fondly advertised in the global media, the policy of health care improvement, as well as other welfare programmes, have lagged behind the efforts to invite tourists into the city. To increase the attractiveness of the city for residents, tourists and investors, policy must incorporate health care improvement programmes into economic growth and development plans.

Keywords: developing countries, Calabar, Cross River State, tourism, health care

INTRODUCTION

This paper examines health care in Cross River State, south eastern Nigeria. It focuses on two major relationships in development studies: first, the relationship established between urbanization and economic growth and development concerning the belief that cities are instrumental to catalyze, as well as to benefit from economic growth and development (World Bank, 2009a). This view is resurgent in economic and urban geography. Resurgent because the belief those urban centres facilitate economic growth has a long history in urban studies: from William Petty's (1623-1687) fascination with the vigorous growth of London City during the 17th century to other researches of the 20th and 21st centuries that have reported findings and beliefs of this phenomenal linkage (World Bank, 2009a; Gantsho, 2008; Redfield, 1954; Redfield and Singer, 1954). However, the literature shows that this positive relationship between urbanization and economic growth has tended to be truer for the countries of the North, where urbanization has been associated with industrialization, economic growth, increases in jobs and other forms of prosperity. Despite the insistence of urban and economic geographers who convinced policy makers to undertake deliberate urbanization (creation of new cities) in some DCs (e.g. Nigeria) by arguing that cities provide the best platforms for creating social order, providing goods and services including welfare (education, health care, recreation, ICTs, etc.), and facilitating modernization of the population (Mabogunje, 1974), the capacity of urban centres in

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most DCs to fulfil the role of satisfying the welfare needs of its residents, tourists, and investors has been compromised.

The urban studies literature is replete with reports demonstrating that the developing countries (DCs) have been characterized by the urbanization of poverty or association between poverty and most of the region's urban areas (Ravallion, Chen, and Sangraula, 2007; Ravallion, 2002). The rapid urbanization in developing countries has been attributed to their experience of rapid demographic and epidemiological transition. These are social processes involving expansion in human population of societies due to declining death rates and increasing birth rates as a result of the increasing use of advanced medical and health care technologies. Second, another relationship has been established between population, improvement in health care, nutrition and economic development in all regions. Health care improvement programmes are promoted for the several benefits they create for the society, be it a country or a city.

Rather than covering all aspects of the foregoing relationships, this paper is concerned with the relationship between population and health care standard (or improvement) in Cross River State. This focus was determined by the rapid growth of the population and urbanization in Cross River State arising from recent implementation of tourism development policies as a means of driving economic growth in the region that has been described as "economically backward" (Omuta and Onokerhoraye, 1986).

Health Care as a Human Capital Development Factor

Despite the way the Washington Consensus and its protagonists in the international financial institutions (IFIs) such as the World Bank Group, International Monetary Fund and so forth coerced developing countries into abandoning health care (and other welfare programmes) as drains on the economy, the value of health care as a factor in developing human capital has been acknowledged. Paradoxically, economists at the World Bank, Warren C. Baum and Tolbert M. Stokes (1985, pp. 213-214), are among those who acknowledged the relationship among population dynamics, health, nutrition and economic development. The affliction of large populations running into millions of people, especially in developing countries, by poverty and poor life quality has been attributed to the development challenges posed by rapid and nearly uncontrolled population growth that swells the existing large population base.

Three reasons have been put forward to explain how economic and social development is hampered by rapid population growth. First, high rhythms of population growth increases demands for scarce goods and services required by people in the present and future, thereby posing difficulties for decision makers responsible for improving people's life quality. The task of increasing the stock of goods and services for the population includes providing more physical and human capital per person for the existing population and those being added to it. Human capital development includes per capita improvements on educational attainment, health status and production skills. Without improvements on the three aspects of a person's life, stagnation or decline in personal productivity and income occurs as a result of the compulsive way individual workers to resort to the use of improper equipment and poor skills at the workplace. Therefore, modern economic planning places high premium on increasing the number of highly skilled workers or at least maintaining the existing level of productivity without incurring a decline. Life quality improvement is impossible or difficult to increasing the stock of human and physical capital per person. Ruefully, most developing countries have been experiencing rapid population growth to the extent that doubling or tripling of their populations have either reportedly occurred or projected to occur within the near future, thereby impeding the achievement of increased human and physical capital and by extension life quality improvement.

Second, several natural resource-dependent agrarian economies have recorded rapid population growth leading to increased pressure on the existing stock of natural resources. Low levels of scientific knowledge and technological know-how is responsible for the natural resource dependence and resort of the teeming population to agricultural employment, which in turn is frequently based on poor farming and production systems that result in low yields. Unlike the

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

advanced capitalist economies which have achieved and used scientific and technological progress for application in industrial manufacturing and to create vibrant tertiary and quaternary economic sectors, developing countries remain entrapped in low-yielding primary agriculture. Consequently, exploding populations of natural resource-dependent developing countries suffer low or declining incomes and life quality. It is projected that the dominance of the labour force by agriculture employment to the tune of about 70 percent will persist in some developing countries (e.g. Kenya) until about 2025.

Moreover, natural resource-dependence of poor agriculture communities drives large populations into areas that pose risks of health, accidents, natural and human disasters. Wetlands, coastal areas, river banks and deltas have been reported to attract large populations of poor people who seek to exploit natural resources existing in areas that either hold large quantities of water or are water-saturated. Yet, such wetlands are prone to annual floods which increase the risk of spreading lethal water-borne diseases.

Third, rapid population growth is considered as a challenge to the promotion of economic and social change management because of the way it makes harder and more difficult the processes of adjustment than they would have been under conditions of stable population. Developing countries have been reported to be experiencing rapid urbanization without increased industrialization, employment and opportunities for improved well-being that were associated with urbanization of the advanced (Western capitalist) nations. The urbanization of poverty in developing countries, resulting from rapid population growth, has been accompanied by large clusters of urban poor, congregating in sectors of urban areas that lack basic services (safe water, improved sanitation, roads, modern electricity, acceptable housing, and so forth) (Ravallion, 2007).

Poor health and malnutrition hampers economic and social development in several ways. Some of the several challenges posed to development by illness and malnutrition include reduction of workers' productivity, retardation of learning, and mental development in educational institutions and workplaces, diversion of resources from public and private entities and from other productive ventures towards health spending and reduction of the efficient use of other resources such as land. Research-derived results on these factors and three ways that rapid population growth hampers economic development have been documented (e.g. Baum and Tolbert, 1985, pp. 213-214). In recognition of the significant role played by health and nutrition in improving the human capital of population, the eight Millennium Development Goals (MDGs) that were declared by member countries of the United Nations in 2000 devoted about three of these goals (G) to health (G4: reduce child mortality; G5: improve maternal health; and G6: combat HIV/AIDS, malaria and other diseases), while nutrition was captured under G1 (eradicate extreme poverty and hunger). These four goals are also related to the rest of the MDGs which mostly concentrate on human capital development including G2: achieve universal primary education; G3: promote gender equality and empower women, while G7: ensure environmental sustainability and G8: develop a global partnership for development; all of which provide basic support for development (United Nations, 2007 in Ingwe et al, 2010). Why have cities of the South (DCs) failed to generate the economic and social benefits that have been associated with cities of the North (advanced countries)? To what extent is health care deficiency in DCs' cities contributed to the failure of urban centres to contribute towards social and economic growth and development?

