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The groove gets deeper

The time taken to implement the National Health Act is soon going to challenge the incubation period of the National Health Insurance Scheme! Both have taken too much time.

Felix Obi (page 4 and 5) has provided us with an excellent detailed account of the steps taken so far since then President Goodluck Jonathan signed tbe Act into law. However the news that the Federal Ministry of Health budget for 2016 has failed to include any anticipated income from the Consolidated Fund is depressing. It was there in 2015, and whilst it didn't happen then, it is not unreasonable to have anticipated that it would still be in the budget plan for 2016. That is appears to have been dropped off, is difficult to understand. When operating properly, there should be something like a billion naira dropping in to the FMoH accounts, enabling it to establish the Basic Health Care Provision Fund (BHCPF). This is the core building block of the new era heralded by the National Health Act.

Without it, nothing can happen.

How this sits with the new minister, Honourable Prof Isaac Adewole, one wonders. He is on record as asserting that the implementation of the Act is a priority. But if there is no cash, there will be no act… nor indeed action.

One area that Prof. Adewole will hopefully be expressing his frustration, is the progress of the Technical Working Group and some of its committees. Reportedly, despite being inaugurated in March 2015, progress has been slow and in some areas there is nothing to show.

It is clear that those of us who thought the hard work was in getting the Act into statute, were misinformed. Getting it into practice looks like it is going to take as much time again. For the millions of Nigerians who do not receive basic health services, this is a gross disservice.

It is now very clear that to make progress, it is going to require a huge amount of energy and leadership from the Federal Ministry of Health. We hope that Prof Adewole will feel empowered to meet the challenge.

Bryan Pearson

Sokoto: debate, complaint and promises

Chikwe Ihekweazu reports on the recently concluded National Health Council meeting in Sokoto. This is a slightly abridged version of his full report on Nigeria Health Watch (www.nigeriahealthwatch.com)

Once every year, the Ministers of Health, leaders of all the health parastatals, and the commissioners of health and their teams gather to agree and harmonise health policy for the Federal Republic. It is the highest policy making body in the health sector for the country. Between the 7 and 11 of March 2016, public health sector leaders congregated in Sokoto, (the State of the Caliphate as it is called), to deliberate on the progress in the Nigerian health sector and to chart a way forward.

The theme of this year's meeting was 'Universal Health Coverage – An Agenda for Change'. Universal Health Coverage (UHC) has stayed on the agenda in Nigeria as an aspiration of the new government. It is an aspiration to which you will not find any contradictory voices. However, the challenge for all the previous governments, as it is for this one, is how to translate this aspiration to reality in the Nigerian context. The Minister of Health has virtually staked his legacy on achieving UHC, with some far reaching promises of delivering universal (primary) health care (PHC) to 100 million Nigerians by making 10 000 PHCs 'functional' by the end of 2017, at the rate of 5000 per year.

At the opening of the Council meeting, the Sultan of Sokoto, His Eminence Alhaji Muhammadu Sa'ad Abubakar expressed his frustration on the state of healthcare in Nigeria. Sokoto, however, has been fairly progressive with health, absorbing the midwives employed under the 'Midwives Service Scheme' and setting up its PHC Development Board.

During the technical sessions that preceded the council meeting, guest lecturers were invited to speak on specific issues, which were ably summarised by Professor Eyitayo Lambo, a former Minister of Health and one of the most credible voices in the Nigerian health sector today. He aptly summarised Dr. Ali Gombe's talk stressing the link between health, economic development and national security. At this point, Dr. Jide Idris, Commissioner of Health in Lagos State shared his experience in having difficulties in convincing his colleagues in Lagos to invest in health until the Ebola outbreak happened, which put health security at the centre of discussion in Lagos.

The other major issue on the agenda was the implementation of the National Health Act. It was pointed out that the National Health Act was first approved in 2004, but it still took 10 years for it to be signed into law in October 2014, and gazetted in December 2015. Discussion on the act seemed to focus primarily on the provisions of the 1% allocation from the consolidated account in the Basic Health Care Provision fund.

Listening to the questions, comments and responses during the meeting illustrated the complexity of the Nigerian health sector. Comments from some states on their frustration with the National Health Insurance Scheme led to the call for a side meeting with the agency to sort out issues. Controversy in some states on the models for implementation of State PHC Boards/ Agencies (as prescribed by the new health act), the position of its leadership vis-a-vis commissioners of health as well as the change of lines of reporting from the local government to states, led to another side meeting with the National Health Care Development Agency (NPHCDA). It is obvious that the on-going tension between State Ministries of Health, their Primary Health Care Development Boards and the Local Government Areas was an area that will need proactive engagement by the leadership of NPHCDA during the year.

