

REFERRAL SYSTEM IN NIGERIA: STUDY OF A TERTIARY HEALTH FACILITY

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Abstract

Background: The three levels of health care delivery in Nigeria should enjoy patronage from clients and a good referral system is the main link between these levels. The primary health centers are supposed to be the point of first contact of patients. Patients are then referred from here to other levels of health care. This survey examines referral system in Nigeria with a study on new patients seen in a tertiary health facility.

Method: This cross-sectional survey was conducted with 1,416 new patients seen at University of Ilorin Teaching Hospital, Ilorin interviewed over a period of 4 weeks to examine the referral system in Nigeria.

Result: A total Only 100 (7.1%) of them were referred to the hospital, the rest (92.9%) reported to the hospital directly without referral. The new patients (87.1%) were predominantly resident in Ilorin. The proportion of those referred is higher among patients from outside Ilorin than those from within. Most of the patients referred were from doctors from private clinics. Both the educated and non-educated bypass the primary and secondary levels of health care.

Conclusions: A high proportion of patients seen in this tertiary health facility were not referred. The result of this is overcrowding of the tertiary health facilities with problems that can be managed at the lower levels. Highly skilled manpower and equipments are wasted on health problems requiring lesser resources to solve. Necessary steps to make clients utilize primary and secondary health facilities need to be put in place and create disincentives for patients by-passing these levels.

Key words: Referral, system, health facility

Introduction

The national health system provides for three tiers of health care; primary, secondary and tertiary. The three should enjoy patronage from clients and a good referral system is the main link between them.¹ In Nigeria many secondary and tertiary health facilities are crowded with people with simple ailments that can be managed at primary health centers, while health workers in many of later are idle.²

The primary health centers are supposed to be the point of first contact of patients. Patients are then referred from here to other levels of health care.^{3, 4} Referral is a process by which a health worker transfers the responsibility of care temporarily or permanently to another health professional or social worker or to the community.⁵ Some patients present directly to the hospital, through emergencies and self-referrals, while a physician, nurse or other health care workers refer other patients.⁶⁻⁸ The hospitals are usually overwhelmed with patients, which make adequate attention difficult to achieve. The tertiary health facilities provide extensive primary and first referral care to clients mainly in urban settlements.⁹

Materials and Methods

All newly registered clients/patients seen at the records unit of the University of Ilorin Teaching Hospital during the month of January 1997 were included in the study population. Old patients who usually present for follow up were excluded from the study. Also excluded were those attending immunization, family planning, Antenatal care clinics and members of staff of the hospital and their families attending the staff clinic.

All the new cases were interviewed by the record clerks using structured questionnaires designed to obtain background information, referral status and other information related to patient referral. The record clerks in contact with all new cases at the various hospital units like General Out-patient Department (GOPD), Consultant clinic, Appointment centre, Accident and Emergency, Eye clinic etc were used in the study. These are the entry points of all registered new patients in the hospital.

The data obtained were entered and analyzed using the EPI-INFO version 6.3 computer software to produce frequency tables and chi-square analysis.

Results

A total of 1,416 new patients were interviewed within the 4 weeks period of data collection. The age of these patients ranged from 0-89 years. About 88.0% of them aged less than 50 years and 41.4% aged below 20 years. The male-female ratio was 1:1. The patients were predominantly Yoruba (84.7%). Only 5.8% were Ibos, 3.2% Hausa/Fulani while the rest (8.2%) were from other ethnic groups. Muslims constituted 52.3% and 47.7% were Christians. Among these patients 59.3% were married and 40.5% not married.

About two-thirds (62.4%) of the new patients had at least primary school education. The rest 37.6% had no formal education. However those with no formal education included children below school age. Among the 906 patients above 15 years age, 222 (24.5%) had no formal education, 160 (17.7%) had primary education, 253 (27.9%) had secondary education and 271 (29.9%) had post-secondary education (Table 1). As much as 54.7% of the new patients were children, students, housewives and adults who were unemployed. The rest 45.3% were employed.

Out of all the new cases (87.1%) of them were resident in Ilorin and the rest (12.9%) came from outside Ilorin. Among those that reside outside Ilorin town, 59.8% of them came from within Kwara State and the rest (40.2%) were from 13 other states in Nigeria but mainly Kogi and Oyo states.

Most of the new patients (80.1%) reported in the hospital between 6.00AM and 2.00PM, 18.0% of them reported between 2.00PM and 10.00PM and the rest 1.9% reported in the hospital between 10.00PM and 6.00AM (Table 2).

Only 172 (12.3%) of the registered new patients were referred. Excluding the new patients that were referred from the GOPD of the UITH to other departments of the hospital, only 100 (7.1%) of these new patients were referred to the UITH, Ilorin from

other health facilities. The remaining 1175(92.9%) new patients reported directly to the hospital without any referral. Among the 172 new patients referred, 93.7% of them had referral note including those referred at the GOPD to other departments/units in the hospital who constituted 41.9% of all referred patients.

Out of the 172 patients that were referred to the hospital, 148 (86.0%) of them were referred by medical doctors and the rest by other health workers. Seventy-two (41.6%) of all new patients referred were referred from the GOPD of the Teaching hospital to other units of the hospital, 59 (34.3%) were referred to the hospital from private clinics, 28 (16.2%) from General hospitals and the rest from health centres (Table 3).

Sixty-nine (27.1%) of the new patients seen in the hospital between 2.00PM-10.00PM were referred compared with only 3 (11.1%) of those seen between 10.00PM and 6.00AM and also 100 (8.8%) of the 1132 patients seen between 6.00AM and 2.00PM. The difference is statistically significant ($p < 0.05$).

Among the patients that were referred, including those referred from the GOPD to other units in the hospital, the highest proportion was found among those aged 70-79yrs (41.7%) and it was as low as 8.1% - 9.5% in the age groups that were less than 30yrs (Table 4). Out of the new patients, only 9.9% of those residing in Ilorin were referred when compared with up to 26.8% of those that came from outside Ilorin. The difference is statistically significant ($p < 0.05$).

There was no significant difference in self-referral of patients when their educational status is considered ($p > 0.05$). Among patients aged more than 15yrs, 11.0% of those with tertiary education were referred and 12.6% of those with secondary education. Also, 19.4% and 15.3% of those with primary education and no formal education respectively were referred. About half (57.6%) of those referred to the teaching hospital from outside Ilorin were from private clinics.

Table 1: Distribution of patients by educational level and referral status

Educational level	Referral status		Total
	Referred (%)	Not referred (%)	
None	34 (15.3)	188 (84.7)	222
Primary	31(19.4)	129 (80.6)	160
Secondary	32 (12.6)	221 (87.4)	253
Post-Secondary	29(11.0)	242 (89.0)	271
Total	126	780	906

Table 2: Patients' reporting time in hospital and referral status

Time	Referred		Total (%)
	Yes (%)	No (%)	
6.00am-2.00pm		1032 (91.2)	1132 (80.1)
2.00pm-10.00pm	69 (27.1)	186 (72.9)	255 (18.0)
10.00pm-6.00am	3 (11.1)	24 (88.9)	27 (1.9)
Total	172	1242	1414

Table 3: Distribution of source of referral

Source	No. (%)
Private clinics	59 (34.3)
Primary health centres	9 (5.2)
Comprehensive health centres	4 (2.3)
General hospital	28 (16.3)
UITH GOPD	72 (41.9)
Total	172 (100)

UITH=University of Ilorin Teaching Hospital; GOPD=general outpatient department

Table 4: Distribution of patients by age group and referral status

Age group (years)	Referral status		Total
	Referred (%)	Not referred (%)	
0 – 9	36 (9.3)	350 (90.7)	386
10 – 19	19 (9.5)	181 (90.5)	200
20 – 29	27 (8.1)	306 (91.9)	333
30 – 39	31 (15.2)	173 (83.2)	125
40 – 49	21 (16.8)	104 (83.2)	125
50 – 59	21 (22.6)	72 (77.4)	93
60 -69	11 (19.3)	46 (80.7)	57
70 – 79	5 (41.7)	7 (58.3)	12
80 – 89	1(25.0)	3 (75.0)	4
Not stated	0 (0.0)	2 (100.0)	2
Total	172	1244	1416

