Exploring Sense-Making in Health Policy: Implementing Health Policy in Nigeria

By

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Abstract

This study employed the concept of sense-making as an interpretive lens to explore the cognitive dimensions of the actions of policy actors implementing the Nigerian Health Insurance Scheme (NHIS) – a major health policy reform launched in 2005.The research follows emergent body of work by cognitive implementation theorists who have demonstrated that the conventional (top-down compliance model) of policy implementation is fundamentally deficient because it pays scant attention to the link between the sense-making of implementing actors and deviations from policy intentions (Spillane et al., 2002; Peck and 6, 2006).Put differently, the sense-making of implementers results in evolution of policy during implementation (Browne and Wildavsky, 1983; Spillane et al, 2002).Using a case study design, the research investigated individual, and collective/distributed sense-making across a spectrum of the actors implementing the NHIS. More specifically, the study investigated the role of formal and informal interactions on actor sense-making , the impact of communities of practice on collective sense-making , and the shaping influences of the political, organisational and bureaucratic context on the sense-making of actors. The conceptual framework for the study assembled theories and concepts covering individual, and collective/distributed sense-making, sense-giving , communities of practice theory, and the role of power and politics in sense-making. A sample of 29 purposively selected policy actors from the ranks of NHIS/Community insurance Scheme officials, HMO executives, medical providers, and three external health policy advisers were interviewed to generate the primary data. Secondary data was obtained from in-depth examinations of various archival and publicly available documents.

The research findings confirm the central thesis that sense-making is socially re-constructed, negotiated and organised. Significantly, individual sense-making variations (based on cognition

and affect) in the cues that actors extracted from the NHIS policy message resulted in different framings of that message. The limitations of the notion of homogeneity within communities of practice, and the relevance of power as a dynamic in communities of practice, were also revealed. Notably, the findings empirically demonstrate the critical impact of power and politics in sense-making. A significant contribution of the study to the literature is the linkage that it establishes between power distance orientation and sense-making.

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Abbreviations

ACF: Advocacy Coalition Framework

AIDS: Acquired Immune Deficiency Syndrome

AGPN: Association of General Practitioners of Nigeria

CBHI: Community Based Health Insurance

CIA: Central Intelligence Agency

DMHIS: District Mutual Health Insurance Scheme

DHS: Demographic and Health Survey

FMC: Federal Medical Centre

FMOH: Federal Ministry of Health

FSSHIP: Formal Sector Social Health Insurance Programme

GDP: Gross Domestic Product

HCP: Health care Provider

HDI: Human Development Index

HCPAN: Health Care Providers Association of Nigeria.

HIV: Human Immunodeficiency Virus

HMCAN: Health and Managed Care Association of Nigeria.

HMO: Health Maintenance Organisation

ILO: International Labour Organisation

LGA: Local Government Area

LGDH: Local Government Health Departments

LMIC: Low and Middle-Income Countries

MDG: Millennium Development Goals

MINECOFIN: Ministry of Economic Planning and Finance

NDHS: Nigeria Demographic and Health Survey

NECA: National Employees Consultative Association

NHI: National Health Insurance

NHIB: National Health Insurance Bill

NHIS: National Health Insurance Scheme

NPC: National Population Commission

NPHDA: National Primary Health Care Development Agency

NSHDP: National Strategic Health Development Plan

OOP: Out of Pocket Payments

PCHIS: Private Commercial Health Insurance Scheme

PHI: Private Health Insurance

PMHIS: Private Mutual Health Insurance Scheme

RCSHIP: Rural Community Social Health Insurance Programme

RSHIP: Retirees Social Health Insurance Programme

RSSB: Rwanda Social Security Board

SCP: Structure Conduct Performance

SHI: Social Health Insurance

SSA: Sub-Saharan Africa

SSHIP: State Social Health Insurance Programme

THE: Total Health Expenditure

TISHIP: Tertiary Institutions' Social Health Insurance Programme.

UHC: Universal Health Coverage

UNDP: United Nations Development Programme

UNESCO: United National Education and Scientific Organisation

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

UPI: United Press International

USAID: US Agency for International Development

USSHIP: Urban Self-Employed Social Health Insurance Programme

WHO: World Health Organisation

WHR: World Health Report

Chapter 1. Introduction and Research Overview

The purpose of this case study is to investigate the role played by agent sense-making in the implementation of the Nigerian Health Insurance Scheme (NHIS) — a major health policy initiative launched in 2005.The study employs a cognitive perspective to investigate the impact of individual and collective/distributed sense-making on the implementation of the scheme and furthermore, examines the extent to which political, organisational, professional and bureaucratic contexts shape the sense-making processes of actors. Following the presentation of the research findings, the thesis discusses it's implications for policy practice.

As it is the case in many low and medium-income countries (LMICs), Nigeria continues to face huge challenges in it's quest to achieve universal health coverage (UHC). Numerous health sector reform initiatives that were incorporated into National Development Plans launched between 1975 and 2015 as well other *ad hoc* health intervention policies have failed to deliver on the promise of UHC. The NHIS policy was introduced in recognition of the need for an alternative financing mechanism for health care, that will be equitable, efficient and protective of vulnerable groups of people from catastrophic health expenditure. Based on the economic benefits of risk sharing and fund pooling, the policy was designed to be driven by pre-payment schemes. Progress towards achieving UHC objectives of the scheme since inception, has however, remained stunted. According to reports, the level of universal financial protection (UFC) provided by the scheme six years later, is just at approximately 5% of the population. This figure is well below the 90% coverage level recommended by the WHO (Onwujekwe, 2011). Such record of under-performance points to a policy reform that is not progressing as enactors envisioned.

The approach to this inquiry departs from prior NHIS studies that have for the most part placed more emphasis on policy content appraisal, problems of programme adoption, scaling up issues

and policy process analysis (Anarado, 2002; McIntyre et al., 2013; Onoka et al., 2014). The decision backing this novel approach was based on prior contextual knowledge suggesting that the divisiveness and controversies around the implementation of the NHIS portended access difficulties to potential interviewees as well as a likelihood of resistance to an investigation targeted at scheme evaluation. The study instead elected to focus more on the processes of meaning making, interpretation and filtration of the NHIS policy message itself and subsequent actions of implementing actors — in the conviction that this approach would uncover salient empirical findings pertaining to other aspects of the implementation of the scheme. Much of the impetus for this research was instigated by a foundational recognition that the process of policy implementation is generally fuzzy and non-linear (Vardaman, 2009). Also instrumental were compelling insights gleaned from complexity theory that characterises policy implementation as a complex adaptive system in which self-organization — a hallmark phenomenon of such systems, is evident in the adaptive capacities of implementation actors (Butler and Allen, 2008). Butler and Allen (2008), further posit that policy implementation self-organizes because centrally enacted policies are re-interpreted at the local level which results in a mix of national objectives and local requirement(s). In essence, the perspective from complexity theory is that policy evolves in part because of this process of re-interpretation.

Additional insights about the nature of policy evolution have been espoused by emergent research postulating a link between the sense-making of implementing agents and deviations from policy goals (Peck and 6, 2006; Spillane et al.,2002; Vardaman, 2009). Peck and 6 (2006) explain that such drifts occur because managers and professionals are inseparable from their predominant worldviews or mental models which invariably impacts on the sense-making they bring to bear in their analysis of issues and decision making. The evolution of policy during implementation asks fundamental questions about the rational, linear, or compliance (top-down model) of policy implementation that normatively expects agents to implement policy as

intended by enactors. Less acknowledged and understood, the role of sense-making in policy implementation has been largely under-explored. Spillane et al., (2002) argue that the negation of the role of human sense-making in policy implementation in conventional studies underscores questions about the theoretical completeness of implementation research.

This research is therefore much influenced by a growing advocacy for the use of sense-making as a conceptual tool for exploring the disjuncture between policy intentions and outcomes at 'multiple levels of analysis' (Vardarman, 2009:3). Following this perspective, the study's conceptual framework brings together relevant concepts to explore the implementation of the NHIS so far — paying attention to the disjuncture seen between intended goals and results since inception. It then relates the empirical findings to the existing literature on cognitive implementation studies to determine the extent to which deviations from the intended goals occurred as a consequence of individual and collective/distributed sense-making. That objective is pursued through analysis of the inter-play of NHIS participants at macro, meso and micro levels. The study's conceptual framework in the main, utilizes sense-making (individual and collective/distributed), sense-giving, and communities of practice theories and their scholarly extensions.

Following this brief introduction is a discussion of the context and subject of inquiry, a presentation of the arguments and rationale for the research, the theoretical approach employed, the objectives of the study, it's research questions, and an overview of the study's research philosophy and methodology. It concludes by providing an outline of the structure of the dissertation and a summary of the chapter.

1.1 Nigeria: Context of Inquiry

The Federal Republic of Nigeria is a West African country of over 923,768 square kilometres

(National Geographic, 2018). With a population of 184 million, Nigeria is the eighth most populous country in the world (World Bank, 2016). It's economic strength as the 12th leading oil-exporting country in the world (CIA, 2014) makes it a relatively wealthy country. Despite the appreciable revenue that Nigeria derives from oil exports, the level of poverty in the country remains significantly high, with some reports indicating that as many as 61% of Nigerians exist on less than US$1.00 per day (UPI, 2012). Nigeria's GDP per capita in 2014 was US$2,177.99 (World Bank, 2016).This poverty level correlates with Nigeria's low human development index (HDI) position of 152 out of the 188 countries ranked (UNDP, 2015). Reports also put the percentage of the population with access to improved water sources and sanitation facilities at 68.5% and 29% respectively (World Bank, 2015). Politically, Nigeria is a federation of 36 states, 774 local government areas (LGAs), and 9,555 wards as micro-political units. The country is composed of six geo-political zones: North-West, North-Central, North-East, South-West, South-South and South-East. Nigeria was under military rule for the most part of it's post-independence history. There has been some degree of peaceful co-existence in the country since the era of civilian rule began in 1999. The polity, however, remains unstable due to sectarian violence in the North-east and ongoing unrest in the oil-producing communities in the South-south zone.

1.1.1 Subject of Inquiry

The key goal of national health policies, regardless of the wide variance in health systems across countries, is to improve health care delivery across populations. To be specific, national health policies aim to ensure access, equity, quality and cost containment (Blank and Burau, 2010). These goals are congruent with the ideal values of UHC. Taken together, the fundamental elements of UHC (equity, quality and financial protection) ensures that all persons have access to health services without undue financial hardship from the burden of

out-of-pocket payments (OOP) for health care (WHO, 2014). In order to achieve UHC, national health systems must run sustainably, and deliver quality care at affordable costs (Onoka, 2014). Notwithstanding all the benefits of UHC, competing budgetary priorities compel policymakers to be efficient in the allocation of resources. Implicitly, tough choices and trade-offs must be made in order to balance the use of resources fairly (Nicholson et al., 2015).

The main driver for the NHIS reform was the Nigerian government's recognition of the limitations of existing health care arrangements in terms of equitable access and financial protection for citizens. Policy makers at the conception of the NHIS envisaged that the scheme would leverage the benefits of fund pooling (mobilised through pre-payment schemes) and risk-sharing to protect vulnerable persons from the burden of out-of-pocket payments (OOP), and provide equitable and efficient access to health services. Nigeria, like many Sub-Saharan African countries, has historically financed it's health care systems from tax-derived revenue. This approach became unsustainable in the face of dwindling government resources and wider economic constraints in these countries. It therefore became imperative to look for additional sources of funding to finance health care costs. Policy reforms to drive this agenda in these countries have mostly been based on implementing different models of health insurance schemes (McIntyre and Mills, 2012).

Nigerian runs a fragmented, weak and poorly structured health care system. The public health sector is not well managed, and the private health sector inadequately regulated. The country's health system has been sub-optimal on several metrics for over three decades. Taking into account Nigeria's unique health sector circumstances, the country opted to implement a social health insurance system (the NHIS) as a major step towards achieving UHC. I elaborate on the weaknesses of the Nigerian health care system and concerted efforts by successive governments to achieve UHC in the country, in conjunction with a discussion of the difficulties of

implementing the NHIS in Chapter 2. The next section discusses the rationale for the research.

1.2 Research Rationale

The rationale for this research is in two strands. The first is to address the paucity of policy research in low and middle-income countries (LMICs) especially in Sub-Saharan countries. The second rationale (theoretical) is two-fold. The first part seeks to employ the concept of sense-making as an interpretative framework to gain insights into how the cognitive dimension of policy actors impacted on the implementation of the NHIS. The second part which is inextricably linked to the first, seeks to contribute to existing theory by addressing identified deficiencies in the concept of sense-making through broadly scoped research questions.

1.2.1 Policy Studies Rationale: Policy-Making Research in LMICs

This rationale derives from a need to address the unacceptable dearth of policy-making research in low and middle-income countries (LMICs) (Walt and Gilson, 1994; Gilson and Raphael, 2008). Walt and Gilson (1994:353) observed that 'policy analysis is an established discipline in the industrial world, yet it's application to developing countries has been limited '. In the context of the health sector, Uneke et al. (2013) note that in Africa, there is a scarcity of policy research to improve policy reforms. More crucially, they emphasise that even where there is useful empirical research, there is little evidence that they are used to plan effectively. Much of the existing literature on the NHIS scheme has focused on policy content appraisal, programme adoption problems, and scaling-up issues (Anarado, 2002; McIntyre et al., 2013), and policy process analysis (Onoka et al., 2014). In the context of this research, results of database searches on Zetoc and Google Scholar did not reveal studies that explored actor sense-making in the implementation of the NHIS. Accordingly, this investigation pursues a different path of inquiry from these prior studies.

1.2.2 Theoretical Rationale: Exploring NHIS Implementation Through Sense-Making Theory

The introduction of the NHIS was a seismic shift from the *status quo* in the Nigerian health sector. As a consequence, such episodic change would have imposed heavy cognitive demands on policy actors since management research suggests that change situations trigger sense-making in participants (Isabella, 1990; Weber and Glynn, 2006). A significant body of literature provides evidence that individuals in change situations experience cognitive tensions as they anticipate how a change initiative will affect them (Watson and Bargiels-Chiappini, 1998). This cognitive tension, according to Hope (2010), is generated in situations of novelty, confusion or ambiguity or by concerns about change outcomes being as anticipated, or being in conflict with expectations (Maitlis and Christianson, 2014). Implicitly, an episodic change initiative of the magnitude of the NHIS would invariably trigger sense-making across the wide spectrum of NHIS implementing actors. Scholars also assert that the new knowledge that must be transferred in a novel change initiative must make sense to implementers for entrenched practices to change (Dougherty, 2003; Filstad, 2014). All of these views underline the link between new knowledge and sense-making.

Research by Peck and 6 (2006) suggests that a drift from policy intentions occurs because managers and professionals are inseparable from their predominant worldviews or mental models — which invariably impacts on the sense-making they bring into the analysis of issues, their responses to them, and ultimately the decisions they make. The evolution of policy during implementation raises fundamental questions about the compliance model ('top-down' model) of policy implementation in which agents are expected to implement policy as intended. Spillane et al. (2002) view the negation of the role of human sense-making in implementation by researchers as missed opportunities to conduct studies that are wider in scope.

Vadarman (2009:3) acknowledged the role sense-making plays in this evolutionary process and

advocates the use of sense-making as a conceptual tool for exploring the disjuncture between policy intentions and outcomes at 'multiple level of analysis'. The conceptual approach of this investigation borrows from his perspective. If the contentious issues between NHIS stakeholders are related to the existing literature on cognitive implementation research (Muller and Surel, 1998; Spillane et al, 2002; Peck and 6, 2006; Vardaman, 2009), there is a strong research basis to investigate the extent to which the deviations from the intended goals of the NHIS policy occurred as a consequence of individual and collective/distributed actor sense-making.

1.3 Theoretical Approach

This research is both problem and theory-driven. In making his case for theory-driven research, Weick (1992:172) suggests that 'All theories are about practice and practicality, and the trick is to discover those settings and conditions under which they hold true'. In essence, Weick's view is that a theory-based approach is an on-going quest to identify contexts in which theoretical postulations are confirmed. Van de Ven's (2007:269), advocacy for problem-driven research on the other hand, argues that theories are embedded in all problems, and that such problems may have their origin in the 'practical world of affairs', the social world or in a theoretical discipline. In context of this research, problems were identified in the implementation of the NHIS (practical world of affairs) as well as theoretical gaps in the policy implementation and sense-making literature (theoretical discipline) — both bolstering the case for a problem/theory driven research.

1.3.1 Policy Implementation Research: The Unsettled Arguments

Policy implementation research – the over-arching domain of this inquiry – is complex. This complexity is reflected in the clashes of perspectives and divergent scholarly positions about policy implementation in the existing literature. The polarisation of views between the schools

of thoughts has made theoretical consensus in the field elusive (O'Toole, 2004). The extant literature on policy implementation is made up of theories from three generations of research (deLeon and deLeon, 2002). Relying on case studies from the early 1970s and 1980s, first generation researchers or the 'top-down camp', which viewed implementation through a hierarchical and bureaucratic prism, were mostly focused on why implementation did not automatically follow authoritative decisions.

The deficiencies in the compliance model ('top-down') of implementation stimulated the work of a second generation ('bottom-up') group of policy implementation researchers. 'Bottom-up' scholars were more theory-driven in explaining implementation failures across single or multiple policy sites. Lipsky's (1980) work in particular, brought to the fore the limitations of conventional understandings of policy implementation. His thesis that policy implementation is dependent on the discretionary power of frontline professionals whom he labelled as street-level bureaucrats is widely acknowledged as a paradigm-shifting contribution from the bottom-up camp. The significant accomplishment of the 'bottom-up' camp according to Peck and 6 (2006:9) is that it changed the question from 'How can this central policy be implemented?' to 'What are the best ways of running services and initiatives following central decisions, whether or not the result reproduces anything reminiscent of the central policy makers' original ideas?'. Peck and 6's (2006) perspective espouses the complex nature of contemporary policy-making. A case in point in the UK is the shift from government to governance 'where the informal authority of networks is seen to supplement or supplant the formal authority of government' (Durose, 2007:218). This shift suggests a pragmatic willingness by government to accommodate the discretionary power of implementing agents — an action that validates Lipsky's street-level bureaucrat theory.

The efforts of third-generation researchers to bridge conceptual gaps in top-down and bottom-

up perspectives through the generation of hybrid theories by synthesising ideas from both camps have been modestly successful at best.

1.3.2 Policy Implementation and Sense-Making: The Theoretical Linkage

Brown et al.'s (2015:266) definition of sense-making as 'those processes by which people seek plausibly to understand ambiguous, equivocal or confusing issues or events' illuminates our understanding of the role of sense-making in policy implementation, especially in the context of the NHIS initiative. Peck and 6's (2006:16) stance that policy implementation should be seen as sense-making and settlement because sense-making 'necessitates a set of sufficient capabilities within and between organisations and […] enough willingness among key players to contribute to, or at least to acquiesce and not actively obstruct the use of those capabilities', is persuasive. The policy implementation literature reveals a growing academic purchase of Peck and 6's (2006) theoretical viewpoint. Coleman et al (2010:289), in acknowledgement, suggest that research has revealed that 'actors (individuals and groups) in policy implementation have agendas and frames of reference of their own and that these factors, along with local contexts, often have a substantial role in shaping what is actually enacted '.

Beset by criticisms that it lacks homogeneity and contains 'disjunctures and disagreements' and 'unresolved tensions' (Brown et al, 2015:4), sense-making theory is weakened by theoretical incompleteness. These weaknesses are discussed further in the theoretical literature review (Chapter 3). This inquiry also pays attention to the criticism that the theory neglects the role of broader societal factors by being too focused on individual actors (Taylor and Van Every, 2000; Weber and Glynn, 2006; Vardaman 2009). It addresses this criticism by exploring sense-making within the communities of practice (CoP) involved in the implementation of the NHIS. In a broader scope, it also explored the role of power and politics in sense-making to address another academic critique that existing sense-making literature also pays scant attention to the dynamics

of power and politics (Weick, Sutcliffe and Obstfeld, 2005).

To investigate these dimensions, the conceptual apparatus of this research is designed with a wide range to examine individual sense-making (cognition and affect), collective sense-making in context (situated, distributed, social, political), as well as the concepts of sense-giving and gatekeeping.

1.4 Research Objectives and Questions

The twin objectives of this study are to explore the sense-making of NHIS actors to reveal the extent of the impact of sense-making on the implementation agenda and also to empirically address gaps in the extant sense-making literature. The objectives are unpacked as follows:

1.4.1 Objectives

1. To investigate the role of formal and informal interactions between policy actors on the sense-making process

2. To investigate the impact of collective sense-making, especially those deriving from communities of practice

3. To examine the extent to which political, organisational, professional and bureaucratic context shapes the sense-making processes of those implementing major health policy reform in Nigeria

4. To determine the impact of the findings of the case study for policy practice.

1.4.2 Research Questions

The following research questions were derived from the above objectives:

1. What cues did policy actors in their individual capacities extract from the policy message that stimulated their sense-making process?

2. To what extent did collective sense-making deriving from communities of practice between policy actors influence the implementation of the NHIS?

3. What role did power and politics play in the sense-making and sense-giving processes of actors in the implementation of the NHIS?

1.5 Research Philosophy and Methodology : An Overview

In this investigation, a multi-paradigmatic epistemological and ontological approach that interplays post-positivist, constructionist and interpretive paradigms has been adopted. This research orientation is based on a rejection of the notion of paradigm incommensurability, and a conviction that paradigms are not mutually exclusive (Shultz and Hatch, 1996). Given that the broad objective of this study was to explore individual and collective sense-making among policy actors, a case study research design located within an over-arching qualitative research strategy was privileged. Primary data was collected from semi-structured interviews with 29 purposively selected NHIS actors. Secondary data was generated from desk analysis of various publicly available NHIS policy-relevant documents and the data analytic strategy was based on Braun and Clarke's (2006) guidelines to thematic analysis (Chapter 4).

1.6 Structure of the Dissertation

Following this introductory chapter, the rest of the dissertation is presented in six subsequent chapters.

Chapter 2 reviews the existing literature pertaining to the policy context. The review provides a background to the Nigerian health care system, highlighting it's current sub-optimalities, as well

as discussing historical efforts at reform initiatives. The chapter discusses and highlights the structural and operational problems that has made it difficult to scale up the NHIS, such as ambiguities in the NHIS Act 35 and conflicts of interest between key stakeholders. Nigeria's quest to achieve UHC is discussed within the ambit of the concept of UHC with reference to typologies of global health systems, to draw out comparisons with different approaches to UHC. Reference is made to case studies of sub-Saharan African countries facing similar health system challenges but prosecuting different approaches to UHC to underscore the uniqueness of the Nigerian situation and hence it's selection as a case study.

Chapter 3 reviews the literature on theories and concepts integral to the conceptual framework of the study. It starts with a synopsis of current perspectives and debates in implementation research, explicating on the limitations of conventional ('top-down') models of policy implementation to strengthen the case for cognitive approaches to policy implementation research that utilise the concept of sense-making as an interpretive framework. The concept of sense-making is foundational to this inquiry, hence the review discussed it in great depth. The multi-participant implementation environment of the NHIS made a multi-lens investigation imperative. Accordingly, the review of the sense-making literature covers sense-making in individual and distributed contexts. The review of the literature on communities of practice (CoP) contextualises collective/distributed sense-making, having identified CoPs of NHIS executives (as civil servants), of HMO executives, and of healthcare providers (HCPs) within the broad spectrum of NHIS actors. The literature on sense-giving provides insights into participant-actors' (NHIS, HMOs and HCP) attempts to influence the interpretation of others in the implementation process. The literature linking power, politics and sense-making serves as a primer for understanding the dynamics of power and politics seen in the implementation of the NHIS. Overall, the chapter explains how a range of theoretical constructs were integrated to develop the conceptual framework of the study.

Chapter 4 discusses the methodology of the research. It states that the research's philosophical orientation is multi-paradigmatic. The chapter explains that a qualitative approach was privileged because the research aimed to study and attempt to make sense of a phenomenon in a natural setting (Denzin and Lincoln, 1994). It also explains that a case study approach was employed because it was better suited to gain an in-depth understanding of a phenomenon involving varied levels of analyses (Christie et al., 2000; Darke and Broadbent, 1998). The chapter then discusses the ethical considerations of the research, data sources, collection activities, and analytic strategy used – explaining why thematic analysis was utilized.

Chapter 5 reports the main empirical findings of the study. The key findings are thematically presented following the themes of the conceptual map (figure 5.1).They reveal the roles of individual and collective/distributed sense-making on the framings of the policy message, the shared understanding and interests of the CoPs, as well as the part played by power and politics in relation to sense-making in the implementation of the NHIS. The findings which fell outside the scope of the research questions but nonetheless empirically correlated the hypothesis underpinning the conceptual framework are reported under other policy implementation findings (5.10).

Chapter 6 discusses the findings of the research in relation to existing theories to espouse confirmations or departures from theoretical expectations. The discussion subsequently focused on the implications of the findings for theoretical development, policy planning and practice — emphasising the theoretical significance of cognition and affect to individual sense-making and implications of communities of practice theory and power distance orientation for sense-making theory.

Chapter 7 reflects on the NHIS study and delves deeper into .

the contributions of the case study to the literature. It discusses it's strengths and limitations, suggests directions for future research, and closes with concluding remarks.

1.7 Chapter Summary

This chapter presented an overview of the research starting with the subject and context of inquiry and moved on to it's rationale and supporting theoretical frameworks. It described the objectives of the study and it's research questions as well as the methodological approach adopted. It states explicitly that the research inquiry is motivated by academic interest in the notion of policy implementation as a complex adaptive system, the evolution of a policy implementation as a phenomenon, and the under-theorisation in the field of policy implementation led by empirical demonstrations of deviations of policy intentions on account of human sense-making. The study's conceptual framework draws on emerging perspectives in sense-making theory to increase the level of the research's rigour. The next chapter presents a review of the literature of the Nigerian health policy context to provide an important background to the case study.

Chapter 2. Literature Review – Policy Context

2.1 Introduction

This chapter provides a background to the Nigerian health care system, highlighting the unique contextual challenges that the country faces as it strives to achieve universal health coverage (UHC). The discussion starts with a description of the policy context, it's demographics and some selected development indicators. The Nigerian health system has been weak and dysfunctional for decades, notwithstanding the country's relative wealth as a world-leading oil exporter. This segment of the discussion identifies the various factors at the core of the health sector's sub-optimal performance. The consensus of health policy analysts is that the overriding constraint to the achievement of UHC in Nigeria is financial – rooted in the failure of successive administrations to put in place an equitable and sustainable funding mechanism for health care (Onwujekwe, 2011). This policy failure has for a long time imposed a heavy burden of out-of-pocket health care expenditure on individuals. Other constraints identified include weak legislative and governance structures, inadequate health services infrastructure, poor service delivery, and poverty (Gustafsson-Wright and Schellekens, 2013).

Compared with some low and medium-income countries (LMICs)/Sub-Saharan African countries, Nigeria has not made appreciable progress towards UHC — a key reason why it's health indices continue to lag behind those of such countries. This case study benchmarks the performance of Nigeria's health system with those of some Sub-Saharan African (SSA) countries facing similar health system challenges to highlight country-specific circumstances and also to compare the outcomes of different approaches to UHC (see Chapter 6). Based on the financial protection that UHC affords the poorest citizens in society in terms of access to health services, it has been advocated as an ideal health policy framework by three multilateral resolutions: The

World Health Assembly (2005), the African Union Conference of Ministers of Health and Finance (2012), and the United Nations (2012). The narrative on the country-specific factors militating against the attainment of UHC in Nigeria is juxtaposed against the discussion of the concept of UHC to put the Nigerian case study into a global context.

Nigeria has a long history of health sector reforms. This chapter gives an overview of typologies of global health systems to frame the current state of the Nigerian health system and it's aspiration to achieve UHC within a global context. It then gives a chronological description of some of the key reform initiatives that has been undertaken, providing a detailed account of efforts to implement a National Health Insurance (NHI) Scheme (NHIS) as a strategic platform to tackle the barriers to UHC in the country (section 2.7). Following the enactment of the NHIS Act 35 of 1999, implementation of the NHIS (the subject of this case study) was formally launched in 2005. The implementation of the NHIS (section 2.7.1) as it is currently structured is delivered through three main programmes: The Formal Sector Social Health Insurance Programme (FSSHIP), the Urban Self-Employed Social Health Insurance Programme (USSHIP) and the Rural Community Social Health Insurance Programme (RCSHIP). The goals that enactors envisioned at the launch of the scheme are however yet to materialise. Dutta and Hongoro (2013) reported that as of 2012, just 3% of the population (equivalent to approximately 5 million individuals) were covered by the scheme. The problems of the NHIS are, however, not limited to scaling-up challenges. Policy analysts have questioned the rationale for an implementation arrangement that allowed the NHIS the dual capacity to function as scheme regulators as well as to act as a quasi-implementor/operator of the scheme. Another policy design flaw identified is the failure of the enactors of the NHIS to make the scheme mandatory across the country given that the 36 states under the constitution of the Nigerian Federation have political and financial autonomy. However, recent developments, specifically the growing push by sub-national governments (states) to set up State Social Health Insurance Schemes (SSHIS), indicates that the issue of poor

state participation in the NHIS is now being boldly addressed (Care Net, 2018).

The role of context in the implementation of policy initiatives is crucial – given the dynamic bearings contextual factors have on policy implementation especially with regards to health sector reforms where a body of research suggests that such factors may be the ultimate determinants of policy success or failure by facilitating or constituting barriers to the implementation of policy initiatives (May et al., 2006). Rycroft-Malone (2002:176) define context simply as 'the environment or setting where the proposed changes is to be implemented'. More broadly, May et al. (2006), define context as 'the physical organizational, institutional, and legislative structures that enable and constrain, and resource and realize, people and procedures'. Context is however problematic in implementation research for two reasons. First, there is little academic agreement on it's specific features and domains and second, the territory covered by it's description and definition is rather vast. In Damschroder et al.'s, (2009) definition, the context in which implementation occurs, has both an outer setting which includes economic, political, and social contexts and an inner setting comprised of elements of structural, political and cultural contexts. They however caution that there is no clear demarcation between the outer and inner settings because the 'interface is dynamic and sometimes precarious' (2009:5). What is implicit from the thread of this discussion, is that the difficulty of specifying the relevant contextual elements prior to the implementation of a policy militates against successful outcomes.

As explained in chapter 3, context is also of central importance in sense-making because sense-making is not a solo affair – it is embedded in the individual's situation or social context. Furthermore, sense-making is shaped by the institutional/organisational, professional and political contexts described above by May et al. (2006). Accordingly, one of the goals of the investigation was to find out the extent to which these contextual factors influenced the

implementation of the NHIS.

With specific reference to the political context in this Nigerian case study, power and politics have been a central dynamic in the implementation of the NHIS *ab initio*. There were contentious issues and conflicts of interests that had to be surmounted prior to scheme implementation. The resolve of the central government to get the programme started as a matter of political priority led to certain pragmatic actions by policy actors who are described in this thesis as *Veto actors* – on the strength of their substantial political leverage in the implementation process (sub-section 2.8.1). As the findings of this case study reveal, some of these actions were arguably altruistic while others were regarded as being motivated purely by the pursuit of self-interest. The actions of these Veto actors provide insights into the role of power and politics in sense-making (research question 3). These actions are analysed further in sub-section 2.6.1 and their implications for theory and practice extensively discussed in Chapters 6 and 7

2.1.1 Nigeria: Geography and Demography

The Federal Republic of Nigeria is a West African country 923,678 square kilometres in size, situated just north of the equator (National Geographic, 2014). The country was created by the amalgamation of the North and South protectorates by the British colonial authorities in 1914. Nigeria borders the Republic of Benin to the west, Cameroon to the east, Chad to the north-east and Niger to the north. With a population of about 184 million, Nigeria is Africa's most populous country and the eighth most populated country in the world (World Bank, 2016). A median age of 18.3 years indicates that Nigeria has a predominantly youthful population. Demographic breakdown figures are indicated in Table 2.1.

Table 2.1: Nigeria's Demographic Statistics

Population Breakdown by Age Group	
0-14 years	42.5%
15-64 years	54.3%
>65 years	3.1%
Population Breakdown by Gender	
0-14 years	**Male:** 41.4m, **Female:** 39.5m
15-64 years	**Male:** 52.9m, **Female:** 50.7m
>65 years	**Male:** 2.8m, **Female:** 3.1m

Source: CIA Factbook 2017

Nigeria is a very ethnically and linguistically diverse country with more than 300 ethnic groups officially identified and about 500 languages spoken across these groups. The country's dominant ethnic groups are Hausas, Igbos and Yorubas.

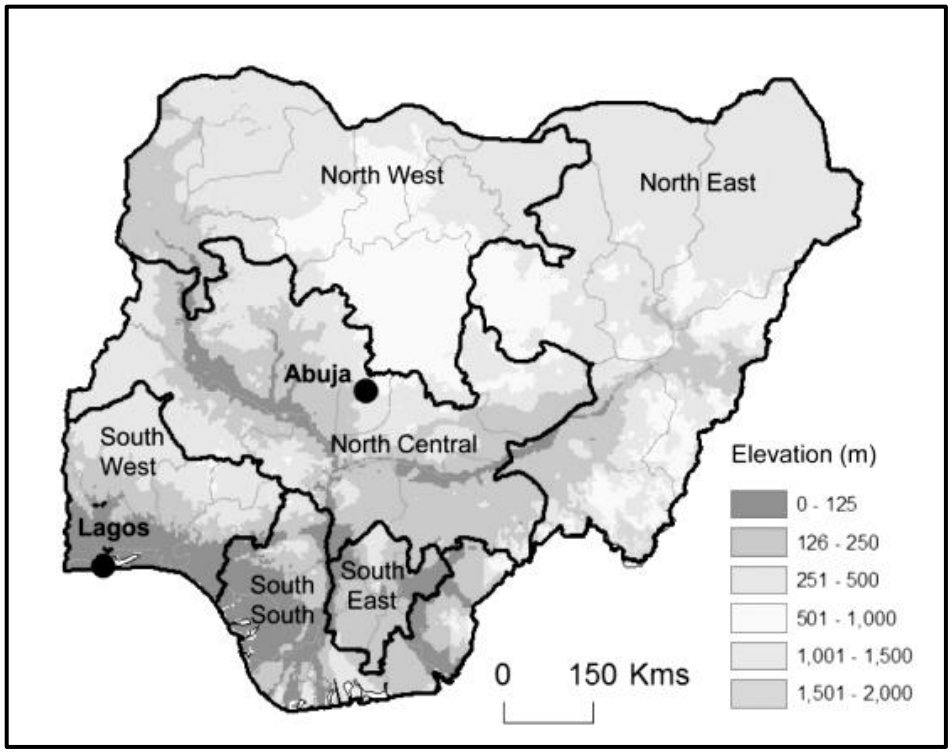
2.1.2 Political Context and Administration

Since Nigeria gained independence from the British in 1960, the country has witnessed intermittent waves of political instability most critically, a major civil war that threatened to disintegrate the country between 1967 and 1970. Nigeria has been ruled by the military for the greater part of it's post-independence existence. The era of democratic civilian rule which began in 1999 brought relative stability but the political climate remains unstable. Peaceful co-existence in the country remains fragile due to persistent religious terrorism in the North-east and intractable unrest in the oil-producing communities of the Niger Delta area (World Bank, 2017).

Nigeria, like some other developing countries including Brazil, India, Mexico and Ethiopia, is a federation under a constitution. The Federal Republic of Nigeria, is structured around a federal

government with 36 states, 774 local government areas (LGAs) and 9,555 wards as micro-political units. The constitution provides for judicial, legislative and executive arms of government at the federal and state levels. The country is often described as being composed of six geo-political zones: North-West, North-Central, North East, South West, South-South and South East.

Figure 2.1: Nigeria's geo-political zones



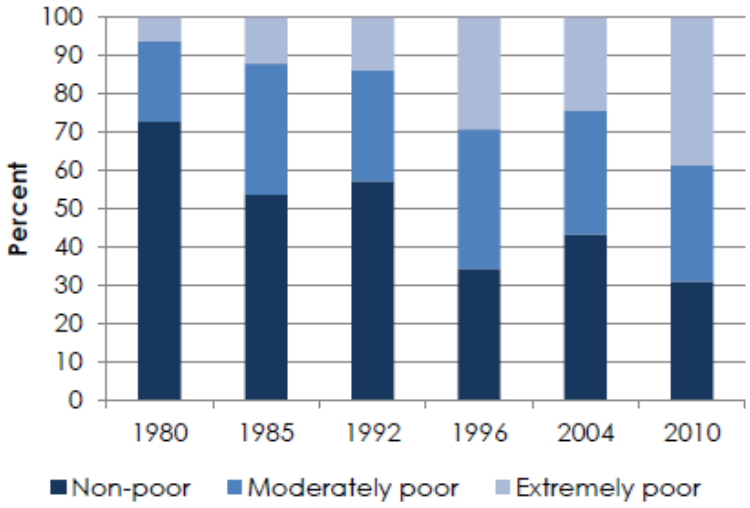
Source: openi. Nlm. Nih.gov 2013

2.1.3 Socio-Economic Situation

The main driver of the Nigerian economy is crude oil exports, contributing 95% of the country's foreign exchange earnings and approximately 80% of the budgetary earnings (KPMG, 2012). Other mineral exports contributing to total foreign exchange receipts include tin, iron ore, coal, lead and zinc. Prior to the exploration and production of crude oil in commercial quantities, the economic base of the country was largely agrarian. GDP per capita in 2014 was $2,177.99 (World

Bank, 2016). In spite of the large inflows of income from oil exports and Nigeria's ranking as a leading oil exporter the level of poverty in the country remains high. Nigeria's relatively low GDP per capita correlates with it's poor ranking in terms of the human development index (HDI). A recent HDI ranking put Nigeria at 152 out of 188 countries (UNDP, 2015). Figure 2.2 below illustrates Nigeria's relative poverty between 1980 and 2010.

Figure 2.2: Relative Poverty in Nigeria (1980-2010)



Sources: Dutta and Hongoro (2013), Harmonized Nigeria Living Standard Survey (National Bureau of Statistics, 2010)

2.2 The Nigerian Health Sector: An Overview

The performance of the Nigerian health sector has been sub-optimal on several metrics for decades. To underline this point, almost two decades ago, the WHO ranked Nigeria's health care delivery system 187th out of 191 countries (WHO, 2000). The Nigerian Federal Ministry of Health, by it's own assessment, described the country's health sector as weak overall (FMOH, 2010). The poor performance of the sector in comparison to African (WHO) region countries and low and middle-income countries (LMICs) is revealed in Table 2.2. The table shows that Nigeria's

vital health indicators (life expectancy and infant mortality rates) are worse in comparison to African region countries and LMICs. Sanitation is generally poor across the country with just 69% and 29% of the population having access to clean water and improved sanitation facilities respectively (World Bank, 2017).

Table 2.2: Nigeria's health status and health service indicator (2012)

Indicator	Nigeria	African region	Lower middle-income countries
Life expectancy at birth (years)	54	58	66
Infant mortality (per 1,000 live births)	79 (69)	63	46
<5 mortality rate (per 100 live births)	124 (128)	95	61
Maternal mortality ratio (per 100,000 live births)	560 (576)	500	240
% of births attended by skilled birth personnel	38 (38.1)	48	64
% of pregnant women with at least 4 antenatal care visits	57 (51)	47	56
% of 1 year olds with measles immunization	42 (42)	73	75
Physicians per 10,000 population	4.1	2.6	7.8
Nurses and midwives per 10,000 population	16.1	12.0	17.8

Source: Onoka (2014); WHO statistics (20140; values in parenthesis are from the 2013 National Demographic and Health Survey of Nigeria

Nigeria has a high incidence of communicable diseases including, diarrhoea, malaria, measles,

respiratory tract infections, tuberculosis, cerebrospinal meningitis, cholera and HIV/AIDS with malnutrition and malaria being responsible for an even higher percentage of child deaths. Non-communicable diseases worsening the epidemiological outlook, include hypertensive heart disease, diabetes mellitus and cancer. Health care in Nigeria is mostly funded by out-of-pocket payments (OOP). Other sources of funding come from tax receipts, donor agencies and health insurance. In comparison to African region countries and LMICs in general, total health expenditure (THE) as a percentage of GDP is lower in Nigeria than in the African region. Table 2.3 below compares health financing and expenditure indices between Nigeria and other countries in the African region and LMICs. THE as a percentage of GDP has, however, improved in the past decade, having risen from 4.6% in 2000 to 5.4% in 2010 (WHO, 2013) and 5.7% in 2012 (WHO, 2014). In contrast, private expenditure is higher in Nigeria than in the African region and LMICs.

Table 2.3: Comparative health care financing and expenditure indicators

Indicator	Nigeria	African Region	Lower Middle Income Countries
Total health expenditure (THE) as % of GDP	5.7	6.2	4.4
General government expenditure on health as % of total government expenditure	6.7	9.7	8.1
Per capita government expenditure on health (PPP int. $)	49	76	60
Per capita THE (PPP int. $)	143	158	163
Government expenditure as % of THE	34.0	48.3	36.6
Private expenditure on health as % of THE	66.0	51.7	63.4
Out-of-pocked expenditure on health as % of THE	95.6	56.6	87.1
Private prepaid plans as % of private expenditure on health	3.1	31.7	4.4
External funding as % of THE	5.1	11.8	2.3

PPP= Purchasing Power Parity

Source: Onoka (2014); WHO statistics (2014)

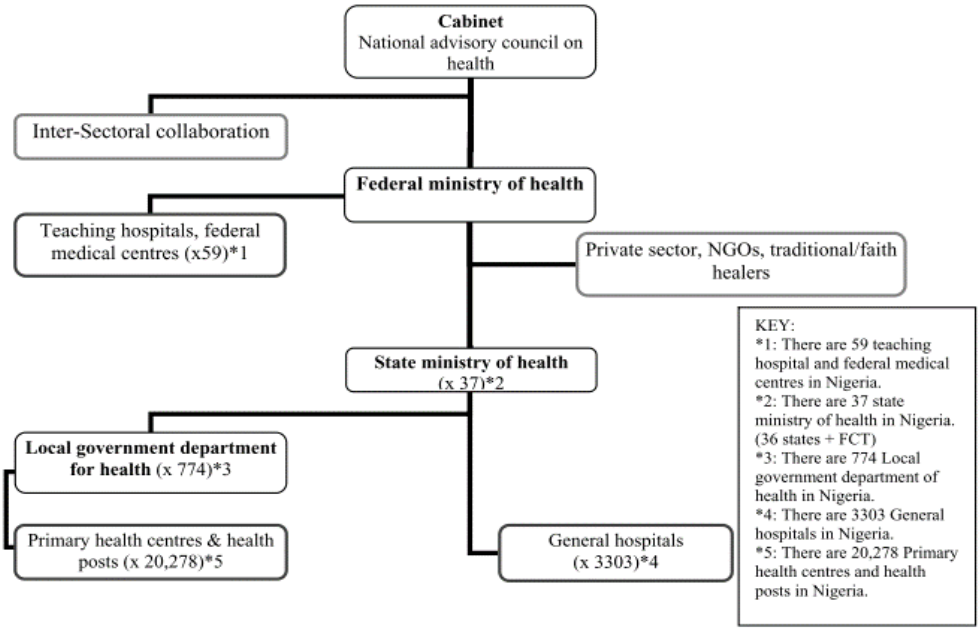
Notably, the WHO reported that OOP as a percentage of THE decreased from 74% in 2003 to 66% in 2012 (WHO, 2014). Onoka (2014) suggests that what is implicit in this reversal of trend is that pre-payment plans via health insurance schemes initially had a positive impact on out-of-pocket health care payments, but the gains could not be sustained as OOPs still account for 90% of total private health expenditure (Onoka, 2014). Reports indicate that in 2008, just 2% of women and 3% of men had health insurance coverage (National Population Commission (NPC)/ICF Macro; 2009, 2013). To further illustrate the limited impact of health insurance

schemes on coverage levels since inception, IFC Macro and ICF International (2014) reported that in 2008, just 5.1% of men and 4.5% of women in the highest quintile had employer-based insurance coverage. In 2013, the figures for those in the highest quintile with employer-based coverage were 7.1% for men and 4.6% for women. These figures clearly suggest that the NHIS initiative is lagging behind expectations.

2.2.1 Structure of the Nigerian Health Care System

Nigeria operates a decentralised health care delivery system. Service provision is delivered by three main groups of providers: 1) the public sector; 2) the private for-profit sector; and 3) the private not-for-profit sector. The Nigerian public health sector operates via a three-tier system administered by the Federal Ministry of Health (FMOH), State Ministries of Health (SMOH) and the local government health departments providing health care at primary, secondary and tertiary levels. Recent developments have seen a number of state governments going outside existing structural arrangements by setting up tertiary medical facilities – a development that has had a negative effect of fragmenting the viability of a functional referral system, as many health care recipients now by-pass the primary care centres to seek care in the tertiary units directly. Also, very active are private-for-profit providers including hospitals and clinics, medical laboratories, patent medicine vendors, pharmacies, non-governmental organisations (NGOs), and traditional and faith healers. The structure of the Nigerian health care system is illustrated in Figure 2.3.

Figure 2.3: Structure of the Nigerian health care system

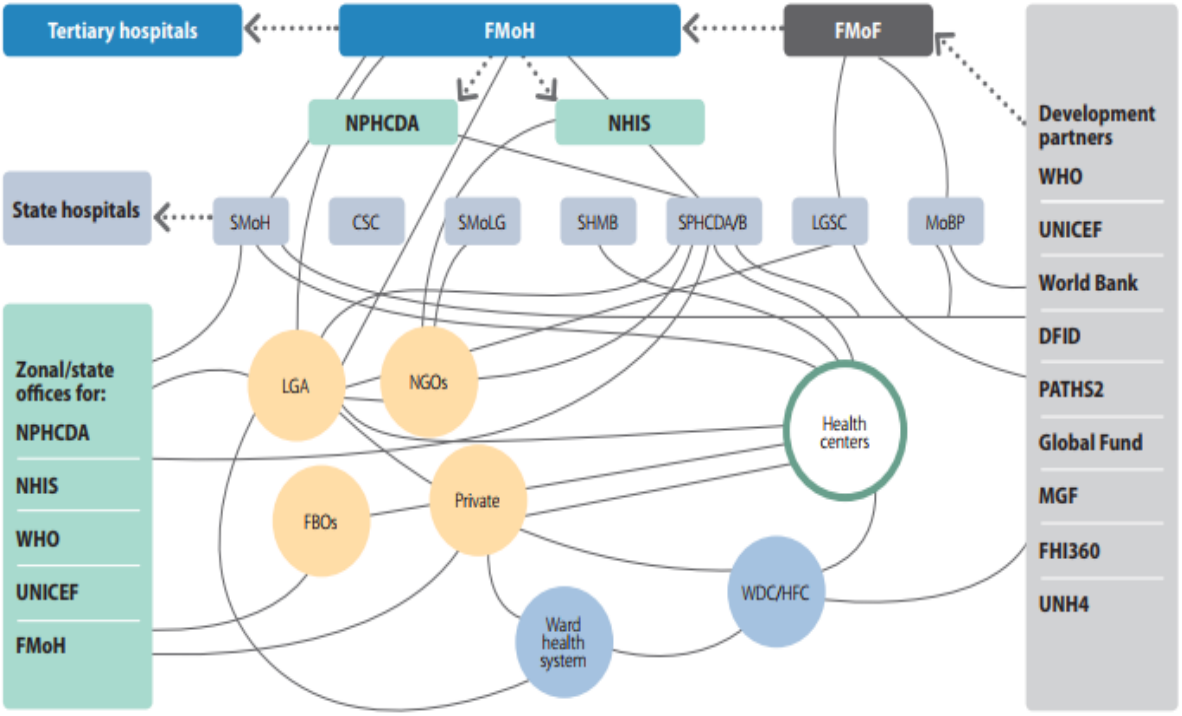


Source: FMOH (2004).

2.2.2 Primary Care

Primary Health Care (PHC) in Nigeria is accessed at the community level. Core services delivered at this level cover preventive and curative care, and evaluation of cases for referral. Providing care are physicians, nurses, community health officers, laboratory technicians, pharmacists, and environmental health care officers. The architecture of the health system and governance arrangements at the PHC level is shown in Figure 2.4. It illustrates the cross linkages between the FMOH, state ministries of health, health management boards, local government areas and development partners. It is important to note that private practitioners are also important participants in PHC.

Figure 2.4: Health system architecture at Primary Health Care (PHC) level



Source: WHO,2017; Bill & Melinda Gates Foundation (2017)

Notes: FMOH = Federal Ministry of Health; **FMoF** = Federal Ministry of Finance; **SMoH** = State Ministry of Health; **LGAs** = Local government areas; **SMoLG** = State ministries of local government; **LGSC** = Local government service commission; **CSC** = Civil service commission; **MoBP** = Ministry of budget and planning; **SHMB** = State hospitals management board; **FBO** = Faith-based organisations; **NPHCDA** = National Primary Health Care Development Agency; **NHIS** = National Health Insurance Scheme.

2.2.3 Secondary Care

Health services at this level are mainly delivered by hospitals – providing general medical and specialist services including surgery, obstetrics and gynaecology, and paediatrics. In addition, a large number of private providers operating through private clinics and hospitals are also active at the secondary care level.

2.2.4 Tertiary Care

Tertiary care is designed to provide the highest level of specialised care for the most serious conditions and specific patient groups. The adoption of latest medical technologies and development of specialist capacities at this level is actively supported by the federal government. Tertiary care is delivered around a hub of specialist teaching hospitals and federal medical centres (FMCs) across the country. Given the human and material resources available at these centres, they serve as a repository of specialised medical knowledge and competencies that are deployed to meet the needs of patients who are typically referred from primary and secondary care institutions. The teaching hospitals also contribute to professional capacity development through the training of medical specialists, community health personnel, nurses and midwives. A key challenge for tertiary level care is the limited number of adequately trained personnel to operate sophisticated medical equipment. Across the country, the disparities in health service provision, human and material resource capacities at this level are a huge concern — especially in the largely under-served northern areas of the country.

2.2.5 Local Government Facilities

Nigeria has 774 local government areas (sub-section 2.2.1) each of which has health care departments delivering primary care at the community level. These centres receive assistance from state ministries of health but operate according to national guidelines set by the FMOH.

2.2.6 The Nigerian Private Health Sector

As stated earlier (sub-section 2.2.2) , private providers comprising medical clinics, general hospitals, specialist centres, laboratories, retail pharmacies, patent medicine vendors, maternity homes and faith/traditional healers are significantly active in PHC in Nigeria. Figures provided by Onwujekwe (2013) confirm the scale of the dominance of the private sector in the provision

of health services in Nigeria. According to Onwujekwe (2011), the total number of health care centres in Nigeria as of 2005 was 23,640, disaggregated as 20,278 (85.8%) primary care centres, 3,303 (14%) secondary health care units, and 59 (0.2%) tertiary care units. Instructively, 9,034 (38%) of these facilities were privately owned although there are higher estimates suggesting that the private sector may be providing up to 60% of the health services delivered in Nigeria.

2.2.7 Access Problems in the Nigerian Health Care System

The problems of access to health care in Nigeria are two-pronged. First is the problem of geographical access to service units, and the second is one of financial barriers (affordability constraints) that derive from a health care system that is largely financed through OOPs. To put the first problem in perspective, the FMOH in 2010 reported that 88% of Nigerian doctors work in hospitals but noted that 74% of these doctors work in private hospitals (FMOH, 2010). Worse still, most of these private centres are concentrated in urban areas where most of those who can afford to pay for their services reside. The problem of access can be better appreciated if one considers that 51% of the total Nigerian population are mostly poor and dwell in rural areas compared to 49% in the urban areas (World Bank, 2011). Table 2.4 below shows some indicators linking economic and human resource problems to the problems of health care access in Nigeria.

Table 2.4: Some basic socio-economic and health access indicators in Nigeria (2005-2010)

Basic indicators	2005	2006	2007	2008	2009	2010
Rural population, % total	54	53	52	52	51	
GNI per capita, PPP$	1,530	1,790	1,860	1,990	2,070	
Fiscal space: government tax as % of GDP	0.2	0.1	0.2	0.3		
Access indicators						
Doctors per 1,000 pop		0.3	0.3	0.3	0.4	0.4
Nurses and Midwives per 1,000 pop		1.7	1.7	1.8	1.6	1.61
Doctors, nurses and midwives per 1,000 pop		2	2		2	2

Source: 1. World Bank (2000-2011) 2. World Health Statistics (2005-2011) 3. Nigeria WHO statistics 4. http://apps.who.int/ghodata/?vid=15000&theme=country

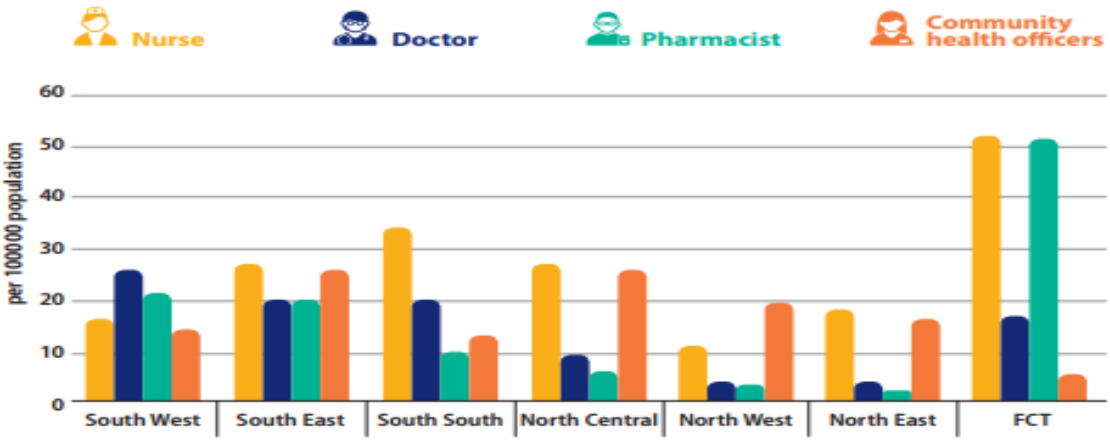
2.2.8 Health Workforce Data

There is a paucity of data concerning Nigeria's health workforce. Data that is available is unreliable due to a lack of a properly developed health information system in the country. Records from the regulating agencies are inaccurate because they are not regularly updated. In December 2007, there were 52,408 medical doctors on the Nigerian register but of this number, only 14,000 had paid the required licence fees for that year. The report also pointed out that neither the medical nor nursing registers have been updated to account for practitioners who are deceased, have left the profession, or have moved abroad to practise (Africa Health Workforce Observatory, 2008).

A useful approach to assess Nigeria's human health care resource capacity is to analyse the data from recent publications that have drawn attention to the disparities in the distribution of the

health workforce across the six geo-political zones of Nigeria. Figure 2.5 indicates the variance in categories of available health care personnel available across the zones — highlighting imbalances and disparities. A significant concern is the high shortage of health care manpower in the northern parts of the country (Obembe et al., 2014). Key workforce performers at the PHC level are community health extension workers and community health assistants, community health officers, doctors, nurses, midwives, laboratory staff and public health nurses (FMOH, 2010) with the majority of doctors and nurses opting to serve in upper-tier centres and private practices. Underscoring the huge threat to ongoing PHC scale-up initiatives is the fact that only about 12% of practising doctors work in PHC services in general (FMOH, 2010). The inference that can be drawn from this data is that medical doctors are less attracted to serving in primary care. This situation has resulted in a skewed distribution of community health workforce at the PHC level — amplifying the problems of access to health services (NPHCDA, 2015).

Figure 2.5: Zonal disparities in the Nigerian health workforce



Source: WHO, 2017; Bill & Melinda Gates Foundation (2017)

The next section chronicle Nigeria's health sector reform initiatives, concentrating on key reforms from 1975 to 2015.

2.3 Background of Health Sector Reforms in Nigeria (1975-2015)

The central objective of a health sector reform (HSR) is to change and improve the existing system. Ewurum et al. (2015: 196, citing the WHO, 1995) defined HSR as 'a sustained process of fundamental change in policies and institutional arrangements, guided by Government, designed to improve the functioning and performance of the Health sector and ultimately the health status of the population'. According to the FMOH, Nigeria's objectives regarding HSR focuses on the delivery of efficient, equitable, and affordable services that will be available to all (FMOH, 2004). The Nigerian health system was built on the model it inherited from the British colonial masters who governed the country prior to independence in 1960. The priority of the then-colonial administration (with regards to the health sector) under both the First Colonial Development Plan (1945-1955) and Second Colonial Development Plan (1956-1962) was to address service delivery imbalances in the country given that rural areas at the time were under-served relatively to the urban areas. Beyond that specific goal, the two colonial plans had no bold ambitions behind them.

2.3.1 Periodisation of Key Health Reforms in Nigeria

This review concentrates on key health policy reforms initiated between 1975 and 2015 and implemented during four significant periods (1975-1989, 1981-1985, 2003-2007, 2010-2015). Overlapping those periods were *ad-hoc* (intervention) policies introduced in 1988, 2005 and 2009. Timelines and summaries of the aims of the reforms are presented in Table 2.5.

