

Guide on the defragmentation of publicly subsidized health insurance schemes



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Abbreviations

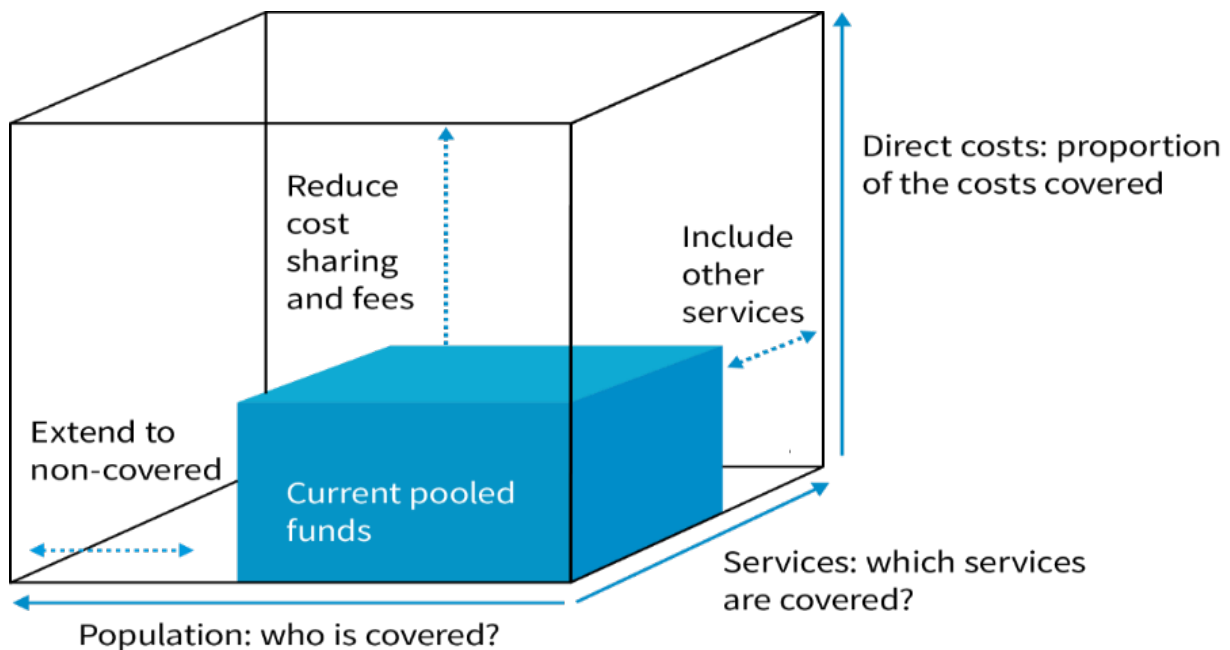
AAA	Atal Amrit Abhiyan
API	application programming interface
BPJS	Badan Penyelenggara Jaminan Sosial
CEA	cost-effectiveness analysis
CEO	chief executive officer
CSO	civil society organization
DRG	diagnosis related groups
GDP	gross domestic product
HBP	health benefit package
HMIS	hospital management information system
HTA	health technology assessment
ICT	information and communication technology
IEC	information education and communication
INA-CBGs	Indonesia case-mix based groups
IPD	inpatient department
JKN	Jaminan Kesehatan Nasional
KASP-PMJAY	Karunya Arogya Suraksha Padhathi Ayushman Bharat
KBF	Karunya Benevolent Fund
LMICs	low- and middle-income countries
M&E	monitoring and evaluation
NFSA	National Food Security Act
OPD	outpatient department
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPM	provider payment mechanism
PSHI	publicly subsidized health insurance
RSBY	Rashtriya Swasthya Bima Yojana
SDGs	sustainable development goals
SNA	State Nodal Agency
THE	total health expenditure
TPA	third party administrator
TWG	technical working group
UHC	universal health coverage
WHO	World Health Organization

1 Background

1.1 Introduction

The Sustainable Development Agenda 2030 has targeted the attainment of universal health coverage (UHC) as a key enabler for improving progress on health and wellbeing. Thus, many countries have been making strategic interventions in their systems to ensure the attainment of this agenda. UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. According to the WHO Report (2010), this implies ensuring that to the greatest extent possible,

- a) Increase the scope of the services covered
- b) Increase the population groups covered by affordable care
- c) Increase the proportion of direct costs for services that are covered at the point of use.



The UHC Cube

Source: World Health Report (2010)(1)

Fig. 1. The UHC Cube

One of the critical pathways that countries have used to advance progress on UHC is reforming the health financing system to ensure that services are affordable and provided in an equitable and efficient manner. One of the factors that has been shown to hamper the ability of a health financing system to achieve this is the fragmentation of the health financing system or landscape.

A fragmented health financing landscape is characterized by more than one scheme or funding pool being used to manage and purchase services for people(s) in a country. The more pools that exist in the system, the more fragmented the system is and, therefore, the less efficient and equitable it is. This system is unable to ensure adequate risk redistribution between people with different risks of ill-health and different ability-to-pay and, therefore, is likely to result in inequities in access to health services. Furthermore, the more pools exist in the system, the more the costs related to the administration and operations of the schemes result in administrative and operational inefficiencies. It has also been shown to be associated with overlaps in service and population coverage in some cases, as well as horizontal inequities in coverage across pools in other instances.