The Problematic Welfare Provision Was Accepted as a Basic Responsibility of Nigeria's Governments since the 1980s

Despite the acknowledgement that welfare provision (including health-care) is a traditional and basic responsibility of the city and improves its attractiveness to residents, tourists and investors (Berg, 2001; Mabogunje, 1974), the recent and ongoing commitment of the Cross River State to tourism development as a means of economic sector diversification away from declining and unstable revenue derived from export of hydrocarbons, managed and allocated by the Federal Government of Nigeria as "pooled resources", there is yet to be a sound understanding of the fundamental issues that facilitate the attraction of tourists and private sector investors to Calabar city. Health care has been recognized as one of the key sectors of human capital development under social welfare policies that

have been implemented by neoliberal capitalist nations such as Britain (UK), the USA, etc. as well as in Scandinavian nations, which are reputed for operating better or superior federal systems and social welfare economies (Harvey, 1979; Raveaud, 2009). Ruefully, in Nigeria, like most DCs, health care has been one of the social welfare and human capital development programmes that suffered enormous neglect under the structural adjustment programmes (SAP) of neoliberal capitalist policies that emphasized reduced spending on health, education, etc, promoted and ruthlessly enforced under the Washington Consensus championed by the International Financial Institutions (IFIs), including the World Bank Group, International Monetary Fund (IMF) and their partners within the past over 30 years since 1979 or thereabout (Adams, 1991; Ingwe et al., 2009; Makanjuola, 2002; Fashina, 2002, etc). Owing to the legacies of neoliberal capitalism, especially the way it has concentrated the powers of arranging external loans from the IFIs in the central government tier to the exclusion of governments of cities and municipalities and local governments that should be responsible for sustainable urban development, the roles and responsibilities of DCs' cities for improving health care has remained poorly understood and neglected. Some of the gross inadequacies of cities in DCs, including Calabar, manifest in the form of availability and use of information and knowledge about the status of health care in the city and the role of health care in contributing towards increasing the attractiveness of the city for managing socioeconomic development. Although academic research on welfare provision in Nigerian cities acknowledges the significance of health care as one of the welfare packages that cities must provide, attention has been concentrated on the provision of education and employment within industrial cities, while the spatial scale of analysis was the national system of cities (Mabogunje, 1974). The way health care is perceived and provided within a single city with distinctive political, economic and socio-cultural characteristics has rarely been undertaken.

Organization of this Article

The rest of this paper is organized in sections. The next section presents the context for health care (inadequacy of health facilities) in Nigeria before describing the socio-economic characteristics and environmental conditions of the study areas involving the relation between the geographic and socio-economic setting of health care in the budding tourism of Calabar City and the infrastructure and service development components of the region. Then, we will frame the discussion on theoretical-conceptual perspectives of welfarism - welfare state regimes, neoliberalism, Structural Adjustment Programmes/Policy and Welfarism in Developing Countries (DCs), urban attractiveness, tourism and sustainable development. We will explain the desirability of creating social order in urban communities through welfare improvement and follow on by justifying the suitability for using the method of description and secondary data from official sources - Cross River State Government's State Planning Commission, an agency responsible for planning/managing development in the State, including two cycles of the State's/region's Economic Empowerment and Development Strategy (CR-SEEDS), comprising the first CR-SEEDS (I) 2005-2007, and, the second CR-SEEDS II (2009-2012). The next section will include our findings on the geodemographic analysis of health in the case study areas of Calabar City and some of Cross River State, and show how gross inadequacy of health professionals and health facilities leads to increasing pressure of the region's population on limited health care resources of the region. The paper will be concluded by highlighting the policy implications of the findings.

The Context for Health Care in Nigeria

Nigeria has a rapidly growing population, rising from 55.6 million people in 1963 to over 161 million in 2011 – according to the projections of the 2006 National Population Commission census (BusinessDay, 2011; National Population Commission, 1990; Nigeria, 2007). The country's 2006 population, of nearly 20% of Sub-Saharan Africa's total population in 2005 (World Resources Institute - WRI, UNDP, UNEP and World Bank, 2005), projected to have risen to over 151.3 million people in 2009 (World Bank, 2009a), makes it retain the existing position as Africa's most populous country. With an area of 909,890 square kilometres, Nigeria is one of Africa's largest countries (Nigeria, 2006). Nigeria has large proven deposits of fossil fuels including, in million metric tonnes of

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

oil equivalent (mtoe), oil, 4635; natural gas, 4497 (WRI, UNDP, UNEP and World Bank, 2005) and coal, about four billion toe (Adekeye, 2008). Irrespective of its reputation for earning huge revenue from being one of the world's leading exporters of oil since the 1970s (and more recently one of the leading exporters of natural gas), the corruption and the stealing of public funds by the elite has made the country present one of the highest levels of poverty worldwide (Adams, 1991; Ribadu Omojola, 2007). Based on surveys undertaken in the late 1990s, about 70% to 90.8 percent of Nigeria's population was classified as poor, unable to earn and spend US\$1 per day and US\$2 per day (WRI, UNDP, UNEP and World Bank, 2005). Although Nigeria had the second largest total gross domestic product in Sub-Saharan Africa in 2002, the country was one of those with the least (37th position overall) per capita government spending on health care in this rather poor region. While South Africa's government per capita spending of US \$270 on health care was the largest (i.e. corresponding to its first position according to the size of its total and per capita GDPs), Nigeria's performance on this human capital building activity was surpassed by Botswana and about 35 other Sub-Saharan African nations. The consequences of these low spending on health care was betrayed by the poor health indicators of the Nigerians. The "life expectancy at birth" was: 48.1 and 51.5 years for the five-year periods between 1980-1985 and 2000-2005 (WRI, UNDP, UNEP and World Bank, 2001-2005).

