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Policy entrepreneurs as catalysts of broad system change: the case of social health insurance adoption in India

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ABSTRACT

Understanding what drives broad, system change is fundamental, as societies seek to adapt to challenges. We highlight the role that policy entrepreneurs can play as catalysts of such change by linking micro-level strategies and broad, system change which remains understudied. Applying a historical perspective, we analyse the adoption of social health insurance programs in India to identify the role played by policy entrepreneurs in driving the adoption of these programs, even as broader structural and institutional factors established the context for policy change. Further analysis of this kind could advance knowledge of what drives broad, system change in other areas.

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Over recent decades, studies of policy entrepreneurs have become more common, and various efforts have been made to integrate interpretations of their role and influence within other theorisations of policymaking processes and policy change (Mintrom & Norman, 2009). In the process, some interim efforts have been made to link the micro-level actions of policy entrepreneurs to broad, system change (e.g., Arnold, Long, and Gottlieb 2017; Falleti, 2010; Mintrom, 1997a). However, considerable work remains to be done along these lines. Understanding what drives broad, system change is fundamental, as societies seek to adapt to challenges from shifting environmental, demographic, economic, and geopolitical circumstances. To contribute to research making these micro-to-macro connections, here we analyse the adoption of social health insurance programs in India. It is a curious case because the first such program was adopted in the 1950s, but it had limited application and impact. A period of many years passed before these programs gained momentum. That change has generally been attributed to structural and institutional shifts. In contrast, we apply a historical perspective to identify the role played by policy entrepreneurs in driving the adoption of social health insurance programs, even as broader structural and institutional factors established the context for policy change.

The paper proceeds as follows. We first discuss the importance of explaining the broad system change. We then note the growing body of scholarship on policy entrepreneurs and how some contributions have linked the micro-level actions of policy entrepreneurs to broad system change. From here, we proceed to introduce our empirical work, starting with the context of social health insurance adoption in India. After discussing alternate

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explanations of the rise of social health insurance, we consider the role of policy entrepreneurs. We then describe how we went about exploring their work in establishing social health insurance programs in India. We conclude with a discussion of emerging insights on policy entrepreneurs. We suggest further analysis along these lines could advance knowledge of how strategic action by policy entrepreneurs can drive broad system change in many areas of public policy.

Explaining broad system change

Explaining broad system change is a fundamental challenge since systems occur in the natural world and across multiple facets of human activity. Our explanation of broad, system change is in the realm of public policy. The motivating question is: What factors explain broad, system-wide policy change? This question will gain in significance, as societies everywhere seek to adapt to challenges arising from shifting environmental, demographic, economic, and geo-political circumstances. It will become especially pressing for large-population countries located within Asia. For such countries, including China, India, and Indonesia, the combination of rapid population growth and wide-scale economic development have begun to generate a series of acute tensions. These spans from environmental sustainability, to food security, to population health and human development. To be effectively met, all such tensions will require broad, system-wide policy change. However, the observed desirability of broad, system-wide policy change rarely translates smoothly into adoption of such change (Kammerer & Namhata, 2018; Peterson, 2011; Rabe, 2004).

Since the mid-twentieth century, a variety of explanations have been put forward to account for broad, system-wide policy change. Among political scientists and scholars of public policy, these explanations have usefully been grouped as theories of the policy process (Weible & Sabatier, 2017). The most salient of those theories includes innovation and diffusion models (Berry & Berry, 2018, Rogers, 1962), interest group and elite theories (Berry & Wilcox, 2018; Dye, 1976, 2014), incrementalism (Lindblom, 1968), and various strands of institutionalism (Hall & Taylor, 1996; March & Olsen, 1989). All of these theories place importance on structural conditions and political power dynamics to explain policy change. Other theories have synthesized components of these. In the process, they have tended to open the way for more discussion of the agency of specific political leaders and teams of actors in catalysing broad, system-wide policy change. Such theories include the advocacy coalition framework (Sabatier, 1988; Sabatier & Jenkins-Smith, 1993), the multiple streams approach (Herweg, Zahariadis, & Zohlnhöfer, 2018; Kingdon, 1984), and punctuated equilibrium theory (Baumgartner & Jones, 1993). In articulating the multiple streams approach (Kingdon, 1984), popularised the notion of the 'policy entrepreneur'. Subsequently, the punctuated equilibrium theory explicitly accounted for the role for policy entrepreneurs in driving change. The advocacy coalition framework has also been shown to be compatible with the practices of such actors. (Meijerink, 2005; Mintrom & Vergari, 1997).

Policy entrepreneurs and broad system change

Policy entrepreneurs are energetic actors who work with others in and around policy-making venues to promote significant policy change (Mintrom & Thomas, 2018). Over recent decades, interest in policy entrepreneurs has grown exponentially. That interest has

come both from scholars of public policy and from individuals working in and around the government. Scholars of public policy have sought to better understand the roles that policy entrepreneurs play in policymaking processes and how and why they matter (Mintrom & Norman, 2009; Narbutaité Aflaki, Petridou, & Miles, 2015). For practitioners, the key concern has been how they might improve their own practice. Practitioners have looked to lessons drawn from the study of policy entrepreneurs to improve how they formulate and advance specific policy positions (Kalil, 2017; Mintrom, 2003).

As they work to promote policy change, policy entrepreneurs exhibit well-documented regularities both in their personal dispositions and in the strategies they deploy (Mintrom, 2000; Mintrom & Luetjens, 2019; Roberts & King, 1996). Policy entrepreneurs are ambitious in pursuit of a cause. They display sociability and exhibit high levels of social acuity. To secure credibility within specific policy circles, they draw on their past accomplishments and expertise, their professional connections, and whatever power or prestige they enjoy in their current positions. They are tenacious. In promoting significant policy change, policy entrepreneurs deploy several important political strategies. These include framing problems and redefining policy solutions (Mintrom & Luetjens, 2017), using and expanding networks (Arnold et al., 2017; Mintrom & Vergari, 1998), creating advocacy teams and coalitions (Mintrom & Vergari, 1996), leading by example (Mintrom, 1997b), and scaling up advocacy efforts to expand the scope of policy change (Mintrom & Thomas, 2018). Yet even as they frequently conform to these observed regularities of disposition and strategy, policy entrepreneurs display diversity in their policy interests, where they operate, and how they engage in advocacy efforts.

Studies of policy entrepreneurs and policy change tend to concentrate on specific change episodes. It is rarer to find studies designed to link the practices of policy entrepreneurs to broad, system change (e.g., Falleti, 2010; Huitema, Lebel, & Meijerink, 2011; Mintrom, 1997a).

The context of health insurance adoption in India

Social health insurance represents an increasingly popular approach to extending access to health care, especially to poor individuals and families in developing countries. Under this approach, people and their employers pay contributions that cover a set of services available to those who have insurance and their dependent family members. Post-independence, India sought to emulate the United Kingdom's National Health Service, primarily focusing on delivering healthcare through a public health system. India launched its first social health insurance program in the early 1950s. However, the program was limited to government employees and selected low-income populations. The Oil Crisis of 1972 and the resulting economic crisis in India negatively impacted government expenditure on health, which went into decline. By 2000, it was reduced to 0.9% of GDP, one of the lowest proportions of health care spending in the world. (Rao, 2005) (Figure 1). The lack of resources stifled the pre-planned growth of the public sector. Along with low levels of public financing, institutional failures and lack of accountability resulted in the failure of India's public health system to deliver healthcare to a majority of population (Rao, 2005)

In rural areas, public services were housed in poor facilities, health-care providers were absent, drugs supplies and consumables were unavailable, and most of the time facilities were closed (Banerjee, Deaton, & Duflo, 2004; Rao, 2005).

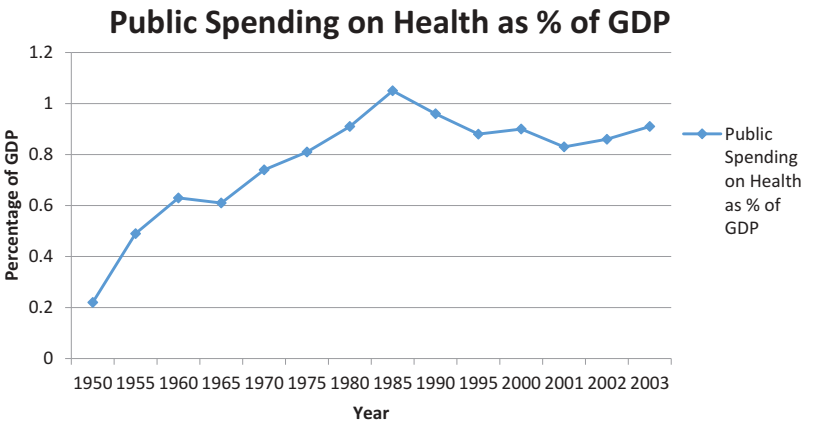

Figure 1. Public Spending on Health as % of GDP over the years (Source: Ramakumar, 2008).

The failure of the public system provided scope for the private sector to grow over the years. Various state governments offered a number of incentives to the private sector such as lower taxes and easier access to credit and subsidies (Baru, 1998). By the end of the twentieth century, the private sector had become India's dominant provider in outpatient care (80%) as well as in-patient care (57%) (Rao, 2005). The majority of the population used private providers, including poorer segments of the population. However, in the absence of financial protection, low-income groups had to either forsake care or pay out-of-pocket, pushing them into poverty (Peters, 2004). Indeed, close to the third of ailments in rural areas went untreated because of lack of money (Rao, 2005) and around 32.5 million persons fell below poverty line in 1999–2000 due to out-of-pocket expenditure (Garg & Karan, 2008).

With the private sector booming and low-income groups unable to afford care, targeted health insurance programs for low-income families were introduced from 2002 onwards. The Indian National Health Policy 2002 stated: 'In the context of a very large number of poor in the country, it would be difficult to conceive of an exclusive government mechanism to provide health services. It has sometimes been felt that a social health insurance program, funded by the government, with service delivery through the private sector, would be the appropriate solution' (pg. 34).

Post 2002, the federal government and many provincial governments launched a number of government-sponsored health insurance programs targeted towards low-income households (see Figure 2). In these programs, generally, a conglomeration of the private sector, NGOs, and the public sector form to provide health insurance to a defined population. The public sector generally funds the insurance premium either partly or completely, participates in the oversight of the program and also competes in service delivery.

By 2014–15, the government was spending INR 25,000 million (the approximate equivalent of USD $350 million) per annum to purchase premiums on around 15 governments supported social health insurance programs operated by both provincial and central government (IRDA, 2016). These programs managed to add health insurance coverage for 214.3 million people over the last decade, increasing the share of the population covered from a mere 5% in 2005 to 18% in 2014, and contributing to around 74% of the total health

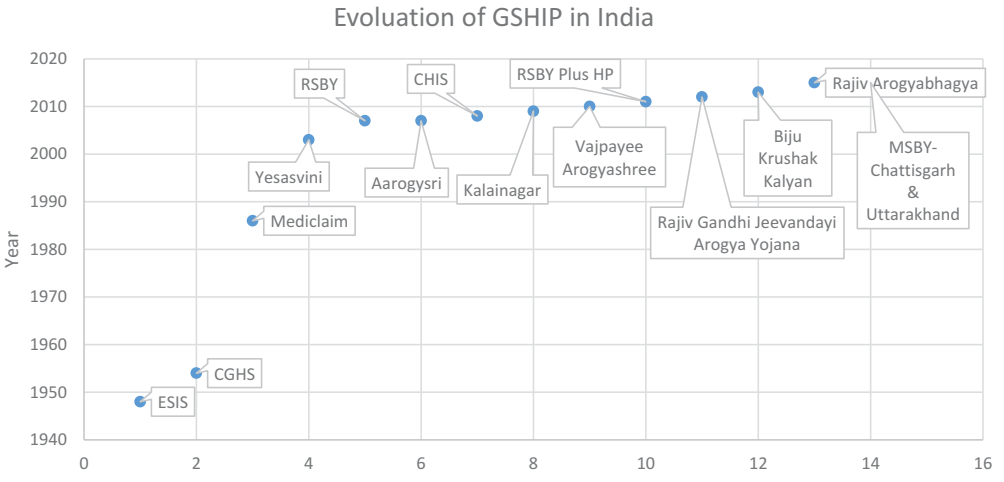

Figure 2. Evolution of GSHIP in India (Source: Authors).

insurance coverage in India (IRDA, 2016). Though the utilization has increased, there has been minimal impact on catastrophic expenditure (Prinja et al., 2017).

Explaining social health insurance adoption in India

India's first two SHI programs – the Employee State Insurance Scheme (ESIS) and the Central Government Health Scheme (CGHS) – were launched in the 1950s. Subsequently, no other health insurance programs were launched by either state or central government until 2002, and there was a lack of insurance policies or programs for around 50 years. Yet, in the past 15 years, from 2003 to 2018, more than 17 health insurance programs have been launched by various governments. What explains this non-incremental change? Here, we briefly consider the degree to which this change can be explained by three popular theories of policy change noted earlier: incrementalism, elite and interest group theory, and institutional theory. We conclude that, even as they give some clues about how this change might have come about, much remains unexplained.

The National Health Policy 2002 highlighted the anomalies that had built up between the existing policy regime, which favoured the public system of health-care delivery, and the reality, where the public system had failed to provide health-care services to the majority of the population. This realization led to experimentation with health insurance programs. Both within the government (The Economic Times 2001a) and outside (The Hindu, 2001), insurance was discussed as one of the choices to address health-care concerns of low-income groups. In 2002, the Government of India announced the launch of Janraksha, a national-level health insurance program (Ministry of Finance 2002). However, no policy development or implementation occurred. A few months later, in November 2002, the Yeshasvini Health Insurance in Karnataka was launched and implemented successfully (The Press Trust of India, 2002). Discussions at the federal level could have influenced the adoption of Yeshasvini in the state of Karnataka. However, the launch of Yeshasvini could not be explained by incrementalism as it happened even before the launch of any federal government programs. In the following year, in its budget of 2003, the federal government announced a Universal Health Insurance Scheme (Reuters News, 2003), however,

implementation was poor and the program remained underutilized. Rashtriya Swasthya Bima Yojana, launched in 2008 by the federal government, was the first health insurance program implemented successfully. Therefore, Yeshasviniand RSBY represent the first successfully implemented social health insurance programs post 2002. Only after the launch of various SHI programs could the successive launch of other SHIs by various states and the federal government be construed as evidence of incrementalism.

Interest group and elite theories also fail to comprehensively explain the rise of SHI programs in India. Health insurance comprised a small, loss-making segment of the insurance industry (The Times of India, 2000), and there was no coalition of health insurance companies (The Economic Times 2001b). Though health insurance was liberalized in 2001, insurance companies were hesitant to enter the health insurance space. The sector was considered largely unviable due to the inability of insurers to have any influence on the costs of private health-care provision and, relatedly, the lack of ability to develop accurate premium pricing (The Economic Times 2001c; Business Standard, 2001). The private hospitals were fragmented and unorganized (Burns, Srinivasan, & Vaidya, 2012) and had limited influence on policy-making during that time (Business Line 2000). However, there was also a growing group that was keen to address issues related to unorganized workers (The Times of India, 2001). Concern on the part of the government formed in 2004 for the welfare of unorganized workers and formation of a national social security scheme for unorganized workers in 2006 reflected a policy community keen to champion the cause of informal workers. This may explain the focus on low-income groups for SHI programs. However, the use of social health insurance as a policy tool for low-income groups at that time had not worked elsewhere (Forbes Asia, 2007). Therefore, these political developments at the elite and interest-group levels do not in themselves explain the adoption of the early SHI programs in India.

Can institutional theory explain this policy change leading to the launch of initial SHI programs? Liberalization of the health insurance industry facilitated the entry of private players and also formalized the role of Third Party Administrators that served as intermediaries between insurance companies and health service providers (Business Standard, 2000). This prompted a shift from a reimbursement-based system to one where patients were not required to pay in advance to receive care. Though these regulatory changes facilitated the adoption of social health insurance programs they cannot be considered to play a critical role in emergence and adoption of the SHIs. The industry was turbulent during that time and, as discussed earlier, the context was not suitable for entry of firms. The regulators, insurance companies and third-party administrators were at war with each other over many facets of the regulations (The Economic 2001c; Business Line, 2001, 2003). In sum, like incrementalism, interest group and elite theory, institutional factors provide a limited explanation for the adoption of SHI.

Policy entrepreneurs as catalysts of social health insurance adoption in India

In a fragmented healthcare policy decision space, split between federal and provincial government, what explains the significant policy change that has occurred? To date, academic assessments of the rise of SHI have typically focused on structural and institutional explanations for policy change (Hsiao, Shaw, & Fraker, 2007; Smith & Cumming, 2017). Except for a few studies (for example, Cohen, 2012; Shroff, Roberts, & Reich, 2015) work of

individual change agents in the adoption of SHI remains limited. A number of studies have investigated policy entrepreneurship in the context of health-care reforms (for example, Oliver & Paul-Shaheen, 1997; Oborn, Barrett, & Exworthy, 2011; Cohen, 2012; Onaka et al., 2015; Smith & Cumming, 2017). But very few have explored the role, motivation, strategies, and activities of policy entrepreneurs in effecting the adoption of SHI programs. Cohen (2012) studied entrepreneurial activities of policy entrepreneurs in the adoption of National Health Insurance Law in Israel. Cohen mapped various strategies and activities used by policy entrepreneurs. However, the focus was on the national-level government. Our study focuses on both the federal and provincial level. Further, our study highlights the different set of challenges entrepreneurs face because of the division of responsibilities within federal systems of government. We also note the resistance that was faced by policy entrepreneurs within the bureaucracy because of vested interests (He 2018). Oliver and Paul-Shaheen (1997) analyse the strategies and activities of policy entrepreneurs during the reform process in six states in the United States which differed in the content of reforms but had similarities in the process. Their work deals with changes in the existing health insurance arrangements rather than adoptions of new programs like those explored here. Onaka et al. (2015) underscore the importance of policy entrepreneurs in the adoption of a national health insurance program. However, their focus primarily is on a policy entrepreneur operating within well-defined governmental processes – the Health Ministry of Nigeria. Further, they provide limited information about the motivations, strategies, and activities undertaken by the identified policy entrepreneur to affect the adoption of SHI. Thus, much room remains for investigating the role of policy entrepreneurs in the adoption of SHI, especially those working outside established public health-care systems.

Research strategy and case selection

Using a broad definition of policy entrepreneurship, we map the role policy entrepreneurs have played in the adoption of two SHI programs across India. We examine the adoption of a provincial level program – the Yeshasvini scheme – and a national program – Rashtriya Swasthya Bima Yojana (hereafter RSBY). These two programs are considered as pioneer SHI programs launched after a gap of five decades that served as a role model to launch another 13 SHI programs in later years by various provincial governments and the federal government.

We do a comparative case analysis of the two cases drawing from primary and secondary sources. The sources used include legislative documents, reports, program documents, contracts available on SHI program websites, and different ministries. Yeshasvini and RSBY were launched in 2003 and 2008 respectively, therefore, an extensive analysis of news reports from 2000 to 2010 was conducted using data collected from the Factiva database. Also, comprising part of the analysis was documents and reports, and interviews (9 formal) and informal discussions with bureaucrats (2), decision-makers (1), researchers (2) and stakeholders associated with the programs from 2011 to 2018.

For both programs, we map entrepreneurial activities, describe various strategies the policy entrepreneurs deployed, and identify factors that led to successful policy entrepreneurship. The analysis reveals policy entrepreneurs played a significant role in the adoption of the SHI program along with structural and institutional factors. The analysis also highlights similarities and differences in strategies deployed by policy entrepreneurs

within government (RSBY Program) and outside government (Yeshasvini Program). Though policy entrepreneurs differed regarding their positions, they used a similar set of strategies. The same policy was championed, but the content of strategies differed. For example, in both cases, policy entrepreneurs used framing extensively, however, the same issue was framed differently in the promotion of the different programs. In the case of RSBY, the issue was framed as a lack of social security for an unorganized sector. In contrast, the Yeshasvini scheme was framed as an intervention to address individual and family poverty caused by unforeseen and catastrophic health-care expenditures.

In both cases, policy entrepreneurs had strong network ties with the government and did some piloting of the SHI program. Our findings highlight the important role policy entrepreneurs play in the Indian context. Shroff et al. (2015) have previously identified the role policy entrepreneurs have played in the context of the RSBY scheme. However, their focus was limited to identifying the policy entrepreneurs involved. We have sought to identify the activities of the policy entrepreneurs. This agency-focused approach to the exploration of policymaking in India has received limited attention until now.[1] It represents a first step in exploring how the micro-level strategies of policy entrepreneurs can explicitly catalyse broad, system change.

Case 1: policy entrepreneurship and the Yeshasvini social health insurance program in Karnataka

In 2002, Yeshasvini became the first state SHI launched in Karnataka. The program primarily covers individual members of the rural cooperative society. In 2017, 4.5 million farmers who previously had no health insurance were enrolled in the program (Rajasekhar, 2017). The program covers hospitalizations up to 200,000 INR (nearly USD $3000) per person per year provided through a network of 725 hospitals across Karnataka. The program is funded by contributions from both beneficiaries as well as state government. With a utilization rate of 2%, the total number of hospitalizations in the year 2009–10 stood at 66,749 (Rajasekhar, 2017).

Adoption of Yeshasvini

The Yeshasvini scheme was launched during the regime of the Indian National Congress. The Yeshasvini scheme was first conceptualized by Dr Shetty, a cardiac surgeon who has pioneered telemedicine and low-cost cardiac operations in India (Kuruvilla & Liu, 2007; Radermarcher et al. 2005; Business Standard 2008b). Concerned about the affordability of surgery among rural masses, Dr Shetty commissioned a study that revealed the inability of rural households to afford surgical care and the extent of healthcare expenditure incurred by families. The study also revealed that there were a sufficient number of hospitals and providers, and the average occupancy rates of these hospitals were very low, only 35% on average (Kuruvilla & Liu, 2007).

But during that time, typical health policy thinking ascribed the problem of access to health care to a lack of facilities and providers. The public sector operated in isolation to the private sector and health policy discussions revolved around the public sector with little consideration given to the role of the private sector (Peters, 2004). By contrast, Shetty linked the low incidence of surgical care, the unaffordability of surgical care, the

existing health-care expenditure made by families, and availability of the private sector to deliver the services (eHealth, 2011; The Times of India, 2002). Shetty reframed the problem from limited public sector facilities to a lack of ability among the rural population to pay for large health-care expenditures (primarily surgeries), which is the ideal case for health insurance (The Times of India, 2002). He advocated the idea of health insurance whereby the small contributions of large numbers of people could overcome the basic financing problem (Forbes Asia, 2007).

After conceptualizing the idea, Dr Shetty initiated a discussion with various health insurance companies. They refused to cooperate (Australian Broadcasting Corporation Transcripts, 2004). During this time, Shetty entered discussions with the State Milk Federation in Karnataka, and he was able to convince the farmers to participate in the health insurance plan (Agriculture Information, 2016; Forbes Asia, 2007). This gave Shetty the idea to mobilize a million dispersed rural farmers and informal sector workers through the rural farmer cooperative society. The cooperative movement has had a long history in Karnataka. In 2005 there were 31,000 rural cooperative societies (Kuruvilla and Liu2007). Shetty also initiated discussions with the Principal Secretary of the Department of Cooperatives of Karnataka State. The Principal Secretary Sri A Ramaswamy was captivated by the novel idea and agreed to cooperate (Kuruvilla & Liu, 2007).

Dr Shetty and his employees went around the state educating the deputy district registrars and secretaries of cooperative societies about the scheme and the advantages of joining up (Kuruvilla & Liu, 2007; Radermacher et al., 2005). The idea was that the secretary of each cooperative society, in turn, would convince the members of the cooperative to join the scheme (Kuruvilla, Liu, & Jacob, 2005). Shetty had conceptualized the scheme to be self-funded and sustainable by the contributions of the members. However, the Karnataka government realized the political advantages of subsidizing this scheme. This became a contentious issue (Kuruvilla et al., 2005). Therefore, a compromise was struck where government financial participation was initially limited to the first year in order to make it self-sustainable. Soon, the government realized it could make political mileage from this scheme. Hence, subsidization has remained continuous since that time.

Shetty additionally obtained buy-in from private hospitals. This was possible because of his credibility, given his record as a cardiac surgeon, philanthropist, educator, telemedicine innovator, and for establishing the state-of-the-art general hospital in Karnataka (Kuruvilla et al., 2005). For his efforts, Shetty received many accolades and awards (The Press Trust of India, 2005). Health insurance programs had not previously been successful in India. However, the success of YeshwiniYeshasvini drew broad interest in the program (Forbes Asia, 2007). Many state governments, private foundations, and insurance companies subsequently invited Shetty to work with them in establishing similar health insurance programs across India (Business Standard 2008a; Business Standard 2008b).

Case 2: policy entrepreneurship and the national health insurance program

The National Health Insurance Program also known as RSBY, launched in 2008, is primarily targeted at members of the population earning less than a dollar per person per day. The benefits package comprises hospitalization expenses up to 30,000 INR (approximately equivalent to USD $400) per family per annum. The scheme is funded through general taxes where state and central government both contribute. At the federal level, the

Ministry of Laborand Employment provides stewardship and oversight of the scheme. If interested, each state can decide to adopt the scheme and implement it, with the ability to make some modifications. By February 2014, approximately 120 million previously uninsured people were covered, and there were 6.5 million hospitalizations under the scheme (Birdshall 2015).

Adoption of RSBY

In 2004 the federal government created a National Commission for Enterprises in the Unorganized Sector (NCEUS) to assess and suggest policy options for the welfare of the workers in the unorganized sector (Press Information Bureau, 2007). One of the key suggestion of NCEUS was to design a tax-funded health insurance scheme for the low-income group (NCEAUS 2006). This idea of health insurance was taken up by a group consisting of the Prime Minister and Chair of the NCEAUS (Shroff et al., 2015). The political leaders believed in the need for a health insurance scheme, given the lack of affordability among unorganized workers. The recommendation of the NCEAUS report suggested collecting one rupee per day from the unorganized sector and delivering healthcare through that. However, the design and features of the scheme – how the money will be collected, what and how the health care will be provided – remained unclear (Swarup, 2018, 2019). Until this time the government had been primarily involved in the supply side of the healthcare system. The need for a change in orientation towards the demand side of healthcare was not obvious to all of the people involved (Swarup, 2018). The Prime Minister set up a committee consisting of Mr P Chidambaram then finance minister (Swarup, 2018).

The scheme was first offered to the Health Ministry for design and implementation however the Health Ministry refused to do so. The Health Ministry was opposed to the idea of health insurance due to questions of its feasibility given its previous experience (Ministry of Labour and Employment Government of India, 2007). The idea was then referred to the Department of Insurance and Banking (later renamed the Department of Financial Services), which was implementing the Universal Health Insurance Scheme. Based on that experience, the Ministry concluded that designing and implementing health insurance was very difficult (Swarup, 2019). Then, the idea was referred to the Ministry of Labour, and Mr Anil Swarup was asked to design and implement the scheme by the Finance Minister (Swarup, 2018). Swarup primarily led the operationalization of the scheme (Fan, 2013; Shroff et al., 2015). Objections came from various ministries including the Ministry of Health, Ministry of Finance, and Ministry of Rural Development, all of which questioned the feasibility of the program (Fan, 2013; Swarup, 2019). The scheme designers thought of using technology to deliver a paperless scheme, but the Ministry of Information Technology was concerned that this would not work (Swarup, 2018; GIZ officer & Jain.N, 2012). At that time there were no health insurance programs in many developing countries which were paperless. Thus, on the design side, there were political, administrative, financial, and technical constraints. There was strong opposition regarding the involvement of insurance companies and private hospitals as it was feared that they would manipulate the scheme to make it function primarily for their own financial gain (Swarup, 2018).

In March 2007, Swarup created a task force to design the health insurance scheme (Shroff et al., 2015). The task force involved officials from the Ministry of Labor along with technical experts from the International Labor Organization, the World Bank, and one

official from the Ministry of Health (Shroff et al., 2015). Later on, the German aid agency (GIZ) also provided significant technical support to the RSBY program (Jain 2012). Most scheme design components were contested and opposed as existing conditions were inhospitable. More specifically, use of smart card technology, health-care package design, involvement of private sector hospitals and insurance companies was hotly contested by different ministries and bureaucracy both within and outside the Ministry for Labour. Mr Anil Swarup involved all those who could facilitate the design of the scheme and borrowed ideas that could help design a scheme which was different from the usual government schemes of that time (Swarup, 2019).

By July 2007, the design elements of the policy were broadly configured – a publicly funded health insurance program using a mix of public and private insurers and providers. Many design elements were kept broad in the initial stages (Jain 2012). With extensive consultations and deliberations, the scheme design evolved into a paperless one that relied on a business model approach with all stakeholders including insurance companies, private and public hospitals and state government. However, all stakeholders had concerns about feasibility, given the complexity of the scheme. Insurance companies were concerned about losses in the existing health insurance segment and lack of data on rural areas. Ministry of Rural Development had concern over the availability of data on poor families, and the Ministry of Finance had concern over the release of funds in such a high frequency. Hospitals were concerned about the profitability given the low rates of healthcare offered in the scheme. Swarup went about meeting each of the stakeholders involved in the scheme design (Swarup, 2018, 2019). For each stakeholder, design elements were discussed in ways that addressed their concerns and that emphasized the benefits the scheme would provide to them. There was opposition within and outside the government. Agencies such as the World Bank and the ILO were strongly supportive. Other agencies such as the Planning Commission were indifferent to the scheme (Swarup, 2019).

The Prime Minister announced the proposed scheme on 15 August 2007 (Business Standard, 2007). After Cabinet approval, it was adopted as a national policy in September 2007 (Press Information Bureau, 2007).

Though the scheme was approved, it had yet to be adopted by the states who were essential for implementation. As per the Indian constitution, states can opt not to implement the policies recommended by the federal government except in certain areas related to disease control. Therefore, the adoption by the state could be considered as the second component of the policy adoption. Swarup and his team considered this challenge as marketing of the scheme. Given the complexity and involvement of multiple stakeholders, many states were not ready to adopt the scheme and a number of objections and resistance arose (Jain 2012; Swarup, 2019). Swarup identified the politicians and bureaucrats at the state government level who could be receptive to the program (Asia Insurance Review, 2009; Swarup, 2018, 2019). Swarup visited every concerned state, ministry, and department and explained the benefits of the scheme, making presentations and holding discussions even at short notice (Jain, 2012). Swarup and his team were able to effectively frame the scheme and market the scheme as a win-win business model to the state governments (Shroff et al., 2015; Swarup, 2019). Swarup and his small team of committed officers provided the support to states in understanding the nuances of the scheme and facilitating implementation. The team considered the problems as 'our problem rather than as my or your problem' (Swarup, 2019, p. 69). The modesty and humility of Swarup an 'unassuming

officer of the Indian Administrative Service' the driving force behind the scheme were considered as a key factor for the success of the scheme (Fan, 2013)

Initially, the scheme received little attention from ministers and other politicians even within the Ministry of Labour (Swarup, 2018, 2019). Swarup, a careful policy entrepreneur, felt that limited political visibility of the scheme in the early years would be very helpful as it would prevent opposition and unwelcome political interference. As a result, policy designers had ample scope to experiment and alter elements of the scheme (Swarup, 2018), significantly improving its design. Over the years the scheme design further evolved as it was implemented. Anil Swarup and his team travelled extensively to all states. Workshops and lesson-sharing meetings were held in states every six months. These ground-level discussions further refined the design and implementation process of the scheme and the scheme designs were revised every year. Swarup and his team were prepared to take risks, innovate, experiment, learn and evolve (Swarup, 2019). One of the officers of the Insurance Company commented that "the program's guidelines are so clear that they do not need to know anything else... One has to just follow the guidelines (specifications in the contract)" (Tripathi 2012)

Emerging insights on policy entrepreneurs as catalysts of broad system change

We have scrutinized the emergence and adoption of two social health insurance programs in India. Previous discussions have tended to attribute the change to structural and institutional shifts. While acknowledging that broader forces always set the context for policy change, we have focused attention on the efforts of specific policy entrepreneurs to take SHI in India from being an idea to being a viable program. Those efforts have been transformative. In the last decade, rapid expansion of social health insurance across India has seen coverage increase more than three-fold. Today, almost a fifth of the nation's population is covered by SHI. This is a case of broad, system-wide policy change.

Our analysis has revealed similarities and differences in strategies deployed by policy entrepreneurs within the government (RSBY Program) and outside government (Yeshasvini Program). Though policy entrepreneurs differed regarding their positions, they used a similar set of strategies. The same policy was championed, but the content of strategies differed. Our discussion points to the importance in these instances of several common strategies of policy entrepreneurship. First, considerable effort was made to engage in effective problem framing. In this regard, shifting the focus from adequacy of health-care services to patient ability to afford access to existing services was vital. Second, the policy entrepreneurs worked in a team-like fashion. Through development of close, trusting interpersonal relationships, the policy entrepreneurs gained access to political support and administrative capabilities that would have otherwise been impossible to tap. Third, networking and coalition-building were constantly used by the policy entrepreneurs. The case of RSBY demonstrates the resistance faced by the policy entrepreneurs within as well as outside the bureaucracy. It reveals that patience and effective networking were critical for developing a group of supporters that championed the policy at various levels. These strategies allowed the policy entrepreneurs to gain insights into what design features would allow SHI to operate effectively. The networks involved actors from the level of international organizations down to local hospital administrators. Through developing a sound knowledge of the key players who could make change happen, the policy entrepreneurs were able to stitch together coalitions to drive the implementation of SHI

schemes. Finally, considerable leadership by example was on display in the cases discussed here. The policy entrepreneurs we highlighted each devoted enormous amount of time, energy, and resources to making SHI a reality.

Conclusion

What factors explain broad, system-wide policy change? Our research has explored how an idea for policy change was transformed into actually working programs that have made real and significant differences in the lives of citizens. To do so, we have studied system-wide change through the lens of policy entrepreneurship. With respect to the rise of social health insurance, most previous assessments have focused on structural and institutional explanations for policy change. Limited consideration has been given to the role played by individual change agents. With Universal Health Coverage being promoted on a global scale, many calls have been made for the adoption of social health insurance. Even when various broader forces are pointing to the need for change, we have shown that it is the creativity, motivation, and tenacity of individuals that ultimately makes change happen. In the case of social health insurance in India, those changes have been dramatic and will have long-lasting, positive impacts. We believe the analytical approach we have applied here could be extended to gain new insights into the political dynamics surrounding the development and adoption of other system-changing public policies in many countries. Such insights would be of high relevance both to those seeking to interpret the drivers of the policy change and those seeking to make the world a better place.

Note

1. The few studies that partially address this issue include: Balarajan, Y., & Reich, M. R. (2016) and Liu, C., & Jayakar, K. (2012).

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