Table 2.5: Timeline of Key Health Sector Reforms in Nigeria

Date Period of Reform	Title of Reform/Plan	Key Aims
1975-1980	Third National Development Plan	The third plan was a Basic Health Service Scheme (BHSS) designed: 1. To widen/boost access from 25%-60% (Omuta et al., 2014); 2. To correct imbalances between preventive and curative care; 3. To provide infrastructure(s) for all preventive health programmes (communicable diseases, family and environmental health and nutrition); 4. To establish a health care system compatible with local conditions and available level of technology. (Omuta et al., 2014; Adeyemo, 2005: 153)
1981-1985	Fourth National Development Plan	To establish three levels of health care facilities: 1. Comprehensive Health Centres (CHC) to provide services to communities of more than 20,000 persons; 2. Primary Health Centres (PHC) to serve communities of 5,000 to 20,000 persons; and 3. Health Clinics (HC) to serve 2,000 to 5,000 persons. (Omuta et al., 2014)
1988	National Health Policy	Instigated by WHO's 1978 Primary Health Care Conference at Alma Ata, the policy was a strategic approach to address community health problems through the promotion of PHC, preventive and curative services. Implementation was given legal backing by

		the enactment of decree 29 of 1992. The implementation strategy focused on community mobilisation and participation, service integration, health research, capacity building, and non-governmental and international collaborations. (Alenoghena et al., 2014)
2003-2007	Health Sector Reform Policy (HSRPP)	The focal point was the revitalisation of PHC by incorporating performance benchmarks into the policy. The strategic framework was designed to be integral to: 1. The New Partnership for Africa's Development (NEPAD) – a pledge by African leaders to pursue sustainable growth and development with the eradication of poverty as a primary objective; 2. Nigeria's Millennium Development Goals (MGDs); and 3. The National Economic Empowerment and Development Strategy (NEEDs). (Ewurum et al.,2015)
2009	National Health Investment Plan (NHIP) and Midwifery Services Scheme (MSS)	To address the intractable problems of high maternal, child morbidity and mortality in Nigeria by direct intervention. The overall aim of the scheme was to increase the level of skilled birth assistance (SBA) in the country. The scheme was a collaborative effort between the three tiers of government (Federal, State and Local governments) and strategic foreign partners including WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN under a jointly executed memorandum of understanding (MOU).

2010-2015	National Strategic Health Development Plan (NSHDP)	Developed as part of the National Planning Commission's (NPC) Vision 2020 plan to strengthen the Nigerian health system by aligning health care objectives at the national and sub-national level with strategic inputs from state health development plans (SHDP) of the 36 states of the country, including the Federal Capital Territory (FCT). The initiative introduced elements of managerialism by incorporating a shared results framework in which health officials would be held to account for goals and targets at all levels. Incorporated into the plan were objectives to develop/implement health financing strategies to ensure allocative efficiency in use of resources and to provide citizens with financial protection from catastrophic health expenditure.
2005- till date	The National Health Insurance Scheme (NHIS)	1. To ensure equitable access to good health care services 2. To provide financial protection against catastrophic health expenditure 3. To limit the rising cost of health care 4. To ensure efficiency in the delivery of health services 5. To improve/harness private sector participation in the provision of health services 6. To ensure sustainable funding for health services

Source: Fawehinmi (2018)

2.3.2 Critical Assessment of Reforms

The main objective of the third plan was to address the skewed distribution of health facilities across the country. The initiative however did not produce the expected results due to poor

policy formulation — critically, the lack of a clear policy framework to support it's goals. Asuzu (2004) criticised it's prioritisation of infrastructural projects and auxiliary health manpower development. He also asserts that the plan failed to structure and designate responsibilities for resource generation and manpower development between the three tiers of government.

The fourth development plan, which was designed to scale up the BHSS launched under the third plan, also failed to achieve it's set objectives for reasons that were mostly financial. Adeyemo (2005) pointed out that the goal of BHSS once again became supplanted by the prioritisation of budgetary allocations for capital infrastructural projects such as teaching and specialist hospitals. The BHSS strategy was subsequently revised when a new military administration came into power in 1983 with a renewed focus on primary care.

The National Health Policy (1988) was not particularly successful due to poor planning cohesion between the three tiers of the Nigerian health system. This major design flaw resulted in a dysfunctional system that allowed the federal government to participate in both primary and secondary care alongside state governments who were also cross-participants in tertiary and primary care. Another unintended effect of this arrangement led to local government PHC units abdicating their PHC roles to federal and state governments. Policy analysts have also pointed out that the participation of all three tiers of government in PHC was duplicitous – arguing that it creates an overlap of responsibilities that generates conflict and waste (World Bank, 2010). Onwujekwe (2011) suggests that the main weakness of the 1998 National Health Policy was that it was not backed by law and that the inadequacies in it's enabling decree reflects the command-and-control mindset of the military rulers in 1992. A recognition of the short-comings of the 1988 health policy lead to it's revision in 2003. The Health Sector (HSRPP) reform has recorded a modest degree of success in PHC but key challenges such as infrastructural impediments and access problems, especially for the financially vulnerable, persist.

The results of the National Health Investment Plan (NHIP) and Midwives Service Scheme (MSS) have been mixed. Whilst there is encouraging improvement in baseline indices for maternal, new-born, and child health (MNCH), progress has not been evenly spread across Nigeria's geographical zones (Abimbola, 2012). The scheme still has sustainability challenges, especially with regards to uncertainty with funding. There are also concerns that the scheme may be hindered by financial problems once the flow of funds from the Paris Club debt relief programme ends.

The NSHDP plan (2010-2015) focused on strengthening funding mechanisms for PHC and improving financial protection of vulnerable persons as part of a global strategy to achieve UHC in the country. This explains why the aims and objectives of the NSHDP (2010-2015) overlap with the goals of the NHIS and those of the legislative actions behind the passing of a National Health Bill (now National Health Act, 2014). In terms of the scale of their significance, the NHIS policy and the enactment of the National Health Act, 2014 represent Nigeria's boldest drive towards UHC in the past decade.

The next section which focuses on international health care systems to place Nigeria's challenges within the context of other approaches to UHC, starts with an overview of the typologies of global health systems. The international health care context is relevant given pivotal influence of the World Health Organisation (WHO) on the health policies of LMICs and Sub-Saharan countries more importantly. Seen in this light, any constructive discussion on Nigeria's health sector reform initiatives must be located in the context of global health systems for two critical reasons: first, the WHO in 2000 ranked the Nigerian health system at a position of 187 out of 191 countries, so Nigeria cannot ignore the international context in planning it's reform initiatives and must draw upon examples of best approaches in other contexts either by lesson drawing or policy transfer (Rose, 1993; Dolowitz and Marsh, 1996). Secondly, the

international context is important because nearly all OECD countries have universal health coverage (Docteur and Oxley, 2003; OECD, 2004). Figure 2.6 illustrates the inter-relationship between the global and the national context of country-health systems at the macro-level.

2.4 The Global Perspective on Approaches to UHC: Typologies of Health Care Systems

Approaches to the description of health systems vary in focus, scope and taxonomy (Wendt et al., 2009). Health systems are defined by their objectives and achievement targets, or by the elements of their configuration (Gilson, 2012). The three main goals of health systems according to the 2000 World Health Report (WHR), quoting Docteur and Oxley (2003:44), are 'better health, fairness in financial protection and responsiveness to people's expectations' (WHO, 2000; Evan, 2002). The context in which health systems are designed is inherently political. These political dimensions include the formal institutions where public policy decisions emerge, such as the legislature, the executive, judicial institutions and regulatory bodies. Not to be discounted in the political arena is the role of informal practices within formal institutions, and strong private interests, mainly from medical professionals, that affect the power relationships between political actors (Blank and Burau 2010). Lister (2007) explained that 'Health systems in different countries will combine varying proportions and roles of public and private providers in finance and provision of services'. Some approaches are mainly public, others mostly private, and many are mixed in varying proportions. Another factor that affects a health system is how care is paid for, whether through taxes (public funding), insurance (social or private), or through payments by consumers.

The goal of health systems is health improvement through various approaches based on curative and preventive services in combination with measures targeted at protection and public health promotion, and rapid response preparedness in emergency situations (Mackintosh and Koivusalo, 2005).

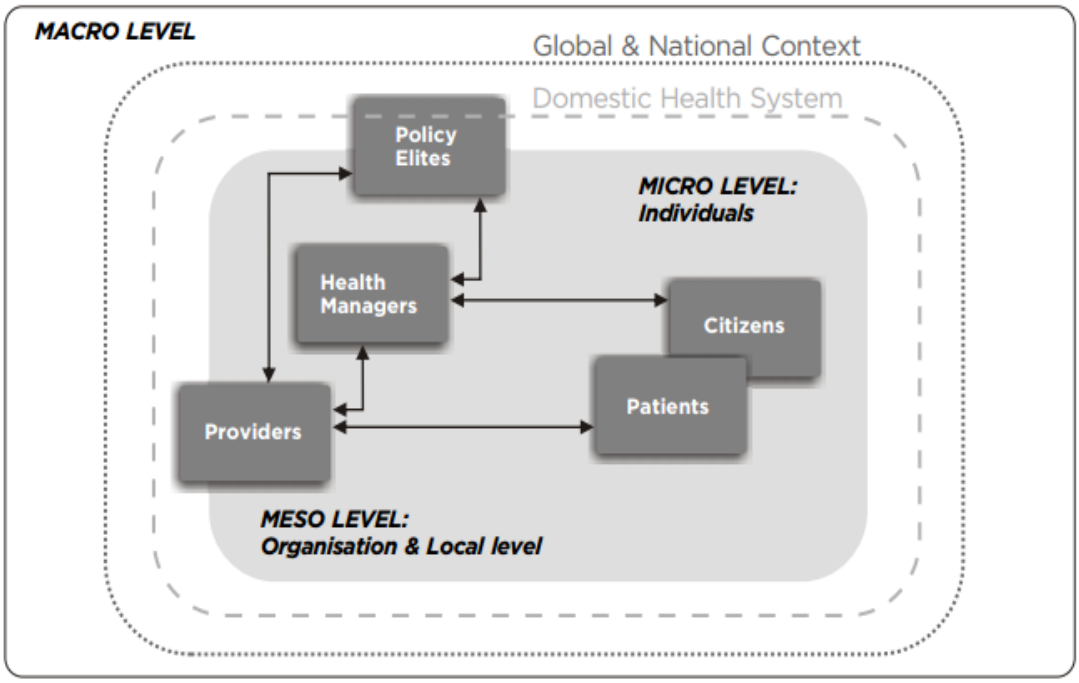
A health system cannot be divorced from the social fabric of any particular country, especially with regards to mitigating the financial burden of high costs and the promotion of the dignity of people. Focusing on the requirements for achieving these utilitarian aspirations, Mackintosh and Koivusalo articulated what is needed: 'Ethical integrity, citizens' rights, participation and involvement of health system users in policy development, planning and accountability, and respect of confidentiality and dignity in service provision' (Mackintosh and Koivusalo, 2005, in Gilson, 2012: 23).

In a similar perspective, Freedman et al. (2005) suggest that what is required is: 'Building and maintaining the social relations that support sustained resource redistribution, through strategies and activities that include, rather than exclude, socially marginalised population groups within all decision-making activities' (Freedman et al., 2005, cited in Gilson, 2012).

2.4.1 Operational Levels of Health Systems

The operations of health systems typically span macro, meso and micro-levels (Fulop et al., 2001). Whilst the micro and meso levels are main focused on domestic health systems, it must be borne in mind that operations at these levels are to a significant degree, influenced by the international health context.

Figure 2.6: Graphical Representation of Operational Levels of Health Systems



Source: Gilson (ed) (2012)

As stated at the beginning of this section, the health system of a nation is largely shaped by it's political system. Although political systems vary, shared characteristics seen in various versions of national health systems and the evident alignment in their underpinning political ideologies have allowed for the development of typologies or 'ideal type' health care systems. That said, one must quickly caveat that health systems are, in practice, remarkably fuzzier in structure than the typologies suggest (Blank and Burau, 2010).

One of the earliest typologies developed by the OECD (1987) descriptively illustrates that health systems, either by provisioning or funding, are typically delivered via a free market system (without government involvement) at one end of the spectrum, and by monopolistic tax-based government provisioning and funding at the other. In the OECD typology, the three main health systems in operation across nations are private insurance (or the consumer sovereignty model), social insurance (or Bismarck model) and the national health service (or Beveridge model). Box

2.0 shows the three main types of health care systems

Box 2.0: Types of Health Care System by Provision and Funding

The Private Insurance Model

The core assumption of this model is based on the economic doctrine of market superiority with regards to allocative efficiency in the use of resources, which provides justification for the idea that funding and provisioning of health services is best left to market forces. Health care provision and the factors of production are designed around private ownership. Under this model, the state plays no direct role in provisioning or funding of health services. Citizens purchase private health insurance individually or through their employers who make significant contributions to the co-payments made by those employees. The system, however, recognises it's structural imperfections, hence it is in-built with the necessary protection and safeguards for vulnerable groups of people such as the young, the elderly and the poor.

Social Insurance (Bismarck model)

This model is a compulsory health insurance scheme with a broad objective of UHC based on a central concept of social security. It is funded by contributions from employers, individuals, and not-for-profit insurance companies that are regulated and subsidised by the state (Blank and Burau, 2010). Although the provision of services is based on fee-for-service arrangements, some of the production factor inputs remain in government ownership. Germany was the first country to implement the social insurance model following the passing of compulsory sickness insurance law in 1883 (Arodiogbu, 2005). France, Switzerland, the Netherlands, South Korea, Taiwan, Mexico and Brazil are examples of other countries operating this model of health system.

The National Health Service (Beveridge Model)

This is a UHC system financed by general taxation. This model is widely identified with the UK, although New Zealand launched it's version of this model of health system in 1938 – well before the UK (Blank and Burau, 2010). In the UK, the introduction of the NHS came on the heels of the 1942 Beveridge report as part of an encompassing solution to a range of welfare problems (Klein 2001). In New Zealand, the model was a policy extension to it's 1938 Social Security Act. In both countries, citizens were guaranteed access to all health care services – free at point of delivery.

Source: Adapted from Blank and Burau 2010

2.5 The Social Health Insurance (SHI) Model in the Context of LMICs

Against a background of recognised constraints to UHC in many LMICs – including but not limited to low health expenditure levels, the vulnerability of citizens due to inadequate social health

protection, and financial burden of household out-of-pocket spending – many such countries have introduced SHI as a mechanism for replacing budgeting as a means of paying for health services. Explaining the SHI concept, Carrin (2002: 3) points out that: 'Social health insurance (SHI) pools both the health risks of it's members, on the one hand, and the financial contributions of enterprises, households and government, on the other. Contributions from households and enterprises are usually based on income, whereas government contributions are mostly financed from general taxes'. In Carrin's (2002) view, SHI by design, is a robust approach to achieving the objectives of UHC, especially in terms of providing populations with equitable access to health care services. Following this overview of global approaches to health service delivery, the next section discusses the NHIS initiative and the National Health Act 2014 in relation to Nigeria's efforts to achieve UHC.

In order to gain a better understanding of the challenges of UHC in Nigeria, a preamble on UHC as an ideal concept/recipe is helpful at this point. Sub-section 2.6 accordingly discusses the concept of UHC in relation to other LMICs that have prioritised UHC-centric policy reforms to highlight the uniqueness of the Nigerian situation.

2.6 Universal Health Coverage in Developing Countries: A Recipe and It's Constraints

The idea of UHC is rooted in the WHO's 1948 constitution, which declared health as a fundamental human right. Three decades later, the WHO Health for All Agenda of 1978 (the Alma Ata declaration) gave further impetus to the idea by enjoining countries to pursue policies towards the achievement of UHC. Following the declaration, a number of multilateral resolutions advocating the adoption of UHC as a global and regional agenda by member states were also passed. These include those passed by the World Health Assembly (2005), the African Union Conference of Ministers of Health and Finance (2012), and the United Nations (2012). These resolutions were aimed at shifting the emphasis of most health systems from targeted

interventions to universal coverage. UHC is defined by the WHO (2014:1) as 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access'. In essence, the goal of UHC is to provide people with access to the range of health services they require and to ensure that they are financially protected in doing so (McIntyre, 2011). With the passing of the resolution of the World Health Assembly in 2005, UHC became a central goal of WHO member states.

According to Knaul et al, (2012:1259) UHC is built around the following three components:

(1) Universal enrolment, a term closely associated with legal coverage on the basis that it entitles all people to benefit from health services funded by publicly organised insurance.

(2) Coverage, that is universal implies regular access to a comprehensive package of health services with financial protection for all.

(3) Universal effective coverage guarantees to all on an equal basis the maximum attainable health care results from an appropriate package of high-quality services that also prevents financial shocks by reducing out-of-pocket payments.

There are differing definitions of UHC but the two elements that are core to any of it's definitions are financial risk protection and geographic access (AfHEA, 2011).

2.6.1 Financing UHC in Developing Countries

Providing UHC in any context is a hugely expensive proposition. The range and quality of services to be provided are the two critical UHC variables with independent cost implications. Policy recommendations from the World Bank, the WHO and Chatham House on approaches to financing UHC in developing countries have proposed a range of options. In the 1980s, the predominant recommendation was for developing countries to look more towards private

financing. In subsequent years, charging patients user fees was the favoured option. However, all of these approaches fell short of delivering UHC across populations — and consequently the poor in those countries bore the burden of inadequately formulated policies. Attempts by UNICEF and the WHO to exempt the poor from user fees through the Bamako initiative in 1987 also failed to achieve the desired results. Thereafter, voluntary community-based insurance schemes were promoted as the most viable option. However, experience has shown that most of those schemes have failed to gain traction with many reporting problems with scaling up coverage.

The discussion so far suggests that the most viable approach to achieve the broad objectives of coverage is yet to be found. In the view of Nicholson et al. (2015:22), mandatory financing mechanisms offers the best pathway to UHC. As they explain:

> 'In recent years, a strong consensus has emerged that mandatory financing mechanisms (from general taxation and compulsory insurance schemes) are the best way to fund UHC. Organisations such as WHO and Chatham House have dismissed the viability of voluntary funding mechanisms. More strikingly, the World Bank has now become one of the leading agencies campaigning for publicly financed UHC. The current World Bank President has described health care user fees as "unjust and unnecessary"'.

The Lancet Commission, in it's 2013 report titled *Global Health 2035*: *A World Converging within a Generation,* published empirical findings that strongly support the use of financing mechanisms that are compulsory and predominantly publicly funded to achieve UHC. Having established that the role of OOPs in UHC is limited because they do not offer enough financial protection against catastrophic health expenditure, the report recommends two approaches that are based on progressive universalism as preferred options. The first approach initially targets poor people by electing to cover them by intervention. The second approach targets poor people at the start of implementation by exempting them from payments of insurance premiums or other co-payments. Giedon et al. (2013:vi), referencing studies that have

demonstrated the positive effects of this approach on 'access, financial protection, and even health status outcomes', suggest that such highly focused interventions are catalytic steps towards achieving UHC. The Lancet report, however, cautions that the pooling of funds via voluntary contributions may not necessarily deliver the expected economies of scale. Restating the WHO position, McIntyre (2011) similarly argued that UHC cannot be achieved via voluntary enrolment alone and suggests that policy makers pursue options that optimise the benefits of cross-subsidisation to achieve this.

2.7 Towards Universal Health Coverage in Nigeria: The Challenges

As stated earlier, Nigeria has taken bold steps in it's pursuit of UHC, but progress towards those goals is far from satisfactory. The NHIS – the country's main policy initiative to accelerate Nigeria's journey towards UHC – is floundering. Scheme coverage has not exceeded 5% of the population since it was launched (Dutta and Hongoro, 2013), which is clearly well below the 90% coverage level recommended by the WHO (Onwujekwe, 2011). The crux of the problem, to reiterate, is largely financial. The barriers to UHC in Nigeria are, however, beyond financial. Other identified constraints include:

1. Deficiencies and ambiguities in the Nigerian NHIS Act 35, 1999.
2. Insufficient risk-pooling as a result of a deficiently designed/implemented NHIS that prioritises formal sector coverage over the larger informal sector with greater health care needs.
3. Lack of a legal framework that makes access to health care (UHC) a fundamental right within the Nigerian Constitution.
4. Poor NHIS implementation across the country as a consequence of an unsupportive three-tier (federal, state and local) political structure, which renders the governments

of Nigeria's 36 states and LGAs semi-autonomous from the federal government.

5. Low willingness to prepay for health care in the country as a result of a poor perception of/attitudes towards the concept of health insurance, and a lack of trust in the benefits of health Insurance – most of which is based on inherent cultural beliefs.

2.7.1 The Nigerian Health Insurance Scheme (NHIS)

The attractiveness of risk sharing and resource pooling as a sustainable financial funding mechanism for UHC are the drivers that have led many LMICs to embrace different versions of health insurance-based pathways to UHC. The NHIS (a SHI model) had a long gestation period from conception to implementation. The very first initiative to introduce a locally designed form of pre-paid contributory health financing mechanism through parliament as far back as 1962 was unsuccessful. Although the effort did not receive parliamentary assent then, it demonstrated the government's recognition that there was indeed a need for a form of insurance-based mechanism to fund health care in Nigeria (Awosika, 2005; Onoka, 2014). It would be many years later before the country launched a National Health Insurance Scheme. Box 2.1 captures the timelines of the legislative and implementation milestones of the NHIS.

Subsequent to the enactment of the NHIS Act 35, 1999, the scheme was formally launched in 2005 with an explicit presidential mandate to improve the quality of health care for all Nigerians via affordable health insurance by 2015 (NHIS online, 2013). Charged with the management of the scheme is a governing council made up of private and public-sector representatives selected from the Nigerian Ministries of Health, Finance and Labour as well as registered HMOs, HCPs and public interest groups.

Box 2.1: Timeline of NHIS implementation

1962: A proposal for the scheme was first considered in 1962, soon after Nigeria gained independence in 1960. With strong resistance from the Nigerian Medical Association (NMA), the proposal however did not gain the necessary momentum.
1984: The National Council on Health under the then Health Minister set up a committee to advise the governments on options for setting up a sustainable health financing system in Nigeria. The Committee recommended National Health Insurance (NHI) as a viable mechanism.
1985: The Health Minister constituted a meeting of stakeholders including labour union leaders, HCP representatives, employers of labour, and development partners as a forum for broad consultations on the viability of NHI in Nigeria.
1988: The Health Minister set up yet another review committee to work on a realistic and acceptable model for implementing health insurance in Nigeria.
1991: The Federal Government of Nigeria signed an agreement with the UNDP and ILO for technical assistance in planning and implementing the scheme.
1993: The Health Secretary in the then Interim National Government (ING) presented a memorandum to the Transitional Council advocating the take-off of the scheme as soon as possible.
1995: A Health Insurance Summit held in Abuja, Nigeria recommended the involvement of the private sector in the implementation of the NHIS. This paved the way for the participation of HMOs in the scheme.
1997: The Nigerian Military Head of State declared the intention of the government to enact

the law to back the NHIS.
1999: The Head of State signs the NHIS decree (Act) 35.
2000: The House of Representative Committee on Health of the National Assembly held a public hearing on the NHIS.
2001: An extra-ordinary session of the National Council on Health met to deliberate on the NHIS in Port-Harcourt, Nigeria in July.
2003: Community Based Health Insurance Schemes (CBHI) launched in the six geo-political zones of the country.
2004: The National Council on Health adopts the recommendations of the Ministers' memorandum as a new blue-print for the launching the NHIS.
2005: NHIS launched. Scheme commenced with the FSHIP.
2014: The Tertiary Institution Social Health Insurance Programme, and the Public Primary School Mobile Health Insurance were launched.

Source: Asoka, 2011; Onoka, 2014

The NHIS implementation plan was phased to start with mandatorily enrolled formal sector employees (federal and state public sector workers), followed by private sector employees and the informal sector. It was structured to be delivered through three main programmes:

1. The Formal Sector Social Health Insurance Programme (FSSHIP).
2. The Urban Self- Employed Social Health Insurance Programme (USSHIP).
3. The Rural Community Social Health Insurance Programme (RCSHIP).

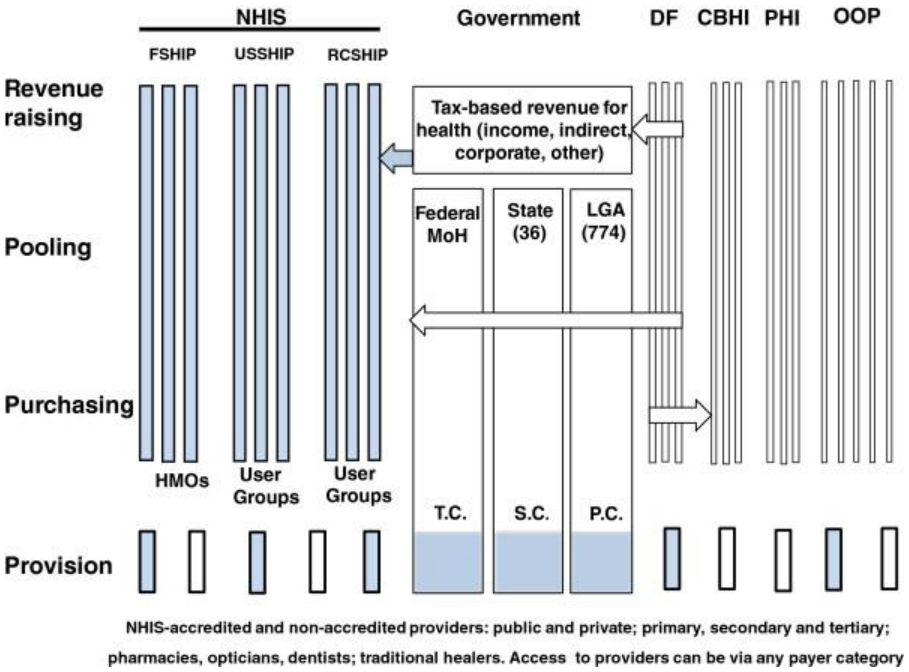
The FSHIP implementation commenced in 2005 with coverage of employees in the public and

private sector (companies with more than 10 employees), representing 40% of the population. Public and private sector employees contribute 15% of their salaries to the scheme. This is matched by a contribution of 10% of each employee's salary by the employer. The benefit to the employees and their dependants is entitlement to in-patient and out-patient care at accredited health centres. Voluntary participation in the scheme is also open to non-fixed-income groups through HMOs. The scheme exempts unemployed, aged and disabled persons from premium payments, and re-insures lower-tier community-based insurance schemes. To expand the reach of the benefits of the NHIS, the Tertiary Institutions Social Insurance programme (TISHIP) for students of institutions of higher education and the Retirees Social Health Insurance Programme (RSHIP) were introduced in 2010 with presidential backing.

As stated above, it is infeasible to fund UHC by voluntary contributions alone. This explains why external donor funding from multilateral institutions such as the World Bank and global health initiatives are also important sources of revenue for the NHIS. A graphic representation of NHIS revenue raising, pooling, purchasing and provision by Odeyemi and Nixon, (2013) shown in Figure 2.6., indicates in-flows of donor funds (DF) into all levels of government (federal, state and LGAs) and directly into communities. Funding is typically targeted to address specific needs through special programmes, some of which are implemented in collaboration with non-governmental organisation (NGOs). DF, according to Odeyemi and Nixon, (2013:8) promotes '[…] horizontal and vertical equity in financing and access to health care facilities, particularly for those in poor rural areas'.

Despite the strong political commitment of central government to the implementation of the NHIS at the start, implementers have found it challenging to scale up the programme. In order to determine the reasons for this inertia, it is necessary to examine the roles of non-governmental stakeholders/policy actors in the implementation process.

Figure 2.7: NHIS Revenue Raising, Pooling Purchasing and Provision



Source: Odeyemi and Nixon 2013

Note: The relative size of each element does not equate to population size.
Shaded boxes = NHIS elements; **NHIS** = National Health Insurance Scheme; **FSHIP** = Formal Sector Social Health Insurance programme; **USSHIP** = Urban Self-Employed Social Health Insurance Programme; **RCSHIP** = Rural Community Social Health Insurance Programme; **DF** = Donor Funding; **CBHI** = Community-Based Health Insurance; **PHI** = Private Health Insurance; **OOP** = Out-of-pocket,
T. C. = Tertiary care; **S. C.** = Secondary care; **P. C.** = Primary care; **LGA** = Local Government Authority; **HMO** = Health Maintenance Organisation; **MoH** = Ministry of Health.
sub-section 2.8.2. explores and discusses the activities of key NHIS stakeholders

2.7.2 Key NHIS Stakeholders Involved in the NHIS Policy Reform

UHC initiatives typically involve a diverse range of stakeholders (Gilson et al., 2012). NHIS stakeholders identified in NHIS publications and academic literature, comprise of Nigerian public, private sector organizations, and foreign participants. The categories of key stakeholders involved in it's implementation are shown in Table 2.6.

Table 2.6: Key NHIS Stakeholders

Stakeholders	Interests
NHIS	The NHIS policy operator, fund holder for formal sector contributions and scheme regulator
Federal Ministry of Health (FMOH) and Minister of Health	Key reform programme of the FMOH
Health Maintenance Organisations (HMOs)	Intermediary (third-party) operators of the scheme
Health Care Providers (HCPs)	Health service delivery
Federal government employees (i.e. civil servants' unions or labour unions)	Beneficiaries of the FSHIP
Private employers/National Employers Consultative Association (NECA)	Representing interests of employers as co-contributors to NHIS premiums
Banks	Safe custody of operational funds accruing to HMOs
Insurance Companies	Provide malpractice and Indemnity insurance cover to HMOs and HCPs
Insurance Brokers	To ensure insurance compliance by HMOs and HCPs
International and collaborating developmental partners	Providing Technical and financial support

Source: Adapted from Onoka, 2014

The above list is by no means exhaustive. Other stakeholders include the media, non-governmental organisations (NGOs), and the boards of trustees (BOTs) of community-based health (CBH) insurance schemes. Particularly influential in the implementation of the NHIS are two supply-side trade associations: The Health and Managed Care Association of Nigeria

(HMCAN) and the Health Care Practitioners Association of Nigeria (HCPAN). The part played by these two trade representatives in the implementation of the NHIS is significant and merits further discussion. In order to gain a full appreciation of the roles of HMCAN and HCPAN in the implementation process, it is necessary to start with an overview of the role of HMOs and HCPs in the scheme.

2.7.3 Role of Health Maintenance Organisations (HMOs) in NHIS Implementation

Private organisations and firms that integrate health financing with the provision of health care services via owned health facilities or through arrangements with networks of health providers to eligible people (enrolees) come under the umbrella term of 'managed care systems' (Onoka, 2014). The three prominent managed care organisations or health plans are Health Maintenance Organisations (HMOs), Preferred Provider Organisations (PPOs) and Point-of-Service Plans (Folland et al., 2007). HMOs are the managed care organisations pertinent to this research. The HMO model is a health service innovation that emerged from the USA where service delivery is more private sector-driven. Onoka (2016) reported that the strongest advocates for the adoption of the model in Nigeria were individuals with prior experience of managed care systems in the USA and insurance industry professionals.

The proponents of these for-profit business entities (HMOs), were mostly former proprietors of large medical centres, private investors and commercial insurance operators. Based on a purchaser/provider model adopted by the NHIS, HMOs serve as third-party operators of the scheme by contracting with HCPs to purchase health services to be delivered to scheme contributors under capitation and fee-for-service agreements. Their functional activities include collection of contributions from eligible employers/employees, serving as insurers and purchasers of private health insurance (PHI) to clients, making payments to HCPs in addition to oversight and quality assurance responsibilities.

2.7.4 Health and Managed Care Association of Nigeria (HMCAN)

This representative trade body serves as a platform to promote HMO interests through information sharing, raising public awareness about health insurance, negotiating favourable business terms for HMOs with the NHIS, and promoting industry best practices through self-regulation. In a review of the NHIS, published by Asoka (2017), 25 HMOs were active members of HMCAN out of a total of 57 registered HMOs. HMCAN's better grasp of the business of health insurance positioned them to influence the implementation of the scheme in ways that were favourable to their business interests. This asymmetrical strength had far-reaching implications for the NHIS reform. The impact of their actions and implications for the NHIS reform policy is discussed in chapters 6 and 7.

2.7.5 Health Care Providers (HCPs)

About 4,000 health care facilities are currently registered with the NHIS as independent HCPs (NHIS, 2013). HCPs are contracted by HMOs to deliver services based on SHI and PHI arrangements. Onoka (2014) identified two categories of HCPs based on the service-purchase contracts that they have with HMOs. The first group are small and medium-sized hospitals willing to accept the payment terms/rates agreed with HMOs. In the second group are large reputable health care centres with luxury offerings targeted at high net worth individuals and corporate executives with the capacity to pay high fees out of pocket. HCP reimbursements for both SHI and PHI are by capitation payments for primary care and fee-for-service payments for secondary and tertiary care.

2.7.6 The Health Care Providers Association of Nigeria (HCPAN)

HCPAN was established as a trade body to promote the interests of NHIS-accredited HCPs and, more importantly, to collectively fight for fair contractual terms in their business dealings with

HMOs. Consistent with the nature of principal-agent problems, the relationship between HMCAN and HCPAN is held in tension by competing business interests. HCPs, for example, have on-going disputes with HMOs over the pricing of services and the limited scope for negotiations in standard HMO-HCP contracts. HCPAN, to it's credit, has been successful negotiating capitation payments with HMOs on behalf of HCPs (see Chapter 5).

2.8 Politics of the Nigerian NHIS

The evidence so far suggests that the NHIS is a highly divisive reform initiative. As a consequence, it's implementation has been very politicised. This was to a large extent inevitable given that the NHIS Act 35 of 1999 was passed by decree under a military administration that paid scant attention to the importance of stakeholder negotiations and consensus building. Several issues that were not addressed under the military later re-surfaced in the democratic political landscape of the subsequent civilian government. The main political issues are as follows:

1. Autonomy of states as federating units of government

The NHIS Act, did not pay sufficient attention to the autonomy of Nigerian states as federating units with separate powers over policy making under the constitution. Given that the scheme was not made mandatory by law, Nigerian states were not bound to implement it. Enthusiasm for the NHIS has been low in the states; where it is regarded as a centralised federal insurance scheme and not a national insurance scheme. Accordingly, the status of state employees in the NHIS became unclear. The states were also reluctant to support the scheme on the basis that they were not adequately consulted in the design of the programme or implementation arrangements. As stated in (section 2.1) bold steps are now being taken to implement SSHIS across Nigeria's states. An update on the progress made so far is presented in sub-section 2.8.3.

2. Resistance of the labour unions

The power of the trade unions was in full deployment in it's resistance to proposed salary deductions (scheme contributions) to the FSSHIP at the time. Their negative stance was based on the government's poor track record with regards to federally initiated contributory schemes. To avoid a stand-off, the Minister of Health adopted a flexible negotiating approach by strategically allowing employees to first access and enjoy the benefits of the scheme prior to making contributions. This step was aimed at presenting the value of the scheme to union leaders in a more favourable light (Onoka, 2014).

3. Resistance of private HCPs to the inclusion of HMOs in the scheme

Private HCPs were initially opposed to the use of HMOs as third-party operators of the scheme. This was because most of the HCPs preferred the previous 'retainership model' of medical service delivery (see Chapter 5) which gave them more independent control over their business. Secondly, some HCPs were resentful of the first mover (financial) advantages enjoyed by their HCP/HMO executive colleagues who had strategically set up or invested in HMOs prior to the launch of the scheme. To win the support of the HCPs, the Minister mandated the NHIS to include public secondary care and tertiary hospitals as primary and secondary care referral centres to stimulate their interest (Onoka, 2014).

4. Resistance of private employers to being included in the pool of public sector funds

Private sector employers were opposed to the pooling of their contributions with public sector funds. They also had an ambivalent attitude towards the scheme in general, arguing that the NHIS Act did not make enrolment mandatory. In the long run, their position shifted and they became active participants.

5. Governance Issues

The exact role of the NHIS in the implementation of the initiative was not clearly defined in the Act. The NHIS, as it is presently organised, controls and manages the FSHIP programme, collecting funds (premiums) deducted directly from the payroll of formal sector workers. It is also charged with regulatory functions. Findings from this case study reveal that NHIS managers have exploited the ambiguity of their remit to expand their role in the scheme to include that of a scheme operator (chapters 5 and 6). Such actions have resulted in charges of conflicts of interest being made against NHIS managers by different stakeholder groups. HMOs in particular have suggested that the large pool of funds under the control of the NHIS is incentivising them to opportunistically become scheme operators for financial gains. In addition, HMOs have accused the NHIS of mandate over-reach by wanting to centrally manage the pool of NHIS contributions for the whole country. A case to buttress this point is the decision taken by NHIS officials to open the NHIS account with a commercial bank contrary to the agreement reached with stakeholders that the NHIS account will be maintained with the Central Bank of Nigeria (Onoka, 2014). All of these have led to relentless clamouring by aggrieved stakeholders for the Act to be revised. These issues are analysed further in chapters 5 and 6.

What the preceding discussion reveals is that there were a significant number of barriers to overcome to get the programme started. Notwithstanding all these contentions and conflicts of interests, there was strong political resolve by the government to commence implementation within a short timeframe. The actions of certain policy actors who were earlier referred to as *Veto Actors* (section 2.1) were instrumental in moving the NHIS agenda forward. The roles played by these actors are discussed in the next sub-section.

2.8.1 Veto Actors

The three main veto actors at the initial stage of the NHIS implementation were the then President of the Federal Republic of Nigeria, the Federal Minister of Health, and the HMOs (Chapters 5 and 6).

The Nigerian President saw the implementation of UHC as a central political objective and was determined to establish/implement the scheme during his tenure. This imperative was behind the decision to appoint a health economist with a background in international health policy as Health Minister. The Minister who was in office between 2003 and 2007 was given pivotal support by the president to rapidly implement the programme (Asoka, 2011). The convergence of the political interest of the President in health policy reform and the professional conviction of the Minister that a private sector-driven NHIS, with HMOs as the main operators, was the best way forward, were critical in getting the programme started.

Upon assuming office in July 2003, the Minister made it clear that he intended to launch the programme in 2005 and made some pragmatic decisions to neutralise some of the forces he perceived as constraining to that objective. Firstly, with the support of the President, he dissolved the existing NHIS governing council and did not re-constitute another one for the entire duration of his four years in office (Onoka, 2014). Secondly, he made key staff changes at the NHIS Secretariat between 2003 and 2007.The Minister took this measure with the intention to foster a better working relationship between NHIS managers and HMOs. To get around the contentious issue of formal sector contributions, he convinced the President to monetise the medical benefits of civil servants and got approval for the funds to be transferred to the FSSHIP of the NHIS. This crucial move injected about NGN 24 billion (US$ 160 million) into the scheme in advance of registration of employees, thus overcoming the initial financial challenges of the scheme (Onoka, 2014). To bring the HCPs on board, the Minister also put in place a National

Health Financing Policy. This was aimed at re-orientating the thinking of HCPs away from the erstwhile retainership system in order to bring them on board the new provider/purchaser model with HMOs. This initiative attracted the support of development partners who subsequently made their technical expertise available for the implementation of the NHIS. Overall, the financing policy stimulated private sector interest and as a result there was increased receptivity towards to the scheme.

The third group of veto actors were the HMOs who used their negotiating leverage to influence policy content. The influence HMOs exercised over other stakeholders derived from their superior technical expertise in the business of health insurance. The situation in which NHIS technocrats became dependent on the technical expertise of the HMOs was arguably created by policy makers, who by their implicit actions at the design stage of the scheme doubted the capacity of the FMOH and allied agencies to implement the (NHI) scheme. The deference of policy makers to the HMOs allowed them to integrate their business interests into the reform policy. The actions of the HMOs are consistent with those of the actors Kingdon (1984:21; 104) described as policy entrepreneurs. These are, according to Kingdon, 'actors who lie in wait in and around government with their solutions at hand, waiting for problems to float by to which they can attach their solutions'. Policy entrepreneurs, Cairney (2012:271) also suggests, may be political leaders or special interest groups with knowledge and or power to advance their 'pet solutions' to policymakers. In defence of the HMOs, they provided the technical capacity that was deficient in the public system to move the NHIS programme forward. HMO inputs, however, became more self-serving over time, prompting other stakeholders to fundamentally question the need for HMOs as third-party administrators in the first place.

The rationale for the participation of HMOs in the NHIS remains questionable and it was the subject of intense debate at the two-day National Assembly Committee on Health Care

conference held between 21/22 June 2017 to assess the progress of the scheme since it's inception. Reporting on the deliberations at the conference, Asoka (2017), in a journal article (forthcoming), posited that competing interests, issues of trust, and mutual suspicion amongst stakeholders were the main factors impeding the successful implementation of the NHIS. According to his report, NHIS officials and HCPs at the meeting were critical of the privileged position of HMOs in the reform process. HMOs, on their part, accused NHIS officials of encroaching on their business by engaging in activities outside of their regulatory remit. Implications of the asymmetrical power of the HMOs for the NHIS reform are discussed further in chapter 6.

In sub-section 2.8.2, legislative efforts to pass a National Health Bill by the National Assembly were described as one of the significant policy moves towards UHC by the Federal Government of Nigeria. The next sub-section discusses how the passing of the bill fits into the overall strategy for achieving UHC in the country.

2.8.2 The National Health Act 2014

The Nigerian National Health Bill (NHB), now National Health Act (NHAct) No. 8 of 2014, was passed by the National Assembly in May 2011 but was not signed into law until December 2014. it's enactment was delayed by 10 years of deliberations and stakeholder disputations. Lecky (2015) gave an overview of the policy thrust of the NHAct in the following quotation:

> 'National Health Act (NHAct), enacted in late 2014, officially recognizes Nigerians' right to health – and through the NHAct, the Basic Health Care Provision Fund provides financial resources to improve primary health care. The NHAct has the potential to fuel dramatic public health improvements and rapid progress towards the attainment of Universal Health Coverage (UHC).'

The larger aim of the passing of the Act was to put in place a proper framework to guide the delivery of health care in Nigeria in order to do away with endless ad-hoc health policy

interventions. Broadly stated, the NHAct, as Ohanyido (2011) suggests, aims to:

1. Promote a sustainable health care system that will enable Nigeria to achieve it's millennium development goals (MGDs).
2. Improve access and quality in service delivery especially at primary care level where sectoral failure is most pronounced.
3. Ensure equitable allocation of resources among individuals across socio-economic groups.
4. Reduce financial and physical constraints to accessing health services.

The legislation provides for the establishment of 'The Basic Health Care Provision Fund' (BHCPF), largely underwritten by a federal government with an annual grant of not less than 1% of it's Consolidated Revenue Fund (CRF). Other sources of funding for the CRF will be derived from grants by international donor partners and funds from other sources. Allocation of grant funds to state and local governments will be subject to restrictions, such as the requirement that they provide 25% counter-party funding to qualify for block grants for health projects and 50% of the amount drawn from the fund must go towards the provision of a basic minimum package of health services in primary and secondary health care to be administered through the NHIS. The Act also authorises the Minister of Health to put in place a framework for identifying categories of people eligible for the provision of free basic health services. This directive is targeted at vulnerable groups such as women, children, the elderly and people with disabilities.

2.8.3 Implementation of State Social Health Insurance Schemes (SSHIS)

The recent enthusiasm by sub-national (state) governments to set up SSHI schemes has been seen by policy analysts as a positive response to the enactment of the NHAct No. 8 of 2014. The directive to set up SSHIS came from the National Council on Health (NCH) – the newly

constituted supreme health policy making body in Nigeria. The Act has created a more enabling policy landscape for state participation in health insurance (Care Net, 2018). Under this arrangement, the NHIS has to some extent achieved it's objective of getting the states to participate in the NHIS – albeit by other means. Explained differently, the NHAct has indirectly addressed a major inadequacy of the NHIS Act 35. Despite being an important step towards UHC in the country, the results so far indicate that only a few states have implemented the SSHIS – with the strongest performances recorded in the Bayelsa, Cross River, Delta and Lagos states. Implications of the SSHIS for health policy are discussed in chapter 6.

2.9 Summary

This chapter focused on Nigeria's attempts to implement UHC in the past three decades. Insights from the above discussion, especially those relating to the challenges of scaling up the NHIS, supports the notion that policymaking in the real world is dynamic, complex, messy and far from linear (Walt and Gilson, 1994). Recent initiatives by a number of sub-national governments (federating states) to launch SSHISs that have widely been viewed as positive developments do not negate the prevailing criticism that the NHIS Act 35 was flawed at it's conception because it was enacted without due regard for the autonomy of sub-national governments (the federating states), as enshrined in the constitution of Nigeria. This, by implication, is a major drawback — and one that many policy analysts attribute to the low enthusiasm for the adoption of the NHIS by the states at scheme inception. There is also merit in the suggestion that insufficient stakeholder engagement prior to the launch of the scheme is a likely reason for the conflicts of interest between HMOs and HCPs. In retrospect, the decision of NHIS officials to obtain technical advice from HMOs (in the design of the NHI scheme and aspects of it's implementation), to the extent that it empowered them to shape the content of the policy to their advantage, was ill-considered.

As a primer to a fuller treatment of the subject in Chapter 5, this review outlined the role played by power and politics in the reform process. Academic precedent suggests that power and politics are always involved whenever there is an initiative to implement equity-promoting policies (Chapter 3). As Gilson (2005:2) suggests: 'such policies are almost always subject to contestation as, in seeking to benefit powerless groups, they challenge the status quo and the associated vested interests'. The resistance of the labour unions to come on board the NHIS must be regarded as one of such contestations.

In what could be regarded as beneficial deployments of power in the NHIS implementation, some studies suggest that the power that key political figures bring to bear on the process can be a critical driver of a reform agenda (HISRO, 2012; McIntyre et al., 2013). The convergence of the Nigerian President's political interest in UHC and his empowerment of the Health Minster to implement the NHIS as a matter of urgency, bolsters that perspective. Other micro-political processes exemplifying the implicit use of political leverage to advance the implementation of the NHIS are revealed in chapter 5.

In the multi-actor implementation environment of the NHIS, participant positions are shaped by their values and beliefs, entrenched professional and institutional practices, networks and contextual factors such as power and politics (Walt and Gilson, 1994). Taken together, these factors enhances the viability of exploring individual and collective/distributed sense-making in policy implementation.

The next chapter (Chapter 3) reviews the literature on policy implementation concentrating on contemporary issues and debates in implementation research – especially the dichotomous theories of the 'top-down' and 'bottom-up' camps of policy implementation. The chapter exposes the limitations of the compliance model (the 'top-down' view) in conventional implementation research to buttress the argument that conventional implementation theories

are deficient because they negate the cognitive action (sense-making) of actors in the process. Finally, the chapter discusses the elements of the conceptual framework of the study, explaining how it is configured to address the research questions.

Chapter 3. Literature Review: Theories and Conceptual Framework

3.1 Introduction

The theoretical Foundation and conceptual framework that guides this case study draws on a range of perspectives from primary and secondary streams of research in the extant literature in policy studies, sociology and organisational research. The coverage of the relevant literature is necessarily extensive given the dynamics and scope of the study's objectives, which to recall, broadly seeks to explore the role of individual and collective/distributed sense-making in the implementation of the NHIS.

Informed by the study's three research questions, the primary streams of the literature covered in this review are: policy implementation research, (Pressman and Wildavsky,1973; Van Horn and Van Meter, 1976; Elmore, 1980; Lipsky, 1980; Sabatier and Mazmanian, 1983; Goggin et al., 1990; Barrett, 2004; Pűzl and Treib, 2007) ; sense-making theory (Weick, 1995; Taylor and Every, 2000; Brown and Humphrey, 2003; Weick et al., 2005; Maitlis and Christianson, 2014; Brown et al., 2015); sense-making in organisations (Barley, 1986; Scott, 1987, 1988; Wiley, 1998 Vaughan, 1996, 1999; Weick, et al., 2005); communities of practice theory (Lave and Wenger, 1991; Wenger, 1998, 2001; Coburn, 2001; Spillane et al., 2002; Coburn and Stein, 2006; Weber and Gynn, 2006); power, politics and sense-making (Pettigrew, 1977; Hofstede, 1980; Hardy and Clegg, 1996; Mullen et al., 2006; Weber and Glynn, 2006; Chen et al., 2014; Maitlis and Christianson, 2014) and sense-giving theory (Gioia and Chittipedi, 1991; Bartunek et al., 1999). The review in particular, discusses, in depth, Spillane et al.'s (2002) distributed sense-making perspective — a key component in the conceptual framework of this research.

Secondary streams of the literature reviewed are: cognitive approaches to policy

implementation (Jobert and Muller, 1987; Sabatier and Jenkins, 1993; Surel, 2000; Gouin and Harguindéguy, 2007), perspectives of multi-level meaning in policy implementation (Pope et al., 2006; Exworthy and Powell, 2004); power distance (Mulder, 1977; Hofstede, 1980; 1984; 1997; 2001; Khatri, 2009; Tayeb, 2003); Power distance orientation (Kirkman et al., 2009; Chen et al., 2013); Institutional theory (Eisenhardt, 1988; Zucker, 1987); Gatekeeping (Coburn, 2002) and policy negotiations (Barrett, 2004; Alford, 1975).

Power is a highly relevant dimension of the policy implementation process , extensively covered in this review. The literature review on power starts with an explication of the nature of power in the landscape of organisations and discusses two candidate views on the subject – the radical view (Lukes, 1974) and the rival post-structuralist/relational view (Balogun, et al., 2005). With regards to sense-making, actors wielding three distinct forms of power — the power of resources, process power, and power of meaning shape and control the narratives of sense-making through political processes that legitimises some interpretations and filters out others (Maitlis and Christianson, 2014)

3.2 Policy Implementation Research: Issues and Perspectives

Three generations of research have produced a substantial literature on policy implementation. The problem, however, is that available information from this 'universe of publications' (Saetren, 2005:567) is so vast and diverse that it has become hugely challenging to extract new knowledge from it (Kirst and Jung, 1981). Implementation, the third stage of an administrative process that is preceded by agenda-setting and formulation in Lasswell's (1956) public policy framework, is defined by Goggin (1986:33) as:

> 'a problem-solving activity that involves behaviours that have both administrative and political content. The manner, or style, of implementation is as a result of certain implementing decisions that are made and actions taken between the time that a plan is adopted by the authorities and the time when it

is more or less successfully put in place'

Academic literatures, Hill (2003:267) suggests, render stories of 'empirical observations of concrete activities'. However, Hill also remarked that the uniqueness of the literature on policy implementation is that it's 'theoretical story' has mostly focused on why the outcomes of enacted policies are more often than not as intended. Goggin (1986) points out that subsequent contributions to empirical implementation studies signalled a shift in research focus from investigations of implementation-expectation deficits to explanations of variability in implementation performance. Such efforts were in large part driven by the huge number of variables with impact-potential on policy implementation that scholars have identified. O'Toole (1986) estimates that there are about 300 such independent variables. Goggin (1986:329) and Hill (2003:267) explain that conceptual frameworks developed by researchers to explain variability have mostly targeted the following four clusters of independent variables:

1. The form and content of the policy itself
2. The capacity of the organisation(s) responsible for making the programme work
3. The qualifications of the people in charge of operations
4. Conditions within the implementation environment covering the behaviour of groups affected by policy, economic conditions and public opinion

Hill (2003) argues further that, viewed as a whole, these generic approaches to examining/explaining variability in implementation performance is contentious for two reasons. Firstly, the underlying assumption behind these conceptual approaches is that the message of an enacted policy is shared by all policy makers/implementing agents in spite of compelling research suggesting that policy messages are often vague or conflicted. The assumption becomes even more questionable if we consider the trade-offs and compromises that legislators

often have to make in policy-making (Calister, 1886; Yanow, 1996). Another source of incoherence in policy implementation is that more often than not, clear policy guidelines for effective implementation, are lacking, or sketchy (Matland, 1995), which results in implementers working with incomplete understandings of policy messages (Matland, 1995; Pressman and Wildavsky, 1973; Van Horn and Van Meter, 1976).

Secondly, established implementation research privileges the study of government or quasi-government entities, negating the part played by non-governmental actors involved in the process.

Implementation variables that fall outside the clusters discussed above suggests incompleteness in extant implementation studies – opening up new opportunities for research. The objective of this research derives from a problematisation of these two gaps in the literature. To drive the objective, it employs the concept of sense-making as a primary lens to investigate the degree to which policy actors understand and subsequently implement the enacted Nigerian health insurance (NHIS) policy. The implementation plan of the NHIS, by design, brought together multiple participants and, for that reason, the investigation combined other theories and concepts from the wider policy literature to explore the roles of non-governmental actors in the implementation of the scheme, thus addressing the second weakness identified in prior implementation studies.

Situated at the intersection of the domains of public administration, organisational theory, public management research and political studies, implementation research is fundamentally interdisciplinary (Schofield and Sausman,2004). Jenkins (1978:203) surmises that implementation is best 'characterised as studies of policy change'. The stimulus for policy studies began around the end of the 1960s when policy makers began to pay attention to prominent cases of policy failures, mainly in the USA – following observations of lags between

expectations and outcomes in policy reforms. Concerns about these policy expectation-outcome deficits and policy effectiveness in general instigated a wholesale rethinking of the process of conducting policy implementation research. Before then, it was widely assumed that administrators implemented policies as enacted by policy makers (Hill and Hupe, 2002).

The size of the policy implementation literature has grown considerably since the publication of Pressman and Wildavsky's (1973, 1984) seminal work, '*Implementation – How Great Expectations in Washington are dashed in Oakland'.* Their thesis challenged the view that policy implementation will automatically 'follow the simple transmission of instructions from the political centre to the periphery' (Coleman et al., 2010:289). These prior studies created the impetus for the work of first-generation researchers, categorised as the top-down school (Derthick, 1972; Pressman and Wildavsky 1973; Van Meter and Van Horn, 1975; Bardach, 1977; Sabatier and Mazmanian, 1979, 1980; Mazamanian and Sabatier, 1983). This approach is described by Pűzl and Treib (2007:89) as being 'characterised by a pessimistic undertone' – because in the main, they were mostly directed at investigating why implementation dd not automatically follow authoritative decisions. Although first-generation researchers were duly credited for raising scholarly awareness of the 'implementation problem' (Peck and 6, 2006: xvi), their body of work has been criticised for being light on theory generation – and this became drivers for the development of theoretical and analytical frameworks to advance studies in the field by second-generation implementation scholars labelled as the 'bottom-up' camp (Lipsky 1971, 1980; Elmore, 1980; Hjern and Porter, 1981; and Hjern and Hull, 1982).

Significant developments in the field are largely attributable to the efforts of third-generation researchers (Goggin et al., 1990; Ripley and Franklin, 1982; Windhoff-Heriter, 1980) who looked beyond the theoretical contest between the top-down and bottom-up camps to instead address the conceptual flaws in the postulations of both camps, to propose hybrid approaches. Barrett

(2004) observed that the dichotomous perspectives of the top-down and bottom-up camps have been unhelpful and has made theoretical consensus elusive in the field. Peck and 6 (2006:xvi) have a similar take on this:

> 'many policy commentators are stuck with the definition of 'the policy implementation problem' – and a set of the basic concepts with which to characterise that problem that seem incapable of eliciting fresh perspectives or providing useful advice.'

The following sub-sections concisely review top-down, bottom-up and hybrid theories of policy implementation.

3.2.1 Policy Implementation: The Top-Down School

The policy implementation literature regards the top-down school as normative, hierarchical and prescriptive – an 'ideal type' approach which, in Parson's view (1995:463), is a 'black box model' of policy-making. Following a rational model approach that is influenced in part by system theory, top-down scholars analysed implementation by treating policy as an input and implementation as an output, unduly decentring the role of policy implementers in the process.

The fundamental inquiry of 'top-down' researchers, Peck and 6, (2006 : 30) suggest, is directed at explaining 'why frontline activity deviates from what the researcher reconstructs as the original intentions of the central policy makers'. Peck and 6, (2005:30) add that scholars of this persuasion focus on factors such as :

- Conflict over goals
- The 'private' interests of local agency managers or professionals (or indeed, clients)
- Inadequate resources
- Weak or inaccurate causal assumptions about the effect of the proposed initiatives

- Weaknesses of training or organisational ability
- Lack of leadership
- Institutional constraints, routines or habits, and so on

Top-down theorists view the exercise of discretion by 'street-level bureaucrats' (Lipsky, 1980) as impinging on explicit policy objectives, and argue that such actions are a conspiracy against democratically enacted policies. This perspective relies on a notion that demarcates policy formation from implementation. Top-down scholars as a body have suggested six criteria for effective policy implementation. Pűzl and Treib (2007:92) summarised them as follows:

1. Policy objectives are clear and consistent.
2. The programme is based on a valid causal theory.
3. The implementation process is structured adequately.
4. Implementation officials are committed to the programme's goals.
5. Interest groups and (executive and legislative) sovereigns are supportive.
6. There are no detrimental changes in the socioeconomic framework conditions.