Thus, defragmentation of health financing systems has become an increasingly common agenda for many countries that are keen to accelerate their progress towards UHC in this guidebook. Defragmentation is defined as reforms that are targeted towards reduction in the number of coverage mechanisms, or expansion of coverage mechanisms to reduce the probability of individuals receiving care through non-coordinated providers, paid out-of-pocket.

1.2 What is the purpose of the guide

The nature of health reform is that it is often opportunistic taking advantage of policy windows that open and, therefore, tends to be constrained by time. It is often difficult to organize the necessary resources to guide the process systematically within the time available. Owing to limited, readily available guidance on the issue of defragmentation, questions often arise among policymakers regarding

- What actions must be taken?
- What areas of the system need to be addressed?
- Who should be included in the process of design of reform?
- What skills and evidence are needed to inform the process?

This guide builds on the experience drawn globally and from some states in India that have undergone such reforms. This guidebook is based on Parts 1 and 2 of the previous report which consisted of a 'Review of Defragmentation Efforts in India and Beyond' and 'Conceptual Framework and Typology for Defragmentation Reforms', respectively. In this guide, we provide information on evidence required, the human resource input and the skill sets needed to support reform efforts. The guide also includes some case studies highlighting how the thematic area is addressed practically and the results of this process. It highlights some of the key determinants of success or failure of reforms in the four Indian settings reviewed (Assam, Chhattisgarh, Kerala and Rajasthan). This guidebook has been developed to inform users of:

- a) The steps that must be addressed in defragmentation efforts in publicly subsidized health insurance (PSHI) schemes.

- b) The potential enabling and constraining factors that should be anticipated and leveraged and/or mitigated in the process.

1.3 Who can use this guide

This guide has been developed to assist reformers and policymakers working in countries and states in which multiple health insurance schemes exist and an agenda of defragmentation of the schemes has been set. The contents herein will provide useful guidance on the following key issues:

- The **key functions and thematic areas** that must be systematically assessed and reformed in the defragmentation process.
- The **processes that must be followed** in the defragmentation of the schemes include the engagement of stakeholders.
- **Identifies some key stakeholder groups** that must be included in the process of defragmentation.
- **The capacities and skills that are needed** to form the reform team that will steer the process as well as conduct the technical analyses necessary to inform the reform process and ensure technical robustness of the process.
- **The communication and change management strategy** for the reforms.

Other potential users of the guide include academic institutions that can use the contents herein to structure courses on defragmentation and students of health financing reform.

Lastly, researchers can use the guidebook to design evaluation projects to evaluate defragmentation processes and their impact on health financing outcomes of efficiency, equity, quality, and transparency.

1.4 The scope of the guide

This guide has been developed by evidence and practice within publicly subsidized health insurance in high-income (South Korea), middle-income (Turkey, China, Thailand, Moldova, Indonesia) countries, covered in Part 1 of the first report(2). The focus on publicly subsidized health insurance is because this has been the greatest focus of the defragmentation agenda in the last two decades, under which most reforms have been done and documented.

Moreover, many countries have identified this as a policy intervention in their health financing strategies and their UHC roadmaps. It is possible to extend some of the thematic areas and the actions included here to other financing mechanisms, but care must be taken in the extrapolation to these mechanisms.

Furthermore, the contexts often include stakeholder dynamics that may not necessarily be representative in other higher-income countries including development partners as key players. These findings would be applicable in most other settings though it does not necessarily serve as an exhaustive checklist of such factors given the large role political economy and other context specific factors across varied settings.