It was hard not to observe the minimal authority of the council in ensuring that decisions taken were actually acted upon. Many of the decisions of the previous National Council of Health meeting were yet to be implemented by some states. Dr. Mike Egbo, leader of the PATHS II project and a long serving leader in the health sector asked a critical question – how do we ensure accountability for the decisions taken during the council at Federal, State and Local Government levels? He suggested a peer-review mechanism, with the states peer-reviewing each other at agreed intervals. This idea gained a lot of traction during the meeting. A zonal coordinator of the NHIS made what was one of the most important comments of the day; that the government should give itself firm targets in health terms, and hold itself accountable to the delivery of these targets.

During the meeting, the Minster of Health made a few bold statements. The one that we will hold on to the most was the assertion that he will put up all funding information for his PHC plans up on the Federal Ministry of Health's website. He promised to be completely and publicly accountable with all the funding streams associated with his plans and the new health act. This may be the most profound change that will come to the sector. At the moment, it is impossible to find almost any document on the Ministry's website, much less information on funding flows.

There were 78 memos considered at the meeting. Some landmark issues discussed and agreed include the adoption of a new task shifting policy, and increasing the range of maternal and child health services that community health extension workers are allowed to carry out.

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Never events and known unknowns

Shima Gyoh on surgical transparency and the importance of learning

A Never Event can be defined as a preventable incident that causes or has the potential to cause serious harm or death to a patient and would not have happened if healthcare workers had followed proper practice and regulations. Examples are retention of surgical instruments or swabs in the peritoneal cavity after laparotomy, 'accidental' overdose with dangerous drugs, operating at the wrong site or on the wrong patient. Such events, as the terminology suggests, should never happen. All health workers should be conscious of the possibility of preventable 'accidents' and must have sufficient self-discipline to follow the right procedure at all times.

Never events are particularly dramatic in surgery, but there are strict protocols to prevent them. To avoid leaving foreign material in body cavities, each operating theatre should have an instrument and swab board on which all the material to be used at laparotomies and thoracotomies are counted and recorded before the operation. The count is repeated twice during wound closure and formally reported to the surgeon each time. The surgeon also has the obligation to do a final inspection of the operative bed before initiating closure, to ensure haemostasis and that no foreign body is left behind. Swabs placed to absorb fluid are tagged with haemostats left to hang outside the wound. Details like these and many other unwritten safety procedures become the subconscious behaviour of the professional surgeon during the long period of training. This is why self-training in surgery, so rampant in developing countries, is not recommended.

Foreign bodies closed within body cavities begin to cause serious trouble within the first few days or weeks, depending on what and where they are. They often give rise to abscesses with acute or chronic ill-health requiring urgent intervention, but some may not do so for months or even years. Recently, there was a press report of a traveller who kept giving positive metal bleeps at the airport security scan despite getting rid of all he was carrying. Abdominal X-ray showed a long Allices' forceps left in his abdomen from a laparotomy done fifteen years back. This was interesting, but most unusual.

It is surprising that operations can be done on the wrong side or even on the wrong person. In the best practice, patients are examined and the site or side of the lesion marked before they go to the operating theatre. The surgeon should see and speak to the patient in the theatre just before anaesthesia and confirm the lesion and the operation to be done. They find this highly reassuring. The results of diagnostic investigations, like X-ray and scans should always be taken to the operating theatre with the patient. Wrist bands with the patients' names and hospital numbers facilitate identification even during coma. In obstetrics wards the labels further prevent inadvertent swapping of babies between mothers.

I saw a recent never event on a man who suffered severe hypoxic brain damage during an hour-long operation and became a 'vegetable', unable to regain full consciousness. It was produced by an inexperienced nurse anaesthetist who, despite prolonged efforts, must have placed the endotracheal tube in the oesophagus. The blood throughout the operation must have been of a dark-blue, almost black colour, but the inexperienced operating doctor obviously failed to recognise its significance. Both clinicians should not have been left alone to carry out procedures beyond their skills without supervision, but supervision is frequently reduced below the ideal where there are heavy clinical loads in the presence of shortage of staff and much task shifting — features prominent in the health services in developing countries. Underfunding further obligates staff to work in a suboptimal environment often with deficient materials and substandard equipment. In attempt to cope, speed and cutting of corners become strong temptations — fertile grounds for never events.