Nigeria's urban population (i.e. the proportion, in percent, of the total population living in cities) has been increasing rapidly. In 1963, when there were 181 urban centres in Nigeria, the total urban population was 19.1 percent. Previously, the urban population (in percent of the total population) increased as follows: 7.2 (1921 and 1931) and 10.6 (1952). The number of urban centres in Nigeria (restrictively defined based on population census statistics and excluding other criteria in the absence of a national urban policy) has increased steadily over the years from 29 (1921), 27 (1931), 56 (1952), 180 (1963). The nation's urban populations in cities with a population of at least 20,000 people were: 1,345,000 (1921), 1,431,000 (1931), 3,237,000 (1952) (Mabogunje 1974, p. 16, citing statistical Digest of Nigeria's 12 states in 1970, and Mabogunje, 1972). From this modest level it rose to 35 percent in 1990, to 44 percent in 2000, and is approaching 50 percent (World Bank, 2009b). As Nigeria's urban population approaches the 50 percent mark, it might constitute a high proportion of about 10% of the total urban population of Sub-Saharan Africa. High proportions (79%) of people living in Nigeria's cities are in slums. In 2002, the urban population, i.e. the proportion, in percent, of the total population living in cities with a population of over 100,000 people was 35 percent, while those in cities with a population of over one million people (2002) was 18 percent (WRI, UNDP, UNEP and World Bank, 2005, p. 217).

The number of physicians per 100,000 inhabitants was only 27 in Nigeria between 1995 and 2003 (compared to a regional average of 516 and 348 physicians per 100,000 people in North America and Europe). The weight of the population using improved water source in 2002 was 49 percent for rural areas and 72 percent for urban areas. The weight of the population using improved sanitation in 2002 was 30 percent for rural areas and 48 percent for urban areas. The percentage of adults aged 15-49 years living with HIV or AIDS in 2003 was 5.4 %, representing a change since the 2001 value of 6.5%. The percentage rate of use of anti-retroviral therapy (ART) between 2002 and 2003 was 1.5, while the incidence rate of tuberculosis per 100,000 inhabitants in 2002 was 304 (WRI, UNDP, UNEP and World Bank, 2005). Considering the rather poor health care indicators presented above, additional funding has been sought from other sources to improve health care in the country.

Inadequacy of Health Facilities in Nigeria

About 70-90 percent of poor Nigerians resort to rely on and contest for the use of a low number of available health facilities. In 2004, the entire country had a total number of 13,951 publicly owned health facilities. Out of this total, the various types were 13,703 primary health centres (PHC), 845 secondary, 59 tertiary. In the same year (2004), Nigeria had a total of 9,029 privately owned health facilities: 6575 PHCs, 2458 secondary and one tertiary (National Bureau of Statistics, NBS 2006, p. 90). The specializations of health facilities in Nigeria in various fields of medicine and health care were as follows: 571 general, one pediatric, 3356 maternities, 47 infectious diseases, four

orthopaedic, 16 neuro-psychiatric, 11 tuberculosis, and 10 ophthalmic (National Bureau of Statistics 2006, p. 91).

The high level of unemployment in urban Nigeria has reportedly been prolonged and has been ignored since Nigeria's independence in 1960, half a century ago. The literature shows that the problem was observed in the late 1960s, when management problems of rapid urbanisation in Nigeria attracted the attention of policy makers (Adedeji and Rowland, 1973, pp. vii-ix). Unemployment and underemployment have increased since then up to the present (Ingwe, 2009). This indicates that this (and related) problems revolve around the failure of public economic planners to harness the country's greatest assets for development, which is human power arising from its large youthful population (Ayida and Onitiri, 1971). More recent reports indicate that increasing unemployment of the youth in urban Nigeria has resulted in the victims resort to crime, violence and social vices (e.g. prostitution). The problem has been described as increasing and uncontrolled by the public and private sectors of the economy. The intensification of unemployment is attributed to the obsolescence of Nigeria's private sector, while the informal sector has become the resort of the embattled youth (Borges, Adubra, Medupin and Okunola, 2003). Yet, the informal sector has suffered due to the way public agencies declare it "illegal" and criminalize those involved in it.

Relating the Geographic and Socio-Economic Setting to Health Care in Calabar City, Nigeria

Calabar urban region officially covers an area of 472.704 square kilometres comprising two Local Government Areas: Calabar Municipality (194.274 square kilometres) and Calabar South (278.430 square kilometres). Nigeria's 2006 census reported the population of the city region to be a total of 371,022 comprising Calabar Municipality (179,392) and Calabar South (191,630) (Nigeria, 2007). Calabar City has a long and reputable history in Nigeria's political life. The sea route and natural seaport potentials of Calabar were instrumental to the movement of European slave traders to establish a slave depot in Calabar during the era of trans-Atlantic slave trade. These facilities also encouraged trade in other commodities such as oil palm, etc. between the Europeans and the Calabar (Efik) people. Calabar has served as an administrative capital for the following political entities: Southern Nigeria Protectorate and by extension for Nigeria as a nation before the capital was moved to Lagos, then, South Eastern State, and currently Cross River State.

The New Tourism Character of Calabar City, Infrastructural and Services Development

The current operation of Calabar urban region extends beyond the aforementioned official limits of the city into neighbouring areas. Since 1999, the Cross River State Government has been developing a tourism economy that exhibits considerable operations in Calabar City. Recent state government policy of developing a national and international tourism destination in Cross River State has been focused on expanding the tourism facilities and capabilities of the city. TINAPA –an elite tourism project advertised as Africa's premier business and leisure resort is located immediately North of Calabar City, in Odukpani Local Government Area, and has become the regular host of national and international socioeconomic and political events such as retreats for the South: South Governors Forums among other politicians, sports people and musical awards. Apart from the Cultural Centres and other recreational areas, Calabar City hosts two of Cross River State's three most important tourist sites advertised by government, including the Marina Resort (a beach recreational area), Tinapa and the Obudu Ranch Resort plateau, located in the environs of the city (State Planning Commission of the Cross River State Government, 2009, p. 21; Esia and Ayara, 2012). Moreover, since its commissioning in April 2007, conference facilities in Tinapa (hotel, halls, etc.) have been hosting several times the Calabar Christmas Carnival, an annual festival that, for nearly a decade, since 2000, has become a regular socio-cultural assembly of tourists and business people from around the world to what is described as "world largest street party" in Calabar City. It was reputed to have attracted several thousands of participants in 2007. According to the Tribune (2012): Cross River State's Governor, "Imoke kicks off (the 2012 version of the) "Carnival Calabar Dry Run". As a means of facilitating the movement of tourists around the numerous sites in Cross River State such as the Obudu

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

Plateau Ranch Resort, Calabar City is accessible through the Margaret Ekpo airport which was recently complemented with a smaller airport (Bebi airstrip) for linking air travellers (tourists and business people) to the towns and tourism sites in northern and central parts of the state. Akpabuyo, another Local Government Area which shares borders with Calabar City has been experiencing vigorous urbanization due to the increasing tourism and increase in the visibility of Calabar and Cross River State's tourism activities. The tourism development policy focused on expenditure of public resources to improve urban environmental sanitation and security above the levels of rival 35 states and Federal Capital Territory of Nigeria has been successful in attracting large numbers of people from outside the city, region and country to Calabar and the state (Cross River State Government, 2009).