3.2.2 Policy Implementation: The Bottom-Up School

The bottom-up school emerged as a direct challenge to the assumption sets of the compliance ('top-down') model. That model in their view, is inadequate since it fails to provide sufficient explanations for the complexities in policy implementation. The bottom-up camp also rejects the idea that causality can be established whenever policy outcomes deviate from initial policy objectives, as the top-down school suggests. The crux of the argument of the bottom-up camp is succinctly put by Barrett (2004:254), referencing (Elmore 1980; Hjern and Porter, 1981), who

argues that: 'due to the complexity of relationships and interactions in the implementation process, action cannot necessarily be directly related to, or evaluated against specific goals'. The bottom-up school, of which Lipsky's (1971, 1980) work is widely regarded as a seminal contribution in the field, strongly advocates for attention to be paid to the network of policy actors or bureaucrats involved in policy implementation at the 'street level' where policy meets the people. This school of thought argues that it is difficult for decision makers to manage street-level bureaucrats by direct action – hence they are likely to exercise their discretionary capacity in the course of executing policy because of the 'inevitability of human judgement' (Hupe and Hill, 2007:283). Scholars have argued that this discretionary power should not be seen as entirely negative – given that street-level bureaucrats are in closer proximity to policy recipients than the higher-level decision makers. Ermin and Gilson (2008), from a health context perspective, suggest that the 'exercise of discretion may reflect implementers' efforts to adapt policies to local circumstances in ways that secure broad policy goals and performance gains' (2008 :362). Such adaptation, they add, is often necessary in health care to address the diverse circumstances of patients. Similarly, Barrett (2004:256) explained that there are situations in the policy space where the use of discretion is actually desirable:

> '[…] those in disciplines or professions where negotiated and contractual relations with clients and consumers were the norm, tended to see discretion as both positive and necessary, as the space within which negotiation and bargaining of positive sum outcomes can take place.'

The work of Elmore (1980) and his idea of 'backward-mapping' is another influential contribution to the bottom-up school. This concept de-centralises policy implementation, allowing more scope for policy flexibility through negotiations and incentive mechanisms. The improvement, Elmore suggests, materialises from simultaneously conducting implementation alongside policy evaluation.

The landmark achievement of the bottom-up camp, according to Peck and 6 (2006:9), was to change the question from 'How can this central policy be implemented?' to 'What are the best ways of running services and initiatives following central decisions, whether or not the result reproduces anything reminiscent of the central policy makers' original ideas?'. The next sub-section discusses hybrid theories of policy implementations as postulated by third-generation researchers.

3.2.3 Hybrid Theories

Third-generation researchers have made attempts to address/mitigate the conceptual flaws in the postulations of both 'top down' and 'bottom up' camps by employing scientific models to analyse their relative strengths and weaknesses. Their quest was driven by a conviction that first- and second-generation theories did not have rigorous science behind them. Also, they did not accept the idea that the theoretical positions of the two camps were mutually exclusive. An important point to note is that some top-down and bottom-up scholars have subsequently become hybrid theorists – thus demonstrating fluidity of thinking across these camps.

Elmore (1985), for example, moved into the hybrid camp after extending his concept of 'backward mapping' to 'forward mapping' (Pűzl and Treib, 2007:95). Pűzl and Treib (2007:95), citing Sabatier (1986a), explain that Elmore's thesis, in essence, is that:

> '"program success is contingent on both elements, as they are intertwined" (Sabatier, 1986a). Policy makers should therefore start with the consideration of policy instruments and the available resources for policy change (forward mapping). In addition, they should identify the incentive structure of implementers and target groups (backward mapping)'.

In a noticeable departure from his earlier top-down approach with Mazmanian (Sabatier and Mazamanian, 1979), Sabatier, in collaboration with Jenkins-Smith (1993), argued through the concept of the advocacy coalition framework (ACF) that policy formation is inseparable from

implementation. The ACF, an example of a cognitive approach to policy analysis, is based on two key assumptions: that policy makers are strongly motivated by beliefs that they bring to bear in policy making , and that those beliefs are shaped by the technical inputs provided by specialists (researchers, analysts and consultants). The ACF posits that most of policy making involves negotiations among groups or coalitions of specialists within the 'policy sub-system' (Sabatier and Jenkins-Smith, 1999). The ACF rejects Lasswell's (1956) 'stages heuristic' policy analytical framework – preferring instead to focus on the policy problem as a starting point. The strength of the ACF is that it broadly facilitates the analysis of the role of a range of actors and their strategic approaches in addressing the policy problem. The framework also suggests that the actions of the specialists are influenced by broader political and socio-economic conditions.

Scharpf's (1978) concept of policy networks straddles both top-down and bottom-up theories. His concept agrees with bottom-up theoretical position that policy implementation is the outcome of the interaction between a range of policy actors, but in the same vein, he accepts the top-down position that the democratic right of government to formulate policy is sacrosanct. Pűzl and Treib (2007:97) acknowledge the efforts of hybrid theorists in drawing attention to the crucial dimensions largely ignored by prior research. However, in a critique of hybrid theories, they observe that:

> 'What is overlooked by advocates of a synthesis of top-down and bottom-up approaches are the fundamentally different views of both sides on the conceptualisation of the policy process and the legitimate allocation of power over the determination of policy outcomes in the light of democratic theory'.

Notwithstanding the innovativeness of hybrid theories, their theoretical depth has been challenged by critics such as Parsons (1995:487) who argued that the underpinning logic of the top-down and bottom-up camps about policy conceptualisation and the locus of power are so fundamentally different that efforts to synthesise both theories seek to combine incompatible

worldviews.

3.2.4 Top-Down Versus Bottom-Up Theories: Comparative Analysis

Pűzl and Treib's, (2007:94) comparative analysis of the key premises of both camps was based on the following parameters: research strategy, goal of analysis, model of policy process, character of implementation process, and underlying model of democracy. The insights from their comparisons are presented in Table 3.1.:

Table 3.1.: Comparing Top-down and Bottom-up Theories

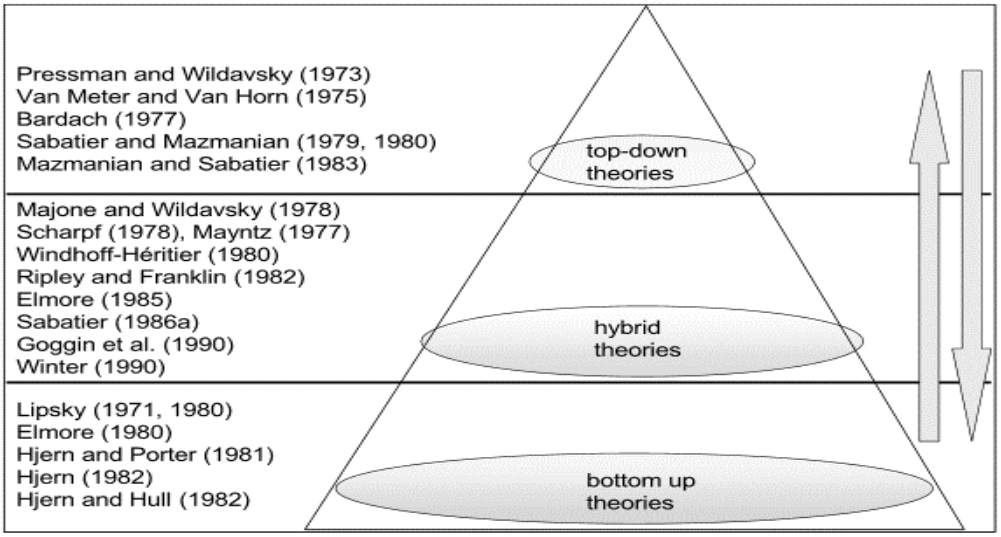
	Top-down theories	Bottom-up theories
Research strategy	Top-down: from political decisions to administrative execution	Bottom-up: from individual bureaucrats to administrative networks
Goal of analysis	Prediction/policy recommendation	Description/explanation
Model of policy process	Stagist	Fusionist
Character of implementation process	Hierarchical guidance	Decentralized problem-solving
Underlying model of democracy	Elitist	Participatory

Source: Pűzl and Treib (2007)

Although the core theses of the two camps are apparently polar opposites, they share common ontological and epistemological foundations. Pűzl and Treib (2007) are concerned that there might be inherent theoretical weaknesses or under-theorisations in the postulations of both camps because their supporting studies were largely based on studies in nation states: an approach that discounts international experience. In their view, the interest of empiricism will be better served if scholars widen their research beyond such limited contextualities.

Key contributors to the literature on the top-down, bottom-up and hybrid theories of implementation are listed graphically in Figure 3.1.

Figure 3.1: - Top-down, Bottom-up and Hybrid Theories – Key Contributors



Source: Pűzl and Treib, (2007:91)

The key question that follows is: What lessons have we learned from the extensive literature on policy implementation? Acknowledging the progress made thus far, Pűzl and Treib (2007) report that the theoretical distance between the three schools of thought is closing, and see a positive shift from doctrinal fixations towards increasing theoretical accommodation as a result of a better understanding of the strengths and weaknesses of the different academic stances.

The five main insightful gains of implementation research according to Pűzl and Treib (2007:91) are:

1. After the intractable intellectual contest between the top-down and bottom-up camps of implementation research, there is now a broad agreement between both camps that implementation is a continuum between central control and local autonomy.
2. The argument put forward by 'bottom-up' theorists that the process of implementation goes beyond the execution of centrally enacted policies has largely

been upheld across the research community.

3. Hybrid theorists now accept that policy formulation and implementation are interdependent – a position long advocated by bottom-uppers.

4. In the view of Sabatier (1986a), policy implementation should not be seen as happening in isolation. Implementation must be viewed in the context of exogenous influences such as macro-economic events.

5. Policy implementation analysis research within the EU has provided evidence that different countries have different 'implementation styles'. This strand of research resets assumptions and informs the proposition that efforts in search of a one-size-fits-all implementation theory are misdirected. To it's proponents, implementation scholarship would benefit greatly from more comparative studies.

These conclusions indicate a growing theoretical convergence in the field – a welcome departure from the inflexible views that did little to advance the course of implementation research.

As noted above, implementing agents work under conditions of imperfect information and the notion that policy makers have a shared understanding of an enacted policy is questionable. The discussion of cognitive approaches to policy analysis brings to the fore the influence of actor worldviews in policy implementation and serves as a primer to understanding the utility of the concept of sense-making in policy implementation research. Section 3.3. discusses the theoretical basis of these approaches.

3.3 Cognitive Approaches to Policy Analysis

Cognitive policy analysis is based on the assumption that ideas and thoughts ingrained within policy makers affects the policy-making process and may partly explain the disjuncture between

policy formulation and implementation. Explicating on the subject, Gouin and Harguindéguy (2007) propose two hypotheses. Firstly, they postulate that cognitive changes alters a person's behaviour and secondly by implication, a change in behaviour may result in a change in policy. The first hypothesis suggests a causal link while the second is an argument based on 'logical equivalence' (Gouin and Harguindéguy, 2007:2).

Traditional policy analysis studies based on Lasswell's framework of policy cycles (problem identification, implementation, policy evaluation, and termination) have for decades been the preferred model. Since the 1980s however, there has been a growing move towards cognitive policy analyses – a development that was given stimulus by an infusion of new ideas from cognitive sciences and cybernetics (Gouin and Harguindéguy, 2007). Putting it in a more concrete context, Surel (2000:495) explains that cognitive policy analyses are influenced by 'ideas, general precepts and representations', adding that that new research assigning considerable weight to cognitive elements are 'attempts [towards] systematising and conceptually constructing the role of these logics of social construction of knowledge and meaning in state action'. Various researchers have operationalised these policy-influencing elements as independent variables and incorporated them into conceptual models and frameworks for analyses (Dudley et al., 2000).

Gouin and Harguindéguy, (2012) recognise the significant contribution of cognitive approaches in policy studies to the knowledge base but question the rationale for ascribing a 'common label' to these bodies of work, given their disparate nature. The observed variance in the different perspectives put forward in conceptual cognitive models strengthens their argument.

The independent variables for cognitive policy analyses, according Sabatier and Schlager (2000:209-234), are supplied by 'ideas, interests and institutions'. These elements run through all the three main approaches to cognitive policy analyses. Firstly, equilibrated cognitive

approaches are focused on ideas, interests and institutions (Sabatier and Jenkins-Smith, 1993; Kingdon, 1984; Baumgartner and Jones, 1991). Secondly, minimalist cognitive approaches are focused on interests and institutions and their bearing on ideas (King, Keohane and Verba, 1994). Thirdly, maximalist cognitive approaches rank ideas over and above all other factors (Radaelli, 1995; Muller, 1990, 1994; and Jobert, 1992). Common to all three approaches are views that suggest that the discourse of actors goes beyond the articulation of fact, that public policy is driven by ideas which structure the intellectual domains of actors, and finally the assumption that changes in initiatives typically generate debate/conflicts (Gouin and Harguindéguy, 2007).

While some researchers ground their work deeply on concepts from cognitive sciences, others do not stretch the notion of cognition beyond the metaphoric. This has resulted in the use of terminologies such as strong/weak cognition (Sperber, 1997) or hard/soft cognition (Gouin and Harguindéguy, 2012) to classify the cognitive quotient of a particular approach in the literature. The distinction that Speber (1997:123-136) makes between strong/weak cognition is that: 'Cognitivism in the weak sense is the rather trivial acknowledgment that cognitive phenomena may play a role in the explanation of social facts. Cognitivism in the strong sense is the adoption of the mechanistic and naturalistic programme of cognitive sciences'. Gouin and Harguindéguy (2007) posit that integration of the notions of cognitive sciences into conceptual elaborations in the social sciences falls into three typologies: the first type is *terminological*, in which what is integrated is neither strictly a concept nor a theory; the second type is *methodological*, where cognitive sciences are employed as a data collection instrument and are integrated without specific reference to cognitive dimensions; and the third type is *theoretical* in which concepts or theories of cognitive sciences are applied to elucidate a problem of social science or phenomenon of social interest (Gouin and Harguindéguy, 2007). Table 3.2. shows the categories that each of these integrations come under in terms of their strength of cognition.

Table 3.2.: Types of Social Science Relations with Cognitive Sciences

Weak cognition	Strong cognition
- Without reference - Terminological integration - Methodological integration	- Theoretical integration

Source: Gouin and Harguindeguy (2007:6)

Among the widely acknowledged cognition-based conceptual models are Hall's policy paradigms (Hall, 1993); the advocacy coalition (ACF) model of Sabatier (1998); and the policy referentials approach of Jobert and Muller (1987).

3.3.1 Hall's Policy Paradigms

Gouin and Harguindéguy (2012) recognise Hall as one of the foremost scholars of cognitive approaches to public policy but note that his incrementalist approach does not specifically make reference to cognition. Nonetheless, evidence suggests that he drew extensively upon Festinger's (1957) theory of cognitive dissonance in his description of how actors 'fight against intellectual inconsistencies' (Gouin and Harguindéguy, 2012:7) during the process of change.

3.3.2 Advocacy Coalition Framework (ACF)

The ACF, as introduced earlier (sub-section 3.2.3.), is an example of hard cognition (Gouin and Harguindéguy, 2012). The model is based on cognitive psychology that is now widely used in policy analysis. Based on the idea of a policy sub-system that encompasses different kinds of actors within government and wider society, these actors typically form coalitions to defend a particular policy position. The authors of the ACF argue that although actors may be

instrumentally rational – deploying available information in pursuit of their goals, the actions of the coalitions are not necessarily guided by rational thinking. In their perspective, the choices and strategies of the coalitions are shaped by 'three concentric spheres' (Gouin and Harguindéguy, 2012:9). First are 'deep core beliefs' in the minds of actors such as liberty and equality; second are policy core beliefs based on knowledge; and third, at a more superficial level, are secondary beliefs that are relevant to concrete policy issues. This framework suggests that policy actors are collectively learning and as such, tensions and conflicts exist between coalitions, which is mediated by policy brokers – actors who possess the capacity to link subsystems. In line with cognitive theories of dissonance, actors' interpretation of reality is shaped by their pre-existing knowledge.

3.3.3 Policy Referentials Approach

This approach is categorised as a case of soft cognition with an emphasis on ideas (Gouin and Harguindéguy, 2012). The referentials approach developed from research that examined transformation of public policies. Findings from large case studies in sectors such as agriculture and aviation were subsequently generalised as analytical frameworks to be broadly employed in public policy studies (Jobert and Muller, 1987; Muller and Surel 1998) and policy analysis (Muller, 1990). Muller (1990; 1992 cited in Gouin and Harguindéguy, 2012:6) define a referential as the 'representation, an image of reality that policy actors want to modify'. This image orients the conception of problems, solutions and proposals elaborated by policy actors. The deeper logic here is that the relationship between policy actors and the problems they are seeking solutions to is shaped by the ideologies they impose on them. The referentials framework, according to Muller (1990; in Gouin and Harguindéguy, 2012) demonstrates that public policies organise around the mental models of actors. Two main theoretical ideas support cognitive analysis and the notion of referentials. First is the idea that a referential 'intellectually connects

a specific policy to society as a whole'; the second is that ' policy interactions can be analysed through the concept of mediation' (Gouin and Harguindéguy, 2012:6). Mediation is facilitated by policy entrepreneurs acting as mediators who are able to diffuse wider societal ideologies and world views into the realm of policy-making. Despite the recognised differences between these conceptualisations, what they have in common, Surel (2000:496) suggests, is the 'macro-level questioning' embedded in them, which enhances our knowledge of the influence of social norms in public policy.

Related bodies of work in implementation research employing cognitive frameworks according to Spillane et al. (2002:392) come under 'rubrics that include 'interpretation', 'cognition', 'learning', 'sense-making' and 'learning''. Notable works include that of Yanow (1996), which focused on interpretive policy, Cohen and Weiss (1993) , which investigated the role of agents' prior knowledge in policy implementation, and Coburn's (2001) research into the reading policy in the US public education system, which focused on how formal and informal networks influence the sense-making of implementing agents. This case study comes under the genre of research that employs the concept of sense-making as a cognitive approach to investigate the phenomenon of policy implementation. The next section explains the nexus between sense-making and policy implementation to locate the concept in the context of this research

3.4 Evolution of Policy during Implementation: Understanding the Role of Sense-Making

The rationalist thinking behind centrally enacted policies assumes that policy intentions are clear enough, and what is expected of implementing agents to achieve policy goals is well-specified. This expectation is based on the belief that implementing actors fully understand what they are meant to do. However, there is a question mark against this assumption. As Spillane et al. (2002: 387) suggest: 'A key dimension of the implementation process is whether, and in what ways, implementing agents come to understand their practice'. The problematic exposed by Spillane

et al. (2002: 392) is that 'the process by which implementing agents come to understand policy, the understanding that results, and the consequences of those understandings for policy implementation are rarely analysed in conventional implementation models'.

What is overlooked by policy makers is that enacted policies may be inherently ambiguous or easily misconstrued by implementing agents.

It is clear from the extant literature that policy evolves during implementation (Browne and Wildavsky, 1983). Researchers have suggested that a possible explanation for such evolution has to do with the process of human sense-making (Spillane et al., 2002), and have enjoined scholars to shift their attention to such dimensions in their research. Spillane et al. (2002: 392) suggest that:

> 'agents must first notice, then frame, interpret, and construct meaning of policy messages [and] by assuming that implementing agents understand what policy makers are asking them to do, most conventional theories fail to take account of the complexity of human sense-making'.

Academic focus is now shifting towards the role of agent sense-making in policy implementation in the field. Recognising this development, Coleman et al. (2010: 289) note that:

> 'Research now generally recognises that actors (individuals and) in policy implementation have agendas and frames of reference of their own and that these factors, along with local contexts, often have a substantial role in shaping what is actually enacted'.

This overview of the relationship between sense-making and policy implementation sets the stage for the comprehensive literature review of sense-making theory that follows.

3.4.1 Sense-Making Theory: An Introduction

The use of sense-making as an interpretive concept in social research is growing rapidly. Maitlis and Christianson (2014) in a database search identified over 4,000 academic articles containing

the word sense-making and over 70,000 references to the word. The origin of the concept of sense-making lies in constructivism but it's interpretation and application has mostly been within a social-constructionist perspective (Craig-Lees, 2001). Sense-making, according to Brown et al. (2015:266), has been variously described as a 'concept, theory, lens or approach'. Brown et al. (2015: 266) also acknowledged sense-making as 'an enormously influential perspective'. Sense-making at it's core is about how people think, but the larger quest of sense-making research is to empirically reveal co-constructions of reality as well as the consequences of such actions (Smerek, 2009). The spectrum of sense-making research ranges from studies focused on the micro-cognitive behaviour/actions of agents in individual contexts (Craig-Lees, 2001; Louis, 1980) to wider social and organisational contexts (Weick, 1995; Weick et al., 2005). Noting the expanding scholarly interest in sense-making, Brown et al. (2015: 266) observe that:

> 'it continues to attract attention from scholars with various interest in distinct, though often overlapping topics at multiple levels of analysis who seek to comprehend and to theorise how people appropriate and enact their realities'.

Sense-making theory facilitates the interrogation of the actions of individuals and agents in organisations. Craig-Lees (2001, citing the work of Magala, 1997) suggests that the academic utility of Weick's (1995) sense-making theory lies in it's capacity to espouse and validate the role of *the agent* in organisational research. Weick (1995, 2005) is widely credited for much of the pioneering work in the theoretical development of the concept, although Weick (1995:64) declared that the knowledge base he borrowed from is vast and 'sufficiently diverse'. The conceptual basis of Weick's thesis evolved from adapted ideas in pragmatism (James, 1907), symbolic interactionism (Bulmer, 1969), ethnomethodology (Garfinkel, 1967), phenomenology (Schutz, 1967) and social constructionism (Berger and Luckmann, 1967).

In recognition of the insightful contribution of Blumer (1969) to the concept, Weick (1995:41) asserts that symbolic interactionism is the 'unofficial theory of sense-making because the theory

keeps in play a crucial set of elements, including self, action, interaction, interpretation, meaning, and joint action'. These elements, Weick explains, are the determinants of sense-making either as individual elements or in combination as symbolic interactionism suggests. The three core principles of symbolic interactionism as described by Smerek (2009:22) reveal the centrality of it's contribution to sense-making theory. These principles hold that:

1) People act towards things, including each other, on the basis of the meanings they have for them;

2) That these meanings are derived through social interaction with others;

3) That these meanings are managed and transformed through an interpretive process that people use to make sense of and handle the objects that constitute their social worlds.

The principles of symbolic interactionism emphasise the meanings that people attach to things individually, and those that emerge interactively in their engagement with others. These three principles reinforce the point made by Weick et al. (2005:409) that: 'Sense-making is central because it is the primary site where meanings materialise that inform and constrain identity and action'. Weick et al. (2005:409) further explain that the materialisation of meanings suggests that sense-making is essentially about 'language, talk and communication, which is used to talk situations, organizations and environments into existence'. Explicating by analogy, Weick et al. (2005:409) reference Taylor and Every's (2000:275) view that sense-making is a 'way station' on the journey to a destination of co-created meanings and action in a co-created world. From all of these emerge a picture of sense-making as a process that is ongoing, subtle, transient and taken for granted (Weick et al., 2005).

3.4.2 Conceptual and Definitional Issues

There are various academic presentations of the concept of sense-making within the literature. Although references to sense-making theory by authors (Holt and Cornelissen, 2013; Jensen, Kjaergaard and Svejvig, 2009) are predominant, other explications of the concept refer to the 'sense-making perspective' (Schultz and Hernes, 2013; Weick, 1995), the 'sense-making lens' (Sonenshein, 2009; Stensaker and Falkenberg, 2007) and the sense-making framework (Helms Mills, Weatherbee and Cowell, 2006).

The sense-making literature suffers from a lack of cohesion due to major 'disjunctures and disagreements' that remain unresolved (Brown et al., 2015:267). According to Brown et al. (2015), there is no agreement as to whether sense-making should be regarded as individual-cognitive (mental schemas), collective-social (people interactions), or discursive (linguistic-communicative). There is also an academic dispute over whether sense-making is a moment-to-moment or ongoing process that is triggered by specific cues that occur at puzzling times or times of crisis – although Weick (1995:43) suggests that sense-making is ongoing and lists it as one of it's seven properties. There are also contentions about whether the concept is prospective or retrospective. Most researchers, no doubt influenced by Weick, have a retrospective orientation about sense-making despite the existence of important empirical evidence supporting a prospective view of sense-making (Bolander and Sandberg, 2013; Gioia, Corley, and Fabbri, 2002).

The concept of sense-making at it's most simplistic is 'the making of sense' (Weick 1995:4). Weick, however, refrains from offering a straight definition, opting instead for an explanation suggesting that sense-making is:

> 'about the placement of items into frameworks, comprehending, redressing surprise, constructing meaning, interacting in pursuit of mutual understanding,

and patterning.' (1995:6)

The many rival definitions of sense-making attest to the difficulty of defining the concept (see Table 3.3 for several versions). Smerek (2009) posits that a consensus definition is elusive because sense-making is not exactly a theory but a meta-theory that has emerged from the synthesis of a wide range of theoretical insights.

Table 3.3. Selected Definitions of Sensemaking

Author	Definition
Louis (1980)	"[S]ense-making can be viewed as a recurring cycle comprised of a sequence of events occurring over time. The cycle begins as individuals form unconscious and conscious anticipations and assumptions, which serve as predictions about future events. Subsequently, individuals experience events that may be discrepant from predictions. Discrepant events, or surprises, trigger a need for explanation, or post-diction, and, correspondingly, for a process through which interpretations of discrepancies are developed. Interpretation, or meaning, is attributed to surprises." (p. 241)
Starbuck and Milliken (1988)	"Sensemaking has many distinct aspects—comprehending, understanding, explaining, attributing, extrapolating, and predicting, at least. For example, understanding seems to precede explaining and to require less input; predicting may occur without either understanding or explaining; attributing is a form of explanation that assigns causes [. . .] What is common to these processes is that they involve placing stimuli into frameworks (or schemata) that make sense of the stimuli (Goleman, 1985)." (p. 51)
Gephart (1993)	"Sensemaking has been defined as the discursive process of constructing and interpreting the social world." (p. 1485)
Hill and Levenhagen (1995)	"To cope with these uncertainties, the entrepreneur must develop a 'vision' or mental model of how the environment works (sensemaking) and then be able to communicate to others and gain their support

	(sensegiving)." (p. 1057)
Weick (1995)	"Sensemaking is understood as a process that is (1) grounded in identity construction, (2) retrospective, (3) enactive of sensible environments, (4) social, (5) ongoing, (6) focused on and by extracted cues, (7) driven by plausibility rather than accuracy." (p. 17)
Taylor and Van Every (2000)	"[S]ensemaking is a way station on the road to a consensually constructed, coordinated system of action." (p. 275)
Balogun and Johnson (2004)	"Sensemaking is a conversational and narrative process through which people create and maintain an intersubjective world (Brown, 2000; Gephart, 1993, 1997; Watson & Bargiela-Chiappini, 1998)." (p. 524)
Balogun and Johnson (2005)	"Sensemaking is primarily a conversational and narrative process (Brown, 2000; Gephart, 1993, 1997) involving a variety of communication genre (Watson & Bargiela-Chiappini, 1998), both spoken and written, and formal and informal. However, more specifically, sensemaking involves 'conversational and social practices' (Gephart, 1993: 1469). It occurs through both verbal and non-verbal means (Gioia & Chittipeddi, 1991; Gioia et al., 1994). Individuals engage in gossip and negotiations, exchange stories, rumours and past experiences, seek information, and take note of physical representations, or non-verbal signs and signals, like behaviours and actions, to infer and give meaning (Isabella, 1990; Gioia & Chittipeddi, 1991; Gioia et al., 1994; Gioia & Thomas, 1996; Poole et al., 1989; Labianca et al., 2000). Change comes about through shifts in conversations and language (Barrett et al., 1995; Brown & Humphreys, 2003; Ford & Ford, 1995; Heracleous & Barrett, 2001)." (p. 1576)
Maitlis (2005)	"Sensemaking occurs in organizations when members confront events, issues, and actions that are somehow surprising or confusing (Gioia & Thomas, 1996; Weick, 1993, 1995). As Weick argued, 'The basic idea of sensemaking is that reality is an ongoing accomplishment that emerges from efforts to create order and make retrospective sense of what occurs' (1993: 635). Thus, sensemaking is a process of social construction (Berger & Luckmann, 1967) in which individuals attempt to interpret and explain sets of cues from their environments. This

	happens through the production of 'accounts'—discursive constructions of reality that interpret or explain (Antaki, 1994)—or through the 'activation' of existing accounts (Gioia & Thomas, 1996; Volkema, Farquhar, & Bergmann, 1997). Organizational sensemaking is a fundamentally social process: organization members interpret their environment in and through interactions with others, constructing accounts that allow them to comprehend the world and act collectively (Isabella, 1990; Sackmann, 1991; Sandelands & Stablein, 1987; Starbuck & Milliken, 1988; Weick & Roberts, 1993)." (p. 21)
Rouleau (2005)	"Sensemaking has to do with the way managers understand, interpret, and create sense for themselves based on the information surrounding the strategic change. Sense-giving is concerned with their attempts to influence the outcome, to communicate their thoughts about the change to others, and to gain their support. Although these processes appear to be conceptually different, the boundaries of each are permeated by the other. As discourse and action, sensemaking and sense-giving are less distinct domains (Hopkinson, 2001) than two sides of the same coin—one implies the other and cannot exist without it." (p. 1,415)
Weick et al. (2005)	"[S]ense-making unfolds as a sequence in which people concerned with identity in the social context of other actors engage ongoing circumstances from which they extract cues and make plausible sense retrospectively, while enacting more or less order into those ongoing circumstances." (p. 409)
Klein et al. (2006)	"Sensemaking is a motivated, continuous effort to understand connections (which can be among people, places, and events) in order to anticipate their trajectories and act effectively." (p. 71)
Gephart, Topal, and Zhang (2010)	"Sensemaking is an ongoing process that creates an intersubjective sense of shared meaning through conversation and non-verbal behaviour in face to face settings where people seek to produce, negotiate, and sustain a shared sense of meaning." (pp. 284–285)
Sonenshein (2010)	"For Weick (1995), sensemaking involves individuals engaging in retrospective and prospective thinking in order to construct an

	interpretation of reality. 'Sensegiving' is a related process by which individuals attempt to influence the sensemaking of others (Gioia & Chittipeddi, 1991; Maitlis & Lawrence, 2007). Both sensemaking and sensegiving are closely related to narratives. In fact, many scholars have treated sensemaking/sensegiving as interchangeable with constructing narratives (Currie & Brown, 2003; Dunford & Jones, 2000; Gabriel, 2004)." (p. 479)
Cornelissen (2012)	"Sensemaking refers to processes of meaning construction whereby people interpret events and issues within and outside of their organizations that are somehow surprising, complex, or confusing to them." (p. 118)

Source: Maitlis and Christianson 2014: 63-65 (Edited)

To get around the definitional challenge, Brown and Humphrey (2003) synthesized a range of sense-making perspectives to provide a very broad definition of sense-making. Sense-making, to quote Brown and Humphery's (2003: 163) in full:

> 'refers to those processes of interpretation and meaning production whereby people interpret phenomena and produce intersubjective accounts (e.g. Weick 1995). It denotes those sets of socio-cognitive processes by which people 'structure the unknown' (Waterman 1990:41) into sensible, 'sensable' events (Huber and Daft, 1987:154) in their efforts 'to comprehend, understand explain attribute, extrapolate, and predict' (Starbuck and Milliken 1988:51). From this perspective, organisational realities are enacted or socially constructed (Berger and Luckmann, 1966), grounded in identity construction (Dutton and Dukerich, 1991), and retrospectively constructed through shared processes of social interchange and negotiation' (Burrell and Morgan, 1979:123).

Weick (1995) is concerned that sense-making can easily be confused with interpretation and strongly cautions against an assumption of synonymity between them regardless of their interconnectedness. Interpretation is a subset action to sense-making because the picking of cues (through sense-making) precedes the process of interpretation (Smerek, 2009). The key distinction Weick (1995:7) points out 'is that sense-making is about the ways people generate what they interpret', whereas, he adds, 'interpretation connotes an activity that is more

detached and passive than the activity of sense-making' (Weick, 1995:14). Explained differently, Schon (1987:4) affirms that sense-making is more focused on the 'authoring of situations', covering both the authoring and interpretation of situations. As Schon (1987:4) explains: 'Through complementarity acts of naming and framing, the practitioner selects things for attention and organises them, guided by an appreciation of the situation that gives it coherence and sets a direction for action'.

Recent developments in sense-making research now support a consensus view that sense-making is essentially about how people seek to understand the ambiguity, uncertainty and equivocality around puzzling issues or events. In these situations, sense-making is triggered by extracted cues (Maitlis and Christianson, 2014).The nature of ambiguity, uncertainty and equivocality however needs further explication to get a better grasp of how they trigger sense-making. Weick (1995:93) identified ambiguity and uncertainty as two important sense-making instigators but explains that the 'shock' that triggers sense-making in each case is different. In the case of ambiguity, it is important to note that it is not ambiguity *per se* that triggers sense-making but disruptive ambiguity that arises from too many interpretations. Whereas in the case of uncertainty, sense-making is instigated by the confusion of people about any interpretation(s).

As with sense-making and interpretation, ambiguity and equivocality are often wrongly used synonymously in the literature, hence it is important to make clear the distinction between the two. Whereas ambiguity is more about unclear meanings or a lack of clarity, equivocality focuses on the confusion that arises from two or more meanings. Weick (1995) suggests that an unhelpful complication is that the term *ambiguity* in itself is *ambiguous*. To clarify the terminological issue, Collville et al. (2012) used the phrases *Ambiguity lessening* and *Reducing equivocality* to draw out the distinction:

> 'Lessening ambiguity implies that through action you can learn to discount what might have been going on and reach an answer to the question as to what is going on ('what is the story?'). Reducing equivocality suggests that action does not clarify by allowing you to eliminate lack of clarity, but that action clarifies by shaping what it is that you are attending to and in the doing, shapes what is going on' (Collvile et al., 2012:7).

The substantial and relevant point of equivocality is that the presence of two or more interpretations is a trigger for sense-making.

During the process of sense-making, the world views of actors get disrupted — 'creating uncertainty about how to act'. These disruptions occur as a result of gaps between expectations and reality, or 'violations of expectations' through unexpected events. Maitlis and Christianson (2014:70) argue that unexpected events do not automatically trigger sense-making because the experience of discrepancy or violations is subjective. Sense-making, they argue, will only be triggered if the gap between expectations and reality is 'great enough, and important enough'. Sense-making triggered by cues from a reality-expectation discrepancy in the realm of organisations is discussed in more depth in sub-section 3.5.3.

Sub-section 3.4.3 discusses the seven interrelated properties of sense-making as presented by Weick (1995).

3.4.3 Sense-making: The Seven Properties

Notwithstanding the theoretical gaps that remain unbridged in the concept of sense-making (section 3.3.), Weick's thesis (1995) that any structured discussion of sense-making must take into account the seven properties (he suggests are key elements for sense-making) has retained it's academic relevance. Mills et al. (2010:184) suggest that these seven properties are central to our understanding of the concept of sense-making because 'we are constantly engaging in making sense of our environment through the influence of [these] seven interrelated

properties'. The seven properties, according to Weick, serve as viable guidelines for inquiry into sense-making. Each property encompasses action and context and, according to Weick (1995:18), 'is a self-contained set of research questions that relate to the other six'. The strength of the seven properties is that they strongly distinguish sense-making from 'other explanatory processes such as understanding, interpretation and attribution' (Weick, 1995:17). As a contribution to sense-making theory, the seven properties are highly insightful for their analytical range when employed by scholars as conceptual lenses. The seven properties are as follows:

1. Grounded in identity construction
2. Retrospective
3. Enactive of sensible environments
4. Social
5. On-going
6. Focused on and by extracted cues
7. Driven by plausibility rather than accuracy

These properties, according to Weick (1995), are not discrete and sequential as the itemisation suggests. They are interrelated by feedback loops that occur in the sense-making process. However, Weick also strongly caveats that the convenient disaggregation of the properties into a sequence is simply a crude representation because in the practical world of sense-making, these properties occur simultaneously.

1. Identity

Identity construction is a fundamental property of sense-making. The identity of the individual is not constructed within a singular self ; rather, it is a 'dynamic construction of different

identities' seeking definition (Mantere, 2000:66). The cues we pick up during sense-making, and then enact, are shaped by who we think we are (identity) and our subsequent interpretation of things, which then influences the image that outsiders have of us, and how they relate to us. All of these preceding actions in effect, 'stabilizes or destabilizes' our identity (Weick et al., 2005:416). The identity recipe, according to Weick (1995:61), 'is a question about who I am as indicated by discovery of how I am and what I think'. Sense-making is self-referential and begins with a self-conscious sense-maker. The start of the process itself, Weick (1995:18) suggests, is a sense-maker – a rhetorical question classically described in the literature by the phrase:

> 'How can I know what I think until I see what I say?'

The problem with the term 'sense-maker' is it's connotation of a singular activity by an individual, which Weick (1995:18 citing Mead, 1934) explains is not the case because any 'one sense-maker is a parliament of selves'. In other words, sense-making involves the multiple identities of individual and group sense-makers. Multiple identities emerge from the need of sense-makers for self-enhancement, the self-efficacy motive, and the need for self-consistency (Erez and Earley, 1993; Dutton and Dukerich, 1991). Sense-making rapidly kicks in whenever there is a threat to identity or a failure to confirm oneself (Maitlis and Christianson, 2014; Weick, 1995). Whilst identity at an individual level directs our attention to the question 'who am I?' at the group (or organisational) level, the question is 'who are we?' The relationship between the process of knowing and the embedded question of who we are is described by Thayer (1988:259):

> 'We are led, in our minding of the world, in our social affairs as in our individual lives by whatever is weightiest in us. We are led not by what is, but by who we are, no more or less,[…] that set of possibilities that is given in how we are able to comprehend, and how we express the world we know, who we are and the world we know are two aspects of the same thing'.

This research will reveal (in Chapter 6) instances of NHIS implementers acting as a 'parliament of selves' through multiple identities, as sense-makers in individual capacities/collective representation.

2. Retrospective

Sense-making focuses on the retrospective because people interpret and attribute meaning to current events from past experiences. Differently put, sense-making employs the past to give meaning to the present. This important property of sense-making is a derivative of Schutz's (1967) notion of 'meaningful lived experience', which espouses the central role of the lived experience in the retrospective property of sense-making. As Pirsig (cited in Winokur, 1990:82) explains further:

> 'Any intellectually conceived object is always in the past and therefore unreal. Reality is always the moment of vision before intellectualisation takes place. There is no other reality'.

There is congruity between Shutz's position and that of Mead (1956) whose view suggests that we always have a consciousness of what we have done but generally have no consciousness of the doing process. To overcome the practical problem of capturing the retrospective nature of sense-making, Weick (1995:25) appeals to researchers to pay more attention to the following four features of the concept of experiencing and experiences:

1. That the creation of meaning is an attentional process to that which has already occurred.
2. Attention is directed backward from a specific point in time; whatever is occurring at the moment will influence what is discovered when people glance backward.
3. Because the text to be interpreted has elapsed, and is only a memory, anything that affects remembering will affect the sense that is made of those memories.

4. The sequence, stimulus-response, can be a misleading analytical unit. Only when a response occurs can a plausible stimulus then be defined.

The retrospective features of sense-making chimes with Shutz's (1967) notion of 'meaningful lived experience'. The use of the word *lived* in the past tense suggests that people can only make sense of experiences by looking back and engaging in retrospective analysis after the fact (Gioia, Corley and Fabbri, 2002).

3. Enactive of sensible environments

This property of sense-making uncovers the relationship between individual sense-making through the use of language and the actions that they subsequently take. As Thurlow and Mills (2009) explain:

> 'As individuals enact their beliefs, they also make sense of them. And in effect, the use of language in the describing of an event enacts the construction of sense-making about the event.' (Thurlow and Mills, 2009 :470)

The enactment recipe suggests that 'the object to be seen and inspected is created when I say or do something**'** (Weick 1995:61). If we break up the word sense-making into it's components, identity and retrospect relate to the 'sensing' activity whilst the 'making' activity, according to Mills et al. (2010:185), 'is about the making sense of an experience within our environment'. The logic is clear – the process of sense-making can be shaped by influences from the environment or may be limited by them since people create their environment, and their environment creates and recreates them. All of this suggests that enactment is an anti-rationalist property because actions are taken before rational planning (Westwood and Clegg, 2003).

4. Social

Sense-making is a social process. According to Smerek (2009), the social context is important because to regard sense-making as an individual process would induce blind spots that limit our

understanding of the concept (Weick, 1995). Building on Resnick, Levine and Teasley's (1991:3) premise that 'human thinking and social functioning […] are essential aspects of another', Weick (1995:39) argues that 'those who forget that sense-making is a social process miss a constant substrate that shapes interpretations and interpreting' and that 'conduct is contingent on the conduct of others, whether those others are imagined or physically present'. The social context referred to by Weick (1995) occurs in face-to-face interactions or whenever human beings consider the thinking of others to guide their own conduct.

5. Ongoing

There is no discontinuity in sense-making. The process is sequential and so sense-making never starts or stops. Weick et al. (2005:144) suggest that sense-making is a progressive process that involves continuous updating. Weick's (1995:43) explanation for this is that 'people are always in the middle of things, which become things only when those same people focus on the past from some point beyond it'. This viewpoint attracted criticism on grounds that it contradicts the notion that sense-making is instigated in situations of shock and ambiguity. Mills et al. (2010), however, reject the contradiction argument, explaining that Weick's position on this property is essentially that, whilst sense-making is actually continuous, we typically interrupt this process to focus on episodic situations.

6. Focused on and by extracted cues

The ease and the effortlessness of the process of sense-making makes it ubiquitous (Weick, 1995). Consequently, investigators of sense-making will have a hard task to observe sense-making in progress and are more likely to see sense after the fact (Weick, 1995:49). To experience the making of sense, investigators need to focus on the response of people in sense-making defying situations such as 'paradoxes, dilemmas, and inconceivable events' (1995:49). To operationalise the investigation, more attention needs to be paid to how people notice which

cues to be extracted, the extracted cues, and the biases they impose on them, having been led by their subjective filters. The extraction of cues is contextual on two levels. Firstly, context affects the cue that is extracted, and secondly, context affects the interpretation of the extracted cue (Weick, 1995).

7. Driven by plausibility rather than accuracy

This property suggests that during sense-making, the accuracy of our perceptions is subordinate to plausibility. In essence, one particular meaning may be weighted higher than candidate meanings (Thurlow and Mills, 2009). Rather than relying on the accuracy of our perceptions, Mills et al. (2010:185) argue that we should instead seek cues that make our sense-making plausible. Mills et al. (2010:185, citing Berry, 2001) suggest that plausibility is responsible for the variance in sense-making among organisational members at different hierarchical levels. This variance may also be evident in organisational group dynamics, especially in terms of the implications it has for 'action, policy or event'. Weick's (1995) summation of this property is that sense-making is about 'plausibility, coherence and reasonableness' (Weick, 1995:61) arguing that whilst accuracy may be desirable, it is a secondary criteria that is not particularly necessary in sense-making. This point restates Starbuck and Milliken's (1988:41) view that 'filtered information is less accurate but, if the filtering is effective, more understandable'. Accuracy, as Weick (1995) argued, may be a worthless pursuit considering that interpretation itself is a political action that is shaped by competing interests and evolving identities in the real world.

These seven properties in combination, Hong (2006) suggests, distils into three core interdependent processes of sense-making, which in hierarchical order are *enactment* (involving the search for and noticing of clues), *selection* (which are attempts at explanations for multiple realities that emerged from enactment), and *retention* (the imprinting of shared understandings from enactment and selection in individual/organisational memory).

3.4.4 Forms of Sense-Making-Related Constructs in Contemporary Research

Recent research has seen scholars develop specialised forms of the concept of sense-making and sense-making related constructs (see Table 3.4.). Maitlis and Christianson (2014) , however, noted that out of these plethora of constructs, only the notion of *sense-giving* and *sense-breaking* have been the most insightful to the core concept. The notion of sense-giving which is explored in this study through research question 3, is also a key component of the conceptual framework of this study.

Table 3.4. Examples of Specific Sensemaking-Related Constructs

Sensemaking-related construct	Definition
Sense-breaking	"the destruction or breaking down of meaning." (Pratt, 2000: 464)
Sense-demanding	"strenuous efforts to acquire and process information so as to establish 'a workable level of uncertainty' and equivocality (Weick 1969, p. 40)." (Vlaar, van Fenema, & Tiwari, 2008: 240)
Sense-exchanging	"different conceptions of organization are negotiated to socially construct the identity of an organization." (Ran & Golden, 2011: 421)
Sense-giving	"attempting to influence the sensemaking and meaning construction of others toward a preferred redefinition of organizational reality." (Gioia & Chittipeddi, 1991: 442)
Sense-hiding	"discourse can be mobilizing in terms of promoting a specific kind of thinking and action or manipulative in terms of hiding particular ideas." (Vaara & Monin, 2010: 6) "silencing alternative senses of integration or marginalization of particular voices." (Monin et al., 2013: 262)
Sense specification	"specification of explicit or implicit norms . . . coining of principles, exemplary decisions and actions, symbolization, and quantification." (Monin et al., 2013: 262)

Source: Maitlis and Christianson 2014:69

The next section sets the stage for a discussion about the relationship between sense-making and organisations with an introduction to the concept of the organisation.

3.5 Introduction to the Concept of the Organisation

This introduction brings into better light the interrelationship between sense-making and organisations. Scott's (1987) treatise on organisations drew on a diverse intellectual base (Weber, 1947; Simon, 1957; Roethlisberger and Dickson, 1939; Barnard, 1938; Parsons, 1960; Buckley, 1968; Boulding, 1956; Katz and Khan, 1966) to define organisations under three broad

categories: rational, natural, and open systems.

1. Rational System: Organisations are collectivities that are oriented to the pursuit of relatively specific goals and that exhibit relatively highly formalised social structures (Scott, 1998:26).

2. Natural System: Organisations are collectivities whose participants are pursuing multiple interests, both disparate and common, but recognise the value of perpetuating the organisation as an important resource. The informal structure of relations that develop among participants provides a more informative and accurate guide to understanding organisational behaviour than the formal (Scott, 1998:26).

3. Open System: Organisations are systems of interdependent activities linking shifting coalitions of participants; the systems are embedded in, or dependent on continuing exchanges with and constituted by environments in which they operate (Scott, 1998:28).

The question which arises is: which of the three conceptual definitions of organisations is most relevant to the concept of sense-making? The above definitions of organisations vary in terms of degrees of openness to the environment, and coupling of systemic elements, which Weick (1995:70) suggests is from 'less to more openness to the environment, and from tighter to looser couplings' among the elements that comprise the system. Implicitly, the conceptual definition of organisations that is most relevant to sense-making is that of organisations as open systems. As Fourie (2008:28) explained:

'[…] organisations represented as open systems should be more susceptible to sense making than those where elements are firmly joined. The reason for this being that environments that are more open, with less structures and procedures, undoubtedly lead to more ambiguity and sense making becomes vital.'

In essence, Fourie's viewpoint is that open systems allow for a higher degree of diverse information exchange (Weick, 1995).

3.5.1 Explaining the Relationship between Sense-making and Organising

The relationship between sense-making and organising is so interwoven that they 'constitute one another' (Weick et al., 2005:410). In agreement, Brown et al. (2015:267) concur that it is best to 'dispense' with the 'and' in 'sense-making and organising', and instead discuss organising 'through' sense-making, or organising 'for' sense-making.

Organisational sense-making is twofold. First, it is about noticing how things become events to people, and second, eliciting the meaning ascribed to such events (Weick et al., 2005). If sense-making and organising constitute each other, what then is organisation? Organisation, as defined by Tsoukas and Chia (2002:570), 'is an attempt to order the intrinsic flux of human action, to channel it toward certain ends, to give it a particular shape, through generalising and institutionalising particular rules'.

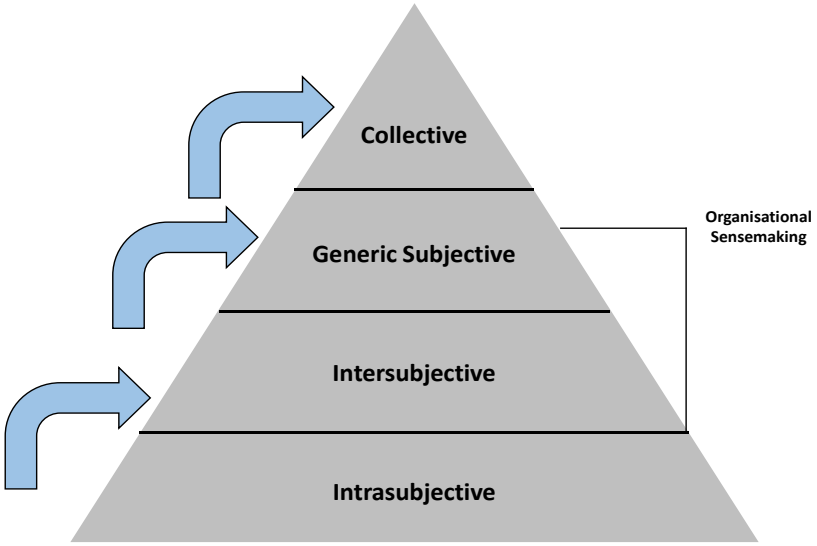
Weick et al. (2005:410) stress that in the relationship between organisation and sense-making, a 'grasp of each is necessary to understand the other'. The image of organisation that Weick et al. (2005) essentially convey, is one in which organisation is a product of sense-making and not one in which organisation is a precursor to sense-making.

3.5.2 Levels of Sense-Making in Organisations

Weick (1995:71) proposed that the best approach to discuss macro level sense-making [sense-making beyond the individual or personal (intrasubjective) level of analysis], is to 'pursue Wiley's (1998) argument that there are three levels of sense-making 'above' the individual (intrasubjective) level of analysis'. These levels in ascending order are the intersubjective, the

generic subjective, and the collective levels of organisational sense-making, which are shown in Figure 3.2 with their features summarised in Box 3.1.

Figure 3.2: Levels of Organisational Sense-making



Source: Fourie (2009:28) Compiled from Weick (1995:70-71).

Box 3.1: Summary of Features of Organisational Sense-making

Intersubjectivity
Intersubjectivity in an interactive transformational process in which intrasubjective (individual) thoughts, feelings, beliefs and intentions, expressed in conversations as 'I' views, is substituted with 'we' views. This transformation Weick (1995:71 citing Wiley 1998:254) suggests is a 'level of social reality form' in which intersubjectivity is the outcome of the 'synthesis of two or more communicating selves'. Following this initial synthesis is another emergence of 'interactional representations' that 'synthesises into Durkheim's social structure or collective consciousness' (ibid:258)
Generic Subjectivity
This is the level of social structure above the intersubjective, which according to Wiley (1988), includes organisations. The distinctive feature at this level is that 'concrete human beings, subjects, are no longer present. Selves are left behind at the interactive level' (ibid:259). In addition, Wiley observed that relation to subject at this level is 'categorical and abstract' (ibid:258). Barley (1986), who researched and analysed changes in technology and it's impact on work and relational roles and social networks, suggested that the abstract generic self is governed by rules and scripts; but in addition, points out that during times of organisational stability, the role of intersubjectivity in sense-making is diminished, and generic subjectivity becomes predominant. During periods of instability or turbulence, uncertainty and ambiguity rise. At such times, Fourie 2009, (citing Barley 1986) suggests that sense-making relies more on intersubjectivity until new meanings that can be absorbed into generic subjectivity emerge.
Extra-subjective
The extra-subjective level is Wiley's final level of sense-making in organisations. Weick (1995) explains that the extra-subjective is in the realm of culture and that, at this level, the role-playing generic self is now replaced by 'pure meanings' (Popper 1972), albeit without a subject (ibid:72). To facilitate our understanding, Weick (ibid:72) described this level as one with the symbolic reality 'we might associate with a subjectless batch of culture such as capitalism or mathematics'. Weick suggests that Barley's, (1986) discussion of the institutional realm implicitly referred to an observed phenomenon similar to that at the cultural level. Weick (1995) notes that Wiley specifically does not link organisation to one level of sense-making. He however, affirms that organizing is positioned above the oscillatory movement between the inter-subjective and the generic subjective. Put differently, organisation is the bridge between inter-subjectivity and generic subjectivity.

Source: Adapted from Weick, 1995.

3.5.3 Sense-Making in Organisations: Violations of Expectations as Triggers of Sense-Making

Unexpected events in an organisational context that violate expectations create a reality-expectation discrepancy, which triggers sense-making in groups just as in an individual context. Robinson and Morrison (2000) explain that such a situation might occur if, for instance, an organisation fails to deliver

on expectations. The experience of violation is, however, subjective and must be of sufficient magnitude to trigger sense-making (Maitlis and Christianson, 2014). Significance will depend on factors such as the 'impact on individual, social, or organisational identity' (Maitlis and Christianson, 2014 :70). In a departure from individual sense-making, violations may not trigger sense-making if a group or organisation accommodates or normalises discrepant cues – a phenomenon Vaughan (1996) referred to as 'normalisation of deviance'. Regardless of the possibility of deviance being normalised, deviance in itself should be seen as a violation of expectation.

Vaughan's (1999) theory of organisational deviance emerged as a development of her prior work on routine non-conformity in organisations. She sees non-conformity and the systematic development of deviance as interchangeable constructs (Vaughan, 1999:274). Her research on how things go wrong in 'socially organised settings' (Vaughan, 1999: 273) focused on three types of routine non-conformity with adverse public consequences: mistake, misconduct, and disaster. Vaughan (1999) defined organisational deviance as:

> 'An event, activity, or circumstance, occurring in and/or produced by a formal organisation, that deviates from both formal design goals and normative standards or expectations, either in the fact of it's occurrence or in it's consequences, and produces a suboptimal outcome.' (1999:273)

The definition of deviance, according to Vaughan, is broad enough to cover violations of 'internal rules, legal mandates and social expectations' (1999:273). Based on her research on organisational misconduct, Vaughan (1996:458) identified three systemic elements that might set the stage for organisational misconduct. These are:

1. The competitive environment (competition, scare resources and norms), which generates pressure on organisations to violate laws and rules to attain goals;
2. Organisational characteristics (structure, processes, and transactions), which provide opportunities to violate;

3. The regulatory environment (autonomy and interdependence), which is affected by the relationship between regulators and the organisations they regulate, frequently minimizing the capacity to control and deter violations, consequently contributing to their occurrence.

Vaughan further suggests that these three elements are integrally tied and, as such, misconduct typically results from a combination of all three. Furthermore, she suggests that power as a dynamic in organisational misconduct cannot be ignored because through it's use, organisations can be defined, created and shaped to suit particular needs (1999:275). Vaughan also suggests that goal displacement and co-optation – two concepts associated with routine non-conformity may be the outcome of power struggles.

3.5.4 Collective Sense-Making: The Distributed Perspective

Recognising the deficiencies in sense-making theory, Weick et al. (2005, citing Lant, 2002) enjoin researchers to expand the frontier of research to explore collective sense-making:

> 'The rhetoric of 'shared understanding', 'common sense' and 'consensus', is commonplace in discussions of organised sense-making. However, the haunting question remain: Are shared beliefs a necessary condition for organised action (Lant 2002:355), and is the construct of collective belief theoretically meaningful?' (Porac *et al*. 2002:593) [Weick et al., 2005:417]

The distributed perspective (Spillane et al., 2002; Coburn, 2001, 2005) has emerged as a lens for pursuing these lines of research in sub-streams of sense-making research. Coburn (2001:147) explains that sense-making is not 'solely an individual affair' because of it's two important social underpinnings. First, it is collective in that it is rooted in interaction and negotiation, and, second, because sense-making is situated in 'embedded contexts'. Differences in knowledge embedded in social contexts, according to Spillane et al. (2002:404), 'affect sense-making and action in implementation'. Spillane et al.'s (2002, citing Greeno, 1998) explication of situation and

contexts in sense-making again starts from the position that sense-making is not something that occurs in silos of individuals but is distributed in the interactive web of actors, artefacts, and the situation, and that this system therefore becomes the appropriate level of analysis (Spillane et al., 2002:404).

The situation or context, according to Spillane et al. (2002:404), is 'a multifaceted construct that includes everything from national and professional identities to the structures of the offices and organisations in which people work'. Implementing agents at the macro and micro levels have to deal with the complexity that comes with organisational structures, professional affiliations, social networks, norms and traditions. Both macro and micro aspects of the situation are important for implementing agents' sense-making – the micro level being sense-making that occurs intrasubjectively (sub-section 3.5.2).

At the macro-level, the mental models for coping with new knowledge are very much a function of their 'thought communities' or 'world views'. It is, however, important to recognise that people often belong to more than one thought community by way of their national and or ethnic identities, religious affiliations, professional or social class membership etc. (Spillane et al., 2002:404). These thought communities where macro-level discourse on sense-making takes place constitute a 'hyper-agentic sense-making environment', where 'individuals, drawing on identity resources, notice, and act on cues, freely share their emerging accounts with available others, and enact new, sensible environments as they do so' (Maitlis and Christianson, 2014:98). Communities of practice are enlarged groups of 'thought communities' that provide us with a context in which to observe and explore sense-making processes in groups. The findings of this NHIS case study will reveal these dynamics in the Nigerian health sector.

