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## Politics Of Healthcare Reform In Africa: Insights From Rural Nigeria

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### ABSTRACT

Healthcare reform is largely a political process which requires a careful analysis for better understanding. The process is often characterized by politics of domination and influence by various actors on the policy scene. This study examines the power relations that shaped the design and implementation of a Community-Based Health Insurance program in Nigeria. Health policy triangle developed by Walt and Gilson serves as the analytical tool. Using a qualitative method of data collection, this study sheds light on the recent trends in health policy transfer to Africa from the global North and reveals the underlying politics in the design and implementation of a CBHI programme in rural Kwara. Specifically, we highlight the process through which the policy was proposed and accepted. Also, our study shows the political underpinnings of the design and implementation of the policy. Finally, we argue for a need to repurpose the role of the state (i.e. government) towards achieving meaningful development and to gainfully improve social services provisioning, especially in the healthcare sector. Given the importance of healthcare to the well-being of the people, productivity and national development, this study contributes to understanding the issues 'behind the scenes' in relation to policy design and implementation.

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## 1. INTRODUCTION

Many countries consider health policy reform for improving access to good healthcare services. The 1960s and 1970s saw a raft of countries winning their independence from former colonial powers (John & Taylor, 2003). The leaders of these newly independent countries faced the challenge of providing quality healthcare services to their people and more importantly, reducing mortality and the spread of diseases. The leadership of the World Health Organization was "impressed by developments in China, India, Africa and Latin America that provided healthcare via local community-controlled services" (Gunn et al., 2008:110). Indeed, comprehensive healthcare programmes which covered the poor were successfully implemented in countries such as Venezuela, Tanzania, Sudan and China (Bennett, 1979).

However, it appears that the time coincided with the period of attempts to fix the economic crises in Europe and the US. This gave way to the emergence of neoliberal ideas and the aggressive neoliberalism in the Western nations. Consequently, neoliberalism became entrenched around the world, with an adverse effect on Nigeria specifically, and many countries in the global South. The effect imposed so much burden on these developing

countries and the ‘palliative programmes’ put in place by the international financial institutions led to significant alterations in the healthcare system of most of the nations. The “World Bank and the IMF initiated the Structural Adjustment Programmes (SAPs) as a condition for the balance of payment support and debt relief” (Baum, 2007:38). The conditionalities required a ‘stabilization’ of public finance involving deep cut in public spending, especially social spending.

The cut in social spending and retrenchment of public social provisioning triggered mass entitlement failure (including declining public healthcare services). The initial effort at introducing co-payment for healthcare services did nothing to compensate for the cut in public spending. It hit most citizens hard on the back of the general decline in income and rising poverty. The response was not to restore public expenditure and investment in healthcare but to press for a stratified, segmented, and segregated social policy architecture for health (see Fischer, 2018 cited in Adésinà, 2020:565). Countries were encouraged/forced to introduce social (health) insurance, and a variety of pre-payment systems outside the top-tier (and middle-tier) social insurance scheme. An example of such low-tier (pre-paid) health insurance systems is the Community-Based Health Insurance Scheme (CBHI).

Some of the countries that have adopted CBHI for healthcare financing are India, China, Bangladesh, Afghanistan, Nepal, Guinea, Benin, Ethiopia, Burkina Faso, Cameroun, Mali, Cote d’Ivoire, Kenya, Ghana, Rwanda, Nigeria, among others. In 2007, the Kwara State Community-Based Health Insurance Scheme became operational, as a joint project of the Kwara State Government and the Dutch Health Insurance Fund (HIF) through the PharmAccess Foundation (PAF) [in the Netherlands], and Nigerian-based health maintenance organization, Hygeia Nigeria Limited. It is claimed that the partnership was to implement a donor-subsidized health insurance scheme to bridge the gap between rural and urban dwellers. The initial agreement expired in 2013, and a new agreement was signed to span 2014 and 2018.

The Kwara State government was lauded for the effort and received various awards for the programme: OECD Finalist Award, Saving Lives at Birth Award, FT/IFC Transformational Business Award etc. It was also recognized by the World Economic Forum (WEF) as an effective model for improving access to healthcare (PharmAccess Group, 2016:9). However, in less than a decade of existence, the programme has come to a halt. Using the health policy triangle developed by Walt and Gilson (1994), we examine the power relations that shaped emergence of the CBHI programme in Kwara State, Nigeria, including the design and implementation of the programme.