When they occur, there are strong temptations to mismanage never events. Staff tend to dissolve into hot arguments in attempts to identify who and what to blame. They vigorously exonerate themselves and at best find fault with the equipment or drugs. Where a particular staff member cannot extricate himself, there is tremendous pressure on the immediate supervisor to have mercy and cover-up. The offender has a wife, children and other dependent relatives that would become destitute if the incident is reported and he loses his job. Besides, nothing should be done to encourage litigation against the institution! One therefore has to balance the social pressures on the one hand, and the famous wise words of Sir Liam Donaldson, the UK's champion of patients' rights on the other: 'To err is human, to cover-up is unforgivable and to fail to learn is inexcusable'.

It is important that each institution should adopt policies that minimise the incidence of never events, promote their reporting, investigation, and the learning of lessons from the unfortunate happenings.

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The National Health Act 2014: slow implementation delays health benefits

Felix Abrahams Obi charts the long and winding road towards the implementation of this key legislation

There is no doubt that the 2014 National Health Act (NHAct) is one of the most innovative reforms within Nigerian health sector since independence, as it provides the legal framework for the organisation of health services delivery in Nigeria. More importantly, it was seen as the pillar upon which Nigeria's drive towards achieving Universal Health Coverage (UHC) can be achieved since it guarantees every Nigeria the right to a minimum package of healthcare. Amidst the excitement that heralded its signing into law by former President Goodluck Jonathan, some health advocates had expressed some concerns on the political commitment by the government towards its operationalisation. Their fears were not unfounded considering the spate of poor implementation of public policies and key reforms over the years.

Governance framework for the implementation of the NHAct

Following the public announcement of its signing by Reuben Abati in December 2014, the then Minister of Health, Dr. Alhassan held a press conference to intimate the Nigerian public on the health benefits to be the derived from the NHAct. To mobilise civil society's support for the implementation, the Health Sector Reform Coalition - which led the advocacy for the passage of the bill by the National Assembly and its signing into Law by the President - began consultations with the Federal Ministry of Health (FMOH) on the processes for the operationalisation of the NHAct. Through the efforts of the Ministry's Director of Planning, Research and Statistics, the Ministry of Finance was engaged on the immediate implementation of the NHAct since there were no budgetary provisions in the 2015 fiscal appropriation for its implementation. The FMOH also set-up a Secretariat within the Department of Planning, Research and Statistics to coordinate the implementation efforts, and inaugurated the Technical Review Committee (TRC) within the Ministry by February 2015.

By the middle of March, a Special National Council on Health (NCH) was convened in Abuja bringing the operational frameworks for the implementation of the NHAct, including the governance structures. At the NCH, the Steering Committee and the Technical Working Group (TWG), including its five sub-committees,

Photo credit: Paul Chenoweth ND; MPH; Global Immunisation Division

were inaugurated with clear terms of reference respectively. The Steering Committee (SC), which is a high-level body includes the Honourable Minister of Health (Chair), Minister of Finance (Co-Chair), Minister of National Planning, Permanent Secretary Health, Director, Health Planning Research and Statistics (Secretary), Accountant General of the Federation, Governor, Central Bank of Nigeria, Healthcare Federation of Nigeria, House Committee Chairman on Health, Senate Committee Chairman on Health, World Health Organization (WHO) Representative, World Bank Representative, and Chairman of Development Partners Group on Health, as well as Health Reform Foundation of Nigeria. The SC is to provide overall leadership, guidance and oversight in implementation of the National Health Act.

On the other hand, members of the TWG were expected to provide highly technical support to the FMOH, including the development of implementation guidelines and manuals for the operationalisation of the key provisions of the NHAct. By April 2015, the TWG was inaugurated in Abuja, and membership of the five sub-committees were constituted and given specific tasks and deliverables against agreed timeframes. The work of each of the five sub-committees were linked to different provisions of the NHAct and they are; (1) Governance and Stewardship; (2) Healthcare Financing, Equity and Investments; (3) Healthcare Quality, Standards and Performance; (4) Research and Knowledge Management; and (5) Advocacy, Communication and Social Mobilisation. The TWG was expected to meet again in May to review the work done by the five sub-committees ahead of the

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29 May inauguration of the new government. However, the TWG did not meet in May as expected, and the TWG has not held a follow-up meeting nearly one year after it was inaugurated in April 2015. Consequently, the key milestones were missed and this delay has negative implications on the realisation of the benefits that Nigerian citizens expect to derive from the NHAct.