The next section discusses the concept of communities of practice and their association with sense-making.

3.6 Communities of Practice Theory: Introduction

Lave and Wenger (1991) developed the concept of communities of practice from their research on situated learning. The value of communities of practice theory as a conceptual tool for this research rests on the notion that learning occurs more from social interaction between people than in the minds of individuals (Coburn and Stein, 2006). To buttress this position, Coburn and Stein (2006), in their investigation of the role of the professional teacher community of practice in educational policy implementation, suggest that socially situated learning as opposed to conventional learning 'occurs as individuals participate in the social and cultural activities of learning' (2006:26). The nub of their contribution is that policy implementation can be conceptualised as 'a social process of learning within and between communities of practice' (2006:26).

The term 'community of practice' has been defined by Coburn and Stein (2006) as 'a group of individuals who, through the pursuit of a joint enterprise, have developed shared practices, historical and social resources, and common perspectives' (Coburn, 2006:28). This definition shares common elements with that of Wenger (2001), who described communities of practice as 'groups of people who share a concern or a passion for something they do and who interact regularly to learn how to do it better' (2001:1). Galluccci (2003) however explained that 'communities of practice' are the locus of shared understandings and the negotiations of meanings about work.

Coburn and Stein (2006) view as misplaced the notion that communities of practice reside only within the confines of formal organisational structures such as, in a school context, grade levels, subject matter departments, or even entire schools. Communities of practice, the literature suggests, for the most part evolve as informal relationship networks that do not have features of a formal organisation (Brown and Duguid, 1991; Wenger, 1998). Wenger (2001) asserts that

a community of practice 'is different from a business or functional unit within a business, in that it defines itself "in the doing", as members develop among themselves their own understanding of what practice is all about' (2001:3). Wenger's framework is, according to Gallucci (2003:4), helpful in the analysis of communities of practice and their interrelationship with the 'external structures' in the policy reform environment

Wenger (1998) suggests that three characteristics are essential to communities of practice, which Coburn and Stein (2006:28) summarised as follows:

1. Mutual engagement: This connotes deep involvement in activities that are significant components of daily work and are important for how individuals experience the world.

2. Joint enterprise: The community's definition of and response to it's shared situation. This enterprise is negotiated among community members and binds the community together.

3. Shared repertoire of practice: The routines, rituals, ways of doing things, definitions of situations, or particular concepts or ways of thinking that participants in a community develop in their interactions with one another.

An important insight from communities of practice theory that this research is particularly influenced by, is the notion that individuals can belong to or participate in more than one community of practice at a time. The findings of this research will reveal to what extent boundary-spanning communities of practice actors impacted on the implementation of the NHIS.

3.6.1 Understanding the Link Between Sense-Making and Communities of Practice

Based on the notion that communities of practice are an important social context, Benn (2004:65) affirmed that communities of practice theory facilitates the understanding of sense-making 'as a group process in which collective meaning emerges as the members influence each other through their individual perspectives'.

Extant sense-making research has established that the sense individuals make of a policy is shaped by their prior knowledge and beliefs. Subsequent elaborations of sense-making theory have also shown that varied differences in knowledge arising from formal and informal 'thought communities' embedded within such social contexts also impact on sense-making and policy implementation (Spillane et al., 2002). This view is basically the substrate of the distributed perspective (sub-section 3.10.4). Given that thought communities are essentially communities of practice, this view signifies that there is much overlap in the key theoretical constructs that guide this inquiry.

Coburn (2001:147) explains that people in thought communities 'make sense of messages in the environment in conversation and interaction with their colleagues, constructing shared understandings, organisation and workgroup specific culture, beliefs, routines along the way'. Coburn and Stein (2006:30) also suggest that the activities in communities of practice stretch beyond the construction of shared understanding. Their work on communities of practices in the teaching profession drew out the potential influence of communities of practice on policy making. As they observe:

> 'policy can be seen as an attempt by members of one community of practice (policy makers) to influence or co-ordinate the practice of others (communities of practice) via boundary objects, brokers, or boundary practices' actions of other communities of practice, with the emphasis that policy often has to travel across boundaries of many thought communities'.

These insights are particularly important in addressing research question 2 of this case study.

The next section presents institutional theory with a focus on it's central themes to provide a background to the discussion on sense-making and the institutional context

3.7 Institutional Theory: The Central Themes

The central idea of institutionalisation is that 'much organizational action reflects a pattern of doing things that evolves over time and becomes legitimated within an organization and an environment' (Eisenhardt, 1988:492, citing Pfeffer, 1982). Zucker (1987:443) expands on this perspective by suggesting that institutional theories are inspired by the notion that organisations are influenced by:

> 'normative pressures, sometimes arising from external sources such as the state, other times arising from within the organization itself. Under some conditions, these pressures lead the organization to be guided by legitimated elements, from standard operating procedures to professional certification and state requirements, which often have the effect of directing attention away from task performance.'

The preceding viewpoints highlight a high degree of social actions (which become taken for granted assumptions) within institutions. It is these taken for granted assumptions that 'obscure espousals of institutional theory' (Zucker, 1987:443). Institutional theory is, according to Zucker (1977:728), linked by two theoretical approaches: '(a) A rule-like, social fact quality of an organizational pattern of action (exterior), and (b), an embedding in formal structures, such as formal aspects of organizations that are not tied to particular actors or situations (nonpersonal/objective)'.Zucker adds that common to the two approaches are three social mechanisms of institutional isomorphism, defined as '[a] constraining process that forces one unit in a population to resemble other units in it that face the same set of environmental conditions' (Dimaggio and Powell, 1983:147). The first mechanism is *imitative* or *mimetic* in

which uncertainty about alternative options encourages imitation of the successful approaches of others. The second is a normative process in which *social facts* may be transmitted into organisations in response to normative pressures imposed from external influences such as professions or through people of similar educational backgrounds or inter-organisational networks. The third mechanism is coercive isomorphism – a term used to describe homogeneity pressures from the authority of state or other powerful body. Such a mechanism may have it's origin in resource dependency (Guler et al., 2002). Eisenhardt (1988) suggests that once the actions taken within organisations become taken for granted, they become legitimised. The key features of institutional theory are presented in Table 3.5.

Table 3.5.: Key Features of Institutional Theory

	Institutional Theory
Key idea	Organisational practices arise from imitative forces and firm traditions.
Basis of organisation	Legitimacy
View of people	Legitimacy-seeking satisfiers
Role of environment	A source of practices to which an organisation conforms
Role of technology	Technology moderates the impact of institutional factors or can be determined institutionally
Problem domain	Organisational practices in general
Independent variables	Industry traditions, legislation, social and political beliefs, founding conditions that comprise the institutional context
Assumptions	People satisfice People conform to external norms

Source: Adapted from Eisenhardt (1988).

The above theoretical viewpoints suggests that institutions over time impose values on organisational members; as Selznick (1957:16-17) stated, to 'institutionalize is to infuse with value'. The notion of value thus summons out the association between institutional theory and

sense-making – since individual cognition is partly influenced by embedded values (sub-section 3.10.6).

3.8 Sense-Making and Institutional Context

Two important perspectives point to the interrelationship between sense-making and institutional theories. First, they share a common social constructivist epistemological grounding, which essentially is that reality is socially re-constructed (Berger and Luckmann, 1966); and second, both theories are concerned about how meaning is produced and developed (Zheng, 2010). Academic espousals of the association between the two have been well articulated in two highly influential publications: *Sense-making in Organisations* (Weick, 1995) and *Institutions and Organisations* (Scott, 1995). Regardless of these commonalities, a considerable theoretical distance still remains between sense-making and institutionalism. Weick et al.'s (2005:417) remark that: 'juxtapositions of sense-making and institutionalism are rare' underscores the point that there is a dearth of empirical research linking the two. Recent efforts to bridge the gap include Jennings and Greenwood (2003), Weber (2003), Weber and Glynn (2006) and Zilber (2007).

There is however ongoing debate as to whether sense-making is the feedstock for institutions or institutions the feedstock for sense-making (Maitlis and Christianson, 2014; Weber and Glynn, 2006). The efforts of researchers in pursuit of integrated studies between sense-making and institutionalism has mostly been directed at finding out if institutions are antecedent to, or emergent from, sense-making. These scholars are split into the 'top-down' camp, who postulate that institutions shape sense-making, and the 'bottom-up' camp who counter-argue that sense-making shapes institutions (Weber and Glynn, 2006).

3.8.1 Sense-Making and Institutions: Analysing the Top-Down and Bottom-Up Views

The 'top-down' view, according to the literature, is the more dominant perspective. It argues that institutions provide the feedstock for sense-making by imposing 'internalised cognitive constraints' on institutions (Weber and Glynn, 2006:1642).

Advocates suggest that institutions are cultural-cognitive, and as such institutional changes must be seen as outcomes of variations in local enactment (Scott, 2003; Weber and Glynn, 2006). Weber and Glynn (2006) are highly rigorous in their exposition of how sense-making shapes institutions. They employed mechanism-based theorising to propose a model that suggests that institutions provide the feedstock for sense-making through three mechanisms: priming, editing and triggering sense-making:

> 'Institutions prime sense-making by providing social cues; (2) institutions edit sense-making through social feedback processes; (3) institutions trigger sense-making, posing puzzles for sense-making through endogenous institutional contradiction and ambivalence.' (Weber and Glynn, 2006:248)

Another perspective offered by Spillane et al. (2002:405) suggests that the strict codes of conduct of institutions largely influence sense-making:

> 'Social agents' thinking and action are situated in institutional sectors that provide norms, rules, and definitions of the environment, both constraining and enabling action'.

Institutionalised roles therefore become embodied in sense-making through shared cognitive structures that become taken for granted as socialisation leads to the internalisation of these structures (Berger and Luckmann, 1966; Zucker, 1991). Other embodied mechanisms include habits or dispositions (Bourdieu, 1990) and enacted action scripts (Barley and Tolbert, 1997). Compelling as the perspectives of the top-down camp may be, they do not diminish the strengths of the alternative views advanced by the bottom-up camp.

Largely inspired by Weick (1995:36), proponents of the 'bottom-up' view support the idea that 'sense-making is the feedstock for institutionalisation'. Weick's argument relies on the central notion that no organisation can be fully understood aside of it's wider socio-cultural context, as well as his conviction that institutions supply the raw materials of sense-making and that these materials are mobilised by 'institutional carriers embedded within these institutions'. To further bolster his stance in the debate, he argues that institutionalists are ignoring evidence that shows that members of organisations, in spite of institutional cognitive constraints, may also be socialised into 'expected' sense-making actions by strong cognitive shaping forces such as the mass media, professions, government bodies and interest groups (Weick et al., 2005:417). Weick (2005), in a finer-grained explanation, suggests that institutions are linked to the extra-subjective level (of pure meanings) while sense-making is an inter-subjective activity among actors. The conclusion that can be inferred from this perspective is that institutional ideas and sense-making cannot be incompatible because they are inextricably interwoven.

Although this research is not aimed directly at examining the role of institutions as an independent variable, it implicitly does so given that the implementing agents purposively selected to investigate sense-making come from key Nigerian health institutions including the NHIS, HMOs/HMCAN and HCPs.

3.8.2 Sense-Giving Theory

Leaders, according to Huzzard (2003), engage in sense-making firstly by defining a situation and thereafter by creating meaning. Sense-giving occurs 'when sense is subsequently disseminated to other actors to define and guide action' (Huzzard, 2003:8). Huzzard (2003) explored sense-giving using a relational lens and posits that sense-making is the thinking action of managers, whereas sense-giving is the action taken to bring subordinates on board. In the psychology-based perspective of Gioia and Chittipedi (1991), sense-making and sense-giving are 'ongoing

and reflexive' individual actions.

Sense-giving theory 'is concerned with the process of attempting to influence the sense-making and meaning construction of others towards a preferred redefinition of organisational reality' (Gioia and Chittipedi, 1991:442). Smerek (2009:6) explains that in the interrelationship between sense-making and sense-giving, sense-giving 'focuses our attention on the outward communicative agency of individuals'. The central point of Gioia and Chittipedi's sense-giving model is that the relationship between sense-making and sense-giving is a dialectic, occurring cyclically in a sequential and reciprocal fashion. If this holds, then sense-making theory is incomplete without the concept of sense-giving.

Sense-giving is more evident in actors occupying leadership positions (Bartunek et al., 1999; Gioia and Chittipedi, 1991). Weick (1995:10, referencing Thayer, 1988:250) adds that 'a leader does not tell it as is; he tells it as it might be, giving what is thereby a different face […] The leader is a sense-giver'. Adherents of the concept of sense-giving argue that sense-making theory falls short because 'less attention has been paid to the sense-making that occurs among large groups of diverse organisational stakeholders as they address a range of issues' (Maitlis, 2005:21). Maitlis and Lawrence (2007:76) claim that sense-giving in leaders and stakeholders is triggered under specific conditions such as :

> 'issues that they perceived as important either to themselves, to a stakeholder group, whom they represented, or to the organisation at large. For leaders, sense-giving was triggered by issues that they perceived as ambiguous, unpredictable, and involving numerous diverse stakeholder'.

Maitlis (2005:29) suggests that activities such as 'contesting a proposal, calling a meeting, explaining a situation, issuing a warning [and] justifying a view' are examples of sense-giving. Matlis and Lawrence (2007) empirically demonstrated that leaders are incapable of anticipating all gaps in sense-making; hence the sense-giving that emerges from stakeholder participation is

crucial to identifying some such gaps. These insights underscore the relevance of, and strengthens the case for, the exploration of sense-giving activities of NHIS-implementing actors in this study as a further opportunity for theoretical contribution (research question 3).

The next section reviews the literature on the role of power and politics in sense-making.

3.9 Power, Politics and Sense-Making

A short review of the literature of power and politics (and relevant theoretical extensions) is presented to preface the discussion on the role of power and politics in sense-making.

3.9.1 Power

It is hard to disguise the negative connotation that the definition of power conveys, which is 'the ability to get others to do what you want them to do, if necessary, against their will, or to get them to do something they otherwise would not do' (Hardy and Clegg, 1996:623). One perspective on the nature of power is the radical view. Explaining this view, Lukes (1974) postulates that in the landscape of organisations, those who wield power are dominant actors—who aside from controlling 'socialisation processes and political agendas' also deploy power 'through shaping common ideologies, common definitions of issues and common beliefs'. This view also suggests that power may be 'exercised subconsciously — disconnected from any notion of intent' (Huzzard, 2003:6). The rival view – the post-structuralist/relational view (Balogun et al., 2005) – argues that power is located in relationships, and as such, power does not reside in any one individual. By that same logic, it follows that a shift in relations will typically alter balances of power. Hardy (1996) identified three forms of power:

1. Power of resources: That is the power over control of resources.
2. Process power: This pertains to how outcomes are influenced by control mechanisms

employed to select those who participate in decision-making.

3. Power of meaning: This form of power is essentially about information control. The power of meaning has been described as 'a process of symbolic construction and use designed to legitimize one's owns actions and delegitimize those of opponents' (Balogun et al., 2005:263).

Huzzard (2003:6) suggests that it is wrong to view the notion of power as a straight choice between the radical (realist ontological) view and the relational (post-structuralist) view. He argues that accepting one view over the other will be a mis-step because 'a notion of power that is relational and unconnected with intentional forms of agency but find it's expression in the discourse through which parties to a relationship interact need not be incompatible with a realist ontology'. The thrust of this perspective is that there is a material (real) world out there that exists independently of discourse, and there is also a socially constructed world where discourse is the means by which the interests (or agential intent) of dominant groups is communicated via reality construction (Huzzard, 2003). In other words, whilst power may be relational, parties, whether dominant or sub-ordinate, have relative power of resources that can be deployed/leveraged in interrelationships.

3.9.2 Politics

Power and politics are inherently linked given that politics is the process by which power is mobilised. A widely cited definition of politics offered by Pettigrew (1977) is:

> 'Politics concerns the creation of legitimacy for certain ideas, values, and demands, not just actions performed as a result of previously acquired legitimacy. The management of meaning refers to a process of symbol construction and values use designed both to create legitimacy for one's own demands and to delegitimize the demands of opponents' (1977:85).

Hodges and Gill (2015:424) reason that politics is a mechanism for creating legitimacy for certain

initiatives/objectives to influence 'the acceptance of change'. If we recall that sense-making is all about 'meaning construction and reconstruction' by key actors or 'change recipients' (Gioia and Chittipeddi, 1991:442; Balogun, 2006), then Hardy's third form of power [of meaning] points towards an association between power/politics and sense-making/sense-giving.

3.9.3 Understanding the Relationship between Power, Politics and Sense-Making

One element of the Weickian concept of sense-making that is much critiqued as a theoretical deficiency is it's negation of the role of power and politics in sense-making. Patriotta et al. (2016) identified several inter-relationships between power and sense-making, and regard the scant attention paid to them as lost opportunities to expand the frontier of knowledge in the domain. Their perspectives on such inter-relationships are presented in Box 3.2.Following up on their observation, they suggest potential sub-themes of inquiry (relating to power, sense-making and organizing) for researchers to explore (Box 3.3).

In the main, the criticism against current sense-making theory is that it is yet to recognise and explore the political processes and manoeuvrings behind the multiple competing accounts seen in organisations, in crisis and change situations, through which some interpretations become legitimised while others are subjugated (Huzzard, 2003; Weick et al., 2005; Mullen et al., 2006; Weber and Glynn, 2006; Vlaar et al., 2006; Hope, 2010; Mills et al., 2010; Maitlis and Christianson, 2015). This charge is part of the wider criticism that theoretical development in sense-making is yet to sufficiently explore the role of macro-level discourses covering the social, cultural, economic and political dimensions in sense-making processes, both within and outside organisations (Brown et al., 2015). Weick et al. (2005:418, citing Mills, 2003:153, and Pfeffer, 1981) acknowledge the theoretical deficiency in sense-making theory in the realm of power and politics, emphasising their criticality as follows:

> ‘Sense-making strikes some people as naïve with regard to the red meat of power, politics, and critical theory. People who are powerful, rich and advantaged seem to have unequal access to roles and positions that give them an unequally strong position to influence the construction of social reality [...] how does power get expressed, increase, decrease, and influence others? Preliminary answers are that power is expressed in acts that shape what people accept, take for granted and reject’. (2005:418)

Power and politics are relevant to sense-making because the ‘creation of new understandings is not free of power issues and self-interested behaviour’ (Vlaar et al., 2006:1629). Similarly, Zilber (2007:1037) affirms that group sense-making is a highly political process because in the process of ‘reconstructing reality’, policy actors are actually engaged in the ‘redistribution of power itself’. Abolafia (2010:350) also noted that policy makers in their sense-making are mostly concerned about the legitimacy of authoritative action because such actions are not taken in neutrality. Authoritative sense-making, he argues, is an act of power that ultimately wins the consent of those it has dominion over. Drawing on studies focused on the construction of intersubjective meaning and discursive analyses in the context of organisational change (Brown et al., 2008; Currie and Brown, 2003; Humphreys and Brown, 2003; Mantere *et al.,* 2012), Maitlis and Christianson (2015:98) assert that: ‘All of these works vividly convey the tussles and tensions (power and political manoeuvrings) of organisational sense-making, as different parties campaign and compete to shape meanings of, and in the organisation, gain acceptance for a preferred account, or subvert the status quo’.

Box 3.2: Perspectives on Dimensions of Power and Sense-making

‘Power affects access to opportunities to sense; it influences how meanings get constructed; it channels multiple voices, narratives, and discourses within and outside organizations. That is, the accounts that dominate and the practices that become accepted in organizational contexts are products of negotiations undertaken in structures that privilege some actors over others.’

Maitlis & Sonenshein, 2010

‘Power structures emerge from multi-party sensemaking and sensegiving.’

Gioia & Chittipeddi, 1991; Maitlis & Lawrence, 2007

‘Power structures crystallize as a result of social interaction processes whereby individuals, drawing on identity resources, navigate controversies, notice and act on cues, develop plausible conjectures, share their emerging accounts with available others, update their understandings, and advocate their preferred meanings of a situation.’

Weick, 1995

‘Power and sensemaking become especially salient in the grey zones of organizing – transitional situations characterized by uncertainty, ambiguity, and equivocality.’

Patriotta, 2003; Weick, 1979, 1995; Weick & Sutcliffe, 2007

‘Power provides a context for sense-making. At the micro level, it influences sensemaking dynamics during interpersonal communication and social encounters.’

Patriotta & Spedale, 2009

‘At the macro level, it constitutes the socio-structural basis within which corporations, social movements, the media, and other stakeholder groups negotiate meaning, and ultimately develop competing definitions of reality.’

Berger & Luckmann, 1967

Source: Patriotta et al. (2016)

Box 3.3: Potential Research Sub-themes: Power, sense-making and organising

1.The interplay of power and sense-making processes across different levels of analysis (individual, group, organizational, network, field, market) and the various mechanisms that link these levels

2.The joint influence of power and sense-making on processes of social construction of reality and negotiation of meaning

3.Breakdowns of power and breakdowns of sense

4.The grey zones of power and sense-making: uncertainty, ambiguity, and equivocality

5.Sense-making as politics of meaning: narratives, power and discourse

6.The effect of power and sense-making in the identity processes

7.The emotional consequences of power and sense-making

8.Sense-making, sense-breaking and sense-giving during communication and social interaction

8.Framing contests between corporations, social movements and the media

10.The influence of market, institutions and macro-level political processes on sense-making

11.The interaction of power and sense-making during institutional work

Source: Patriotta et al. (2016)

In chapter 1, it was stated that one of the objectives of this case study is to address the criticism that current sense-making research is inadequate with regards to the role of power and politics in the processes. The research question specifically targets that objective. The themes of the

linkages between sense-making and politics that research question 3 aims to explore are in alignment with themes 1, 2, 4, 5, 10 and 11 identified by Patriotta et al. (2016) as potential research themes in the subfield (Box 3.3).

The study in particular seeks to extend recent research thinking postulating that the role of power and politics in sense-making is strongly exhibited in sense-giving – it's dialectic. The next sub-section discusses the notion that sense-giving is largely a political process.

3.9.4 Sense-Giving as a Political Process

A number of scholars have suggested that sense-giving is a political process *per se* (Dreyfus and Rabinow, 1982; Foucault, 1997; Fox, 2000; Clegg et al., 2006; Maitlis and Lawrence, 2007; Hope, 2010; Mørk et al., 2010; Filstad, 2014); since politics is a process of influencing interpretations through the pulling of the levers of power [of meaning] in order to control or shape 'perceptions, cognitions and preferences' (Hope, 2010:1898). Filstad in this quote (2014:6) explained the notion that sense-giving is a political process:

> 'Sense-making and sense-giving must be acknowledged as processes, where these processes and activities related to the implementation of, for instance new knowledge, are fuelled with enacted power, and occur as a result of political activities. Sense-giving is bound up with power as it either normalises or shuts down alternative interpretations as a result of leaders' decisions and their facilitation of activities related to how to implement new knowledge and also how leaders might limit who participates in sense-making processes'.

Filstad's view may make explicit the inter-relationship between sense-giving and power but it offers no insights into the mechanism by which sense-giving is bounded up with power and politics. Huzzard (2003:8, referencing Fairclough, 2001), however suggests that sense-giving is driven by discourse which 'confers power in three ways: first, through normalising, second, through constraining the way it takes place and where it originates and third through limiting access to the discourse itself'. These three elements serve as important lenses to prosecute this

research inquiry.

3.9.5 Power Distance and Cultural Diversity: Revisiting Hofstede.

Hofstede's (1980; 1984; 1997; 2001) longitudinal investigation of cultural diversity across 70 countries applied cultural analysis to examine the behavioural implications of the cultural values of people, organisations, and societies for management practice (Khatri, 2009; Tayeb, 2003). He developed a widely used cultural framework to analyse national cultures based on six cultural dimensions: power distance index (PDI); individualism vs collectivism (IVD); uncertainty avoidance index (UAI); masculinity vs femininity (MAS); long-term orientation vs short-term orientation (LTO), also known as Confucian dynamism; and indulgence vs restraint (IND). The dimension of particular interest to this study is PDI because of it's potential value in better understanding of the role of power and politics in this NHIS case study.

Power-distance is defined by Mulder (1977: 99) as 'the degree of inequality in power between a less powerful individual and a more powerful other, in which the individual and others belong to the same (loosely or tightly knit) social system'. Power distance, Khatri (2009) suggests, is as important a dimension as individual-collectivism but notes that it receives less academic attention, inspite of evidence supporting the view that organisations in a high-power distance context will exhibit behaviours that will be different from those in a low power distance context, as well as research suggesting that 'it influences employee behaviours and organisational structure and processes' (Khatri, 2009:2). These are important elements explored in this research project (chapter 6).

Extensions of the concept of power distance feature in several cultural value frameworks in the literature (Kirkman et al., 2009; House et al. and Globe Associates, 2004). High power distance is hierarchical, according to Schwart (1992), while lower power distance is egalitarian. Khatri

(2009, citing Earley and Gibson, 1998; Triandis, 1995), however, stresses that individuals and organisations within the same national culture context may still exhibit variations in their value orientations: 'Although one may expect most individuals and organisations in a high power distance culture to hold high power distance values, it is possible to find some individuals and organisations that may not share these values' (Khatri, 2009:2).

3.9.6 Power Distance Orientation

Power distance orientation is an outgrowth from the concept of power distance. It is a theoretical construct which, according to Kirkman et al., (2009:745), can be used to 'distinguish between power distance at the country and individual level of analysis'. Kirkman et al. (2009:745) suggest that power distance orientation 'deals with individuals' beliefs about status, authority and power in organisations'. In a high-power distance environment, such as the Nigerian context, the implementation of the NHIS provides a context to capture individual power orientation. This insight is important because individual power orientation can bring out views about 'the legitimacy of and acceptability of organisational power and authority differentials' (Chen et al., 2014:140). Power distance orientation also impacts on organisational management, especially during change management initiatives. As Chen et al. (2013:140) note:

> 'Previous studies found that individual power distance orientation weakened modernistic management practices such as delegation (Chen and Aryee, 2007), participative decision making (Liam et al., 2002) and transformational leadership (Kirkman, Chen, Farh, Chen and Lowe, 2009).

The relevance of this perspective is brought into play in the analysis of the power dynamics between implementing NHIS actors presented in chapter 6.

3.10 Research Questions and Conceptual Framework

The central aim of deriving and formulating research questions is to narrow the objectives of a

research inquiry into questions that the study will investigate (Creswell, 2013). The questions this research seeks to answer are as follows:

1. What cues did policy actors in their individual capacities extract from the policy message that stimulated their sense-making process?
2. To what extent did collective sense-making deriving from communities of practice between policy actors influence the implementation of the NHIS?
3. What role did power and politics play in the sense-making and sense-giving processes of actors in the implementation of the NHIS?

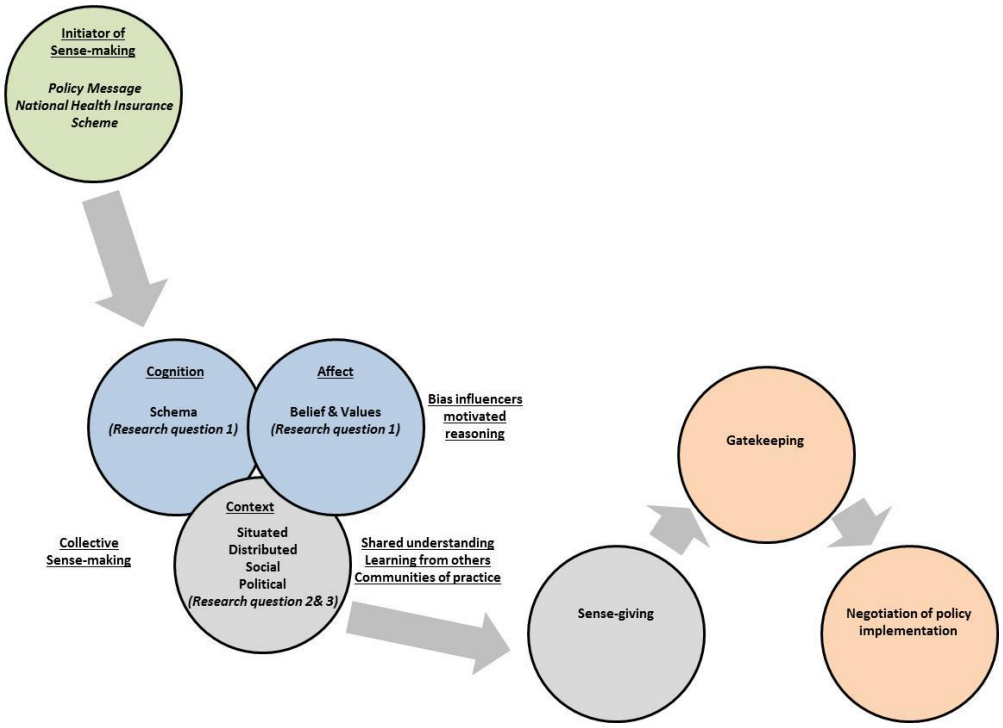
The study's conceptual framework, which is discussed next, is designed to provide answers to each of these research questions

3.10.1 Conceptual Overview

Influenced by systems thinking, the conceptual framework of this study is a synthesis of theoretical constructs and concepts from public policy and organisational studies — reflecting the core assumptions that inform and guide the inquiry, with the defined aim of addressing the three research questions. It pays attention to and meets the conditions of a viable conceptual framework prescribed by Miles and Huberman (1994). Miles and Hubermann (1994:440) suggest a viable conceptual framework is one that 'lays out the key factors, constructs, or variables and presumes relationships among them'. Starting from the proposition that the compliance (top-down) model of policy implementation is flawed, the framework privileges and adopts the perspective of the cognitive school of policy implementation. If the study's conceptual framework is likened to a hub and spoke of theoretical constructs and concepts, then Spillane et al.'s (2002) distributed sense-making framework (a cognitive implementation approach) is the hub around which the assembly of contributory theories and concepts spin.

Given that the implementation of the NHIS is based on a multi-participant arrangement, the conceptual framework draws on Pope et al.'s (2006) perspectives on multi-level meaning in organisational research to explore sense-making at three levels of the scheme's implementation in order to conduct a more rigorous inquiry. The framework is, in essence, a model or tentative theory of what the investigation aims to find. For that reason, it is linked to the research questions. The conceptual map (Figure 3.3) displays the interrelationships between the employed theoretical concepts and the three research questions. It hypothesises that sense-making is initiated by the NHIS policy initiative, which then feeds into individual cognition and affect (Research question 1). The framework also assumes that context is interrelated with cognition and affect because sense-making does not take place in isolation (Research question 2 and 3). In this framework, context (or the situation) is explored via communities of practice to explore/investigate collective sense-making across the ranks of NHIS officials, HMO executives, and HCPS, and also the role of power and politics in sense-making. The pathway leading to the final segment of the conceptual framework follows a sequential assumption that actor sense-giving and gatekeeping influences the negotiation of policy implementation.

Figure 3.3: Conceptual Framework for the Analysis of Sense-making in NHIS Implementation



Source: Fawehinmi (2015)

3.10.2 Conceptual Framework: Theories and Concepts

The conceptual framework of this study is built from gaps that emerged during the literature review exercise. The theoretical and conceptual discussion starts with a primer on multi-level meaning in policy implementation to provide a rationale for the exploration of NHIS actor-sense-making on three levels of analyses. The discussion then progresses to explain the relevance of and justification for the inclusion/combination of the other theories and concepts in the theoretical framework.

3.10.3 Perspectives on Multi-Level Meaning in Policy Implementation

The central purpose of a conceptual framework is to identify what will and will not be

investigated in a study (Miles and Hubermann, 1994:18). Following Pope et al.'s (2006) compelling advocacy of the value of a meso paradigm in organisational research, to operationalize the meso-paradigm the conceptual framework employed a third lens to explore/examine the interaction between policy signals, individual cognition, and the collective sense-making of agents, mediated through communities of practice to exhibit sense-making at the macro, meso and micro level units of analysis. The disaggregated units are as follows:

Macro-level/Government frame:

- Group 1-Health Ministry/NHIS officials.
- Group 2-Community (CBHI) scheme officials.

Meso-level/Purchaser Frame: Executives of HMO organisations.

Micro-level/Provider Frame: HCPs (CEOs of Medical Hospital/Clinics)

A multi-level analysis is imperative in this inquiry given that the implementation of the NHIS involves multi-level governance. With the recent growth in multi-level governance in the contemporary landscape of policy making, the use of multi-level analysis in policy studies is now seen as normative (Exworthy and Powell, 2004). According to Exworthy and Powell (2004:264), the era of central, local-vertical silos, 'often linking a single central government department and a local agency' is long gone — now supplanted by multi-organisational governance. Furthermore, Exworthy and Powell (2004:264) suggest that implementing policies in 'the congested state' involves a plurality of governance forms, multiple layers, and inter-organisational networks of decision makers (Skelcher, 2000; Sullivan and Skelcher, 2002). The implementation of the NHIS involves a plurality of governance forms and networks of oversight actors; it is therefore important to examine sense-making across the loosely coupled system which comprises the NHIS as a body corporate, HMOs as private operators, and HCPs as

public/private sector operators.

3.10.4 Sense-Making in a Wider Context: Spillane et al.'s Distributed Framework

Spillane et al.'s (2002) distributed framework, and it's subsequent elaboration by Quinn (2009), supplies this conceptual framework with a broad analytic capacity to examine individual and collective sense-making in the NHIS. It advances on the central notion that the sense-making of implementing agents, especially how they 'understand policy messages about local behaviour', stems from the interactions of three dimensions: individual cognition (prior knowledge, world views or *weltanschauung*, experiences and attitudes), with their situation or context (cognitive situation) and policy signals (stimuli or representation) (2002: 388). The dimensions of actor sense-making targeted for investigation are briefly defined and explained as follows:

> **Cognition:** The implementing agent's schema or world view.
>
> **Affect:** The implementing agent's beliefs and values.
>
> **Context:** The implementing agent's working situation, and formal and informal social networks.

3.10.5 Cognition (schema)

The understanding implementing agents have about a new message is highly dependent on the knowledge base they already possess. However, Spillane et al. (2002:395) warn that a lack of knowledge does not necessarily 'interfere with [the] ability to understand'. Individual schema results in different understandings that derive from the variances in the pre-existing knowledge of agents. The same variances equally result in different interpretations of the same message. The concern expressed by Spillane et al. (2002) is that there may be a propensity for agents to misunderstand new ideas as familiar, thus 'hindering change' (Spillane et al., 2002:397). In other

words, the implementation of any change initiative is likely to be negatively impacted when agents mostly focus on 'superficial similarities' and '[miss] deeper relationships' by paying less attention to divergences from the familiar. Individual schema is important in the context of the NHIS because NHIS officials, HMO executives and HCPs will have different interpretations of the scheme on the basis that they all came into implementation process with varied pre-existing knowledge of health care services.

3.10.6 Affect (Beliefs and Values)

Beliefs and values are also biases that influence individual sense-making. Any policy reform affects one's core beliefs and values, which is inseparable from one's self image, reinforcing the notion that reasoning about reforms is motivated by one's beliefs and values. The conceptual framework assumes that the core beliefs and values of implementing actors, especially with respect to their orientation towards socialised or private sector-driven health services, will affect the sense-making processes they bring to bear on the implementation of the NHIS.

3.10.7 Context (Situated, Distributed, Social and Political)

This conceptual framework employs insights from communities of practice theory to explore and apprehend collective sense-making in the communities of practice of different NHIS actors (NHIS officials, HMO/HMCAN executives and HCPs) and more importantly to provide answers to the second research question. The power/political context is a pivotal part of this conceptual framework in order to provide answers to research question 3. The process of sense-giving was earlier presented as a political process (sub-section 3.9.4) so further exploration of the power/political context extends to the sense-giving component of the conceptual framework.

3.10.8 Sense-Giving

The policy context review (Chapter 2) provided sufficient evidence that the implementation of the NHIS has thus far been highly political. Against this background, there is a good case to explore the sense-giving actions of NHIS participants and hence it's incorporation into the conceptual framework.

Literature insights suggesting that sense-giving is a political process (sub-section 3.9.4) are instructive for the development of this conceptual framework. These insights are employed to conduct a more nuanced and rigorous investigation of the political dimensions of the implementation of the NHIS in order to answer research question 3.

3.10.9 Gatekeeping

The conceptual framework borrows from Coburn's (2002) notion of gate-keeping to uncover other dimensions of collective sense-making within the communities of practices of NHIS actors – especially the mechanisms by which some policy messages filter in and others are selected out. Coburn (2001:154) lists gatekeeping as one of the sub-processes that 'characterise and facilitate' collective sense-making and asserts that the main role of communities of practice is gatekeeping. The pathway of the conceptual framework proceeds on the assumption that collective sense-making at all three levels funnels into actor sense-giving, gatekeeping, and policy negotiations/bargaining across stakeholder groups (Gioia and Chittipeddi, 1991; Maitlis and Lawrence, 2007).

3.10.10 Policy Negotiations

The conceptual framework draws on Barrett's (2004) notion of 'negotiated order' to analyse the negotiations/bargaining between NHIS actors (HMOs, HCPs and the NHIS). Helpful to development of this aspect of the framework were findings from Alford's (1975) study of politics

of key interest groups in health care in the USA. Alford identified three key such interest groups that are pivotal to the implementation of health care reforms: dominant interests represented by professional monopolists – mainly practising doctors; challenging interests – the corporate rationalisers largely represented by government civil servants; and repressed interests held by the community. Such tribal attitudes among the ranks of medical professionals are not peculiar to US practitioners alone. In a UK study, Ham (2004:10) also reported on the challenges of overcoming the dominant interest of UK GPs when the National Health Insurance Act was introduced in 1911. These perspectives shed much light on the Nigerian health reform situation.

3.10.11 Summary

This review started by highlighting a significant flaw in the compliance (top-down) model of policy implementation — it's negation of the role of human sense-making in the process. The identification of this gap in extant studies was subsequent to the review of prevailing perspectives from three generations of policy implementation research. The breadth of the three research questions in the Nigerian NHIS case study called for a conceptual framework that integrated several theoretical constructs. Led by the compelling insights of Pope et al. (2006) and Exworthy and Powell (2004), the review defended the value of multi-level analysis in this case study as an enhanced lens to examine sense-making across a broad spectrum of NHIS actors.

On the premise that sense-making is a communicative process of 'making sense of the circumstances in which people collectively find ourselves' (Weick et al., 2005:413), the conceptual framework drew upon Spillane et al.'s (2002) distributed sense-making framework to explore collective/distributed sense-making among NHIS participants. The conceptual framework relied on two streams of research: Spillane et al.'s (2005) perspective that sense-making is not a solo affair but one that occurs in a social context; and Coburn's (2001; 2005)

work on sense-making in communities of practice, hence it's incorporation into the conceptual framework to specifically address research question 2.

An in-depth review of the concept of power and politics and the relationship between power/politics and sense-making was presented firstly because the political leanings of people have an impact on their mental schemas and world views at a macro level; and secondly because the relationship between power and politics in sense-making is an important gap in sense-making research that remains under-researched (sub-section 3.9.3). To that end, the review was necessarily comprehensive in order to examine the power/political dynamics in the implementation of the NHIS (research question 3).

Incorporated into the conceptual framework are relevant concepts such as sense-giving, which as stated earlier is considered as a political process, and gatekeeping. Of practical relevance to this case study is the review of the literature on policy negotiations (Barrett, 2004; Alford, 1975) given it's capacity to espouse the practical realities of negotiations/bargaining in policy implementation as well as the politics of interest groups (especially in the domain of health care).

The next chapter (Chapter 4) discusses the philosophy and methodology that guided the research.

Chapter 4. Research Methods

4.1 Introduction

This chapter outlines the research methods of this inquiry. It starts by describing the methodology of the research, and the paradigm and philosophical beliefs (epistemological and ontological) it is based on. This paradigmatic orientation guided the methodological choices employed in the investigation of the action of policy actors in the implementation of the NHIS. The chapter explains that the basis for employing a qualitative research strategy and a case study design derived from a conviction that the objectives of this inquiry would be best served by that approach.

This chapter also presents an overview of a range of intellectual propositions to support the use of the case study approach in this research inquiry. It addresses it's weaknesses, and in tandem discusses the steps taken to raise the level of it's methodological rigour. Included in the chapter is a discussion on ethical considerations and issues relevant to the investigation. Next, the chapter describes the study's data sources, collection methods, interview techniques, and some important features of the study sample and how these were employed to strengthen the case study.

The last segment of the chapter describes the analytical strategy of the research, making the case for the adoption of Braun and Clarke's (2006) guidelines for conducting thematic analysis. Considerable time is devoted to explaining the operationalisation of the guidelines by detailing the five phases of the coding process.

4.2 Research Methodology

Remenyi et al. (2003) described methodology as the 'overall approach to a problem which could

be put into practice in a research process — from the theoretical underpinning to the collection and analysis of data'. In qualitative inquiry, the nature of the research questions to be investigated typically determines the choice of methodology adopted. Methodological choices are, however, influenced by a number of factors. Gray (2004:29) suggests that choice may be determined by the belief of the researcher in some 'external truth' to be discovered, their inclination towards a positivist or interpretivist stance, or whether the researcher believes that 'research should begin with a theoretical model or perspective (deductive approach) or whether such models should emerge from data itself (inductively)'. This discussion explains how the research paradigm in this study grounds the preference for a qualitative research strategy and presents the rationale for a research design based on an in-depth case study.

4.2.1 Terminological and Definitional Issues

Much confusion arises from the interchangeable use of the terms research strategy and research design in the literature. To clarify this matter, it is necessary to explain how both terms are used in the context of this research. Bryman's (2012:715) definitions of both research strategy and research design are preferred in this study for their explanatory strength. Bryman defined research strategy as a 'general orientation to the conduct of social research; that is quantitative or qualitative research' and research design as a term that 'refers to a framework for the collection and analysis of data […] [the] choice of research design reflects the decisions made about the priority being given to a range of dimensions of the research process (such as causality and generalisation)'.

4.2.2 Research Paradigm

Social research starts with a philosophical underpinning — a paradigm or thinking guide. Since researchers cannot easily disengage themselves from their theoretical and epistemological leanings, Bryman (2012:714) explained that a paradigm is '[…] is used to describe a cluster of

beliefs and dictates that, for scientists in particular, discipline influences what should be studied, how research should be done, and how results should be interpreted'. Corbin and Strauss (2008:89) stressed that the practical value of a paradigm is that it is 'one tool for helping the researcher to identify contextual factors and then link them with process'. Researchers, by design or default, bring certain ingrained beliefs and philosophical worldviews or assumptions (implicit or explicit) into their investigation; consequently, the methodological approach of researchers reflects their philosophical stance. Burrell and Morgan (1979:1) suggests that these assumptions may be of an *ontological* nature, focused on the phenomena under investigation, or may be of an *epistemological* nature concerned about the basis of knowledge to view and understand the world out there and how subsequently such knowledge is communicated to others. In essence, the conduct of this study, reflects the researcher's personal orientation towards ontology, epistemology, and methodology.

As Grbich (1999:6) observed, social scientists – methodologists in particular have made various attempts 'to capture the historical and multidisciplinary complexities of research with overarching theoretical paradigms that join schools of theories' (Grbich, 1999:6). Denzin and Lincoln's (1994) delineation of paradigms as post-positivist, interpretive, critical, and constructivist is one approach that is theoretically congruent with the four sociological paradigms (radical humanist, radical structuralist, interpretive and functionalist) presented by Burrell and Morgan (1979) as theoretical lenses for analysing social theories.

The objectives of this investigation, and the questions that it seeks answers to, through exploration and understanding of the subjective experience of policy actors, are best supported by a multi-paradigmatic approach. This approach interplays post-positivist, constructivist, and interpretive paradigms (Schultz and Hatch, 1996). My methodology draws together these three philosophical stances on the basis that paradigms are not mutually exclusive. This approach is

aligned with the views of scholars such as Shultz and Hatch (1990:530) who reject the paradigm incommensurability argument and instead advocate that researchers should feel free to 'challenge and cross paradigm borders' (Gioia and Pitre, 1990; Schultz and Hatch, 1996; Hassard, 1988). Paradigm boundary-crossing, in this researcher's view, offers huge potentials for enriched scholarship, particularly in the context of this inquiry.

4.2.3 Post-Positivist Paradigm

This paradigm holds that our knowledge of reality is at best approximate because reality is unknowable. Post-positivists believe that reality can be elicited through rigorous methods such as those exemplified in the analytic inductive technique of grounded theory (Grbich, 1999). Post-positivists, Creswell (2013:23) suggests:

> 'do not strictly believe in cause and effect but recognise that all cause and effect is a probability that may or may not occur […] post-positivist researchers view inquiry as a series of logically elated steps, believe in multiple perspectives from participants rather than a single reality, and espouse rigorous methods of qualitative data collection and analysis.'

In post-positivism, the pursuit of objective reality in positivism is replaced with a goal of apprehending replicable findings or patterns to arrive at a proof of 'truth'. The steps taken in the pursuit of proof of truth in this inquiry relies on the 'replication logic' case studies offer that strengthens generalisability. Explaining the notion of replication logic, Exworthy and Powell (2012:7) suggest that 'such logic arises from theories about the case'. Case selection, according to Yin (2009:48-49), is important because in order to accomplish replicability, the case must 'predict similar results (literal replication) or reproduce contrary results but for predictable reasons (theoretical replication)'. The range of concepts that this study drew upon to address it's research questions supports the goal of replicability.

4.2.4 Constructivist Paradigm

Constructivism directs attention to how people construct meaning in their worlds. Williamson (2006:85) explains that there are two major intellectual paths to constructivism: 'one focusing on individual personal constructions, and the other on shared meanings that could be said to reflect social constructions'. Of these two, the dominant approach is that of the social constructivists, which sees reality as socially constructed. The conceptual basis of this approach was developed from the insightful thesis of Berger and Luckman (1966) in their publication, *The Social Construction of Reality* (1966, 1967). Bryman (2012:710) suggests that this paradigm is 'an ontological position that asserts that social phenomena and their meanings are continually being accomplished by social actors'. Implicitly, researchers' accounts of their own experiences of the social world are also constructions. The compelling constructivist argument is that the subjectivity of meanings of experiences and the multiple constructions arising therefrom imply that knowledge is indeterminable. In Corbin and Strauss (2008:10), '[o]ut of these multiple constructions, analysts construct something they call knowledge'. Schawndt's (1998:237) perspective on the in-determinability affirms that:

> 'We are all constructivists if we believe that the mind is active in the construction of knowledge… We invent concepts, models, and schemes to make sense of our experience and, further, we continually test and modify these constructions in light of new experience'.

The adoption of a constructivist approach in this investigation is influenced by Creswell's (2013:25) view that 'constructivist researchers often address the "processes" of interaction among individuals' and that 'constructivists also focus on the specific contexts in which people live and work to understand the historical and cultural settings of the participants'. Led by this perspective, this research is about the processes of interaction between a spectrum of Nigerian policy (NHIS) actors whose sense-making derives from their constructions of reality as implementation progressed, as much as it is about specific contexts. The importance that this

study assigned to contextuality is demonstrated in the decision to examine actor sense-making in situated (distributed, social and political) contexts. The value of a constructivist approach as an integral paradigm of this study is thus underscored.

4.2.5 Interpretivist Paradigm

Interpretivism is an anti-positivist philosophical stance which, in the words of Crotty (1998:67), 'looks for culturally derived and historically situated interpretations of the social life-world'. Burrell and Morgan (1979:28) advance the view that:

> 'the interpretive paradigm is informed by a concern to understand the world as it is, to understand the fundamental nature of the social world at the level of subjective experience. It seeks explanation within the realm of individual consciousness and subjectivity, within the frame of reference of the participant as opposed to the observer of the action'.

The scholarly position of interpretivism is that it is a research approach that recognises the fundamental differences between people and the physical objects of the natural sciences that are required to facilitate our understanding of the subjective meaning of social action (Bryman, 2012). From an epistemological perspective, interpretivism, which sees reality and knowledge as socially constructed, subjective, and situational, is therefore logically related to constructivism.

The broad intellectual base of interpretivism derives from three intellectual origins. First is Max Weber's (1947:88) idea of *Verstehen,* which means interpretive understanding, but in strict terms embraces explanation and understanding, or interpretive understanding of social action. Second is the hermeneutic-phenomenological tradition, in which hermeneutics advocates that interpretation should be privileged over observation due to the complexity of social reality, and from phenomenology which argues that research must be grounded in people's lived experience to understand social reality. Third is sociological tradition of symbolic interactionism, which at

it's very core advances the view that people are constantly interpreting the meanings of objects and events around them, and the actions of others, and then act on such interpretations, and that meanings generated from such social interactions also get modified in the process (Gray, 2004; Bryman, 2012). The social dimension is one of the seven properties of sense-making (Weick, 1995). In this study, the exploration of distributed sense-making among NHIS participant actors to address research question 2 uncovered sense-making that emerged from the social interaction of actors (chapter 5).

4.3 Research Strategy

Again, with reference to Bryman (2012:715), 'this term refers to the general orientation to the conduct of social research' be it quantitative or qualitative. The thrust of this research to reiterate, is to explore the sense-making of policy actors in a change initiative and from that standpoint, it is best served by a qualitative research strategy – since qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomenon, in terms of the meanings people bring to them' (Denzin and Lincoln's (1994:3). There are, however, definitional issues with the term qualitative research, and many competing definitions have been offered for it. The reason for the definitional challenge, as Denzin and Lincoln (1994:4) put it, is because this field of inquiry 'crosscuts disciplines, fields and subject matters' and constitutes 'a complex, interconnected family of concepts and assumptions'.

To overcome the problem, some authors have suggested that it is more appropriate to do away with attempts at a fixed definition of qualitative research and instead explain this strategy in terms of it's characteristics (Symon and Cassell, 2004). Creswell (2008:45) presented some of these characteristics, as presented in Box 4.1.

Box 4.1: Characteristics of Qualitative Research

1. **Natural setting**: Qualitative researchers often collect data in the field at sites where participants experience the issue or problem under study.
2. **Researcher as key instrument:** The qualitative researchers collect data themselves through examining documents, observing behaviour, and intervening participants.
3. **Multiple methods:** Qualitative researchers typically gather multiple forms of data, such as interviews, observations and documents rather than rely on single data sources.
4. **Complex reasoning through inductive and deductive logic:** Qualitative researchers build their patterns, categories, and themes from the bottom up by organising the data into increasingly more abstract units of information.

Source: Creswell (2004:45)

Box 4.2 shows the characteristics of qualitative research to highlight the commonalities between

the normative approach and the path followed by this study.

Box 4.2: Characteristics of Qualitative Research in the Context of the NHIS Investigation

1. **Natural Setting:** The multi-participant NHIS policy implementation environment involving NHIS officials (including CBHI officials) HMO executives and HCPs.
2. **Researcher as a key instrument:** To collect the primary data, the qualitative researcher conducted all of the semi-structured interviews in person and also collected and analysed all secondary data (documentary sources).
3. **Multiple Methods:** This research employed multiple sources of data (interviews, health policy publications, newspaper articles, health insurance newsletters and official memos) to triangulate the evidence and more importantly to strengthen the generalisability of the case study.
4. **Complex reasoning through inductive and deductive logic:** The conceptual framework of the study operationalised several theories and theoretical constructs to guide the conduct of the research. The analytic strategy (thematic analysis) relied on inductive and deductive logic to arrive at patterns and themes that provide answers to the research questions as well as a 'thick description' of patterns.

Source: Fawehinmi (2018)

Creswell (2008:48) also suggests that a qualitative approach is appropriate when the research

objective is to explore a problem or issue in a study population when a deeper understanding of a complex problems is needed; when there is a need to empower people to tell their stories; and when the goal is focused on theory development or seeks to address theoretical insufficiency. Applying the foregoing criteria, a qualitative research strategy bests suits this study's research objectives.

4.4 Research Design: Case Study

Exworthy and Powell (2012:3) note that case studies 'have become arguably the predominant method by which much of social science is conducted'. The 'striking paradox' that Yin (2009) observed is that in spite of the established weaknesses regarding the method, it's use in qualitative research continues to grow exponentially. Exworthy and Powell (2012:8) notably reported that the use of case studies in health policy research has been on the rise since the 1990s. Exworthy and Powell conducted a database search (Zetoc and Google Scholar) for the term 'case study health policy' in 2010 , and produced the statistics shown in Table 4.1. The findings indicate the rising trend in the use of case studies in health policy.

Table 4.1: The rise of case study research in health policy

Year	Number of hits	
	Zetoc	Google Scholar
1980 – 84	0	35,200
1985 – 89	1	76,200
1990 – 94	11	150,000
1995 – 99	61	356,000
2000 – 04	61	410,000
2005 – 10	354	417,000

Source: Exworthy and Powell (2012)

As stated earlier, a case study design guided the framework for the collection and analysis of this study's data. It is however important to explain the notion(s) of a 'case' and 'case study' given the variation in scholarly emphasis on the features of a case study (Johansson, 2003). Johansson (2003), for example, assets that there must be a 'case' (the objective of the study) in the first place, which must meet three pre-conditions. The case, he suggests, should be a complex functioning unit, be investigated in it's natural context with a multitude of methods, and be contemporary. The NHIS inquiry, especially in terms of it's complexity, fulfils all of Johansson's pre-conditions given that the case study encompasses several mini-cases that drew on multiple sources of evidence in it's investigation of the sense-making processes of multiple actors (NHIS officials, HMO executives, and HCPs).

Two definitions of case study research are helpful to get a good grasp of the wider dimensions of this design.

Cassell and Symon (2004:332) defined case study research as a:

> 'heterogeneous activity covering a range of research methods and techniques, a range of coverage (from the single case study through carefully matched pairs up to multiple cases), varied levels of analysis (individuals, groups, organisations, organisational fields or social policies) and differing lengths and levels of involvement in organisational functioning'.

Taking a different approach, Yin (1994:13) defined a case study more broadly as 'an empirical inquiry that investigates a contemporary phenomenon within it's real-life context, especially when the boundaries between phenomenon and context are not clearly evident'. Case study research involves a detailed investigation to answer exploratory 'why' and 'what' questions, typically combining a range of data collection techniques such as interviews, observations, questionnaires, archival records and document analysis, with the overarching aim of an in-depth understanding of the phenomenon and it's context (Darke and Broadbent, 1998; Cavaye, 1996).

Case studies, according to Tellis (1997:1), are 'multi-perspectival analyses'. For that reason, the researcher must capture not only the views of individual actors but must also account for the views of other groups of relevant actors, paying particular attention to how cross interactions between them affects those views. An important advantage of a case study research design is it's in-built flexibility to explore theoretical hypotheses and also adapt to emergent theory (Cassell and Symon, 2004).

4.4.1 Types of Case Study

The extant literature provides two main typologies of case studies. The first is based on the size of the bounded case with size in this context implying 'one individual, several individuals, a group, program or activity' (Creswell 2008:99). The second typology distinguishes case studies in terms of intent. Under this typology, Stake (1995) identified three versions: The instrumental case study aimed at a better understanding of an issue or theory, the collective case study, which is an expanded instrumental study employing multiple cases, and the intrinsic case study for

better understanding of a particular case. More succinctly stated, case studies are either designed as single or multiple cases.

Logically, one might then ask: what research questions can a case study design provide answers to and how and why? Meyer (2001:330; citing Hartley, 1994) explains that 'case studies are tailor-made for exploring new processes or behaviours or ones that are little understood'. Leonard-Barton (1990) suggests that the case study design is useful when investigating how and why questions about a 'contemporary set of events' (Meyer, 2001:330). Broadly stated, the research questions best answered by a case study design will depend on the goals that the researcher sets out to achieve. Eisenhardt (1989), citing bodies of work by others, suggests three academic objectives that can be accomplished by the use of case studies. First is to provide descriptions (Kidder, 1982); second is to test theory (Pinfield, 1986); and third is to generate theory (Gersick, 1988).

Cassell and Symon (2004:325), in a more granular treatment of the subject, presented research goals (Box 4.3) that can be better accomplished via the use of case studies.

Box 4.3: Research Goals Best Accomplished by Case Studies

1. Where it is important to understand how the organisational and environmental context is having an impact on or influencing social processes.
2. For exploring new or emerging processes or behaviours, that is generating a hypothesis and building theory.
3. Where the intention is to explore, not typicality, but unusualness or extremity with the intention of illuminating processes.
4. In capturing the emergent and changing properties of life in organisations.
5. Where organisational behaviour that is informal, unusual, secret or even illicit is being investigated.
6. To understand everyday practices and their meanings to those involved, which would not be revealed in brief contact.
7. In cross-national comparative research, where an intimate understanding of what concepts mean to people is being investigated.

Source: Cassell and Symon (2004:325)

A case study is an appropriate approach when it is difficult to delineate the phenomenon under study from it's context (Yin, 1994). The NHIS, the phenomenon of study in this research, is highly contextual given the unique drivers for Nigeria's pursuit of UHC, thus underscoring the fitness of a case study design for the investigation. With reference to Stake's (1995) typology of case studies, my version of case study for this inquiry straddles across instrumental case study aimed at illuminating an issue or theory, and intrinsic case study that seeks to gain a better understanding of a particular case. Notwithstanding the inherent weaknesses of single case studies, Denzin (1989) suggests that single case research facilitates in-depth investigations of phenomena, and in the process captures it's complexity to arrive at a 'thick description' (Denzin, 1989:83) that provides an enriched understanding of the phenomenon being studied (Walsham, 1995).

