# Enabling Health Reform in Odisha, India: The Role of Applied Political Analysis

# ENABLING HEALTH REFORM IN ODISHA, INDIA: THE ROLE OF APPLIED POLITICAL ANALYSIS

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**Abstract**

Creating large-scale health system change requires a combination of technical solutions and political skills, analysis, and strategies. Understanding the political context of health reform is crucial to improving the chances of effectively designing, adopting, and implementing health policies that can achieve their intended objectives. Applied political analysis has been used to support health reform in diverse national contexts in low- and middle-income countries for different purposes. However, there are few published accounts of the process of conducting applied political analyses, let alone evaluations of the outcomes of political strategies. This gap in the literature hampers the development of the field of applied political analysis for health reform. A proper understanding of what works and what does not in doing applied political analysis is required to support health reform processes.

This DELTA thesis examines the process of conducting an applied political analysis to inform the development of policy proposals to improve the performance of the health system in Odisha, India. An applied political analysis of the position, power and interest of the stakeholders involved in health policy changes helps to understand their role in promoting, resisting, or blocking implementation, and the dynamics of their interactions (Reich, 2002). I followed the Six Steps for Applied Political Analysis (Reich & Campos, 2019): 1) Define the audience (client) and the problem; 2) Identify the policy to promote; 3) Describe the context of the policy; 4) Conduct a stakeholder analysis; 5) Design a set of political strategies; and 6) Assess the impacts of your political strategies. A purposive sample of stakeholders was selected

to represent five different groups in the health policy ecosystem in Odisha: interest groups, bureaucrats, financial decision-makers, leaders, and beneficiaries (Campos & Reich, 2019).

Applied political analysis does not guarantee success in policy reform or implementation. Policy processes are often unpredictable, and the context may change from one day to the next. However, being prepared to manage the political dimensions of health policy processes can increase the likelihood that the changes will be adopted and will achieve the desired outcomes. The role of applied political analysis is to help reformers engage effectively with the political context to create political feasibility for health reform. I offer four key lessons on how to improve the process of conducting a stakeholder analysis: 1) Purpose and framing: having a clear purpose for the analysis, a clear problem, and an engaged audience; 2) Timing: harmonized timelines and workplans of the technical and political analyses teams are needed; 3) Organizational context: a team of internal and external analysts, and regular communication with the client are essential; 4) Methods: the choice of the methods will depend on the purpose of the analysis and on the resources available to conduct it. Repeating the analysis over time as the policy process unfolds, and keeping track of stakeholders and strategies, can increase the chances of successful reform.

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## Introduction

Enabling and sustaining large-scale health system change requires a combination of technical solutions and political skills, analysis, and strategies (Roberts et al., 2004). Political analysis and strategies are needed because health sector reforms often result in a redistribution of resources; changing "who gets what and how." Furthermore, health sector reform requires organizations and individuals to behave differently. People may resist change because change disrupts established power structures and ways of getting things done; change often requires breaking old habits and relationships and starting new ones. The process of health reform creates political challenges. However, explicit attention to the political dimensions of health reform is often missing in health system frameworks and courses (Reich et al., 2016). An understanding and analysis of the political context —human agency of key actors, nature of political system, and civil society, among others— in which health policies are envisioned, developed, and implemented is crucial to improving the chances of their success in realizing their goals (Shiffman, 2019).

Applied political analysis is a way to actively engage with the political context in order to effectively manage health reform processes. Applied political analysis has been used to support health reform in diverse national contexts in low- and middle-income countries for different purposes. It has been used to help advocates promote maternal health as a political priority in Nigeria and India (Shiffman & Okonofua, 2007; Shiffman & Ved, 2007); to support the adoption of national health reform in Mexico (Gómez-Dantés, Reich, & Garrido-Latorre, 2015); to increase the chances of health reform adoption in the Dominican Republic (Glassman et al., 1999); and to explain the lack of implementation of tobacco policies in low-income

countries (Bump & Reich, 2013). Applied political analysis and political strategies have resulted in diverse outcomes; not always in successful health reform.

The objective of this DELTA project on health reform in Odisha was to conduct an applied political analysis to inform the development of policy proposals to improve the performance of the health system. For this purpose, I first helped to write a guide on how to do an applied political analysis (Reich & Campos, 2019). I reviewed the literature related to applied political analysis and reviewed other guides that had been published mainly by development agencies such as the United States Agency for International Development (USAID) and the UK Department for International Development (DFID). I then conducted a stakeholder analysis of Primary Health Care (PHC) in Odisha to inform policy development. The stakeholder analysis included a health policy landscape report detailing the health policies that the state of Odisha has adopted in the last twenty years.

**Context of the India Health Systems Project**

The India Health System project brings together an interdisciplinary group of health system experts from Harvard University to conduct health system and policy analyses to help the state of Odisha improve the performance of its health system. The primary objectives of the proposed program are to:

1. Conduct evidence-based health system and policy (HS&P) analyses that would contribute to innovations in health system reforms to achieve socially desirable outcomes.

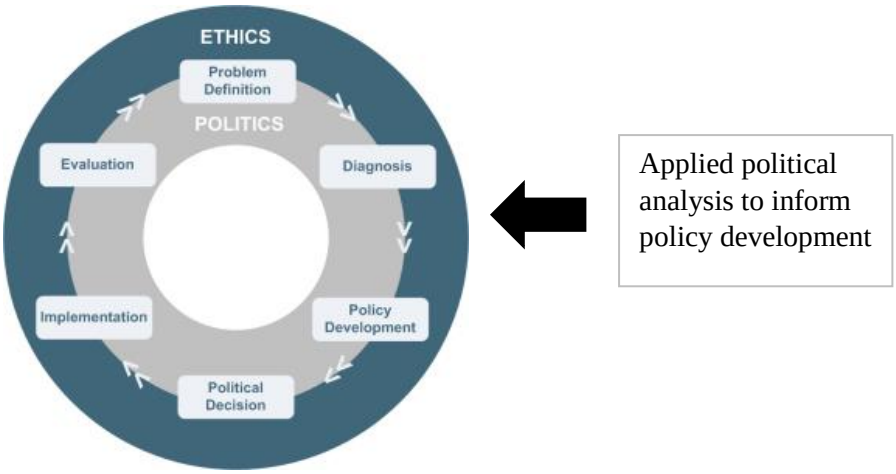
2. Train a new cadre of Indian researchers/analysts in HS&P research; this group can serve as locally embedded objective and evidence-based advisors to health policymakers in Odisha and elsewhere in India to improve the performance of their health systems

The project follows the logic of a policy cycle starting with an assessment of the strengths and weaknesses of Odisha's current health care system. The evidence generated by these analyses informs the design of health system reform options. The process is guided by stakeholder and political analyses that clarify and identify priority problems to address, and political, fiscal and institutional constraints that need to be incorporated into the design. Based on the state government's decision, a subset of the reform options will be selected for detailed design and implementation.

Each member of the Harvard group and their own teams work on a specific dimension of health systems research. The Harvard group has partnered with a team of researchers from the Indian Institute of Public Health (IIPH-B) in Bhubaneshwar to conduct health system research in the state. My responsibility was to contribute to the stakeholder and political analyses component of the project while ensuring that my engagement with IIPH-B, Odisha's broader stakeholders, and other member and institutions helps the Harvard team realize the project's objectives.

The policy cycle framework (Roberts et al., 2004) below helps to situate my work at a specific policy stage.

**Figure 1 Policy Cycle Framework**



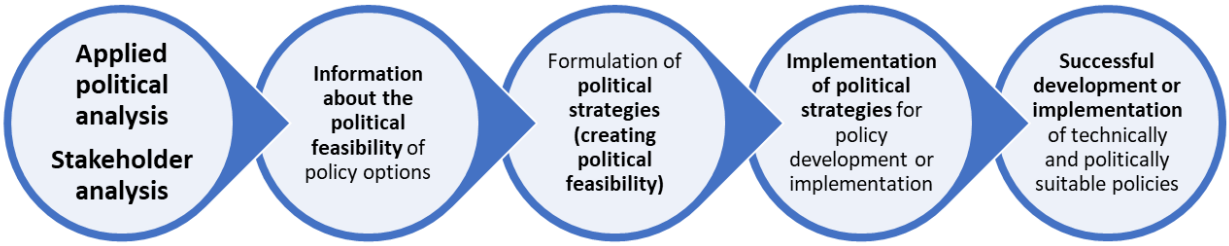

Source: Adapted from (Roberts et al., 2004).

While the technical team of the India Health Systems project worked on identifying the causes of the health system's problems and proposing policy solutions to address those causes; I worked on exploring the political feasibility of PHC policy solutions. Different policy options have different levels of political feasibility, due in part to stakeholder interests, institutional contexts and social values (Reich & Campos 2019). The technical and the political need to be linked together and speak to each other, in order to design public policies that can be adopted and implemented effectively, in health as in other sector (Sparkes et al., 2019).

**Theory of change**

Applied political analysis is a key component of translating knowledge into policy and practice. Politics affect how policies are developed, adopted, implemented, and evaluated (Reich, 2002). Health system reformers need political analysis and strategies to translate evidence into policy, and policy plans into tangible outcomes (Sparkes, 2019). An analysis of the position, power and interest of the stakeholders involved in health reform process helps to understand their role in promoting, resisting, or blocking implementation, and the dynamics of their interactions (Reich, 2002). This analysis informs the development of policies by providing information about the political feasibility and appropriateness of different policy options. Furthermore, an applied political analysis can also help to create political feasibility of a specific policy by implementing political strategies. The expected outcome of applied political analysis and political strategies is the successful development or implementation of health reform as shown in the figure below.

**Figure 2 Theory of Change**




Applied political analysis does not guarantee success in policy reform or implementation. Policy processes are often unpredictable, and the context may change from one day to the next. However, being prepared to manage the political dimensions of health policy processes can increase the likelihood that the changes will be adopted and will achieve the desired outcomes.

**DELTA thesis outline**

The thesis is organized as follows:

1. **Chapter 1 Applied political analysis for health policy implementation**

   This section presents the analytical platform of the DELTA project. It presents a paper on applied political analysis for health policy implementation, focusing on the management of stakeholders in order to improve the chances of achieving policy objectives (Campos & Reich, 2019). This paper provides a characterization of stakeholder groupings that are relevant for all phases of policy reform, but we focus on the challenges for health policy implementation. For my DELTA project, I used the stakeholder groupings in the analysis to inform policy development.

2. **Chapter 2 Health policy landscape in Odisha**

   This section provides a summary of the history of health policy in Odisha in the last twenty years to inform future health system reform options to improve the

performance of the health system. At the beginning of conducting an applied political analysis it is helpful to understand the context of the proposed policy; and analyze contextual factors that may hamper and facilitate health reform (Shiffman, 2019). It is important to learn about whether similar policies have been debated before, whether there have been past attempts at solving the problem at hand, and whether they worked.

3. **Chapter 3 Results Statement: Conducting an applied political analysis in Odisha**

   This section presents the results statement. It provides a narrative discussion of what transpired during the period of the project in terms of the degree to which stated goals and objectives of the DELTA project were achieved. The focus of this section is on the process of conducting applied political analysis. This section ends with key lessons on how to improve the process of conducting an applied political analysis.

4. **Chapter 4 Conclusions**

   In this section, I present my reflections about how to improve the process of conducting an applied political analysis, focusing on two major issues that emerged during my DELTA project: timing and relevance. I also discuss the limitations of this project.

5. **Appendix A**.

   A Guide to Applied Political Analysis for Health Reform (Reich & Campos, 2019)

**Relevance of the DELTA thesis**

This DELTA thesis contributes to the body of knowledge of using applied political analysis to inform the development and implementation of health system reforms. Several authors (Gilson et al., 2018; Reich, 1993; Walt et al., 2008) highlight the need for applied political analysis in health policy processes and provide “how to guides.” However, there are few

published accounts of the process of conducting applied political analyses, let alone evaluations of the outcomes of political strategies. Learning about what works and what doesn't in conducting applied political analysis is key to advancing the field and making political analysis a useful health reform tool. I hope that this DELTA thesis provides helpful reflections about the process of conducting applied political analysis to enable health reforms.

This DELTA thesis examines the process of conducting an applied political analysis through a single case study which limits the generalizability of the conclusions. However, single case studies are helpful to reveal process details; some of the challenges I encountered are likely to appear in other contexts. In the last section of the thesis I offer key lessons based on my experience of conducting an applied political analysis in Odisha.

Applied political analysis can be a useful tool in supporting the process of health reform at different stages of the policy cycle. The role of applied political analysis is to help reformers engage effectively with the political context to create political feasibility for health reform. I present my reflections about how to improve the process of conducting an applied political analysis, focusing on two major issues that emerged throughout my DELTA project: timing and relevance.

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# CHAPTER 1 Political Analysis for Health Policy Implementation[1]

## Introduction

Any policy effort to improve health system performance must address the challenges of policy implementation (1). But health policy analysis in general tends to emphasize issues of policy design and adoption over questions of policy implementation. Although these policy cycle phases may overlap and share common challenges, a focus on policy implementation is still needed. This article seeks to correct this gap in the literature. We build on existing knowledge about health policy implementation in low- and middle-income countries to propose a way of both identifying and addressing some of the central challenges.

Policy implementation is a complex phenomenon and cannot be adequately covered in a short paper. We therefore focus only on certain aspects of health policy implementation using the lens of political science. Even this focus is not easy, however, in part because few political analyses have been conducted of health policy implementation in low-income and middle-income countries (LMICs) (2,3). This article examines one aspect of implementation—the politics of policy implementation for the health sector—particularly the management of stakeholders in order to improve the chances of achieving policy objectives. We provide a characterization of stakeholder groupings that are relevant for all phases of policy reform, but we focus on the challenges for health policy implementation.

Throughout the article, we refer to health policy or health reform implementation with the understanding that health reform usually involves multiple policies seeking to achieve system-

[1] Campos, P.A. & Reich, M.R. (2019). Political Analysis for Health Policy Implementation, Health Systems & Reform, 5(3), 224-235. https://doi.org/10.1080/23288604.2019.1625251. Published with license by Taylor & Francis Group, LLC© 2019.This is an Open Access article distributed under the terms of the Creative Commons Attribution License.

wide change. By health policy, we mean a government decision and plan of action to make progress towards the goals of the health system: improved population health status, increased financial risk protection, and increased client satisfaction; or the intermediate outcomes for health systems, under which we include: quality, access and efficiency (1).

The conceptual framework for this article draws on the theoretical literature in political science and sociology while being practice oriented. The article is intended to assist people tasked with strategic planning for health policy implementation; these people include government policy makers and high-level implementers but may also include policy actors outside of government. They may belong to a stakeholder category themselves. We call these people "policy implementers" or "change teams," although in practice, they may not be officially formed teams with a clear implementation mandate. Our argument, in short, is that a group of people need to plan for and manage health policy implementation for it to be successful, and they will often confront political challenges in dealing with implementation stakeholders. This article may also assist those responsible for designing health policy, in helping them anticipate implementation challenges that can be addressed in the design phase.

**The challenges of implementing health policy**

The implementation of a new health policy demands more than providing instructions around a policy document or designing a set of standard operating procedures (1,4). Effective health policy implementation requires "the aggregation of the separate actions of many individuals, and [an understanding of] how and why the actions in questions are consistently reproduced by the behavior of individuals" (5). One fundamental implementation challenge is that the responsibility for health policy implementation usually rests with a different set of governmental actors than the ones who designed the policy (6). Policy designers often do not

understand the perspective of the implementers. The process of policy implementation thus requires working with and through a set of actors and organizations to communicate policy objectives, ensure availability of resources, achieve ownership of the policy by implementers, manage conflict and cooperation, and sustain policy changes. To start a new program and maintain it, joint efforts and contributions from multiple governmental agencies or private actors are needed. This frequently results in delays, renegotiation of resources and responsibilities, and confusion among the beneficiaries (6). In short, implementation is messy.

To move health policy forward into practice, implementers must realistically consider the difficulties of implementing a policy in their particular national context (1). Policy implementers or change teams need to recognize the complexities and characteristics of the administrative context in which their policies will become operational (7). Those leading policy implementations need "persistence, discipline, and rigor" to work within their particular contexts, and they need to make difficult decisions regarding staffing, organizational structure, and relationships with stakeholders (8) to make policy implementation happen. Doing all of this in real time is not easy.

**Different approaches to the study of policy implementation**

Given the complexity of policy implementation as a social phenomenon, it is no surprise that multiple approaches exist to study and understand it. Here we discuss a few of the different approaches and their conclusions.

Starting in the 1970s, political science as a discipline began to recognize that public policies were rarely implemented as designed and that policy outcomes were rarely achieved as desired. The seminal book by Pressman and Wildavsky (9) brought the challenges of policy implementation front and center. They coined the term "implementation deficit," referring to

when the linkages get fractured between levels of government and among organizations at the local level. According to the authors, “the longer the chain of causality, the more numerous the reciprocal relationships among the links and the more complex implementation becomes.” The book’s subtitle remains striking in its length and its message: *Implementation: how great expectations in Washington are dashed in Oakland: or, why it’s amazing that federal programs work at all, this being a saga of the Economic Development Administration as told by two sympathetic observers who seek to build morals on a foundation of ruined hopes.* The book persists as a classic and required reading in the study of implementation (9).

From this time forward, studies of implementation began to expand in political science and in the field of public administration. The term “implementation gap” appeared to refer to a judgement made after comparing what is achieved and what was expected from policy (10,11). “Implementation studies” sought to explain why policy implementation failed and to identify effective approaches for affecting “what happens” (11). These studies sometimes contrasted “top–down” approaches with “bottom–up” approaches to improving the chances of implementation. Hill and Hupe identified a key implementation challenge in the governance arrangements that occur in different policy layers, also called the “multi-layer problem” (7).

More recently, “implementation science” has appeared. In public health, these studies seek to bridge the gap between what is known to work and what can be put in practice to improve population health. This is also called the “know-do gap.” Implementation science uses multidisciplinary methods to systematically drive progress in scaling up evidence-based interventions. Implementation science has its own methods and set of tools, including stakeholder analysis, effectiveness evaluations, and mathematical modeling, all used to scale up and sustain evidence-based interventions (12).

Another approach to the study of implementation is called *Deliverology*, "the science of delivering results," which provides a package of methods to drive progress and deliver results in government and public policy (8). The main proponent of *Deliverology* is Michael Barber, who served as Chief Adviser on Delivery to the British Prime Minister Tony Blair (starting in 2001) and headed the Delivery Unit for the public policies of the Prime Minister. Barber developed these methods for many kinds of public policy, including health, education, agriculture, and other areas of public service. The methods are designed to measure and drive progress for specific public policy targets by focusing on outcomes.

As mentioned above, this article focuses on only one aspect of implementation—the politics of policy implementation for the health sector—particularly the management of stakeholders in order to improve the chances of achieving policy objectives. Attention to diverse stakeholders is a common theme in various approaches to the study of implementation. The focus on the politics of implementation shares with other approaches the common objective of seeking to make implementation more effective in delivering policy goals.

**Why study the politics of policy implementation?**

Health sector reform requires organizations and individuals to behave differently (1). Yet modifying behavior is a difficult task because change is almost always resisted. People resist change because change disrupts established power structures and ways of getting things done (13); change often requires breaking old habits and relationships and starting new habits and relationships. Furthermore, turning an adopted policy into specific activities, outputs and outcomes involves a redistribution of resources and responsibilities. In short, policy implementation inevitably involves politics.

The politics of policy implementation is about managing actors, organizations and institutions that have a stake in health reform. Barber talks about "the alchemy of relationships"—referring to the process of building constructive relationships with all the ministers and officials involved with implementing the prime minister's ambitious agenda, in order to assure delivery (8). Implementation requires paying attention to the interests of the actors involved in a policy and to the structured relationships between them (7).

Implementation often entails consensus building, conflict management, and power bargaining among stakeholders located in different corners of the policy environment: members of budget and oversight committees in the legislature; formal and informal policy advisors for political leaders; affected organizations and interest groups; political appointees in charge of the implementing agency; bureaucrats across various agencies; and beneficiaries both powerful and powerless. The complex bargaining process required for implementation can result in the "adaptation, modification, negotiation, replacement or even undermining of policy goals" (7).

**Implementation in the policy cycle**

Policy processes for health (and other fields) can be viewed as a cycle. According to one theoretical perspective, public policy moves through a cycle of six stages—problems are defined, a causal diagnosis is made, plans are developed, a political decision is made on reform initiatives (policy adoption), the reforms are then implemented, and their impact is evaluated (1). This logical and linear sequence, however, rarely occurs in the real world. In practice, health policy efforts begin in different places and skip stages, or several stages may occur at the same time. For example, as John Kingdon pointed out, policy entrepreneurs for certain solutions often seek out social problems that create opportunities for adopting the solutions they support (14). This

sequence reverses the logical relationships among the stages of the policy cycle; solutions actively pursue problems, rather than having rational analysis of problems produce solutions.