Walt and Gilson (1994:354) observed that “much health policy wrongly focuses attention on the *content* of reform and neglect the *actors* involved in policy reform (at international, national and sub-national levels), the *process* contingent on developing and implementing change and the *context* within which policy is developed”. They believed that focusing on the content of policy ignores the other dimensions of process, actors, and context which can make difference between effective and ineffective policy choice and implementation (Walt & Gilson, 1994; Walt et al., 2008). Thus, there is a need to pay attention to the processes of developing policy as well as how the policy issue arises, how decisions

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are made in the policy development and lastly, how the policy is implemented (Taegtmeier et al., 2011:3).

## **2. METHODOLOGY**

The study was carried out in Kwara State Nigeria using key informant interviews. The programme operated in 43 healthcare facilities across 11 Local Government Areas (LGAs) out of the 16 LGAs (comprising Kwara State), and two tertiary referral centres within the state capital (Ilorin). Therefore, the community with highest enrolment in each of the LGAs were purposively sampled into the study. The data was collected in 2019 in 11 rural communities and the state capital. We conducted 32 interviews and the participants were selected based on their knowledge and experience with the CBHI programme. They include community leaders (11), healthcare providers (12), policy makers (4), officials of the international implementation partner – PharmAccess Foundation (2) and the health maintenance organization (2) as well as a researcher on the programme. The data collected were transcribed, typed and exported into ATLAS.ti for thematic analysis. Ethical clearance was obtained for the study from the Research Ethics Review Committee of the College of Human Sciences of the University of South Africa and the Kwara State Ministry of Health in Nigeria before embarking on the fieldwork.

## **3. RESULTS AND DISCUSSION**

### **3.1. Emergence of the CBHI Programme in Kwara State: The Process**

Arguably, “as the political economy changes, some policy contexts also change, in turn affecting which actors are involved, which policy decisions are made, and what processes take place at various levels, including the operational and service delivery levels” (Mthethwa, 2012:41). Also, “a policy is an output of a political process, and politics come into play at all stages of the policy reform process” (Fox & Reich, 2015:1021). Like in many parts of the country, the poor healthcare situation in Kwara State (since the cut in public provisioning of social services), particularly in the rural areas continued until the emergence of the CBHI programme in some of the communities during the tenure of Dr Bukola Saraki as Executive Governor (2003-2011). The programme emerged from a partnership involving the Kwara State Government, PharmAccess Foundation and Hygeia Nigeria Limited to provide healthcare services to selected rural communities in the State. The CBHI programme was co-funded by the KWSG and the HIF. At inception, the programme was fully-funded by the international partner as a pilot in a Local Government Area (LGA) and extended to a second LGA after two years. However, like many other transfer programmes, the international partner offered to mainly finance the programme for the first five years of implementation with a view to reducing its financial commitment by 20% per annum in the subsequent years (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). The ultimate goal was that after at least ten years of implementation, the state government would take full ownership of the programme and continue to run it ‘sustainably’.

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### 3.2. Policy Introduction and Offer

Social policy is often introduced to solve a particular social problem or improve a situation. Usually, the needs for a policy are justified, and the implication for adoption and/or rejection is clearly stated. They are, however, cascaded in framings that make adoption convincing and urgent (Fox & Reich, 2015:1026); at times, involving discreetly coercive process (Dolowitz & Marsh, 2000:11). Similarly, the poor healthcare situation in rural Kwara and the need for a solution provided a basis for framing the need to adopt the CBHI model. Also, the emphasis around the time was on UHC and alternative health financing mechanisms (Gustafsson-Wright & Schellekens, 2013:2). Consequently, this window of opportunity was taken to develop and promote CBHI policy instrument.

The Dutch government proposed the Kwara CBHI programme through the Health Insurance Fund and PharmAccess Foundation. On how it commenced, most of the participants noted that it was in a bid to improve the health status of the rural dwellers. An HMO Official remarked that: “The purpose of the programme was to improve the health indices in the State because before the commencement of the programme, the health indicators of the State were poor” (KII, HMO Official 1, 26/7/2019, Ilorin). Also, a government official explained that: “The initial motive of the programme was to see if health insurance could work in rural communities. It was also introduced to provide quality health services to the people and see the possibility of using it to achieve UHC” (KII, KWSG Official 2, 24/07/2019, Ilorin).