Discussion

A two-way referral system is advocated from the lowest level of health care to the highest (Village health worker to health post, to primary health care, to comprehensive health centre and to state General Hospital), except in emergency when patients can be referred to any of the facilities for immediate treatment.⁵ This is hardly the case in many of the developing countries. This study has shown that only 127(7.1%) of all the new patients that attended the University of Ilorin Teaching Hospital during that period went through the referral system. A high proportion (93%) of these patients make the Teaching Hospital their first contact with the National Health System. This is irrespective of the types of disease. Most of the ailments were treated at the GOPD of the Teaching Hospital. This supports the observation that outpatient departments of many hospitals continue to be crowded, often with people with simple ailment that can be treated at the primary health centres.⁹⁻¹²

The majority (80%) of these patients reported in the Teaching hospital between 6.00am and 2.00pm when the health centres are usually open for services, restricted operation/service hours of the lower level health facilities can not be a reason for not making them the place of first contact. Also a small proportion of these new patients were seen at the emergency units, this suggests that it is not the emergency nature of their health problem that made them bypass the lower levels of health care delivery.

Verbal referral (without referral notes) does occur

since up to 7.0% of the referred patients did not come with referral notes. This can make it difficult to accurately determine what had been done for the patient before the referral. This practice is likely to be found mostly among patients that were not referred by doctors. Medical doctors referred almost 90% of the patients.

This study suggests that the chances of attending to a referred patient in the Teaching Hospital is more among patients seen after the usual busy hours of 8.00am to 2.00pm. The result is that the consulting clinics in the out-patient departments of the Teaching Hospitals are likely to be filled with new patients who bypassed the lower levels of health care where sufficient knowledge and skills exist to cope with many of the uncomplicated ailments.² It is known that the absence or inadequacy of many village clinics, health care centers and small rural hospitals make them to be bypassed by potential clients who decide to seek better care at full fledged urban hospitals.⁹

In the urban areas there are quite a number of primary health centres, private clinics and secondary health facilities, yet a large proportion of patients seen in the Teaching Hospitals in Nigeria are not referred. In this study, a large proportion of the patients seen reside in Ilorin which is typically urban. A higher proportion of new patients living outside Ilorin than those living within Ilorin were referred. Africa's major hospitals are usually located in metropolitan areas. Even when their stated purpose is to provide tertiary care for a broad population base they actually

provide large amount of primary and first referral care to a disproportionately urban clientele⁸. The provision of primary care by hospitals is uneconomical; treatment cost per illness is much more expensive than a health centre or dispensary. By some estimates it can be ten to twenty-five times for as much.⁹

In this study patients' educational status had no influence on whether they were referred or not. So, both the educated and uneducated bypass the lower levels of health care to obtain health care at the Teaching Hospital. Some reasons for this include; the fact that people have little confidence in the care they would receive outside the hospital and lack of well-designed referral system with defined procedures, management support and appropriate forms.^{6,10}

The practice of bypassing the lower levels of health care make many patients spend long waiting hours to see highly trained medical workers in hospitals. This is not only a waste of time but also a misapplication of the highly trained health workers time². Provision of primary care distorts a hospital function. It is believed many of the apparent shortcomings of hospitals are linked to congested outpatient departments and overworked laboratories performing hundreds of routine tests. Overqualified staff and expensive facilities are therefore used in ways their planners did not contemplate.⁹

The pressure of primary care on hospital facilities sometimes distorts health program development at the community level; because it fixes attention on the distressed hospital, creating the impression that further extension and development is required when the real need is for a very large increase in the number of effectively functioning health centers.⁸ This is why a number of state governments are ambitious in converting health centres to cottage hospitals.

It is important to address this situation, believed to be similar in most Nigerian teaching hospitals. It may affect the running of the National Health Insurance Scheme (NHIS). It is good to ensure that hospitals concentrate on their roles as referral centers and not made to perform functions of health centres. To realise this, people must be made to have confidence in these health centres by providing the necessary manpower, drugs and facilities.

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