1.5 How to use the guide

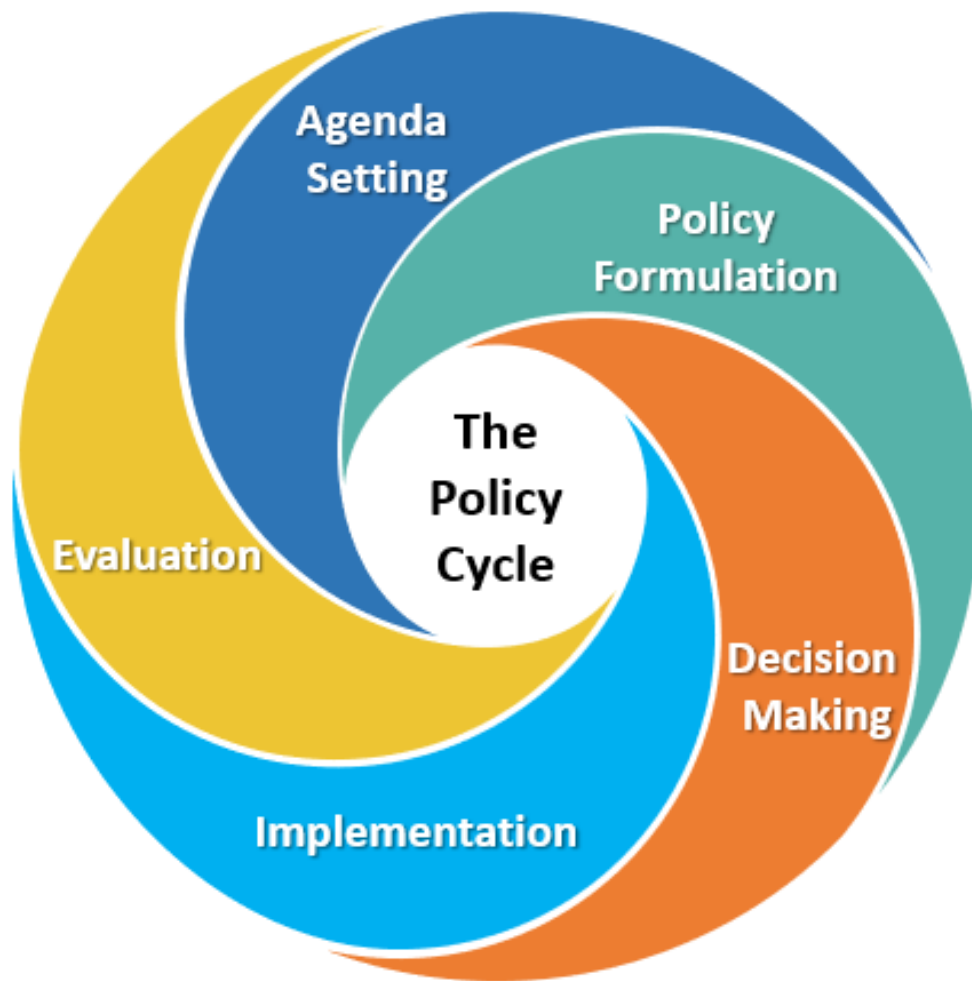
This guide is a synthesis of evidence-based practices elaborated on in Part 1 of the first report that have been used successfully in different contexts. It provides a good framework for approaching the defragmentation process but is by no means prescriptive. While the guide endeavors to cater for different defragmentation scenarios, it is by no means a comprehensive account of what should be done. Additionally, the guidebook should also be reviewed keeping in mind some of the conceptual models delineated in Part 2 of the first report to ensure that these reforms can build on existing knowledge on the variations in design and implementation pathways that exist.

It is, therefore, important for reformers to adapt the guide to their context and policy time frames as well as local stakeholder dynamics.

2 Approach for defragmentation: The policy cycle

The policy cycle is a useful public policy tool that describes the different phases of the policy process. Fig. 2. below shows the different phases of the cycle and their relation to each other. The phases are briefly described below:

1. **Agenda setting:** This has been defined as the phase in which the government draws up a list of public issues that need to be addressed. Usually, no set of problems has been finalized and there is a lot of lobbying from stakeholders of different issues to get their public policy issue of interest for government consideration.
2. **Policy formulation:** This is the stage at which a policy issue has been identified as a priority and systematic assessment of the problem and contextual issues framing the issue as well as policy options for addressing the problem are identified.
3. **Decision-making:** In this phase all the evidence on the policy issue and the options for addressing it are reviewed by a core group of decision-makers and a course of action adopted for implementing solutions for the problem. This may include development of a strategic and implementation plan with clear goals and targets included in a monitoring and evaluation plan/framework.
4. **Implementation:** This stage involves the implementation of the actions that have been devised to address the policy problem. Necessary resources are mobilized and allocated for this purpose, including human resources, time, financing, and others. This includes ensuring teams have appropriate skills and knowledge to execute the required tasks.
5. **Evaluation:** In this phase the reform team is evaluating the implementation of the plans *vis a viz* what was planned and the targets and goals that were set to be achieved. This ideally must start right from the policy cycle and is ongoing with routine data collection methods instituted.



Source: Policy Cycle (Savarde J, 2012)(3)

Fig. 2. The Policy Cycle

This guide commences at the point of policy formulation because it is assumed that at the time the user is engaging with the guide, the decision to defragment schemes is already firmly on the government's agenda and, therefore, the remaining questions are what the best way is to execute it. Thus, the focus is on steps 2-5 of the cycle.

3 Steps in the defragmentation process

3.1 Formulation of the reform

This is the first step after the agenda has been set by the government to defragment the health financing scheme. The steps in this process are divided into two sub-phases. The first is the *planning for the reform*. It is essential that the process is guided strategically by a supervisory team consisting of high-level policymakers responsible for decision-making to ensure accountability and legitimacy of the reform. The other is the *development of relevant policy options* based on evidence by technical teams. These teams are multi-stakeholder teams arranged around thematic areas that need to be addressed in the form. The supervisory team will determine these and must answer to the team. The sections below elaborate on these two sub-phases.

3.1.1 Planning for the reform

- **Institute governance structures**

Following the decision to defragment the health financing landscape, the department or organization in charge of this reform should establish governance structures that will steward the reform process. These are usually in the form of committees or working groups. In cases where reform was successful, multi-stakeholder and intersectoral stewardship team was instituted to take ownership of reform efforts and drive them forward. This engenders the support of senior administrative leadership and political heads. These often systematically communicate with political leaders to apprise of them the progress of the reform process and the policy options whilst getting feedback. These committees include:

1. Stewardship or oversight committee that oversees the process
2. Technical working groups (TWGs) under a technical committee's guidance that develops policy options for reform. These are based in identified thematic areas necessary for reform.