The five crucial elements of a case study identified by Yin (1994:20) are listed below:

1. A study's questions.
2. Its propositions, if any.
3. Its unit(s) of analysis.
4. The logic linking the data to the propositions.
5. The criteria for interpreting the findings.

This case study operationalised all of the above elements but more importantly exploited the natural flexibility of case studies to explore theoretical hypotheses and also adapt to emergent theory (Cassell and Symon, 2004). This research to recall, argues that the compliance model (top-down) of policy implementation is inadequate because it pays scant attention to the cognitive aspects of policy-making (chapter 3). An important step in case study design is to define the unit of analysis to be used. Based on the theoretical gaps in the policy studies literature, the unit of analysis of this study is to analyse the implementation of the NHIS by employing sense-making theory and related constructs as an interpretive framework. To prosecute the inquiry, it is necessary to build a conceptual framework to link the propositions of the research with it's questions in order to widely explore individual and collective/distributed sense-making. Through the cross-referencing of empirical findings with the existing literature, the logic linking the data to the propositions are espoused.

4.4.2 NHIS Case Study Design: Key Elements

Following Cassell and Symon (2004) Box 4.4 shows the goals that can be best accomplished by a case study in this NHIS investigation

Box 4.4: NHIS Research Goals Best Accomplished by a Case Study Design

1. To uncover the cues that individual policy actors extracted from the NHIS policy message and the impact of such cues on their sense-making
2. To understand the impact of distributed sense-making in communities of practice (CoPs) of NHIS policy actors by investigating sense-making in each community of practice of actors as mini-case studies (multiple methods)
3. To capture the influence of power and politics on the sense-making and sense-giving processes of NHIS policy actors
4. To explore the influence of power distance orientation as a (subset of the concept of power distance) on the sense-making of NHIS actors and it's impact on NHIS implementation
5. To explore the wider theoretical concepts hypothesised and operationalised in the study's conceptual framework
6. To arrive at a 'thick description' of the research, and benchmark the performance of the NHIS with other versions of SHI in Sub-Saharan Africa for the purpose of lesson drawing.

Source : Fawehinmi 2018 adapted from Cassell and Symon (2004:325)

4.4.3 Criticisms of Case Study Research Design and Mitigation Approaches

There is a great deal of criticism of the case study research design in the literature, mostly pointing to it's methodological deficiencies. A standard criticism is that findings dependent on a single case cannot result in generalisable conclusions. Proponents of the design, have however, challenged this view with coherent arguments (Yin, 1989; Ragin, 1992; Flyvberg, 2006; Bryman, 2012). They assert that the purpose of the design is not to generalise findings beyond the case under study, but to conduct an intensive examination of the single case and then subsequently engage in theoretical analysis (Bryman, 2012). Bryman (2012) argues that the authenticity of case study research rests on other parameters such as the theoretical engagement of the case study researcher, and the degree to which data findings supports theoretical arguments.

Flyvberg (2006) also rebuts the widely held view that single case studies are not generalisable

and lists this notion as one of five misunderstandings about case study research. He argued from a perspective steeped in scientific history, emphasising that Galileo's paradigm-shifting 'rejection of Aristotle's law of gravity was not based on observation across a wide range' but on one conceptual and one practical experiment (Flyvberg, 2006:225). Flyvberg also observes that over-ranking formal generalisations as a key determinant of scientific development underrates the 'power of an example'. Flyvberg's compelling argument is that science (*wissenschaft*) literarily means to gain knowledge and that there are many ways in which knowledge is gained and accumulated, formal generalisation being only one such way.

Bryman (2012:71), referencing Yin's (2009) notion of 'analytical generalisation' and Mitchell's (1983) 'theoretical generalisation', concludes that what is most important is not wider population generalisation but rather the authenticity of the theoretical reasoning that emanates from the researchers' findings. Aside from concerns about generalisability in case study research, Christie et al. (2000) argue that the methodological rigour of validity and integrity in case study research can still be achieved by other means. This researcher took the foregoing weaknesses of case study research seriously and addressed them through a number of approaches to ensure that the case study design employed in this study satisfies the requirements of construct validity: confirmability; internal validity/credibility; external validity; and reliability/dependability. A theoretical overview of scholarly approaches to mitigating concerns about generalisability in case studies is illustrated in Box 4.5. below. Following that is a description of how they were employed to strengthen the methodological rigour of this case study.

Box 4.5: Methods of Achieving Methodological Rigour in Case Studies: Theoretical overview

Construct validity

Construct validity is concerned about the 'legitimacy of the application of a given concept or theory to establish facts' (Meyer 2001:345). The objective is to find out if theoretical constructs derived from the literature are substantially supported by observations (Kirk and Miller, 1986). Construct validity can be achieved through the theoretical constructs developed from the literature review exercise, and 'the use of multiple sources of evidence, establishing a chain of evidence, and having key external informants review draft case study reports' (Christie, 2006:16). Construct validity can also be strengthened by the use of feedback loops (Meyer,2001), such as re-interviewing key informants following interpretations and emerging theory from the data to find explanations for contradictions (Crabtree and Miller, 1992; King, 1994). Researchers have explained how multiple sources of evidence or triangulation in research can enhance construct validity (Webb et al., 1966; Denzin, 1978; Van de Ven, 2007). Van de Ven (2007: 284), referring to the work of Mathison (1988), suggests that the idea behind the concept of triangulation is the assumption that 'the bias inherent in any particular source of investigator, data, model, or method will cancel out when used in conjunction with other sources'. One way of reducing inherent subjectivity in a case study design is by purposive selection of interviewees followed by rigorous data collection/interpretation to hold the chain of evidence from the beginning to the end (Dick, 1990; Lincoln and Guba, 1985).

Confirmability

Regardless of the elusiveness of the pursuit of objective truth in social research, observer researchers need an 'audit trail' (Shenton, 2003) of sequential research steps to show that they have 'acted in good faith' (Bryman, 2012:392) and not allowed theoretical bent and inherent subjectivity to get in the way of best research practice. The concept of confirmability, Shelton (2003: 72) explains, 'is the qualitative investigator's comparable concern to objectivity'. Sheldon also suggests that triangulation supports confirmability by mitigating the effects of investigator bias.

Internal validity and credibility

Internal validity is concerned with the validity of the assumed relationships between concepts (Meyer 2001). Internal validity, Meyer (2001:347) suggests, 'results from strategies that eliminate ambiguity and contradiction, filling in detail and establishing strong connections in the data'. In case study research, internal validity can be ensured by the use of pattern matching. This is described as 'a technique for linking data to the propositions […] and is a situation where several pieces of information from the same case may be related to some theoretical proposition' (Tellis, 1997:6; citing Campbell, 1975). Other approaches include explanation building, case and cross-case analysis, and a rigorous test of the coherence of findings (Yin, 1993; Christie et al., 2000). Credibility can be established through triangulation and academic peer review of research findings and conclusions drawn (Lincoln and Guba, 1985). The aim of research credibility, as Merriman (1998) suggests, is to determine the degree to which findings are congruent with reality – to strengthen research trustworthiness.

External validity and transferability

External validity in case studies is concerned with whether research findings are generalisable beyond the proximate case, which is typically established through corroborated evidence from multiple cases where 'each case is analogous to an experiment' (Eisenhardt, 1989:542) to arrive at analytical generalisation based on the logic of replication (Yin, 1994; Eisenhardt, 1989). Other approaches for ensuring external validity and transferability include the use of 'thick descriptions', cross-case analysis, intended interview protocols, and procedures for coding and analysis (Christie et al., 2000). Flyvberg (2006:229; referencing Ragin,1992) suggests that generalisability of case studies can be raised by 'strategic selection of cases' in which the objective of an inquiry should be to maximise the amount of information that can be obtained from a particular problem or phenomenon of interest.

Reliability and dependability

Meyer (2001:348, citing Miles and Huberman, 1994) suggests the reliability criteria focuses on 'whether the process of the study is consistent and reasonably stable over time and across researchers and methods'. If a case study meets the criteria of reliability and dependability, then other researchers conducting the same study in similar contexts should arrive at the same results. The assumption is that a case study represents a single reality, which is far from what is seen in the real world of research. Reliability and dependability in case studies can be ensured by the use of a case study protocol (as a research instrument) that makes rules for data collection clear as well as aids the development of a case study database, both of which must be accessible to other researchers (Yin, 1989).

Source: Literature Sources - Fawehinmi (2018)

4.4.4 Approach to Methodological Rigour in the NHIS Case Study

As explained in Chapter 3, the investigation was designed to investigate the sense-making of NHIS implementers at the macro (NHIS/CBHI officials), meso (HMO executives), and micro (HCPs) levels of policy implementation. The triangulation of the data from these multiple sources of evidence (as well information from external policy advisers and archival data) synergistically supported the construct validity, confirmability, and credibility of this study. Construct validity was also strengthened on two additional levels, firstly by a wide range of relevant theoretical constructs from the policy studies and sense-making literature, and secondly from feedback loops from updated information from health policy advisers/commentators and further interrogation of the data to uncover departures from theoretical propositions (Crabtree and Miller, 1992; King, 1994).

Cognisant of the elusiveness of the determination of objective truth in social research, it is necessary to describe the steps taken in 'good faith' to approximate objective truth. Purposive targeting of a broad spectrum of NHIS informants (including external policy advisers), in-depth explanations of the conceptual framework and data analytic strategy of the study provide an audit trail of steps taken to achieve confirmability (Shenton, 2003). The pursuit of internal validity involved both 'pattern matching' to link data evidence with the theoretical constructs of the propositions of the research to elicit confirmations of disconfirmations, and in-depth within-case analysis (which focused on the mini-cases within communities of practice of NHIS actors) (Christie et al., 2000).

Research credibility was supported on three levels: first by producing a 'thick description' of the implementation of the NHIS as a major policy reform; second, by adopting Braun and Clarke's (2006) rigorous procedure for coding and analysis (section 4.7); and third, by maximising the use of evidence from the information data. Data maximisation resulted in the collaboration of

interview data by the views expressed by stakeholders at the Abuja (Nigeria) house committee/stakeholder meeting – a step that strengthened the research's credibility.

As stated previously, the view that single case studies are flawed on grounds of generalisability has been competently rebutted by scholars. This research borrows from Eisenhardt's (1989) advocacy for the use of 'multiple cases' to approximate an acceptable level of generalisability by other means. From a macroscopic point of view, this NHIS investigation as a phenomenon of interest is a single case study, but in practical terms, it is a composite of mini cases. Investigations of sense-making at each level of NHIS participants (NHIS officials, HMO executives, and HCPs) represents the diverse realities in the mini cases. Taken together, each of these case studies fulfils Eisenhardt's prescription and accordingly reinforces study's generalisability. Crucially, this is an example of a research inquiry which suggests that it may not always be feasible to make clear distinctions between single and multiple case studies.

4.4.5 Role of the Researcher

Research by it's nature is a dynamic process in which the researcher is an active participant (Smith and Osborne, 2003). At play is a two-stage interpretation process, referred to as a double hermeneutic, in which: 'the participants are trying to make sense of their world; [and] the researcher is trying to make sense of the participants trying to make sense of their world' (Smith and Osborne, 2003:53). Researcher bias introduced consciously or unconsciously during the process of data collection or interpretation is unavoidable (Hatch, 1996). As Smith and Osborne (2003:53) explain, this is because '[a]ccess depends on, and is complicated by, the researcher's own conceptions; indeed, these are required to make sense of that other personal world through a process of interpretative activity'. Creswell (2003:182) quotes Mertens (2003) to assert that the qualitative researcher 'reflects on, and is sensitive to the personal biography' that they bring to the study:

> 'This introspection and acknowledgement of biases, values and interests (*or reflexivity*) typifies qualitative research today. The personal-self becomes inseparable from the researcher-self. It also represents honesty and openness to research, acknowledging that all inquiry is laden with values' (Mertens, 2003).

4.4.6 Reflexivity and the Researcher

Reflexivity enjoins the researcher to be conscious of the 'biases, values and experiences' they bring to a study (Creswell, 2013:216). The reflexive researcher, Mason (1996:6) suggests, 'should constantly take stock of their actions and their role in the research process and subject these to the same critical scrutiny as the rest of their data'. In line with best research practice, the qualitative researcher should make their position explicit (Hammersley and Atkinson, 1995). This is a two-stage process in which the researcher describes their experience of the phenomenon under investigation, and the extent to which such experience affects their interpretation (Creswell, 2013).I brought into the investigation my interest in systems theory and non-linearities (located within a broader domain of complex adaptive systems) in public policymaking, and it's potential explanatory capacity to provide reasons for the gap between policy intention and outcomes. This interest in complex adaptive systems is not mis-placed if one considers Butler and Allen's (2008:422) perspective that:

> 'Policy implementation processes should be understood as a self-organizing system in which adaptive abilities are extremely important for stakeholders. Policy implementation is self-organizing because national policy is reinterpreted at the local level, with each local organization uniquely mixing elements of national policy with their own requirements. Policy implementation at the local level becomes unpredictable and compliance with national policy more sketchy.'

Emergent research suggesting that knowledge of complex theory may illuminate our understanding of the policy process is growing (Butler and Allen, 2008; Cairney, 2012). This study's investigation of the phenomenon of sense-making in health policy must also be viewed as an embedded quest to understand the non-linear dynamics involved in implementing a health policy reform.

In the prosecution of this inquiry, four significant issues and events challenged my own *sense-making* as a researcher and influenced decisions taken in my approach to data collection, and the analysis of the data that followed. First, entrenched in my mental model as a researcher was a bias based on prior knowledge of pervasive failure of policy initiatives in Nigeria. So, from the start I had to consciously disengage from a fixation that most policy initiatives were simply unimplementable in Nigeria. Second, I was influenced by an awareness of the divisiveness and controversies around the implementation of the NHIS and was mindful of the likelihood of access difficulties to potential interviewees and therefore envisaged the likelihood of resistance to an investigation targeted at scheme evaluation. All of these considerations reinforced the decision to focus on the cognitive dimensions of actor-actions in the conviction that broader empirical findings from this approach would emerge to illuminate other aspects of the implementation of the scheme. Third, as discussed in sub-section (4.5.5), official approval to interview NHIS officials proved difficult and I had to rely on a snowball sampling strategy to gain interview access to key informants. In spite of the shortcomings of snowball sampling , I achieved equivalent representativeness between the respondents I gained access to, and those purposively targeted initially. Fourth, during a pilot field trip to Nigeria in December 2014, I found out very quickly that the political dimension of the implementation NHIS reform was too important to be ignored. Following that trip, I drew the attention of my supervisors to this important field observation and made a case for the inclusion of a third research question to explore the impact of power and politics in the sense-making of NHIS implementing actors. Given that the objectives of the study broadly covered the political context *a priori*, the idea received their support.

I experienced many of such highs and lows in my quest to make an original contribution to knowledge in the course of the research. I believe this is a phenomenon that is all too familiar to doctoral researchers. On a positive note, there was much fulfilment from the deeper insights

that came with the several course corrections instigated by supervisor's advice.

4.4.7 Ethical Issues and Considerations

The relationship between reflexivity and ethics is an important one. McGraw et al. (2000) view ethics as a dimension of reflexivity:

> 'Reflexivity is a process whereby researchers place themselves and their practices under scrutiny, acknowledging the ethical dilemmas that permeate the research process and impinge on the creation of knowledge'. (2000:68)

The qualitative researcher is typically confronted with ethical issues during data collection and at other stages of the research process, such as data analysis and reporting of findings. Ethical considerations cannot be overlooked in the conduct of research because the integrity of a research objective depends on the values of a researcher. According to Bryman (2012:130), ethical considerations ask two key questions of the researcher: first, 'How should we treat people on whom we conduct research? ' and second, 'Are there activities in which we should or should not engage in our relations with them?'

To acquaint myself with best practices in conducting ethical qualitative research, I relied on the code of research ethics of the UK Research Integrity Office (UKRIO). Following that, I applied for ethical approval from the faculty of business approval. This was granted at the PhD transfer stage in 2014 and I proceeded to commence fieldwork shortly thereafter. My uppermost ethical considerations before conducting interviews was to ensure the transparency of the process and assure participants of the confidentiality of the information they volunteer. This was important considering the public standing and potential reputational risks to some of the interviewees. My opening statement to each of the interviewees was to make clear the aims of the study, emphasising that the investigation was not focused on evaluating the performance of the NHIS scheme *per se*, or designed to question or rate how well they have individually performed in the

roles in the implementation of the scheme. These were the steps I took to gain the informed consent of interviewees. Crucially, I guaranteed the anonymity of informants in the reporting of my findings. A sample participant information sheet and consent form is provided in Appendix I. Audio recordings of the interviews were saved as computer audio files. I personally transcribed the interviews and saved them as Microsoft Word files on my password-protected computer. Participants were only referred to by their job titles and unique identifier labels.

The next section discusses the data-collection process of this research inquiry.

4.5 Data Sources and Collection

4.5.1 Introduction

The qualitative researcher has wide options when it comes to data sources. Interviews, questionnaires, observations, focus groups, documents, videos and archival records are sources of data that a researcher can employ in qualitative inquiry. These data sources are not mutually exclusive, and the investigator may use these sources independently or in combination – a widely accepted approach to achieve triangulation.

4.5.2 Explaining the Relationship between Theory and Data in the Case Study

The underpinning theories that a theoretical/conceptual framework consist are of central importance in a qualitative research. The function of theory Maxwell (2004) explains: 'is to inform the rest of your design — to help you assess and refine your goals, develop realistic and relevant research questions, select appropriate methods, and identify potential validity threats to your conclusion. It also helps you justify your research' (2004: 33-34). The thrust of Maxwell's perspective is that theory should always be related theory to data collection and analysis. The focus of the discussion under this heading is to explain how theory driven thinking guided data

collection activities and the subsequent analysis of the empirical data in this NHIS case study (section 4.6).

In section 4.2.2, I stated that my philosophical orientation in this study was multi-paradigmatic — in a rebuttal of the notion of mutually exclusive paradigms, and as such, my methodology drew together post-positivist, constructivist and interpretive paradigms. My convictions about the use of theory in qualitative research, derives from a meaningful rejection of naïve inductivism — which posits that the only valid knowledge is one that is based on empirical observation that is theoretically free (Chalmers, 1999).Furthermore, I argued that it is near infeasible to commence research from a blank slate or *tabula rasa* because of the difficulty of setting aside the pre-conceived ideas (theories and concepts) that the researcher is infused with during the literature review exercise.

The use of theory in this study relies on Yin's (2008) widely referenced guideline that case study research should start from a theoretical perspective. As Ridder (2017:287) explains: 'Existing theory is the starting point of case study research. In addition, propositions or frameworks provide direction, reflect theoretical perspectives, and guide the search for relevant evidence'. Accordingly, theoretical perspectives from the review of the literature shaped the research questions, data collection, analysis and interpretation of findings.

This case study therefore set out to test sense-making theory (deductive approach) in a hypothetic-deductive tradition, as well as build theory (contributing to sense-making and policy implementation theories) inductively from the collected data. From a philosophical standpoint, theory-testing follows a positivist belief of pre-existing relationships in a phenomenon of interest to be identified and tested, whilst theory building is supported by combinations of positivist and interpretive paradigms. Further explications of how theory influenced the conduct of the inquiry are discussed under sections covering data collection and analysis. The next

section discusses the data-collection process of this research inquiry.

4.5.3 Data Collection Activities

Data collection activities have been described by Creswell (2013:146) as 'a series of interrelated activities aimed at gathering good information to answer emerging research questions'. These activities are illustrated in Figure 4.1.

Figure 4.1: Data Collection Activities

Source: Creswell (2013)

Creswell (2013) also suggests that data collection activities in qualitative inquiry may appear similar across the five recognised methodological approaches (narrative, phenomenological, grounded theory, ethnography and case study) but stressed that there are important procedural differences between them. Following a theoretically guided data collection approach, primary data was collected through semi-structured interviews of NHIS policy actors. In Table 4.2, I summarise the various methods employed for data collection in this study, listing the secondary sources of data employed.

4.5.4 Interviews

Interviews are widely used in qualitative inquiry but approaches vary— hence the term

'qualitative interview' refers to different types of qualitative research interviews (Bryman, 2012). Interviews are typically conducted with individuals but several people may be interviewed in versions such as focus groups. Approaches to qualitative interviews vary. Bryman (2012:213) lists the major types of interviews employed in qualitative research as follows:

1. Structured interview
2. Standardised interview
3. Semi-structured interview
4. Unstructured interview
5. Intensive interview
6. In-depth interview
7. Focused interview
8. Focus group
9. Group interview
10. Oral history interview
11. Life history interview

In line with a theoretically guided data collection approach, primary data was collected through semi-structured interviews of key NHIS policy actors. In Table 4.2, I summarise the various methods employed for data collection alongside a list of the secondary sources of data employed. The semi-structured interview approach was preferred for it's potential to generate data that supports theory-testing and theory building analyses. This as Alaranta (2006:4) noted is necessary because: 'empirical evidence must cover all data relevant to the theory-testing analyses, but should not be totally structured, to support theory-building analysis'. A semi-structured interview offers much flexibility for the qualitative researcher (Bryman, 2013). Bryman (2013: 212) explained that semi-structured interviews:

> 'refers to a context in which the interviewer has a series of questions, that are the general form of an interview scheduled but is able to vary the sequence of questions. These questions are frequently somewhat more general in the frame

> of reference from that typically found in a structured interview. Also, the interviewer usually has some latitude to ask further questions in response to what are seen as significant replies'.

A researcher conducting a semi-structured interview will typically be guided by a set of pre-determined issues to be covered. However, they will also retain the flexibility to ask questions outside of the interview guide as the interview proceeds.

4.5.5 Interview Approach

To restate the earlier point, semi-structured interviews were my key data collection instrument. Due to bureaucratic impediments and other constraints, the researcher found it infeasible to gain official approval to interview top-level NHIS officials. To get around the problem I relied on snowball sampling to access key respondents, NHIS officials included. Snowball sampling an informal approach to accessing target respondents, is defined by Vogt, (1999) as 'A technique for finding research subjects. One subject gives the researcher the name of another subject, who in turn, provides the name of a third and so on'. In comparison to purposive sampling in which the researcher makes value judgements about target respondents, snowball sampling remains a contentious sampling method in qualitative research. Critics have asserted that it violates sampling principles. Atkinson and Flint (2001) pointed out that it's deficiencies include: 1) problems of representativeness, 2) finding respondents and initiating chain referral, 3) engaging respondents as informal research assistants.

Notwithstanding the afore-described limitations of snowball sampling, my sampling strategy, achieved equivalence in representativeness between the respondents I gained access to, and those purposively targeted initially. In other words, the deficiencies of snowball sampling were largely mitigated. Two key contacts in the professional nexus of targeted respondents initiated the chain and through them, I was able to access key informants in this diverse group of policy

actors. More importantly, through this approach, I was also able to obtain invaluable information from a number of higher echelon respondents. Whilst I did not engage any persons as informal research assistants, I benefited from the unbiased information provided by the three external policy advisors interviewed who provided corroborating or contradictory evidence.

Data collection began in April 2015 and ended in December 2015. I interviewed a total of 29 key actors (28 in person and 1 by telephone) drawn from the ranks of key participants in the implementation of the NHIS. It is, however, important to note that some of the policy actors had boundary-spanning roles. For example, some HMO executives had dual roles as decision makers in HMCAN, the HMO trade association. Similarly, some HCPs were also proponents of HCPAN, the HCP trade body. Following my conceptual framework, the policy actors interviewed were purposively selected from the following three participant frames:

Macro-level/Government frame:

- Group 1 - Health ministry/NHIS officials
- Group 2 - Community (CBHI) scheme officials

Meso-level/Purchaser Frame: Executives of HMO organisations.

Micro-level/Provider Frame: HCPs (CEOs of Medical Hospital/Clinics)

In addition, three external policy advisors who were active participants in the formulation and implementation of the NHIS were also interviewed. Significant weightings were attached to the views of these external policy advisors given that they had a neutral economic interest in the scheme. The neutrality of their position/views, through confirmation or disconfirmation of the evidence, provided considerable credibility to interview data. The duration of the in-depth interviews ranged between 45 minutes and an hour. Each informant was interviewed once except in one instance when it was necessary to re-interview one health policy adviser (who was also a publisher of a health insurance newsletter) for further clarification in light of updated

information about the new initiative by sub-national (state) governments to implement State Social Health Insurance Schemes (SSHIS). Questions were open-ended, allowing the interviewees to tell their stories as freely as they chose. Interviews, according to Webb and Webb, (1932) are purposeful conversations, so in pursuit of that purpose, I started the semi-structured interviews with a set of questions that were based on my conceptual framework whilst retaining the flexibility to vary the questions from informant to informant. It is important to state that the wording and sequencing of the questions were not predetermined (Erlandson et al., 1993).

Following the qualitative research interview protocol of Hammer and Wildavsky (1993), I cultivated relationships with would-be interviewees by developing rapports across a nexus of influential actors within the NHIS network. I then familiarised myself with the objectives of the interview to ensure that there was alignment between the objectives and the interviewee situation. I also acquainted myself with the structure and *modus operandi* of the institutions involved in the implementation of the scheme. Introductory questions were aimed at establishing the role of each interviewee in the implementation of the scheme, and the context in which they function. Central to the collection of interview data was the need to explore and unearth the cognitive perspective of policy-making through actor sense-making. The whole thread of my interview questions was aimed at building evidence to support this objective. Interviewees were asked about their prior views of the concept of health insurance to understand their cognitive frames (cognition), and the extent to which those frames were shaped by their values and beliefs (affect). Interviewees were also asked to recount events or situations that were challenging or surprising, premised on the notion that sense-making is a 'process of structuring the unknown' (Waterman, 1990:41). To elicit distributed sense-making during actor interactions, I also sought to find out by cross-interviewing what the focal issues at various meetings were. It was sometimes necessary during interviews to ask unstructured

probing questions whenever it was necessary to confirm or clarify statements or comments. Sample interview questions can be found in Appendix G.

The interviews were digitally recorded with the consent of each interviewee, assuring them of their anonymity and the confidentiality of the information that they were to provide. Interview data was then transferred individually as audio files on to a password-protected computer. Interviews were then transcribed shortly after. The transcripts were subsequently imported into NVivo 11 Pro, a qualitative research data analysis software package for the analysis of findings.

Table 4.2: Summary of Data Collection Methods

Data Sources	**Approach**
1. Data Source: Semi-structured interviews	Approach: Interviewed 29 NHIS policy actors including 3 external policy advisers (28 in-person and 1 telephone interview). This provided the primary data (subsequently used to triangulate secondary data sources) to elicit themes of individual and collective/distributed sense-making, as well as expositions of wider themes relating to other theoretical constructs in the conceptual framework.
2. Document review	Approach: Conducted inductive analysis of various health policy publications, especially those pertaining to the NHIS initiative, and official memos. Reviewed the academic literature (journal articles) on the NHIS.
3. Media Review	Approach: Reviewed newspaper articles on the NHIS and privately published health insurance newsletters (Health Insurance Affairs; Care Net in particular). In addition, I supplemented these materials with publicly available information from the websites of participating institutions and professional bodies (the NHIS, Health and Managed care association of Nigeria (HMCAN), and the Health Care Providers Association of Nigeria, HCPAN). These materials constituted part of the secondary data which I subsequently cross-referred to in an effort to triangulate the interview data.
4. Researcher	Approach: Useful information obtained from pilot interviews in the field was helpful in snowball-targeting informants. More critically, the exercise signalled likely pitfalls in accessing primary data.

Source: Fawehinmi : 2018

4.6 Data Analytic Strategy

Analysis of qualitative data is a rather challenging process. It typically involves dealing with a huge volume of unstructured textual data, which may be from multiple primary and secondary sources (field notes, interview transcripts and documents). The central challenge confronting the researcher in qualitative data analysis is the lack of specific guidelines or 'clear-cut' rules about how qualitative data analysis should be conducted (Bryman, 2012:565).

Researcher methodologies for analysing sense-making vary, with many rival approaches adopted in established research. Approaches that have been widely used include participant story-telling (Boje, 1991), which is often interchangeably described as narrative analysis (Humphreys and Brown, 2002), even though there are subtle but important differences between them. Other approaches include critical incident technique (Mills et al., 2010) and grounded theory (Gioia and Chittipeddi, 1991). It is worth stressing that I elected to employ thematic analysis as my analytic strategy for two reasons. Firstly, the wide breadth of the research questions made it imperative to espouse themes beyond cognitive schemas and maps (sense-making). Secondly, I was drawn to the relative flexibility and accessibility of thematic analysis (Braun and Clark, 2012).

Thematic analysis can be carried out in different ways given it's capacity to straddle 'three main continua' (Braun and Clarke, 2012:58) in qualitative research. It is therefore incumbent on the researcher to make their choice and defend the decision. The three optional pathways are:

1. Inductive versus deductive or theory driven-driven data coding and analysis.
2. An experiential versus critical orientation to data.
3. An essentialist versus constructionist theoretical perspective.

The pathway of this NHIS study to thematic analysis combined both inductive and deductive approaches. The inductive is employed as a bottom-up data-led process, implying that I allowed

themes and patterns to emerge from the data set. The deductive approach is top-down — given that I imposed certain predetermined concepts and ideas contained in my conceptual framework and employed it's components to code and interpret the data. The deductive approach suggests that themes derive more from the conceptual framework than from the narratives in the data set. In defence of my pathway, I relied on Braun and Clarke's (2012:59) view that, in practice, coding is far from a clearly demarcated process as analysts tend to combine both approaches. As they explain :

> 'In reality, coding and analysis often use a combination of both approaches. It is impossible to be purely inductive as we always bring something to the data when we analyse it, and we rarely completely ignore the semantic content of the data when we code for a particular theoretical construct; at the very least, we have to know whether it is worth coding the data for that construct'.

This explanation justifies my combination of inductive and deductive approaches to thematic analysis. Theoretical constructs from my conceptual framework were employed to code and interpret my data and supplemented with inductively generated codes from the data. Braun and Clark (2006:6) describe thematic analysis 'as a method for identifying, analysing and reporting patterns or themes within data. It minimally organises and describes your data set in rich detail. However, it also often gets further than this, and interprets various aspects of the research topic'.

The flexibility of thematic analysis, Bryman (2012:581) explains, is what favours it's employment in relation to several of the different ways of analysing qualitative data 'such as grounded theory, narrative analysis, critical discourse analysis and qualitative content analysis'.

Braun and Clarke (2006) place thematic analysis in the camp of qualitative data analytical methods that are independent of theory and epistemology. Within the broad sphere of qualitative research approaches, Aronson (1994), Roulston (2001) and Braun and Clarke (2006)

frame the philosophical underpinning of thematic analysis as a realist/experientialist or constructionist paradigm. This philosophical stance is not incompatible with the multi-paradigmatic bent of my research. My philosophical defence rests on the substantive argument made by Frazer and Lacey (1993:182) that: 'even if one is a realist at the ontological level, one could be an epistemological interpretivist […] our knowledge of the real world is inevitably interpretive and provisional rather than straightforwardly representational'.

Regardless of it's strengths, thematic analysis is not without weaknesses. Braun and Clark (2006:4) see the method as 'poorly demarcated and rarely acknowledged'. In Bryman's (2012:578) view, the approach has no 'identifiable heritage'. Furthermore, Bryman (2012) questions the need for a specific labelling of the approach since the search for themes is the essential activity that goes on in most qualitative data analysis. Also contentious is the notion of what exactly constitutes a theme. Taylor and Bogdan (1989:131) define themes 'as units derived from patterns such as conversation topics, vocabulary, recurring activities, meanings, feelings, or folk sayings and proverbs'. Leininger (1985:60, cited in Aronson, 1995) explains that:

> 'themes are identified by bringing together components of fragments of ideas or experiences, which are often meaningless when viewed alone […] the coherence of ideas rests with the analyst who has rigorously studied how different ideas or components fit together in a meaningful way when linked together'.

Bryman (2012) observed that a theme is often wrongly used interchangeably for a code by researchers. In other words, what constitutes a theme is often poorly specified. A theme Bryman (2012: 580), suggests is:

1. A category identified by the analyst through their data.

2. Relates to a research focus (and quite possibly the research question).

3. Built on codes identified in transcripts and/or field notes.

4. Something which provides the researcher with the basis for a theoretical understanding of his or her data that can make a theoretical contribution to the literature relating to the research focus.

Academics have recently introduced guidelines to make up for the insufficiency of thematic analysis. Their advocacy is for a more structured process that will confer on it the rigour to make it an analytical method in it's own right. Researchers at the forefront of the change effort include Ryan and Bernard (2003) and Braun and Clarke (2006). Box 4.6 describes the themes Ryan and Bernard (2003, cited in Bryman 2012:580) suggest that qualitative researchers should pay attention to in thematic analysis.

Box 4.6: Important Themes in Thematic Analysis

1. Repetition: Topics that recur again and again.
2. Indigenous typologies or categories: Local expressions that are either unfamiliar or are used in an unfamiliar way.
3. Metaphors and analogies: The ways in which participants represent their thoughts in terms of metaphors or analogies.
4. Transitions: The ways in which topics shift in transcripts and other materials.
5. Similarities and differences: Exploring how interviewees might discuss a topic in different ways or differs from each other in certain ways or exploring whole texts like transcripts and asking how they differ.
6. Linguistic connectors: Examining the use of words like 'because' or 'since' because such terms point to casual connections in the minds of participants.
7. Missing data: Reflecting on what is not in the data by asking questions about what interviewees, for example, omit in their answers to questions.
8. Theory-related material: Using social scientific concepts as a springboard for themes.

Source: Bryman (2012: 580)

The seminal contribution of Braun and Clarke (2006) to making thematic analysis more rigorous is the development of a six-phase approach to the process. They however caution, that the process is not necessarily linear — emphasising that the steps in their approach are not to be regarded as rigidly prescriptive but employed simply as guidelines. A computer-aided qualitative data analysis software (CAQDAS) package was used to facilitate the analysis of the data in a more manageable and rigorous way. NVivo 11 Pro was selected as the researcher was persuaded by it's advantages – especially the software's capability to handle large volumes of data, which was likely to be the case in this study. Table 4.3 shows how Braun and Clarke's (2006) guidelines for conducting thematic analysis were operationalised in the analysis of this study's data.

Table 4.3: Braun and Clarke's Guidelines for Conducting Thematic Analysis

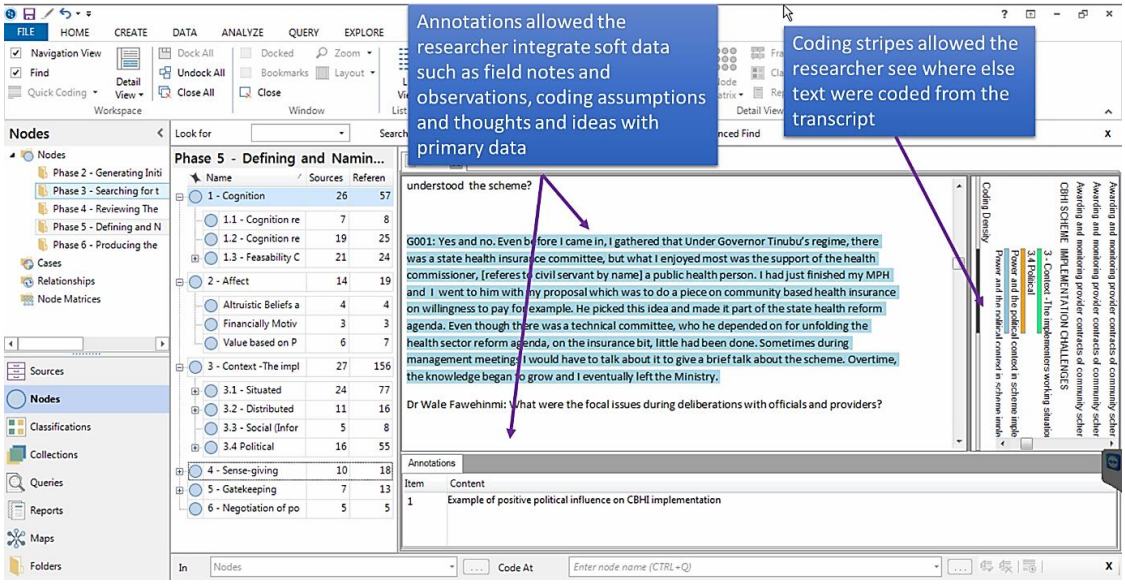
Guidelines from Braun and Clarke (2006) for Conducting a Thematic Analysis	Practical Application of Braun and Clarke (2006) for Conducting a Thematic Analysis
Phase 1: Familiarisation with the data. This involves a deep analytical and critical engagement with the data by reading and re-reading the text of interview transcripts and re-listening to audio recordings to develop a level of intimacy with the data.	**Phase 1: Familiarisation with the data.** This phase involved transcribing from audio files and reading and re-reading the transcripts several times and annotating and creating memos of early ideas for the coding to follow in phase 2. With a focus on the research questions, the familiarisation process included a review of secondary data (literature and documents and memos).
Phase 2: Generating Initial Codes. Codes represent the building blocks of data analysis. This phase involves open coding of the interview transcripts, paying attention to research-relevant features, systematically across the data set. Codes according to Boyatzis (1998:63) suggest that 'Codes identify a feature of the data (semantic content or latent) that appears interesting to the analyst'. In practice, codes are typically a blend of the descriptive and interpretative. It is important to keep re-interrogating the data for excerpts that may fit into an initial code or need to be treated as a new code. It is important to bear in mind that modifications of existing codes will be required as new material emerges from the data.	**Phase 2: Generating Initial Codes**. This phase involved importing the data. Working with NVivo Pro 11, interview transcripts, literature and electronically available documents were stored as internals; non- electronically available documents were scanned and held under externals. Each transcript was read and initial broad-brush codes were created. This process resulted in deconstructing the data from it's original chronology into an initial set of non-hierarchical codes. Each code had a clear label and a definition for coding consistency to guide the researcher as to whether a given text segment or unit of meaning belongs in an existing code (Maykut and Morehouse, 1994). Ninety-one codes were created in this phase (Appendix).
Phase 3: Searching for Themes. This phase involves the collation of codes from phase 2 and then aggregating and organising them into potential themes to be developed further. It is important to recall from Bryman (2012) that a theme encompasses something in the data that is relevant to the research question(s). In a strict sense, themes are not exactly	**Phase 3: Searching for Themes.** Searching for themes involved merging, renaming, distilling, and clustering related codes created in phase 2 into broader categories of codes in phase 3 to reconstruct the data into an initial framework that makes sense to further this particular piece of analysis in the context of the research question. The ninety-one

searched for and discovered. They are constructed or generated (Braun and Clarke, 2012). During this phase, the analyst examines the coded data for areas of overlap or similarities to identify clustering among subject matters or issues. This active process will, in practice, result in the generation of sub-themes.	initial codes were organised into seven categories of code (Appendix).
Phase 4: Reviewing Potential Themes. This phase, which is sometimes referred to as 'coding on' (from phase 3), involves the generation of sub-themes to gain granular insights about divergent and / or consensus views, attitudes and beliefs, to check if a theme is consistent with the entire data corpus. If a theme does not work, it may be necessary to discard some codes or move or collapse them to another theme where they fit better. It may sometimes be necessary to widen the scope of a theme.	**Phase 4: Reviewing Potential Themes.** Reviewing themes involved breaking down the now reorganised codes in to sub-codes to better understand the meanings embedded therein. For example, the code '*Provider community views about their situation'* which now sat under the category '*Stakeholder cross perspectives*', was then drilled down and recoded into seven sub-codes to offer deeper insights into the data in the original code.
Phase 5: Defining and Naming Themes. Data reduction by way of code consolidation is the objective of this phase. Here the analyst specifies and makes clear the essence of each theme as succinctly as possible. In this phase, narrative excerpts that strongly support a theme are extracted from the data. Arriving at the theme names is an important exercise. Braun and Clarke (2012:67) suggests that a 'a good name for a theme is informative, concise, and catchy'.	**1. Phase 5: Defining and Naming Themes.** Defining and naming themes involved conceptually mapping and collapsing the categories and codes developed in phases 3 and 4 into a broader thematic framework. Six themes and 13 sub-themes were developed in phase 5 (see codebook). The relationships across and between the thematic framework developed in phase 5 were explored using conceptual mapping as the tool. Conceptual maps allow the researcher to show abstraction which cannot be seen in the codebook as it happens in the researcher's brain.
Phase 6: Producing the report. The aim at this stage is to present your findings as a compellingly academic report. The report must reflect rigour and must be backed-up by valid arguments that answer the research question(s). The reporting format adopted borrows from the five key elements of Braun and Clarke's (2006) proposition that analytical memos in thematic analysis should cover to produce a compelling narrative that is strongly coherent in addressing the	**Phase 6: Producing the report.** Producing the report involved writing a series of analytical memos to conduct a systematic review of the thematic framework developed in phase 5. The memos reflected: 1. What was said (stored in the codes), and how it was said (stored in annotations and memos). Figure 4.2 provides an example of annotation of the primary

research question(s). The analytical memo should pay attention to the following: What was said (by whom). Discussion of dominant themes. Linkage of themes with the literature paying attention to overlaps and gap. Implications for the research questions. Overlaps with other codes.	(interview) data. 2. How much of it was said (reoccurring phenomena). How many people said it; and how many times they said it. This analysis considered the distribution of the participant voice across the thematic framework. 3. Further literature and secondary data re-visits were necessary during the systematic review of the primary data. Figure 4.3 provides an example of cross-linkage of a theme with the literature. 4. Who said it (stored in cases and classifications). This allowed the researcher to explore the representation of different voices or stakeholder types across the thematic framework. Creating the narrative involved synthesising and cohering the analytical memos created in phase 5 into a narrative that told the story of sense-making in health policy in a Nigerian context.

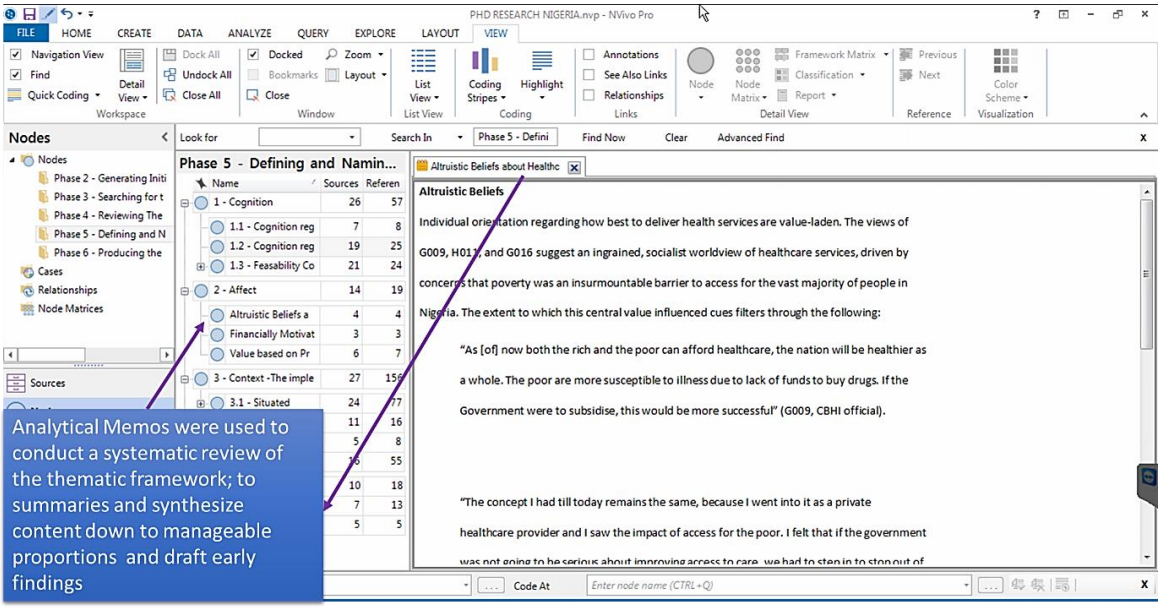
Sources: Braun and Clarke (2006); Fawehinmi research data (2017)

Figure 4.2: NVivo screenshot of annotation linking coding assumptions with primary data



Source: Fawehinmi research data (2017)

Figure 4.3: NVivo screenshot linkage of theory (Affect) with data (Altruistic belief) in analytical memo



Source: Fawehinmi research data (2017)

4.7 Summary

This chapter started by declaring the multi-paradigmatic philosophical orientation of this research and the part it played in the decision to conduct the inquiry by a case study research design within the wider sphere of a qualitative research strategy. It discussed the value of multiple sources of data to achieve triangulation of the evidence in light of the weaknesses of case study research. Crucially, the chapter argued that this case study is not a single case study in the strictest sense because the inquiry examined the actions of policy actors at several levels, each of which qualifies as a 'mini-case' in it's own right. The multiple perspectives elicited from these mini-cases accordingly mitigates some of the flaws of case-study research – and approximates generalisability by other means (Eisenhardt, 1989).

The chapter described the sources of data and justifications for the selected methods of collection and concludes by discussing the basis for privileging Braun and Clarke's (2006) version of thematic analysis in a coding process that relied on the use of NVivo as a coding software package to operationalise Braun and Clarke's guidelines as the analytical strategy of the research. Examples of some of the steps taken in the coding process were illustrated by computer screen-shots in this chapter. A complete table of all of the coding phases (codebook) to provide an audit trail of the steps taken to strengthen empiricism at each coding phase is presented in Appendix A. Chapter 5 presents and discusses the findings of the analysis of the data.

Chapter 5 Findings from Case Study

5.1 Introduction

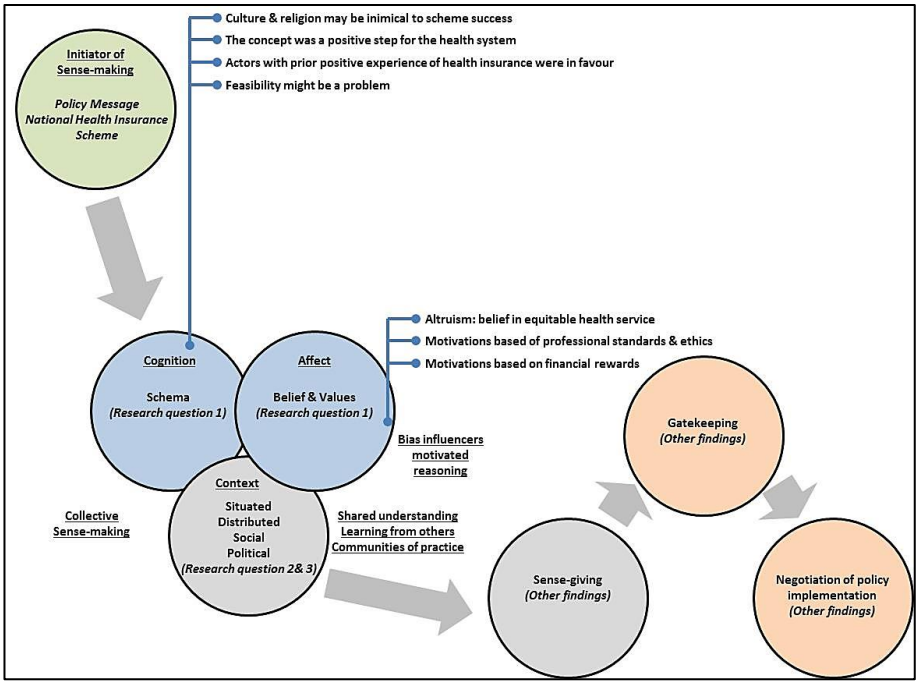
The previous chapter discussed the philosophical orientation and methodology that guided this case study. It acknowledged the deficiencies of the case study approach in qualitative inquiry and explained the strategies employed to strengthen methodological rigour. This chapter presents the findings that follow the analyses of the data (primary) sourced from interviewed agents (chapter 4) , and information from secondary sources employed to triangulate interview evidence. These other sources were listed in the previous chapter (Table 4.2).

The findings are thematically presented — following themes illustrated in the study's conceptual framework (Figure 3.3). Conceptual frameworks, Berman (2013:13) explains are useful for presenting findings because they allow for 'meaningful interpretation of the data with respect to the theory and reality of the study'. The conceptual framework (section 3.10.1), aside of bringing together connected concepts (derived from the relevant literature base), also graphically maps the assumed relationships between those concepts — all of which serve to provide a structure to address the study's research questions. Summarised findings relevant to research questions 1, 2 and 3 were embedded into the diagrammatic iterations of the conceptual framework (Figures 5.1 and 5.2). Although the maps apparently suggest an orderly and sequential approach to the presentation of the findings, it must be recognised that this was not quite the case because of the significant degree of overlap in the findings. Beyond that, some of the emergent findings revealed additional themes and threads that strengthened both the chain of evidence and conceptual validity. Such findings, particularly those highlighting the role of gatekeeping and policy negotiation in the implementation of the NHIS

are presented under 'other policy implementation findings' (see section 5.9).

Findings were ranked on their substantive significance, consistency, the extent to which they expand the understanding of the phenomenon under investigation, provide answers to the research questions, the degree to which they confirm or depart from previous research, or contribute to theoretical development in the field (Patton, 2002). Figure 5.1 summarises findings pertaining to two important properties of individual sense-making — cognition and affect.

Figure 5.1 Summarised Findings of Individual Sense-making: Cognition and Affect



Source: Fawehinmi (2017)

Following figure 5.1, the presentation of the findings starts with a brief recapitulation of the background of the NHIS policy reform – the policy message that was the initiator of sense-making across the wide spectrum of implementing agents.

5.2 Policy Message

As discussed in chapter 2, the National Health Insurance (NHI) Scheme (NHIS) was a strategic platform to tackle the barriers to UHC in the country (sub-section 2.8.1).Following the passing of the NHIS Act 1999, implementation of the NHIS (the subject of this case study) was formally launched in 2005.The objectives of the NHIS thus constituted the policy message. The scheme is currently being delivered through the Formal Sector Social Health Insurance Programme (FSSHIP), the Urban Self-Employed Social Health Insurance Programme (USSHIP) and the Rural Community Social Health Insurance Programme (RCSHIP). The key implementing agents are drawn from the government frame (Health Ministry/NHIS officials and community scheme officials); the purchaser frame (executives of HMO organisations) and the provider frame (HCPs as proprietors of medical hospitals/clinics).

Given the multi-dimensional nature of the initiative, the researcher inferred that the anxiety and confusion it must have imposed on implementers would have been of sufficient magnitude to trigger sense-making as they sought to understand the NHIS policy message — since sense-making is triggered by cues emanating from issues, events and situations of ambiguous meaning or uncertain outcomes (Weick, 1995; Maitlis and Christianson, 2014; Gonzalez, 2008).To recall the literature (chapter 3), sense-making conditions are set whenever, an individual's cognition, existing worldviews, or the status quo is disrupted by an unexpected event; and when this happens, existing frames of reference are challenged. These frames, which allow individuals to make sense of their world, are often interchangeably referred to as cognitive frames, mental models, or schema (chapter 3). In those disruptive situations, 'sense-making serves as a springboard into action'(Weick et al., 2005:409).

5.3 Individual Sense-making: The Role of Cognition and Affect

At the individual (intra-subjective) level, sense-making is largely influenced by individual cognition (the implementing agent's schema as an individual sense-maker) and affect — the implementing agent's beliefs and values.

5.3.1 Individual Cognition: Influence of Prior Knowledge, Experiences and Attitudes

To understand the cues that NHIS policy actors extracted from the policy message, I analysed the data for evidence of sense-making triggering cues (issues and events) that impacted on individual actor cognition (prior knowledge, experiences and attitudes) and affect (values, beliefs and motivated reasoning). Table 5.1 presents the emergent themes of individual cognition disaggregated as cognition regarding cultural attitudes to health insurance, the broad concept of health insurance and feasibility concerns. The table indicates that most of the reference to themes pertaining to cognition were from NHIS officials, followed by HMO executives, HCPs and external Health Policy Advisors.

Table 5.1. References to elements of cognition by policy actors

T1 – Cognition by Stakeholder Type	NHIS Official	HMO Executive	Health Provider	External Policy Advisors
1- Cognition	24	13	11	7
1.1 – Cognition regarding Cultural Attitudes to Health Insurance	6	2	0	0
1.2 – Cognition regarding the Concept of Health Insurance	12	4	5	4
1.3 – Feasibility Concerns	8	7	6	3

Source: Fawehinmi interview data (2018)

5.3.2 Implementation Concerns: Cultural factors

A number of the interviewed policy actors (n=8) expressed concerns to the effect that cultural attitudes, especially perceptions of the vast majority of citizens to the idea of health insurance, was a potential impediment to successful implementation. A former NHIS official's comments exposed the depth of these attitudes:

> 'Our cultural and religious mindset was an impediment in seeing insurance as wishing or inviting ill-health. We thought getting people to make health insurance contributions will be easy given the culture of grassroots community saving schemes that was widespread across Nigeria' (G010, former NHIS Official).

A physician and community (CBHI) scheme official echoed this, albeit rhetorically:

> 'My concern was: would people culturally accept the concept of insurance given that disease is a taboo [topic]; would people want to pay ahead for what may afflict them in future?' (G015, Community Scheme Official).

The observation that negative cultural attitudes to the idea of health insurance posed potential risks to implementation did not only emerge from the primary data. Asoka (2008: 4), in a newsletter article (Health Insurance Affairs, Care Net, Nigeria, 2008), also drew attention to the problem:

> 'The word insurance evokes certain unpleasant emotions in many cultures and thus create a situation for an excuse to reject the concept of health insurance altogether.' (Asoka, 2008:4)

A physician and CBHI official recounted his first-hand experience of negativity to the concept of health insurance from potential enrolees:

> 'Many people expressed [their] discontent with questions such as 'if I am not sick then why should I continue to pay for health care?' G019, CBHI Official)

A former high-ranking health official offered a different perspective on the cultural attitudes of

Nigerians:

> 'The concept of insurance is hated in Nigeria, maybe because of the experience people have had with automobile insurance – the difficulty of claiming compensation after an accident.' (G028, former Health Ministry official)

Thus, the perception that negative cultural attitudes to insurance within the citizenry posed a threat to NHIS implementation was a view shared by national and community health insurance officials and external policy advisers.

5.3.3 Views about the Concept of Health Insurance

Notwithstanding the concerns of the respondents about negative cultural attitudes towards health insurance in the country, some respondents (n=10) expressed strong convictions that the scheme was a strategically astute approach to improving the performance of the country's health sector. Actors with a positive disposition towards the scheme were in two categories: those persuaded by the value proposition of health insurance and those with a positive prior experience of such a system.

5.3.3.1. Positive views based on the value proposition of health insurance

The value of financial protection against catastrophic health care costs that health insurance offers was broadly covered in chapter 2. Quotations from the following informants, regardless of differences in their articulations of the positives of health insurance, suggest that they had a clear understanding of the health coverage benefits of the NHIS through the cross-subsidisation provided by risk-pooling. As Awosika (2005: 41) explains:

> 'Insurance is based on the principle of probability and all parties predicate it's sustainability on the law of large numbers and the meticulous observation of the principles of insurance. From the small contributions of the large numbers, the few who access the system for services are paid for.'

The following quotations reveal the 'buy-in' of some of the respondents about the concept:

A former high-ranking health [NHIS] official commented as follows:

> 'I saw health insurance as a mechanism capable of providing health care to Nigerians in rural communities. I saw health insurance as the key answer to providing health care in rural areas by giving incentives to Health Care Providers.' (G021, former health (NHIS) official)

G021's comments suggest that his particular interest in the NHIS was rural coverage.

The attraction of one HMO executive to the NHIS was more technical. As he explained:

> 'I believed it would bring an alternative source of funding as opposed to budgetary allocations, from local to state to federal and to developmental partners who invest money. I was a student of health insurance. Risk pooling decreases pressure on central government.' (H006, HMO executive)

Evidently H006 believes that the NHIS is a viable source of sustainable health care funding (through risk pooling) in contrast to tax-based government allocations.

One CBHI official saw the benefits of the NHIS from a different perspective:

> 'The old private system of retainership [of service delivery] could not even cope with the numbers under health insurance. Health insurance empowered the enrolees who could even now demand quality care. I was eager to prove that the scheme could work.' (G001 Community Based Health Insurance (CBHI) official)

In the view of G001, the NHIS system was comparatively better than previous health delivery systems, especially the erstwhile retainership model.

Implicit in the above comments is a general perception that health insurance was a step in the right direction in addressing the challenges of the Nigerian health sector. From the comments, it can be inferred that some of the policy actors were attracted to the positive idea of health insurance, especially with regards to the mitigation of financial and geographical access constraints.

5.3.3.2. Positive views based on prior experience of a health insurance system

One HMO executive expressed optimism about the concept in the following comments:

> 'We had practised health insurance on a small scale in my practice at Obalende [Lagos, Nigeria] with a company that had around 200 people. The following year, we proposed to them that we can look after their entire company for the sum of 50,000 naira; [local currency; about [£100.00] and, being an American company, they saw the advantage of budgeting and they agreed.' (H013, HMO Executive)

H013's comments suggest that his individual schema was positively disposed towards the concept of health insurance because his previous experience of a small-scale health insurance system had been positive.