The city's stadium comprising a football arena with a carrying capacity of about 40,000, located within the city, has been a host of international, national, regional and local sports tourism events. Some of the notable events hosted in the city include the 1999 Junior World Football Cup and the more recent Junior World Football Cup, from October to November 2009.

Socio-economic and Environmental Characteristics/Conditions

Calabar seaport remains one of Nigeria's most important transportation facilities. This made it an easy choice for the nation's premier export processing and free trade zone (Cross River State Government, 2009, p. 9). It is regarded as a strategic location for linking Nigeria's eastern coast with the rest of the interior regions in the eastern and northern Nigeria. The Calabar (Margaret Ekpo) international airport is linked to a smaller airport-strip in Bebi, within Calabar city's environs, to enable tourists to rapidly access the Obudu (Cattle) Ranch Resort - the temperate-type climate region resort located at a plateau at an altitude higher than the surrounding region equipped with electronically operated cable cars for transporting tourists, thereby avoiding frightening road travel through numerous meanders including the notorious "devil elbow" (Cross River State Government, 2009).

The vegetation of non-urbanised parts of Calabar and environs is mangrove swamp forests. The climatic conditions of Calabar make it highly vulnerable to climate change impacts. For example, the region experiences high rainfall: annual mean of 3424.8 mm in 1997 and 3218.8 mm in 2006, and annual mean maximum temperature of 32.0 °C in 1997 and 34.1 °C in 1998 (Nigeria, 2006, pp. 4, 5), which indicate that extreme climate events such as flooding and heat are possible in the city. Owing to the administrative capital status of Calabar City, it hosts a large proportion of the 20,000 public servants population of the state (Cross River State Government, 2009). A large proportion of the rest of the city population is employed in agriculture, commerce, IT, among other sectors.

The level of availability of urban healthcare in one of Nigeria's most enterprising cities deserves examination for several reasons. Calabar City has most recently been developed to become West Africa's and Nigeria's most preferred tourist destinations under the Cross River State's tourism sector development programme. What strategies could be formulated and promoted by policy makers responsible for sustainable urban and regional development in DCs characterized by the urbanization of poverty, and also interested in promoting tourism sector as a means of diversifying the economy away from monoculturalism? The Cross River State Government, which undertook tourism sector development since 2000 involving investment of public funds, acknowledges that up till 2009, the tourism sector of the region that has been concentrated in Calabar City was yet to receive serious partnership from the private sector (Cross River State Government, 2009).

WELFARE, URBAN ATTRACTIVENESS, TOURISM AND SUSTAINABLE DEVELOPMENT: A CONCEPTUAL FRAMEWORK

Under the context of an increasingly competitive global economy and increasingly democratizing polities, both the residents of the city and the tourists expect and demand for improved welfare. Competitiveness involves exceeding the levels of social welfare obtained in other cities by increasing the attractiveness, increasing the stock of social welfare services (health care, education, tourism sites, cultural resources, etc.) of the city for residents, tourists and companies beyond the

levels offered by rival cities (Berg, 2001, p. 98). However, the extent to which a city provides social welfare has historically depended on the overall national political, economic and social characteristics or the kind of policies formulated by national governments. Therefore, examination of the concept of welfarism (welfare state) offers a means of facilitating the discussion of the city and the degree of health care (and other welfare goods and services and human capital development).

Welfarism and Welfare State

The concept of welfarism or welfare state which has received the attention of scholars, including Mick Carpenter (McClellan and McMillan, 2003) and Obasi Igwe (2005), describes an ideology that represents the middle position between the extremes of two of the most popular and diametrically opposite postulations on the most appropriate systems for effectively organizing economic, political and social institutions of nations in the bid to provide the highest level of welfare within countries, namely: capitalism and socialism.

Capitalism is the system that was espoused by Adam Smith (1776) and his Glasgow papers, urged nations to allow individuals to pursue their own selfish goals (the quest for profit in the economic transactions, i.e. exchange of goods and services) with other people because this creates advantages, namely satisfaction of the goals of the entire society and its individual members. The adoption of this capitalist system called the free laissez faire market enterprise, which argues that such as a system creates wealth by some countries (e.g. the USA, the UK, Japan, and so forth) is believed to have resulted in the achievement of enormous wealth in these countries usually described as advanced capitalist countries of the North.

In contrast, socialism is a rival ideology that espouses the benefits of state control of the institutions connected with the economy, polity and society and limits ownership of property by individuals and discourages unbridled pursuit of profit which is achieved through the exploitation of the working class (surplus value). This system emerged through the works of Karl Marx (1867), and the earlier publication (1848) by Marx and his colleague, Frederick Engels. These works influenced the creation of socialist countries in Eastern Europe (especially the former USSR, and neighbouring countries, China and other places), where significant successes were achieved in the establishment of socialist structures, institutions, processes, and attitudes through adaptations of the ideas of Marx and his followers before the collapse of most of these countries in the late 1980s.

Despite the theoretical finesse of the two major ideologies (capitalism and socialism), it has been observed that their operationalisation in numerous countries has revealed that neither have they been implemented as fully as they were formulated or postulated nor have the benefits promised by their formulators (delivery of the desired high standards of welfare for citizens) been fully realized. Rather, it has been profusely documented that both capitalist and socialist countries exhibit features that are strange and deviate from their original prescriptions and do not conform to the conditions described by theorists; undesirable consequences of the ideologies have been found in both economic and political systems. This undesirable situation led to the quest for better alternatives which could create policies that are capable of yielding higher social welfare.

Pioneering work in designing an alternative to capitalism and socialism was undertaken by John Maynard Keynes, resulting in the publication of his advocacy for government intervention to use its power to create jobs, and catalyse increased production of goods and services in his well received book in 1936 (Igwe, 2005). This might have encouraged the production of the Beveridge Report in 1942, proposing that wide idea encompassing the United Kingdom's political and economic systems in order to improve the welfare of citizens to be implemented after achieving victory in the Second World War. Some factors that strengthened the implementation of welfarism include: the 1944 White Paper that enshrined welfarism as a government policy priority and the Butler Act, which extended welfarism to include universal secondary education. The perception of Britain's electorate of the Labour Party as possessing the characteristics required for adopting the Beveridge Report caused it to win the 1945 elections. After its electoral success, the Labour government embarked on enactments to found and guaranteed the implementation of welfarist policies for the enjoyment of their benefits (mainly full employment) by citizens. This includes two enactments, namely the National Insurance

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

Act and the National Health Service Act (1946), which enabled citizens to enjoy free health service at the point of use, followed rapidly by the National Assistance Act (1948) and the launching of a more ambitious policy of building a million homes shortly afterwards. The Times editorial is quoted as describing these ambitious and wide ranging welfarist programmes as creating “security from the cradle to the grave for every citizen”.