Also, an official of the foreign agency stated that:

Our stay in Kwara State has been since 2007 when the then Governor of Kwara State, Dr Abubakar Bukola Saraki wanted to ensure that he improved the health status of the people in rural areas. The Dutch Ministry of Foreign Affairs through the Health Insurance Fund, an organization under the Ministry, supported Kwara State in starting a community-based health insurance scheme focused on the rural areas in the State. (KII, Foreign Agency Official 1, 02/09/2019, Ilorin).

The Health Insurance Fund claimed that the idea of the CBHI was motivated by the poor healthcare situation in most parts of Africa. The HIF (2012:5) noted that: “The healthcare delivery system in sub-Saharan Africa is confronted with low supply and low demand for healthcare services”. However, the above submission is a remarkably ahistorical account of health systems and health financing in post-colonial Africa. Many African countries ramped up investment in their health systems after formal colonial rule. According to Tidjani (2009:6), “these states, which are now discredited for their poor achievements, were perceived, in the 1960s, as strategic actors in terms of economic and social policy”.

Thus, the story that the HIF tells above is the healthcare system after it was defunded and damaged by structural adjustment programmes – the same programme that European countries (such as the Netherlands) supported when it was imposed on African countries. The crisis with the narratives of Africa’s failure is precisely this. Ignore the achievements of the pre-1980s, start history from 1985, when the ‘pet policies’ were imposed. Cast an eye on the ruined landscape created by the ‘pet policies’, then blame the failure on Africa and Africans, and then offer new rounds of proto-neoliberal policy doses to address the problems they created in the first instance.

Often, promoters of transferred policies and their agents come up with ‘scary’ problem definitions. They also introduce the policies as forms of ‘best practices’ and back them with research to drive acceptability (Foli et al., 2018:121). At times, “these researches are produced in relatively insecure contexts and are marred with reliability issues” (Tidjani, 2009:11). The policies are, however, susceptible to failure if they are not in tune with the realities of the recipient country (Dolowitz & Marsh, 2000:17). Nevertheless, the claim on the sustainability of the CBHI model has been defeated with the stoppage of the programme. What is not on the policy table is universal, publicly-funded healthcare system. It is not ‘free healthcare’, someone is paying for it—through tax or sovereign wealth.

### **3.3. Alliance with Local Actors and Choice of Kwara**

Policy transfers are often crafted in alliance with local actors “because non-state actors rarely operate without the consent facilitation of state actors” (Hanafi, 2020:8). In Kwara, the programme was characterized by three (3) primary levels of alliance. The first was between the Dutch government and the PharmAccess Foundation; the second was between the PharmAccess Foundation and Hygeia Nigeria Limited, and the third was the alliance of these actors with the Kwara State Government. Apart from the partnership with the Kwara State Government, other threads of the alliance in the communities included the engagement of healthcare providers, as well as community leaders and religious leaders (used as policy ambassadors) towards the implementation of the programme. In other words, the Dutch government (through the HIF) and PAF were the policy purveyors (i.e. actors behind the introduction of the policy); Hygeia HMO was a policy conduit (through which the policy was implemented); and the target of the policy was the Kwara State Government (in policy adoption). Further, the health care providers (HCPs), community leaders and religious leaders were conduit belts for securing the implementation of the policy.

The first organization to be identified in Nigeria by the PharmAccess Foundation was Hygeia Nigeria Limited (i.e. the implementing HMO). A participant noted that: “The Dutch NGO needed a local partner to work with and the partner they got in Nigeria was Hygeia HMO. Therefore, the programme had a tripartite arrangement including the Dutch HIF, Hygeia HMO and the Kwara State Government” (KII, HMO Official 1, 26/07/2019, Ilorin). The HMO official further explained that the primary objective of the international agency was to attend to the HIV menace, but it changed to CBHI programme. The Dutch government relied on the wide engagement of PAF in Africa to sell its policy ideas. He added that: “The then governor, Dr Bukola Saraki had a relationship with the Hygeia HMO to partner with a Dutch NGO to cater for HIV incidences in the State, but they decided to take a holistic approach to have health insurance” (KII, HMO Official 1, 26/7/2019, Ilorin).

It was with the assistance of the HMO that Kwara State was identified and its government contacted. According to a participant:

The CBHI Programme in Kwara State started with the late Prof. Lange [the founder of PharmAccess Foundation] in Amsterdam who had a lofty idea about HIV/AIDS; he sought to get the involvement of Prof. Elebute, Chairman of Hygiea HMO then. They came up with the idea of having a broad programme and not just HIV/AIDS to allow people to have access to healthcare, and the idea of CBHI came up among the rural poor in Kwara State Government (KII, Researcher, 30/07/2019, Ilorin).

As noted earlier, policy transfer involves an alliance with local actors, and therefore, the appointment of Hygeia Nigeria Limited by PAF was to ease the transfer process further. The HMO came on board because it was profitable for them. The HCPs were selected by a team of PharmAccess Foundation and Hygeia HMO (England, 2008:59). Also, the network of alliances might partly be responsible for the non-curtailement of the excesses of the HMO (KII, HCP, 27/07/2019, Oro) in the implementation of the CBHI and thus, contributing to the challenges of the programme.

### **3.4. Policy Acceptance**

Essentially, four (4) main reasons informed the acceptance of the offer: the glaring poor condition of healthcare in the State; the lack of clear healthcare policy in the State; the political relevance of the CBHI programme; and the funding relief at inception, whereby funding was not a responsibility of the State government but that of the international partner. Consequently, the state government 'eagerly' accepted the partnership offer since the programme did not place many responsibilities on it. According to Brals (2019:74), "the Kwara State health system is characterized by weak governance and legislation, inadequate government funding, and poor health infrastructure and service quality". Thus, the general context of Kwara State (i.e. economic, social, cultural, environmental etc. – including the healthcare situation) was part of the reasons the programme was proposed and piloted in the State. One of the HMO officials explained that: "It was an opportunity readily available, and the state government tapped into it" (KII, HMO Official 1, 26/07/2019, Ilorin).

An official of the international agency claimed that: "The Kwara State Government had a dream but did not have the fund, but the Dutch government supported the dream to come through" (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). This is the common narrative trend for policy merchants to 'conceal' their roles. According to Adésínà (2020:573), the current trend in policy merchandising or policy transfer is that policy promoters infiltrate the political setting and exert their influence on the political actors to adopt the offered policies. In the case of Kwara CBHI, the international partner had its goal and policy option to be implemented, and the most powerful tool to actualise this was fund.

Also, the initial acceptance of the state government to allow for the implementation of the CBHI programme in the State has political undertones. This is because with the poor state of healthcare in the State and absence of concrete policy plans for implementation (KII, KWSG Official 2, 24/07/2019, Ilorin), it was 'necessary' to accept such an offer. The establishment of the programme, expectedly, boosted the 'popularity' of the state government among the people; particularly, in the rural areas where the programme was operational. One of the government officials confirmed the political relevance of the programme and noted that: "It was in appreciation [i.e. of the programme] that the communities voted the administration in 2015 to return the favour" (KII, KWSG Official 2, 24/07/2019, Ilorin). He added that: "As a politician, if anyone comes to you that their child or wife is sick, all you need to do is to enrol them in the programme" (KII, KWSG Official 2, 24/07/2019, Ilorin).

In the early period of implementation, the programme started to get applauses and recognitions. Therefore, the KWSG requested an expansion to another LGA, perhaps, because of its political relevance. It was, however given a conditionality of financial commitment by

the international partner (KII, KWSG Official 2, 24/07/2019, Ilorin). Therefore, the state government agreed to spend on the programme and had to accommodate it in the budget. Unfortunately, the KWSG did not take full ownership of the programme, partly leading to its stoppage. In most cases, the common tactic used by donors and transfer agents is to give an impression that a proposed programme would not cost much in part-funding; conditionalities often follow acceptance and threat follows refusal of conditions by the government (see Foli et al., 2018:113).

### **3.5. Policy Design: “Who Pays the Piper Dictates the Tune”**

The content of a policy instrument is a critical part of any programme. Generally, however, the design of social policies in Africa are influenced by interests, ideas, path dependence and international norms (Mkandawire, 2015:591). Primarily, the powerful player amongst policy actors tends to have the most influence within a policy environment. One of the officials of the foreign agency declared that: “The CBHI model was designed by PharmAccess Foundation” (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). The Kwara State Government was neither in-charge of the design of the policy nor given a space to have an input somewhat. Therefore, the policy instrument was like a ‘ready-made’ policy design implemented in the State without the input of the local policymakers and imposed in the form of ‘assistance’ or ‘support’. One of the government officials explained that: “They brought in the policy and said, can we test this here?” (KII, KWSG Official 2, 24/07/2019, Ilorin).

One of the strategies being adopted by foreign policy actors to dominate the policy sphere is the technical know-know or expertise, which is ‘believed’ to be very limited in the developing countries. However, this provides an avenue for transnational organizations to take charge of policy decisions (Le et al., 2019:4). One HMO official explained that: “The PharmAccess Foundation designed the policy because they had the technical know-how” (KII, HMO Official 1, 26/07/2019, Ilorin).

All the healthcare providers, including the referral centres (i.e. 12 HCPs) noted that they were not involved in the policy design. They were just engaged and provided with operational guidelines on how the programme should be implemented. Some of the observations and suggestions of the HCPs on the programme were taken, while the others were not. An HCP explained that: “We were not involved in the policy design. Whenever we had suggestions, we gave them; they might take it or not” (KII, HCP, 20/06/2019, Bode Saadu). The healthcare benefits inherent in the proposed programme (at a lower cost) for the rural populace who were in dire need of access to care beclouded the need to challenge the non-involvement of local policymakers or actors (KII, HCP, 19/06/2019, Bacita). Supposing the various relevant actors in the healthcare system took part in the design of the policy content, perhaps, it might have reflected more realities in the State in terms of the workability and sustainability of the programme.

This confirms that the healthcare providers were also not involved in the policy design and they were merely given directives on how the programme should be implemented regardless of their abilities to add value to the policy content and their experience about their respective communities. The CBHI programme in Kwara State was established (in 2007) before the National Health Insurance Scheme (NHIS) came up with its

model known as Community-Based Social Health Insurance Programme (in 2010) but then, the input of the NHIS in the policy design might have been useful before the implementation of the Kwara programme.

However, the NHIS was relatively sidelined in the design and implementation of the programme, and its involvement was limited to facilities inspection. Very few (2 out of 9) among the participants (i.e. officials of the state government, international partner, HMO, NHIS, and the researcher) asked, claimed that the NHIS was carried along. An NHIS official noted that: “The NHIS was carried along in the design and implementation of the Kwara CBHI in terms of inspecting the facilities used and quality of service rendered” (KII, NHIS, 01/08/2019, Ilorin). Some participants expressed that the non-involvement of the NHIS was exemplified by a clash of interest at some point when the two authorities were separately attempting to establish CBHI and CBSHIP in a particular community (KII, HMO Official 1, 26/07/2019, Ilorin). Thus, the finding reveals that the NHIS, which is the regulatory agency for health insurance programmes in Nigeria, was not adequately involved in the design and implementation of the programme.

### **3.6. Policy Implementation and Domination**

Like policy design, policy implementation is a political process with complexities involving many actors (Campos & Reich, 2019:226) and partly influenced by ideas, knowledge, interests and motivations (Dolowitz & Marsh, 2012:341). Also, in a policy cycle, actors with different ideas and interests are always involved in the politics of domination and influence, especially during agenda-setting or policy formulation (Fox & Reich, 2015). Another window of influence often targeted by the dominated groups is the implementation stage to ‘right the wrongs’ by tilting implementation towards their interests. However, the CBHI policy space in Kwara relatively left no opportunity for such, especially for the local policymakers.

Though the KWSG (through its agency known as Community Health Insurance Scheme) was responsible for overseeing the implementation of the programme in selected public health facilities. Nevertheless, the implementation of the CBHI programme was seemingly dominated by the international partner because of the resources brought to the policy space – idea, knowledge and fund. When the involvement of the state government became contributory, the financial contributions of the state government were remitted to the PharmAccess Foundation (KII, Foreign Agency Official 1, 02/09/2019, Ilorin). The Foundation was responsible for releasing fund to the HMO that was commissioned for implementing the programme (i.e. HCHC).

This suggests that the state government, in addition to its non-involvement in policy design, had a secondary role in the implementation of the programme. Also, some decisions were exclusively made by the foreign partner, especially regarding choice of the community for the programme and standard of care (KII, KWSG Official 1, 20/08/2019, Ilorin). These are often done with influence, expertise, skills and other resources (see Hussain & Cornelius, 2009:201) to shape the direction of implementation.