Another HCP explained that he was well informed about the concept because he had been previously resident in the US, where he benefited from a health insurance plan:

> 'As I schooled in America, I understood the concept of health insurance and the role of HMOs. I benefited from health insurance when I had my appendix removed in 1997. Most Americans don't want unexpectedly high bills for health.' (P014, HCP)

Another HCP with previous experience of health insurance in the US made similar comments:

> 'I studied in the USA and I was exposed to health insurance in the early 1980s and so I knew how it worked. I undertook my fellowship in the USA and knew that health insurance was the only way to take the burden off family and other dependants to cope with the demands of an out of pocket payment system.' (P018, HCP)

What is noteworthy is that these actors with a positive prior experience of health insurance came from the ranks of HMO executives and HCPs.

Comments made by H013, P014, and P018 are particularly illustrative of the retrospective nature of the sense-making process given that all three actors looked back to past experiences of health insurance to attribute meaning to the present situation (see chapter 3). This is one of

Weick's (1995) seven distinguishing characteristics of sense-making, which Schutz (1967) suggests is based on 'meaningful lived experience'.

5.4 NHIS Feasibility Issues: Concerns of Implementing Actors

Several respondents (n=24) had concerns about the feasibility of the scheme for a variety of reasons. A former health official believed that the approach to implementing the scheme was profoundly flawed because more attention was paid to the formal sector programme over the informal (Urban Self-Employed Social Health Insurance and Rural Community Social Health Insurance) programme. This, in his view, was against better judgement given that the informal sector was disproportionately under-served:

> 'I had a big doubt [about feasibility] for a number of reasons. It is normal practice to start with the formal sector when implementing health insurance because it is easier to make payroll deductions from this group. My concern was that in Nigeria, the formal sector is very small: less than 10%. Most of the people (90%) are in the informal sector.' (G028, former Health Ministry Official)

This interviewee's comments suggest that while it might have been expedient to start implementation with the formal sector, that approach can be seen as counterintuitive in the light of the scheme's wider goals, and was therefore misplaced. His perspective points at a deeply flawed NHIS implementation plan that had far-reaching consequences for the attainment of UHC in Nigeria. Chapter 6 examines this weakness in the NHIS policy design in more detail.

Concerns were also expressed about the capacity of the vast majority of poor people to make contributory payments:

> 'Affordability has always been the most significant problem, as 500 naira [about £10] is a lot of money where people live on less than one dollar a day.' (G009, CBHI official)

These interviewees' concerns were premised on the propensity of the government itself to

impede on the implementation of policy initiatives:

> 'My doubt was that perhaps the government may stand more in the way of progress than be enabling. I was a disciple of Alex Preker of the World Bank, who had written so many journals……. I felt that the private sector had to lead the development.' (H011, HMO Executive)

One HCP observed that the tendency of Nigerians to act opportunistically by putting selfish motivations over and above the greater good was the real threat:

> 'Things don't always go the way they are applied. There are always issues of people trying to hijack plans in Nigeria for their own selfish ends. This derails the main objective of the scheme.' (P07, HCP)

Another respondent noted that the implementation arrangement allowing the NHIS to function as both a regulator and an operator was another impediment:

> 'NHIS for me has a fundamental structural flaw – the positioning of the NHIS as both an operator and a regulator simultaneously. This anomaly will create a deficiency in the system and make it more difficult to regulate. Today, when a body both operates alongside operators and regulators, you have chaos. You cannot regulate when you have the yam and the knife [local metaphor].' (H024, HMO Executive)

A more fundamental structural flaw was that not enough consideration was given to the political feasibility of implementing the scheme in Nigeria. The argument advanced by one of the respondents was that the failure to consider structural feasibility alongside political feasibility made the implementation plan too loosely coupled to the extent that it introduced dysfunctionality into the arrangement:

> 'A technically feasible policy may not be politically feasible, and vice versa. I met the commissioner of my state, who reflected to me why he opposed the implementation of NHIS. The NHIS framework was based on a unitary form of government but did not take into account that Nigeria is a federation. The NHIS came at a time when the country was moving away from military government for over 20 years to civilian government. People were more concerned about the workability of democracy itself and not the NHIS or any other thing.' (C020, external policy adviser)

This respondent also explained why he believed the present structure was unworkable – arguing that the governance of the system was not fit for purpose and further asserting that he did not believe that the NHIS could be implemented under the present political structure because Nigeria's 36 states are autonomous and not answerable to the NHIS CEO.

This segment of the discussion uncovered the extent to which individual cognition underpinned the sense-making cues extracted from the policy message. Even though there was a consensus that the NHIS was a step in the right direction, the extracted cues highlight two strands of concerns: first, concerns actors had about the risks posed to NHIS implementation by cultural anchors of the people; and second, concerns over the feasibility of the scheme.

5.5 Affect: Influences of Values, Beliefs and Motivated Reasoning on Sense-Making

The central point of affect (values, beliefs and motivated reasoning) is that 'people are biased towards interpretations consistent with their prior beliefs and values' (Spillane et al., 2002: 401), and the actions that follow reveal such cues. Table 5.2 illustrates the number of references made that broadly relate to affect in the context of this study (Altruistic beliefs about health care, financially motivated reasoning, and values based on professional standards).

Table 5.2.: References to Elements of Affect by Actors

T2 Affect by Stakeholder Type	NHIS Official	HMO Executive	Health Provider	External Policy Advisors
2 – Affect	6	8	3	2
2.1 - Altruistic Beliefs about health care	4	0	0	0
2.2 - Financially Motivated Reasoning	0	2	0	1
2.3 - Value based on Professional Standards	2	3	2	0

Source: Fawehinmi interview data (2017)

The receptivity of some policy actors towards the propositions of health insurance reflected the degree to which they were influenced by *affect* – a notion based on individual values, beliefs and motivated reasoning.

5.5.1. Altruistic Beliefs

Individual orientation regarding how best to deliver health services are value-laden. The views of G009, H011, and G016 suggest an ingrained, socialist world view of health care services, driven by concerns that poverty was an insurmountable barrier to health care access for the vast majority of people in Nigeria. The extent to which this central value influenced cues can be discerned through the following narratives:

> 'As [of] now, both the rich and the poor can afford health care, the nation will be healthier as a whole. The poor are more susceptible to illness due to lack of funds to buy drugs. If the government were to subsidise, this would be more successful.' (G009, CBHI official)

> The concept I had until today remains the same, because I went into it as a private health care provider and I saw the impact of access for the poor. I felt

> that if the government was not going to be serious about improving access to care, we had to step in to stop out of pocket payment systems harming access of the poor to health care and creating impoverishment.' (H011, HMO Executive)

'My personal view is that there is no way to practice medicine in a system that doesn't have even a solid insurance scheme, whether public or private. But in a country where a majority can't even afford a meal, in a country with such widespread poverty, a social insurance scheme must be implemented to better protect the poor; whether social, contributory or paid for by government.' (G016, Ex-NHIS official)

G009's view suggests that the widespread poverty in Nigeria not only limits access to health care but more importantly it makes financially constrained persons more susceptible to disease. H011 essentially restates the same point. Whereas, in G016's view, Social Health Insurance (SHI) is *sin qua non* to the attainment of UHC in Nigeria. Clearly, equitable access to health care was uppermost in the minds of these respondents.

5.5.2 Professional Standards, Values and Ethics

Some of the HCPs made remarks conveying the point that their priority was the delivery of good health care to their patients over and above financial benefits:

> 'Quality of care mattered more to me than profit. However, there is no HMO that does not do business with Gold Cross at Bourdillon [a Lagos high-end Medical Centre]. We corrected the impression that health insurance will not be able to provide the best care. We can see that everybody wants to use Bourdillon because of the affordable prices [fees] and quality service. Our own competitors in the same industry also use Bourdillon. It's about standards, and people will tell you how many good hospitals are there in Lagos'. (H012, HMO Executive and HCP)

Table 5.2 illustrates that aside from HCPs, some of the other interviewed policy actors (n=7) also made references to the effect that they placed a high value on professional standards. A former NHIS official (G010), for example, stated that it was on the basis of the value he placed on high standards at the NHIS that he approved a number of foreign professional training trips abroad during his tenure.

5.5.3 Financially Motivated Reasoning

One actor (n=1), however, came across as solely motivated by financial gain – stating unequivocally that he had little interest in the social value of equitable health care access. The following quotation reveals such motivations:

> 'I am not interested in community-based insurance because I invested to make a return… A for-profit organisation should not be thinking of the social aspect alone. The only time this should happen is where a company has got it's foot well dug in the sand. Equity is not the job of the investor – it is the job of government. You don't give until you have amassed [wealth].' (H006, HMO Executive)

The main cues that this individual extracted from the policy message was that this was a scheme that presented them (HMOs) with a huge opportunity for financial gains. They visualised the NHIS policy through this prism of self-interest.

The comments by C029, an external policy adviser, suggest that this mental schema cuts across ranks of HMOs:

> 'They just wanted to go in there and hijack the scheme and make money; making money was their focus. They basically hijacked the policy-making process off NHIS before the policy came into law. They are not interested in spending money to promote universal health care. Their sole concern is about money.' (C029, external policy adviser)

The preceding discussion in part supplies answers to research question 1.

In recent sense-making research, there has been an increased emphasis on the dimension of context on the strength of empirical studies backing the claim that sense-making is not a solo affair, because it is embedded in the individual's situation or context and as such it is situated, distributed and social (Spillane et al., 2002) is situated, distributed and social. Sections 5.6 , 5.7 and 5.8 presents findings relating to sense making in context.

In chapter 3, it was stated that one of the concrete criticisms of extant sense-making research is that it negates the role broader social contexts play in the concept (Weick et al., 2005; Weber and Glynn, 2006). It is for the same reason that this study explored the shaping influences of the organisational and bureaucratic context on the sense-making of NHIS policy actors.

5.6 Situated Sense-Making Within Institutions: Bureaucratic and Organisational Context

A genre of sense-making research suggests that the sense-making of agents is shaped by institutional factors which encompass organisational and bureaucratic contexts – given that bureaucracy is a feature of institutions. The link between institutional theory and sense-making (chapter3) offers much insight into the sense-making observed in the bureaucratic/organisational context of the NHIS. The main point of the institutional perspective is that the environment of institutions makes them culturally cognitive. The effect of this, according to Spillane et al. (2002:405), is the imposition of 'norms, rules, and definitions' on the sense-making of agents. With regards to this study, the bureaucratic and organisational context is the NHIS (government frame). A number of respondents made comments that revealed the institutional impact of the NHIS environment on the sense-making of officials. This is implicit in two quotations that suggest that NHIS officials were possessed of a civil servant mindset and as such, they had a poor understanding of the idea of a health insurance driven health service :

> 'They cared little about how to improve the market for health insurance. They had little understanding of how to create the framework for the scheme. I think they felt that the government wanted them to set up an NHS-like scheme and they even saw us as interlopers.' (H011, HMO Executive)

The portrayal of NHIS officials as policy actors that are guided by a 'civil servant mind-set' referenced by one HMO executive strengthens the 'top down' camp's argument that institutions provide the feedstock for sense-making:

> 'It is the mindset of a civil servant. Civil servant mentality. If you are going to make a difference, you need someone from the industry there and you will see the difference – just like they appointed the bankers to head the central bank, telecoms experts to head the regulatory body in the telecom industry. You can't put someone who has no clue [in charge] to regulate [something] he/she does not understand.' (H012, HMO executive)

Contrary to the views of H011 and H012, one HMO executive (H017) rejected the view that the civil servant mindset was a hindrance to the implementation of the NHIS – with remarks that suggest that he held the civil service institution in high regard:

> 'Most of my colleagues would say they don't know what they are doing – but I disagree with that view because civil servants are better drilled than most private sector people, they go for all the training and so on – but I believe it is the guidelines that they are following that makes it look as if they do not know what they are doing.' (H017, HMO Executive)

5.7 Situated Sense-Making: Social context

Findings from the data support a central tenet of sense-making theory that informal interactions in social contexts within professional affiliations influence sense-making in policy implementation. The following quotes present two examples of informal sense-making events that confirm the postulation. As this respondent recalls:

> 'Myself and two other colleagues of mine attended a World Bank conference for health care financing and we were the only delegation from Nigeria. We met the WHO rep from Congo. He was quite impressed that we attended the conference and we kept [in] contact. Years after, he became Minister of Health. We created an informal market [network] so that when [the] federal government were going to enforce it in the country, we were the only group knowledgeable about it. We are the architects of the whole foundation.' (H012, HMO Executive)

Here, we observe a situation of knowledge acquisition from sense-making in a non-system or informal context (Spillane et al., 2002: 409, citing Clarke, 1983; Van Maanen and Barley, 1984). With insights from the conference, H012 and his colleagues became pivotal policy entrepreneurs (Kingdon, 1984) of the NHIS policy initiative.

A second HMO Executive with a medical background offered important insights about the role of professional specialisations in informal sense-making in describing how he went about his advocacy of the scheme's benefits to a group of hostile and negative HCPs:

> 'In 2003, in those days at the start of the programme, I saw myself as a sort of evangelist for the scheme, especially with regards to educating doctors about it. I went to the conference of the association of general practitioners of Nigeria (AGPN) in Abuja. I asked my company then to sponsor the programme because I wanted to have the opportunity to educate the body of providers and general practitioners to prepare them as colleagues – that this programme was coming and that this was the way health care was being delivered across the world today. Amongst the assembly were providers that I was already dealing with on my panel. There was a lot of negativity to my presentation. They became quite violent, saying that the programme will never work in Nigeria and so on. They then issued a communiqué in response to my presentation restating that the programme will not work and went on to make demands about what they wanted the government to do for health care in Nigeria. That position reflects what the problem has always been with providers.' (H017, HMO Executive)

The perspective put forward in recent cognitive implementation research is that much construction of meaning comes from the informal sense-making that takes place in a social context, especially within networks of professional affiliation (Spillane et al., 2002). The views of H012 and H017 support that scholarly claim.

5.6.1 Situated Sense-making: Communities of Practice (CoPs)

Recent research suggests that communities of practice (CoPs) serve as a context for collective sense-making as well as distributed sense-making through cross-interactions between CoPs (Chapter 3). CoPs have a huge bearing on sense-making by influencing existing knowledge (through situated learning) in socially entrenched practices and commonly held beliefs in a community (Spillane et al., 2002). In a CoP, we have a context to observe group schemas in which actors in organisational structures, professional affiliations, social networks etc, are participants in 'thought communities' that act as filters for shared understanding and negotiated meaning. The learning that occurs in these communities shapes the sense-making of these actors (Spillane

et al., 2002: 404, 406).

The CoPs identified during the data analysis were health maintenance organisations (HMOs), represented by their trade body – The Health and Managed Care Association of Nigeria (HMCAN); health care providers (HCPs), represented by the Health Care Providers Association of Nigeria (HCPAN); and NHIS officials, a community of government actors. To understand sense-making in each of these practice communities, the researcher relied on evidence from cross-interrogation of interviewed informants which was subsequently triangulated with views from external policy advisers and other documentary sources.

5.7.1 HMO (HMCAN)

Data analysis revealed that the HMO-HMCAN CoP was a strong platform for collective/distributed sense-making. HMOs, as key players in the NHIS, deliver financial and medical services to medical providers and enrolled individuals who, in return, make pre-payments towards future costs to be incurred.

A HMO executive and active HMCAN decision maker stated that HMCAN was established in the early 2000s to unify and promote the aims and objectives of HMOs, set industry standards, act as a watchdog for government action, and function as a lobby group to push for action to raise health care indices in Nigeria.

The overwhelming consensus across HCPs and NHIS officials (n=15) was that the driving interest of HMCAN was to maximise economic rents from the NHIS scheme. As one HCP observed:

> 'The HMOs understood health insurance only from their own financial perspective; their bottom line was money, period. They had all sorts of arguments against improving the system. Anytime providers [HCPs] informed them of poor returns, they will ask us to support our position with data when they knew fully well that good data was lacking across the board.' (P005, HCP)

Two external policy advisers also supported the view that the primary interest of HMOs/HMCAN was financial gain:

> 'The HMOs wanted to grow their businesses and support the growth of the scheme. [Their] largest focus was on private interest; what money can they raise out of the scheme?' (C004, External Policy Adviser)

> 'They are basically interested in their business and how the policy affects their business. Their most primed interest was on how the policy environment would affect their profitability. They only wanted policies which positively improved their profitability and this mindset has not changed. I got this impression from my dealings with them.' (C020, External Policy Adviser)

Even from within the ranks of HMO executives, their fixation on financial gain also came across as overriding when some of them were probed for their views on the social aspects of the scheme – specifically, equity and universal access. For instance, one HMO executive remarked that:

> 'You have to develop an industry before you can give back. In essence, the HMOs had to have a sound financial footing before they started to think about offering social services. So, the financial constraint is there. Except[unless] you are able to obtain some grants because the providers are going to send you bills. No service was free.' (H012, HMO Executive)

The reluctance of HMOs to set up community health insurance schemes buttresses the view that they were more interested in the pursuit of financial returns. Evidently, what underpinned sense-making in the HMO-HMCAN CoP was a shared interest in financial return. Notwithstanding the weight of views to the effect that HMOs were mostly concerned about their economic interest, there is contrary evidence indicating that a few HMO executives also had other positive motivations regarding the scheme. One HMO executive, who by virtue of his proprietorship of a private hospital also belonged to the HCP CoP, remarked that his motivation to deliver quality health care superseded his interest in financial returns. This is an important finding of theoretical significance given that it departs from the notion of homogeneity in CoP.

This point is explored further in chapter 7.

5.7.2 Central NHIS Officials' Community of Practice

The findings regarding this CoP were drawn from the cross-perspectives of HMO executives and HCPs. A key finding was that the behavioural pattern of members revealed sense-making processes which suggested a lack of clarity of purpose. This led NHIS officials to depart from their core remit as regulators of the scheme towards self-interested actions which appeared to be motivated essentially by financial opportunism. Another important finding was the observation (widely regarded as negative across other actor groups) that members of this community were 'muddling through' the implementation process (Lindblom, 1959:79). One HMO executive put the situation into perspective as follows :

> 'The people were fundamentally civil servants who were learning on the job. Yes, the NHIS is a regulatory authority, but my view is that a regulatory institution must have on board people who have worked in the private sector, and have had some exposure to working with clear and well-structured mandates.' (H023, HMO Executive)

The perception among the ranks of HMOs and HCPs was that there was an intention on the part of the NHIS to benefit financially from the large pool of funds under it's administration is implicitly and explicitly expressed in the following quotes:

> 'There was some confusion as the NHIS was trying to play a dual role even though they were set up to be a regulator; not a participator. Now successive executives of the organisation want to withhold funds, disburse funds and pay fees for services, whereas these should have been left to HMOs while they focus on ensuring compliance to rules. You cannot participate and regulate [at the same time] as a natural conflict of interest is created.' (P018, HCP)

> 'Once they saw the money [coming into their coffers], they totally lost focus and began to look for ways not to pay [out] money [but] to keep it. They created schemes to stop money being used appropriately.' (H006, HMO Executive)

The financial dimension in the relationship between NHIS officials and HMOs cannot be

overlooked, if we consider that NHIS officials had a more positive relationship with community-based health insurance (CBHI) officials, charged with the implementation of community-level health insurance — a relationship that was free of cross-financial obligations between parties. The absence of financial obligations between them may partly explain this different pattern of behaviour.

Instructively, two CBHI facilitators reported that they enjoyed recognition and support for their community programmes from NHIS officials:

> 'The program was piloted as Anambra State Community Health System [or] Health Care financing scheme, Igbokwu. I was Chairman of the committee set up to manage the pilot scheme in Igbokwu. In 2005, the then Minister of Health paid a working visit to Anambra state, and was brought to Igbokwu. The scheme was showcased to him. He was so impressed that he linked us up with the National Health Insurance Scheme, which since then has provided lots of training. Now I am facilitator of CBHIS.' (G008, Facilitator, CBHI)

> 'At the zonal level, at the state level and the federal level [of the NHIS] we are having [had] increased engagement as they call us to present on the Kwara experience which they see as a success. They are impressed with the Kwara experience and see it as a model that can be adapted and adopted in different states. There is no Minister of Health who has not visited Kwara state to see the success of the scheme with a view to learning from our experience.' (G015, managing director of a Public-Private Community Insurance Scheme).

In chapter 6, I discuss the activities and motivations of the NHIS officials with regards to the financial contentions it created in their interrelationship with HMOs in the context of the extant literature.

5.7.3 Health Care Provider (HCP) Community of Practice

From the beginning of the scheme, HCP sense-making was behind the perception that the NHIS initiative was threatening to their financial prospects. Such concerns came across in the comments of majority of the interviewed HCPs. This finding is entirely consistent with CoP and

structured interest theory. This perceived financial threat fuelled their reluctance to embrace a new service model that required them to give up the financial independence they had under the old retainership model of providing health care services (chapter 2). To put the financial antecedents of the HCPs in context, a synoptic overview of the retainership model is presented in Box 5.1.

Box 5.1 The Retainership Model

The retainership model was developed in the late 1970s and 1980s by HCPs of entrepreneurial bent. The arrangement involved HCPs (a physician, clinic or hospital) contracting directly with employers (mostly private sector companies) to provide medical services to their employees. Service delivery arrangements took several forms. The most prevalent model was one wherein an employer offers employees a list of appointed HCPs they can receive care from. Employees were, however, free to change HCPs without notice. While dependants were covered, the number was typically capped. HCPs fees were invoiced on an item-of-service basis to be settled in 30-60 days.

The model, however, was beset with inefficiencies and malpractices. Under this model, HCPs often experienced cashflow problems and many became dependent on bank financing to meet short-term cash obligations. Employers themselves found their relationship with HCPs too open-ended to allow for proper budgeting and utilisation control. Compounding the picture were numerous reports of opportunistic practices between HCPs and executives of service-retaining organisations. Asoka (2002: 1) in a piece in Health Insurance Affairs (Care Net,2008) reported on malpractices observed as follows:

'The prevalence of fraud is [was] rated as moderate to high. This could take the form of oversupply of services, overbilling by HCPs, the use of services by unauthorised people – uncovered relations or friends of the insured, and the conversion of medical benefits to cash at the request of the insured.'

Onoka (2014: 74) reported on the short-comings of the retainership model as follows:

'Over time, the retainership system became bedevilled with moral hazard and rising costs, as company employees connived with and received unnecessary care from HCPs, leading to it's abandonment by private firms'.

Source: Fawehinmi research data (2017)

Two of the interviewees described what they perceived as the short-comings of the retainership system and how, in their view, the HMO-driven model was better. One HMO executive and one HCP offered insights on the reluctance of HCPs to remove their mental anchors from the retainership system. The HMO executive commented as follows:

> 'Many of them [HCPs] did not like it [health insurance] as many of them were benefiting from the old system of retainership; the sharp practices and abuses etc. They resisted it whilst those of us that wanted to elevate the industry to another level were the ones that now transited from pure provider to HMO administrators. This new system was resisted by health care providers as it shook them out of their comfort zone, but the old system was not adding any value.' (H012, HMO Executive)

The HCP responded with a similar but more nuanced answer:

> 'Many were sceptical as they saw it as a threat to their retainerships. In the past, you would go to a chairman of a company and he would give you the retainership for the company. Some of us were beneficiaries of this and we got Nitel [Nigerian Telecommunications Company]. Employees had no choice over this regardless of where they lived or even the appropriateness of the doctor's skill set; they had to see that doctor. Providers were unwilling to give up their comfort zones; they did not want health insurance because their skillset [business savvy] as socialites; liaising with the MDs [Managing Directors] of companies would be lost. Also, now patients [with the power shift] could choose who they want to see which they couldn't do before. Thus, they were only concerned with business.' (P018, HCP)

Regardless of it's imperfections, the retainership model remained the preferred model for many HCPs. The logic behind this was simple: it gave them more control over fee-for-service income and, ultimately, profits. The previous extracts show this was the world they knew and were comfortable with. Overall, in the collective sense-making of the community of HCPs, the widespread belief was that the retainership model of services, which seemed less threatening to their financial prospects, was preferable.

5.8 Distributed Context: Inter-Communities of Practice

The findings presented thus far have focused on sense-making within mutually exclusive CoPs. Next presented are findings relating to sense-making observed in a distributed context during wider actor-interactions, described by Spillane et al. (2002) as 'sense-making and action, distributed in the interactive web, of actors' (2002:404). First, the findings from the interactions between practice communities of HMCAN (HMOs) and NHIS officials are presented; second,

those resulting from HCP (HCPAN) and NHIS official(s) interactions.

5.8.1 Distributed Context: Sense-Making in HMCAN (HMO) – NHIS Interactions.

Interactions between HMOs through their representative industry body, HMCAN, and NHIS officials exposed the level of distributed sense-making between these two groups. Some informants remarked that although HMCAN drove the business agenda of the HMOs, it did not necessarily speak for all HMOs as several members of the latter were not members of the former. In other words, a 'caucus' of HMOs under the auspices of HMCAN pushed the agenda of HMOs. One external policy adviser commented on HMCAN's dominance of the agenda of HMOs as follows:

> 'HMCAN is a small coalition group and is not carrying along all HMOs. The HMO group is divided and those who are really involved in health care are the ones who actually have the enrolees; not the new entrants. This division harms their overall representative front.' (C004, External Policy Adviser)

This comment suggests that distributed sense-making between NHIS officials and the HMOs represented by HMCAN was limited by the under-representation of HMOs in the interest body. Discussing the issue of under-representation in HMCAN, Asoka (2017), in an article (forthcoming), reported that membership of HMCAN in 2017 was made up of 25 HMOs out of the total of 57 registered HMOs in the country. Looking at distributed sense-making within this web, HMCAN members reported that their inexperience and inadequate grasp of dealing with public sector (NHIS) officials led to some ill-considered and seemingly short-sighted decisions and agreements. A major implementation challenge at the start was that the NHIS Act did not specify a framework for the control of the funds that would flow into the scheme. HMOs believed that they made a major error of judgement by agreeing to cede control of funds from formal sector contributions into the NHIS. Poor decision-making in their view led them to consent to an arrangement whereby the regulator effectively became the gatekeeper of the

funds from enrolees:

> 'We were partly the problem because we were clueless as to how the public sector works in that we were working in good faith. We suggested that premiums should be paid to NHIS as a gatekeeper, thinking that would be faster and more regulated. We didn't want HMOs to go to the Ministry to lobby for their interest. We wanted NHIS to allocate lives [Insured enrolees] and for money to be kept in an escrow account with NHIS. This was our suggestion and undoing for the industry. This is what has led to NHIS operating more as fund managers. We wanted the federal government to transfer premiums to an NHIS escrow account.' (H011 HMO/HMCAN executive)

5.8.2 Distributed Context: Sense-Making in HCPAN/HCP – NHIS Interactions

There was also some degree of distributed sense-making between the HCP CoPs represented by HCPAN and those of the NHIS officials. However, interaction between HCPs and NHIS officials was limited. Given that HCPs did not have a direct relationship with the NHIS, their interactions were mostly with HMOs. HCPs reported that NHIS officials' receptiveness to HCPAN demands ranged from limited to progressive. Contentious issues mostly related to demands for upward reviews of capitation payment rates.

One HCP was emphatic that there was little value in attending meetings between HCPAN and NHIS to deliberate on operational matters:

> 'They were not helping matters so I didn't bother to go to meetings with NHIS officials anymore.' (P014, HCP)

Another HCP had a more positive view of the interactions:

> 'We were told by the NHIS that where we had issues, we were to bring it under the provider's platform such as HCPAN, where it would have more weight than individual doctors voicing complaints. Like I said earlier, they are listening better. We are not where we should be but things are improving' (P005, HCP).

In the view of a former high-ranking government health official, the overriding interest of HCPAN was financial:

> 'To summarise, the collective thinking is through HCPAN, but it is certainly about financial interest.' (G016, ex-health official)

It can be argued that the limited distributed sense-making between CoPs of HCP and NHIS officials could be as a result of the implementation structure of the NHIS that made HCPs sub-ordinate to HMOs. Under that arrangement, NHIS officials only had indirect interactions with HCPs.

5.8.3 Distributed Sense-Making in Three Communities of Practice (HCPAN-HMCAN-NHIS interactions)

To promote better working relationships between NHIS stakeholders, an informal tripartite committee consisting of three main parties – the Health Care Providers Association of Nigeria (HCPAN), the Health and Managed Care Association of Nigeria (HMCAN), the NHIS, and in a lesser capacity, the National Employees Consultative Association (NECA) – was established around 2007 to deliberate on issues of concern among stakeholders. Contrary to expectations, the committee failed to serve as a viable platform for constructive deliberation. Some members were however quick to point out that meaningful exchange was hindered by problems of equivocality, mutual suspicion between parties, lack of transparency and good governance from the regulator. As one HMO executive commented:

> 'There are three key players; the HMOS, the drivers, the providers who assure the supply side, and the regulator. Unfortunately, even till now, the HMOs are speaking Latin, providers speak Greek and regulators are speaking Russian.' (H006, HMO Executive)

One HMO executive confirmed that the dysfunctionality of the committee was mostly due to problems of trust and mutual suspicion:

> 'The stakeholder environment has become more acrimonious than it should be. There has been lack of trust. Providers [HCPs] believe that you are collecting good premiums and paying them peanuts because they forget the inelasticity of

> consumers' willingness to pay given their low earnings. Providers' costs were going up and they expected us to match their costs and we told them that that is not how the premiums worked. We belonged to the Nigerian Employers' Consultative Association and consulted with them to gain support for the providers. This forum allowed providers to see that HMOs were intending to support them thoroughly. But somehow NHIS got involved with the tripartite meeting and progress was stalled. The regulator was not doing their role.' (H011, HMO Executive)

The entrenched thinking of HCPs (that the HMOs were out to short-change them financially) and that of the regulators (that HMOs were only interested in maximising their utility) worsened the outlook:

> 'The initial HMOs were owned by medics and they were driven to ensure the development of the provision side of health care. Providers think HMOs are out to scheme [scam] them and regulators think HMOs are only out for themselves.' (H011, HMO Executive)

Evidence suggests that poor transparency and little commitment to good governance from the regulator impacted on the sense-making processes of actors. The charge that policy implementation suffered as a result of the regulator's conduct was emphatically made by H024:

> 'We have had meetings where decisions have been debated by the three stakeholders, the regulator, HMCAN and HCPAN (HCP association). This forum happens infrequently. In my experience, there has been little fruitful gain from such meetings, because a party is not totally committed to good governance. Where there is lack of transparency, poor governance curbs growth. This forum has not been properly used to achieve set objectives and the key cause for this negative state of affairs is NHIS leadership.' (H024, HMO Executive)

These view-points suggest that deliberations within the tripartite committee were too hampered by structural and relational tensions to advance the interests of stakeholders. That aside, it was still an active platform for distributed sense-making. The intractable issues pertained to the capital adequacy of HMOs and determination of capitation fees. These issues are presented and discussed further under other findings.

5.8.4 Inter-Communities of Practice Interactions: Corroborating the Primary Data

Recently available data (secondary) from a two-day National Assembly (Committee on Health Care Services) meeting are consistent with the distributed context findings reported above. The meeting between key NHIS stakeholders was convened on 21 and 22 June 2017 to assess the performance of the NHIS since inception. The corroborating evidence was contained in an unpublished review article by Asoka (2017). According to the review, allegations and counter-allegations rooted in competing vested interests, issues of trust, and mutual suspicion, resonated in the comments made by NHIS officials, HMO executives, and HCPs.

Claims and counter-claims made by representatives of NHIS officials, HMO executives and HCPs at the meeting are presented in quotations from the article below in boxes 5.2a and 5.2b.

Box 5.2a: Stakeholder Forum Comments

NHIS:
'I see a potential of the NHIS to fund health care in Nigeria…but HMOs are everywhere trying to influence the system…they have corrupted our system, they have corrupted our database…they have padded the number of enrolees…our database was violated by HMOs to increase the number of enrolees so that they get paid'. **'We cannot hand over people's money to HMOs…25 of them have formed themselves into a cartel called HMCAN…Let's ask HMOs how much have they contributed to universal coverage…how many Nigerians have they covered?' (Executive Secretary, NHIS)**
HMOs:
'…all the actions of the Executive Secretary since July 2016 have pointed to a clear case of open hatred for the operations of health maintenance organisations, direct victimisation, deliberate attempt to stifle, disrupt and destroy the health insurance scheme and poor knowledge of working of health insurance'.
Health and Managed Care Association of Nigeria (HMCAN).
'NHIS abandoned their regulatory role to marketing, thereby competing with HMOs and creating confusion among the prospective clients.' (The Association of HMO Practitioners of Nigeria)
'NHIS serially blame the HMOs and above all the whole expenditure on health insurance is not matching health outcomes as all have continued in downward spiral of all health care actions of the Executive Secretary since July 2016 pointed to a clear case of open indices used to measure healthy populations like mortality rates in women and children and other illness burden' [AXA MANSARD- HMO].
HCPs:
'HMOs have been allowed to become too powerful in the scheme. They operate with impunity and play the role of operators and regulators'. (Association of General and Private Medical Practitioners of Nigeria (AGPMN))
'NHIS has not assumed their overall regulatory functions and roles adequately. The guidelines for eligibility of the HMOs and conditions for it's accreditation including the procedures for accreditation are rarely observed.' [Family Physician/NHIS Coordinator, Ahmadu Bello University Teaching Hospital]

Source: Asoka (2017)

What is important to note is that there were admissions of service delivery inadequacies by some of the stakeholders at the same forum. Some of these admissions appear in Box 5.2b below.

Box 5.2b: Comments Highlighting Admissions of Service Delivery Failings

NHIS
'We as the regulator have been sleeping on duty for the past 12 years… if we'd been doing the right thing, we wouldn't be in the mess we are in today… we have handed over everything to the HMOs… from enrolment to the money, to regulation… we are complicit in this. We've not been the regulator we are supposed to be.' (NHIS Executive Secretary)
HMO
'Some HMOs delay in paying capitation to the health care providers. Capitation is supposed to be paid to the health care providers before commencement of care so that adequate drugs and consumables can be stocked, but some HMOs delay in paying capitation (even when the NHIS pay them quarterly upfront). This hampers the prompt rendering of health services to enrolees. Capitation under the NHIS is to cover some outpatient care and laboratory investigation. HMOs also delay the payment of fee-for-service claims to the health care providers. Some HMOs delay this payment for up to two years, thereby making health care providers demand cash payments from enrolees or without necessary services.' (HMO Executive)
HCPs
'Some health care facilities lack competent medical personnel especially at the primary level… they are also acquainted with how the scheme works. Some HCPs are too profit-oriented and render services at the expense of quality of care, especially at private hospitals. Most health care facilities are not aware of the standard treatment guidelines and referral protocols for primary care providers, and it is not user friendly.' (A HCP)

Source: Asoka (2017)

These multiple narratives indicate a climate of divergent views about the implementation of NHIS among key stakeholders, all of which culminated in a cross-blamings for the short-comings of the process. Although there is some degree of acceptance of culpability by NHIS officials,

HMO executives and HCPs for certain oversight and operational failings, the comments, taken together, raise fundamental questions about the fitness for purpose of the design and implementation blueprint of the NHIS initiative. The strong corroboration of the interview data evident in stakeholder comments at the Abuja house committee/stakeholder meeting highlights the difficulties and complexities of implementing the NHIS. The implications of these dysfunctionalities for policy planners are discussed in chapter 7.

5.9 Political Context and Sense-Making

Established research has revealed the role played by power and politics in sense-making (chapter 3).In this section, the presentation of the influence of the political context is focus on sense-making. In section 5.10.1, I expand the coverage of the findings to include the role played by power and sense-giving – the dialectic of sense-making, under other findings.

Recent research (Chapter 3) suggests that sense-making is not neutral to forces of politics and power in the creation of new understanding (chapter 3). Scholarly neglect of the role played by power and politics in sense-making has been identified by researchers as a gap in the extant literature (Mullen et al., 2006; Mills et al., 2010; Maitlis and Christianson 2014; Weick et al.2005; Weber and Glynn 2006; Vlaar et al., 2006; Hope 2010). Of relevance here is Hofstede's (1980) concept of power distance, and power distance orientation. A number of perspectives on how political forces and power manoeuvrings impacted the implementation of the NHIS were articulated by several respondents. They captured the multi-dimensionality of power and politics in action through varying accounts containing several references to elements of a political nature in the scheme's implementation process. This was distilled into five broad categories, as shown in Table 5.3. The table shows the variability in views and relative weighting attached to what was considered politically significant from the perspective of the interviewed actors.

Table 5.3: Political Elements by Participant Type Representation (tabular view)

Number of political elements by participant type	NHIS Official (20)	HMO Executive (11)	Health Provider (2)	Health Policy Adviser (5)
HMCAN, the HMO interest body, had the power to influence policy implementation	4	9	1	0
Political power negatively influenced scheme implementation	3	0	0	2
Political power positively influenced scheme implementation	5	1	0	1
Power and politics played a significant role in scheme implementation in both formal and informal NHIS sectors	9	3	1	3
Risk to scheme sustainability if supportive political person departs office	2	1	0	0

Source: Fawehinmi primary data (2018)

5.9.1 Sense-Making and Power: HMCAN's Asymmetrical Power of Meaning

In Chapter 3, the power of meaning was defined as the power over information control (Balogun et al., 2005). HMCAN's power of meaning gave it the leverage to influence the scheme's implementation more favourably in it's interest. As Table 5.3 indicated, there were (n=14) references to HMCAN's power of meaning. This view was conveyed in the words of one of the

interviewees:

> 'HMOs have HMCAN, which allows them to pool their thoughts and concerns. HMOs have a very strong role under the Act; if they do not like something NHIS is doing, they can always shoot it down and they have the resources they need.' (G012, ex-government health official)

One HCP ascribed the power differential of the HMCAN/HMO interest body to it's better grasp of the scheme's mechanics:

> 'The HMOs knew more about health insurance than providers. They did more research and so had a head start. HMOs met those who established NHIS and we were sent for global training to learn about health insurance. We were appointed to the committee having met the Minister KR and were enthusiastic about the scheme.' (P018, HCP)

Onoka (2014: 76) quoted a policy maker whose explanation of how the NHIS became dependent on the superior knowledge of HMOs corroborates the above views:

> 'Neither the NHIS nor the governing council appeared to have capacity to develop or implement the programme. The council chairman had no knowledge of insurance; the rest of the members were politicians [policy makers]'.

To underscore the same point, Onoka (2016:8) quotes another NHIS official who spoke in the same vein:

> 'At that time, many other key stakeholders were not really interested in what was happening. So, they (HMOs) moved in and they were able to influence the operational guidelines and policy.' (NHIS official)

The above views elucidate sense-making in action in a political context. The HMOs effectively deployed their advantage of power of information and knowledge to promote their business interests. However, the power resource of HMCAN derived not only from it's possession of a superior power of meaning (Balogun et al.,2005). As a duly constituted and mandated trade body, it had formal authority to influence the sense-making as well as the sense-giving of other

key implementation actors. Owoyemi (2017:1) suggests that the technical capacity gap within implementing government agents created the opportunity for the implementation agenda to be captured by HMOs:

> 'First, we must consider how the HMOs came to be big players in the insurance sector, as at the time of execution of the health insurance act, there was a lack of technical capacity amongst government bureaucrats, which occasioned a reliance on the private sector for input into public policies meant to regulate their own operations. This led to alteration of the policy, states were excluded as stakeholders and uptake was made voluntary while the HMOs were used as intermediaries; this also compromised the potential for effective regulation and mobilisation of funds from states to extend coverage'.

5.9.2 Sense-Making Revealing Negative Political Influence on Scheme Implementation

As indicated in Table 5.3 (n=5) respondents viewed the use of political power as inimical to the implementation of the NHIS. The findings revealed examples of executive power overreach, which in the sense-making of some actors was deemed as negative to the implementation of the scheme. These actions truncated the tenure of several NHIS CEOs, as reported in the discussion of the role of HMOs in the NHIS (see chapter 1) and, according to respondents, resulted in the appointment of individuals without prerequisite qualifications into important NHIS positions. This point was emphasised by an NHIS official:

> 'A lack of continuity across the different administrations of the scheme have impacted the operations. In the last ten years only one CEO has spent 1 full term and even he was unable to get a second term. The others have all spent less than 2 years either in full or acting capacity. This in itself has bedevilled the scheme's laudable initiatives' . (G026, NHIS official)

A former NHIS executive was critical of the actions of a former health official in high office who concentrated power to the extent that at some point, in the respondent's view, he singularly ran the NHIS:

> 'As a health economist, he had a clear blueprint to implement before he actually became the Health Minister. Given that the Minister had a very strong and well-

> articulated plan for the scheme he was rigid and determined to implement his plan. The perception was that he knew it all and we had to follow his plan. The Minister was able to give directives of a general nature and you were compelled to follow. The NHIS had no board so the Minister was essentially the board. Everything came from the Minister.' (G002, former NHIS Executive)

An external policy adviser also recalled a classic case of financial impropriety:

> 'One executive took the federal government to court and they couldn't remove him so he stayed through until the end of his tenure. They said that he left about 72 billion naira [approx. £140 million] in the coffers of the NHIS. This is evidence of underperformance; the scheme was not meeting the needs of as many people as it ought to have. A project to buy land by the NHIS for almost a billion naira went ahead without the approval of the federal executive council. This reflected an opportunity cost in that so many enrolees could have been joined to the scheme in place of this executive wastage.' (C004, External Policy Adviser)

Political power-play has significant bearings on major policy-initiative design and implementation, especially in the context of low and medium-income countries (LMICs). Ageypong and Adjei (2008:150), who investigated the impact of complex socio-cultural, economic and political interactions in the implementation of the Ghana NHIS, commented as follows:

> 'In the low-income developing country context, there can be imbalances of policy decision-making power related to strong and dominant political actors combined with weak civil society engagement, accountability systems and technical analyst power and position.'

Such political manoeuvrings vividly demonstrate propensities to abuse power, which derives from control of resources (Hardy, 1996; Alison, 1969). This phenomenon is discussed further in Chapter 8.

In a written submission (a secondary data source) to the Nigerian House of Representatives probe panel on the slow progress of the NHIS, Lambo (2013: 11), asserted that political

appointments made without due regard for relevant qualifications have had unintended consequences for implementation effectiveness:

> 'The Chairman of the NHIS governing council should not be a politician but someone whose educational background and working experience is in health economics, especially health financing/health insurance, so that he/she can effectively lead council in providing strategic direction to the management of the NHIS'.

A former health official also identified the preference of the NHIS leadership at the start of the scheme for centralised management as being in part responsible for the slow adoption of the scheme in the states:

> 'One of the things impeding the implementation of the scheme was that states were not being carried on. The states had little faith in the Central Government because they thought they were meant to enrol in the scheme centrally, so they were reluctant to part with the funds.' (G028, former Health Ministry Official)

Other health care observers have suggested that poor leadership is a major constraint to the successful implementation of NHIS. In an editorial in Health Insurance Affairs, Asoka (2010) remarked that :

> 'Poor leadership of the NHIS has been one of the binding constraints preventing rapid expansion of the programme. The absence of a figurehead makes the situation even worse. Management of the NHIS is quite pathetic, more so, the council over the years has failed to step up to challenge of providing effective policy direction to achieve results.' (Asoka, 2010)

To date, there is no evidence of a concerted effort by government to address the problems of discontinuous leadership at the NHIS. The problems may partly be due to political interference, but the present structure in which the NHIS is both operator and regulator does not augur well for effective leadership in the future. This subject is discussed further under implications of empirical findings for policy in chapter 6.

5.9.3 Sense-Making Revealing Positive Political Influence on Scheme Implementation

Some respondents recalled cases of actor sense-making suggesting positive receptivity to the direct use of political power by influential actors with immense power over resources. As table 5.3 shows, (n=7) respondents believed such actions were in the best interests of the scheme's implementation. A community insurance scheme official described the unique support she had received from a health commissioner in the quote below:

> 'What I enjoyed most was the support of the health commissioner, a public health person. I had just finished my MPH and I went to him with my proposal, which was to do a piece on community-based health insurance on willingness to pay, for example. He picked this idea and made it part of the state health reform agenda.' (G001, CBHI official)

Respondents also reported observations and personal experience of positive power contributions to scheme implementation derived from formal authority. One HMO executive drew attention to the unique insights of a particular minister, who used his position to give more traction to the implementation effort :

> 'The good thing was that we had a Minister who was a health economist who understood those aspects and was also against disproportionate spending on administration over the health services itself.' (H017, HMO Executive)

The accounts of these actors provide cogent evidence of positive contributions to scheme implementation through the use of formal authority. They constitute reconstructions of reality (sense-making), which legitimise authoritative actions – again underscoring the relevance of power and politics in the process of actor sense-making.

5.10 Other Policy Implementation Findings

As stated in section 5.1, emergent findings that were not directly relevant to the three research questions but were nonetheless significant to the study will be reported under other findings.

These findings again support the notion that sense-making is socially re-constructed, negotiated, and organised and therefore completes the loop of the hypothesis operationalised in the study's conceptual framework. The findings under this heading also provide insights relating to: sense-giving, gatekeeping, negotiation of policy implementation and NHIS design and implementation concerns. It is important to stress that findings under sense-giving have two component parts. The first revealing the power and political dimensions of sense-giving and the second highlighting sense-giving as a dialectic that completes the sense-making cycle.

5.10.1 Findings Relating to Sense-Giving Processes of Implementers

Sense-giving actions are defined as the process of attempting to influence the sense-making of others by redefining reality (Chapter 3). Findings relating to instances of HMCAN and HCPAN's sense-giving influences on aspects of the implementation of the NHIS are presented below.

5.10.2 Sense-Giving by HMCAN

In several ways, HMCAN influenced the implementation of the scheme through sense-giving capacities. it's leverage, to reiterate, stemmed from it's better grasp of the health insurance business. One particular HMO Executive and HMCAN activist (H012), affirmed that their sense-giving role went beyond the pursuit of HMO interests. According to him, it encompassed watchdog functions such as monitoring implementation to ensure no derailment of the fundamental objective: namely, to provide universal health coverage to Nigerian citizens:

> 'We realised it was necessary for us to come together as a body to articulate our aims and objectives as industry players and then present ourselves to the public. Part of what we also tried to achieve was setting standards for the industry because in anything that you do, Nigeria especially, it seems as if this is what 'everybody' wants to be a part of. We are also there as watchdogs so that the government program is not derailed by people who have their own agenda. It is a lobby group and a pressure group to advise government on how to turn this into a universal concept that can improve the health care indices of the country.' (H012, HMO Executive/HMCAN)

Another HMO executive (H017) acknowledged the power of information wielded by HMOs but asserted that a positive side to that power was that it was channelled towards greater enlightenment of other participants through sense-giving. Two quotations excerpted from his interview reveal the logic behind his assertions. First that:

> 'The HMOs were better informed about the scheme and as such had an unfair advantage, which was why we were trying to educate providers, because without doing that, we would not be able to percolate ideas. Sometimes when you are doing this sort of stakeholder engagement, proper representation is not there, it is always skewed on the side of the government or NHIS sometimes.' (H017, HMO Executive)

He also added that:

> 'The little progress we made was forced out of them. Even the concept of how the NHIS as it is being run now did not come from them. They saw quickly that the model they wanted to run would not work. And we had an actuarial model to prove it.' (H017, HMO Executive)

This apparently valuable sense-giving role of HMCAN is, however, undermined by charges that it was orchestrated to drive the agenda of a just a few HMOs since many HMOs who had doubts about the motives of HMCAN did not join the association:

> 'We share experiences and ideas. There were concerns in the industry about the dominance of HMCAN, the association of HMOs, because not all HMOs were members of this union – the Health and Managed Care Association of Nigeria (HMCAN). This organisation purports to be the voice of all HMOs but it merely drove the agenda of a few people who were opposed to the superior business model that Hygeia proposed at the time.' (H023, HMO Executive)

The above comments provide evidence of the micro-political play between HMCAN and HMOs who did not buy into HMCAN's agenda for HMOs. This political dynamic culminated in a power contest. In this case, a contest over meaning — all of which were essentially about shaping perceptions, cognition and preferences. The reference to the superior 'business model of Hygeia' (an upper tier HMO) by H023 exemplifies an attempt to shape perception since his

comments suggests that the business models of other HMOs were inferior to that of Hygeia. The upshot of this finding is that a few HMOs under the auspices of HMCAN dominated the agenda of HMOs. This imbalance of power strongly endorses the notion that sense-giving is in essence a political process (Maitlis and Lawrence, 2007; Filstad, 2014).

If the position of the body of research that postulates that sense-giving is a political process is accepted, then it becomes easier to understand why HMCAN has been able to drive the global HMO agenda inspite of many HMOs not being members.

5.10.3 Sense-Giving by HCPAN

The findings also reveal that HCPAN, the health care provider's trade association, played a sense-giving role in the scheme's implementation, albeit to a lesser degree than HMCAN. Again, it must be reiterated that HCPs were resource-dependent given that HMOs were their payers. The privileged control of HMOs over financial resources meant that the balance of power was in their favour. Nonetheless, HCPAN's sense-giving role could not be discounted.

One external policy adviser suggested that HCPAN has had a measurable degree of influence over micro-level implementation issues, such as the review of capitation fees that followed the concerted effort it mounted. HCPAN, however, has been far less effective in influencing broader changes in NHIS implementation:

> 'The General Practitioners association has been very vocal and successful in bringing about changes as far as micro-level service issues are concerned; but HCPAN has been less successful with macro issues, such as getting the NHIS to regulate the industry better.' (C004, External Policy Adviser)

Another HCP also referred to the successful push for an upward review of capitation fees as an instance of sense-giving by HCPAN:

> 'We were told by the NHIS that where we had issues, we were to bring it under the provider's platform such as HCPAN where it would have more weight than individual doctors voicing complaints. Like I said earlier, they are listening better. We are not where we should be but things are improving. The scheme started with 550 [local currency] but rose to 750 after 5 years and this was from pressure. They listened to the fact that some government teaching hospitals should not be allowed to have primary care patients, which results in competition with us. They have accepted that in principle because it is not necessary for them to compete with us.' (P005, HCP)

The sense-giving role of HCPAN in raising the level of capitation payments to providers was acknowledged by yet another HCP:

> 'They have an association for providers organised by doctors who agitated a lot over the capitation not being sufficient to provide treatment.' (P014, medical provider)

The fundamental point here is that sense-giving is not necessarily about the degree of influence it brings to bear on policy. Although the sense-giving role of HCPAN was not of huge significance, the role it played in the review of capitation fees to HCPs was an important one. This is discussed further in chapter 6

5.10.4 Gatekeeping

In Chapter 3, I explained that the inclusion of gate-keeping as a component of my conceptual apparatus drew upon the insight of Coburn (2001) who in her research described gatekeeping as one of three sub-processes that 'characterise and facilitate' collective sense-making, constructing understanding through interpersonal interaction, gatekeeping, and negotiating technical and practical details' (Coburn, 2001:154).

Gatekeeping is an important dimension of this research because of it's critical relationship with message selectivity. Coburn argues that not all policy messages will be accurately understood and implemented by agents – implicitly suggesting that in the process of sense-giving, some

messages permeate through and others filtered out. Instances of message selectivity by key actors were discernible from the responses of respondents, especially within the HMO/HMCAN group.

One HMO executive cited an instance in which HMO/HMCAN gatekeeping provided the rationale for a crucial NHIS implementation decision. In that instance, the HMCAN position prevailed because of it's superior technical grasp. Describing the initial tensions between NHIS management and the HMOs in reaching agreement on the ideal model to run the scheme on, he recalled that:

> 'They saw quickly that the model they wanted to run would not work. And we had an actuarial model to prove it. So by default of the NHIS, the basic framework and most of the operational aspects, payment mechanisms and even the benefit package that was agreed on etc. were designed by HMOs.' (H017, HMO executive)

A former government health official also recounted another example of gatekeeping which involved HMCAN surreptitiously mobilising public opinion against NHIS management prior to an important meeting, forcing the hands of the latter:

> 'There was a paid advert in a national newspaper put up by HMCAN on it's perceptions on the challenges and inadequacies of the NHIS and the intention of the advert was to reveal them to the public. The NHIS did not have prior notice of this advert but at the subsequent meeting we decided that the issues raised in the advert should be the agenda of the meeting. At the end of the day, we concluded that their concerns were just a matter of misunderstandings between them and the NHIS. The capitation charge and fee for service was influenced by feedback from HMOs.' (G016, former government official)

Arguably, the root causes of the above misunderstandings can be ascribed to message selectivity. HMCAN decided on what to select from the policy message and filtered out others. G016 did not see the basis for HMCAN's distrust of the motives of the NHIS a – point he

buttresses with the demonstrable transparency the NHIS exhibited when it adopted HMCAN's concerns as the agenda for their joint meeting.

5.10.5 Negotiation of Policy Implementation

The hypothesis of this research, as operationalised in it's conceptual framework, is that the negotiation of policy (with favourable expectation) is the central aim of all sense-making, sense-giving, and gatekeeping processes of CoP members (chapter 3). Evidence supplied by respondents suggests that top-down authority (NHIS formal authority and institutional backing) was used at various fora to blunt the capacity of key stakeholders (HCPAN/providers, and HMCAN/HMOs) to negotiate. One example of such manoeuvring was cited by an HMO executive. According to him, NHIS officials at some point attempted to use their authoritative position to split the ranks of stakeholders :

> 'We formed a tripartite committee, made up of HCPAN, HMCAN, the NHIS and NECA (National Employees Consultants Association). We were meeting on a regular basis, but as usual, NHIS wanted to use divide and rule tactics.' (H012, HMO executive)

Another HMO Executive confirmed the negativity of NHIS officials to stakeholder deliberations:

> 'There is a stipulation whereby NHIS must meet HMOS. NHIS only call meetings to insult HMOs; they are negative and rarely did cross-discussion bring about policy change.' (H013, HMO Executive)

Regardless of the above views, there is some evidence to suggest that some of the negotiations led to positive outcomes. For instance, sense-giving and gatekeeping helped persuade NHIS officials to reach agreements with stakeholders on some operational issues such as the clamouring for a rise in capitation fees as discussed earlier (sections 5.8.2) in which one HCP stated that under the auspices of HCPAN, HCPs were able to demand and successfully negotiate an increase in capitation fees for their members.

As discussed in chapter 1 (sub-section 1.1), I anticipated that a cognitive approach to this research would bring to light findings that will uncover other dimensions of the implementation of the NHIS. Compelling evidence suggesting that the design of the NHIS was fundamentally flawed from the start, was a resonant finding and I analyse those perspectives in the next sub-section

5.10.6 NHIS Implementation : Design Flaws and Missed Opportunities

Findings from the study's primary and secondary data revealed widely expressed concerns about the design and implementation of the NHIS. In retrospect, failure to anticipate these concerns *ab initio* had unintended consequences for the successful implementation of the scheme. Concerns about the NHIS Act itself were in two strands. First, (n=6) respondents believed that growth of the scheme has been hindered by a weak enabling legislation that failed to take into account the status of Nigeria as a country comprised of semi-autonomous federating units. Differently stated, the enacted scheme was not made mandatory for all Nigerians. The second impediment identified, relates to the ambiguity in the NHIS Act itself that allowed the NHIS the latitude to function both as a scheme regulator and operator – making way for their encroachment into the business of HMOs. This was widely regarded by HMOs/HMCAN as a significant barrier to the scheme's prospects.

Closely linked to criticisms of the act were observations made by (n=11) interview respondents to the effect that the strategy for implementation was wrongly focused. The logic behind prioritising implementation in the formal sector over the informal sector group with a disproportionately higher need for health care access, and the decision to involve HMOs in the implementation process were widely questioned. These issues could have been mitigated at the design stage if enactors recognised earlier on, that despite the value proposition of social health insurance as a blueprint for UHC in LMICs – for implementation to be successful, implementers

need to take into account local contextual factors. Enactors should also have directed their attention to, and recognised that the power asymmetries among the stakeholder groups especially those that skewed resource control were a potential impediment to successful policy implementation. NHIS implementers could have conducted pilot studies to understand the perceptions, motivations and beliefs of different stakeholder groups in order to better align incentives. Chapter 6 discusses these design flaws further. With the benefit of hindsight, these design problems were not insurmountable had the blueprint for the scheme been subjected to extensive scrutiny as part of a due diligence exercise.