The roles of the stewardship or oversight committee:

- a) Defining the objectives of the reforms and the areas that shall be addressed during the reform. This also includes the definition of the timelines of the reform exercise and the procedures and frequency for meeting for feedback, consultation, and validation.
- b) Developing the technical committee that will oversee the technical components of the reforms. These will be related to the thematic areas identified within the work programme drawn up above.
- c) Facilitating access to data and any resources needed for the defragmentation process. This is especially important as it pertains to data such as claims and financial data across departments that is needed to inform the formulation of the reforms.

- d) Regularly reviewing the defragmentation efforts and enable decision-making, where necessary, especially when working across multiple departments and heads.
- e) Identifying and mobilizing different stakeholders in the reform process, identifying their roles and responsibilities within different TWGs.
- f) Appraising and approving the proposals that technical teams put forward bearing factors pertinent to attainment of UHC such as equity, efficiency, financial protection, and political feasibility. This structure is critical for weighing the technical options against the political and legal considerations pertaining to the reforms.

Representatives of the steering committee could include the executive leadership of the purchasing agency as well as representatives of different Ministries such as Finance, Labour, Social Development, Statistics, etc., renowned clinicians and academicians, representative from the public, policy think tanks, domain experts.

A dedicated transformation team led by a technical committee for planning and operationalization: As with any reform planned for operationalization, a core technical committee to coordinate with the capacity for planning and managing programme implementation is vital to the process. Transformation teams were important enablers for other countries as well. The key roles of this team are to provide subject matter knowledge in health systems financing principles, functions, policy, and best practices knowledge can drive reforms that go beyond common practice, central guidelines, and frameworks, and can lead states/countries to take bolder steps in their reform designs. Large reforms in countries such as Thailand and Turkey were driven by technical experts and ‘champions’ who could drive and sustain the momentum of reforms.

“During the defragmentation process in Chhattisgarh, a reform team was instituted by the Department of Health and Family Welfare. This constituted representation from Information Communication and Technology (ICT), health benefits rationalization, health economist, a change management expert a communication expert and more. The team received terms of reference for the exercise of defragmenting the schemes. The team met regularly to review.”

Former Official, SNA Chhattisgarh

In cases where such capacities are limited, it is critical to ensure the development of relevant capacity in the team that will drive the transformation agenda. Rapid methods of increasing the capacity may include bringing in an expert on health financing reforms that could guide the process remotely or physically. It may also include knowledge sharing experiences which may be virtual or physical. For instance, in one state in India, a team that was charged with driving the defragmentation agenda had a benchmarking visit to Thailand which has had several years of well-documented experience in implementing such reform.

Based on the experiences in various contexts, for implementation, the following areas form key Technical Working Groups (TWGs) to operationalize strategic purchasing within the integrated schemes. The transformation or technical committee has a key role in ensuring adequate coordination and synergies across these TWGs. Some of the processes specific to defragmentation efforts, for which these capacities are necessary, are described in the next section.

- **Fiscal sustainability team**

It is critical that the reform is affordable and sustainable. Challenges to scale up of PSHI usually include financial gaps in the long term. Thus, the policy option that is selected for defragmentation must be financially viable. In short, revenues available for the scheme(s) must be greater than the costs of running the scheme(s). This requires an assessment of the financial viability over a medium-term horizon.

This team is essential for conducting the fiscal sustainability assessment of the scheme. The team guides the discussions that are related to policy scenarios and the evidence needed. It also incorporates the feedback from the committees that have been convened to guide the assessment. Therefore, there must be continuous interaction of the group with other teams including the team reviewing options on the benefit package, the teams reviewing the provider payments and the price-setting team. It ensures the validation of estimates and provides the best policy scenarios.

The skills of the team should include a health economist with good costing skills, an actuary with experience in risk assessments, epidemiologist, public finance expert and statistician *inter alia*.

- **ICT team**

For defragmentation efforts, the digital platforms that support data and processes for streamlining purchasing functions are crucial for its successful implementation. An experienced team is necessary to support the development and rollout of these integrated digital systems. Harmonizing or merging processes like claims management and provider empanelment, has often been seen to precede other dimensions of defragmentation. For these reasons, building ICT capacities are necessary for initiating defragmentation efforts across health insurance schemes.

- **Medical management team**

This team should have some clinical and health economics experts. It should also have representation of beneficiaries who provide inputs on the following: developing guidelines and processes for benefits package development, developing standard treatment guidelines; defragmentation of claim adjudication processes, and to inform audit and fraud management. Frequent interactions with other teams including the fiscal sustainability assessment team are critical.

- **Hospital empanelment and quality management team**

Several schemes would have different hospital empanelment criteria and would in many cases have empanelled the same providers. There is, therefore, a need to rationalize the empanelment process whilst ensuring access to services is equitable and the quality of the services is maintained or improved.