Further, the international partner was solely in charge of monitoring and evaluation of the programme, though, the Kwara State Government officials were always present but without a technical role in the exercise. For instance, a participant lamented that the State government did not have its teams that could allow it to match up with the level of

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involvement of the international agency as equal partners. He noted that “The government did not have its independent Quality Assurance Team apart from the HMO’s that is privately-based; that could serve as checks and balances and as well, tame the excesses of the HMO (KII, HCP, 27/07/2019, Oro).

Same applies to the research conducted to carry out an impact assessment of the programme. Though a team of researchers was engaged from the University of Ilorin Teaching Hospital (UIITH), they were seemingly less involved compared to the teams from Amsterdam (see Amsterdam Institute for Global Health and Development, 2017). Aside from the constraints that the engagement of ‘foreign experts’ place on the in-country consultants (Stone, 2001), more often, these pave the way for the transnational organizations to generate an evaluation and research reports in ways that suit their interests. Two reasons pointed out that implementation of the programme was tuned to the interests of the international partner. One, the HMO was unilaterally engaged by the international partner. Two, the release of fund for implementation of the programme was through the international partner, notwithstanding the counterpart funding by the state government. According to Tidjani (2009:13), “this positioning of the experts includes the risk of leading governments to shed their responsibilities, owing to their intense workloads and the weakness of their capacities, thereby becoming secondary actors who merely endorse decisions that were taken at the technical stage, and which they cannot hope to change or shape”. Contexts like this create opportunities for policy domination.

Clearly, the ultimate goal of every healthcare reform is the attainment of UHC. The poor level of development in Africa makes it vulnerable, and it is seen as a testing ground for all sorts of social experiments. Though the programme was meant to enhance the people’s state of health in rural communities; some participants noted that it was also a way of testing hypothesis. A government official stated that: “It was a way of testing hypothesis and at the same time, it became an institution of learning itself” (KII, KWSG Official 2, 24/07/2019, Ilorin). Mostly, when hypotheses are tested, or experiments are conducted, there are chances that they may go wrong even if various kinds of precisions are considered. Fundamentally, policy options that are not home-grown are to be closely aligned with the realities obtainable in the recipient nations have high chances to fail (Dolowitz & Marsh, 2000:17). It is as a result of this that ethics is increasingly gaining prominence in research around the world. To liken this analogy to the use of Africa as a testing ground for social policies or programmes, more often than not, the people of Africa are left to their fates whenever these experiments (mainly promoted by the global North) go awful.

In fact, aside from the Kwara CBHI programme, other CBHI programmes sponsored by “HIF/PAF in Lagos (for market women and Computer and Allied Products Dealers Association), Kenya (for tea producers) and Tanzania (for coffee producers) collapsed as a result of financial sustainability and partly low enrolment” (Boston Consulting Group, 2015:20). This shows that the CBHI intervention programmes of the Dutch government in Africa have all stopped suggesting that the policy option is not appropriate. It is clear that CBHI is not new in the developing countries. However, the sustainability challenges of the health policy option appear to be a thing of concern to policymakers. Before the implementation of the Kwara programme in 2007, scholars such as Ekman (2004), Acharya

and Ranson (2005) and Tabor (2005) have expressed serious concerns about its sustainability, especially in terms of funding and enrolment which were the leading causes of the collapse of HIF-sponsored CBHI programmes in Africa. Similarly, Onwujekwe et al. (2009) and Uzochukwu et al. (2010) analyzed the challenges and eventual collapse of a CBHI programme in Anambra State Nigeria. Perhaps, the implementation of the Kwara CBHI had ideational underpinnings because these concerns could have been ‘convincingly’ addressed before implementation. Moreover, policy failures in Africa are closely related to “rent-seeking and neopatrimonialism, which leaves no room for learning or the interplay of ideas” (Mkandawire, 2015:598).

#### 4. CONCLUSION

Based on the case of Kwara CBHI, the study exposed the underlying goals that often characterise the introduction, design and implementation of policies in Africa. It elucidates the process through which policies are transferred and how the design and implementation are dominated by foreign sponsors. Given the various findings, the study argues that for a meaningful result in social services provisioning, repurposing the role of the state would be necessary with a view to ideationally taking full and decisive responsibility for community and national development. In other words, there is a need to unthink neoliberalism to rethink a new thing. Since the ability to pay for care is a significant impediment to access, it becomes necessary to adopt a more equitable and effective healthcare policy that will make healthcare accessible to all.

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