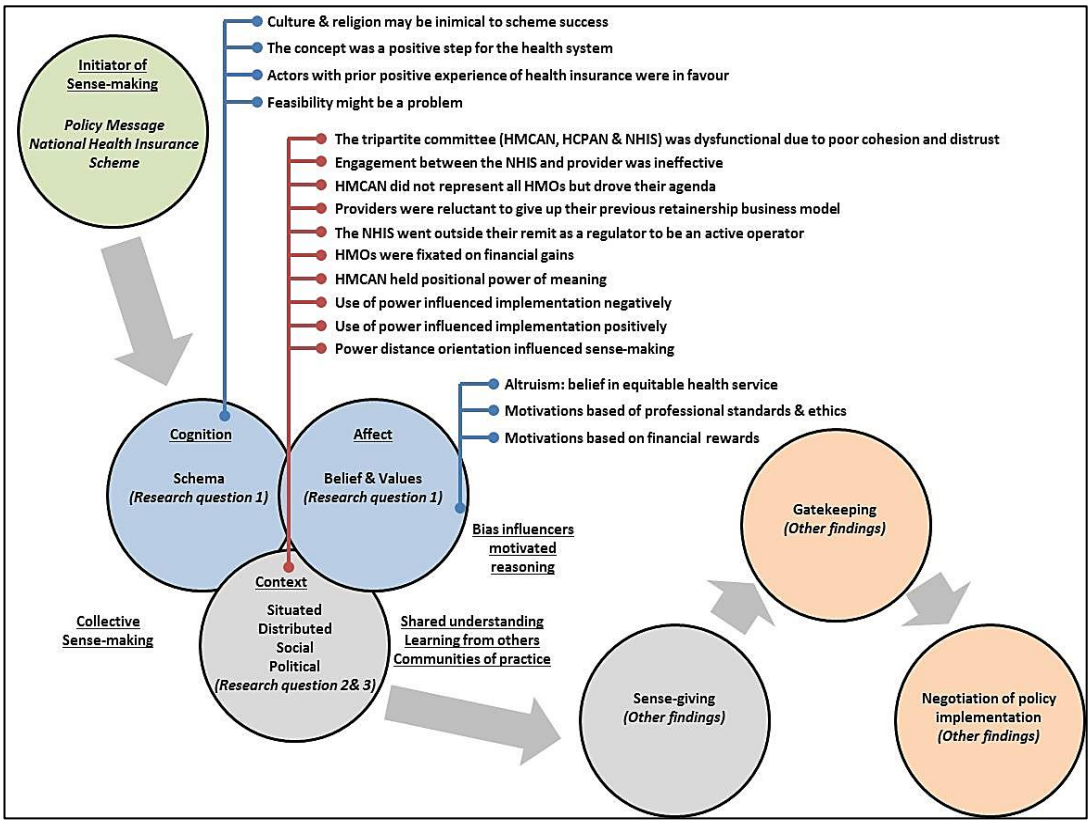
5.11 Summary

Findings presented in this chapter empirically demonstrate that cues based on individual cognition and affect resulted in different policy-message framings (sense-making) by NHIS actors. Cues based on individual cognition also pin-pointed some cultural issues as likely impediments to implementation, influenced views about the concept of health insurance, and raised broad concerns about scheme feasibility. With respect to affect, we observe two sides of motivated reasoning (a component of affect) in evidence. Motivated reasoning was at the core of the sense-making of actors whose persuasions were based on a belief in equitable health care coverage, as well as those whose goals are purely financial. The observed variances in the motivated reasoning of respondents confirms the notion that the same policy message can be interpreted differently by actors, and furthermore, suggests a selective extraction of cues *a priori* (Spillane et al., 2002). The case study also revealed that individual interpretations of the NHIS policy message were impacted by cognition and affect to varying degrees

The findings suggest that sense-making from shared understandings within each Communities of Practice (CoP) of NHIS officials, HMOs and HCPs were for the most part self-serving — confirming that their central interests were divorced from the larger goals of the NHIS

Expositions of the influences of macro and micro political dynamics on actor sense-making in the implementation of the NHIS was a key finding. It is however important to note that not all the respondents viewed the exercise of power (without due process) in a negative light. Some of the actors found them justifiable in as much as such actions achieved certain objectives. This finding is of contemporary significance in sense-making research because the role of power and politics in sense-making has been identified as an under-researched area in the literature (chapter 3). Finally the findings also revealed that power and politics influenced the sense-giving processes of actors — enabling some key actors were to impose on the sense-making of others to drive certain objectives. These findings as summarised in Figure 5.2 provide answers to the study's research questions

Figure 5.2. - Conceptual Framework with Annotated Findings Relating to Research Questions 1, 2 & 3



Source: Fawehinmi primary data (2018)

In sum, the purpose of this chapter was to present the findings from the analysis of the primary data from the participant interviews conducted. In presenting the findings, the researcher triangulated the primary evidence with secondary (documentary) data, relating both to the extant literature to strengthen this study's empiricism. More crucially, the chapter, revealed findings that highlighted design flaws in the NHIS at conception. The next chapter discusses the above empirical findings in the context of established research, focusing on theoretical and methodological contributions and implications for policy and practice.

Chapter 6 Discussion of Findings

6.1 Introduction

This discussion follows on from the presentation of findings in the previous chapter. In this chapter the focus is on drawing out the relationships between empirical findings and the existing literature on sense-making theory and other theoretical components of the conceptual framework. From a policy design perspective, the chapter also discusses the impact of the enabling NHIS legislation and governance arrangements on the implementation of the reform. The last segment of the chapter discusses the implications of the findings for theory-building, policy, and practice. The discussion is necessarily thick to facilitate a deep understanding of the data.

6.2 Summary of Key Findings

This chapter starts with a recap of the findings presented in the previous chapter as a preface to the discussion of their contributions to knowledge and implications for theory and practice. The key findings covered themes revealing sense-making in the individual and wider context (situated, distributed and social), operationalised through the political context, communities of practice (CoPs) and institutions in this NHIS case study. The findings are summarised as follows:

1. Cognition and affect resulted in different framings of the policy message by different policy actors.

2. The findings revealed that the communities of practice (CoPs) became silos of self-interest. The drawback of this was that they became disconnected from the larger goals of the NHIS, and consequently had a negative impact on policy implementation.

3. Power and politics within the Nigerian health care system (government and private sector interest proponents) influenced actor sense-making.

4. Sense-making in distributed contexts, mostly through informal learning situated in CoPs, was influential to policy implementation.

5. Sense-giving by HMCAN/HCPAN influenced certain policy decisions taken by NHIS officials.

6. Value of negotiations between HMOs and NHIS officials in the implementation process was limited.

7. The impact of gatekeeping was insignificant.

8. The NHI scheme design, especially with regards to the NHIS Act itself was faulty and scheme implementation was poorly articulated.

9. The remit of NHIS was ambiguous resulting in contentions about non-conformity and mandate overreach.

6.2.1 Cognition and Affect

Findings from the study revealed instances when actors extracted similar cues from certain aspects of the NHIS policy but individual logic behind the interpretation of such cues varied significantly, resulting in different framings of the same message. Put differently, the individual logic behind the interpretation of such cues varied according to the strength of what influenced their mental schemas more — cognition or affect (both hallmarks of the individual sense-maker). The observed variation(s) in the framing of cues is consistent with the perspective in sense-

making theory that suggests that prior experiences and pre-existing schemas are unique to individual actors. As Spillane et al. (2002: 394, citing Weick, 1995: 34) noted, variations will occur because 'what is novel is always seen in terms of past understandings' and 'in large part, people generate what they interpret, they create the environment and select the cues and signals that they interpret'.

The impact of affect (the individual's values, beliefs and motivated reasoning) was particularly pivotal in such framings. Affect, more than cognition, was responsible for the different framings of aspects of NHIS policy, such as expressions of altruistic beliefs about the inequity of out-of-pocket health expenditure for the poor; values about high professional standards; and motivations about financial remuneration. The actions of NHIS actors highlight the difficulty of disengaging from hard-to-restructure biases embedded in pre-existing structures (Quinn, 2009). It is on this basis that they assigned a higher weighting to tangible and familiar experiences.

6.2.2 The Communities of Practice of Policy Actors: Identified disconnections

Overriding self-interest within each of the Communities of Practice (CoP) resulted in disconnections from the larger goals of the NHIS. Shared understandings within each of the CoPs mostly served to reinforce their paramount self-interest in the NHIS – with less attention paid to the wider social objectives of the scheme. Extant research posits that the situated learning which occurs in CoPs shapes actor sense-making (Lave and Wenger, 1991; Coburn and Stein, 2006). The findings of the study exposing the dominant logic of self-interest featured within each of the three CoPs are unpacked as follows:

1. HMCAN/HMO community

The shared concern of HMOs/HMCAN behind their fixations on financial gains as well as their scant interest in the social aspect of the scheme explicates Spillane et al.'s (2002: 406) view on CoP theory that:

> 'As members of a community interact over time on problems of shared concern, they negotiate meanings about the nature of their work and in some instances shared understandings about what they need from outsiders to do their work well.'

This stance of the HMOs/HMCAN cannot be said to have developed from new learning given that their financial interest was an entrenched position before the fact – since many proponents of HMOs were medical practitioners of an entrepreneurial bent (chapter 2) and had internalised business practices under the retainership delivery model.

2. NHIS officials community

The conduct of NHIS officials with respect to their position on a number of NHIS implementation issues also exhibited patterns in line with the principal tenets of CoP theory. Sense-making within central NHIS officials CoP exposed problems of remit clarity and mandate overreach. A number of respondents accused the NHIS of non-conformity with their core remit as regulators of the scheme (chapter 5). Added to this were allegations of arrogance regarding their relationship with other stakeholders. A case in point was the poor receptivity of NHIS officials to the demands of HCPs/HCPAN when operational or service delivery issues were brought to their attention. All these drawbacks, including institutional constraints, which arguably may have been foisted on NHIS officials by their organisational and bureaucratic schemas, resulted in conduct inimical to the goals of the scheme.

3. HCPAN/HCP community

The HCPs, as the findings showed, were more overtly concerned about perceived threats to their financial prospects. Many were more comfortable with the erstwhile retainership model, and were less inclined to embrace a new system (chapters 2 and 5). Alford's (1975) thesis on structured interests provides academic explanations for the stance of the Nigerian HCPs. In Alford's (1975: 195) study of the role of interest groups in the politics of health care (see chapter 3), he categorised medical providers as professional monopolists who: 'By and large are satisfied with the status quo and do not form part of the market reformers, who regard them as performing the core health functions'.

His findings are applicable to the Nigerian situation given that HCPs generally preferred the retainership system and initially did not welcome the new HMO-led model of service delivery. Over time, they saw the positives of the scheme. Health policy reform scholars have asserted that the typical challenge in any new policy initiative is to win over the support of medical practitioners. In the context of the UK, Ham (2004:10) supports this assertion with reference to the negotiations between the UK government and doctors when the UK National Insurance Act was introduced in 1911, and subsequently passed into law in 1913. As Ham (2004:10, quoting Gilbert, 1966:290) notes: 'The story of the growth of national health insurance is to a great extent the story of lobby influence and pressure groups'. Furthermore, Ham (2004:10) adds that:

> 'Lloyd George pushed through the Act to come into operation in 1913, but only after considerable opposition from the medical profession... They were persuaded into the scheme when the government agreed that payment should be based on the number of patients on a doctor's list, the capitation system, rather than on a salary, thereby preserving GPs' independence'.

The actions of George as afore-described, have striking similarities with those pragmatically taken by the Nigerian Health Minister to get the NHIS started in 2003 (Chapter 2).

6.2.3 Distributed Sense-making in CoPs

Conceptually, distributed sense-making spans boundaries – traversing apparently mutually exclusive CoPs. Interactions across NHIS CoPs were, however, too contentious for effective sense-making. This hindrance was borne out of relational tensions and sustained by competing interests, structural conflicts, mutual suspicion, transparency issues and poor governance. HMO under-representation in HMCAN was a significant problem, and the association was seen as serving the interests of a few HMOs. The complication, however, was that in terms of technical expertise, the balance of power was with the HMOs (chapter 2). That leverage was however off-set by their lack of experience in dealing with public sector officials.

6.3 NHIS Implementation by Other Means: Contextual Perspectives on the Role of Power and Politics

Power and politics affected the implementation of the NHIS in many dimensions. The findings of this study reveal that power was in many cases deployed to promote the self-interested agenda of those who controlled the power of resources and power of meaning (information asymmetries). That notwithstanding, there were also instances where the use of power was seemingly altruistic.

In chapter 5, the multi-dimensionality of power and politics in the implementation of the NHIS scheme was espoused. Situations of deployment of power that were deemed altruistic or negative imposed new understandings on other policy actors by altering their pre-existing cognitive frameworks. In the context of this study, we can infer that control of resources was the key source of power.

1. NHIS implementation: Positive power influences

Some respondents cited instances where direct use of power, mostly by government officials, favoured their implementation objectives. This explicitly demonstrates that the sense-making of these implementing agents has been altered so much that they found themselves agreeable to interventions that should have been unnecessary had the implementing arrangements been fit for purpose in the first place. Such endorsements suggest a power distance orientation that accepts such actions as legitimate (chapter 3). This phenomenon has significant implications for theoretical development and policy practice and I expand on it in chapter 7.

2. NHIS implementation: Negative power influences

Actor sense-making underpinned the narrative that certain actions of high-level government officials were deeply political and negative to the goals of the NHIS (see chapter 5). Examples of such unacceptable conduct included power concentration, financial misappropriation, politically motivated appointments of under-qualified individuals, and premature termination of the service tenure of out-of-favour NHIS chief executives. All of these made the implementation of the NHIS more challenging. This, however, is not a uniquely Nigerian situation. Agyepong and Adjei (2008: 158) observed in their Ghanaian study that:

> 'The stronger power position of political actors to control and direct the policy process, combined with some political sense of insecurity and therefore relatively non-discriminatory reliance on trusted political associates for technical guidance, alongside the weaker power position of technical and other interest group actors, somewhat weakened the checks and balances inherent in a democratic system to protect the processes of a reform genuinely in the public interest.'

The influence of power (deriving from control of resources) on sense-making (Hardy, 1996; Alison, 1969) alerts us to Weick et al.'s (2005) and Mills' (2003) perspective that the rich and powerful are advantaged and have access to positions where they can influence sense-making through constructions of reality. As Vlaar et al. (2006: 1629) concur: 'The creation of new

understandings is not free of power and self-interested behaviour'. The rich and powerful in the context of the NHIS are top ranking officials of the health ministry and the NHIS, and influential HMO executives under the auspices of HMCAN. By exercising their power (over resources), NHIS officials were able to drive certain self-interested objectives, whereas HMO/HMCAN executives advanced their business interests through the deployment of a different form of power that derived from technical expertise in health insurance.

3. Controlling the power of meaning: HMCAN's information asymmetry leverage

HMCAN, the HMO trade body to reiterate, wielded asymmetrical power in the NHIS implementation process due to the strength of it's superior knowledge of the business of health insurance – which conferred on it positional power of meaning (chapter 5). HMCAN effectively exploited this advantage to influence the implementation of the scheme in favour of the HMOs. To recall, the proponents of HMCAN's agenda at the start of the NHIS, were mostly medical entrepreneurs who had identified an opportunity to maximise financial gains in the business of HMOs (chapter 5). To put this point in academic context, Vaghely and Julien (2010:73) suggest that the process of 'opportunity construction' which follows opportunity identification is based on social constructionism. Social constructionism (chapter 3) is relevant to this study because sense-making is essentially a social construction of reality, which supports the proposition that HMCAN/HMOs for the most part interpreted, enacted and processed information pertaining to the scheme through the prism of their business interests. The constructionist perspective, according to Vaghely and Julien (2010: 73):

> 'Relies on a trial-and-error or heuristic model. Entrepreneurs process information in an interpretive way; they construct their reality by using information from there. To share information, create new knowledge and innovation and construct opportunities, the entrepreneur must justify the beliefs that are based on that information […] this they combine with patterns of information based on their experience to identify opportunities.'

In practical terms, HMCAN's actions were political to the extent that they were able to exercise power that did not enjoy the broad support of all HMOs. This capacity confirms the notion that sense-giving (the dialectic of sense-making) is a political process.

6.4 Sense-Making in Social Contexts: Informal Learning Pivotal to NHIS Implementation

The findings under this heading reveal much alignment with previous research suggesting that sense-making in policy implementation is also influenced by informal actor-interactions. In the NHIS, the setting for shared sense-making was mostly in a non-system context, specifically in a nexus of professional affiliations (Spillane et al., 2002; Clarke, 1983; Van Maanen and Barley, 1984). The value of such interactions lies in the social (informal) learning opportunities provided through meaning construction. Two HMO executives, for instance, recounted how exchanges between them and a World Bank official at an international conference became pivotal to their understanding of health insurance. Another HMO executive recalled how he successfully won over a group of sceptical HCPs about the benefits of health insurance. Such findings validate theoretical postulations about the influence of the social contexts in sense-making.

6.5 Situating Sense-Giving in Policy Implementation

The data provides evidence that HMCAN and HCPAN were able to influence certain decisions of the NHIS, especially in the area of capitation payments through their advocacy of positions that were again re-definitions of reality or sense-giving — the latter being the process of attempting to influence the sense-making of others (Gioia and Chittipedi, 1991:442; Huzzard, 2003; see chapter 2). If we recall Weick's statement that sense-making begins with the rhetorical question: 'how can I know what I think until I see what I say?' then implicitly, it is through sense-giving that we know what the sense-maker is thinking (Smerek, 2009). Sense-giving is evident in exchanges between NHIS policy actors but the value of such exchanges was underutilised.

HMCAN acted in various sense-giving capacities to educate NHIS officials and other participants. Regardless of the apparent value of such contributions, the criticism that HMCAN did not speak for all HMOs continued to raise questions about the legitimacy of it's actions. Sense-giving by HCPAN was more limited, although it did bring about some micro-level changes such as the decision to raise capitation fees.

6.6 Effect of Gatekeeping in NHIS Implementation

Gatekeeping in the NHIS was evident in terms of message filtration and selectivity (Coburn, 2001). Overall, the impact of gatekeeping on implementation was insignificant. Although there is much overlap between the concepts of sense-giving and gatekeeping in the NHIS, the differences are far from subtle. A good example of gatekeeping was when HMCAN's advocacy for an ideal implementation model for the NHIS prevailed because NHIS officials deferred to it's superior technical knowledge. There was also an example of gatekeeping through agenda-setting by HMCAN. In this instance, queries about NHIS operations/motives raised by HMCAN in a national newspaper publication were promptly adopted by the NHIS as the agenda for a joint meeting (sub-section 5.10.4).

6.7 NHIS Implementation: Limited Value of Negotiations

Negotiations were hindered by the inflexibility of NHIS officials who viewed the motives of HMOs with suspicion. The parallel distrust between HCPs and HMOs also did not augur well for such negotiations. In sum, a common ground could not be reached over many implementation issues. Findings pertaining to negotiations of implementation demonstrate how the imposition of top-down authority by the NHIS blunted the capacity of key stakeholders to negotiate. The findings suggest that NHIS officials were too authoritarian to engage in meaningful deliberations, preferring a *modus operandi* of divide-and-rule to split the stakeholders' ranks (chapter 5).

Nonetheless, HCPAN successfully negotiated an increase of capitation fees for HCPs. The details of negotiations about capitations are not publicly available but vignettes derived from Onoka's (2014: 164) doctoral thesis (documentary source) provide insights into the contentions around capitation payments that preceded the negotiations.

Onoka (2014) explained that HCPs were drawn towards capitation payments because of the attraction of guaranteed income, which allowed them to manage their cash flows better. However, cost control/recovery imperatives led to selectivity in the use of the capitation mechanism by both HMOs and HCPs vis-à-vis Social Health Insurance (SHI) and Permanent Health Insurance (PHI) plans. In concrete terms, HCPs did not want to sign up to a capitation fee arrangement if there were fewer than 50 registered members from a particular HMO. The HMOs, on their part, were uncomfortable with capitation payments for SHI plans that covered a large number of enrolees. In contrast, they preferred fee-for-service arrangements for PHI plans in which the pools were much smaller. In other words, the selectivity of the HCPs regarding payments was consistent with the economic idea that positive financial returns correlate with larger-scale operations. One complaint of HMOs was that HCPs did not – as stipulated by their contractual guidelines – make service utilisation data available in a timely manner, hence it was difficult to assess the adequacy of the level of existing capitation payment arrangements. Furthermore, the evidence suggests that HMOs exploited the unwillingness of HCPs to provide service utilisation data to resist the clamouring of HCPs to raise capitation rates. The convincing argument in the negotiations of HCPs in pursuit of an upward review of capitation rates was described by one of the interviewed external policy advisers:

> 'There was a time I really raised issues at many places before they finally decided to raise capitation for primary care. Over the years, since inception of the [NHIS] scheme, the Government salary [salaries] had increased by up to three times. Capitation was 20% of salaries and remained stagnant even though salaries had increased markedly. I challenged NHIS to review the level of Capitation payments as was expected under the Act and they finally added 200 naira [local

currency about £4] to the 550 naira [about £10.50] capitation' (C004)

What C004's comments convey is that policy negotiation is in essence about bargaining. As Barrett (2004:253) suggests, it is a 'policy action' dialectic which entails negotiation and bargaining between those charged with effecting policy and those who the action depends on:

> 'The political processes by which policy is mediated, negotiated and modified during it's formulation continue in the behaviour of those involved in it's implementation acting to protect or pursue their own values and interests. Policy may thus be regarded as both a statement of intent by those seeking to change or control behaviour, and a negotiated output emerging from the implementation process'.

Viewed through this lens, negotiating parties will naturally be determined to pursue their values and interests, but the purpose of meaningful negotiation is for parties to come to a fair agreement on issues. The disposition of NHIS officials towards negotiations, it can be argued, fell well short of Barrett's normative stance.

6.8 Theoretical Implications of the Study: Contributions to the Literature

Potential theoretical contributions to sense-making theory emerged in the course of analysis of the data in the following under-researched areas: sense-making and community of practice, the role of power and politics in sense-making and sense-making and institutional theory.

1. Community of practice theory: Ambiguity and theoretical incoherence

In considering the linkage with sense-making theory (see chapter 2), and CoP theory, I cited Benn's (2004:65) view that CoPs provide us with a 'naturalistic context' for understanding sense-making. CoPs are a social learning system – a group process in which collective meaning emerges from the influence of individual perspectives on other group members. Situated learning theory (Lave and Wenger, 1991) also suggests that in a CoP, individuals learn by adopting practices (values, norms and relationships) that are in alignment with those of that

particular community. Whereas individual sense-making focuses on 'what goes on in individual heads', CoPs are more about emergent collective sense-making from 'practices of groups' (Weick and Westley, 1999:442). The study's theoretical implications for CoP theory are in two strands: first, it challenges the core assumption of homogeneity within CoPs, and second, it confirms the theoretical postulations of the literature on power relations in CoPs.

a) Communities of practice theory: Rethinking the notion of homogeneity

Researchers have empirically demonstrated fluidity in CoP membership. Spillane et al. (2002) note that people may, by religious affiliation, social class membership, professional identity or political leaning, belong to multiple thought communities, while Coburn and Stein (2006) claim that policy often has to traverse boundaries of thought communities. This phenomenon was confirmed during the interviews with policy actors. For example, in chapter 5, it was reported that interviewee H012, an actor who belonged to two CoPs by virtue of being a HMO executive as well as a proprietor of a private hospital, explained that he set up his hospital because 'quality of care mattered to him more than profit'. From his narrative, his aspirations are apparently in conflict but his views must be understood in the light of his membership of two 'thought communities': HMOs, and HCPs. Wenger's (1988: 169) view on communities of practice helps our understanding of H012's stance:

> 'We engage in different practices in each of the communities of practice to which we belong. We often behave rather differently in each of them, construct different aspects of ourselves and gain different perspectives.'

Interviewee H023, an HMO Executive, also noted that a number of HCPs did not enjoy clinical practice and were more drawn towards HMO business because of the prospects of better financial returns. Again, we have a clear example of individuals portraying attitudes of a CoP other than that to which they apparently belong. H023's view that some HCPs find the corporate image of HMO executive more appealing than clinical practice, emphasises the role of identity,

especially identity construction and the notion of self, in CoP theory. In a perspective on the identity dynamic, Handley et al. (2006:644) suggest that: 'The project of the self goes some way to explaining how the nature of individuals' participation (for example, in a workplace community) influences their understanding of "self ''.

These examples suggest that the assumption of homogeneity in CoP theory is problematic. Handley et al. (2006: 642) also views CoP as inseparable from the socio-cultural context in which individuals are located:

> 'The cultural richness of this broader context generates a fluidity and heterogeneity within communities which belies the idealisation of communities as cohesive, homogenous social objects.'

From the narratives of H012 and H023, we observe aspirational conflicts that reinforce the view of situated learning theory that there are 'possibilities for variation and even intra-community conflict' in CoP theory (Handley et al., 2006:642). Such conflicts, according to Handley et al. (2006) 'need to be negotiated and reconciled at least in part if the individual is going to achieve a coherent sense of self' (2006:642). This study challenges the assumption of homogeneity in CoPs by it's empirical demonstration of fluidity with CoPs.

b) Community real practice: Relevance of power as a dynamic

A common criticism of CoP theory is that it under-explores issues of power within such communities (Contu and Willmott, 2003; Lave and Wenger, 1991). The findings in this study relating to the dimensions of power relations in the NHIS identified these dimensions and contribute to the existing research on this subject. To better understand power relations within CoPs, it is helpful to reference Roberts (2006), who posits that:

> 'An organisation's overall power structure may be reflected in power relations within it's communities of practice. For instance, in decentralised network type organisations, where power is distributed, one might expect to find greater

> variety in the possible range of knowledge created and shared. Whereas in hierarchical organisational structures where power is centralised, negotiation may be limited to key figures of authority within the organisation, the voices of members of a community may be somewhat muted.' (Roberts: 628)

To put Roberts' (2006) comments in context, HMOs, as the findings reveal, were under-represented in HMCAN, yet the latter essentially drove the agenda of the former. HMCAN wielded this degree of influence because a caucus of HMO executives at the helm of HMCAN were more knowledgeable on the business of health insurance than other HMO executives. Put differently, HMCAN's power of meaning through knowledge dissemination created unequal power relations within the community of HMOs. A full understanding of HMCAN's influential role requires a sound grasp of established research on power dynamics in CoP (Contu and Willmott, 2003; Lave and Wenger, 1991; Roberts, 2006).

Roberts (2006:627) also suggests that recognition of the role of power in the process of meaning negotiation is important because 'communities of practice will include members of varying standing in terms of experience, expertise, age, personality authority within the organisation and so on'. Lave and Wenger (1991:37) used the phrase 'legitimate peripheral participation' to describe how the power dynamic plays out in CoPs. As they grow in knowledge and skills, new or novice community members move from peripheral positions to full participation, at which point they acquire more power and influence over the negotiation of meaning. There are, however, problems associated with legitimate peripheral participation. The power rationale that views peripheral or implicitly limited participation by novices as justifiable has negative consequences for situated learning. As Contu and Willmott (2003: 285) argue:

> 'It is clearly difficult, if not impossible, to learn a practice and thereby to become an (identical) member of a community of practice, when power relations impede or deny access to it's more accomplished exponents; and conversely, power relations can enable access to these learning practices.'

Power relations matter because if they are unequal, the power differential confers on some CoP participants a 'hegemony over resources for learning' (Lave and Wenger, 1991:42). This explains how and why HMCAN wielded it's hegemonic power. The observed imbalance of power within the ranks of HMOs as empirical evidence of unequal power relations in CoPs is the second contribution that this study makes to CoP theory.

6.9 Beyond Hofstede: Implications of Power-Distance Orientation for Sense-Making Theory

Power-distance orientation (Kirkman et al., 2009; Chen et al., 2013; Chen and Ayree, 2007) is relevant to this research because Nigeria is a high power-distance country. This was discernible from the assumptions, attitudes and conduct reflected in the narratives of this study's interviewees (Helpap, 2016). The literature on the role of power-distance orientation on sense-making is rather scant because the relationship between them has been largely unexplored. The findings of this study contribute to the current literature in this nascent sub-field of inquiry.

The sense-making research canon has espoused it's relationship with power and politics (Mullen et al., 2006; Mills et al., 2010; Maitlis and Christianson, 2015; Weick et al., 2005; Weber and Glynn, 2006; Vlaar et al., 2006; Hope, 2010). However, not much is known about the part played by power-distance orientation in sense-making. In exploring the links between power-distance orientation and sense-making, I was much influenced by the work of Helpap (2016:9), who suggests that: 'Sense-making serves as a conceptual bridge between individual values, such as power distance orientation and change commitment in organisational change'

To further understand the link, I drew upon Weick and Daft's (1984:291) sense-making selection model and the notion of 'assembly rules', defined as 'procedures or guides used to process data into interpretation'. Assembly rules are in action during the selection phase of sense-making processes and reflect the part played by individual values in the process (Helpap, 2016:10). In

contemporary interpretive research, 'assembly rules' have become interchangeable with 'interpretation schemes' (Weber and Manning, 2001). Osland and Bird (2000), in their extension of Weick's selection model, argue that values such as power distance are important in interpretative scheme selection.

Another rationale for the exploration of the link was the observation that the power distance orientation among actors is a cognitive dynamic with roots in social cognition (Fiske and Taylor, 1991). Sense-making and social cognition are interrelated, and in the social world, our behaviours and interactions are guided by our schemas, which ultimately shape our worldviews and expectations (Fiske and Taylor, 1991). Research by Fiske and Taylor (1991) has also identified four main schema types: person schemas, self-schemas, role schemas and event schemas, of which person and role schemas are the most relevant to this research.

Power-distance orientation is a theoretical elaboration of Hofstede's notion of power distance (Chapter 3). Power-distance orientation, according to Helpap, (2016:9, citing Clugston et al., 2000; Farh, Hackett and Liang, 2007), 'refers to values concerning the distribution of power, equality, and the status of individuals in institutions or organisations.' Power-distance orientation suggests that there may be significant variation in the value orientations of individuals and organisations, even if they exist in the same national culture (Earley and Gibson, 1998). In practical terms, some individuals and organisations in a high power-distance culture may not unquestioningly adhere to high power-distance values (Khatri, 2009). Helpap (2016:21) also described the impact of power-distance orientation on individual responses to change situations as follows:

> 'A person's values regarding status, authority and power in organisations are reflected not only in their interpretation of a given situation, as suggested by the assembling rules, but also indirectly in their behavioural intention to engage in a specific response toward a change initiative'.

Helpap's perspective establishes a connection between sense-making and power-distance orientation if we recall that assembly rules are integral to the process of sense-making. The attitudes of participant actors towards positive and negative use of power by high calibre, resource-controlling health officials point to a general acceptability of such conduct. Interviewee G002, a former NHIS executive, recalled that a Health Minister seized on the absence of a functioning board to drive his agenda for the NHIS. Whilst the Minister's action might have been high-handed, it was deemed as acceptable. Given that such acceptance derives from their cognitive frameworks or schemas (person and role schemas), a conclusion can be reached that power-distance orientation influences the sense-making of actors. The significance of this finding goes beyond it's contribution to theoretical perspectives as power-distance orientation has implications for policy practice too (section 6.7).

6.9.1 Power-Distance Orientation and the Legitimacy of Official Actions

Discussions under this heading have common themes that overlap with those described under the control of power of meaning given that the central theme linking both headings is power. A number of interviewees (n=3) raised concerns about the legitimacy of certain actions of high-ranking officials in the implementation of NHIS, viewing them as unjustifiable, but accepted them in deference to the power of authority. Others (n=5) saw such political interventions in a more positive light, deeming them as being favourable to implementation goals. Khatri (2009: 5) explains that this happens because:

> 'People in a high power-distance culture live with institutionalised injustice and consider hierarchical order to be normal and even desirable and accept the inequalities of power'.

Helpap (2016:9) makes very much the same point, noting that:

> 'Individuals with high power-distance orientation believe that status and power

> differences are important. Consequently, they prefer autocratic superiors and are dependent on supervision and paternalistic decision making.'

G002, a former NHIS official, provided an example of institutionalised injustice by referring to a power-concentrating Health Minister with a penchant for issuing general directives that must be followed. This empirically demonstrates that such negative use of power had become normalised in the mental models of individuals with high power orientation.

Alternative dispositions or orientations towards policy interventions generate unhelpful tensions, which cannot bode well for implementation – especially those relating to what Chen et al. (2013: 140) describe as 'the legitimacy of acceptability of organisational power and authority differentials'. Chen et al. (2014: 140) identified other unintended effects too:

> 'Previous studies found that individual power-distance orientation weakened modernistic management practices such as delegation (Chen and Aryee, 2007), participative decision making (Liam et al., 2002), and transformational leadership (Kirkman, Chen, Farh, Chen and Lowe, 2009).'

In this case study, decision-making in the NHIS was mostly non-participative, hierarchical and highly centralised. This situation is according to Khatri (2009:4) a feature of high power-distance organisations who further postulates weakens decision formulation, implementation and effectiveness :

> 'In high power-distance organisations, decision-making processes are centralised in a few hands and the superiors are expected to lead and make decisions autocratically…this enables top management to reach decisions much more rapidly since superiors do not need to consult subordinates for their inputs and views […] employees in a low power-distance organisation may resist implementation of decisions which were made without consulting them. The problem of communication gap between the superiors and the subordinates tends to hamper the reaching of effective decisions.'

In sum, orientations of power-distance that accepts actions violating due process as legitimate, leads to problems for effective policy making and implementation. In the NHIS case study, such actions led to transparency and governance issues as unintended consequences.

6.10 Implications for Sense-Making and Institutional Theory

Frequent references to the shaping influences of a bureaucratic and institutional nature underscore the under-theorisation that exists between institutional and sense-making theories. This reopens an unsettled debate in sense-making theory: Is sense-making the feedstock for institutions or are institutions the feedstock for sense-making? (Maitlis and Christianson, 2014; Weber and Glynn, 2006).

In this discussion, the terms bureaucratic and organisational context are to be regarded as used interchangeably with the institutional context. To recall, a significant critique of Weick's work on sense-making is that it neglects the role of wider social contexts – especially the role of institutions (chapter 3). Subsequent research aimed at identifying whether institutions are antecedent to, or emergent from sense-making processes are split into bottom-up and top-down camps (Weber and Glynn, 2006).

1. Bottom-up camp: Sense-making shapes institutions

The 'bottom-up' camp, inspired by Weick (1995: 36) , asserts that 'sense-making is the feedstock for institutionalisation'. Weick argues that institutions supply the raw materials of sense-making, mobilised and effected through 'institutional carriers' embedded within these institutions. The principal tenet of this camp is that institutions are cultural-cognitive; thus, institutional changes must be seen as outcomes of variations in local enactment (Scott, 2003; Weber and Glynn, 2006). A significant body of research is aligned with this school of thought (Lounsbury and Glynn, 2001; Grossan et al., 1999; Jennings and Greenwood, 2003). Weber and Glynn (2006) are

especially influential for their rigorous exposition of how sense-making shapes institutions. They propose a model which suggests that institutions may be the feedstock for sense-making through three mechanisms: priming, editing, and triggering sense-making.

2. Top-down camp: Institutions shape sense-making

The 'top-down' camp's perspective that institutions provide the feedstock for sense-making by imposing 'internalised cognitive constraints' represents the dominant view of the role of institutions in sense-making (Weber and Glynn, 2006:1642). This argument is founded on the claim that institutions are guided by codes of conduct that shape their thinking and actions. As Spillane et al. (2002: 405) note:

> 'From an institutional perspective, social agents' thinking and action are situated in institutional sectors that provide norms, rules, and definitions of the environment, both constraining and enabling action.'

There is much congruence between the above perspective and the insight of Heymans and Pycroft (2003:3), who described institutions as 'frameworks of rules structuring the behaviour of agents'. The structuring , Scott (2001: 48) explains, happens because institutions are 'cultural-cognitive, normative and regulative elements that, together with associated activities and resources, provide stability and meaning to social life'.

Institutionalised roles become part and parcel of sense-making through shared cognitive structures which are taken for granted. These structures are internalised through socialisation (Berger and Luckmann, 1966; Zucker, 1991) and other mechanisms such as embodied habits or dispositions (Bourdieu, 1990) , and enacted action scripts (Barley and Tolbert, 1997). In this research, institutional norms (as a feedstock) significantly influence sense-making.

The findings reported comments by respondents that suggested that sense-making across the spectrum of NHIS officials was constrained by assumed norms and rules of the civil service

(chapter 5). Underscoring this point is the view of respondents H012 and H013 in which references were made to a 'civil servant mindset' and 'civil servant environment' to explain the impenetrability of the minds (schemata) of NHIS officials and their obstructive attitude towards negotiations.

Institutional logic drove the sense-making of HMOs/HMCAN and consequently shaped the widely held position that it was anomalous for the NHIS to be an operator and regulator at the same time. This institutional logic explains their profit orientation and preference for the NHIS to be run by qualified insurance professionals.

Also from an institutional standpoint, two HCPs (P005 and P014) contended that it was unfair for the NHIS to allow tertiary institutions (teaching hospitals) to accept primary care patients, as this brought them into direct competition with HCPs – further supporting the notion that institutions are a feedstock for sense-making.

1. Inadequate legislation: Weaknesses in the NHIS Act 35 1999

The NHIS itself is not oblivious to the weaknesses in the NHIS Act 35, as reported by Ihekweazu (2010:2) in an article (documentary source D) quoting a former executive secretary of the NHIS, as follows: 'The first challenge is the Act, which has a lot of inadequacies and until the right amendments are done, we will not be able to have a very long legal document to operate.' A major flaw is that the Act did not make the scheme mandatory for all Nigerians. Citizen participation remains low because the Act made SHI optional. This structural limitation left the Act fundamentally at odds with aspirations for universal health coverage. Policy analysts have also identified deep legal framework weaknesses in Nigerian health care. Lambo (2013) observes that the Nigerian Constitution does not make access to health care a fundamental human right.

The study also revealed that implementation was hampered by the failure to factor in the three-tier (federal, state, and local) political structure which confers semi-autonomous status on the governments of Nigeria's 36 states and local government areas (LGAs). On this point, Ihekweazu (2010:2) also reported that the former executive secretary gave his viewpoint on how the present political structure has frustrated NHIS efforts to grow:

> 'Because it is not mandatory, you find out that despite our advocacy to states and local government areas (LGAs), they are not doing anything about joining the scheme and the only way we can make it mandatory is to amend the Act.' (Ihekweazu, 2010:2)

Viewed in light of current implementation arrangements, which prioritise enrolment/access to formal sector employees over the informal sector and the low participation of sub-national (state) governments (chapter 2), G016, a former executive secretary, suggested that Nigeria is currently running a federal insurance scheme by default – not an SHI scheme as intended.

2. Poor programme implementation

Policy analysts and observers in addition, have attributed the sluggish growth in NHIS coverage to an ill-considered three-tier roll-out arrangement segmenting implementation into FSHIP, USSHIP and RCSHIP sub-schemes (Odeyemi and Nixon 2013). This view was reinforced by a number of interviewees. The underlying logic was that it would be best to start with the formal sector, where it would be easier to fund the scheme through payroll deductions. G028, however, suggested that this was ill-considered, arguing that implementers should have prioritised the informal sector, which makes up 90% of the population.

Odeyemi and Nixon (2013) note that the underlying conceptual thinking at the time was to first grow the pool of funds through the formal sector then scale up the voluntary CBHI-based lower-tier scheme. Aside from the arguments in favour of the Nigerian approach, planning for the informal sector was clearly inadequate. The assumption of planners that the trickle-down effect

of pooled formal sector funds will scale up CBHI schemes and make the entire scheme self-sustainable was without basis. As the case of the highly successful Rwandan Health Insurance Scheme has shown (University of Rwanda et al., 2016), the challenge of an SHI scheme lies in meeting the funding requirements of the much larger informal sector. What can be inferred from the Rwandan experience is that the Nigerian scheme, with it's selective focus on the formal sector, was in all likelihood going to have sustainability problems both in the short and long run.

6.11 NHIS Remit Clarity Issues and Consequences of Non-Conformity

6.11.1 Remit Ambiguity

The remit of the NHIS under the Act 'is to regulate, monitor, enforce quality controls and administer the system, including care to the disadvantaged sectors in Nigerian society' (Odeyemi and Nixon, 2013:10). Arguments have been made that there is no ambiguity in the act from a legal standpoint, and that implicitly the NHIS has wide discretion and sufficient justification to do more than just regulate the scheme. HMOs under HMCAN's auspices, however, remain unpersuaded, and are strongly against the NHIS departing from what they consider to be their primary remit – the regulation of the scheme

This study's findings revealed a prevailing view that implementation of the scheme went off-track because the NHIS had veered from it's core function of regulating the industry to encroach on the business of HMOs as parallel operators. HMOs have not relented in their demands for ambiguities in the NHIS Act to be corrected. HMCAN's Publicity Secretary (Businessday Newspaper), as reported by Edeh (2017), expressed clear frustrations about the activities of the NHIS as a quasi-implementer and regulator:

> 'If there [is] anything that has been affecting the growth of health insurance in Nigeria, it is the fact that the existing agency that is meant to regulate the scheme is operating as a regulator and operator, which is a major setback for

the scheme.' (Edeh, 2017:5)

The conviction of HMOs that the NHIS was bent on the pursuit of financial gains is based on the notion that the large pool of funds under it's control created the incentive for opportunistic conduct.

6.11.2 NHIS Non-Conformity

The ambiguity in the NHIS seemingly created the opportunity for the NHIS to act as parallel scheme operators. HMOs/HMCAN executives, however, perceive such actions negatively, and there are suggestions that they exemplify organisational non-conformity or deviance in extremis. HMO/HMCAN sense-making is based on a reality that is socially reconstructed since sense-making is triggered by unexpected, ambiguous events that disrupt the schemas of those involved (Maitlis et al., 2013; Maitlis and Christianson, 2014).

HMOs/HMCAN had particular expectations from the NHIS. This is reasonable, according to Vaughan (1999: 273), who suggests that: 'Formal organisations are designed to produce means-ends-oriented social action by formal structures and processes intended to assure certainty, conformity, and goal attainment'. In the view of HMOs/HMCAN, the actions of the NHIS did not conform with the provisions of the act, nor did they 'assure certainty'. The reality-expectation deficit experienced by HMO actors in terms of their business relationship with the NHIS left them with a sense of violation. However, the determination of violation is in itself subjective because violations depend on factors such as it's 'impact on individual, social, or organisational identity' (Maitlis and Christianson, 2014:70).

According to Vaughan's (1999:273) research on how things go wrong in 'socially organised settings', non-conformity may be made routine; in other words, deviance from the norm may be normalised in an organisation. It can be argued that deviance became normalised in the NHIS

because it persisted in non-conforming activities such as it's foray into scheme operation. Vaughan's definition of deviance broadly includes non-conformist behaviour by individuals in an organisation as well as mistakes, misconduct and disaster. All of which may result in violations of 'internal rules, legal mandates and social expectations' (Vaughan, 1999:273). To the HMOs/HMCAN, the NHIS's actions might appear to be a wilful disregard of it's core regulatory remit but they must be viewed in light of the contextual conditions in the operating environment. Vaughan (1996:458) listed three elements which provide a possible institutional logic for the actions of the NHIS. First is 'the competitive environment (competition, scare resources, and norms), which generates pressure on organisations to violate laws and rules to attain goals'. Second is the 'organisational characteristics (structure, processes, and transactions), which provide opportunities to violate'. Third is 'the regulatory environment (autonomy and interdependence), affected by the relationship between regulators and the organisations they regulate, frequently minimizing the capacity to control and deter violations, contributing to their occurrence'.

The data suggests that all three elements featured in the inter-relationships between the NHIS as a regulatory body (which HMOs deemed as their remit) and the HMOs in the implementation of the scheme. Onoka (2016) reported that NHIS managers felt threatened by the positive disposition of one Health Minister towards HMOs, and interpreted such actions as suspicious of an underlying financial motive. The HMOs regarded the Minister's actions as a strong expression of the interest of the government in the viability and sustainability of the business of the HMOs, and for that reason, they were more willing to fulfil their role in the implementation of the scheme. Onoka's (2016:81) quotation of one HMO owner puts the situation in context:

> 'Because that kind of money (retained by the NHIS) was so much, it gave him (Executive Secretary) so much power and arrogance and fearlessness. Thanks to (the President) who was in charge and (the Minister of Health) who anytime we raised issues would call him (Executive Secretary) to order.' (HMO owner).

While these elements do not necessarily justify the deviant actions of the NHIS, they definitely help our understanding of the dynamics at work.

6.12 Lesson Drawing: Comparative Analysis of the Nigerian Scheme with Two Sub-Saharan Initiatives

This section directs attention to opportunities for lesson drawing (Rose, 1993) in the implementation of UHC initiatives using the SHI programmes of Rwanda and Ghana (both widely acknowledged as successful reform initiatives) as case studies (Sekabaraga et al., 2008; Fusheini, 2016). Rose (1991) expressed the view that policy makers can learn from both positive and negative experiences of others in the following words: 'confronted with common problems, policy-makers in cities, regional governments, and nations can learn from how their counterparts elsewhere respond. Beyond that, it raises the possibility that policy-makers can draw lessons that will help them deal better with their own problems' (Rose, 1991:4).

The focus of lesson-drawing, Page (2000:2) suggests, 'is on understanding the conditions under which policies or practices operate in exporter jurisdictions and whether and how the conditions which might make them work in a similar way can be created in importer jurisdictions'. Rose (1993, cited in Page, 2000:2) posits that there are four phases to the activity of lesson drawing:

> "'Searching' for sources of lessons, 'making a model' of how the policy or practice works in situ, 'creating a lesson' by assessing what can be extracted from the practice in the exporter jurisdiction to produce the desired results in the importer and 'prospective evaluation' of the way in which the policy or practice are likely to work in the importer jurisdiction and adaptations needed to make it work. This requires knowledge about the conditions that contributes the relevant features of the policies or programmes in the exporter jurisdiction."

In the analysis of these two case studies, the emphasis is on 'prospective evaluation' to uncover what the success drivers were and relate them to the Nigerian experience.

To recapitulate, the broad aims of Sub-Saharan countries (Nigeria, Ghana, Rwanda, Kenya,

Tanzania and Zimbabwe) in launching UHC schemes was to make progressive steps towards achieving their Millennium Development Goals (MDGs), and to implement the recommendations of the 1988 Bamako initiative targeted at reducing and eliminating barriers to health care access resulting from the burden of out-of-pocket payments on households. In this analysis, I compare the performance of the Nigerian NHIS with the Rwandan and Ghanaian programmes, primarily on the metric of coverage. The Rwandan programme is widely acclaimed as one of the world's best socially driven UHC programmes. Similarly, Ghana's scheme has been assessed as performing better than the Nigerian scheme (Odeyemi and Nixon, 2013).

This comparison will unavoidably pitch versions of UHC against others (chapter 2). UHC aims to facilitate access to health services and comes with in-built protection against out-of-pocket payments. All UHCs have a pre-payment element, and are designed to pool risks across population segments (Gustafsson-Wright and Schellekens, 2013). The concept itself does not prescribe a particular arrangement as the ideal. Gustafsson-Wright and Schellekens (2013:3) suggest that approaches may include Social Health Insurance (SHI), 'generally designed for working populations and financed by payroll taxes collected from employers and employees'. They also state that 'a third model of risk pooling and pre-payment is Community-based Health Insurance (CBHI)'. The Nigerian and Ghanaian schemes are a hybrid of both systems whereas the Rwanda scheme is a pure version of CBHI.

In Rwanda and Ghana, the central objective was to achieve universal coverage within the shortest possible time whereas the NHIS elected for a phased implementation plan that did not prioritise community insurance schemes, even when it was abundantly clear that the 90% of those in need of access were in the informal sector. A Rwandan publication asserted that it's scheme was 'built on community solidarity and mutual aid values that are embedded in Rwandan culture' (University of Rwanda, et al., 2016:44). Interview respondents in this study

also pointed out that unlike in Rwanda, planners of the Nigerian scheme ignored the country's cultural belief systems. The Ghanaian initiative also clearly recognised *ab initio* that the poor and vulnerable were hugely disadvantaged by the out-of-pocket system. As Fusheini (2016:243) explains:

> 'The health insurance scheme was an effort at reducing impoverishment and excessive health expenditure. Clearly, it was an acknowledgment that the then system of health care (cash and carry) could not fully identify and protect the poor, vulnerable, children, aged, and other marginalised groups in Ghanaian society. Thus, the main goal of the NHIS is to make health care affordable to all by removing OOP payment at the point of service, and to achieve equity of access based on need, rather than ability to pay.'

The implementation strategy of the Ghanaian scheme also differed sharply from the Nigerian initiative. Ghana's scheme began in 2004 through widely inclusive District Mutual Health Insurance Schemes (DMHIS), a decentralised, public, non-commercial scheme in 145 National Health Insurance Authority (NHIA)-accredited DMHISs, open to anyone, including the poor and unemployed. From the thread of the discussion so far, the under-performance of the NHIS relative to the Ghanaian scheme is traceable in part to the failure of the NHIS to expand it's version of SHI beyond the formal sector again calls into question the rationale for an implementation plan that prioritises the formal sector in the first place.

A fundamental difference between the three schemes is that both the Rwandan *Mutuelles de Sante* and the Ghanaian Act 650 (2003) are mandatory national insurance schemes, whereas the Nigerian scheme is voluntary. The Rwandan and Ghanaian schemes are deeply rooted in their communities. In both, we see robust partnerships between the communities and the government, as well as a strong integral relationship between national and local governments. Nigeria's CBHI schemes, however, remain loosely-coupled – with the central scheme adopted only in a few states and local government areas. The emphasis on formal sector coverage to spearhead the scheme appears misguided. One overlooked dynamic was that the non-

mandatory nature of the Nigerian scheme and the country's three-tiered political system meant that the support base necessary to implement a national health insurance scheme was lacking. However, recent reports (Health Insurance Affairs, 2018) indicating a new push by sub-national Nigerian (state) governments to set up State Social Health Insurance Schemes (SSHIS) indicates that the issue of poor participation of the states in the NHIS is now receiving some much-needed attention (chapter 2).

The governments of Rwanda and Ghana demonstrated a greater political commitment to provide for the poor through subsidisation than that of Nigeria. This view was explicit in a three-party report on the development of SHI in Rwanda (University of Rwanda et al., 2016):

> 'In any developing country, it is not likely that a scheme that includes the informal sector and the poor will be self-financing. Subsidies from the government and support from donors are likely. However, these should be carefully planned so as not to create too much dependency.'

The Ghanaian government set clear goals to provide for the poorest people via selective premium subsidies (Gajate-Garrido and Owusu, 2013). Ghana's NHIS subsidised it's scheme up to 82% of total expenditure, mostly to support the DMHISs. The Nigerian scheme was implemented on the comfortable assumption that incremental growth in the funding pool from the three implementation segments would bring about cross-subsidisation.

However, with poor enrolment figures correlating with low fund pooling, this is yet to materialise.

Given that all three schemes at inception faced similar challenges (such as poor legislative and regulatory frameworks, low enrolment/participation rates and managerial capacity inadequacies) , the superior performance of the Rwandan and Ghanaian schemes, with no HMO or equivalent private sector participants in the design of either scheme, calls into

question the need for HMOs as participants in the NHIS. Enrolment in the Nigerian scheme significantly lags behind that of Ghana. In 2011, enrolment in Nigeria stood at 5.3% of the population, while in Ghana in the same year , coverage was recorded at 53%. A pertinent point is that both schemes were launched in 2005. Rwanda's scheme, which is rated by observers as a model of a successful health insurance initiative in Sub-Saharan Africa, has shown a more solid performance in comparison to those in Nigeria and Ghana. Enrolment in the Rwandan scheme at it's start in 2003 covered 7% of the population. In 2013, coverage had grown to 74% (Rwanda Ministry of Health, 2014).

In the light of revelations from this study, the inference can be made that the Nigerian scheme is faulty in conception and flawed in implementation. Weighing up the evidence, the conclusion can be drawn that the Ghanaian scheme is better structured from the standpoint that it clearly identified the exemption groups, and ensured that they were funded by general taxation and provided with the same benefit package as for all other enrolees. The Nigerian NHIS Act is therefore in urgent need of revision to correct it's inherent structural deficiencies.

There are, however, other impediments beyond those of a structural nature. The low public awareness of the scheme, for instance, needs to be addressed. Policymakers must take into account the pervasive poverty in Nigeria and recognise that subsidisation is a crucial element in any future course-correction strategy.

6.13 Summary

In pursuit of confirmations or departures from theoretical expectations, much of this discussion focused on the relationship between the empirical findings presented in chapter 5 and the relevant concepts and theoretical constructs in the extant literature. The impact of cognition and affect on NHIS policy actors confirmed Spillane et al.'s (2002) perspective that policy actors

often relate what is new in terms of antecedent experiences and can struggle to disengage from the biases in their pre-existing structures (Quinn, 2009).

In alignment with structural interest theory (Alford, 1975) are findings that revealed competing interests between the CoPs of the NHIS. Crucially, the findings indicate that such interests were strongly shared within those CoPs. With reference to some boundary-spanning NHIS policy actors, the findings confirm the fluidity observed in CoP, lending weight to academic rejections of the notion of homogeneity in CoP (Handley et al., 2006). Findings also exposed the unequal power relations within CoPs using the HMCAN/HMO power dynamic as an example.

Findings about the role of power and politics confirm the literature position that such power derives from the control of power of resources (Hardy, 1996; Alison, 1969; Agyepong and Adjei, 2008). The same finding confirmed that the power of meaning wielded by HMCAN also derived from micro-political processes (Contu and Willmott, 2003; Roberts, 2006).

A notable finding highlighting violations of authoritative power to advance certain NHIS policy objectives, and the general acceptance of such actions by a cross-section of policy actors contributes to contemporary theories that postulates that in high power-distance cultures, 'institutionalised injustice' may be accepted as normal in deference to 'hierarchical order' (Khatri, 2009:5).

The rest of the discussion addressed other NHIS issues such as poor programme implementation, inadequate legislation, and governance matters. Finally, it concludes with a discussion on lesson drawing by benchmarking the NHIS with the relatively more successful SHI programmes of Rwanda and Ghana.

The next chapter presents the case study's conclusions with reflections that look back at a pertinent issue put forward by many policy actors – the rationale for the inclusion of HMOs in

the NHIs. Also discussed in the concluding chapter is the validity of the research, it's limitations and directions for future research.

Chapter 7 Conclusions and Reflections

7.1 Introduction

This dissertation is the culmination of research that started from a premise challenging conventional understandings of the policy implementation process. In order to provide cognitive explanations for the gaps between policy intent and outcomes, it utilised the concept of sense-making as an interpretive framework to reveal the role of actor sense-making in the implementation of the Nigerian Health Insurance Scheme (NHIS). The literature review (chapter 3) identified important gaps in extant sense-making studies such as the over-privileging of the role of the individual sense-making to the negation of the distributed sense-making that occurs in the social context of a web of actors (Weick et al., 2005; Spillane et al., 2002), the inadequate exposition of the linkage between sense-making and institutional theory to reveal how individual sense-making and agency are constrained by institutional factors and the neglect of the impact of power and politics on sense-making.

From the start, there was an embedded objective within this case study to address the deficiencies of sense-making theory alongside the primary objective to utilise the concept of sense-making to investigate the actions of NHIS implementation actors. To this end, the study's three research questions were widely scoped to generate insightful findings for theory building. Overall, findings relating to the research questions and other broader findings ground the notion that sense-making is socially re-constructed, negotiated, and organised through the core processes of enactment, selection and retention (Hong, 2006). The empirical findings of the investigation demonstrated the utility of sense-making theory as an interpretive framework in organisational and policy studies. It extends the literature on sense-making theory – covering

individual and distributed sense-making, sense-making and institutional theory, sense-giving and the role of power and politics in sense-making, and communities of practice theory. The theoretical contributions are discussed in detail in sub-section 7.3.2

7.2 Reflections on the Case Study

This discussion reflects on the fundamental problems identified with the Nigerian NHIS initiative some of which were brought to the fore in chapter 5 (section 5.10). First, that the design of the scheme was conceptually faulty because it was based on questionable assumptions — such as the logic behind the decision to drive the scheme through the HMOs, which had unintended consequences going by the divisiveness it created between HMOs and other NHIS stakeholders in the implementation process (chapters 5 and 6). Second, all the key participants (HMOs, HCPs and NHIS officials) framed the policy message differently — shaping the ideas implementers had about the NHIS policy and their subsequent conduct in the implementation process. As within-case analysis revealed, HCPs as a stakeholder group were reluctant to do away with mental schemas rooted in the retainership service delivery model, so they initially framed the initiative as a threat to their financial prospects. HMOs considered NHIS activities outside a regulatory remit to be unacceptable. They also regarded the social equity part of the scheme as non-core to their business objectives. NHIS officials, on their part, believed that the Act empowered them to run the scheme as they deemed fit. Third, political influence from *Veto Actors* – comprising the President of the Federal Republic of Nigeria, the Federal Minister of Health and the HMOs under HMCAN as a trade body (sub-section 2.8.1) – had an impact on the implementation of the scheme. The framings of the role of power in the implementation of the scheme were mixed with some stakeholders viewing political interference in a positive light and others identifying it as a major impediment to scheme implementation. Contentions around the use of power were mostly centred around the use of

executive fiat to push through certain stages of the implementation process as a political imperative without stakeholder consultations, and also the technical power of the HMOs that gave them asymmetrical dominance of the implementation agenda of the NHIS. In the dysfunctional NHIS implementation environment, sense-giving and negotiations of policy did little to shift hard-to-restructure world views (Spillane et al., 2002; Quinn, 2009).

This study exposed a multitude of flaws with Nigeria's centrally planned health sector initiative, which resulted in a well-intentioned policy that has so far fallen short of it's deliverables. Arguably, the lack of traction in the NHIS is traceable to the enormous complexity of the NHIS and amplified dysfunctionalities that derived from the multiple subjective realities in the multi-actor NHIS implementation arrangement that Nigeria opted for. This assertion is in line with the view of Althaus et al. (2013:177) who posit that: 'Policies frequently fail if responsibility is shared among too many players … As more agencies become involved, the complexity of coordination overwhelms the original policy intent. A successful policy therefore will be implemented by just one, or at most, a small number of agencies'.