This team should include representatives of the Ministry or Department of Health as the stewards of the providers, the representatives of the public and private providers, and technical experts on clinical governance, including accreditation and service delivery. The roles include establishing empanelment criteria and processes, managing provider contracts, setting quality standards, and monitoring services delivered.

- **Audit and fraud management**

Sustainable reform requires efficient and transparent processes and systems. Fraud and abuse would undermine the attainment of UHC goals. Thus, a robust anti-fraud and abuse system is necessary. This TWG provides recommendations for setting up systems for conducting regular audits of hospitals, claims, and beneficiaries; to establish robust fraud triggers that are specific to local contexts, investigate trigger alerts and implement actions based on these findings. This team should have experts in fraud management and clinical experts.

- **Grievance management**

During the process of defragmentation, several issues may arise on the part of beneficiaries and providers due to changes in existing systems. Furthermore, there is need to review the grievance processes and systems that were in the former schemes. A dedicated team to harmonize, anticipate and propose options for management of all grievances is essential to a smooth and efficient change management process. The team should have a change management expert as well as experts in designing grievance systems for public health insurance.

- **Communications team**

A team that can develop the necessary messaging to communicate changes in the features and processes of the merged (and expanded) schemes is essential to the transformation process. This information needs to be targeted at beneficiaries, but can also work to communicate effectively with providers, both empanelled and not empanelled, to improve the network of the defragmented scheme. As explained in the final section on challenges of defragmentation, a lack of clear communication channels between the purchaser and providers could augment several problems related to the effective implementation of reforms.

Consequently, it becomes imperative that any existing organization where the above-listed capacities are available or have been developed to the greatest extent becomes the ideal focal point for the management of the defragmentation of the financing schemes.

3.1.2 Design of the reform

Reform design entails several steps that will contribute to a review of what exists currently as well as decisions on what systems would be best suited to address the revised mandate of the defragmented scheme. Each one of these steps further requires some vital data and to inform decision-making and provide an important baseline for measuring progress and performance. The illustration below highlights some of these key steps *though their sequencing is not necessarily linear*. Further, details of the data elements are provided in the paragraph below as well as details on essential input and considerations for simulating policy scenarios emerging from various design options:

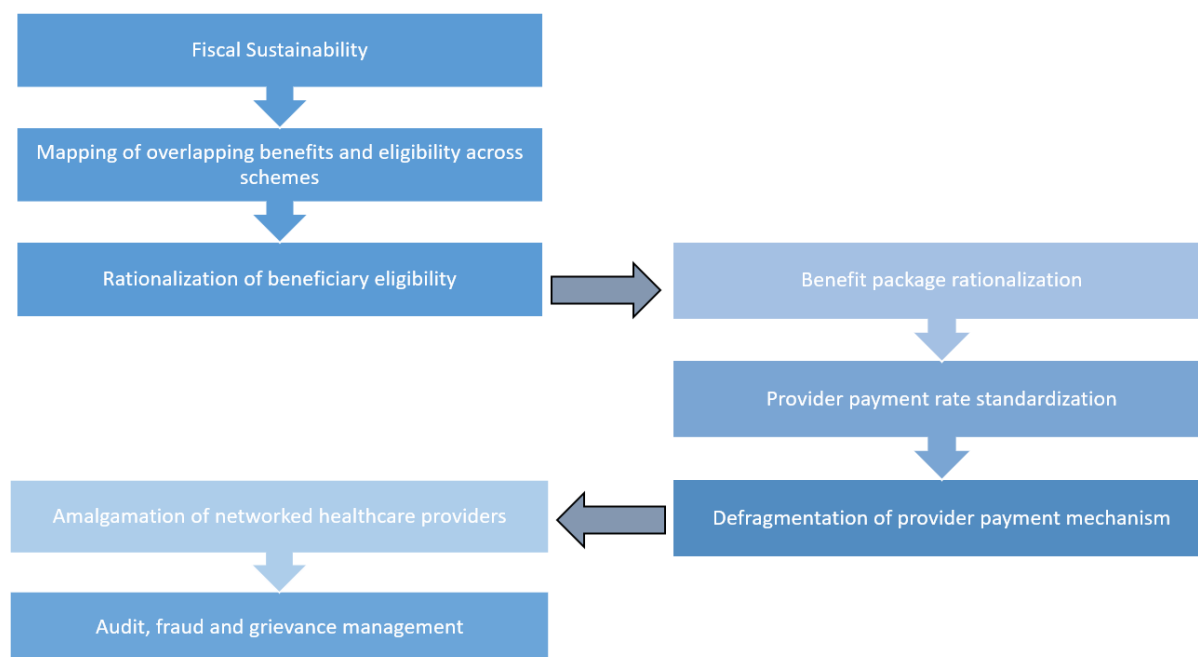


Fig. 3. Key Steps in Defragmentation Reform Design

a. Fiscal sustainability

This step is critical to determine the scheme's financial viability following the defragmentation exercise. This entails aspects of ensuring effective financial planning, conducting detailed actuarial analysis, and discussing state budget transfers in decentralized settings. The analysis should be able to project the multi-year expenditure that is anticipated under different policy scenarios that may be under consideration in the redesign of the scheme. Following this, the multi-year revenue that can feasibly be raised from various sources, given various factors in the context (macro-economic and policy) and design features of the scheme, is projected. Different sources may include government revenue, premiums from some groups, donor contributions and employer/employee contributions. After this, a financial gap analysis is conducted to estimate the sustainability of the scheme. Policy recommendations are based on the most fiscally sustainable option. The formula for estimating this health expenditure can be computed as:

$$HE_t = \sum P_t * U_t * SC_t * PVL_t, \text{ where:}$$

HE = Health expenditure

P = Price of services rendered

U = Utilization of services

SC = Service coverage which is part of the benefit package

PVL = Prevalence of covered diseases

t = Reference period which is usually considered as one year

Details of this process are outlined below:

- The fiscal sustainability is managed and steered by the technical committee following an approval from the steering committee. An overview of some of the important TWGs to be formed have been highlighted in the section above. The terms of reference of the team should be drawn and should include the tasks outlined in the steps below:

- Define the time-frame of the assessment. This includes the number of years for which the assessment is to be conducted. It ideally should have policy relevance for instance it is aligned to the medium-term plan in which the government is operating or linked to national health policy. This is because policy goals and objectives and targets would have been defined to which the policy scenarios must be linked. Furthermore, revenue and budget and fiscal projections at a broader government and sectoral level for these time frames are more likely to have been defined at this level providing a fiscal framework within which the reform can be conducted.
- Define the policy scenarios to be considered in the study. This step is very crucial for defining the bounds of the analysis. It is done in close consultation with the steering committee as all policy scenarios must be politically acceptable. Thus, the process is very consultative including iterative consultations with the stakeholders in the health sector including the Ministry of Health, erstwhile health schemes, providers, representatives of citizens and academia. The policy scenarios may include policy options on:
 - Expenditure estimates are conducted using data on factors that will have implications for the cost including:
 - *The scope of services in the benefit package:* The coverage rates of interventions and the annual changes anticipated. In cases where restrictions are being considered in the availability of services, for instance, services covered only at a particular level or service provider type, this should also be considered.
 - *Scope of population coverage based on policy dialogue:* Related to this is the enrolment and utilization rates and the annual growth therein and related assumptions in growth rate over the period projected must be agreed with the stakeholders to ensure the legitimacy of the estimates.
 - *The price rates of interventions* and the annual changes in the prices including inflation rates and price revisions over the years in the planning timeframe should also be considered.
 - *Assumptions on the administration costs* are also important to include. These include the costs of Human Resources, Information Education and Communication (IEC), financial management, etc. These can be drawn from the experience of the erstwhile schemes as well as the experience globally. Assumptions can be built into the analysis on the changes in the costs of administration-based evidence globally and the likely changes in scheme implementation, for example, the change in scale of the scheme over the years of implementation included in the study.
 - Revenue projections:
 - Macro-economic context of the defragmentation including the Gross Domestic Product (GDP), the public revenue proportion of GDP as this will determine how much is available at the level of the government to mobilize additional revenue for the scheme, the debt sustainability of the government and other potential sources of revenue, for example, donor funds.
 - The total allocation to the health sector is also considered in these projections and assumptions are made to the growth rates in health budget for health. These are informed by evidence but must be discussed and agreed to by stakeholders.
 - Any other revenue to the health sector must be considered for the analysis including premiums, contribution rates from employers and employees, individual premiums, and co-payments by patients, etc., must be included in the analysis.

- Identify the evidence that is needed and the sources of evidence for the analysis. This includes:
 - Data sources for expenditure estimation:
 - The benefit packages that are going to be merged and the scenarios regarding content of the packages.
 - If recent cost data is available, this is even better than price data as it minimizes inefficiencies. Each intervention's price lists/tariffs and a market survey of prevalent prices.
 - This analysis should also include any cost-saving measures or efficiency measures that are likely to be introduced in the scheme including price changes, etc.
 - As much as possible, the data on administration costs should also be collected. If this is unavailable, estimates of the proportion of expenditure for the scheme can be estimated from data from prevailing schemes.
 - The demographic profile of the country/state and estimated changes over the projected time horizon.
 - Data on the informal and formal sector changes as well as changes in the population groups that are covered like the population that is poor and indigent as per national goals or targets. These population estimates can be obtained from labour surveys and household or living standards surveys.
 - Data on local epidemiology and how it is anticipated to change over time and with policies that have been introduced in the sector that may result in changes in utilisation patterns. This can be obtained from Hospital Management Information Systems (HMIS). Estimates of Burden of Disease can also be obtained from the Global Burden of Disease database. Programmatic estimates of incidence and prevalence of conditions can also be used.
 - This data also includes the utilization rates for each level of care including OPD and IPD services. It also includes utilization by type of provider (public and private), etc. This can be obtained from routine administration data such as claims data, HMIS, etc.
 - Revenue: *This evidence includes:*
 - Macro-fiscal projections over the time frame of the study and may include changes in GDP, in public revenue, in public revenue as proportion of GDP as well as the projections of additional sources of revenue that will be introduced to support the scheme, for example, tax, donor funds or grants.
- The projections of the budget for health and the schemes (erstwhile).
Some software and excel-based models exist that can be used to conduct the analysis for different scenarios. These should also include the ability to independently review the analyses by other experts to ensure that the results are reproducible and accurate based on the assumptions. The team can also develop their own software.
- The next step involves conducting the actuarial analysis based on the data. Any assumptions made in the projections for each scenario must be evidence-based and must be agreed to with the stakeholders. They also must be made explicit.

- The preliminary projections made by the team must be presented to stakeholders and the steering committees to get the feedback on the estimates and the plausible options. Once the team has incorporated the inputs of the stakeholders and the steering committees, the team should develop the final report and present to the technical committee to augment the overall process of the defragmentation.

b. Mapping of overlapping benefits and eligibility across schemes

- To effectively commence the defragmentation process, there is need to identify the schemes that will be merged and harmonized. This step should include detailing the schemes' administrative and purchasing functions, identifying the similarities that can be leveraged and the differences that should be harmonized. These administrative and purchasing functions have been identified in the framework for defragmentation of schemes developed by WHO(2).
- Once overlaps and differences in functions across schemes are identified, the team(s) should identify the necessary data and evidence sources for each function and scheme that are requisite for facilitating the merging or harmonization process. These are defined in the relevant sections below.
- Identify with approval of the steering committee, the criteria for determining which option to consider for harmonization or merging. These may include, but not be limited to, the strength of evidence on:
 - Effectiveness of the reform in achieving the objectives, for example, improving efficiency or equity.
 - The political feasibility of implementation of the reform. This will be determined by the entrenched interests in the different schemes and perceived benefits or losses that would emerge from changes in functions or sub-functions.
 - The cost of the reform option relative to others.
 - The relative cost-effectiveness of the reform.

c. Rationalization of beneficiary eligibility

There are four major sub-steps in this step of the defragmentation including:

- **Define target groups for all the schemes** included in the defragmentation process and include the nature of affiliation, that is, whether it is mandatory or voluntary or a mix of both, that is, mandatory for some groups and voluntary for some.
- **Develop a process/mechanism to identify the beneficiaries that are eligible for the new scheme:** This will be based on the eligibility criteria defined for the new scheme. In some cases, the schemes are universal; therefore, there is no need to determine eligibility criteria or targeting mechanisms as the enrolment is mandatory and automatic. However, it is important to determine these criteria in cases where the coverage is targeted. They are determined depending on the context and may be driven by:
 - Normative guidance or principles include inclusivity and equity in which the government is using the scheme to address social injustices related to access to health and financial protection. The prevalent social values in that country or state also determine the population groups that must be included.
 - Global and regional goals in addressing social inequities such as the SDGs.

- The macro-economic constraints in the country determine the scope of financial coverage and population coverage.
- This may also include historical context of health reform in the country that may have systematically discriminated some population groups and the scheme is an opportunity to address this.
- **Determine the mode of targeting/identifying the eligible population:** Various measures can be used to determine the people to include in the new scheme. The measure you use depends on the availability of data and data systems in the country. Targeting refers to any mechanism to identify eligible individuals, households, and groups to transfer resources or preferential access to social services (4). Different measures exist to assist in targeting populations for services in various contexts. These include means testing, proxy means tests, categorical, geographic, community-based, and self-selection. The table below includes a description of these measures and the advantages and limitations of the same:

Targeting mechanisms	Definition	Administrative costs	Susceptibility to inclusion and exclusion errors	Political aspects
Means-testing	Based on an assessment of income, assets or wealth of applicants (including unverified means-testing).	High – incomes are very difficult to assess	Low, providing accurate information can be obtained, depending on honesty of administrators.	Degree of intelligence required to verify claims may be unpalatable; politically may be only way to make acceptable to elite.
Proxy indicators	Based on a weighted combination of characteristics that are believed to be highly correlated with wellbeing or deprivation.	Medium	Medium	

Categorical testing	Programmes using categorical targeting typically identify proxy indicators of poverty or vulnerability, often demographic categories such as older persons (social pensions), people with disabilities (disability grants), and orphans or 'vulnerable children' (child allowances).		High inclusion and exclusion errors in terms of the poverty profile of beneficiaries.	
Community-based	Based on an eligibility assessment performed by the community where a programme is implemented.	Low for government; but high for local community which must take invidious decisions. May perceive targeting as irrational or impossible: 'we are all poor'.	Variable – necessary transparency and flexibility hard to achieve in practice.	Liable to local elite capture and to replicate existing forms of discrimination. May exacerbate divisions in a community.
Self-targeting	Based on voluntary participation or self-selection.	Low	Low if well designed. However, targeting is usually not the driving feature of design.	Can create stigma for poorest and socially excluded households if achieved through low wages, or inferior food payments.
Geographical Targeting	Geographical targeting is most effective in contexts where poverty rates are high and poverty is spatially concentrated,	Low	Geographically targeted programmes are associated with relatively high inclusion and (especially) exclusion errors by design,	

Multiple mechanisms:	More than one mechanism is used to identify programme participants, either simultaneously, sequential or in parallel.			
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Source Devereux et al (4).