Two major arguments formed the guiding philosophy of these policies. The first was that shortages of the welfarist goods and services were the result of systemic problems neither the fault of nor the responsibilities of the individual. Second, the adverse consequences of the inadequacies of the goods and services were detrimental to the maintenance of the integrity and achievement of the goals of the society. Although Britain pioneered the implementation of welfarism, the intensity of this ideology or policy has declined in the country since its inauguration in the mid 1949s due to some factors including the opposition to Keynesianism by neoclassical or mainstream economists led by Frederick A. Hayek; arising from the foregoing, the emergence of extremists of neoliberal capitalism, thereby increasing the existing variation in the perception of political, economic and policy issues, and directions and beliefs within Britain’s two major political parties (Labour and Conservatives), policy changes that have accompanied regime changes (and political parties), inadequacy of resources to satisfy the increasing pressure exerted on the government by citizens demanding for improved welfare standard beyond the existing level. The emergence of Thatcherism describing the economic, political and social policies associated with the ascension to the British Prime Ministership of Margaret Thatcher in 1979 to rule for two terms characterized by the rise to dominance of neoliberal extremism, which led to the valorisation of neoliberalism globally, as was exemplified by the collaboration between the governments of Thatcher and President Ronald Reagan in the USA - another bastion and pioneer of neoliberal globalization from 1979 onwards (Hurrell and Laura-Gomez, 2003). While the foregoing concepts elucidate on the social welfare history in the USA and Britain, the social welfare scenarios in various countries remain poorly understood and unclear.

Welfare State Regimes

The combined influences of the works of the Austrian economist F.A. Hayek, which fuelled opposition to Keynesianism, the groundwork of the US Governments in collaboration with its academics and economic policy teams since Jimmy Carter’s regime, subsequently complemented by the neoliberal extremism of Thatcherism in Britain, culminated in the rise of neoliberal capitalism to global dominance in 1979 and thereafter led to the collapse of the socialist states (former USSR, Eastern Germany, and so forth) in the late 1980s. The collapse of the USSR and its socialist partners facilitated the penetration of neoliberalism globally to the point that it has been acknowledged that neoliberalism is believed to have become globalised and even adopted, with enormous profit, in combination with socialist features and characteristics in socialist states such as China (Bayer, 2009; Sum, 2009). Consequently, since the emergence of Keynesianism (welfarism) and the earlier observation that neither capitalism nor socialism has been fully implemented in any country of the world, it has been acknowledged that policies of most, if not all countries, exhibit features that combine capitalism and socialism of varying intensity of welfarism. Mick Carpenter draws from G. Esping-Anderson’s formulation of a schema for facilitating the mapping the type of welfare state regime based on the intensity and type of welfarism being practiced in various countries. Three major types of welfare state regimes include: conservative, social democratic, and liberal.

The conservative welfare state regime is characterized by high welfare provision under the context of hierarchical and ordered society as in Germany. The social democratic regime exhibits characteristics of egalitarianism (equality of individuals in terms of their rights, status in the face and “eyes” of the law, opportunities available to citizens, etc). Sweden and some Scandinavian nations present approximate features of social democratic welfare states. Liberal welfare state regimes are characterized by limited provision of welfare. Under this system, welfare provision is selectively and seasonally undertaken only as a means of mitigating problems and conflicts arising from gross inadequacies and acute inequalities in welfare between and among regions. Typical examples of such states include the USA and Britain (Carpenter, 2003). Guilles Raveaud recently showed how health

care in the Scandinavian countries has been ranked higher than the level in the USA (2009). While the foregoing concepts and classifications elucidate on the type of welfarism in advanced countries, they fail to account for the scenarios of welfarism in developing countries.

Neoliberalism, Structural Adjustment Programmes and Welfarism in Developing Countries

Since the global financial meltdown which rapidly degenerated into an economic recession from 2007 to 2008, neoliberalism has been more sharply defined by authors. It is the era of the hegemony of liberal market capitalism of the global economy, involving an all-encompassing transformation of the social, political, and economic sectors using social and political forces. It involves policies designed by the Bretton Woods Institutions (BWIs) with support from the US Government, which has been at the forefront of promoting privatization of public enterprises, deregulation and liberalization of financial markets (especially the Wall Street in the USA), trade policies that have created favourable socio-economic conditions in the North but deterioration of economic, social, and environmental conditions in countries and regions of the South. It is an anthropocentric policy due to its emphasis on growth and disregard for the environment and ecosystem. Contradictorily, it retains asocial characteristics by also disregarding employment for society's improvement while promoting profit for the capitalist elite (i.e. restrictive anthropocentrism). Although its origin (i.e. succession of the previous liberalism) has been traced to 1945, neoliberalism attained prominence in the 1970s when its protagonists pushed it to replace the existing Keynesianism, an economic system that placed premium on the need for nations to maintain good employment and other social levels while pursuing economic goals and objectives.

Neoliberalism reached its lowest point in August 2008 with the global financial meltdown and global economic recession (Altvater, 2009). The era of neoliberalism is one that succeeded the previous era of liberalism, which started in 1789 and collapsed in 1914 due to its degeneration into barbarity, attempts at global political domination of its ideas and other intolerable socio-economic problems associated with it such as violence and spectacular paradoxes and contradictions (Brie, 2009, p. 16), oppression, suppression and exclusion of people, social products (e.g. capital) systems and values, involving vigorous valorization of capital (Altvater, 2009; Cecena, 2009). The elite who created, developed and propagated or globalised neoliberalism have been concentrated in the USA, comprising a small group of neoliberals, who have circulated in the project of advancing the self-interest of the US Government in commanding or leading the global economy including the New York-based US Federal Reserve (FED), private consulting, university teaching since the 1970s up to the present. The current US Government under President Obama remains stuck to the pursuit of neoliberalism despite the damage it has inflicted on developing economies. Most of the economic advisors and top functionaries who were appointed to serve the US President Barack Obama during his inauguration in January 2009 have been ardent neoliberalistic individuals who have circulated within these institutions and active in the US hegemony of the global free-market capitalist system since the 1970s (Bond, 2009). Owing to the multiple failure of their project to maintain the hegemony of the US on the global economy and the series of crises that have occurred since the creation of the project, they have been supported by the top functionaries of the US Government and its allies (Britain, etc) to wage wars and military incursions into foreign national territories (Iraq, Afghanistan, etc). Neoliberalism characterization by capitalists' resort to waging wars as a means of accessing scarce resources of foreign countries (Brie, 2009) suggests that with oil being, the major driving force for the flourishing of neoliberal capitalism, the rapid depletion of oil resources (Altvater, 2009) and the way the US-led invasion and threats of invasion of oil-rich countries makes the projection of the persistence of mercenary capitalism (Cecena, 2009) persuasive and convincing. This mercenary capitalism poses a threat to Africa because of the intention of the US to establish a military base (Africom) on the continent and the nearly unanimous refusal of all African states approached except Liberia to host the headquarters which has remained in Stuttgart, Germany (Bond, 2009). Informal jobs have being increasingly promoted as a bottom-up neoliberalistic strategy and as a way of managing the crisis of unemployment arising from abdication of job creation as a responsibility of

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

globalised neoliberalism (Altvater, 2009). This represents a grossly inadequate response to the failure of neoliberalism, especially considering how micro-financing programmes funded by neoliberal IFIs and partners have been charging high interest rates, thereby exploiting the poor people of developing countries (Bond, 2009). Previously, Martin Khor (2001) showed how neoliberals claim that liberalized (open) trade beneficial to developing countries that have a comparative advantage in agriculture was subverted by the policies of advanced nations, involving massive subsidization of their agriculture sector, protectionism of some of the sectors, thereby rendering developing countries frustrated. Patricia Adams reported on the environmental and human degradation caused by mega-projects (oil, nuclear and large-hydro dams) funded through odious debt and structural adjustment policies from the IFIs under the auspices of thieving despots and dictators imposed on the people of the Third World states and assisted militarily and otherwise by advanced nations' governments and their institutions (Adams, 1991).

Neoliberalism has been used to describe two broad things: (i) different sets of market-liberal economic policies in both advanced and developing countries, and (ii) academic international relations. The market-liberal perspective of neoliberalism in advanced nations has been equated with Thatcherism and a rejection of Keynesianism. Owing to space constraints, we shall leave out details of the variants of neoliberalism as practiced in the North (Thatcherism and critiques of it), and developing countries' free-market-liberal notion of neoliberalism. Since these have already been described in the literature (e.g. see Ingwe et al., 2009, citing Hurrel and Gomez-Mera, 2005, p. 368; Brand and Sekler, 2009, pp. 5-6), we turn at this juncture towards elaborating the features of structural adjustment programme (SAP), a policy of the World Bank Group that has contributed enormously towards worsening the fortunes of health care and other welfarist and human capital development programmes in the Third World countries since the rise to dominance of neoliberalism.

Structural Adjustment Programme (SAP)

Although SAP has frequently been presented as one of several components of neoliberalism, its elaboration as a separate dogma highlights issues deserving representation here. It is a package of conditionalities associated with certain insidious characteristics, contrived by the IMF and its sponsors (western nations) for ensuring that its adopters in the developing countries remain perpetually entrapped in debt and a helpless state of payment the interest on loans, thereby subsidizing its originators. The debt crises that SAP is associated with owes its origin to the manipulation of IFIs similar to what the USA contrived through recycling of excess Middle East petrodollars as loans to developing countries after the crises of the 1970s. As soon as developing countries took the loans, the US financial institutions raised interest rates (the Volcker explosion) and made the loans un-repayable or difficult to be repaid by the borrowing states (Altvater, 2009). The IMF-entrapped most developing states through subtle and direct manipulations, persuasions of unpatriotic rulers (contrasted to leaders of developing countries), usually supported by western world neocolonialists to take the loans for adjusting the structures of developing economies by describing states that were yet to borrow as "under-borrowed" and re-stating huge benefits (without costs) accruable from SAP-related borrowing.

SAP is also associated with evil policies, so described because contrary to the initial claims of their formulators, they have almost always failed to yield benefits in every country it was implemented but caused worse problems. The transactions between the IMF and the borrower under SAP, after a loan was sought for and granted, were mostly non-transparent "round-tripping" of loans. Although entries are entered into creditor and borrower states' accounts, frequently no money is transferred. The IMF and their collaborators (rulers of their clientele states) encouraged use of the loans to fund importation of luxury goods and services (usually produced and sold by entities in the membership of the "IMF-family"), thereby creating serious balance of payment problems and increasing indebtedness or crisis for their recipient states. SAP discouraged government from investing in or subsidizing human capital development sectors such as education and healthcare, among others. It discourages governments they claim to be supporting from pursuing the programmes desired by their citizens including employment, security, production, and democracy, improved well-being of the population such as increase in purchasing power, freedom and so forth (Ingwe, 2005, pp. 427-429; Adams, 1991).

Developing economies have been devastated in two major phases: first, through neoliberalistic inducement to fund “development” liberalization of trade, finance capital, less government intervention, privatization and commercialization among others. On exhausting all existing IFIs’ credit, SAP loans are offered by the same IFIs to further indebtedness (Adams, 1991; Hurrell and Gomez-Mera, 2003).

Creating a Desirable Community with Social Order in the City

Some efforts have been invested into bringing the theories of capitalism, socialism and welfarism to bear on the city. One commendable work in this regard arose from the recognition of the failure of neoliberal capitalism to cause the achievement of the goals of providing adequate welfare and social order in the city generally and in particular under the context of rapid urbanization in developing countries. Nurudeen Alao advocated for the adoption of the “visible hand”, referring to deliberate planning of welfarist programmes in the city (“the optiville”, as he described it). To him, high welfare provision (perhaps, following the practices of those who engage in either high welfare provision, in a conservative welfare state regime, or practice it in an egalitarian way), are a *sine qua non* for the creation of desirable community life, thereby promoting social order and social justice within the city (1982).

METHODS AND DATA

We used the methods of geodemography, description and case study to highlight the social problem of inadequacy of health care in Calabar City, as well as techniques of survey to interpret data on various dimensions of health care over the possible temporal scale for which data was available. We preferred to use description because of the experience the researchers who applied the method have had in terms of the profitable results they obtained. The method is suitable and beneficial for this type of study for several reasons: for investigating the status of things (in this case, inadequacy of health care); highlighting the relationship between this subject matter and the aspiration to achieve sustainable urban development in the Calabar city and urban Nigeria; investigating and understanding urban health in Calabar, an issue which has been ignored by academic researchers. Owing to its capability of highlighting factors that underlie most societal conditions, thereby exposing clues and hunches from which hypotheses could be framed for conducting further studies on the same or related themes and topics, description is suitable for highlighting clues about factors underlying the issue of poor urban health in Calabar and urban Nigeria, both for the present study and for subsequent further studies, policies and actions. It facilitates the creation of hypotheses for further studies that might be amenable to the application of experimental research methods.