If sense-making, as Waterman (1990: 41) suggests, is about 'structuring the unknown', this NHIS case study classically exemplifies a situation in which all key actors structured the unknown (in the context of the NHIS policy) differently. All of this goes to suggest that policy implementation is a complex process that often results in unintended effects, and that success or failure is determined by a myriad of factors (Mclaughlin, 1987).

Local actor perceptions are important in policy making and should not be overlooked (Recesso, 1999). Perception in the context of this research is inter-changeable for sense-making given that perception is a cognitive function. In his articulation of the role of perceptions in policy making, Recesso (1999:6) suggests that: 'policy is created and exists for the local actor to follow as a guide for implementation. The local actor has perceptions of the policy and those perceptions

have a relationship to decision making. Decision-making results in implementing or non-implementing'.

The planners of the NHIS evidently did not factor in the influence of actor/stakeholder perceptions into the implementation plan. One step that could have revealed actor perceptions and mitigated the foregoing problems of NHIS implementation would have been to simultaneously evaluate policy outcomes alongside the implementation process using Elmore's (1980) backward-mapping methodology (chapter 3). Backward-mapping, Recesso (1999:7) posits, 'does not assume that all organizations are even interested in implementation. The backward lens places value on the role of the local actor and on the local organization that is focusing on resolution of the problem'.

Recesso's (1999) perspective is instructive given that it questions the *a priori* 'top-down' assumptions that NHIS planners made at the start. Another robust cognitive approach would have been to conduct pilot studies to espouse actor framings of the NHIS policy message.

The findings revealed that many stakeholders had a questioning view of the value of HMO participation in the implementation of NHIS. Some specifically singled out HMOs as responsible for the arrested growth in NHIS coverage. Under the design of the scheme, HMOs were to serve as alternative mobilisers of health care funds, to support the diminishing financial capacity of the government. Thus far, HMOs have not lived up to that expectation. Since the inception of the scheme, HMOs have not shown any enthusiasm to actively enrol participants in rural communities. They continue to be over-reliant on formal sector funds derived from employee deductions. As a former NHIS executive secretary suggested, HMOs were only interested in 'low-hanging fruit'. HMOs are, in practical terms, just third-party administrators for the NHIS. Questions as to whether the role of HMOs as third-party administrators was more of an impediment than anything else resurfaced at the two-day National Assembly Committee on

Health Care Services meeting on 21 and 22 June 2017, convened to assess the performance of the NHIS since inception (see chapter 5). At the forum, the current NHIS executive secretary made the following comments: 'We should pay the hospitals directly […] HMOs [should] go and find patients and bring into the pool […] we are not killing HMOs' (Asoka, 2017:7).

The anticipated cross-subsidisation from enrolling participants across income segments has not materialised because HMOs have remained in the comfort zone of government patronage. The following issues were flagged about HMO operations:

1. That they lacked adequate capacity to deliver services
2. That some were not paying HCPs in a timely manner
3. That some failed to assure enrolees of the quality of service they would receive
4 That secondary referrals were not being done in accordance with the guidelines

Critics also raised concerns about the over-reliance of NHIS officials on HMOs for technical support at the start of implementation, pointing out that this allowed the HMOs to capture the NHIS agenda and subordinate it to their business interests. Onoka (2016:85, citing Walt et al., 2008) observed that such dependence weakens the capacity of the regulator to discharge their responsibilities effectively.

> 'Public officials in many low and middle-income countries often depend on private sector actors whom they are meant to regulate either to overcome deficiencies in capacity (Walt et al., 2008), or to gain support for the policy. The evidence here suggests that such dependence can be harmful to the goals of universal coverage.'

Nigerian NHIS implementers, according to Onoka (2014), could have followed the example of South Africa (Thomas and Gilson, 2004) and Thailand (HISRO, 2012), which elected to use the technical expertise of consultants over interested private-sector actors such as HMOs.

The findings from the exploration of individual, collective (and distributed) sense-making broadly identified cultural attitudes, power asymmetries and a poorly designed/implemented

scheme as factors limiting the growth of NHIS. Archival records also point to other impediments including a rural/urban and class disparity in health care access across the country that leaves the poor disadvantaged, poor scheme awareness, problems with distribution of medical facilities and pervasive poverty. The enormity of the design and implementation flaws is better appreciated if we consider that 90% of the disease burden in Nigeria is in rural areas where less than 10% of facilities are located.

7.3 Organisational and Theoretical Contributions to Research and Policy Practice

This case study makes contributions to qualitative research methodology, the existing literature in policy implementation, research and organisational studies, and policy practice. These contributions derive from the wide breadth of insights that emerged from the findings of the research. In acknowledgement of a lack of consensus on what exactly constitutes a theoretical contribution (Corley and Gioia, 2011), the claims of this thesis to theoretical contribution rely on the criteria of Sutton and Staw (1995:9), which suggests that 'theory is about the connections among phenomena, a story about why acts, events, structure, and thoughts occur'. Cairney (2012a:5), in a similar view, explained that a theory is 'a set of analytical principles designed to structure our observation and explanation of the world'. This inquiry's contribution fulfils Sutton and Staw's conditions through a conceptually rigorous approach that revealed the cognitive process (sense-making) behind the social constructions of reality by various NHIS actors. Furthermore, it identified and drew out critical interrelationships and causal effects in the complex NHIS policy context. The contributions also lends utility for academic research and policy practice.

7.3.1 Methodological Contribution

This inquiry makes an important methodological contribution to qualitative research methods through a case study that empirically strengthens the value of adopting a meso-paradigm to investigate complex group phenomena such as the NHIS (House et al., 1995; Pope et al., 2006). Based on the identified short-comings of emphasis on macro and micro paradigms in organisation research, in the literature review (chapter 3), the researcher explicated on the value of the meso notion to justify the adoption of a multi-level paradigm in this study. Meso notion proponents enjoin researchers to look at the layers above and below the phenomenon of interest to uncover important factors that have might have bearings upon it. This point is particularly instructive because of the fluidity observed across the boundaries of the NHIS actor levels and the deep cross-relationships between NHIS officials and HMOs/HMCAN that the study exposed .

The goal of the meso paradigm in multi-level research, Mathieu and Chen (2011:612) affirm, 'is to synthesize micro and macro organizational processes […] The central feature of such thinking is that organizational entities reside in nested arrangements', and the saliencies in these nested arrangements are important sources of insights for theory building and research development. The multi-level methodological approach employed to examine the interactions between policy signals and individual and distributed sense-making of NHIS actors at the macro (NHIS official), meso (HMOs) and micro (HCPs) levels exposed the nuances of the nested arrangements within each level. More importantly, the approach revealed complex interactions across these levels that had both positive and negative consequences for the implementation of the scheme. This case study accordingly contributes to qualitative research methodology by providing empirical evidence to support use of a multi-level approach in investigations of complex group phenomena.

A methodological criticism of current sense-making studies is that they are mostly based on single case studies. The reason for this trend, as Maitlis and Christianson (2014:106) suggest, is that this approach 'is well suited for studying both every day and extreme examples of sense-making'. They advocate new approaches that investigate sense-making 'within the same organization or across organizations' to generate new insights. Through the investigation of NHIS, HMO and HCP actor-groups as mini cases, the case study validates the methodological value of the approach advocated by Maitlis and Christianson (2014), even though the rationale for it overlaps with the use of a multi-level paradigm discussed earlier.

7.3.2 Theoretical Contributions

The study makes a number of important contributions to the concept of sense-making – addressing criticisms in the extant literature that it is theoretically deficient in it's explication of the role of macro-level discourses covering the social, cultural, economic and political dimensions within and outside organisations (chapter 3). It makes theoretical contributions to distributed sense-making and institutional theory – two important domains of study that remain under-explored in contemporary research (Maitlis and Christianson, 2014).

7.4 Contributions to the Central Tenets of Sense-making Theory

The findings from this study contribute to sense-making theory through confirmations of aspects of it's central tenets. It extends understanding regarding the role of individuals in sense-making, firstly through empirical findings that demonstrate that individual actor sense-making (cues picked about a phenomenon) is influenced by cognition , the implementing agent's schema of worldview and affect, the implementing agents beliefs and values. Secondly, through other expositions of the properties of sense-making (the substrate of Weick's thesis). In the context of this research, the study confirmed that sense-making is grounded in identity construction,

retrospective, enactive of sensible environments, social, on-going, and driven by plausibility rather than accuracy. Through the negative perceptions of the non-conformity of NHIS officials with their core remit, HMOs/HMCAN confirmed the notion that sense-making is triggered by unexpected or ambiguous events that violate expectations (Maitlis and Christianson, 2014; Vaughan, 1999).

7.4.1 Role of Institutions in Sense-Making

The study contributes to the ongoing debate as to whether sense-making is the feedstock for institutions or institutions are the feedstock for sense-making (Chapters 3 and 5). Revelations that the (implementation) actions of NHIS officials were constrained by assumed norms and rules of the civil service as well as the dominant institutional logic of HMOs/HMCAN on aspects of the NHIS implementation empirically support the 'top-down' camp's perspective that institutions shape sense-making (Weber and Glynn, 2006).

7.4.2 Role of Context (Political) in Sense-Making: Politics, Power and Power Distance

This study makes a substantial contribution that addresses the charge that sense-making theory is deficient in the realm of power and politics because it is naïve to think that new understandings will be free of power dynamics and self-interested motives (Vlaar et al., 2006). The contributions to the role of power and politics (research question 3) are in three strands:

1. It demonstrates that power derives from the control of resources (financial power), as exhibited by the actions of NHIS officials and (technical) power of meaning which HMOs/HMCAN possessed as a result of the superior industry expertise they had over other stakeholders.

2. The study contributes to recent research advancing the notion that sense-giving is a political process (Maitlis and Lawrence, 2007; Filstad, 2014). In empirical terms, the latitude that HMCAN had to exercise power without a broad mandate of HMOs supports the perspective that sense-giving (the dialectic of sense-making) is a political process (chapter 5).

3. It extends the concept of power-distance (Hofstede, 1980, 1984; Mulder, 1977) by drawing out the linkage between sense-making and the notion of power-distance orientation (Kirkman et al., 2009; Chen et al., 2013). This contribution is novel in the sense that there has been little academic exploration of the linkage between power-distance orientation and sense-making to date. The case study elaborates Helpap's (2016) perspectives on the association between individual values, power distance and change commitment by demonstrating that the receptivity of some NHIS actors both towards positive and negative use of power by high calibre, resource-controlling health officials derived from their cognitive frameworks or schemas (person and role schemas). Implicitly, the conclusion can accordingly be drawn that power-distance orientation influences the sense-making of actors. This is a significant contribution to a nascent subfield of inquiry.

7.4.3 Role of the Social Context in Sense-Making

Through expositions of instances of social exchanges that provided opportunities for learning about health insurance, the study contributes to theoretical postulations that informal actor interactions (in social contexts) most noticeably in the nexus of professional affiliations influence policy implementation (Spillane et al., 2002; Van Maanen and Barley, 1984).

7.4.4 Role of Distributed Sense-Making: Sense-Making in Communities of Practice (CoP)

CoP is a naturalistic context for exploring sense-making as a group process. The case study empirically demonstrated that the sense-making behind shared understandings within each of the CoPs of NHIS, HMO/HMCAN and HCP actors – revealing sense-making anchored the promotion of self-interest as well as highlighting disconnections from the social objectives of the NHIS. In tandem, it provides support for the distributed perspective in sense-making research, which postulates that sense-making does not only happen in silos of individuals because it is also influenced by the shared knowledge/understanding embedded within and across formal and informal thought communities (Spillane et al., 2002).

7.4.5 Contribution to Communities of Practice Theory

Apart from the contribution linking CoP to sense-making, the study also made contributions to CoP theory itself. The contributions are two-fold. First, it provided empirical evidence that challenges the assumption of homogeneity in CoP. The findings suggest that the notion is problematic on the basis that the demonstrated fluidity across NHIS CoPs – substantiated by examples of some actors portraying attitudes/characteristics of CoPs other than the one to which they apparently belong. The second contribution comes from expositions of power issues within CoPs, that addressed the criticism that CoP theory currently discounts the role of power relations in CoP (Lave and Wenger, 1991; Contu and Willmott, 2003). The revelation of an imbalance of power between many HMO executives and the select few that drove the HMO agenda under the auspices of HMCAN lends empirical weight to the notion of 'legitimate peripheral participation' (Lave and Wenger, 1991:37), which suggests that existing power differentials in CoPs initially put novice CoP members into peripheral positions before they subsequently grow into full participation. The notion of 'legitimate peripheral participation' in part explains the unequal power relations with the CoP of HMOs.

7.5 Contributions to Research and Policy Practice

7.5.1 Contributions to Research Practice

The case study demonstrates the utility of the cognitive perspective as a research instrument in investigations/evaluations of policy implementation – especially complex policy initiatives. In particular, it empirically demonstrates the part played by sense-making in the evolution of policy during implementation. A cognitive perspective reinforced the idea that 'individuals do not make sense of their world in [a] vacuum' (Spillane et al., 2002:393) by revealing how the key actor groups (NHIS officials, HMO executives and HCPs) through their individual and contextual (social and situated) perspectives framed the same NHIS policy message differently. It confirmed the claim that implementers could easily misconstrue the intentions of policymakers – portending practical consequences for policy implementation. The value of a cognitive approach to the analysis of policy implementation lies in it's complementarity to traditional approaches. While this approach may not or should not replace conventional methods, it equips analysts with an additional toolkit for exploring the actions/behaviour of implementing agents and ultimately may provide wider explanations for policy failure (Spillane et al., 2002).

7.5.2 Implications for Policy Practice

The findings of this thesis, beyond contributions to the literature, have significant implications for policy and practice that policymakers should be guided by. The NHIS study in the main, uncovered the existence of a chasm between policy (as enacted) and practice (its implementation). A major factor in this study had to do with the policy message itself – most especially the way it was framed by various implementing agents. Sense-making research has established that at an individual level, people are biased towards interpretations aligned with their own beliefs and values (cognition and affect). Crucially, the study finds that sense-making is also influenced by the wider context of agents. That is, it is distributed. Different framings of

a policy messages may also introduce substantial risks into policy implementation – the greatest threat being the adaptation of such understandings to prosecute self-interested ends, as seen in the actions of HMOs/HMCAN (Spillane et al., 2002). The consequences of different framings of the NHIS policy were however more far-reaching in terms of the dysfunctionality it brought into the implementation process. These include ambiguity in the role play of participants such as the unclear remit of the NHIS and poor policy integration exemplified by the under-performing community based (CBHI) scheme.

The foregoing discussion suggest that the disjuncture between policy and practice deriving from the sense-making of agents should not be overlooked if policy is to be effectively implemented. Based on the notion that sense-making is socially re-constructed, negotiated and organised, this calls for a strategic approach by enactors/implementers that would involve filtration of the policy message through sense-giving at the start, and at different stages of implementation. One promising channel for filtering the policy message would be through active engagement with the identified communities of practice – considering that findings highlighted commonly-held views within each of the communities.

It would also have been useful to include implementers/stakeholders in key decision making much earlier to gauge and factor-in their beliefs, perceptions and values into the process and then work in a bottom-up approach that approximates the concept of backward-mapping (Elmore, 1980; Recesso; 1999) as explicated in section 7.2.

The study revealed several instances of unequal distribution of power or power asymmetries in play when certain key decisions were taken in the course of the NHIS implementation. It is important for policy makers to understand that such power dynamics can contribute to policy failure on several levels. Also significant is the finding relating to power-distance orientation. The study suggests that power-distance orientation (that accepts or normalises negative use of

power by executive fiat) may contribute to policy failure by weakening effective policy implementation and enjoins policy makers to be mindful of this (Khatri, 2009).

Overall, the case study directs the attention of policy makers to the criticality of contextual factors in policy design and implementation by demonstrating that such factors can constitute barriers to successful policy implementation.

7.6 Validity of the Study

As discussed in Chapter 4, any research project is open to questions challenging it's methodological rigour. This research is no exception. In chapter 4, I stated that the major criticism against case study research is that findings that emerge from a single case cannot result in generalisable conclusions. Bryman (2012) rejected this notion,– arguing that what matters in research is the depth of the theory that emanates from the researcher's findings – not wider population generalisations. Following Bryman (2012), the theoretical contributions from this study strengthened generalisability through construct validity, confirmability, internal validity, external validity and transferability. To achieve construct validity, the study employed multiple sources of evidence: interview data, field notes, memos, archival documents analysis and publicly available information.

Confirmability is challenging in social research because the idea of objective truth is elusive. Confirmability in this case study was again achieved by triangulation of the data to mitigate 'the effects of investigator bias' (Shelton, 2007:72). Internal validity focuses on *a priori* assumptions between concepts. This can be achieved through pattern matching (Tellis, 1997; Campbell, 1975). To achieve this, I linked findings from the data to the theoretical propositions in my conceptual framework. External validity and transferability were achieved by thick descriptions of the findings, a semi-structured interview protocol that offered a wide latitude for further

questioning of informants, and a rigorous coding framework that was guided by Braun and Clarke's (2006) approach to thematic analysis.

7.6.1 Strengths and Limitations of the Case Study

It is important that a researcher recognises and reports on the strengths and limitations of a research inquiry. A key strength of this inquiry derived from the exploratory range of the research questions and the integration of multiple theoretical constructs into the conceptual framework. To explain further:

1. The broad scope of the research questions facilitated in-depth expositions of individual and distributed sense-making.
2. The incorporation of multiple theoretical constructs into the conceptual framework expanded opportunities for theoretical contributions beyond sense-making theory.
3. The decision to address some of the identified deficiencies in extant sense-making studies through the research *a priori* created the impetus to make original contributions to the literature.
4. The investigation of sense-making across NHIS, HMO and HCP actors as mini-cases within the overarching case study strengthened the generalisability of the findings.

Limitations

Implementation of the NIHS is still ongoing, so a longitudinal study might have been a more appropriate methodology. However, this may not have been possible in the normal timespan of a PhD programme. Also, there was a paucity of data from community-based insurance schemes – largely because of the limited traction of CBHI schemes across the country. The research also involved methodological trade-offs such as the decision to employ thematic analysis as the data analytic strategy in preference to other methods. Thematic analysis was

privileged in anticipation of the emergence of a range of themes (beyond those pertaining to sense-making) – given the breadth of the research questions. An alternative approach would have been to employ a story-telling or narrative methodology, which would have produced revealed more about the sense-making processes of actors, but generated fewer insights into other theoretical constructs.

7.7 Directions for Future Research

The findings of this study offer a range of opportunities for further research. Based on it's empirical challenge of the notion of homogeneity in CoP theory, a potential line of inquiry would be to examine the mechanisms by which individuals in multiple CoPs compartmentalise their practices within each of the communities to which they belong, and then determine the impact of such compartmentalisation(s) on decision making. In this study, the hegemonic control of insurance industry knowledge by HMCAN – highlighted the power dynamics at play within the CoP of HMO/HMCAN. A research project with a starting hypothesis that legitimate peripheral participation (Lave and Wenger, 1991; Contu and Williams, 2003) does not impede access to learning in CoPs could be investigated to explain how power relations impact on situated learning in these communities.

7.8 Researcher's Concluding Remarks

In Chapter 4, I stated that my initial conceptualisation of this research project was motivated by an interest in systems theory — in particular complex adaptive systems which I see as useful to generate insights into non-linearities in public policy making , especially in the health policy field (Exworthy and Powell, 2012:11). The findings that emerged from this case study demonstrated patterns of self-organisation and co-evolution – the hallmarks of complex adaptive systems all through the implementation process. The practical value of a complexity perspective is on two

levels. First, as the complexity of implementing the NHIS showed, it is critical for policy planners to think in systems. This view is underscored by Wilson and Rosenfield (1990:315) who noted that 'In any organisation, the multitude of parts and processes are so interrelated and so interdependent that a small change in one part necessitates changes and adaptation in other parts'. In this study, we observe a great deal of dysfunctionality from 'loosely coupled' implementation units. Systems theory, according to Exworthy and Powell (2012:136), is most useful when utilised to frame sense-making in order to better understand 'the nature of things' as opposed to it's use as a toolkit in problem intervention. Secondly, a complexity perspective enhances the capacity of policy scholars and planners to observe 'emergent processes' in policy-making (Butler and Allen (2008). The use of sense-making as an interpretive framework in this case study does not diminish the value of conventional approaches to policy implementation studies. It's value lies in advancing the edge of scholarship – by facilitating a better grasp of the evolving nature of policy implementation and a deeper understanding of the wider ramifications of policy failures.

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Appendices

Appendix A: Codebook - Phase 2 - Generating Initial Codes (Open Coding)

Phase 2 – Generating Initial Codes	Interviews Coded	Units of Meaning Coded
Adverse selection envisaged as an implementation problem	1	1
Awarding and monitoring provider contracts of community schemes challenging	1	2
Believed the implementation of NHIS scheme was feasible	8	8
Board of Trustee (BOT) officials were highly motivated and served with altruistic intentions	3	4
Board of trustees were collectively sceptical about CBHI at the start	2	2
Capitation and services fees issues were contentious between HMOs and Providers	4	5
Capitation payments paid to providers lagged behind salary increases in the formal sector	1	1
CBHI facilitators were concerned if the technical capacity to implement the scheme was available	1	1
CBHI is a promising insurance approach but sustainability depends on strong federal government	1	1

participation		
Centralisation of the scheme was identified as a reason for the low adoption of the scheme by the states	5	5
Collective thinking of CBHI providers was unclear and unrealistic	1	2
Community members expected the scheme to provide a completely free service	1	1
Complaints about remuneration by BOT members	1	1
Concerns about citizen buy-in of the scheme	4	4
Concerns about maintenance of standards across service levels	3	3
Conflict of interest issues hindered decision making	1	1
Degree of receptivity to suggestions was generally positive	5	7
Doubts about the feasibility of an insurance scheme	8	11
Erratic remittances from HMOs was a cause for concern	2	3
Health Insurance is an improvement over the retainership model	2	2
Health Insurance is not financially viable in many states	1	1
Health Ministry Officials were well receptive in exchanges with NHIS Officials	1	1

HMCAN the HMO interest body and scheme watchdog was instrumental to notable changes	7	10
HMO Accountability was not seriously considered at start of implementation	1	1
HMO accreditation was not based on rigorous criteria	1	1
Implementation challenges anticipated by state officials mostly focused on citizen buy-in providers' capacity to deliver and accountability and moral hazard	1	1
Implementation has been hindered by NHIS - HMO interest conflicts	6	7
Implementation was affected by unreliable data and inadequate ICT facilities	2	2
Inadequate NHIS accountability about capitation payments	1	1
Initial focus of state officials was on raising citizen awareness and operational take-off	3	3
Key state officials were highly motivated because many came from a public health background	1	2
Many Providers did not have a good grasp of the scheme	5	5
Money and the control of funds was the sole focus of the NHIS at the start of implementation	4	4

Negative receptivity to suggestions to the NHIS to focus on regulation and not operations of scheme	1	1
Negative response to the suggestion to demand for data access	2	3
NHIS anticipated that Beneficiaries would want to be assured of the benefits to be derived for their contributions	3	3
NHIS has HR capacity limitations but has improved	10	10
NHIS HR Capacity was inadequate at the start and has worsened	8	8
NHIS Officials had a good grasp of the concept of health insurance	2	2
NHIS officials had a good grasp of the scheme but had management and bureaucratic limitations	6	6
NHIS officials had good intentions about growing the scheme but were misguided by a desire to control the process	4	5
NHIS Officials have little understanding of how insurance works	14	18
NHIS officials to some degree have shown receptivity to suggestions	9	14
NHIS officials understood the scheme but mixed up about their remit	3	3
NHIS Officials were	11	20

collectively negative to external advice		
NHIS Officials were concerned about service tariffs	1	1
NHIS Officials were receptive to CBHI issues brought to it's attention	1	1
NHIS structure is seemingly fit for purpose but has been poor for policy implementation	11	13
No doubts about feasibility of scheme but had some reservations	6	6
One initial focal issue was how to determine the CBHI'S scheme's starting premium	1	1
People expected and believed health care should be free	3	4
Political power influenced scheme implementation negatively	2	4
Political power influenced scheme implementation positively	5	7
Poor infrastructure was an anticipated as an impediment to scheme success	2	2
Positive response to HCPAN's demand for capitation fee increase	3	3
Positive response by NHIS to rejection of HMOs to provide operational data access	1	1
Positive response to demand for increase in service fees	2	2

Poverty identified as major impediment to scheme implementation	5	8
Power and politics played a significant role in scheme implementation in both formal and informal sectors	9	14
Provider attitudes and interests to the NHIS became more positive over time	8	10
Provider Collective thinking focused on financial returns and was mostly negative	19	21
Providers believe funding should have been allocated to improve health infrastructure	1	1
Providers find it difficult to influence NHIS policies directly	3	3
Providers resented the perceived better prospects of the HMOs and feel short changed by them	7	8
Providers should not be expected to prioritise social equitableness over their business sustainability	2	2
Providers were mostly accessible in the big cities of Lagos and Abuja	1	1
Providers with fewer enrolees had poorer financial prospects	2	3
Risk to scheme sustainability if supportive political person departs office	3	3
Scheme design was	6	11

structurally flawed from the start		
Scheme should have been made compulsory to increase scalability	5	6
Slow response from the NHIS to operational issues raised by HMO officials	1	2
Some HMOs were weak financially and operationally and are conducting business unethically	8	10
Some state officials had a good understanding of the CBHI scheme	4	4
State Officials were concerned about shortage of health care workers	1	2
State officials had limited grasp of insurance and remained traditional and inflexible in their thinking	2	2
Sustainability was a major challenge of the CBHI scheme	1	2
Teaching and General Hospitals should not have been providers of primary care	1	1
The collective mindset of HMOs was fixated on their economic interest	15	23
The concept of health insurance was new to me	2	2
The health care practitioner's association(HCPAN) was successful in bringing about micro-level changes but not macro	0	0

The Health insurance scheme was a positive health initiative	26	48
The NHIS anticipated that providers would be resistant to embrace the new scheme	2	2
The NHIS ignored it's remit, lost it's way and became rent-seeking and began to compete directly with operators(HMOs)	12	20
The NHIS ignored the level of distrust the people had for a federal based programme	1	1
The objective(s) of NHIS scheme is too broad making it's many programmes hard to implement	1	1
The operational relationship between HMOs Provider and NHIS or the regulator is dysfunctional	5	5
There is a cultural and religious rejection of the idea of health insurance in the country	7	8
There is no proper supervision or monitoring of the scheme	1	1
Unfair to expect HMOs alone to deliver on the social equitableness of the scheme	6	7
Utilisation control is a major challenge in the formal sector scheme	2	2
Younger officials were more forward looking and innovative in their thinking	1	2

Appendix B: Codebook - Phase 3 - Searching for Themes (Developing Categories).

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
Facilitator engagement with state officials (community insurance)	7	33
BOARD OF TRUSTEE (BOT) ATTITUDES TO CBHI	5	6
Board of Trustee(BOT) officials were highly motivated and served with altruistic intentions	3	4
Board of trustees were collectively sceptical about CBHI at the start	2	2
CBHI IMPLEMENTATION ISSUES	4	5
Conflict of interest issues hindered decision making	1	1
Implementation challenges anticipated by state officials mostly focused on citizen buy-in providers' capacity to deliver and accountability and moral hazard	1	1
One initial focal issue was how to determine the CBHI'S scheme's starting premium	1	1
Sustainability was a major challenge of the CBHI scheme	1	2
DIMENSIONS OF STATE OFFICIAL(S) ENGAGEMENT	6	22

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
Degree of receptivity to suggestions was generally positive	5	7
Initial focus of state officials was on raising citizen awareness and operational take-off	3	3
Key state officials were highly motivated because many came from a public health background	1	2
Some state officials had a good understanding of the CBHI scheme	4	4
State Officials were concerned about shortage of health care workers	1	2
State officials had limited grasp of insurance and remained traditional and inflexible in their thinking	2	2
Younger officials were more forward looking and innovative in their thinking	1	2
Implementation challenges	25	82
Adverse selection envisaged as an implementation problem	1	1
Awarding and monitoring provider contracts of community schemes challenging	1	2
CBHI facilitators were concerned if the technical capacity to implement the scheme was available	1	1

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
Community members expected the scheme to provide a completely free service	1	1
Complaints about remuneration by BOT members	1	1
Concerned about buy-in of the scheme by citizens	4	4
Concerned about maintenance of standards across service levels	3	3
Health Insurance is not financially viable in many states	1	1
HMO accreditation was not based on rigorous criteria	1	1
Implementation was affected by unreliable data and inadequate ICT facilities	2	2
Money and the control of funds was the sole focus of the NHIS at the start of implementation	4	4
NHIS anticipated that Beneficiaries would want to be assured of the benefits to be derived for their contributions	3	3
NHIS HR Capacity was inadequate at the start and has worsened	8	8
NHIS Officials had a good grasp of the concept of health insurance	2	2
NHIS officials had a good	6	6

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
grasp of the scheme but had management and bureaucratic limitations		
NHIS officials had good intentions about growing the scheme but were misguided by a desire to control the process	4	5
NHIS Officials were concerned about service tariffs	1	1
People expected and believed health care should be free	3	4
Poor infrastructure was anticipated as an impediment to scheme success	2	2
Poverty identified as major impediment to scheme implementation	5	8
Providers were mostly accessible in the big cities of Lagos and Abuja	1	1
Scheme should have been made compulsory to increase scalability	5	6
Teaching and General Hospitals should not have been providers of primary care	1	1
The NHIS anticipated that providers would be resistant to embrace the new scheme	2	2
The NHIS ignored the level of distrust the people had for a federal based programme	1	1
The objective(s) of NHIS scheme is too broad	1	1

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
making it's many programmes hard to implement		
There is a cultural and religious rejection of the idea of health insurance in the country	7	8
Utilisation control is a major challenge in the formal sector scheme	2	2
Individual perspectives on health insurance	28	87
Believed the implementation of NHIS scheme was feasible	8	8
CBHI is a promising insurance approach but sustainability depends on strong federal government participation	1	1
Doubted the feasibility of an insurance scheme	8	11
Health Insurance is an improvement over the retainership model	2	2
No doubts about feasibility of scheme but had some reservations	6	6
Providers should not be expected to prioritise social equitableness over their business sustainability	2	2
The concept of health insurance was new to me	2	2
The Health insurance scheme was a positive health initiative	26	48
Unfair to expect HMOs alone to deliver on the	6	7

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
social equitableness of the scheme		
Power and the political context in scheme implementation	10	28
Political power influenced scheme implementation negatively	2	4
Political power influenced scheme implementation positively	5	7
Power and politics played a significant role in scheme implementation in both formal and informal sectors	9	14
Risk to scheme sustainability if supportive political person departs office	3	3
Regulator receptivity to stakeholder representations	21	48
Negative receptivity to suggestions to the NHIS to focus on regulation and not operations of scheme	1	1
Negative response to the suggestion to demand for data access	2	3
NHIS officials to some degree have shown receptivity to suggestions	9	14
NHIS Officials were collectively negative to external advice	11	20
NHIS Officials were	1	1

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
receptive to CBHI issues brought to it's attention		
Positive response to HPCAN's demand for capitation fee increase	3	3
Positive response by NHIS to rejection of HMOs to provide operational data access	1	1
Positive response to demand for increase in service fees	2	2
Providers find it difficult to influence NHIS policies directly	3	3
Scheme operational challenges	14	27
Capitation and services fees issues were contentious between HMOs and Providers	4	5
Capitation payments paid to providers lagged behind salary increases in the formal sector	1	1
Collective thinking of CBHI providers was unclear and unrealistic	1	2
Erratic remittances from HMOs was a cause for concern	2	3
HMO Accountability was not seriously considered at start of implementation	1	1
Inadequate NHIS accountability about capitation payments	1	1
Providers believe funding should have been allocated to improve health	1	1

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
infrastructure		
Slow response from the NHIS to operational issues raised by HMO officials	1	2
Some HMOs were weak financially and operationally and are conducting business unethically	8	10
There is no proper supervision or monitoring of the scheme	1	1
Stakeholder cross perspectives	25	173
Centralisation of the scheme was identified as a reason for the low adoption of the scheme by the states	5	5
Health Ministry Officials were well receptive in exchanges with NHIS Officials	1	1
HMCAN the HMO interest body and scheme watchdog was instrumental to notable changes	7	10
Implementation has been hindered by NHIS - HMO interest conflicts	6	7
Many Providers did not have a good grasp of the scheme	5	5
NHIS has HR capacity limitations but has improved	10	10
NHIS Officials have little understanding of how insurance works	14	18

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
NHIS officials understood the scheme but mixed up about their remit	3	3
NHIS structure is seemingly fit for purpose but has been poor for policy implementation	11	13
Provider attitudes and interests to the NHIS became more positive over time	8	10
Provider Collective thinking focused on financial returns and was mostly negative	19	21
Providers resented the perceived better prospects of the HMOs and feel short changed by them	7	8
Providers with fewer enrolees had poorer financial prospects	2	3
Scheme design was structurally flawed from the start	6	11
The collective mindset of HMOs was fixated on their economic interest	15	23
The health care practitioner's association (HCPAN) was successful in bringing about micro-level changes but not macro	0	0
The NHIS ignored it's remit, lost it's way, and became rent-seeking and began to compete directly with operators(HMOs)	12	20
The operational	5	5

Phase 3 – Searching for Themes	Interviews Coded	Units of Meaning Coded
relationship between HMOs Providers/ NHIS or the regulator is dysfunctional		

Appendix C: Codebook - Phase 4 - Reviewing Themes (Drilling Down).

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
Facilitator engagement with state officials(CBHI)	7	37
CBHI SCHEME IMPLEMENTATION CHALLENGES	4	8
Awarding and monitoring provider contracts of community schemes challenging	1	2
Board of trustees were collectively sceptical about CBHI at the start	2	2
CBHI facilitators were concerned if the technical capacity to implement the scheme was available	1	1
Complaints about remuneration by BOT members	1	1
Sustainability was a major challenge of the CBHI scheme	1	2
INITIAL FOCUS AND CONCERNS OF STATE OFFICIALS	3	7
Implementation challenges anticipated by state officials mostly focused on citizens buy-	1	1

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
in and providers' capacity to deliver and accountability and moral hazard		
Initial focus of state officials was on raising citizen awareness and operational take-off	3	3
One initial focal issue was how to determine the CBHI'S scheme's starting premium f	1	1
State Officials were concerned about shortage of health care workers	1	2
NEGATIVE VIEWS ABOUT THE ACTIONS OF STATE OFFICIALS	2	3
Conflict of interest issues hindered decision making	1	1
State officials had limited grasp of insurance and remained traditional and inflexible in their thinking	2	2
POSITIVE VIEWS ABOUT ACTIONS OF STATE OFFICIALS	7	19
Board of Trustee (BOT) officials were highly motivated and served with altruistic intentions	3	4
Degree of receptivity to suggestions was generally positive	5	7
Key state officials were highly motivated because many came from a public health background	1	2

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
Some state officials had a good understanding of the CBHI scheme	4	4
Younger officials were more forward looking and innovative in their thinking	1	2
Implementation challenges	23	55
Citizen related implementation challenges	11	21
Adverse selection envisaged as an implementation problem	1	1
People expected and believed health care should be free	3	4
Poverty identified as major impediment to scheme implementation	5	8
There is a cultural and religious rejection of the idea of health insurance in the country	7	8
Initial challenges and concerns identified by the NHIS	0	0
Concerns about maintenance of standards across service levels	3	3
Concerns about buy-in of the scheme by citizens	4	4
NHIS anticipated that Beneficiaries would want to be assured of the benefits to be derived for their contributions	3	3

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
NHIS Officials were concerned about service tariffs	1	1
Poor infrastructure was anticipated as an impediment to scheme success	2	2
Providers were mostly accessible in the big cities of Lagos and Abuja	1	1
The NHIS anticipated that providers would be resistant to embrace the new scheme	2	2
NHIS located regulatory and implementation problems	18	34
HMO accreditation was not based on rigorous criteria	1	1
Implementation was affected by unreliable data and inadequate ICT facilities	2	2
Money and the control of funds was the sole focus of the NHIS at the start of implementation	4	4
NHIS HR Capacity was inadequate at the start and has worsened	8	8
NHIS officials had a good grasp of the scheme but had management and bureaucratic limitations	6	6
NHIS officials had good intentions about growing the scheme but were misguided by a desire to control the process	4	5
Scheme should have	5	6

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
been made compulsory to increase scalability		
The NHIS ignored the level of distrust the people had for a federal based programme	1	1
The objective(s) of NHIS scheme is too broad making it's many programmes hard to implement	1	1
Individual perspectives on health insurance	28	88
Expressed reservations about scheme implementation	14	17
CBHI is a promising insurance approach but sustainability depends on strong federal government participation	1	1
Doubted the feasibility of an insurance scheme	7	10
No doubts about feasibility of scheme but had some reservations	6	6
Positive views about health insurance and implementation	28	60
Believed the implementation of NHIS scheme was feasible	8	8
Health Insurance is an improvement over the retainership model	2	2
The Health insurance scheme was a positive health initiative	26	50
Affected by personal beliefs and values regarding health	17	22

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
financing		
Affected by prior working experience in a health insurance scheme	3	3
Based on professional knowledge of health economics	3	3
Based on professional knowledge of insurance business	6	6
Provider and HMO views about social insurance	8	9
Providers should not be expected to prioritise social equitableness over their business sustainability	2	2
Unfair to expect HMOs alone to deliver on the social equitableness of the scheme	6	7
The concept of health insurance was new to me	2	2
Power and the political context in scheme implementation	15	51
HMCAN the HMO interest body had the positional power to influence policy implementation	9	18
HMCAN and some HMO proponents had power of meaning and information control	6	7
HMCAN leveraged their positional power to influence implementation politics	1	1
Political power influenced scheme	2	4

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
implementation negatively		
Political power influenced scheme implementation positively	5	7
Power and politics played a significant role in scheme implementation in both formal and informal sectors	9	19
Politics and power underpinned authoritative sense-making	5	5
Risk to scheme sustainability if supportive political person departs office	3	3
Regulator receptivity to stakeholder representations	22	49
Community members expected the scheme to provide a completely free service	1	1
MODESTLY POSITIVE NHIS RECEPTIVITY TO STAKEHOLDER REPRESENTATIONS	9	14
NHIS officials to some degree have shown receptivity to suggestions	9	14
NEGATIVE NHIS RECEPTIVITY TO STAKEHOLDER REPRESENTATIONS	11	24
Negative receptivity to suggestions to the NHIS to focus on regulation and not operations of	1	1

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
scheme		
Negative response to the suggestion to demand for data access	2	3
NHIS Officials were collectively negative to external advice	11	20
POSITIVE NHIS RESPONSE TO STAKEHOLDER REPRESENTATIONS	8	10
NHIS Officials were receptive to CBHI issues brought to it's attention	1	1
Positive response to HPCAN's demand for capitation fee increase	3	3
Positive response by NHIS to rejection of HMOs to provide operational data access	1	1
Positive response to demand for increase in service fees	2	2
Providers find it difficult to influence NHIS policies directly	3	3
Scheme operational challenges	14	27
Capitation and services fees issues were contentious between HMOs and Providers	4	5
Capitation payments paid to providers lagged behind salary increases in the formal sector	1	1
Collective thinking of CBHI providers was unclear and unrealistic	1	2
Erratic remittances from	2	3

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
HMOs was a cause for concern		
HMO Accountability was not seriously considered at start of implementation	1	1
Inadequate NHIS accountability about capitation payments	1	1
Providers believe funding should have been allocated to improve health infrastructure	1	1
Slow response from the NHIS to operational issues raised by HMO officials	1	2
Some HMOs were weak financially and operationally and are conducting business unethically	8	10
There is no proper supervision or monitoring of the scheme	1	1
Stakeholder cross perspectives	27	183
HMO Community agenda	19	35
HMCAN the HMO interest organisation was instrumental to notable changes	8	11
HMCAN are the apparent gatekeepers of HMO responses to implementation issues roles through message selectivity	7	11
HMCAN played a sense-	5	7

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
giving role in the HMO community through meaning creation		
The collective mindset of HMOs was fixated on their economic interest	16	24
Provider community views about their situation	24	51
Many Providers did not have a good grasp of the scheme	5	5
Provider attitudes and interests to the NHIS became more positive over time	8	10
Provider Collective thinking focused on financial returns and was mostly negative	19	21
Providers believe funding should have been allocated to improve health infrastructure	1	1
Providers resented the perceived better prospects of the HMOs and feel short changed by them	7	8
Providers with fewer enrolees had poorer financial prospects	2	3
The health care practitioner's association (HCPAN) was successful in bringing about micro-level changes but not macro	3	3
Views about NHIS structural and capacity issues	24	97

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
Centralisation of the scheme was identified as a reason for the low adoption of the scheme by the states	5	5
Health Insurance is not financially viable in many states	1	1
Health Ministry Officials were well receptive in exchanges with NHIS Officials	1	1
Implementation has been hindered by NHIS - HMO interest conflicts	5	6
NHIS has HR capacity limitations but has improved	10	10
NHIS Officials had a good grasp of the concept of health insurance	2	2
NHIS Officials have little understanding of how insurance works	14	20
The civil service context influenced and shaped the collective thinking of NHIS officials	7	7
NHIS officials understood the scheme but mixed up about their remit	3	3
NHIS structure is seemingly fit for purpose but has been poor for policy implementation	11	13
Scheme design was structurally flawed from the start	5	10
Teaching and General Hospitals should not	1	1

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
have been providers of primary care		
The NHIS ignored it's remit, lost it's way and became rent-seeking and began to compete directly with operators(HMOs)	12	19
The NHIS negated it's primary role as a regulator of the scheme	5	5
The operational relationship between HMOs Provider and NHIS or the regulator is dysfunctional	4	4
Utilisation control is a major challenge in the formal sector scheme	2	2

Appendix D: Codebook - Phase 5 - Defining & Naming Themes (Data Reduction).

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
1 – Cognition	26	57
1. 1 - Cognition regarding Cultural Attitudes to Health Insurance	7	8
1. 2 - Cognition regarding the Concept of Health Insurance	19	25
1. 3 - Feasibility Concerns	21	24
Believed the implementation of NHIS scheme was feasible	8	8
Doubted the feasibility of an insurance scheme	7	10
No doubts about feasibility of scheme but had some reservations	6	6
2 – Affect	14	19
2. 1 - Altruistic Beliefs about Health care	4	4
2. 2 - Financially Motivated Reasoning	3	3
2. 3 - Value based on Professional Standards	6	7
3 - Context -The implementers working situation, and formal and informal social networks	27	156
3. 1 – Situated	24	77
HMO Community of Practice	19	26
NHIS (Government) Official Community of	8	15

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
Practice		
Provider Community of Practice	18	34
3. 2 – Distributed	11	16
HMCAN - HMO - NHIS Actor(s) Web of interaction	6	6
NHIS - Provider - HPCAN Interactive Web of Actors	4	5
Provider - HPCAN - HMO -HMCAN -NHIS interactive Web of Actors	5	5
3. 3 - Social (Informal)	5	8
3. 4 Political	16	55
HMCAN the HMO interest body had the positional power to influence policy implementation	9	17
HMCAN and some HMO proponents had power of meaning and information control	5	6
HMCAN leveraged their positional power to influence implementation politics	1	1
Political power influenced scheme implementation negatively	3	5
Political power influenced scheme implementation positively	5	7
Positional Power of Meaning (HMCAN)	2	2
Power and politics	10	21

Phase 4 – Reviewing Themes	Interviews Coded	Units of Meaning Coded
played a significant role in scheme implementation in both formal and informal sectors		
Politics and power underpinned authoritative sense-making	5	5
Risk to scheme sustainability if supportive political person departs office	3	3
4 - Sense-giving	10	18
4. 1 HMCAN played a sense-giving role in the HMO community through meaning creation	7	11
4. 2 HCPAN played a sense-giving role in terms of provider interests	3	3
5 – Gatekeeping	7	13
5. 1 HMCAN are the apparent gatekeepers of HMO responses to implementation issues roles through message selectivity	7	12
6 - Negotiation of policy implementation	5	5

Appendix E: Interviewee Job Designation, Interview location and Date

S/No.	Interviewee Code	Job Designation	Location	Date
1	G001	CBHI Official	Lagos, Nigeria	December 2015
2	G002	Ex-NHIS Official	London, UK	April 2015
3	P003	HCP	Lagos, Nigeria	April 2015
4	C004	Health Policy Adviser	Telephone Interview	August 2015
5	P005	HCP	Lagos, Nigeria	April 2015
6	H006	HMO Executive	Lagos, Nigeria	April 2015
7	P007	HCP	Lagos, Nigeria	April 2015
8	G008	CBHI Official	Igbo – Ukwu, Nigeria	August 2015
9	G009	CBHI Official	Lagos, Nigeria	April 2015
10	G010	Ex-NHIS Official	Abuja, Nigeria	August 2015
11	H011	HMO Executive	Lagos, Nigeria	April 2015
12	H012	HMO Executive	Lagos, Nigeria	April 2015
13	H013	HMO Executive	Lagos, Nigeria	April 2015
14	P014	HCP	Lagos, Nigeria	April, 2015

15	G015	CBHI Official	Lagos, Nigeria	Dec 2015
16	G016	Ex-NHIS Official	Abuja, Nigeria	August 2015
17	H017	HMO Executive	Lagos, Nigeria	April 2015
18	P018	HCP	Lagos, Nigeria	April 2015
19	G019	CBHI Official	Lagos, Nigeria	April 2015
20	C020	Health Policy Adviser	London, UK	March 2015
21	G021	Ex-NHIS Official	Abuja, Nigeria	August 2015
22	G022	CBHI Official	Lagos, Nigeria	April 2015
23	H023	HMO Executive	Lagos, Nigeria	April 2015
24	H024	HMO Executive	Lagos, Nigeria	April 2015
25	H025	HMO Executive	Lagos Nigeria	April 2015
26	G026	NHIS Official	Abuja, Nigeria	August 2015
27	H027	HMO Executive	Lagos, Nigeria	April 2015
28	G028	Ministry of Health	Abuja, Nigeria	August 2015
29	C029	Health Policy Adviser	London, UK	May 2015

Appendix F: List of Secondary Data Sources

No	Publication Title	Publication Type & Author	Source code
1.	CareNet: Health Insurance Report /Health insurance Affairs 2002 – 2017	Newsletter Articles	DS1
2.	The Private Sector in National Health Financing Systems: The role of Health Maintenance Organisations and Private Health Care providers in Nigeria London School of Hygiene and Tropical Medicine	PhD Thesis: Onoka C.A(2014)	DS2
3.	The Feasibility of Managed Clinical Networks in Nigeria: a case of policy transfer to less advanced settings University of Keele, UK	DBA Thesis: Asoka T.A (2016)	DS3
4.	HMOs and Health Insurance in Nigeria: The Future.	Web News Article Owoyemi. A https: //www. medicalworldnigeria. Com	DS4
5.	HMCAN Explains position on the repealing of the NHIS Act	Web News Article: Edeh, H., (2017) Nigeria Today http://www.nigeriatoday.ng/2017/05/hm	DS5
6.	What can be done to improve health care in Nigeria	Web News, World Economic Forum Article: Lecky M.M (2015) https://www.weforum.org/age	DS6

		nda/2015	
7.	Implementation of the NHIS: Evolution Implementation Constraints and way Forward	Written submission by E. Lambo (Former Minister of Health) to the Nigerian House of Representative Panel on the NHIS 2013	D7
8.	The Road to Universal Health Coverage	Thisday Newspaper Article By Olaokun Soyinka 24th	DS8
9.	Jonathan Signs National Health Bill Into Law	Punch Newspaper Article 22nd February 2015	DS9
10.	Health Insurance in Nigeria	Unpublished Article Awokoya, K. 2013	DS10
11.	National Health Insurance Scheme in Nigeria: Rhetoric, Reality, and Results	Asoka, T,2017 Unpublished Report on the two Day House of Representative/ NHIS stakeholders Meeting Abuja 21st – 22nd June 2017	DS11

Appendix G: Sample Interview Questions H013 – HMO Executive.

Thank you very much for agreeing to participate in my research. The purpose of the investigation is to examine the role of sense-making (how people think) and sense-giving (how people influence the thinking of others) in the on-going implementation of the NHIS. The study aims to espouse how both actions are shaped by thought communities, within the cadre of health ministry and NHIS officials, policy brokers, HMO executives, and HCPs.

QUESTION 1.

Pertains to your role in the implementation of the NHIS as a HMO executive.

a) Can you recall when you first got involved with the implementation of the NHIS and the context of your participation?

b) How long have you been in this role?

c) Can you briefly describe your functional activities?

QUESTION 2.

What were your prior views about the concept of health insurance and SHI in particular?

a) What difference did you think it would make to the Nigerian health care system as it then was?

b) Did you have any doubts about the feasibility of implementing the scheme in Nigeria?

QUESTION 3.

a) Focusing on the NHIS did you think officials had a good enough grasp of the concept of SHI to implement it.

b) How would you describe the NHIS as an organisation; focusing on it's organisational structure, and modus operandi.

c) Looking back from the launching of the scheme in 2005, what in terms of it's human resource capacities has changed at the NHIS?

QUESTION 4.

What were the focal issues at initial meetings and conversations with NHIS OFFICIALS?

QUESTION 5.

What specific implementation problems did officials anticipate? During your conversations and interactions with NHIS and health ministry officials as implementation progressed, what messages did you get that reflected the mental models or collective official thinking amongst the ranks of these key decision makers.

Give an overview of their collective thinking.

QUESTION 6.

What implementation difficulties were of concern to your organisation as an HMO going forward and in retrospect, what events in your view, were surprising or challenging.

QUESTION 7.

How would you describe the receptivity of officials to your professional suggestions and advice, and to what degree?.

Can you recall instances when receptivity to your perspectives and suggestions were negative and what do you think was responsible for that?

QUESTION 8.

In terms of influence, can you describe how your role has changed as implementation progressed?

QUESTION 9.

Focusing now on HMOs as a for profit business interest group.

A) What basically were their starting beliefs about the schemes in terms of their business interest?

b) How can you best describe the collective thinking within the body of HMOs?

C) Aside of the incentive to generate a return on investment capital, how much of a buy-in was there amongst the group regarding the social value of a health insurance scheme. Put another way, did HMOs see their organisations as key participants in a health sector initiative that was aimed at universal health care access in Nigeria?

QUESTION 10.

During your formal and informal interactions and conversations with health care providers HCPs directors in particular; at meetings or at any other for, how well do you think the concept of SHI was understood by this group?

b) What do you think was their starting beliefs about the scheme in terms of their business interest?

c) How can you best describe their collective thinking?

d) What do you think was the driver of that collective thinking?

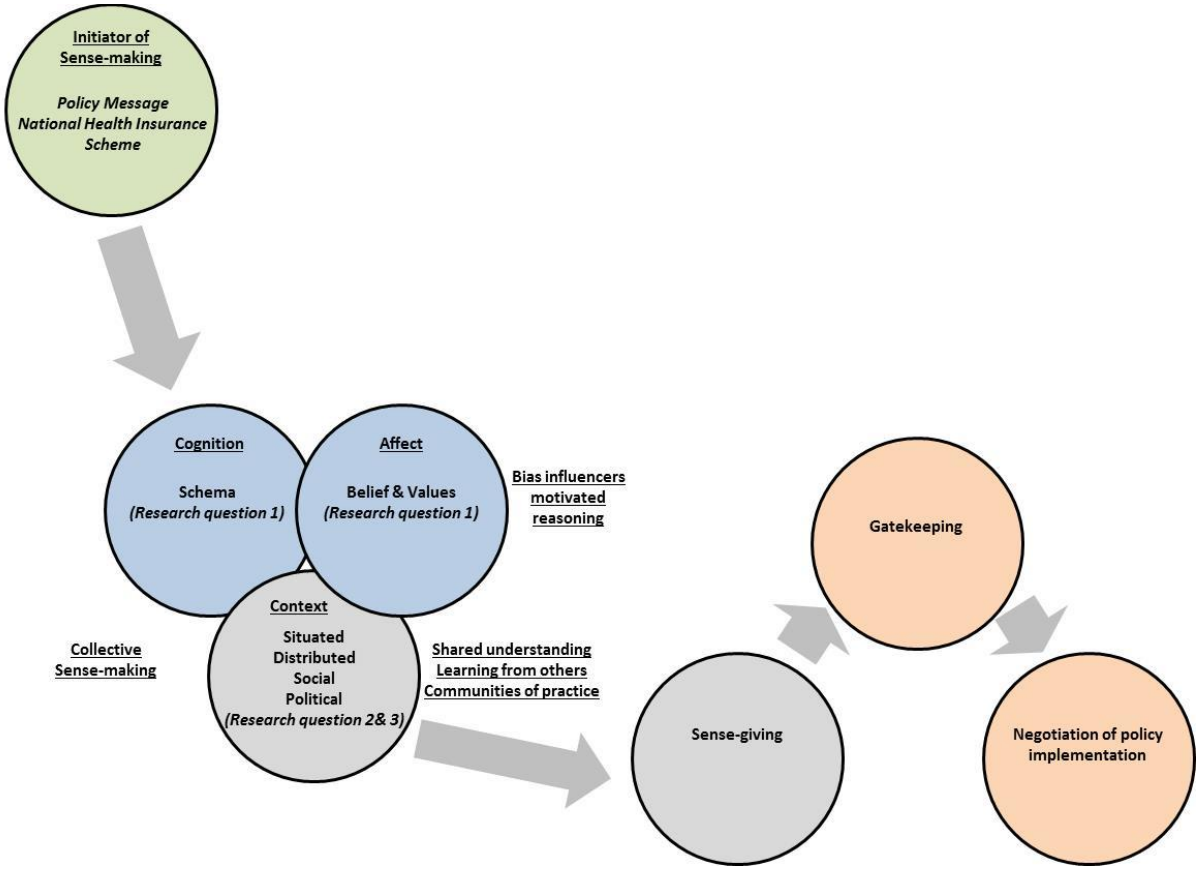
e) Did their collective thinking change over time and if so what influenced the shift.

QUESTION 11.Finally, I would want you to describe the degree of exchange of implementation ideas between the cross-section of HMO executives, medical providers and NHIS officials.

a) How receptive was the NHIS to ideas filtering through from these interest groups.

b) Did such exchange(s) influence key decisions taken in the course of implementation?

Appendix H : Conceptual Framework for Study



Sources : Fawehinmi 2015

Appendix I: Interview Consent for Participants

Information for Participants

Thank you for agreeing to be interviewed as part of this doctoral research project. You have been requested to participate on the basis of your potential to provide relevant data. In accordance with ethical research practice, it is necessary to have your formal consent so that you have a clear understanding of the purpose your involvement and you agree to the terms and conditions attached to your participation. Please carefully read the following information to assist you in making an informed decision regarding your participation. I do not envisage any risks associated with your participation. You retain the right to withdraw from the interview or research at any time.

Title of the Study: Exploring Sense-making in Health Policy: Implementing Health Policy in Nigeria

Research Investigator: Olawale O. Fawehinmi

Study Location: Faculty of Business and Law,

Health Policy Research Unit,

De Montfort University

Leicester, UK

Research Participants Name:

General Information

The purpose of the study is to explore the cognitive dimensions of the implementation of the Nigerian Health Insurance Scheme using the concept of sense-making as an interpretive

framework. Using a case study methodology, the objective of the research is to investigate the role of formal and informal interactions, the impact of communities of practice and political and bureaucratic influences on individual and collective sense-making in the implementation of the NHIS. The study aims to interview approximately 30 NHIS implementation agents

● The interview will last approximately 45 – 60minutes

●The interview will be recorded and a transcript will be produced

●The transcript will be analysed by Olawale Fawehinmi (research Investigator)

●Access to the interview transcript will be restricted to the research investigator.Electronically held data will be password protected

●Interview content in paraphrased or direct quotations will be anonymized to protect your identity

●The master recording will be destroyed at the end of the project in 2018

● You will be duly informed and your explicit approval sought should there be a need to vary any of the foregoing conditions

By signing this form I agree that;

1. I am a voluntarily participant in this project. I understand that I don't have to take part, and I can withdraw from the interview/research at any time;

2. The transcribed interview or extracts from it may be used as described above;

3. I have read the Information sheet;

4. I don't expect to receive any benefit or payment for my participation;

5. I can request a copy of the transcript of my interview and may make edits I feel necessary to ensure compliance with agreement on confidentiality;

6. I have been able to ask any questions or raise concerns I might have, and I understand that I am free to contact the researcher with any questions I may have in the future.

_____

Printed Name

_____ _____

Participants Signature Date

_____ _____

Researchers Signature Date

Contact Information

This research has been granted ethical approval by the Faculty of Business and Law of De Montfort University, Leicester, UK. If you have any further questions or concerns about this study, please contact:

Name of researcher
Full address
Tel:
E-mail:

You can also contact (Researchers name) supervisor:

Name of researcher
Full address
Tel:
E-mail: