How tertiary hospitals can strengthen primary health care in Nigeria

Sir,

In keeping with the results of previous studies,[1,2] Nnebue and colleagues[3] show the weak state of primary health care (PHC) in Nigeria. None of the health facilities they surveyed had the minimum equipment package, essential drugs or staff complement required to deliver maternal health services. Their findings imply that although, in theory, there are three levels of healthcare delivery in Nigeria (primary, secondary and tertiary), many potential patients are likely to bypass the PHC level. Those who can afford it enter the system at a higher level, and those who cannot afford healthcare at higher levels seek informal care from drug shops, traditional healers or not at all.[4] The reason PHC is generally weak in Nigeria is partly due to the decentralised structure of the health system, in which the primary responsibility for the most important level of care (PHC) is often left to the weakest level of government (local governments).[5,6] We must therefore look beyond local governments for the solutions.

The weak state of PHC places a heavy burden on tertiary hospitals, especially where secondary care is also weak or mostly provided by the private sector, inverting the pyramidal distribution of patients such that the bulk of patients are seen at the tertiary level.[7] In response to this trend, there are General Outpatient Departments (GOPDs) in tertiary hospitals where family physicians trained for the PHC level attend patients presenting with primary care complaints. Our modest proposal is for family physicians to attend these patients at the PHC level. Let us close down the GOPDs in tertiary hospitals and move the family physicians to PHC facilities in the communities around the tertiary hospitals. Each PHC facility within a 10-km radius of the tertiary hospital should operate physician-led clinics 2-3 days a week. For example, if there are 7 doctors in a GOPD, then at least 7 PHC facilities will have a doctor present at least for 2-3 days in a week. This strategy alone has the potential to improve the quality of care in a number of PHC facilities in Nigeria and may have a rollover effect on overall PHC services in Nigeria.

Tertiary hospitals have everything to gain from this proposed partnership — real world PHC conditions within which to train their family medicine resident physicians and to provide exposure for their medical students to the reality of the Nigerian health system. Implementing this proposal is not likely to be much of a challenge. Most tertiary hospitals are operated by the federal government, while in most cases PHC facilities are operated by local governments, sometimes with the support of their state governments. Local governments are typically weak (as state governments are in control of their revenue)[4] and will likely welcome support from federal government-owned tertiary hospitals. In 1992, the Nigerian government made provision for federal support for PHC through the National PHC Development Agency.[8] Federal support for PHC can be extended to include support through tertiary hospitals run by the federal government. Indeed, similar initiatives were implemented by the early generation of teaching hospitals in Nigeria, which operated rural PHC practices in order to expose their undergraduate and postgraduate trainees to real life PHC, and conducted health research in these communities while fulfilling an articulated social responsibility to rural communities.[9] We believe these token initiatives can be formalised and scaled up to all tertiary hospitals in Nigeria.

We propose that the federal government mandate partnerships between tertiary hospitals and PHC facilities within their catchment communities. We also propose that the Medical and Dental Council of Nigeria require that rural PHC postings become a compulsory component of not only undergraduate medical training but also postgraduate family medicine training at the National Postgraduate Medical College and the West African College of Physicians. We propose that these colleges also insist on proper training for their family medicine residents at the PHC level instead of being trained in primary care departments nestled within tertiary hospitals. In addition, we propose that an incentive for doctors to train in family medicine should be that audited and supervised work of doctors during their national service (NYSC) counts towards their postgraduate training in family medicine, should they choose to follow that track. We believe that these are simple, relatively inexpensive strategies to right some inequities in access to health services, ensure a level of social responsibility for tertiary hospitals, stimulate PHC revitalisation, encourage doctors to train towards working at the PHC level, and ultimately improve health outcomes for Nigerians.

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REFERENCES

1. Musa EO, Ejembi CL. Reasons and routine of paediatric referrals from first level health of facilities in Sabon Gari Zaria, Northwest Nigeria. J Community Med Prim Health Care 2004;16:10-5.
2. Ijadunola KT, Fatusi AO, Orji EO, Adeyemi BA, Owolabi OO, Ojofeitimi EO, *et al*. Unavailability of essential obstetric care services in a Local Government Area of south-west Nigeria. J Health Popul Nutr 2007;25:94-100.
3. Nnebue CC, Ebenebe UE, Adogu PO, Adinma ED, Ifeadike CO, Nwabueze AS. Adequacy of resources for provision of maternal health services at the primary health care level in Nnewi, Nigeria. Niger Med J 2014;55:235-41.
4. Brieger WR, Osamor PE, Salami KK, Oladepo O, Otusanya SA. Interactions between patent medicine vendors and customers in urban and rural Nigeria. Health Policy Plan 2004;19:177-82.
5. Okafor J. Local government financial autonomy in Nigeria: The State Joint Local Government Account. Commonwealth J Local Govern 2010;6:124-31.
6. Okorafor OA. Primary healthcare spending: Striving for equity under fiscal federalism. Cape Town: UCT Press; 2010.
7. Akande TM. Referral system in Nigeria: Study of a tertiary health facility. Ann Afr Med 2004;3:130-3.
8. Federal Republic of Nigeria. The National Primary Health Care Development Agency Decree. Lagos: Government Press; 1992.
9. Reynolds LA, Tansey EM, editors. British Contributions to Medical Research and Education in Africa after the Second World War. Welcome Witnesses to Twentieth Century Medicine. Vol 10. London; 2001. Available from: http://www.history.qmul.ac.uk/research/modbiomed/Publications/wit_vols/44832.pdf [Last accessed on 2014 Jul 6].

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Quick Response Code:	Website: www.nigeriamedj.com
	DOI: 10.4103/0300-1652.144715