Missed opportunities and achievements

To understand the extent of missed opportunities occasioned by delay in the implementation process, it is imperative we take a look at some of the deliverables and milestones that were set for 2015 to ensure the NHAct becomes operational.

Delay in gazette process: For any law to take effect, it has to be gazetted and printed by the Government Press in Lagos. Although the bill was signed into law on 31 October 2014, the gazette process was unduly delayed and took the intervention of the Health Reform Foundation of Nigeria (HERFON), which advocated and liaised with the Office of the Clerk of the National Assembly to get the NHAct gazette process completed by December 2015; 14 months after the NHAct was signed into law.

Delay in development of guidelines and manuals: According to the NHAct costed work plan, several guidelines and manuals which were expected to have been developed by the end of 2015 have yet to be drafted or finalised. These include Certificate of Standards for Health Establishments, National Policy on Clinical Audit, Certification and Accreditation of Healthcare Facilities, National Healthcare Quality Performance (HQP) Policy, National Referral Guidelines, Client Satisfaction Guidelines, Review of Treatment Guidelines, Minimum Standards for Establishment and Maintenance of Health Facilities, guidelines for Conformity Assessment Bodies (CAB) for healthcare, Guidelines for National Quality Management System (QMS) for Continuous Quality Improvement of Healthcare, National Policy for the Use and Protection of Personal Health Information, Guidelines for Dissemination of Health Information to the General Public, Harmonised Donor Partners Framework, Guidelines for the National Consultative Health Forum, five-year Strategic Plan for the National Health Research and Knowledge Management, among others.

Low awareness of NHAct among Nigerians: Most Nigerians including key stakeholders, within the health and related sectors, are not aware of the signing of NHAct, let alone the key provisions. A survey conducted by UNICEF through its U-Reports in 2015 showed that about 80% are unware of the NHAct. To increase awareness around the key provisions of the NHAct, the sub-committee on Advocacy, Communication and Social Mobilisation was expected to interpret the NHAct into the three major Nigerian languages, and develop information materials and use different media platforms to sensitive and create awareness on the benefits of the health law to the average Nigerian. Although the members of the Health Sector Reform Coalition have worked closely with the FMOH to develop stakeholder specific information materials, these have yet to be printed for dissemination across the country, save for some information materials produced, and used by HERFON in its awareness creation activities.

Key achievements: While most of the TWG sub-committees have not met regularly as expected; however, the Healthcare Financing, Equity and Investments sub-committee (coordinated by the Healthcare Financing Unit of the FMOH) has been the most active and productive of the five sub-committees. Following the inauguration of the TWG, this sub-committee has met about five times and delegated different tasks to core teams. This has resulted in the development of the Draft Harmonised Basic Minimum Healthcare Package, Draft Guidelines for Coordinating, Assessing, Disbursing, and Utilising the Basic Health Care Provision Fund (BHCPF), Draft National Policy on Health Investments, Ongoing Review of the National Healthcare Financing and Equity Policy, etc. These achievements have been through the leadership of the FMOH, National Primary Health Care Development Agency (NPHCDA), and the National Health Insurance Scheme (NHIS) who have worked closely with members of the sub-committee to mobilise both human and technical resources needed for the work. It's likely that if other sub-committees had the adequate funding and requisite resources, the implementation of the NHAct would have gone seamlessly as initially expected.

One key achievement in the implementation process in recent times is the development of the draft 2016 National Health Policy, which was developed by a National Steering Committee (led by former Minister of Health, Prof Eyitayo Lambo), which met in Enugu earlier in February 2016. The new policy incorporates the key provisions of the NHAct into its policy thrusts and directions, and will hopefully chart a new course for our country's health sector after its review and adoption by stakeholders, and eventual approval by the National Council on Health and the Federal Executive Council as the new health policy, which will replace the 2004 policy.

How committed is the government towards NHAct implementation?

President Buhari, during the visit of the Africa Regional Director of the WHO, had publicly made a commitment to establish the Basic Health Care Provision Fund (BHCPF) and reportedly directed the Federal Ministry of Finance to set up structures for the establishment of the fund. Stakeholders within the health sector are alarmed that funds for the BHCPF which were to be statutorily deducted from the Consolidated Revenue of the Federation, were not included in the 2016 Budget for the FMOH. Although about one billion Naira is needed for the operationalisation of the NHAct by the FMOH and its agencies, a review of the FMOH budget as submitted to the National Assembly, shows that little or no funds were earmarked for the implementation of the NHAct in 2016; as it was in 2015.