Policy *adoption* and policy *implementation* thus have a complex relationship:

- *Policy adoption can require compromises that complicate implementation*; in order to assure adoption of a policy, it may be necessary to change the content of a policy (to win the support of certain stakeholders), for example, in ways that reduce accountability and thereby reduce the likelihood of effective implementation.
- *Policy makers may not anticipate implementation requirements*; the separation between policy makers and policy implementers may make it difficult for the designers to fully understand how a policy will be accepted in the field.
- *Policy makers may not want to see a policy implemented* and may use the expected implementation gap to assure ineffectiveness of a policy (i.e., "the policy was well-intended but there were implementation challenges").
- *Implementation can re-shape the statutory policy*. The decisions of "street-level bureaucrats" (those in direct and regular contact with citizens) create established routines and devices to cope with work pressures and uncertainties, which transform statutory policy into the public policies that are carried out (5). Policymaking thus continues in the implementation stage (11).
- *Policy development and implementation may overlap*. Often policies are hastily adopted, without attention to details, resulting in a concurrence of policy development and implementation; policy designs are finalized as the policy is implemented.
- *Policy implementation may come before policy adoption*, for example, when pilot projects occur before a political decision on the policy has been made.

These examples illustrate the complex dynamics between policy development, adoption and implementation. When designing a policy, it is important to look forward in the cycle to matters of political decisions, implementation, and evaluation. Policy development is important, because it shapes implementation; but as noted above, implementation can change what the policy is.

Policy evaluation represents the last stage in the theoretical policy cycle—when policy processes, outputs and outcomes may be assessed, depending on the type of evaluation. But in practice, evaluation may also happen out of cycle. Evaluation may occur before a policy has a chance to produce robust results—for example, when a government seeks to show *some* results before an administration ends; or when a government seeks to show *no* results in order to eliminate a policy. Or an evaluation may be delayed for a long time, in order to avoid showing limited outcomes that might embarrass a government in power.

The main point is that the policy cycle is a useful heuristic device, to think about how a logical sequence of events could occur in the field of public policy. But it should not be confused with what happens in public policy in practice.

**Methods**

For this review, we conducted a literature scan of political analyses of health policy implementation in LMICs in PubMed and Google Scholar. Due to the limited available literature, we broadened the scope of the search to include descriptions of health policy implementation, including some articles that use an historic lens to discuss particular health policies, to draw insights and inferences about the politics of implementation. We decided to look at health policy implementation according to six major categories of actors that participate in health policy implementation in LMICs. These six categories are explained in the next section. Each category relates to a significant group of stakeholders involved in health policy

implementation and also at a broader conceptual level, to a significant theoretical literature in political science.

To illustrate the varying roles of different stakeholder categories, we selected examples of published case studies on the challenges policy implementers may encounter and how they can use different political strategies to promote, slow-down or resist effective implementation related to specific stakeholder groups. The examples we use do not necessarily illustrate the most common strategies nor are they necessarily applicable to other contexts. As mentioned before, decision-makers need to consider and address the challenges of implementing a policy idea in their particular national context (1).

Four of the seven illustrative examples we use are from Asia (at the request of the sponsor for the original background paper, on which this article is based). We refer to examples in other parts of the world to illustrate key concepts, given the limited availability of published studies of health policy implementation in LMICs in Asia.

**Conceptual Framework**

One way to think about the politics of policy implementation is to identify stakeholders involved in the process. For implementation of health policy, we identified six different categories of stakeholders that need to be managed in promoting implementation. Understanding their interests, their positions, and their power is key to developing effective strategies to manage the stakeholders and move implementation forward.

We believe that officials responsible for implementing health policy, change teams or policy implementers, need to consider management in six different directions for different kinds of stakeholders:

- "Manage outside" by managing **interest groups** that may resist or promote policy implementation to protect their interest.
- "Manage within and around" by managing **bureaucrats** working in the multiple layers of administrative organizations.
- "Manage money" by managing **financial decision-makers** within the system.
- "Manage up" by managing their superiors, often **political leaders** to ensure their commitment to policy implementation.
- "Manage down" by managing the intended **beneficiaries** of the policy and mobilize their engagement and elicit their feedback.
- "Manage donors" by managing **external actors** that may fund health policies and influence implementation, especially in low-income countries.

Implementers also need to manage themselves, to drive a high performing change team. Setting up systems for self-directed learning and feedback is one key aspect of creating an effective implementation team. However, this aspect is beyond the scope of this essay. Figure 3 presents the six categories of stakeholders for policy implementation.

**Figure 3 Six Groups of Stakeholders for Implementation.**

## Managing the stakeholders of policy implementation

This section is written from the perspective of the policy implementation team. For each stakeholder group, we provide a general assessment of the political circumstances of implementation related to those stakeholders, and then discuss how the implementation team can manage those political dynamics. We then present a brief case study, as an illustrative example of the complexity of managing stakeholders. The example is not intended to be exhaustive or complete, but rather illustrative.

The categories of stakeholders can be overlapping; bureaucrats can be beneficiaries at the same time, if a health policy affects, for example, their access to healthcare; leaders can be part of an interest group, in the case for example of political leaders with a medical degree. It is also important to bear in mind that stakeholders may use similar strategies or a mix of overlapping strategies to promote, block or slow down policy implementation.

### Interest group politics ("managing outside")

Interest groups often seek to influence health policy at different stages of the policy cycle, to minimize their losses and maximize their gains from the proposed changes. Producer groups that typically seek to influence health policy include medical professionals, health insurance companies, hospital owners, and producers of pharmaceuticals and medical technology. For example, in India the medical association mobilized to block workforce policy reforms that would have diminished medical professionals' control over health markets (15).

Groups on which concentrated costs of policy changes are perceived to fall (such physicians, insurers, employers) are typically better organized and more powerful than groups of beneficiaries who tend to be not well organized and less powerful (general consumers, rural residents, and poor people). This creates what Mancur Olson called a "collective action

dilemma" (16). However, consumer groups are becoming increasingly important in many LMICs, especially with the rise of social media and with economic and political development.

Interest groups use various political strategies to influence implementation. For example, interest groups can capture the regulatory agency responsible for decisions to obtain increased influence over how policy is put into practice. The concept of regulatory capture (17) is used to describe the takeover of government agencies by interest groups that seek to weaken regulation and enforcement or shape regulation to fit the industry's interests, and thereby advance their agendas. In effect, the regulatee takes over the regulator. Interest groups can also resist policy implementation by using discretion to exercise authority as they interact with beneficiaries.

How can an implementation team resist these efforts by interest groups? When a powerful interest group actively resists or passively ignores a policy, the implementation team may need to design policies to counter the group's influence or may need to create incentives (financial or symbolic) to mobilize the interest group to implement the policy (see Example 1 below). When an interest group does not exist to support a policy (see Example 2 below), the implementation team may need to create a new organization that has direct interests in promoting implementation or mobilize beneficiaries to act as an interest group in favor of policy implementation. Civil society can be mobilized to monitor policy implementation. This was the case, for example, of women's group's participation in ensuring that actions followed the commitments about sexual and reproductive health stipulated in the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 fourth World Conference on Women in Beijing (18).

Example 1 illustrates the use of discretionary power by an interest group to resist implementation. In this case, Indian medical practitioners were successful in opposing the efforts

of authorities to enforce HIV testing guidelines (15). These less visible ways of influencing the implementation processes and outcomes of health polices might be more prevalent and important than very organized, direct and instrumental resistance (19).

*Example 1 – Resisting Implementation by an Interest Group in India*

In 2006, India's National HIV/AIDS Prevention and Control Program launched its third phase. The program was the official source of national policies and guidelines for HIV care and treatment including HIV testing. Some of the guidelines applied to the behavior of doctors, including the requirement of taking written informed consent before prescribing an HIV test, and maintenance of strict confidentiality around test results.

Practitioners in both private and government hospitals attempted to resist or subvert the efforts of regulators to enforce the guidelines. One senior physician said (19):

> ''Everybody knew that there is this policy, but nobody knew where it has come from. And they all agreed with me—they said yes, there is no reason for it. I visited people in NACO [National AIDS Control Organization] . . . Nobody could tell me where this has come from. Finally [a senior HIV/AIDS program official] agreed—they have this, but they don't know where it has come from. He just said 'it's there'.''

Doctors widely resisted the regulator's authority and protected their interests in different ways entailing either subversion or simple disregard of official norms.

*Example 2* shows a different way that interest groups can affect implementation. Hawkes and colleagues show how the lack of interest groups can result in a low level of implementation of evidence-based interventions (20).

*Example 2 – Low Implementation Due to Lack of Interest Groups Supporting the Policy*

Screening pregnant women for syphilis has long been a recommended intervention for reproductive health programs; treating women found to be serologically positive is a simple and highly cost-effective intervention. The treatment relies on penicillin, which is inexpensive and on WHO's essential drug list. Many countries have had syphilis screening policies in place for years. Despite the existence of policies, however, the same countries often lack functioning screening programs. Programs exist, but they have not been scaled up or sustained beyond successful pilot interventions.

Hawkes and colleagues (20) analyzed why syphilis screening programs have not been effectively implemented and concluded that one important reason is that few interest groups stand to gain economically from major efforts to diagnose and treat this disease. Interest groups such as pharmaceutical companies are not financially interested in supporting the implementation of syphilis screening programs. In addition, those who stand to benefit from the program, pregnant women, are not aware of the problem and are not well-organized. There seems to be a lack of interest group mobilization associated with syphilis treatment.

**Bureaucratic politics ("managing within & around")**

Bureaucrats are often the key actors responsible for implementing a health policy. Even if they are not part of the policy design process, they are none the less tasked with implementation. Furthermore, when multiple government agencies have responsibility for a given health policy, interagency collaboration may be challenging. Competition and conflict can arise among different government agencies to control a policy and its implementation, as different agencies seek to expand their own authority, budget, personnel, and general influence. This kind of

horizontal fragmentation, across different government agencies, can disrupt implementation, which can be compounded by budget politics (discussed below). Competition can also arise within a single agency between departments or units.

Implementation of health policy also depends on the actions of street-level bureaucrats. Lipsky's theory of street-level bureaucracies claims that the exercise of discretion by implementers is a critical component of what frontline workers do in their regular contact with citizens (5). Street-level bureaucrats' discretionary use of authority to change, block, or promote the delivery of benefits to beneficiaries turns them into de facto frontline policy makers, as they shape what policy implementation means in practice. Workers at the frontlines "ultimately translate policy intentions into practice, influencing the lived experience of patients and citizens" (4). Managing a decentralized bureaucracy has its challenges because bureaucracies cannot simply be led from the center through command-and-control approaches. Gilson (4) proposes the use of distributed leadership to promote policy implementation through chains of leaders located across levels and positions within the health system. This strategy uses a flow of energy and power to harness the wide range of actors across the system to achieve collective goals (4). Reich and colleagues (21) echo the need to think about how to create leadership that involves "many systems, many levels, many leaders"—from the national, to the regional, to the point of health delivery.

Adopting this more participatory approach to leadership encourages challenges due to ingrained habits of centralized decision-making, individualized decision-making by top leaders, and the dominance of the medical profession (22). Implementation teams need to invest time in finding common ground across stakeholders and in building credibility and trust.

High-ranking bureaucrats benefit from a varying degree of bureaucratic autonomy from organizational authority and may draw on various resources that make them key players in health policy processes. This point is illustrated by the decision of high-level bureaucrats in Thailand to implement a new UHC policy as a "national pilot project"—before the policy was passed as law by Parliament, to avoid potential delays in implementation by the new government and to avert expected pressure from the medical profession (23). The policy implementation team must consider the critical roles of both high-ranking bureaucrats and frontline workers in designing strategies to promote implementation.

Example 3 illustrates bureaucratic conflicts that arose when an interest group, the tobacco industry, became part of the bureaucracy in China, and created significant challenges to an administratively weak Ministry of Health in implementing tobacco control policies (24).

*Example 3. When an Interest Group Becomes Part of the Bureaucracy: Tobacco Policies in China*

This case shows the challenges of implementing WHO's Framework Convention on Tobacco Control (FCTC) in China because of the political power of the pro-tobacco interest groups within bureaucratic institutions and policy networks. WHO's Framework Convention on Tobacco Control (FCTC) is a treaty that obliges member states to adopt national legislation and implement specific policies to reduce the prevalence of smoking (24).

China ratified the FCTC in 2003 and 2005, but little progress has been made in implementing the policies, compared to Brazil and India, due to powerful domestic stakeholders. China has the largest tobacco industry in the world with the state-owned China National Tobacco Corporation (CNTC). After the ratification of FCTC, China set

> up institutional arrangements that legitimized the CNTC as an official stakeholder in the implementation of the FCTC. When the FCTC took effect in 2006, China's State Council established a cross-ministerial task force to implement it comprised of the MOH, the Ministry of Foreign Affairs, and China's State Tobacco Monopoly Administration (STMA). Then after 2008, the Ministry of Industry and Information Technology (MIIT) became the agency tasked with implementing FCTC, with one of the eight standing committee members being STMA, the political representative of the tobacco industry.
>
> The MOH is the weakest bureaucratic agency in the FCTC-implementing institutions in China, and the STMA has successfully managed to block implementation of the FCTC with its political connections and financial power. It is like "having a proxy for Philip Morris appointed to the US Federal Drug Administration to make tobacco control policies" (24). Without an increase in the relative power of the MOH compared to tobacco industry representatives in the bureaucratic institution responsible for implementing tobacco control, it will be difficult for the FCTC policies to be effectively realized in China.

**Budget politics ("managing money")**

A major challenge in health policy implementation is that available or allocated financial resources may not be sufficient for the activities required for effective policy implementation. Health policy is often about redistribution of resources and equity considerations, which make the budget process politically sensitive. The ministry of finance allocates public resources across different sectors with competing interests. The ministry of health often fails to provide persuasive technical evidence on the potential financial implications of their health policy proposals. Furthermore, election campaigns often trigger promises to implement ambitious

health schemes that may not have sufficient financial resources to be implemented or sustained. In addition, systems of budget allocation and budget expenditure are often not transparent or well understood. The politics of deciding and disbursing budgets, therefore, has great impacts on policy implementation. While bureaucratic actors are usually at the center of budget politics, we have separated bureaucratic politics from budget politics because of its importance in health policy implementation.

Implementation teams therefore need to develop effective strategies to create alliances with the ministry of finance and with legislative committees that oversee budget development and approval. In Mexico, for example, the Ministry of Health created an economic analysis unit that could undertake studies that would be understood and accepted by the Ministry of Finance, and the Minister of Health supported policies proposed by the Minister of Finance in order to develop a relationship of trust at the highest personal level (even if the proposed policies had some political costs for the Health Minister) (25).

Example 4 illustrates how Thailand's Prime Minister used his leadership position and political skill to expand the country's fiscal capacity and change the way budgets were decided in order to ensure adequate funding for UHC policy implementation (26).

> *Example 4 – Securing Adequate Policy Budget by HighLlevel Political Actions in Thailand*
>
> In 2001, Prime Minister Shinawatra obtained a victory for his Thai Rak Thai (TRT) Party. Just two months before the election, the TRT announced, as part of its policy platform, the "30 baht treat all" scheme for universal access to subsidized health care. Under the scheme, people would pay 30 baht (about $1.00 USD) for each visit or admission. At the time, the gross national income (GNI) per capita was not high ($1990

USD per capita), and the domestic fiscal space was small (government tax amounted to 13% of GDP) (26).

In 2002, PM Shinawatra created a new institution, the National Health Security Office, through which he implemented his policies and channeled government funds. He took the financial resources from the Ministry of Public Health and channeled most of the health budget through the new institution. The Prime Minister was able to re-direct the funds from hospital construction to the operation of the 30-baht scheme. He was able to do this because of his power as the leader of a majority party; for the first time in the democratic era of Thailand, a single party had won a majority in parliament (27,28).

The Prime Minister also had the leadership ability and capacity to mobilize an additional 30 billion Thai Baht from general taxes. He adopted closed-end budgets, per capita budgets based on unit cost and utilization rates of different types of services, and capitation payments which facilitated the projection of total funding needs and hence the assessment of financial feasibility.

**Leadership politics ("managing up")**

It is well-known that the commitment and competence of leaders to a policy profoundly affects its adoption and implementation. Indeed, health systems need leaders with strategic vision, technical knowledge, political skills, and ethical orientation to direct the processes of policy formulation and implementation (29). Overcoming the many sources of resistance to change (that arise in response to adoption and implementation of new policy ideas) requires sophisticated leadership and management skills. Few health system leaders have had experience as the chief executive of a large organization, and they rarely fully grasp the importance of management skills (1).

To assure policy implementation, leaders must promote, enable, and support decision-making and execution by actors at all levels of the health system. Ultimately, policy takes effect or is blocked at the frontlines of service delivery and community engagement (4), far from the center of policymaking—but obstacles can arise at all levels in a health system. In a decentralized or federal political system, the center has limited capacity or direct leverage to promote effective action at lower levels, as a form of vertical fragmentation. Sub-national units led by other political parties often make their own political calculations and take an independent position. Sometimes a sub-national unit (a state or province) may openly refuse to adopt a national policy even when significant economic incentives are offered by the center (as has occurred in India and the United States for health policy).

Sometimes, an implementation team needs to call on and mobilize higher political leaders in order to assure implementation of a controversial health policy. This relationship with the top political leader can also be critical in the adoption of a major health reform, as illustrated by the case of Mexico's Seguro Popular (25). In that instance, the Minister of Health presented the health reform effort in terms of "democratization" to align with President Vicente Fox's priorities for Mexico, and thereby gave higher attention to health reform as a political goal for the administration.

In Example 5, Turkey's Minister of Health confronted obstacles from the Ministry of Labor, which resisted his efforts to unify the nation's hospitals under his Ministry. He ultimately needed to call on the Prime Minister to transfer the social security hospitals, managed by the Ministry of Labor, to the Ministry of Health in a sudden and strong political move (30).

*Example 5 – Managing Your Boss in Turkey*

In 2003, the incoming Minister of Health, Recep Akdag, introduced a series of reforms under the Ministry of Health's (MoH) Health Transformation Program (HTP), with the goal of providing health coverage to all citizens through a unified system. Even with a parliamentary majority of the AK party, Minister Akdag's proposal to create a single-payer system was not universally accepted within his political party. He also confronted opposition from the bureaucracy, executive leadership and judicial branch. The Minister of Health and his team of advisors therefore designed and used political strategies to address and overcome opposition (30).

The health reform sought to bring together Turkey's three separate social security institutions: SSK and Bag-Kur managed by the Ministry of Labor and Social Security (MoLSS), and the Emekli Sandıgı managed by the Ministry of Finance. The three social security institutions were funded through a combination of payroll taxes, employer contributions, and general government tax revenues. There was also a Green-Card Program for the unemployed and informal workers.

One of the main opponents to this merger was the MoLSS, because the unification policy would diminish its power and influence in the health sector. As part of the reform, the MoLSS had to transfer its health facilities to the MoH. However, the MoH was unable to persuade the MoLSS to transfer its SSK hospitals to the MoH. Minister Akdag and his team therefore "managed-up" by requesting direct intervention by the prime minister to ensure the transfer of hospitals. After months of back-and-forth discussions between the MoH and MoLSS, "the prime minister personally called the minister of labor and social security to inform him that all SSK hospitals would be moved under the MoH virtually overnight" (30).

**Beneficiary politics (managing down)**

For health policy implementation to be successful, the implementation team needs to consider how the new policy will change existing benefits. Some beneficiaries may see their benefits limited or decreased; others may see their benefits increase or improve. To implement a new health policy, it is important to build trust with new beneficiaries, solicit feedback from them, and sometimes mobilize them into action. Implementers may encounter situations where beneficiaries are not informed about the new benefits or are not interested in the new health policy, which may pose obstacles for enrollment. Another challenge is that beneficiaries' opinions about the new health policy may be swayed by competing visions of other stakeholders. Effective, early and regular communication with beneficiaries can be essential to policy implementation.

Health systems have opportunities for engaging with beneficiary communities to improve the delivery of health services and achieve better health outcomes. Engagement with beneficiaries is important to drive implementation towards intermediate performance goals—quality, access, efficiency—and equity of the three ultimate goals: improved health, satisfaction, and financial protection (1). For this, beneficiaries may be encouraged to participate in planning meetings, in health committees; raise their needs and concerns; and collaborate with state actors in assessing implementation performance and problems (31). Feedback from beneficiaries is key to monitor implementation and adjust it along the way.

With adequate institutional incentives, community engagement can strengthen direct accountability relationships between the users of health services, the government and service providers to improve health outcomes (32). However, this requires adequate investment by the state, and usually it requires more and not less investment (33). And sometimes it can require

that other stakeholders (such as the central or state government) give up some power. National governments need to set up support and incentives to encourage service providers to recognize and respond to beneficiaries' feedback and changing needs. Without such institutional arrangements, local officials may be incentivized to focus their attention upwards, towards their superiors, rather than downwards (31).

Digital technologies open new opportunities for beneficiary engagement (34). For example, social media, and mobile apps can serve as platforms for informing citizens on their rights and minimum service standards; accessing information; providing mechanisms to hold service providers accountable; raising awareness; or developing easily accessible complaint mechanisms. These technologies can help address collective action dilemmas by facilitating the mobilization and organization of beneficiaries.

Example 6 illustrates the case of patient navigators for the implementation of the Affordable Care Act in the United States. It shows how beneficiaries can be engaged to ensure policy implementation by creating a new role with the explicit responsibility of engaging with beneficiaries (35, 36, 37). "Navigators" were insurance brokers and/or non-profit groups that explain to the public just what exactly a "health exchange plan" was (36). The example also shows how implementation was made difficult through targeted efforts to undermine the implementation of the patient navigators program by certain states (and later the Trump administration), seeking to prevent people from being informed and engaged.

*Example 6 – Creating New Roles for Beneficiary Engagement: "Obamacare's Navigators"*

In 2010, the United States embarked on a comprehensive health care reform. The example of Obamacare's "navigators" highlights how the government planned for

"beneficiary engagement" to ensure successful implementation of the Affordable Care Act (35, 36, 37).

Previous experience with Medicaid, for example, showed the difficulty in getting people enrolled (33). The ACA's success was said to depend on enrolling eligible people into plans. The position of "navigators" was created as the first contact point to explain to people how to apply, show available insurance options, and guide consumers through the new system (36).

States were required to establish navigator programs through their health benefit exchanges, a marketplace where consumers purchase insurance. The Affordable Care Act provided $67 million in federal grant money to local community groups to hire navigators (37).

The implementation of this strategy to enroll beneficiaries confronted various challenges. Lack of funding, competing priorities, and the influence of interest groups made the navigator program a difficult one to run. In at least 17 states across the country, Republican legislatures and officials used bureaucratic roadblocks to stop the programs. They imposed high fees, background checks, tests, extra training, certifications, and threats of civil penalties to stop the program from running, and thereby obstruct implementation of the ACA (37).

Contact with health beneficiaries can also have political implications in LMICs. In China, for example, household visits to collect contributions for the New Cooperative Medical Scheme were used as a mechanism for social mobilization (38).

**Donor politics (managing externally)**

Effectively implementing health policy in LMICs (especially in low-income countries) can involve managing external actors, including bilateral aid organizations, multilateral agencies, and international financial institutions, as well as external non-state actors (non-governmental organizations and private-for-profit entities). The influence that donors can exert on national health policy processes due to the control over funding sources or perceived stronger technical expertise creates multiple challenges but also opportunities (38). Some of these challenges include overshadowing of countries' existing programs, ignoring the capacities of national health systems, giving bad advice based on ideology or inappropriate experience in other countries, or derailing national priorities (39). For example, there is an on-going debate, with mixed results from studies, about whether externally funded vertical programs (such as HIV treatment programs) strengthen or weaken the existing health systems (40).

Donor politics can also result in positive contributions to national health policy processes. Recently, there has been a trend towards reduced conditionality on funding and increased direct budgetary aid, to ensure that donor engagements contribute positively to national goals. For example, the Sector Wide Approach (SWAp) by channels all significant donor funding for the sector to a single sector policy under government leadership (41). The SWAp approach (compared to the traditional project approach) is thought to increase health sector coordination, strengthen national ownership, and strengthen countrywide management and delivery systems. In Nepal, for example, all Global Fund grants are being captured within the health sector budget; subsequently, TB and malaria services were found to be well integrated into the public health care delivery system (42). Countries can also leverage external actors to provide technical analyses to underpin reform efforts such as occurred for health reform in Turkey (43).

In example 7, we present the results of a study about the impact of donor funding for human resources for health (HRH) on health systems strengthening (39).

*Example 7 – Donor Politics: Human Resources Funding and Health Systems Strengthening*

The Global Fund to Fight AIDS, Tuberculosis and Malaria (The Global Fund) is the largest external funder of human resources for health. Six countries included in this study were awarded a total of 47 grants amounting to $1.2 billion USD and human resources for health budgets of $276 million USD. The funds were invested in disease-focused in-service and short-term training activities. Bangladesh, Ethiopia, Indonesia, Malawi, Ukraine, and Honduras used the funds as salary top-ups, performance incentives, extra compensation and contracting of workers for part-time work, and to pay health workers. The study (39) found several challenges in the implementation of HRH policies due to donor politics.

- Short-term approach: the majority of Global Fund-supported trainings were targeted at in-service, short-term activities. Due to national restrictions on the use of external funds, it was difficult to use Global Fund grants for direct salary support.
- Sustainability concerns: In Ukraine, Bangladesh and Indonesia, there were no formal mechanism or plans in place to continue paying for the salaries that were funded by the Global Fund. Only in a few countries did the Ministries of Health develop plans to absorb the salaries of workers previously covered by the Global Fund.
- Lack of coordination: minimal coordination occurred between Global Fund HRH activities and national HRH programs and strategies (except in Malawi). The lack of

> coordination with respect to training led to "duplication, excessive spending on in-service training, and inefficiency in HRH planning and activities" (39).

Policy makers need to manage donors to guarantee they contribute to implementation in a way that is consistent with national goals and likely to continue after external funds stop. Country ownership of the processes of implementation is important to guarantee efforts that external funds are aligned to meet national policy objectives. But the power dynamics of relationships with external donors can make it difficult for domestic priorities to win out.

**Conclusions**

Understanding the political dimensions of implementation can help those responsible for implementation to drive policy into practice more effectively. A political analysis of the position, power and interest of the stakeholders involved in health policy implementation helps to understand their role in promoting, resisting, or blocking implementation, and the dynamics of their interactions (44). The framework presented in this article is a tool to think ahead about the challenges in health policy implementation. As we have noted, however, the categories of stakeholders are not mutually exclusive, as illustrated by some of the examples, and not all categories may be relevant, depending on the context.

Understanding and addressing conflict, resistance and cooperation among stakeholders are key to managing the implementation process but they are also important during the policy design and adoption phases. This framework therefore may have broader application beyond implementation. Systematic and continuous political analysis of stakeholders can help decision-makers and high-level implementers improve the chances for successful policy design and implementation (1,44).

It is important to recognize that some challenges in implementation may be the result of poorly designed health policy, intentionally or unintentionally. For example, during elections, politicians may knowingly announce ambitious health policies that are not financially or administratively feasible (in the short or medium term). Some policies may be adopted for aspirational purposes and in order to drive budgetary or organizational changes that are necessary for implementation. But some implementation challenges cannot be solved at the implementation stage; some challenges may require re-designing the policy.

This article identifies the different challenges and provides examples of effective strategies to manage policy implementation for health policy. We need to expand on the strategies available to policy implementers to manage stakeholders who may resist or block implementation, and also add to strategies for managing those who support or promote implementation. The examples presented above could be expanded to include more political strategies available to policy implementers to address implementation obstacles, persuade or overpower opponents, and mobilize those in favor of policy implementation.

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# CHAPTER 2 Health policy in Odisha: a historical perspective

## Introduction

The objective of this working paper is to provide a summary of the history of health policy implementation in Odisha in the last twenty years to inform future policy proposals. At the beginning of conducting an applied political analysis it is helpful to understand the context of the proposed policy. It is important to learn about whether similar policies have been debated before, whether there have been past attempts at solving the problem at hand, and if yes, whether they work.

The audience for this working paper is the Harvard India Health Systems team composed of professors and students of Harvard T.H. Chan School of Public Health. The team members have different levels of experience and expertise in health systems in India.

The following two questions guide the working paper:

1. What are the main health policies implemented since 2000 in Odisha? Who designed them and who implemented them?
2. What was the political context of the development of the main health policies?

To answer these questions, the working paper does the following:

1) Compiles and list the major health policies and programs in the state since 2000, following the Flagship Health System Framework (Roberts et al., 2004). *See table 2 for a summary*.
2) Highlights political events that may be relevant to the understanding of health policy development in Odisha.
3) Draws preliminary insights about how and why health policies are developed and implemented in Odisha to inform future policy proposals.

To understand the development and implementation of health policy in the state of Odisha, is important to bear in mind the federal system of India and its decentralized governance structure. A complex relationship exists between the national and subnational governments. Health in India is a state subject per the Constitution. Constitutional amendments have given the central government joint responsibility in areas such as reproductive health, prevention of infectious diseases, and food and drugs regulation (Fan et al., 2018). This working paper begins with an overview of federalism and decentralization in India to contextualize the following sections on the health policies that have been adopted in the state.

**Background on federalism and decentralization in India**

India, as other large and diverse countries such as Nigeria and Mexico, functions according to the principles of federalism. The Indian constitution explicitly incorporates a federal structure; states are assigned political and fiscal authorities. The constitution envisages a federal structure but unitary spirit (Panda & Thakur, 2016). Indian federalism evolved as a two-tier structure – central and state government – until 1992. Starting in 1991, the adoption of market oriented reforms redefined the role of the state and resulted in the examination of political and fiscal arrangements between different levels of government (Rao, 2000). Decades of debate on decentralization resulted in two constitutional amendments that gave legal recognition, increased political status, and increased expenditure responsibilities to urban and rural local governments (Singh, 2008). Two constitutional amendments established provisions for political and fiscal decentralization to local governments in India. Before these amendments, local government units did exist both in urban and rural areas; in rural areas, Panchayat Raj (PR) institutions in villages provided basic community services and dispensed justice (Rao, 2000). However, PRIs faced resistance at the state level to share power and revenues; they also lacked adequate resources and

capacity, and faced domination by elite groups (World Bank, 2008); these problems may still exist.

Regarding fiscal decentralization, India's constitution stipulates the transfer of funds from the union to state governments via tax devolution and grants in aid. To this end, the president appoints a Finance Commission every five years to review the finances of the union and states and recommend devolution of taxes and grants-in aid of revenues to them (Rao, 2000). In addition to these transfers, the Planning Commission also gives assistance to the states based on a formula determined by the National Development Council. The constitutional amendments of 1992 and 1993 instituted a formal system of state-local fiscal transfers by changing tax and expenditure assignments to local governments and determining their authority and responsibilities (Singh, 2008). State governments are required to appoint a State Finance Commission to review the finances of the local bodies and assign tax shares and make grants to local governments.

In India's federal structure, the central government designs and partially funds major national programs in the health sector. A number of centrally sponsored schemes are implemented by local governments with earmarked funds passed from the state governments to them (Rao, 2000). Center-state relations are critical to understanding the adoption of health policies at the state level. On the one hand, states in India have the responsibility to deliver health care with a high level of autonomy (Reddy, 2018). On the other hand, the central government plays a key role in designing and financing health policies, especially in states that have low state capabilities.

**Brief political history of Odisha**

Odisha became a separate state in 1936 based on linguistic characteristics. It was the last state to come under British rule. To some extent, Oriya regions were neglected by the British

government and the former were dominated by Bengalis, Biharis and Andhraites. At the time of India's independence, in 1947, Odisha (then Orissa) was comprised of six districts: Balasore, Cuttack, Puri, Sambalpur, Ganjam and Koratpur. The other so-called "native states" were feudal territories under the control of zamindars, large landowners. Under the rule of the native rulers these regions remained backward and poor. When Independence was gained in 1947, there were already regional inequities within Odisha. Twenty-five new states merged with the province of Odisha following independence.

The first decades after independence were marked by political instability. The Indian National Congress was the first party to form a government. The central government took over the state government several times, imposing President´s rule, the first one in 1961. The Communist party has not been popular in the state, partly because the state has a small industrial worker and urban population and the workers are not well organized. The Praja Socialist Party (PSP) which had influence in state politics, merged with Congress in 1971.

The state has experienced a series of ethnic, class, religious, resource, and political conflicts which have affected the state (Ambagudia, 2015). These conflicts are increasingly threatening peace in different parts of Odisha. About half of all inhabitants of Odisha live in the hills (Pfeffer, 2014). The official term by which they are referred to is Scheduled Tribes (ST), a bureaucratic label, often substituted by Adivasi, or "original inhabitants." This term has been assigned to some – but not to all – hill people who, by certain administrative "privileges" are meant to be transformed into educated and democratic citizens (Pfeffer, 2014). According to the 2011 census, whereas the population of Scheduled Tribes in India is 8.6%, in Odisha the ST population is 22.8% (Kale, 2013). Militant anti-state groups of "Naxalites" have their strongholds in many tribal areas (Pfeffer, 2014). The southern belt of 11 districts in the state is

known as KBK+ and is made up of the districts of Bolangir, Boudh, Gajapati, Kalahandi, Khandamal, Koraput, Malkangiri, Nabarangpur, Nuapada, Rayagada, and Sonepur. KBK+ is poorer than other regions in Odisha.

The current model of industrial development in Odisha is focused on mining and mining-related activities and there is little political opposition to the view that mineral resource-based industrialization is the path of economic development for the state even at the expense of displaced communities (Kale, 2013). However, Odisha has a long history of social movements that oppose projects related to the extraction of its abundant natural resources that lead to displacement of people (Kale, 2013).

Since 2000, the Biju Janata Dal Party, a regionalist and socialist party, has been in power. The Chief Minister, the son of a former Chief Minister and prominent figure in Odisha's history, entered politics after the passing away of his father. The current Chief Minister, Naveen Patnaik, has been in power since 2000. He is largely perceived as a pro-poor and honest, "clean" leader, but also criticized for his dynastic origins. The state of Odisha, home to about 41 million people, is one of the few states in the country not ruled by Prime Minister Modi's *Bharatiya Janata Party* (BJP) or one of its allies. Once allies, BJP was BJD's main political rival in the 2019 elections. In May 2019, the state assembly election results revealed the victory of the BJD party, making Naveen Patnaik Chief Minister for the fifth consecutive time. Patnaik's party secured 112 seats in the 147-member state assembly. Most parties in most states of India rule in partnership, the record of the BJD of ruling without a coalition since 2009 is rare (Kale, 2013).

**Methods**

To understand health policy development and adoption in Odisha, I first conducted a literature review of peer-reviewed articles about the history of the health sector in the state. A

keyword search in PUBMED resulted in 8 articles with the following keyword strategy: ((odisha[Title/Abstract] OR orissa[Title/Abstract])) AND (health policy[Title/Abstract] OR health sector[Title/Abstract] OR health scheme[Title/Abstract]). Only four articles were found relevant. I then conducted an additional search in Google Scholar about previously identified health policies and topics (i.e., decentralization). Lastly, government documents, newspaper articles, and unpublished reports were reviewed. Three documents were particularly helpful:

- Meena Gupta's account of health policies in Odisha up to 2000 (Gupta, 2002)
- Health Sector Reforms in India: Initiatives from nine states (GoI, 2004).
- Landmark achievements (2005-2017), and 17 years, 17 milestones (DHFW, 2018).

The lack of written accounts of what has happened in Odisha in terms of health policy implementation, let alone published evaluations of health policies, has posed a challenge to this working paper. Consultations with key actors helped fill some of the gaps in the literature and allowed me to triangulate information. Eight key actors were consulted from different sectors: government, media, research, and international development sector.

In the following sections, I provide a brief summary of the health policies that have been implemented in Odisha. The original purpose was to describe the historical and political context of the implementation of these policies in Odisha, but the lack of information prevented me from doing this consistently throughout the working paper. I provide the national political context of the main health policies; and for state-led health policies, I provide details of the policies.

**Political context of major health policies adopted in Odisha since 2000**

Interest in health sector reform in Odisha began in the mid-1990s. Two events seem to have marked the beginning: (1) the formation of a Committee of the Odisha Legislature chaired by the Health Minister (called the House Committee) which looked into three important aspects of

health care and advised the raising of additional resources for health care; (2) the evaluation done by the British government's Department for International Development (DFID) of its two health and family welfare projects in Odisha which found that further capital investment in the health sector would be inadvisable unless certain systemic changes were undertaken (Gupta, 2002). However, government health spending remained low during the 1990s. Most of the state spending was on salaries. As a result, user fees were introduced in tertiary and secondary hospitals to mobilize local resources.

By the year 2000, some progress had been made in increasing immunization coverage and in developing a health delivery platform with sub-centers, primary health centers, and community health centers (Gupta, 2002). An extensive network of *Anganwadi centers* under the Integrated Child Development Services (ICDS) program was also built, with services for pregnant and lactating mothers, and children. The table below presents key maternal and child health indicators in the year 2000 and in 2015 for Odisha and for India.

**Table 1 Odisha health indicators in 2000 and in 2015**

| | **2000[1]** | | **2015[2]** | |
|---|---|---|---|---|
| **Indicator** | **Odisha** | **India** | **Odisha** | **India** |
| Infant Mortality Rate | 97 | 72 | 40 | 41 |
| Maternal Mortality Rate | 367 | 407 | 222 | 167 |
| Under 5 Mortality Rate | 104.4 | 94.9 | 48 | 50 |
| Total Fertility Rate | 2.5 | 3.07 | 2.1 | 2.2 |
| % of institutional deliveries | 22.6 | 33.6 | 85.3 | 78.9 |
| % children aged 12-24 months fully immunized | 43.7 | 42 | 78.6 | 62 |

Source: [1]adapted from (Gupta, 2002); [2] National Family Health Survey 2015-2016

At the turn of the 21st century, the state of Odisha was focused on reducing infant and maternal mortality, according to consultations with key actors. Nutrition, immunization, and

family planning were at the top of the political agenda at the central and state level. Central-level policies such as the 2000 National Population Policy and the 2001 Infant Mortality Reduction Mission pushed states to focus on these topics and on the implementation of vertical programs.

**Main health policies implemented in Odisha:**

1. **2000**: National Population Policy

In 1952, India was the first country in the world to launch a National Family Planning Program (NFPP), a component of the first five-year development plan. Targeted sterilization during the "Emergency Period" from 1975 to 1977, declared by Prime Minister Indira Gandhi, put an end to the National Family Planning Program. During this period employees of the government had numerical targets for sterilization, the failure to achieve the targets resulted in penalties. Indira Gandhi's Congress Party was defeated in the 1977 national election.

In 1996, the government of India announced a new national population policy that eliminated numerical targets. The Indian government openly publicized its new commitment to reproductive health with the Reproductive and Child Health Program (RCH) of 1997. Three years later, the National Population Policy (NPP-2000) simultaneously promoted reproductive health and population stabilization, influenced by RCH and the International Conference on Population and Development in Cairo. The policy was based on a draft policy written by M. S. Swaminathan, a world renowned agriculture scientist, when the Indian Government appointed him to chair the committee responsible for composing a new national population policy (Agrawal, 2009). The intent of NPP-2000 was to eliminate unmet contraceptive needs by providing high quality reproductive healthcare. This National Health Policy also focused on decentralized planning and program implementation (Raut & Sekher, 2013).

2. **2002**: National Health Policy

The previous national health policy was formulated in 1983. The National Health Policy of 1983 was strongly based in the rhetoric of the Bhore Commission, which gave direction to an improved public health system at the time of Independence (Bhore et al. 1946), as well as the influence of the Alma Ata Declaration of Health for All by the Year 2000 (WHO and UNICEF 1978) (Peters et al., 2003). The 2002 National Health Policy emphasized cross sectoral strategies, decentralized planning and the involvement of the Panchayati Raj and community groups (Peters et al., 2003). Another new feature was the recognition that different states had different planning needs, leading to a focus on reducing fertility in five states with high fertility rates (Bihar, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh). This policy represented a first example of considering the heterogeneity of states in India in health policy making. Several states developed their own population policies, some even preceding the national policy (Peters et al., 2003). Critics pointed out the 2002 National Health Policy departure from the "health for all" commitment of the 1983 policy.

3. **2003/4**: Odisha Health Vision 2010

The Odisha Health Vision 2010 was developed in 2003 and 2004. The first term of Chief Minister Naveen Patnaik was beginning when this health policy was developed. The Health and Family Welfare Department under the guidance of the Principal Secretary led the process, and then the policy was approved by the State Cabinet. The department obtained support from the Institute for Health Systems Development in the UK under a DFID contract.

The policy document aimed to provide a framework for the "integral development of the health sector in Orissa to meet its stated social goals and objectives" (GoO, 2002). This state health policy draws upon the National Health Policy of 1983 and 2002, and on the National

Population Policy of 2000. The document presents seven priority outcomes: 1) eradicate polio and yaws; 2) eliminate leprosy; 3) reduce mortality due to malaria by 50%; 4) reduce IMR and MMR; 5) increase utilization of public health facilities from current level of 75%; 6) establish networks between public, voluntary and private sectors at state, district and local levels; and 7) create adequate infrastructure for the public health system with maintenance and management systems (GoO, 2002). Some of the strategies to achieve these outcomes were to increase health spending; partner with the non-profit sector; devolve authority to local government bodies; and promote social health insurance schemes. This document expressed the state government's concern with equity and emphasized the need to develop a pro-poor health system.

4. **2005**: National Rural Health Mission

In 2004, The United Progressive Alliance (UPA) led by the Congress Party formed the government after obtaining the majority of seats. Sonia Gandhi (who would have been the Prime Minister) chose Dr. Manmohan Singh, an economist and former finance minister in the Congress, to head the government. Dr Singh had prepared an economic policy paper in which he proposed creating a commission to address the problems of the unorganized sector (Shroff et al., 2015). The policy paper served as the basis for the Common Minimum Program (CMP), which defined the goals of the winning coalition, giving emphasis to the welfare of unorganized workers and the establishment of a national commission to address issues facing this group (Shroff et al., 2015). This was in line with the electoral platform of the Congress Party; the party ran the election with the slogan "aam aadmi" which means "common man." The CMP articulated the political commitment to rural health and access to primary health care, and this commitment took the form of the National Rural Health Mission (Shroff et al., 2015).

The launch of the National Rural Health Mission (NRHM) was a major policy response to the failures in public health services delivery. Elements of this initiative were partnerships with nongovernmental organizations (NGOs); flexible funds for state and local governments; appointment of an Accredited Social Health Activist (ASHA) in each village; and strengthening of the public health infrastructure (Singh, 2008). ASHAs were introduced as frontline cadres in 2006 in Odisha. There was also discussion about the regulation of the private sector to improve equity and reduce out-of-pocket expenses, and introduction of effective risk-pooling mechanisms and social health insurance (Singh, 2008).

Odisha adopted this centrally sponsored scheme. In 2004–2005, increased national financing for social sector programs and direct state budget support to Odisha from DFID helped assure diverse sources of funding to implement national programs including NRHM. This also facilitated the implementation of state-level initiatives and innovations (Kohli et al., 2017).

5. **2005**: Janani Surakhya Yojana (JSY)

The Government of India's conditional cash incentive scheme for institutional deliveries, Janani Suraksha Yojana, was launched in 2005 with the goal of reducing the number of maternal and neonatal deaths. This scheme was launched under the umbrella of the National Rural Health Mission and is one of the largest conditional cash transfer programs in the world based on the number of beneficiaries. It provides a cash incentive of Rs.1400 to the mothers who give birth in a public health facility, and Rs.500 to the women below poverty line who deliver at home assisted by trained professionals. This centrally sponsored scheme was adopted in Odisha in 2006 and continues to run. There is some evidence that the scheme has resulted in an increase in institutional deliveries but one of the major concerns is the quality of maternal and neonatal

health at health facilities. Another concern is whether JSY reaches the most marginalized women.

6. **2009**: Rashtriya Swastya Bima Yojana (RSBY)

Launched in 2007, RSBY is a national health insurance scheme for people below the poverty line; it was adopted and implemented in Odisha in 2009. A group of policy entrepreneurs, including Congress Party leaders, technocrats, and senior government officials, collaborated with international agencies to develop the RSBY approach, place it on the agenda, and assure its adoption as national policy (Shroff et al., 2015). The 2004 elections provided a policy window for this change, an innovative, publicly funded insurance program at the time, largely using private providers and private insurers. It also helped that the Indian economy's annual growth rate was as high as 9% during the first seven years of the 2000s. As a result, central government revenue went from Rs.2,972 billion in 1999-2000 to Rs. 13,187 billion in 2011-2012. RSBY covers cashless hospitalization of up to Rs. 30,000 per year per family and it covers pre-existing conditions.

The RSBY program marks a major departure from India's traditional public health care delivery system that largely includes government owned health care facilities, and salaried providers paid through general tax revenues (Shroff et al., 2015). RSBY was discontinued in Odisha in December 2018; the state government announced its own health assurance scheme which will also cover RSBY beneficiaries.

7. **2011**: Odisha State Treatment Fund

Apart from RSBY, the state government also launched the Odisha State Treatment Fund (OSTF) which is a top-up to RSBY and applicable to people below the poverty line with annual

income not exceeding Rs.40,000 in rural areas and Rs. 60,000 in urban areas. OSTF is only for critical health conditions to be treated in government or empanelled private health institutions.

8. **2011**: Mamata Scheme (conditional cash transfer program)

The state of Odisha launched a conditional cash transfer scheme called the Mamata Scheme in 2011, with the goal of promoting care during the first 1,000 days of a child's life. It aims to reduce maternal and neonatal mortality and improve the health and nutritional status of pregnant and lactating women and their children by providing partial wage compensation. It was founded on the principle of timely cash entitlements through electronic transfers, designed to mitigate the household financial burden at critical stages of child development. All pregnant women above 19 years of age are entitled to receive Rs. 5,000 in four installments (at the end of the second trimester, three months after delivery, after she completes 6 months, and after the child completes 9 months) based on meeting conditionalities for the first two live births (Avula, 2013).

9. **2013**: Biju Krushak Kalyan Yojana (BKKY)

"Odisha lives in its Villages and farmers are its backbone," says the Government of Odisha website of BKKY. BKKY was launched in 2013 along with a new agriculture policy. A decline in agricultural growth and profitability in the agriculture sector in the face of the rapid growth of the non-farm sector was a major concern at the time. In the new agriculture policy, the state government provides more subsidies for agriculture equipment, irrigation and agroindustry.

The BKKY scheme has two streams, i.e., Stream I and Stream II. The enrolled farmer families are entitled to receive maternity and newborn care up to Rs. 30,000 per family per year, in any of the empanelled hospitals across Odisha under Stream I. Under Stream II, the same farmer families can also receive secondary and tertiary care up to Rs. 70,000 per family.

10. **2017**: National Health Policy

The National Health Policy of 2017 (NHP) set the stage for the new wave of reforms. Fourteen years had passed since the last National Health Policy in 2002. The new policy highlights four major changes in the health sector:

1) Changing health priorities: maternal and child mortality have rapidly declined, but there is growing burden of noncommunicable diseases.
2) Emergence of a robust health care industry estimated to be growing at double digits.
3) Growing incidences of catastrophic expenditure due to health care costs; major contributors to poverty.
4) Rising economic growth enables enhanced fiscal capacity.

This policy not only highlighted the high rates of child and maternal mortality, but also highlighted the increasing disease burdens of noncommunicable diseases, mental illness, and road traffic crashes. The threat of drug resistant tuberculosis and vector-borne diseases was also recognized (Reddy, 2018). The policy envisages universal access to good quality healthcare without financial hardship. It also proposes raising public health expenditure up to 2.5% of the GDP and allocating two-thirds of government spending to primary care. Regarding primary healthcare, the policy proposes a shift from selective primary care to comprehensive primary care.

11. **2018**: The launch of Biju Swasthya Kalyan Yojana (BSKY)

On June 12th, 2018, Odisha's Chief Minister Naveen Patnaik announced the launch of a new scheme which will provide health care assistance of Rs 500,000 per family for secondary and tertiary care. The scheme provides health assurance coverage to 7 million families, covering more than 70% of the state's population. At the time, the Odisha government decided not to adopt the central government scheme, Pradhan Mantri Jan Arogya Yojana (PMJAY). Odisha's

government argued that the central scheme would not cover all the population that needed to be covered because it was based on the 2011 socio economic and caste census.

BSKY was launched on August 15th, on the 72nd Independence Day. Patnaik launched the scheme at Capital Hospital in Bhubaneswar and said: “Healthy Odisha, Happy Odisha. Let us continue our endeavor to build a prosperous and strong state.” He also announced that BSKY is not an insurance but an assurance to people. BSKY also provides health services offered at health facilities up to a district headquarter hospital free of cost, including free drugs, free diagnostics, free dialysis, and free cancer chemotherapy.

12. **2018**: Affordable Healthcare Project Odisha

The government of Odisha intends to enhance equitable access to quality and affordable healthcare services to people across the state. As part of this initiative the government is ensuring the creation of hospitals in 25 locations across Odisha, in partnership with the private sector in a Public Private Partnership (PPP) mode. The hospitals will provide secondary and basic tertiary care services (DHFW, 2018).

13. **2019**: State Health Policy and Vision for 2025

As of July 2019, the government of Odisha is in the process of formulating a State Health Policy and Vision for 2025. The Chief Minister has emphasized that healthcare for all is a priority for the state. In public statements, health officials have mentioned the need to move from fragmented healthcare delivery to a comprehensive health agenda. Health had not been prioritized in previous governments. With health being a key agenda topic during the 2019 elections, it seems that the government of Odisha is paying more attention to it.

**Summary of health initiatives in Odisha**

The following table summarizes health initiatives in Odisha since approximately 2000. Some health initiatives have been developed by the central government and adopted and implemented by the state of Odisha; in other cases, the state developed and implemented its own health initiatives. Within the term health initiatives, I include large-scale health policies such as National Rural Health Mission as well as narrow programs such as improved maternity waiting rooms. I have organized the health initiatives according to the main control knob that is used to effect the change, using the Flagship Health Systems framework (Roberts et al., 2004) . In most cases, more than one control know is required to enable the change.

**Table 2 Summary of main health policies and initiatives in Odisha since 2000**

| **Primary control knob** | **Health initiatives** | **Year** | **State/Central initiative [tbc]** |
|---|---|---|---|
| **Financing** | Introduction of user charges in hospitals | 1997 | State initiative |
| | Free drug services at hospitals – Niramaya and the establishment of "Odisha State Medical Corporation Limited" (OSMCL) | 2015 | State initiative |
| | Free diagnostics services - Nidaan | 2017 | State initiative |
| | Provision of Corpus funds of Rs. 1 cr. each KBK and KBK+ district per annum to address HR issues | na | State initiative |
| | NRHM – National rural health mission | 2005 | Centrally sponsored scheme |
| | RSBY – health insurance scheme | 2009 | Centrally sponsored scheme |
| | OSTF – Odisha State Treatment Fund | 2011 | State initiative |
| | BKKY – health insurance scheme for farmers | 2013 | State scheme |
| | BSKY – health insurance scheme | 2018 | State scheme |

**(Table 2 continued)**

| | | | |
|---|---|---|---|
| | Affordable Healthcare Project – creation of new hospitals with PPPs | 2018 | PPP – state initiative |
| **Payment** | Appointment of staff on a contractual basis | na | State initiative |
| | Introduced Place Based Incentives in order to attract the Medical Officers to work in KBK, KBK+ and Tribal Sub-Plan areas | na | State initiative |
| **Organization** | Decentralization | 1997 | Central government initiative |
| | Amalgamation of District Health Societies | 1999 | Central government initiative |
| | Mobile Health Units - Swasthya Sanjog 177 MHUs are operational in tribal and KBK districts under state budget | na | State initiative |
| | Maternity waiting Home | na | State initiative |
| | NRHM – National Rural Health Mission | 2005 | Central government initiative |
| | Village Health Nutrition Days | na | State initiative |
| | Digital Dispensaries – telemedicine for PHC | na | State initiative |
| | Created Directorate of Nursing, 1st in the Country for development of nursing cadre | na | State initiative |
| | Mo-Mashari provision of providing Long Lasting Insecticidal Nets (LLIN) in high malaria burden districts | 2009 | State initiative |
| **Regulation** | Mandatory pre-PG rural service | 1999 | |

**(Table 2 continued)**

| | | | |
|---|---|---|---|
| **Behavior** | Provision of financial assistance of Rs 1000 as transportation incentive to help patients reach on time to the hospital | 2017 | State initiative |
| | 'Kayakalp' award system to monitor the quality of government facilities | na | State initiative |
| | JSY – incentives for institutional deliveries | na | Central government initiative |
| | Mo- Mashari - long lasting insecticidal nets were distributed in high risk areas in 26 districts | 2012 | State initiative |

Documenting health policy adoption and implementation is challenging when few published accounts are available. This is a work in progress and several gaps need to be addressed. Filling the gaps will require extensive consultations with key actors of the health policy landscape in Odisha.

**Support from international and development organizations**

Several development partners have provided technical assistance and financial resources to the state of Odisha with the aim of improving health outcomes. The World Bank has had a long-standing engagement with Odisha. The World Bank supported the Odisha Health System Development Project (OHSDP), to strengthen health institutions and develop infrastructure of public health facilities for improved health outcomes. The Odisha Health System Development Project aimed to assist the government of Odisha to 1) improve efficiency in allocating and using health resources, and 2) improve the performance of the health care system by improving quality, effectiveness, and coverage at the referral level and select coverage at the community level.

UK's Department for International Development has also been a strong development partner for the health sector of Odisha. The Odisha Health Sector and Nutrition Plan (OHSNP) was implemented by the government of Odisha between April 2008 and March 2015, with financial and technical support from the UK Department for International Development (DFID). The Odisha Health Sector Plan (OHSP) translates the Odisha 2010 Vision into an action plan and is aligned with the National Rural Health Mission (NHRM). OHSP marks the beginning of a change from input-based approaches in public health to a focus on health outcomes (DFID, 2012). The four immediate objectives of OHSP were: 1) improved access to priority health, nutrition and water and sanitation services in underserved areas; 2) public health management systems strengthened; 3) positive health, nutrition and hygiene practices and health seeking behavior of communities improved; 4) improved use of evidence in planning and delivery of equitable health, nutrition and water and sanitation services. DFID's financial support to the Odisha government for the health and nutrition sector was about 99 million UK pounds between 2008 and 2015; it included direct budget support to the Odisha government as well as funding for technical support (Kohli et al., 2017).

**Preliminary insights**

This section presents seven preliminary insights about health policy making in Odisha drawn from the literature review presented above and informal consultations with key actors during three field visits to India. These preliminary insights would need to be further explored and researched to inform the development of policy proposals.

1. **Challenges and strengths of a decentralized health system**

A common problem in decentralized health system is the lack of capacity for strategic planning of subnational governments. Some states are highly dependent on the central

government for policy design. This limits the potential of decentralization for delivering health services that are responsive to the needs of the population. States may end up adopting central government policies because of their lack of capacity to collect and use their data, analyze them, and develop health policies to improve the health system. This lack of capacity is also reflected in the inability of some states to absorb the financial resources provided by the center (Peters et al., 2003). This topic came up as a theme during the consultations with key actors. One of them suggested that some states may prefer to adopt the "pre-packaged" solutions from the central government that also come with funds rather than design their own policies. States need to undergo audits and may find it easier to follow the guidelines and norms dictated by the central government.

The fiscal capacity of the states is another challenge. In India, most of the health budget comes from state and provincial revenues which creates large regional variations in fiscal capacity (Roberts et al., 2004). As the states struggle to manage and improve secondary and tertiary level facilities, they become increasingly dependent on the central government for financial assistance to implement disease control programs, and community-based health services. In turn, the central government increasingly gains financial and programmatic control of these areas, adversely affecting the development of technical and organizational capacity in the states, as well as eroding their sense of ownership and accountability to outcomes (Misra et al., 2002; Peters et al., 2003). There is also the risk of "public crowding out" at the state level because of funding coming from the centrally sponsored health schemes. This is an issue that was raised by one of the actors consulted.

On a positive note, the role of Panchayati Raj Institutions (PRIs) have become quite relevant. They are important means of furthering decentralized planning and program implementation

(Raut & Sekher, 2013). The Village Health Plan and Fund, Village Health and Sanitation Committees are ways of decentralizing the powers, functions and funds to the local frontline health workers and to empower them to respond to the needs of the population (Raut & Sekher, 2013). This decentralized structure could be leveraged to improve the delivery of health services and increase accountability of the health system to deliver quality care.

2. **Odisha and central government relations**

Despite Odisha being governed by the same regional party since 2000, it has kept pragmatic relations with the central government. Odisha has traditionally agreed to adopt central government norms, guidelines, policies and programs for health. Odisha, as one of the poorest states in the country in terms of per capita income and socio-economic development, faces many challenges. Centrally sponsored schemes present "pre-packaged solutions" to health issues and funding to implement them. Odisha has adopted all of the major health programs promoted and partly financed by the central government, for example, the National Rural Health Mission, RSBY health insurance schemes, and most of the vertical programs to eradicate communicable diseases.

Odisha's refusal to adopt the central government health protection scheme, Pradhan Mantri Jan Arogya Yojana (PM-JAY), represented a departure from its traditional adoption of central government health policies. However, this happened during an election year and based on consultations with key players it is expected that Odisha will adopt this policy before the end of 2019.

3. **Moderate state innovation in health policies**

A question that emerged during the research for this working paper is the extent of innovation in policy design in Odisha. It may seem at first that Odisha being a poor state, with low strategic capacity, has not been able to design innovative health policies.

Based on consultations with key actors, I learnt that there is very little documentation of Odisha's efforts to design innovative policies but that there have been examples of innovative policy making. One example is the Mamata conditional cash transfer program, which was first adopted and implemented in Odisha before becoming a centrally sponsored scheme. Furthermore, Odisha has made efforts to develop its own health policy document based on evidence from health surveys.

However, the political context has not promoted an environment where disruptive health policies can emerge. There is absence of real political competition and conflict, and no opposition to the kind of development vision that the BJD-led government has been steadily implementing since 2000 (Kale, 2013).

4. **Health policy design**

Regarding the question of who makes health policy in the state, based on consultations with key actors, it seems that the Chief Minister Office has a lot of power partly because Naveen Patnaik has been in power for 19 years. Policy is said to be designed by bureaucrats close to the Chief Minister. The Chief Minister's party is not so involved in designing policies. Furthermore, as mentioned before, health has not been a strong pillar of the Chief Minister's development agenda. Industrial development and attracting investments to the state seems to be the priority of the Chief Minister. The 2019 elections proved to be a window of opportunity for health topics to rise to the political agenda.

5. **Bureaucracy**

Related to the previous question, bureaucrats are key players in health policy making in the state. The Chief Minister can initiate reform but so can high-level bureaucrats. Dynamic bureaucrats can make a difference in state health policy and based on key actor's insights, Odisha's bureaucracy seems to be competent and committed. However, political cycles affect the size of the change bureaucrats are willing to implement at any given point. Bureaucrats know how to "protect themselves" (i.e., keep their jobs and their reputation) by controlling (delaying, slowing down) the process of policy implementation. They may have an incentive to be in good position with the central government versus the state government because of their aspirations to eventually obtain a position at the central level. In this way, the bureaucracy can be a centralizing force instead of a decentralizing force.

6. **Intersectoral coordination**

There is some evidence of effective intersectoral coordination in Odisha to implement programs for health. There is coordination between state officials from the Department of Women and Child Development (DWCD) and the Department of Health and Family Welfare (DHFW) to implement Integrated Child Development Services (ICDS) and National Rural Health Mission (NRHM). Other initiatives that have required coordination at the local level are the Village Health and Nutrition Days (VHNDs, locally known as Mamata Diwas) and Village Health and Sanitation Committees, as well as the maternal conditional cash transfer scheme (Mamata Scheme). One of the key players consulted, highlighted the good coordination that exists among front line workers that belong to different programs (and departments) for immunization.

7. **Private sector in Odisha**

There is some evidence to suggest that the government of Odisha does not have a strong opinion against partnering with the private sector. The general development vision of the government has been based on attracting private investment to Odisha's resource and industrial sectors; and there has not been political opposition to this vision (Kale, 2013). Related to health, the recently announced Affordable Health Care Project aims to increase hospital infrastructure in the state in partnership with the private sector in a Public Private Partnership (PPP) mode. However, private participation in delivering PHC services was not perceived as a feasible intervention by the key actors consulted. Private sector players mentioned their lack of interest in delivering PHC services due to the low economic status of the population.

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## CHAPTER 3 Conducting an Applied Political Analysis

Conducting a stakeholder analysis is an essential element in designing political strategies to shape the political context of policy reform (Reich & Campos, 2019).The technical and the political need to be linked together and speak to each other, in order to design public policies that can be adopted and implemented effectively, in health as in other sectors (Sparkes et al., 2019). A stakeholder analysis is an approach to link together the technical and the political aspects of enabling health reform.

The objective of this DELTA project on health reform in Odisha, India, was to conduct a stakeholder analysis to inform the development of policy proposals to improve the performance of the health system. For this purpose, I first helped to write a guide on how to do an applied political analysis (Reich & Campos, 2019). I reviewed the literature related to applied political analysis and reviewed other guides that had been published mainly by development agencies such as The United States Agency for International Development (USAID) and The UK Department for International Development (DFID). There are few published examples of how the guides have been used and the results they have produced. This is a major gap in the literature that hampers the development of the field of applied political analysis for health reform. Without evaluations of what works in doing applied political analysis for health reform, it is hard to improve on the existing guides and methods. With this caveat, a new guide was developed for this project based on the literature review and on the experiences of the authors working in different countries. The guide is included in the appendix (Reich & Campos, 2019).

I used the guide to conduct a stakeholder analysis about Primary Health Care (PHC) in Odisha. This section presents a narrative discussion of what transpired during the period of the project in terms of the degree to which stated goals and objectives of the DELTA project were

achieved. Due to delays in obtaining Institutional Review Board approval the analysis could not be completed. The focus of this section is on the process of conducting the applied political analysis and related learnings. Lessons learnt after using the guide were used to produce a revised version of the guide on how to do applied political analysis.

The guide proposes six steps in conducting an applied political analysis.

**Six Steps for Applied Political Analysis:**

1. Define the audience (client) and the problem
2. Identify the policy to promote
3. Describe the context of the policy
4. Conduct a stakeholder analysis
5. Design a set of political strategies
6. Assess the impacts of your political strategies

I followed these six steps in presenting my activities related to the stakeholder analysis in Odisha.

**Step 1: Define the audience (client) and the problem**

In conducting an applied political analysis, it is important to have an identified client, or customer, or decision maker who is interested in promoting the adoption of a policy or responsible for its implementation. In short, who has asked for the analysis, and who will be seeking to apply the recommendations? In some cases, this client could be the Minister of Health, or the Director of Planning in the Ministry. It could also be a non-governmental advocate, for example, the head of a group seeking to improve primary care services in rural areas. Having a clear client is important for defining the problem to be addressed (since different people may have markedly different ideas of what “the problem” is) and for designing political

strategies, since the relevant question then is, what could the client do to change the political circumstances around this policy proposal?

For my DELTA project, I started with the idea that the final client would be the Department of Health and Family Welfare (DHFW) of Odisha and a top official who would be in charge of adopting and implementing a health policy. However, this year (2019) was an election year for India and Odisha, and the political climate created uncertainties about the adoption and implementation of health policies in the state. In February 2018, the central government of India led by Prime Minister Narendra Modi, announced a major health policy initiative, *Ayushman Bharat*, to strengthen primary care and provide health insurance for 100 million poor and vulnerable families (based on Socio Economic and Caste Census database). States needed to decide whether to adopt the scheme or not. Many states currently have their own state-funded health insurance schemes which would need to be harmonized with *Ayushman Bharat* (Bakshi et al., 2018). The adoption of *Ayushman Bharat*, I thought, would then be shaped by political players at the state level, by each state's relationship with the central government, and by the context of the 2019 general election. By October 2018, three states and union territories had not agreed to sign the memorandum of understanding (MOU) to adopt *Ayushman Bharat*: Odisha, Telangana, and Delhi. The Odisha government rejected the *Ayushman Bharat*'s National Health Protection Scheme saying that it covered less people in Odisha because it used the 2011 Socio Economic and Caste Census to identify beneficiaries. Odisha's Chief Minister, Naveen Patnaik, announced that the state government would launch its own health scheme providing up to Rs. 500,000 per family for secondary and tertiary care, to 7 million families, more than 70% of the state's population.

My initial research questions were about the implementation of this new health insurance scheme called *Biju Swasthya Kalyan Yojana* (BSKY) in Odisha to help the Department of Health and Family Wellness (DHFW) increase the chances of its successful implementation. I thought to explore how the implementation of BSKY would be shaped by the interests, positions, and power of stakeholders. I sought to identify the strategies stakeholder used to promote, block or slow down its implementation. However, after conducting informal consultations with government officials to understand the details of BSKY, I learnt that the policy did not entail a real operational change. One state official referred to the scheme as "an umbrella term"; BSKY would bring under its name the different health schemes but without implementing major changes. Another state official mentioned that no major changes would happen before the election; for example, they were not planning on producing new beneficiaries' cards for BSKY until after the election. The announcement of BSKY had political motivations and lacked clarity about the details of its implementation.

For the first time in India, healthcare was on the national political agenda during an election campaign. This may have rushed politicians to make early announcements about health programs or policies. It may seem surprising that reformers sometimes do not have a clear idea of what the policy will include. Policymakers may be focused on the problem (for example, high maternal mortality) or a given objective (for example, achieving universal health coverage), without a strong notion of how to address the problem through policy action. Or policymakers may be focused on the impacts of announcing a new policy on an election campaign; or on taking advantage of a policy window to introduce one.

It is challenging to conduct an applied political analysis for health reform in a rapidly changing political context. Knowing that BSKY was far from being a detailed technical policy

proposal, I had to find a different client and problem. As this project evolved, it became clear that the main audience for my analysis could be the India Health Systems Project team (Harvard team) and the primary client would be Professor Winnie Yip, the leader of the project. They could use the results from the stakeholder analysis to develop technical policy solutions that would be politically feasible in Odisha. Then, of course, the Chief Minister's Cabinet of Odisha would decide whether to adopt and implement the policy proposals and they would need political guidance as well, but this process would happen further down the line. The client for this analysis, then, was the Harvard team tasked with helping the government of Odisha to improve health outcomes and financial risk protection for the population.

The organizational context of the project is complex because the client, the Harvard team, is comprised of individuals with different roles, expertise, and levels of authority. The Harvard team includes several researchers and experts working on different components of the project that need to be integrated. The Harvard team needs to deliver results to its funder, and to the government of Odisha. In addition, the Harvard team partnered with researchers from the Indian Institute of Public Health in Bhubaneswar, with its own organizational structure, to carry out the project.

Through discussions with the client, a clear problem needed to be identified. This may seem like a straightforward process, but it can take extended discussion and on-going communication with the client or decision-maker in order to develop a clear definition of "the problem" and convey to the team the purpose of the analysis. Another important aspect of defining the problem is to identify the stage of the policy cycle. Is this at the point of problem definition and agenda-setting? Or policy adoption in the legislature? Or policy implementation after the policy has been officially adopted by the government? In this case, the stakeholder

analysis aimed to support the Harvard team during the policy development stage. However, due to delays in receiving Institutional Review Board (IRB) approvals and other administrative issues, the stakeholder analysis happened in parallel with the diagnosis of the problem and not with the development of policies. This is an issue I discuss in the next section about identifying the policy to promote. Ideally, the applied political analysis would have gone hand in hand with the development of technical policy solutions. But this sequencing did not happen in this case, and I faced challenges in attempting to integrate the applied political analysis with the technical diagnosis and policy development. I discuss these challenges in the conclusions. Below is the summary of the first step: "Define the audience/client, the problem, and the policy cycle stage":

**Figure 4 The Client**

| | |
|---|---|
| **Client:** | Harvard India Health Systems project team: a group of Harvard professors and researchers, with a team leader and project objectives. |
| **Problem:** | Poor performance of the health system in Odisha |
| **Policy cycle stage:** | Diagnosis/Policy development |

**Step 2: Identify the policy/solution**

The second step is to define the policy the client is seeking to introduce or implement to address the identified problem. It is worth spending sufficient time and effort on this first task to make sure that the details of the policy content are clear and appropriate for the identified problem. Not all policies are amenable to applied political analysis. If a policy is already set and has not flexibility in its design, an applied political analysis won't be as helpful. Furthermore, the policy needs to specific enough so that stakeholders can anticipate how the changes may affect them or not. As part of this second step, analysts should understand how the major elements of the policy are intended to address the problem identified both from a technical and a political

perspective. This process underscores that formulation of a policy requires both technical and political expertise.

After deciding that the end client would be the Harvard team, I then approached the leaders of the team to ask whether they had any particular policy proposals in mind. Due to delays in the roll out of the project mentioned before, the technical team was still working on diagnosing the performance of the health system in Odisha. They had not been able to formulate specific policies, but they mentioned that they would be developing proposals to address the problems of the poor performance of primary health care in the state. With this information, and in consensus with the local team from IIPH-B, the stakeholder analysis team (comprised of Harvard and IIPH-B members) decided to focus the analysis on primary health care, specifically a policy that was proposed by the central government, the "Health and Wellness Centers", described below:

**Figure 5 The policy: "Health and Wellness Centers"**

**The policy: Health and Wellness Centers (HWCs)**

**Problem definition**:

The burden due to noncommunicable diseases and injuries overall has overtaken that of communicable, maternal, neonatal and nutritional disorders in all states of India (Ved et al., 2019). In 2016, an estimated 62% of deaths were due to noncommunicable diseases in India (Ved et al., 2019).

Also, the National Sample Survey for 2014 showed that 11.5% of people in rural areas and 3.9% in urban areas accessed primary healthcare facilities for healthcare needs other than childbirth.

**Political decision:**

On February 1, 2018, the central government of India led by Prime Minister Narendra Modi, announced a major policy initiative to strengthen primary care and provide health insurance for 100 million poor and vulnerable families (based on Socio Economic and Caste Census 2011). Finance and Corporate Affairs

**Figure 5 (Continued)**

Minister Arun Jaitley made the announcement during his Union Budget speech. On March 21, the Cabinet approved the *Ayushman Bharat,* "blessed India," scheme. The announcement came one year before the 2019 elections.

**Policy:** The National Health Policy 2017 has envisioned Health and Wellness Centers as the foundation of India's health system. Under this, 150,000 centers will bring health care system closer to the homes of people and provide comprehensive primary healthcare. These centers will provide comprehensive health care, including for non-communicable diseases and maternal and child health services. These centers will also provide free essential drugs and diagnostic services.

**Key elements** (Ved et al., 2019):

* Provision of comprehensive health care services including prevention and management of non-communicable diseases.

* Staff of HWCs: services will be delivered through a team, led by a new cadre of non-physician health worker, a mid-level health provider, supported by one or two multipurpose workers, and ASHAs.

* The mid-level health provider is either a nurse or an ayurvedic practitioner, trained in a 6-month Certificate Programme in Community Health and accredited for primary health care and public health competencies.

* The dispensation of free medicines for chronic care.

* Changes in provider payment mechanisms.

**Implementation:**

Completion of roll-out across India is planned for the end of 2022.

Knowledge of the details of the policy and an assessment of stakeholders' level of understanding of the policy are key in preparing for the stakeholder analysis. This can be done through informal stakeholder consultations where actors are asked about their knowledge of the policy. In my case, after the first round of interviews, I learnt that stakeholders were not familiar with the specific components of the policy. They had a general understanding about HWCs; they understood that it entailed investments in infrastructure and a shift from selective primary care to comprehensive primary care, but they were not as aware of the staffing proposals, or the changes in provider-payment mechanisms. The information about the policy, designed by the central government and a group of experts, did not flow as quickly as I thought. I then decided to broaden the policy focus to include PHC policies in general, including asking stakeholders about their perspectives on the strengths and weaknesses of the current PHC system in Odisha. I also included a paragraph about the policy in the interview guide, in this way, the stakeholder analysis had an educational function too. I was both helping stakeholders understand the policy and interviewing them about it.

**Step 3: Describe the context of the policy**

At the beginning of conducting an applied political analysis it is helpful to understand the context of the proposed policy. It is important to learn about whether similar policies have been debated before, whether there have been past attempts at solving the problem at hand, and if yes, why they did or did not work. This historical description of the context can present important political events, such as elections or conflicts or natural disasters, and suggest their relevance for the problem to be addressed. The depth and scope of this review will depend importantly on the audience for the political analysis, especially whether the primary audience is someone deeply

familiar with national history (such as a political leader) or is someone with limited local knowledge (such as an official with a multilateral agency or aid organization).

For this project, I focused on answering the following two questions to provide relevant contextual information:

1.What are the main health policies adopted since 2000 in Odisha? Who designed them and who implemented them?

2.What was the political context of the development of the main health policies?

I reviewed published literature about health policy in Odisha and gathered unpublished materials during my visits to the states. However, the lack of written and published accounts of what has happened in Odisha in terms of health policy posed a challenge to this exercise. Consultations with key players partly helped fill in some of the gaps in the literature and triangulate information. During my first two visits to India, I scheduled meetings with key actors to understand the political and health policy context in Odisha. My report of the historical context of health policy in Odisha is presented in the previous chapter.

**Step 4: Conduct a stakeholder analysis**

A stakeholder analysis creates a description of the political landscape surrounding a proposed policy, by examining the relevant groups and individuals inside and outside government who might influence the overall process of policy reform (Roberts et al., 2004). This portrait of the political landscape identifies key stakeholders, their position on the policy under analysis, and the power of each stakeholder to affect that policy.

Stakeholders are actors (persons or organizations) with a vested interest in a specific policy and the potential to influence related decisions. They can be individual actors and organizations (i.e., a government ministry or a particular labor union). I adapted the framework

presented in Chapter 1 (Campos & Reich, 2019) that proposes six major categories of stakeholder groupings that are likely to influence health reform: interest groups, bureaucracy, financial decision-makers, leaders, beneficiaries, and donors or external actors. I use these categories in this stakeholder analysis.

**Select an analyst**

The stakeholder analysis can be done by a team of analysts or by an individual analyst depending on the resources available. In some cases, an internal analyst from within the organization or institution of the client or decision-maker can be assigned the task of conducting an applied political analysis. In other cases, an external analyst may be hired to help the client. Finding the right analyst to conduct the political analysis is a crucial step to producing a successful and useful document.

In this case, a team was formed to conduct the stakeholder analysis, and it was composed of: Professor Michael Reich from Harvard, Professor Bhuputra Panda from IIPH-B, Dr. Mrinal Mohapatra from IIPH-B, and myself. The advantages of having both internal and external analysts in the same team is that external analysts bring a more impartial perspective and can be better positioned to inquire about stakeholders' positions in interviews; and internal analysts can provide in-depth local knowledge of the political context and possess the ability to identify important information quickly and interpret it with nuance. A team that includes both internal and external analysts may work best if conclusions are triangulated and if there is good communication to assess biases and assumptions in the interpretation of the findings. On the other hand, creating a team that involves internal and external analysts requires having effective and regular communications, sharing a common language, and aligning timelines and motivations to deliver results.

**Develop a list of stakeholders**

Stakeholder analysis depends on creating a list of actors, groups or institutions that have a stake in the adoption or implementation of the policy. Who is likely to be affected by the change? Who believes they will be affected by the policy change? Actors at different levels need to be considered: at the national, state, and community levels. Campos and Reich propose six categories of stakeholder groups that are likely to influence health policy (as shown in Chapter 1): interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics. Together with the team at IIPH-B, I developed the following list of stakeholders to interview:

**Table 3 List of stakeholders**

| **Stakeholders categories** | **Stakeholders** |
|---|---|
| Interest groups | 1. Indian Medical Association, Odisha<br>2. Private healthcare providers<br>3. Public Hospital Managers<br>4. Health insurance companies<br>5. Journalist – Indian Express<br>6. President of Private Medical Establishment Forum |
| Bureaucracy | 7. Principal Secretary<br>8. Mission Director, National Health Mission<br>9. CEO State Health Assurance Society<br>10. OSTF State officer<br>11. Chief District Medical Officers (2)<br>12. Principal Secretary Department of Agriculture and Farmer's Empowerment<br>13. Women and Child Development Department |
| Financial decision-makers | 14. Principal Secretary<br>15. District collector (2) |
| External actors | 16. UNFPA, Odisha<br>17. WHO |
| Beneficiaries | 18. Patient advocate - COPASAH Global Convener |
| Political leadership | 19. Office of the Chief Minister<br>20. BJD political leaders<br>21. BJP political leaders<br>22. CP political leaders |

This list was revised several times. We also used a "snowball sampling" approach in which interviewees were asked to identify other stakeholders that they think should be consulted. Therefore, the final list of stakeholders interviewed will be different from this list.

**4.3 Decide on how to approach stakeholders**

If direct interviews are to be conducted with stakeholders, the analyst team will need to think in advance about how stakeholders will be reached and who will reach out to them, and how the project's objectives will be explained. An external analyst may be well positioned to reach out to stakeholders if the external person or group is perceived as impartial. However, the analyst may need help with contacting stakeholders and securing appointments. This is an aspect of a stakeholder analysis that is rarely discussed in detail in other guides but that is crucial to the success of an analysis. Approaching stakeholders is difficult for several reasons:

- Distrust in research
- Lack of time
- Sensitive political landscape
- Conflict of interest: stakeholders may not want to reveal their positions to help the opposition develop strategies
- Unavailability of high-level stakeholders

The team of analysts needs to discuss the different strategies they will use such as sending cold emails or making direct phone calls; using personal connections; asking to be introduced by a second-degree acquaintance; even contacting stakeholders via social media. For the interviews I conducted, I used all the strategies mentioned above. I contacted stakeholders through personal connections; I sent cold-emails and messages via social media; and asked to be introduced to stakeholders by other acquaintances. These strategies did not always work. For example, I was

not able to contact a patient advocate group during the duration of the fieldwork. While a stakeholder analysis is not intended to have a representative sample, it is important to gather different perspectives. We will need to discuss with the team what to do about "the voices" that are missing from the analysis. We will need to acknowledge that they are missing from this first analysis, and plan to include them in a follow-up analysis.

Interviews are not the only way to understand the perspective of stakeholders; media articles, position statements, and other written materials can be used. During the period of the fieldwork, I regularly read news on Odisha from regional and national media: OdishaTV; Times of India; New Indian Express, among others. In addition, I consulted the pages of Odisha's Department of Health and Family Welfare for official announcements.

**4.4 Develop interview guide and conduct interviews**

Once the list of stakeholders has been developed, based on key stakeholder groupings, an interview guide needs to be created to gather information regarding the interests, the positions and the power of each stakeholder. Assessing position and power is not an easy task. This requires a careful triangulation of perspectives across interviews and other data (i.e., published and unpublished documents) (Schmeer, 2000). These questions also have to be developed in a politically sensitive and objective manner to obtain useful data and not to alienate stakeholders. The team of analysts needs to decide on the methods and the instruments to collect information. In this case, I chose a semi-structured interview guide which allowed me flexibility to explore emerging themes from the interviews, but it ensured that I could compare responses to the same questions.

I developed an interview guide with input from all members of the stakeholder analysis team with the understanding that it would have to be adapted to each stakeholder.

**Figure 6 Interview Guide**

Guiding questions for stakeholder interviews.

Questions will be tailored to each specific stakeholder.

1. Could you please describe to me your role and primary responsibilities?

Perception

2. How do you see the current PHC approach in Odisha? (i.e. how do most people receive PHC services in the state)
3. What are some of the strengths of this approach?
4. What are some of its challenges?

Position

5. Can you tell something about the Health and Wellness Centers?
6. How this policy will turn out for Odisha?
7. Do you have any concerns about the policy?

Power

8. Does your organization/institution engage with policy makers in the state? How so?
9. What are the main on-going collaborations that your organization has with the government of Odisha?
10. Who else do you think we should interview?

As mentioned before, after a first round of interviews, I modified the interview guide based on the early insights that, in general, stakeholders had little in-depth knowledge about the components of the policy. Instead of focusing solely on the adoption of HWCs in Odisha, I broadened the research question to capture stakeholders' views on PHC policies in the state. I

attempted to capture stakeholders' views on the strengths and weaknesses of PHC in Odisha to inform the development of technical proposals to improve PHC services. The interview guide was adapted to each stakeholder by adding questions about their specific areas of expertise.

I planned to record and then transcribe the interviews, after obtaining informed consent from the interviewees. However, after the first interviews, I realized that asking participants for permission to record the interviews was met with suspicion. Given the politically sensitive context due to the elections, I opted for taking notes and not recording the interviews. This represented a trade-off between having verbatim documentation of notes and obtaining more explicit and truthful answers from participants.

Unexpected events can also influence the interview process. In this case, due to a cyclone that hit the state of Odisha during the period of the fieldwork in May 2019, I was able to conduct seven interviews mainly with donors and interest groups but the interviews with local government officials had to be postponed. The IIPH-B members of team will be completing the interviews with local government officials in the coming months. In total, we aim to interview between 18 and 20 stakeholders. Usually interviews are stopped at the point of "saturation," when no new information is obtained from new interviewees (Flick, 2008).

Lastly, conducting interviews may require IRB approval if the stakeholder analysis constitutes a research activity that involves human subjects. For example, if the stakeholder analysis is being conducted by the same organization that wishes to implement policy changes with the intention to improve the implementation, an IRB approval may not be needed. However, if an outside team of analysts conducts the stakeholder analysis and intends to publish the results of the exercise, then an IRB approval is needed. Federal regulations and institutional policy will also determine whether a stakeholder analysis requires IRB approval.

In this case, obtaining IRB approval proved to be a major obstacle to the analysis. As a doctoral student, I needed to submit an IRB application to Harvard's Review Board. The stakeholder analysis met the criteria for exemption. Then, I had to submit an IRB application to the review board of the partner organization, Indian Institute of Public Health in Bhubaneswar (IIPH-B). I received IIPH-B IRB approval in August 2018. An additional IRB application was submitted to the Ministry of Health in India. It took eight months to obtain their approval and this caused a major delay in conducting the stakeholder analysis.

**4.5 Analyze the position and power of each stakeholder**

The analysis of the stakeholder interviews may be guided by the following kinds of questions (Schmeer, 2000):

- Who are the most important stakeholders for this issue (who holds more power/and has access to the decision-making process)?
- What are the stakeholders' positions on the proposed policy? Do they support it, are they neutral, or do they oppose the policy, and with what level of intensity?
- What are the stakeholder interests in the policy?

The aim of the analysis is to establish the position of each stakeholder (support, non-mobilized, or opposed, and the intensity of support or opposition as high, medium, or low); their power (financial and administrative resources, access to decision-making process, also assessed as high, medium, or low), and their formal and informal relations with other stakeholders.

I analyzed the position, perceptions, and power around PHC policies in Odisha of the seven stakeholders that I interviewed:

1. Apollo hospitals
2. The United Nations Children's Fund (UNICEF)

3. The United Nations Population Fund (UNFPA)
4. The World Bank Group (WB)
5. Manipal hospitals
6. World Health Organization (WHO)
7. National Health System Resource Center/ Ministry of Health and Family Welfare

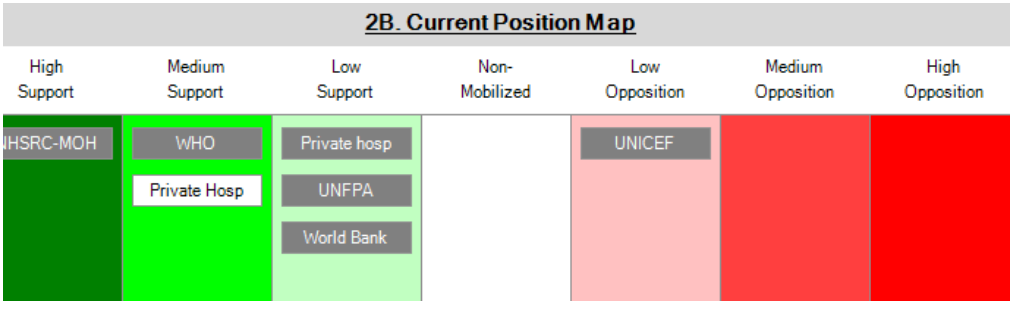
As mentioned before, the partners at IIPH-B are in charge of conducting interviews with state government officials to complete the analysis. In the next section, I present preliminary results to illustrate how the analysis could be done and draw early insights that can be helpful to the client.

### 4.6 Present the stakeholder analysis

The results of a stakeholder analysis can be presented in a table showing the position and power of each stakeholder. I used *PolicyMaker* (Reich & Cooper, 2015), a political analysis software developed by Reich and Cooper, to present the political map of stakeholders. *PolicyMaker* produces a visual representation of the "political map" of stakeholders in the policy landscape.

Below is the position map of stakeholders regarding the adoption and implementation of Health and Wellness Centers in the state of Odisha:

**Figure 7 Position Map**




There seems to be no strong opposition to the implementation of HWCs in Odisha. Only one stakeholder expressed low opposition. However, most stakeholders expressed low or

medium support. The main supporter of HWCs being the Ministry of Health of India and the institution that played a role in the design of the policy.

**Preliminary findings**

I organized the presentation of the preliminary findings according to the three variables that guide the stakeholder analysis: position, perception, and power.

**Position**

- Interest groups [two interviews]:

The two private players that were interviewed shared their perspectives as large hospital companies. They both expressed the view that it is not "a good business proposition" for the private sector to deliver PHC services in Odisha. Their companies would find it hard to staff healthcare workers, notably medical doctors, at PHC clinics below the district level. They both supported the policy of HWCs. They supported the idea that the government should be responsible for providing health services at this level of care.

- Donors/UN System [four interviews]:

The individuals interviewed did not express strong opposition to the adoption of HWCs. They shared the idea that HWCs is a good policy on paper but that implementation challenges may reduce its desired impact. Regarding the adoption of HWCs in the state of Odisha, it does not seem like there is strong opposition from donors or international organizations. However, there is a lack of strong support. The following comment by one of the interviewees captures the general feeling, "It is a good idea, but the implementation will face many challenges." Stakeholders expressed concerns regarding the staffing of the new Health and Wellness Centers. One of the stakeholders worried about the policy not including a strong health promotion

component. Another stakeholder worried that there is no coordination of care between the HWCs and the health insurance scheme for secondary and tertiary care.

- Bureaucracy [one interview]:

The individual interviewed expressed strong support for HWCs. The institution, part of the central government, to which the interviewee belongs is tasked with facilitating the implementation of HWCs in the states and thus, has a stake in the adoption and implementation of HWCs.

**Perception**

- Interest groups [two interviews]:

Both stakeholders perceived the government to be responsible for improving PHC services and strengthening the referral system so they, as private actors, can serve more people at the tertiary level. One of the interviewees said, “It will become far easier for us if the government does their work”. Regarding their partnership with the state of Odisha in implementing two health insurance schemes for secondary and tertiary care, one of them said, “We do it as a duty to the state but is not good business for us”.

- Donors/UN System [four interviews]:

In general, interviewees perceived HWCs to be a nascent and optimistic initiative with significant implementation challenges ahead. One challenge is that the unit within the MoH leading the implementation of HWCs is under-resourced in terms of staff and financial resources. Another challenge is the political tension between the central government and the states; and states’ concern with their ability to deliver on this policy. Others perceived the policy to be a good starting point, but that the policy could be strengthened. This was partly due to a superficial understanding about the policy. One interviewee noted, “HWCs are only about increasing the

range of services offered at existing facilities." However, other interviewees mentioned specific components that could strengthen HWCs. One of the stakeholders said, "We need to help the government think about what else they could do given the existing PHC platform." One interviewee mentioned that it is important to include adolescent health services and community health in the package of services of HWCs. Another stakeholder mentioned that the government of Odisha needs to think about using disaster resisting technology to upgrade the sub-centers and primary health centers.

- Bureaucracy [one interview]:

The perception about the adoption and implementation of HWCs of this interviewee was mainly about the low level of awareness of different stakeholders about the elements of the policy. There seems to be a general and superficial understanding of HWCs among stakeholders. The interviewee also perceived the implementation of HWCs as a challenging task because it entails forming an entirely new cadre of health workers to staff the health centers; it requires major investments in infrastructure, and it entails a reorientation of the PHC system towards preventing and managing chronic diseases.

**Power**

- Interest groups [two interviews]:

  The two private players mentioned that they have a good relationship with the government; they belong to the Indian Chamber of Commerce. Through the Indian Chamber of Commerce, they are able to raise issues and voice concerns. However, it does not seem that they hold a powerful position at the state level to influence PHC policy in Odisha.

- Donors/UN System [four interviews]:

They seem to hold moderate power to influence PHC policy in Odisha because they provide technical expertise and financial resources to the state government. WHO seems to be working specifically on HWCs and advising the government on continuity of care and performance-based financing. UNICEF changed its strategy of technical assistance; they are taking more of a systems approach and focusing on sustainability. One of them mentioned that Odisha's policy makers are open to suggestions and collaboration with international partners.

- Bureaucracy [one interview]:

As a stakeholder working for the central government, the interviewee mentioned that their role is one of implementation facilitators. One of their priorities is to help states build the teams that will operate the HWCs. The interviewee mentioned that due to the political spotlight that *Ayushman Bharat* has, state health ministers go to them to seek support in implementing the policies. This stakeholder and their organization hold a position of relative authority over the state government. Their power is increased by the political momentum behind *Ayushman Bharat*. However, as mentioned, before they seem to be understaffed which reduces their influence on the implementation of HWCs at the state level.

**Step 5: Design a set of political strategies**

Stakeholder analysis is not an end but rather a means to enabling and managing change. A description of the political landscape is not sufficient to produce change. The results of the stakeholder analysis need to be used to develop strategies that can change the political landscape in ways that improve the political feasibility of the desired policy reform (Reich & Campos, 2019).

At this stage, the analyst seeks to identify strategies for change, especially changes that could alter the balance of power and the feasibility of health reform. The basic logic is to design political strategies that strengthen the number and power of supporters, reduce the number and power of opponents, and mobilize new supporters from the non-mobilized stakeholders (or the opposite, if the goal is to stop a specific reform).

To develop political strategies, the applied political analysis uses two main sources of information:

1. The landscape report developed in step 3.
2. Interviews with stakeholders.

In addition, several rounds of discussions among the analyst team members are needed to triangulate information and develop creative strategies that have a good chance of being effective. Below, I present my early insights about potential political strategies that could be developed. Discussions with the stakeholder analysis team are pending and will take place once all the interviews have been completed by the IIPH-B team.

If the Harvard team wanted to support the state in adopting HWCs, these are some of the kind of political strategies they could advice the state to implement. The following four factors (power of actors, position of actors, number of actors, and perception of problem and solution) all influence the political feasibility of adoption of a proposed policy or the political feasibility of implementation of an accepted policy. The reform team will want to consider political strategies for each stakeholder, when looking at the political map.

Political strategies that the Harvard team could advice the state to implement to increase the likelihood of adoption of Health and Wellness Centers in Odisha:

a. Change the power of actors:

- Increase the number of staff in charge of implementing HWCs in the state.
- Appoint a nodal officer with experience and assign the officer a budget to give higher visibility to PHC.
- Form partnerships with international donors to secure financial resources and technical assistance from them.

b. Change the position of actors:

- Discuss and negotiate technical aspects of the policy with donors to gather more support.

c. Change the number of actors (in support or opposed):

- Mobilize civil society and patient advocate groups to support and enforce the implementation of HWCs.

d. Change the perception of the problem or the solution:

- Communicate the solution effectively. Identify all the key players and make sure there is a shared understanding of what the policy entails, including all its components.
- Use the media to highlight the problem of increasing chronic diseases prevalence and the need to provide prevention and treatment services as close to the people as possible.

The strategies so far should be focused on communicating effectively the different components of the policy and gathering more support from donors. Also, mobilizing civil society might be an effective strategy to ensure timely adoption and implementation of the policy. Civil society can play an important role in monitoring the implementation of HWCs and strengthening accountability. Once the interviews with state officials are completed, a full stakeholder analysis can be conducted.

For each key stakeholder, the Harvard team can identify a strategy to advice to the government of Odisha to improve the political feasibility of HWCs: the specific action to be

taken, the expected impacts of that action (on power and position and number of actors), and any anticipated problems with the action. Political strategies can be creative, but they can also involve risks and potential adverse consequences.

**Table 4 Summary of preliminary political strategies**

| Stakeholder | Purpose of the political strategy | Political strategy | Expected impact | Anticipated problems |
|---|---|---|---|---|
| 1. Private hospitals | To increase their support in favor of HWCs in Odisha | To appoint a person in charge of private sector affairs. The person should focus on communicating the benefits to the private sector of having a strong PHC with a better referral system. | Private hospital managers become strong supporters of HWCs and support the implementation of HWCs, including an effective referral system. | Odisha is not seen as a profitable business context and private hospitals may not be interested in investing resources to support PHC. |
| 2. Donors/ development agencies | To increase their support in favor of HWCs in Odisha | Negotiations may take place regarding certain components of the policy. | Donors strongly support HWCs and provide coordinated technical expertise and financial resources. | Each donor has an agenda and may not be interested in supporting the policy in a cohesive way. |
| 3. Civil society | To mobilize civil society to increase the number of supporters. | To appoint a person in charge of reaching out to civil society groups and patient advocacy groups. | Civil society is mobilized and will ensure on-going political momentum to implement HWCs. | Civil society may not necessarily agree with the technical proposal of the policy or may not be willing to put it on their agenda. |

### Step 6: Assess the impacts of your political strategies

The last step of applied political analysis is to assess the likely impacts of your political strategies and estimate whether you have adequately increased the political feasibility of your desired policy reform. This estimate is not an exact science and requires judgement on various points, such as: Do you think you have reduced the intensity of opposition from a key stakeholder that resists the policy? What are the chances that your compromise with a non-

mobilized group will encourage them to publicly support the reform? (Reich & Campos, 2019). Strategies can also interact with one another in ways that make it difficult to predict the consequences. A group discussion among team members may help this assessment, but ultimately some uncertainties will remain.

It is important to have clarity about "what success looks like" for the team and the client early on. Hypotheses can be developed for each strategy with indicators to measure its impact. This step is complicated, but it is necessary to develop better political strategies based on evaluation results, and also to build evidence about what works and what doesn't in applying political analysis to real life health reform.

Here is one possible matrix to assess the likely outcomes of political strategies:

| Political strategy | Inputs | Activities | Output | Outcomes-Impact |
|---|---|---|---|---|
| Political strategy #1 | | | | |
| Political strategy #2 | | | | |

I was not able to assess the impact of the political strategies because the strategies have not been implemented. The stakeholder analysis is not complete, and the preliminary results are yet to be shared with the Harvard team. In the following section I offer a reflection on how I could have established a more effective communication strategy with the Harvard team regarding the workplan and purpose of the applied political analysis. This would have ensured a receptive audience for the preliminary results; and it may have increased the likelihood that the Harvard team used the results to support the state of Odisha. The end goal of an applied political analysis is to support the client in implementing the desired policy solutions effectively, in other words, in making change happen.

# CHAPTER 4 Discussion and Conclusions

Applied political analysis can be a useful tool at different stages of the policy cycle. This DELTA thesis aimed to conduct an applied political analysis for health policy development. Chapter 3 described the process of conducting an applied political analysis and identified the challenges that emerged throughout the process. I present a summary of the challenges encountered below:

**Dynamic political context**: A dynamic political context makes it hard to study the position of stakeholders regarding a certain policy and predict certain outcomes. The rapid changes in the policy and political landscape over the past year in India and Odisha due to the elections, posed a challenge to the analysis. Overall, I made four trips to Odisha, however, a longer fieldwork period would have improved the quality of the analysis. I was able to conduct two rounds of interviews: the first one was an informal round of consultations with key actors to understand the context and define the policy; and the second round of interviews aimed to find out the position, power, and perception of stakeholders regarding PHC in Odisha. A third round of interviews is needed to gather more perspectives of stakeholders regarding PHC in Odisha and deepen the analysis.

**External analyst**: Understanding the political context of a place and of a policy requires iteration, patience, and determination to understand the different layers of meanings, and make sense of often contradictory information. As an external analyst, it was challenging to understand the political and bureaucratic culture in Odisha; and understand the different layers of meaning of statements issued by stakeholders. For example, after several consultations with key actors, I learnt that the public announcement of the state of Odisha to refuse to implement *Ayushman Bharat*, contradicted what bureaucrats would say during the consultations. Bureaucrats would

say that they would implement the centrally sponsored scheme once the elections had passed. The team members, researchers from IIPH-B, provided helpful insights into the state political context.

**Access to stakeholders**: Ensuring access to stakeholders may prove difficult, and assessing their position and power is challenging. The process of contacting stakeholders is rarely discussed in guides on "how to do political analysis"; however, it is not an easy task. As mentioned before, I was not able to interview certain stakeholders like those representing the beneficiaries. While having a representative sample was not the purpose of the stakeholder analysis, it is important to reflect on the impact of not having included certain perspectives on the analysis and formulation of political strategies.

**Coordination and effective communication**: applied political analysis is challenging because it requires coordination and effective communication with multiple stakeholders. As mentioned in Chapter 3, determining the client, the problem and the policy solution entailed recurrent conversations with the Harvard team, and IIPH-B. This process was challenging and long. I failed at communicating early and effectively the purpose of this analysis to the Harvard team so they would be receptive to the early findings and implement the suggested strategies. I should have ensured that the Harvard team kept the focus on the purpose of the analysis to obtain more regular feedback from them; and thus, increase the usefulness of the analysis. Communicating the purpose and scope of the analysis effectively and regularly to the team is necessary to ensure that the results of the analysis are useful and used. Effective communication plays a key role in step 1 and 2 of the analysis; defining the audience, the problem, and the policy solution.

## Limitations

This project did not come full circle. Due to delays in obtaining IRB and the project's timeline, the stakeholder analysis was not completed, and the political strategies were not implemented. Thus, I was unable to evaluate the effectiveness of the strategies. Without information on the outcomes of the strategies, I was not able to evaluate what worked and what did not in conducting this applied political analysis. This DELTA thesis had to focus instead on the process of conducting an applied political analysis – of the first four steps.

Furthermore, this DELTA thesis examines the process of conducting an applied political analysis through a single case study which limits the generalizability of the conclusions. However, single case studies are helpful to expose process details; some of the challenges I encountered are likely to appear in other contexts. I hope that the lessons learnt presented in the next section help health reformers and teams of analysts better plan for an applied political analysis.

## Lessons Learnt

In this section, I present my reflections about how I could have improved the process of conducting an applied political analysis, focusing on two major issues that emerged throughout my DELTA project: timing and relevance. In order to ensure that the results of the applied political analysis are relevant to the client, in my case the Harvard team, the results of the analysis needed to be ready at the right time or times. Due to the delay in obtaining IRB approval from the Ministry of Health in India, only one round of formal interviews and analysis was done. The analysis could be repeated once the technical team identifies a policy solution. It would be helpful to conduct an analysis once the technical team identifies a policy solution to plan for an effective implementation of the policy.

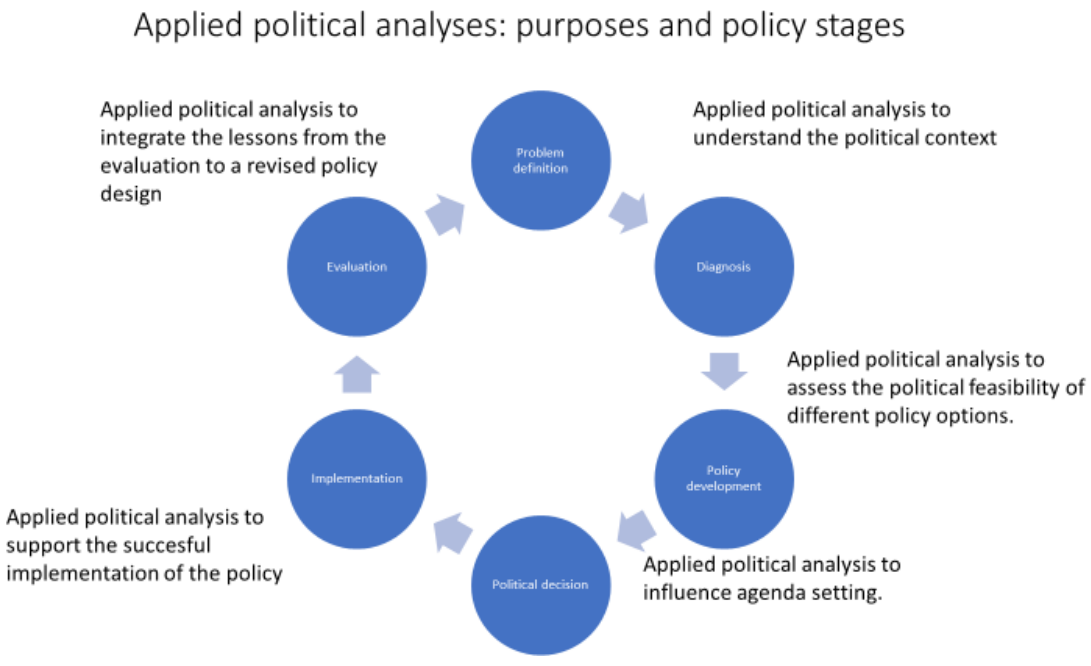
Below I present four lessons learnt based on my experience of conducting an applied political analysis in Odisha.

**Purpose and framing**

Having a clear problem, solution, and purpose for the applied political analysis early on is essential. Having clarity about the problem and the policy to be addressed, and about the purpose of the applied political analysis requires extended discussions with the audience or client, and consultations with key actors. It takes time to define the audience, purpose, and policy to analyze and this should be accounted for in project timelines.

Below, I summarize the different purposes that an applied political analysis can have at different stages of the policy cycle. The methods will also vary depending on the purpose of the analysis; I discuss this in the last point.

**Figure 8 Applied Political Analyses: Purposes and Policy Stages**




Policy cycle adapted from (Roberts et al., 2004)

I underestimated the time required to identify the client, the problem and the policy solution. Having better communication with the client would have helped speed up the process of identifying the problem and the policy solution. The early consultations I had with various actors were helpful. Understanding the context is key to identifying a policy solution that does result in operational changes and thus, in actors having stakes in it. It was helpful for me to develop the report on health policies in Odisha to understand the health policy context in the state.

**Timing**

The question of when the right time is to do an applied political analysis is conditional on the first question about the purpose of the analysis. To ensure that the results of the applied political analysis and the political strategies that result from it are useful; timing is critical. The technical and political analysis teams need to be in constant communication and harmonize timelines and workplans to ensure that the results are available at the right time to aid the client. In my case, regular communication with the client and the technical team would have allowed us to conduct the analysis at a time when it was most useful to them. The original idea for this analysis was to help the technical team assess the political feasibility of different policy options they were considering advising the government of Odisha. However, both the technical team and our team experienced delays in obtaining the ethical review approvals needed to conduct research in India. Due to these delays in receiving Institutional Review Board (IRB) approvals and other administrative issues, the stakeholder analysis happened in parallel with the diagnosis stage and not with the development of policies. And I had to focus the stakeholder analysis on a broad theme, PHC, instead of a specific policy.

Applied political analysis is not a one-off exercise and rather it should be done often in the policy cycle. Repeated analysis is needed because political challenges continuously evolve and change. However, doing applied political analyses continuously, at different stages of a policy cycle, requires time, and economic and human resources.

**Organizational context**

The organizational context in which the project is situated matters. This analysis was conducted within the scope of a larger project with various stakeholders: the Harvard team; the funder, both the headquarters and the India Office; the Government of Odisha; and the partner organization, IIPH-B. The Harvard team itself was comprised of many researchers in charge of different aspects of the project. The project had a complex organizational structure. I encountered challenges in identifying a counterpart within IIPH-B to work on the analysis; then one of the researchers working on the analysis left the organization. I should have managed the different stakeholders of the project better. I would have needed to spend more time in Odisha, to work closely with the researchers at IIPH-B and ensure the completion of the analysis.

Forming a team of internal or external analysts trained in applied political analysis is important. Promoting shared ownership of the project is often challenging but essential to deliver results, as well as clear lines of accountability.

**Methods**

A stakeholder analysis and a political analysis, both can be approached as a research activity, with a theoretical grounding in social sciences, and with the intention of obtaining generalizable knowledge; or as a practice-oriented exercise to improve a project or policy. The choice of the methods will depend on the purpose of the analysis, the question to be addressed, and on the time and resources available for the analysis. In this case, the applied political analysis was a practical

exercise with the goal of producing effective political strategies. I borrowed methods from qualitative research to gather perspectives from stakeholders. I used semi-structured interviews to gather these perspectives but did not record them and transcribed them. I also used as sources of information written materials, published and unpublished, and informal consultations with key actors. The choice of the methods will have an impact on the type of ethics approvals the analysis needs to undergo. And the process of obtaining ethics approval will impact the timeline of the analysis. It is important to anticipate challenges in obtaining ethics approvals because, as discussed above, the timing of an applied political analysis is key.

Despite de limitations, this DELTA project identifies challenges in conducting an applied political analysis and offers key insights to overcome them. Applied political analysis is at the center of translating knowledge into health policy and health reform; which are inherently complex processes. Applied political analysis requires patience and persistence to systematize the information about the political context as a project evolves with the aim of supporting the achievement of a policy goal (i.e., policy development, adoption, implementation, or evaluation). More single case studies like this one and evidence on the effectiveness of political strategies are needed to strengthen the role of applied political analysis in helping reformers engage effectively with the political context to create political feasibility for health reform.

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**Appendix A**

# A Guide to Applied Political Analysis for Health Reform

By Michael R. Reich and Paola Abril Campos

November 2019

Draft

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## Introduction

Creating large-scale health system change requires a combination of technical solutions and political skill. Understanding the political context of health policies is crucial to improving the chances of effectively designing, adopting, and implementing health reforms that can achieve their intended objectives. This guide seeks to help reformers navigate the political processes involved in changing and implementing health policies that will improve societal health and well-being. Policy reform is a profoundly political process, and advocates need to manage the politics of change, through careful political analysis and innovative political strategies (Reich, 2002). It is important to note that this guide is aimed to assist in *applied* political analysis—not in advancing theory, but in supporting practitioners. We seek to provide guidance that will help in the art of policy reform, through step-by-step suggestions for analysis. (See Appendix 1 for a glossary of some terms used in this guide.)

Applied political analysis is a core component of the Flagship Approach to Health Reform that has been developed over the past two decades by a team of health system researchers at Harvard University in collaboration with the World Bank and other institutions.[1,2] This guide complements the analytical framework presented in the Flagship Approach and provides policy makers and policy analysts with guidance on how to manage the political processes of reform. The guide helps identify political, fiscal and institutional constraints that need to be addressed by strategies that can improve the design and implementation plan for reform.

### What is applied political analysis?

Applied political analysis is a systematic investigation of the interests, positions, and power of stakeholders regarding the formulation, adoption, or implementation of a policy. Applied political analysis helps decision-makers improve the chances that a policy will be politically feasible and achieve its intended effects. This recognizes that "political feasibility" has to be created through specific and intentional actions by political actors. In short, policy reformers need to design political strategies that influence each step in the policy cycle for health reform, in order to move the processes in certain specified directions.

Political analysis plays different roles at different points in the policy cycle, and can aid with the following actions in the reform process, helping to:

- Design strategies to put a particular topic on the policy agenda and influence policy formulation.
- Increase the likelihood of support of critical groups for a proposed policy.
- Manage key stakeholders affected by a proposed policy.
- Identify implementation risks early on.
- Assist in communication among different organizations.
- Contribute to building consensus around difficult issues and conflicting values.
- Improve the political acceptability of decisions related to a proposed policy.
- Provide strategies for implementation after a policy has been adopted.

This guide is intended to assist policy reformers on the use of prospective political analysis to manage policy processes in the real world (and is not intended to support academic research and writing; that would require a different approach and different instructions).

**Why do applied political analysis?**

Technical evidence alone rarely is enough to create successful policy reform. Designing, adopting, and implementing policies is profoundly political, because it entails a redistribution of resources and power to achieve the policy goal. The short answer to "why do political analysis?" is that it helps improve your chances at success in changing public policies.[3] Applied political analysis can be used retrospectively to understand why and how policies were adopted or not; and it can be used prospectively to help shape reform trajectories in real-time.

Applied political analysis has been used to support health reform in diverse national contexts in low- and middle-income countries for different purposes. It has been used to help advocates promote maternal health as a political priority in Nigeria and India.[4,5] Political analysis has been used to help reformers manage the processes of adopting health financing reforms in Mexico and Turkey—with success. It has been used in a project to increase the chances of health reform adoption in the Dominican Republic,[6] although without success.

Applied political analysis has been done in some cases as retrospective analysis to understand a reform process and outcome. For example, it has been used to explain how a new health policy (Rashtriya Swasthya Bima Yojana) was adopted as a national policy in India.[7] It has also been used to identify the political strategies used in Mexico to achieve legislative adoption of the landmark reform of Seguro Popular.[8] And political analysis has been used to explain the lack of implementation of tobacco policies in low-income countries.[9]

A number of large countries with federal systems are now grappling with major health reforms, including India, Brazil, Mexico, Nigeria, and the United States. When health reform occurs in a decentralized system (and in situations with devolved decision-making authority), the political context at both the national and the sub-national levels affects all aspects of the policy cycle: from how problems are defined and agendas are set, to how policy is designed, adopted, implemented, and evaluated. The interaction of political factors at the national and state levels shapes reform trajectory, often in ways that result in significant differences at the sub-national level.

**When to do applied political analysis?**

Political analysis is not a one-off exercise and rather it should be done early and often in the policy cycle. Repeated analysis is needed because political challenges continuously evolve and change. Figure 1 provides one model for the policy cycle; each stage in this model creates a different set of political challenges. Let us briefly consider the political challenges for the six stages in this model.

[Figure 1 here]

*Problem Definition:* In this stage, reformers seek to define the problem in a way that places it on the social agenda for change and the government agenda for policy. Governments typically can address only a limited number of major public problems at any moment in time. Public issues thus compete for high-priority attention by governments. The processes of problem definition and agenda-setting thus are critical for shaping how much attention both society and government pay to a particular issue. How problems are defined reflects key ethical and social values and affects the responses of different social groups, mass media, and decision makers.

*Diagnosis*: The stage of identifying the causes of a social problem and proposing interventions to address those causes is often viewed as a technical process. Different interventions have different levels of political feasibility, due in part to stakeholder interests, institutional contexts and social values. The political feasibility of a reform will be determined in large part by the choice of interventions.

*Policy Development*: Deciding what to include in a policy proposal is often a political negotiation with key stakeholders, with substantive policy components used as bargaining chips to raise the probability of policy adoption. In short, the technical work of developing a policy needs to occur at the same time as a political feasibility assessment to increase the likelihood of policy adoption.[1]

*Political decision:* The process of making a political decision is often viewed as something that happens with a single individual—a political leader—but it is usually more complicated. This point is typically when policy adoption happens, and it can occur in different institutions: a legislature, a cabinet, a single government ministry, a semi-autonomous public agency, a judicial agency, or even in a private organization. Understanding where and how the policy adoption process occurs, and who is involved and how the decision is made (by individual decision, by vote, or by consensus, for example), is critical. Sometimes policy reformers have a choice about the institutional location for adoption; that choice can be based on a combination of political analysis and technical requirements.

*Implementation:* Despite limited literature on the politics of health policy implementation, it is an inherently political process.[10] Whether implementers participate in the policy design and adoption processes can affect the politics and probability of success. Sometimes, compromises made to assure adoption (in order to gain the support of specific interest groups) can complicate and undermine the chances of implementation. Understanding the political challenges of implementation early on can improve the processes of actually putting the policy into action.

*Evaluation*: Decisions about what is evaluated, who does the evaluation, and when the evaluation occurs all are influenced by political choices. When an election brings in a new political party to government, the evaluation of policies supported by the previous government can be politically driven, with limited analysis and evidence.

In conclusion, systematic and continuous political analysis is required at every stage of policy making and implementation, and should be conducted throughout the policy cycle, and sometimes within a given cycle in the case of change. At the same time, it is important to identify which stage of the policy cycle you are located in, and the associated political challenges to address.

In Figure 2, we present a summary of the different purposes that an applied political analysis can have at different stages of the policy cycle. The methods will also vary depending on the purpose of the analysis.

[Figure 2 here]

The question of when the right time is to do an applied political analysis is conditional on the first question about the purpose of the analysis. To ensure that the results of the applied political analysis and the political strategies that result from it are useful; timing is critical. The technical team and the political analysis teams need to be in constant communication and harmonize timeline and workplans to ensure that the technical and the political work go hand in hand.

**Six Steps for Applied Political Analysis**

This guide proposes six steps in conducting an applied political analysis:

7. Define the problem and the audience (client)
8. Identify the policy to promote
9. Describe the context of the policy
10. Conduct a stakeholder analysis
11. Design a set of political strategies
12. Assess the political feasibility of your policy, using the political strategies

Next, we describe each step and the analytical actions to be taken at each step.

**Step 1: Define the audience (client) and the problem**

To start, who will be using the results from the analysis? In conducting an applied political analysis, it is important to have an identified client, or customer, or decision maker. Who has asked for the analysis, and who will be seeking to apply the recommendations? In some cases, this client could be the Minister of

Health, or the Director of Planning in the Ministry. It could also be a non-governmental advocate, for example, the head of a group seeking to improve primary care services in rural areas in a particular state. Having a clear client is important for defining the problem to be addressed (since different people may have markedly different ideas of what the problem is) and for designing political strategies, since the relevant question then is, what could the client do to change the political circumstances around this policy proposal?

In the Flagship Framework for Health Reform, the definition of the problem focuses on a health system performance problem related to health status, patient satisfaction, or financial risk protection.[1] For the purposes of applied political analysis, we recommend thinking more broadly about the political context in addition to the performance problem.

Having clarity about the problem to be addressed and about the purpose of the applied political analysis requires extended discussions with the audience or client, and consultations with key actors. It takes time to define the right audience, purpose, and policy to analyze and this should be accounted for in project timelines; even if political analysis timelines are difficult to control.

Another important aspect of defining the problem is to identify the stage of the policy cycle. Is this at the point of problem definition and agenda-setting? Or policy adoption in the legislature? Or policy implementation after the policy has been officially adopted by the government? A clear statement on the stage in the policy cycle will help set the main purpose and key parameters of the analysis.

It is important to note that applied political analysis is not intended to tell decision-makers where they should go (that is, what their policy objectives should be), but rather how to get there from here. As a result, political analysis will need to go hand in hand with the development of technical policy solutions and with an understanding of policy goals and social values. Policy makers decide on where they want to go, and political analysts provide guidance on options on how to get there.

At this point, you should have clarity on the following issues:

| | |
|---|---|
| Audience/Client:<br>Who will be putting into action the results from the applied political analysis? | |
| Problem to be addressed: | |
| Stage of the policy cycle: | |

**Step 2: Identify the policy/solution to promote**

The second step is to define the policy you are seeking to introduce or implement. It is worth spending sufficient time and effort on this first task to make sure that the details of the policy content are set and appropriate for the identified problem. What is "sufficient" will depend on the particular circumstances and is ultimately a judgement call. Sometimes, policy reformers will spend years to diagnose the causes of the problem and delineate a detailed course of action. In other cases, the policy content may be rapidly defined to meet a window of political opportunity. Sometimes, policy entrepreneurs prepare a policy proposal in detail, and then wait for problems to arise and windows of opportunity to open, so that they can push their proposal onto the agenda.[11]

As part of this second step, analysts should understand how the major elements of the policy are intended to address the problems identified both from a technical and a political perspective. This process underscores that formulation of a policy requires both technical and political expertise. However, it may seem surprising that reformers sometimes do not have a clear idea of what the policy will include. Policymakers may be focused on the problem (for example, high maternal mortality) or a given objective (for example, achieving universal health coverage), without a strong notion of how to address the problem through policy action. Or policymakers may be focused on eliminating the policy introduced by a predecessor, for political reasons (because of different political parties) or for value reasons (as too market-oriented, or giving too much discretion to states, or too government-oriented). These broad motivations, however, may not be followed by specific details of what the new policy should include.

It is important to develop some details on the policy, because this is what stakeholders use in deciding their position. This is in many ways the "solution" to the "problem" identified in the first step. Using the Flagship Framework, a policy analyst can conduct a diagnostic journey, to identify causal factors that contribute to the health system performance problem, and then would ask why (five times) until proposing specific control knobs that could be used.[1] This analytical process would help define the elements of the proposed policy reform. Knowledge of the details of the policy and an assessment of the understanding of the policy by different actors are key in preparing for the stakeholder analysis. This can be done through direct interviews with key individuals or informal stakeholder consultations where actors are asked about their knowledge of the policy. In some cases, the stakeholder analysis may have the dual role of educating stakeholders about the contents of the policy and identifying their position and interest regarding the policy. Stakeholders need time to think about how a certain policy may affect them.

Not all policies are amenable to applied political analysis. If a policy is already set and has not flexibility in its design, an applied political analysis won't be as helpful. Furthermore, the policy needs to specific enough so that stakeholders can anticipate how the changes may affect them or not.

Finally, the proposed policy is not always the adopted policy. As the policy enters political negotiations over adoption, certain elements may be dropped and other elements may be added, in order win over specific stakeholders and create political feasibility. As we discuss below, political strategies can include adjustments in policy content, sometimes in major ways and sometimes in contradictory ways.

**Step 3: Describe the context of the policy**

At the beginning of a political analysis it is helpful to understand the context of the proposed policy. It is important to learn about whether similar policies have been debated before, whether there have been past attempts at solving the problem at hand, and if yes, why they did or did not work. This review of the policy context can include a description of the interests, institutions, ideas, and ideologies involved.[12] This historical description can present important political events, such as elections or conflicts or natural disasters, and suggest their relevance for the problem to be addressed. The depth and scope of this review will depend importantly on the audience for the political analysis, especially whether the primary audience

is someone deeply familiar with national history (such as a political leader) or is someone with limited local knowledge (such as an official with a multilateral agency or aid organization).

The main objective of this description of context is to place the problem and the policy within the local political moment and culture, to explain why the problem is politically salient and why the proposed policy is socially important, from the perspective of the primary audience. This description can be succinct and to the point; indeed, the shorter the better. The description of context helps explain to the primary audience why the policy reform is needed and what the political analysis seeks to accomplish. To this end, the team of analysts can review: published literature; unpublished government or policy documents; news articles; and evaluation reports of previous policies. The team can also conduct informal stakeholder consultations to fill in the gaps in the literature.

**Step 4: Conduct a stakeholder analysis**

A stakeholder analysis creates a description of the political landscape surrounding a proposed policy, by examining the relevant groups and individuals inside and outside government who might influence the overall process of policy reform.[1] This portrait of the political landscape identifies key stakeholders, their position on the policy under analysis, and the power of each stakeholder to affect that policy.

Stakeholders are actors (persons or organizations) with a vested interest in a specific policy and the potential to influence related decisions. They can be individual actors and organizations (i.e., a government ministry or a particular labor union). In the context of universal health coverage policies, common stakeholders include the ministries of health and finance, provider associations, insurance companies, unions, business, beneficiaries, and donor agencies.[12] Stakeholders can also include units or groups within organizations or institutions, which may themselves hold different positions on the policy.[13]

Over the past two decades, various approaches to stakeholder analysis have been developed in the field of health policy. At the end of this guide, we include a list of different publications that present these approaches to stakeholder analysis. They share similar features, including the identification of key stakeholders and their positions and power (or influence) with regard to a specific health policy. The

different approaches have not been systematically evaluated or assessed. The approach used in this guide draws on the work presented in the Flagship Framework on Health Reform and the ***PolicyMaker*** software for political analysis developed by Reich and Cooper.[14] This approach has been widely taught and used around the world, and is most familiar to the authors of this guide. One distinctive feature of this approach is that it combines stakeholder analysis with strategy development in order to assess the impacts of actions on the political feasibility of a policy.

The methods of stakeholder analysis are also similar in the various approaches. The methods generally combine document review of published and unpublished material, with media analysis and in-person interviews with stakeholders. The materials and interview transcripts are analyzed with qualitative methods to assess the position and power of each stakeholder on the policy under consideration.

Stakeholder analysis inevitably involves subjective judgments about all of the key factors: who are the stakeholders, their position on the policy, and their level of power on the policy. The analyst needs to decide which individuals and organizations are most affected by a policy, and whether to include organizational leaders as distinct from organizational members. For example, should the medical association president be identified as a key stakeholder in addition to the medical association members? Deciding on a position involves a judgment whether a stakeholder is for or against a policy, and how strongly, or not currently mobilized (no position). This question can be decided by directly asking the person or group, or by assessing the position based on public statements or actions. Making these critical judgements can also be done by a team of analysts who discuss the data collected and different options and come to a collective decision; this can help reduce subjectivity or at least create shared subjectivity.

These decisions about key stakeholders, and their position and power on the proposed policy change, are the key data points for this analysis, because they are the inputs into determining the assessment of political feasibility. One way to assess political feasibility is through discussion of the "political map" produced by the data on stakeholders, position, and power, as shown in examples in Figure 3 (produced using the *PolicyMaker* software[14]).

[Figure 3 here]

**Select an analyst**

The stakeholder analysis can be done by a team of analysts or by an individual analyst depending on the resources available. For example, the stakeholder analysis can be done by the reform team seeking to change a policy, often working directly for the decision maker in charge as the client; or the analysis can be done by an external analyst, for example, a person from an academic institution, or international organization. Usually, the analyst would have prior training and experience in applied political analysis. However, in cases where this is not possible, this guide provides a step-by-step set of instructions on how to conduct an applied political analysis.

It is also important to think about the implications of selecting an internal or external analyst. Internal analysts working within an organization that has a stake at the change in question, may bring some biases to the analysis. Furthermore, the relationship that the analyst already has with the stakeholders to be interviewed may also introduce bias. Stakeholders may not feel comfortable disclosing their interests and position. However, an internal analyst poses in-depth knowledge of the local context and may be able to identify important information quickly and interpret it with nuance. External analysts, who do not have a stake at the change in question, may bring a more impartial perspective and may be better positioned to inquire about stakeholders' positions in interviews. However, they may lack knowledge of the local context and culture, which may lead them to miss important information or misinterpret what they collect. A team that includes both internal and external analysts may work best if information is triangulated and if there is good communication to assess biases and assumptions in the interpretation of the findings. The organizational context of the project matters. Forming the right team of internal or external analysts trained in political analysis is important. Effective and regular communication is key among team members; and with the audience/client. Having a shared understanding of the purpose of the analysis is critical so the client can best use the political strategies that result from the analysis.

**Develop a list of stakeholders**

Stakeholder analysis depends on creating a list of actors, groups or institutions that have a stake in the adoption or implementation of the policy. Who is likely to be affected by the change? Who believes

they will be affected by the policy change? Actors at different levels need to be considered: at the national, state, and community levels. Campos and Reich[10] propose six categories of stakeholder groups that are likely to influence health policy (shown in Figure 4): interest group politics, bureaucratic politics, budget politics, leadership politics, beneficiary politics, and external actor politics. Local experts may be able to identify key actors within each stakeholder group to include in the analysis, and to be considered for direct interviews (if they are to be conducted). If interviews are conducted, the analysts should consider a "snowball sampling" in which interviewees are asked to identify other stakeholders that they think should be consulted. Usually interviews are stopped at the point of "saturation," when no new information is obtained from new interviewees.[16,17] We include an example of a list of stakeholders in Appendix 2.

[Figure 4 here]

**Decide on how to approach stakeholders**

If direct interviews are to be conducted with stakeholders, the analyst team will need to think in advance about how stakeholders will be reached and who will reach out to them. An external analyst may be well positioned to reach out to stakeholders if the external person or group is perceived as relatively impartial. However, the analyst may need help with contacting stakeholders and securing appointments. This is an aspect of a stakeholder analysis that is rarely discussed in detail but that is crucial to the success of an analysis. Approaching stakeholders can be difficult for several reasons:

- Distrust in research
- Lack of time
- Sensitive information in the political landscape
- Conflict of interest: stakeholders may not want to reveal their positions to help the opposition develop strategies
- Unavailability of high-level stakeholders

The team of analysts needs to discuss different strategies they will use to approach stakeholders, such as: sending cold emails or making phone calls; using personal connections; asking to be introduced by a second-degree acquaintance; even contacting stakeholders via social media. It is also important to

acknowledge whether stakeholders were not able to be contacted and thus not included in the analysis. There may be other ways of assessing the position and power of the "missing" stakeholders via public statements or media articles. However, it is important to note who is being left out from the analysis that could have a stake in the policy.

In some cases, when the analyst team may decide not to conduct interviews, if the team believes that it knows quite well the political landscape and positions of specific stakeholders. Another reason for not conducting direct interviews is if the problem or policy is considered to be highly sensitive, so that even asking for interviews would be considered controversial or disruptive to the policy environment. On the other hand, using direct interviews could be part of a consultative and deliberative process of involving different stakeholders. Whether to use this kind of participative approach to policy reform will depend on local circumstances and the client's preferences and judgement.

**Develop interview guide and conduct interviews**

Once the list of stakeholders has been developed based on key stakeholder groupings, an interview guide needs to be created with the questions to gather information regarding the interests, the positions and the power of each actor. Here are some questions that can guide the development of a more detailed interview guide:

- What are the main objectives or interests of the organization/individual actor in the proposed policy?
- How important to the organization are those interests in the proposed policy?
- What kinds of formal access do different organizations have to the decision-making agency?

Assessing position and power is not an easy task. Stakeholders may not state their positions and interests explicitly; the analysts will have to identify the underlying motivations of stakeholders. This requires a careful triangulation of perspectives across interviews and other data (i.e. public announcements, news media, published and unpublished documents).[13] The questions in the interview guide also have to be developed in a politically sensitive and objective manner to ascertain useful data and not to alienate different

groups ex ante. One possible question to assess the power of stakeholders is: Who do you have to go through to voice your opinion/concerns about a new program or policy?

It is also important to keep in mind that the interview guide may change as the analysis progresses. Unexpected political events can result in some questions becoming irrelevant; or new questions may need to be added. We include an example of a simple interview guide in Appendix 3.

**Analyze the position and power of each stakeholder**

The analysis of the stakeholder interviews may be guided by the following kind of questions:[15]

- Who are the most important stakeholders for this issue (who holds more power/and has access to the decision-making process)?
- What are the stakeholders' positions on the proposed policy? Do they support it, are they neutral, or do they oppose the policy, and with what level of intensity?
- What are the stakeholder interests in the policy?
- Which stakeholders have formed alliances or might form alliances?

The aim of the analysis is to establish the position of each stakeholder (support, non-mobilized, opposed, and the intensity of support or opposition as high, medium, or low); their power (financial and administrative resources, access to decision-making process, also assessed as high, medium, or low), and their formal and informal relations with other stakeholders. If working in a team, each member could conduct their own analysis and then compare insights and results to reduce bias. Alternatively, the entire group could meet together to assess the position and power of each stakeholder and come to a collective decision.

**Present the stakeholder analysis**

The results of a stakeholder analysis can be presented in a table showing the position and power of each stakeholder. In addition, *PolicyMaker* software can be used to produce a visual representation of the "political map" of stakeholders in the policy landscape (see Figure 3).[14] This representation will allow the analyst or the team to develop strategies that seek to influence different stakeholders and thereby improve

the political feasibility of the policy reform. One published example of applied political analysis using *PolicyMaker* software is provided by Glassman et al.[6]

A brief narrative describing the position, power and perception of each category of stakeholder is also helpful.

**Step 4: Design a set of political strategies**

Stakeholder analysis is not an end in itself but rather a means to enabling and managing change. A description of the political landscape is not sufficient to produce change. The results of the stakeholder analysis need to be used to develop strategies that can change the political landscape in ways that improve the political feasibility of the desired policy reform. Below we present some examples of political strategies that produce change in the feasibility of policy reform.

In this stage, the analyst seeks to identify strategies for change in the decision-making process, especially changes that could alter the balance of power and the feasibility of reform. The basic logic is to design political strategies that strengthen the number and power of supporters, reduce the number and power of opponents, and mobilize new supporters from the non-mobilized stakeholders (or the opposite, if the goal is to stop a specific reform).

Political strategies can be designed around four factors:

- seeking to change the power of actors;
- seeking to change the position of actors;
- seeking to change the number of actors (in support or opposed); and
- seeking to change the perception of the problem or the solution

These four factors (power of actors, position of actors, number of actors, and perception of problem and solution) all influence the political feasibility of adoption of a proposed policy or the political feasibility of implementation of an accepted policy. The reform team will want to consider political strategies for each stakeholder, when looking at the political map, to address questions such as:

- How can a key opponent be persuaded to change its position from high opposition to low opposition or even support? This could involve strategies to negotiate over change in a technical aspect of the policy, or to provide of desired resources.
- How can the power of supporter be increased, so that they have more influence over the policy process? This could involve strategies to increase the financial resources of the supporter, or to give them more visibility in public media.
- How can the power of opponents be decreased?
- How can the number of supporters be increased? This could involve strategies to mobilize actors that are neutral, by providing them with technical analysis about how the policy would benefit them or by offering them incentives to show public support for this policy.
- How can the perception of the problem and the policy be changed, so that the desired policy reform is more likely? This could involve strategies to give more public and media visibility to the problem and the policy solution, including use of social media.

For each key stakeholder, the reform team can identify a strategy that will improve the political feasibility of the proposed reform: the specific action to be taken, the expected impacts of that action (on power and position and number of actors), and any anticipated problems with the action. Political strategies can be creative, but they can also involve risks and potential adverse consequences.

Where can the reform team find political strategies that might improve the feasibility of their policy? Past experience in the local context (in the health sector and in other sectors) is one source for ideas. The reform team may include individuals with expertise in managing political issues in the local context, and they can be used as resource people in strategy brainstorming discussions. The published literature includes many case studies on particular health policy processes and political strategies used to promote adoption or implementation.[10] In addition, the *PolicyMaker* software includes a toolbox of around 30 political strategies that can be adapted to particular contexts.[14] Finally, there may be professional political strategy or lobbying companies that can provide assistance with this process in specific localities.

It is worth noting that other guides to stakeholder analysis often put more emphasis on the analysis of political actors rather than the development of political strategies. As noted above, one distinctive feature of this approach is its emphasis on the development of specific strategies that can lead to actions to shape the political environment for policy.

**Step 5: Assess the impacts of your political strategies**

The last step of this analysis is to assess the likely impacts of your political strategies and estimate whether you have adequately increased the political feasibility of your desired policy reform. This estimate is not an exact science and requires judgement. Do you think you have reduced the intensity of opposition from a key stakeholder that resists the policy? What are the chances that your compromise with a non-mobilized group will encourage them to publicly support the reform? Strategies can also interact with one another in ways that make it difficult to predict the consequences. A group discussion among team members may help this assessment, but ultimately some uncertainties will remain.

Hypotheses can be developed for each strategy with indicators to measure its impact. This step is complicated, but it can help develop better political strategies based on the assessments but also to build evidence about what works and what doesn't in applying political analysis to real-life situations.

**Write a Report**

In most cases, a written report will be needed to inform the client about the results of the analysis. The length and detail of the report should be adapted to the particular client and their requests. The document may be confidential depending on who the client is and what the client decides. The client may decide, for example, to keep the report confidential within the immediate reform team, because it can contain sensitive information and judgements about specific stakeholders, and its dissemination could create tensions and could inform stakeholders about the client's proposed actions and thereby change the reform dynamics.

The report should probably cover the following topics:

1. Policy definition and the problems intended to be solved

2. Context of the policy

3. Summary of findings from stakeholder analysis, including a table showing the position and power of each stakeholder (can use visual representations from *PolicyMaker* software)

4. Proposed political strategies, including information on who will take action and likely consequences of each action

**Conclusions**

Applied political analysis cannot guarantee success in policy reform or implementation. The real world is more complex than the kind of analysis proposed here. Policy processes are often unpredictable, and the context may change from one day to the next. However, being prepared to manage the political dimensions of health policy processes can increase the likelihood that the changes will achieve the desired outcomes. Repeating the analysis over time as the policy process unfolds, and keeping track of stakeholders and strategies, can increase the chances of successful

Thinking about these challenges ahead may improve the success of the political analysis. Conducting a stakeholder analysis is an essential element in designing political strategies to shape the political context of policy reform. The technical and the political need to be linked together and speak to each other, in order to design public policies that can be adopted and implemented effectively, in health as in other sectors.

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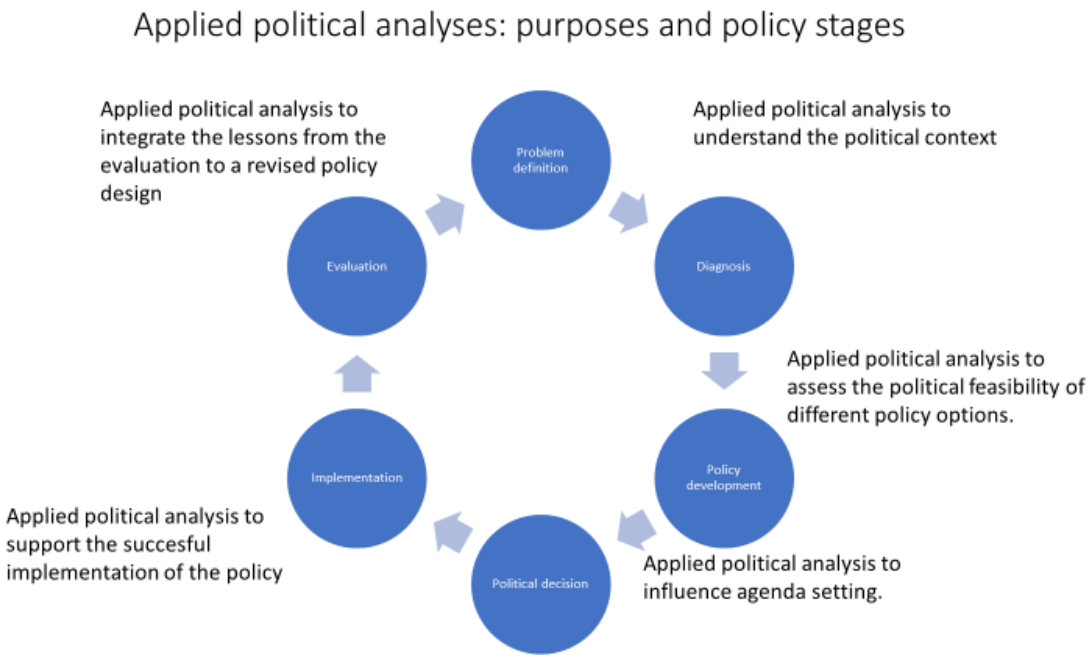
**Figures**

**Figure 9: Policy cycle**


Source: Roberts et al., 2004[1]

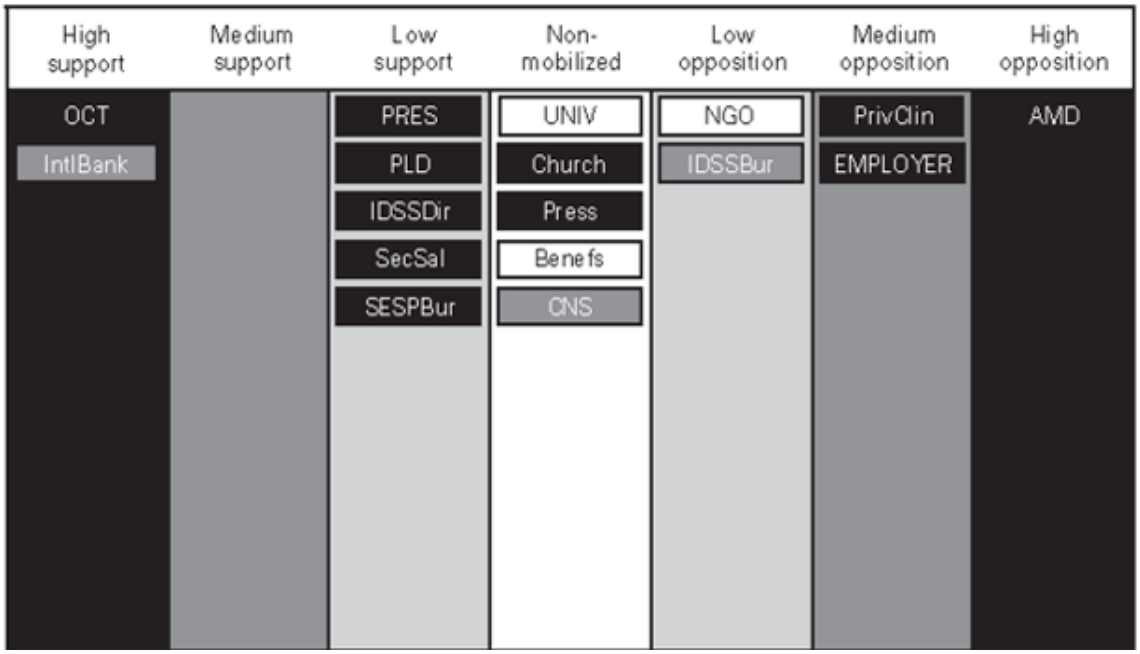
**Figure 2: When to do applied political analysis**




Source: Policy cycle adapted from Roberts et al., 2004[1]

**Figure 3: Examples of political maps**

Example 1: Dominican Republic Health Reform



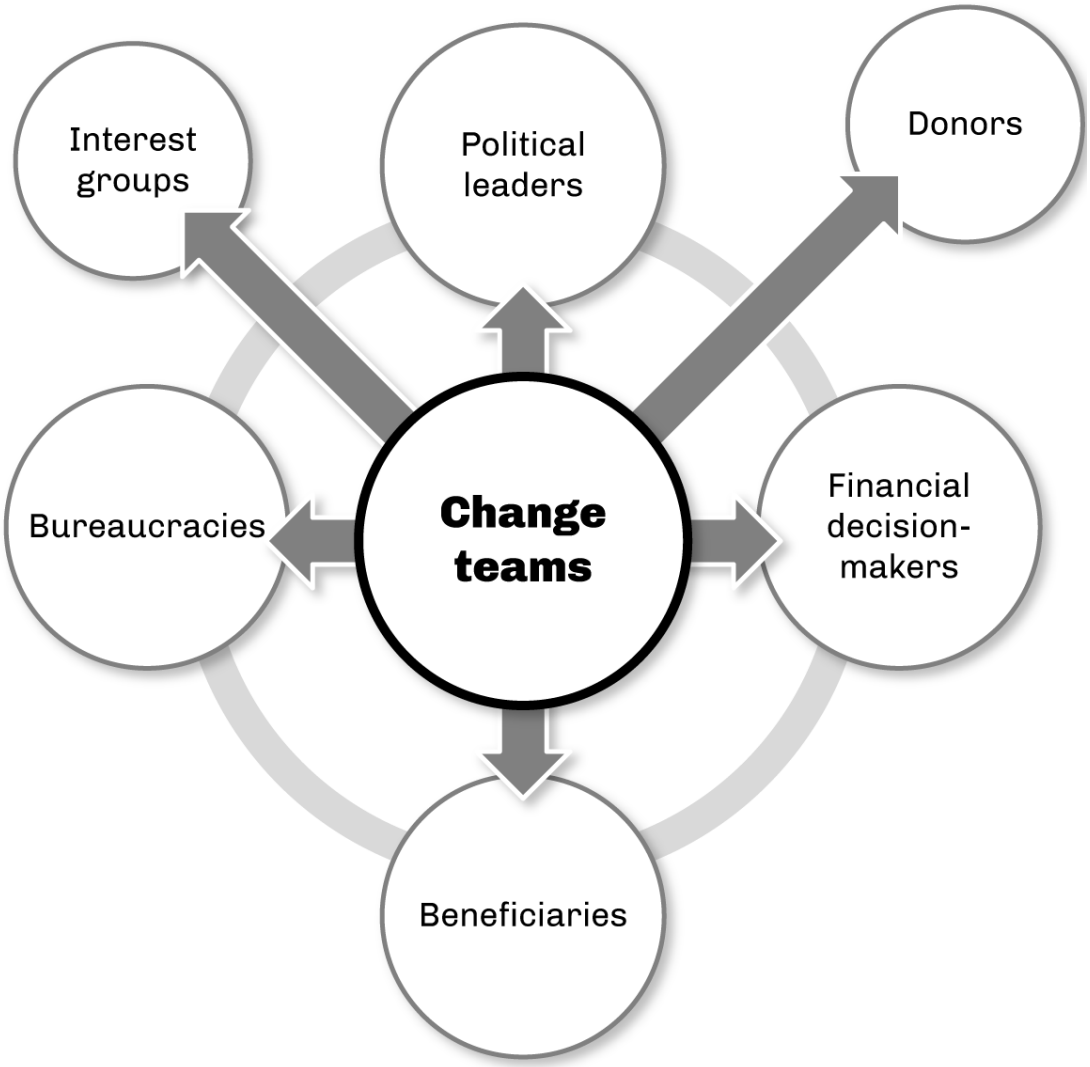

Key: white box = low power; grey box = medium power; black box = high power.

Source: Glassman et al., 1999[6]

Example 2: Guatemala Reproductive Health Policy


Source: Barros et al.

**Figure 4: Stakeholder groups**




Source: Campos and Reich, 2019[10]

**Glossary**

| | |
|---|---|
| **ANALYSIS, POLITICAL** | A process for assessing the political factors that affect the feasibility of adopting or implementing a selected health reform. |
| **CHANGE/REFORM TEAM** | A group of people who collaborate to shepherd a health reform through policy design and adoption. Change team members are often people with policy expertise and the political capacity to mobilize others in support of the reform. The composition, positioning and power of a change team has a significant impact on the likely success of the reform efforts. |
| **CONTROL KNOB (OR POLICY INSTRUMENT)** | An area of the health sector that can be changed by public policy, is typically under the control of policy makers, and which affects the performance of the health sector. The Flagship Framework proposes five control knobs (or policy instruments): financing, payment, regulation, organization and behavior/persuasion (see separate entries). |
| **HEALTH REFORM CYCLE** | A model describing how policies for the health sector are designed, implemented and evaluated. In the Flagship Framework, the health policy cycle is an iterative process that involves: problem definition, causal diagnosis, policy development, political decision, implementation and finally, evaluation. Evaluation leads to identification of new problems and the cycle begins again. |
| **HEALTH SECTOR REFORM** | The complex process of designing and implementing policies that purposefully seek to influence the societal and institutional policies and organizations that create, protect and promote the health of the population. |
| **IMPLEMENTATION** | The process through which a public policy is carried out in practice to produce social impacts. |

| | |
|---|---|
| **INTEREST GROUP** | A social group that has a set of common interests and seeks to influence the government (or other institution) to move in a particular direction to protect those interests. Examples of interest groups in the health sector include consumer groups, medical associations, and pharmaceutical industry associations. |
| **POLICY CYCLE** | The process by which policies are designed and utilized. (See separate entry: health reform cycle.) The Flagship Framework's cycle is: Problem definition → Diagnosis → Policy development → Political decision → Implementation → Evaluation; the Flagship Framework also emphasizes the role of ethics and politics throughout the policy cycle. |
| **POLITICAL FEASIBILITY** | The likelihood that a proposed health policy or reform can successfully be adopted and implemented within a particular society. Political feasibility depends on the relevant players, their levels of power, their positions on the proposed reform, and perceptions of its likely impact. |
| **STAKEHOLDER ANALYSIS** | The process of determining which individuals and groups have an interest in a particular policy, what their positions on the policy are, and the level of power that each has, in order to develop strategies that improve the political feasibility of adopting or implementing a public policy by strengthening supporters and weakening detractors. |