Health, according to WHO is a state of complete physical, mental, and social (environmental inclusive) well being and not merely the absence of disease or infirmity. In other words for one to be healthy the body must be fit, mind at ease and one must be able to live and work well in the family and with the community.

It is most unpleasant to know that many of our people fall sick and die from preventable diseases and conditions.

The Alma-Ata (central Asia of defunct USSR) conference of 1978 recognized the disparity in the provision of health services between the wealthy and healthy nations on one hand and the poor and unhealthy nations of the world on the other; as well as the disparity in the provisions within the so called developing (poor) nations. The goal then was encapsulated in the slogan "health for all”. The means of achieving that goal was the services of primary health care (PHC) equitably provided within a country like ours-Nigeria.

PHC is that health care service structured on the foundation of community involvement, at a cost they,(the community)can afford, based on acceptable and scientifically sound technology.

Primary Health Care activities which were made up originally of 8 components had recently been increased to 10, viz;

I. Immunization against major childhood diseases.
II. Prevention and control of locally endemic diseases.
III. Treatment of common diseases and injuries or ailments.
IV. Provision of essential drugs.
V. Maternal and child health (lately referred to as reproductive health), family planning inclusive.
VI. Health education.
VII. Nutrition i.e. production of food security.
VIII. Adequate safe water supply and sanitation (WATSAN).
IX. Community mental health care.
X. Dental health.

From all the above, it is clear that the PHC system attempts to justify the WHO definition of health.

As an integrated multi sectoral system of approach, the PHC is designed to address not just the medical services of the people but their entire health needs through the organs of health, agriculture, housing, education, public works, transport and other agencies of social services.

The PHC was launched in Nigeria in 1988, and the NPHC development agency was put in place and the agency was supposed to be replicated through the state to the local government.

With the launching of the NPHCDA came the upgrading of schools of hygiene to schools of colleges of health technology and establishment of new ones throughout Nigeria. A lot of other steps were taken under the ministerial tenure of Prof, Olikoye Kuti. Some progress was made in the health service delivery in this country, but unfortunately since about the mid 90’s health indices have been deteriorating due to poor or inconsistent policy implementation. It was in the 1990’s that tons of vaccines were imported and abandoned at the airport warehouse, those
were vaccines which should have been kept under cold chain controlled temperature. Any surprise than that the level of immunization crashed from 95% to below 12% in some local government areas and at national levels? It was also in those years that a particular local government chairman/sole administrator in Nigeria, out of pure ignorance and resistance to reasoning, insisted that there was no "river Blindness" in his local government area despite the availability of scientific data to the contrary. The sole administrator refused to release 10,000 naira only for free distributions of ivermectin in his domain. These are just token samples of some of the obstacles confronting PHC implementation in Nigeria.

From the studies of D.O.Adeyemo on Ife East local government health care delivery (J.Himm.ecol.18 (2) 2005) it is clear that public-private partnership (P.P.P) may be the way out of the myriad of problems bedeviling PHC implementation in Nigeria. No Proprietor of private health establishment will likely remove the electricity generator of the cold chain freezer from the hospital to his personal abode or convert the hospital ambulance or PHC-project vehicle into a "rice truck".

In terms of equity, value for money, and stewardship, if private health establishments were made to work along with the government settings, they will definitely be of immense benefit to the populace. The commonest disease affecting the people; malaria, diarrhoea, communicable diseases, nutrition and some injuries are well within the capability of private health establishments.

Superficially, one may think that the private medical practitioner is concerned only with treatment of ailments and injuries. In the real sense, all the 10 components of PHC can be adequately handled by the private centers. Water supply which is of public nature could be addressed by the private practitioner through health education by indicating good sources of water, water-treatment at home, storage etc. It is on record that majority of business men and women, traders and artisans prefer to patronize private health establishments for quick, time saving and quality service rather than wait endlessly at government establishment where at the end of it all, they still have to get their consumables from elsewhere.

If and when the PPP initiative is implemented at the PHC level, the large crowd often encountered in government centres will reduce drastically and the quality of service is bound to improve. With active PPP, the cases of inflation of number of hospital beds (by the LGAs) in order to attract higher level of fund allocation from federal resources (revenue) will definitely be minimized if not completely eradicated.

In the formulation of government health policy (PHC especially), the resources available in the private sector should be harnessed for the benefit of the populace. In the opinion and words Prof. Pat Utomi (med-link journal, May 2010) “we have to use a portfolio of incentives and flexible structures to improve access. From tax credits for builders of hospitals to innovation grants to physician practices who create new treatment protocol.”

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