While delay in the implementation and operationalisation of the NHAct is unfortunate, the Government runs the risk of being sued by a section of Nigerians to enforce their health rights as guaranteed by the NHAct. It behoves the government to show political will and commitment by providing the much needed resources to fast-track the stalled implementation process in 2016, as we step into the post-2015 era which has UHC, as the key target for the health sector.

Imagining a new future for healthcare services in Nigeria

Tarry Asoka challenges notions on what makes up the basic building blocks for health. Bottom-up can be more effective than top-down in mainstreaming ideas and initiatives

The challenge

Uncertain as it may seem, visualising and realising a predictable future for healthcare services in Nigeria other than conceiving an ideal situation, is a task that largely draws out a meaning from the past. The basic premise is that a differently configured healthcare delivery system is inevitable, given the unsatisfactory performance of the Nigerian health system despite massive efforts at revitalising it.[1] The key challenges remain: inadequate release of appropriated funds; weak absorptive capacity of available resources; weak execution capacity to deliver results; and poor stakeholder collaboration. Apart from these notable weak governance systems at Federal and State levels, the country also lacks adequate infrastructure, human resources, and technical know-how to achieve better physical and mental health outcomes across all demographic and socio-economic groups.[2,3]

And as noted by the World Economic Forum,[4] the government-led health system, in a bid to catch-up with more advanced health systems, continues to replicate the financially unsustainable path taken by developed nations. It further explains that emerging economies like Nigeria can leverage technological advances and learn from the mistakes of developed countries - with prohibitive costs, and entrenched interests that are not responsive to changing demand and supply for health services. Moreover, 'They also have at their disposal disruptive technological innovations, alternative operating and financing models and new legal frameworks that were not previously evident or even possible for developed economies'. On these bases, similar to the way agents in the broader Nigerian context have attempted to bypass critical constraints in the past to attain desirable goals;[5] the assumed outlook of healthcare services in the coming years would be essentially driven by innovation, partly technology, but essentially by the methods in which health sector stakeholders are bound to respond to the structural impediments that have undermined the scale-up of services to the majority of the population.

Prospects of an emergent healthcare delivery system

Interestingly, the improvements that are highlighted in this piece are evidence-based trends from within the country that are also instigating sustainable thematic solutions in related areas. Taken together they paint a rich mosaic of a healthcare scenario that engenders equitable access to high-quality care for everyone in Nigeria, and that can promote economic growth and political stability. The key feature is the organisation and delivery of clinical and supportive services targeted at addressing a specific issue that expresses an outcome, and around which a broad-range of stakeholders can come together in each case to jointly achieve that particular outcome. And just about any health problem or concern can constitute an issue, so long as an outcome, around which contemporary forces for change can be mobilised.[6] Two such issues — mental health and undernutrition, in which the author is closely associated, are used to demonstrate the evolving healthcare delivery models in Nigeria.

Mental health in Benue State

A few years ago, the situation in Benue State was typical in Nigeria. As mental health services were limited to the Federal Medical Centre at Makurdi the State capital, and three non-government organisation (NGO)-run projects - there were very few accessible services available for people with psychosocial disabilities. Without access to basic services, people with psychosocial disabilities were not able to gain true social inclusion due to persistent distressing symptoms of mental illness, and the stigma that is often associated with unusual behaviour. Learning from the experience of a programme[7] that supported government primary health care (PHC) services to provide mental healthcare in four South-eastern States in Nigeria; it was noted that with the right type of partnership between NGOs and Government it is possible to run community mental health services that meet the needs of the vast majority of people with disabling mental health problems close to their homes. But the Benue State experiment[8] in addition incorporated an array of stakeholders with an interest in mental health that were willing to act together to achieve better outcomes for people with psychosocial disorders — improving access to mental healthcare at community level and reduce social exclusion.