The case study method was the specific type of description used. Owing to the existence of thousands of urban centres in Nigeria, we had to apply the case study method which involved using purposive sampling to select Calabar City, as one of the numerous cities in Nigeria for detailed study, because it possesses characteristics that are representative of the population of urban centres in Nigeria. We used the redemptive-cosmological approach of case study because of its suitability for operationalising our sympathetic and empathetic research commitment which aims to contribute solutions to the problem of health care inadequacy in urban Nigeria (Ogunniyi, 1992, pp. 65-78). The data analysis under description involves simple interpretation (Ogunniyi, 1992, pp. 65-66). Description involves a set of essential activities that form the initial steps in the development of most academic disciplinary fragments (urban health analysis). Therefore, having accomplished the identification of a topic (or the issue of inadequate health care in Calabar City), that is yet to be well known and convincing readers about the significance of the topic, we proceeded to collect, record and analyse data based on simple interpretation and the creation of concepts and methods of classification designed to impose some structural refinement on the data (Howard and Sharp, 1983, p. 106).

DATA AND SOURCES

We used secondary data from reliable sources, including official records of government agencies, for example the State Planning Commission of the Cross River State Government, which has

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

been responsible for managing two cycles of the region's Economic Empowerment and Development Strategy, first the CR-SEEDS (I) 2005-2007 and second the CR-SEEDS II (2009-2012). To analyse the data, we used geodemographic techniques involving geo-computation of per capita shares of healthcare infrastructure and professionals for the populations of the study area - Calabar Municipality and Calabar South Local Government Areas. Geodemographic analysis is being increasingly applied to study a wide variety of development challenges. Recently, the method has been used to achieve the following academic research objectives: to show how Nigeria's Federal Government shared Internet resources to secondary schools in the nation's 36 states and federal capital territory in the Fourth Republic, which started in 1999 (Ingwe, Otu, Agi, Eja and Ukwayi, 2008); to elucidate on the intensity of agro-forestry practice in Nigeria's 36 states and federal capital territory (Ingwe, Ushie, Ojong, and Okeme, 2009); to clarify the geospatial distribution of degree-awarding tertiary institutions in Nigeria by the nation's six geo-political zones (Ingwe, Ikeji and Ugwu, 2011); to highlight urban environmental quality in sub-Saharan Africa -including slumisation, poverty, diseases burden, etc., (Ingwe, 2012a), and to increase understanding of the geospatial distribution of physical health facilities in Nigeria's 36 states and federal capital (Abuja), Ingwe (2012b). The key element of this method is the division of the resource (i.e. health care institution or professional by the human population that is using the resource within a specific area which constitutes the geographical space). The method is derived from the concepts of Euclidian space and spatial analysis. The details on how this method is implemented have recently been described in the literature.

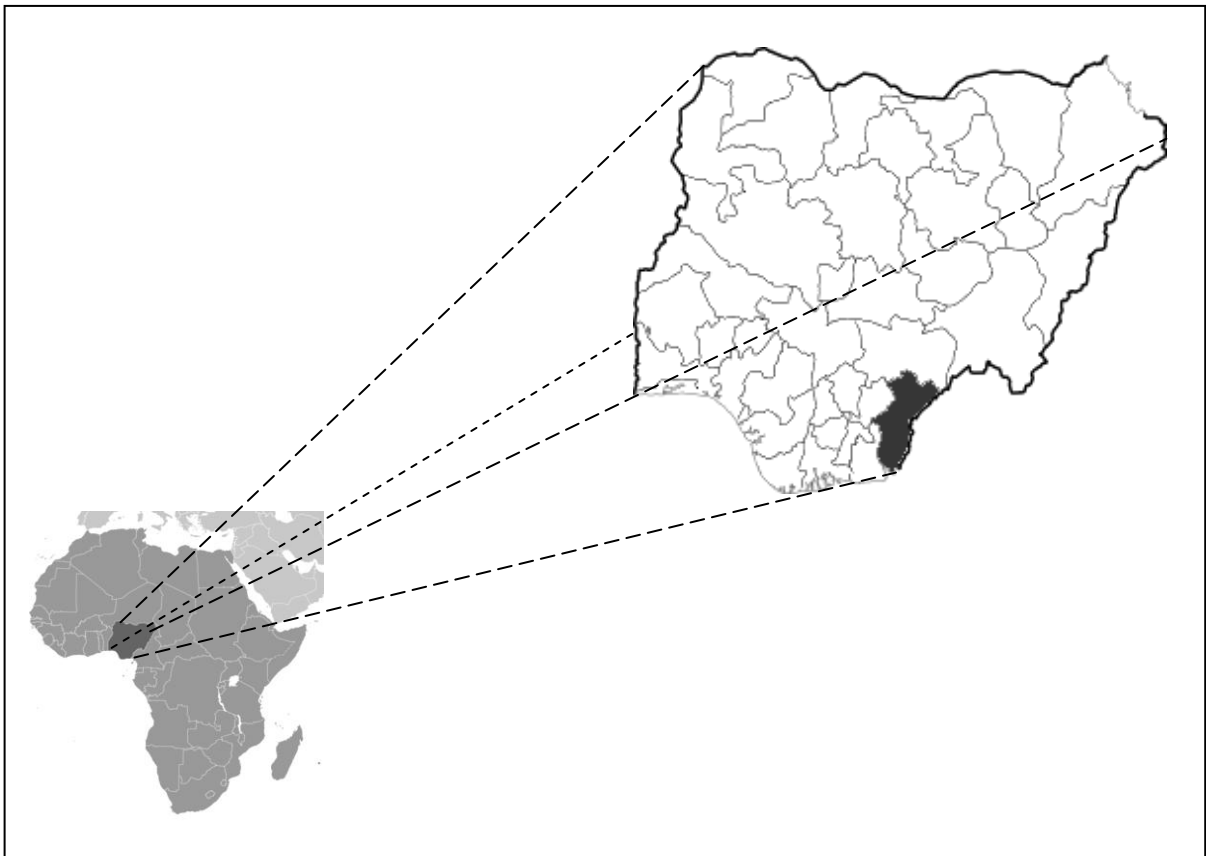


Figure 1. Location of the study area in Nigeria (Cross River State - shaded area)

GEODEMOGRAPHY OF HEALTH CARE IN CALABAR URBAN REGION AND URBAN CROSS RIVER STATE

The health care condition in Calabar urban region between 1999 to the mid-2000s was rather poor. Two aspects of the inadequacy in health care can be shown in two dimensions. First, we considered the number of health facilities (institutions) available and the per capita shares of health facilities for the inhabitants of the two local government areas in the urban region. Second, we took into account the number of health professional and workers available and also their per capita shares for the population. These can be reported in various levels or categories. They include: two federally owned and managed health institutions - University of Calabar Teaching Hospital (CUTH) and Infectious Diseases Hospital (IDH) whose location in Calabar South gives the area a per capita share for the population of this area of 5.22×10^{-06} for each of these health facilities. Owing to the contiguous location of the two Local Government Areas (Calabar Municipality and Calabar South) in one urban region, computation shows that the per capita share of the two federally managed health institutions for the population of the urban region of this integrity was 5.4×10^{-06} . Two state-owned institutions (Calabar Municipality: 5.57×10^{-06} and Calabar South: 5.22×10^{-06}) bring the total shares of these institutions to 5.4×10^{-06} .