The essential ingredients of this holistic approach included: the use of non-specialist health workers - Nurses and Community Health Extension Workers (CHEWs) trained on the World Health Organization (WHO) Mental Health GAP Action Programme (mhGAP) 'Packages of Care' to identify and treat common mental health disorders; operating from PHC clinics provided with psychotropic medication; and supported by on-going supervision by specialist

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Photo credit: Jane Miller/DFID

A child is checked for signs of malnutrition in Katsina State, Nigeria, March 2011.

psychiatrists. In addition, there was the development and maintenance of a State Stakeholder Alliance - as a platform to effect change in government attitudes towards mental health services and enhance better funding for mental health; and an independent user-led Self-Help Group in each Local Government Area (LGA) — as a structure for peer-support, self-advocacy, and through which means to build livelihoods can be accessed. Furthermore, community-based Mental Health Advocates were also trained and supported to raise awareness about service availability at the community level, and to effect change in community perception that mental health is treatable and can be treated with medication, as well as safeguarding the human rights of persons with psychosocial disability.

The results from the combination of these efforts indicate that there was a surge in service uptake and a progressive annual increase of the number of patients attending mental health services at PHC level from a baseline of 1025 in 2010 to 10 985 in 2015; as persons with psychosocial disability were also being empowered to fully participate socially and financially in their communities through peer support.[9]

Undernutrition in Northern Nigeria

Out of about one million children that die every year in Nigeria, it is said that 35% are due to causes attributed to malnutrition.[10] And the situation is especially severe in the North of the country, as more than one-third of children are underweight and one in five suffer from acute malnutrition. The economic and societal consequences of undernutrition include reduced school attendance, educational attainment, and low workforce participation. Recognising that evidence-based direct and indirect interventions to reverse the undernutrition situation in Northern Nigeria exist, it was observed that it is feasible to deliver evidence-based direct nutrition services while also promoting linkages between programmes relevant to nutrition, in addition to enhancing the understanding of undernutrition in Northern Nigeria through advocacy informed by research.[11] Focusing on five selected States — Jigawa, Katsina, Kebbi, Yobe, and Zamfara with very high prevalence of undernutrition, a broad-range of stakeholders were mobilised to jointly work towards the goal of achieving a common outcome — better-nourished children in Northern Nigeria.

The core components of this model comprised: the engagement of trained nurses and community health extension workers to identify and treat large numbers of children with severe acute malnutrition (SAM) through out-patient visits at PHC clinics supplied with ready to use therapeutic foods, without the need to admit them into a health facility or therapeutic feeding centre; mobilising community-based health workers and volunteers to institute actions aimed at behaviour change for Infant and Young Child Feeding (IYCF) practices — the first six months of life, when breastfeeding should be exclusive, and the transition phase when complementary foods are introduced. In addition, there were efforts at promoting women's attendance at antenatal clinics during pregnancy where micronutrient supplementation and messages on child health promotion are provided; as well as the promotion of greater autonomy for women - access to schooling, reproductive health services, income-earning opportunities — aimed at increasing women's capacity to make decisions by themselves. Furthermore, actions were also taken to develop and maintain Food and Nutrition Committees at State and LGA levels — as platforms for the coordination of nutrition-related sectoral and community efforts to achieve a common purpose, as well as leveraging resources for nutrition.

As a result of these combined efforts, over 80% recovery rate for SAM has been achieved, as IYCF messages have also reached a large number of community members with high levels of knowledge and indications of reported good practice.[12] At the same time, all five States now have budget lines for nutrition.

The intention

The common theme running through the above illustrative cases and several others currently in operation in the country is the recognition of a wider ecosystem of health and healthcare that goes beyond the traditional building blocks of the health system as structured by the WHO.[13] As the two cases demonstrated, though the six health system building blocks (service delivery, human resources, medical products and devices, financing, information, and governance and leadership) may still be relevant, it is clear that even as these elements are being reconfigured, they are not sufficient on their own to sustainably deliver better health outcomes for population groups, achieve individual satisfaction

with healthcare services, and keep the provision of healthcare affordable for both individuals and the economy as a whole.[4] Moreover, many contemporary health issues have become 'wicked problems' — where the causes are multiple, and many of them are interdependent; at the same, the solutions are inter-connected, and in some cases contradictory.[14]

Therefore, there needs to be a paradigm shift away from designing better healthcare delivery systems that rely on the health systems building blocks, to repeatedly developing and maintaining a 'system of collaboration' that creates value — delivers an outcome for a given health issue. In doing this, it is the intensity of collaboration among individual stakeholder-groups rather than the structure of the set of the relations that is important.[15] And the significance of these leading developments in creating a new world order for healthcare delivery in Nigeria is the evidence that while they have been initially targeted at under-served populations, they soon become mainstream — as they get better and meet the needs of the vast majority of users.[16] In essence, healthcare industry incumbents are not only challenged; the entire healthcare delivery system may be disrupted for good.

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