The per capita shares of the 18 and 14 health institutions managed by the two local governments are Calabar Municipality 1.00×10^{-04} and Calabar South 7.31×10^{-05} , respectively. The total per capita shares for the entire urban region is 8.62×10^{-05} .

The per capita shares for privately owned and managed health institutions, six in Calabar Municipality and 80 in Calabar South, are 3.34×10^{-05} and 4.17×10^{-04} , and 2.32×10^{-04} for the whole urban region (Ingwe, 2009; State Planning Commission, 2005).

Gross Inadequacy of Health Professionals in the Larger Environs of Calabar City: Cross River State

Data on available health professionals was only provided for the entire state (Cross River). It was not possible to obtain data on health professionals that was disaggregated into each of the 18 Local Government Areas forming Cross River State including those constituting the Calabar urban region. The wider political region also had a weak health base of professionals, discernible from aggregate data covering the entire Cross River State. The number of various health professionals and their per capita shares were as follows: 73 medical doctors –general- (2.53×10^{-05}), only two dental surgeons (6.92×10^{-07}), 1,150 nurses (grade A) (3.98×10^{-04}), 203 nurses (of grade B) (7.03×10^{-05}), and ten pharmacists (3.46×10^{-06}). Others are: 19 medical laboratory technologists (6.58×10^{-06}), four dental technologists (1.38×10^{-06}), one radiographer (3.46×10^{-07}), 78 CHEWS (Community health education workers) and no physiotherapist (Ingwe, 2009). Considering the foregoing description of the poor health facilities on offer in Calabar urban region, there is needed to seek innovative solutions for providing improved healthcare in the city.

Inadequacy of Health Facilities in Cross River State

Nationwide surveys have shown that the total number of health facilities in the state was only 544 to cater for the large population of the state in 2004, comprising 429 publicly owned health facilities and 115 privately owned health facilities. The various categories or levels of the publicly-owned health facilities in the state were: 406 primary health centres, 21 secondary health facilities and two tertiary health facilities. In the privately-owned health facilities category, there were 72 primary health centres and 43 secondary health facilities. There was no tertiary health facility that was privately owned in the state. In 1999, the various categories of medical specialization of the health facilities that were available in the state were as follows: 28 general, 99 maternities, one infectious disease, one neuropsychiatric, one tuberculosis, and none of the ophthalmic health facilities (National Bureau of Statistics, 2006, pp. 90-91).

GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF RAPIDLY URBANISING CROSS RIVER STATE, SOUTH-EAST NIGERIA

Increasing Pressure on Limited Health Care Resources in Calabar Urban Region

The health care resources available in Calabar City have been under increasing demand from people residing beyond the bounded area of the region. Two dimensions of this increasing pressure deserve attention. The first results from the fact that only Calabar City (i.e. the two Local Government Areas within its urban region out of the 18 forming the state) possesses the two federally owned and managed health institutions and the high calibre of health professionals. Therefore, Calabar City receives most of the state's patients who undertake health tourism trips to get medical treatment from the two specialized health institutions that are restrictively located in the extreme South of the region. This alters the computation reported above such that the per capita shares of health care from the two federal institutions declines further to 6.92×10^{-07} .

The second dimension of increasing demand for health care in Calabar urban region results from both regular and seasonal influx of ordinary tourists into the city since tourism gained the attention of the state government. This influx is especially high during the annual Calabar Carnival, which is organized for about 32 days during year endings, from the first to the last days of December every year and is reputed to have attracted tens of thousands of tourists to the Calabar annual carnival, fondly advertised as "world's largest street party" in the export free zone city. While it is not being sadistically suggested that all participants in the city's regular and seasonal tourism events would become ill, sound planning ought to anticipate mass emergencies under the context of global-scale health threats such as bird flu, Ebola fever, Lassa fever and so forth. It is the responsibility of the city, which seeks to be considered as attractive for tourists, investors and residents, to strive towards realizing or concretising its attractiveness by undertaking serious planning programmes designed for managing health emergencies, when these may occur. The findings of this study confirm most results of extant research on and documentation of Nigeria's development. Despite successive claims in national development plans and laws (Constitutions) that Nigeria's values are founded on aspirations to institutionalize and create a society that offers opportunities for achieving the full potentialities of every citizen based on egalitarianism, social and distributive justice (Nigeria, 1970; National Planning Commission, 2004; Nigeria, 1999), the elitist rulers have failed woefully to fulfil these promises as the masses of Nigerians wallow in abject poverty and gross deprivation of welfare (Mabogunje, 1974; National Planning Commission, 2004). The failure to increase welfare provision to most Nigerians has been attributed to the high level of corruption of the government elite (Ribadu, 2009; Omojola, 2007) and to the economic mismanagement (Ogwuma, 1996).

CONCLUSION

This study has shown that health care (including institutions and professionals excluding equipment, which was not part of the analysis) in Calabar City has been grossly inadequate for residents. By the vice of this lag in health care compared to other countries, the State Government's policy of creating a preferred tourism destination in the city and the entire state is compromised because of the way the steady influx of tourists seeking health care from within the state, Nigeria and abroad, has been over-stretching the existing facilities. This has happened because the state government's tourism development policy presents a lack of coherence between the tourism sector and the health care sector.

POLICY IMPLICATIONS

The findings of this paper show that tourism development policy must be integrated to welfare (including health care, education, etc) provision policy. This is because, as noted in the conceptual framework, contrary to the dubious impressions created by the Washington Consensus and the international financial institutions (World Bank Group, International Monetary Fund, etc.), welfare provision (especially health care) is one of the best ways of creating human capital required for increasing production, increasing the revenue generated by the city by increasing the attractiveness of the city to tourists. Although the IFIs have discouraged welfare provision through stringent implementation of the structural adjustment programmes, it is well known that some of those countries spearheading the SAP in the IFIs have either been reputed for providing welfare (e.g. Britain) or are

beginning to improve welfare provision policies in their own countries (President Obama's health care policy in the United States of America).

RECOMMENDATIONS

Civil society should rise to the occasion to point out to the state government the extent to which health care has been neglected, over stretched beyond the carrying capacity of the limited amount provided to residents due to the increasing tourist population.

ACKNOWLEDGEMENTS

Many thanks go to the Centre for Research and Action on Developing Locales, Regions and the Environment (CRADLE) for funding the research programme from which this article was prepared.

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GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF
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GEODEMOGRAPHY OF HEALTH CARE SERVICES IN THE BUDDING TOURISM DESTINATIONS OF
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