Table 1. Targeting Mechanisms

- The criteria for selecting targeting mechanisms used includes:
 - i. **The effectiveness** of the targeting mechanism in determining the eligible population.
 - ii. **The costs of administering** the targeting program including the administration costs, the private costs of targeting (for example, travel costs for the beneficiaries; social costs of the mechanism relating to, community cohesion; psycho-social costs including stigma and loss of self-esteem, the political costs of targeting, for example, loss of political support and incentive-based costs such as behavioural change to meet the eligibility criteria).
 - iii. The **political feasibility** of implementing the targeting mechanism.
 - iv. The **availability of data or data base** from which information about eligible beneficiaries can easily obtained.

This step will also include verifying the beneficiaries that were in the pre-existing schemes to weed out people that were erroneously included in the scheme(s) and are not eligible for the new scheme. The team should also remove any duplications that may exist in the databases in the instances where the beneficiary(ies) were members of more than one scheme. This step is essential in realizing the objective of efficiency that the reform is aiming to achieve.

Potential data sources for this step include:

- Population census with evidence on the consumption levels of different groups of people that can guide in determining the wealth profile of citizens.
 - Databases of social protection schemes that are used to provide subsidies for social protection or for food can be used as well if the eligibility criteria are mapped to these. For example, a Public Distribution System/Social protection scheme database to determine eligibility within their schemes.
 - Beneficiary lists of the pre-existing schemes that will be merged. These must be verified with documentary evidence from beneficiaries to weed out cases that were formerly registered and not eligible.
- **A single point of entry or database should be created by the end of the process that will warehouse the data related to the beneficiaries.** Adapting a previously existing information system in one of the pre-existing schemes has been the most efficient practice used in merging the schemes. In the case of multiple pre-existing schemes with their own information systems, an assessment of the pros and cons of each information system will have to be done. Based on this analysis this will be used to guide the choice of information system to use.

Box 1: Rationalization of beneficiary eligibility in Chhattisgarh, India

Chhattisgarh is a state in India with a population of nearly 30 million. The state has implemented PSHI, including RSBY, for several years. The state had six schemes with different populations covered, different services covered and different management systems and administrative services. A political decision was taken to merge the schemes into one scheme in 2018.

For *pool merging* defragmentation decisions targeted at the dimensions of eligibility and risk pools, an updated and reliable database is necessary to be able to map beneficiaries across the different schemes targeted for integration. This was an important step when states had to defragment existing state schemes with PMJAY, by merging additional population groups as eligible beneficiaries. Chhattisgarh was able to do this effectively using the National Food Security Act (NFSA) database for the state which includes a list of households eligible for public distribution programmes such as food distribution (5, 6). They were able to identify overlapping beneficiaries under the SECC criteria with ration card details in the state. This is also necessary for budgetary planning, especially when financing is shared between central and state general revenues. One of the most significant benefits of defragmentation in Chhattisgarh was that a single-entry point was created for beneficiaries to access the expanded benefits package, as opposed to the different schemes for different diseases, as earlier. This was possible due to a strong database that could be used for means-tested eligibility criteria validation. A reliable, state-wide updated database (such as the NFSA) has been seen to be key for a better system of delineating/identifying eligible beneficiaries based on means-tested criteria.

d. Benefit package rationalization

The rationalization upon the benefit package will depend on the reform plan that the government is considering for the defragmentation. As noted in the framework this may be a harmonization process across separate pools or a merging (partial or full) of existing schemes.

- A) In the case of harmonization across separate schemes, the differences in the benefit package may result from:
- a. Differences in the schemes are due to differences in population covered for instance a scheme that is targeting the elderly will have specific interventions that are not included in a scheme that covers pregnant women and children of a certain age group or a scheme covering the general population.
 - b. Differences in financial coverage of the scheme that may result in a limited range of services in schemes with less funds and vice versa.
 - c. Rolling out of specific schemes to cater to political ends which target specific issues without any plan to align with existing system elements.

In this case, when it is not feasible to merge the schemes, there is still opportunity to ensure equity in access according to need and allocative efficiency. Thus, there is need to review the benefit packages according to the burden of disease related to different population groups. Systematic review of the interventions in each package must be made relative to the epidemiological needs of each of the population groups in the schemes. Criteria for selection of the interventions include effectiveness or capacity to benefit, cost-effectiveness implying that interventions that result in maximum benefits for the cost are prioritized. As much as

possible, the resource allocation per capita for the benefit package should be similar across different schemes.

- B) Merging benefit package in merged schemes: In *pool merging* this step may be the first in the defragmentation process targeted toward reducing fragmentation in benefits packages. This is the case for instance in Turkey where it facilitated or enabled the reform in other purchasing functions. This step perhaps requires more evidence than any other step in the defragmentation process. It also requires specific skills, including health economics skills (costing, health technology assessment), epidemiology, clinical experts *inter alia*.

The evidence inputs needed for this include:

- Guidelines and benefit package lists from the pre-existing schemes that detail the interventions and/or the service delivery levels and types for each intervention.
- The fee schedules or price lists for the benefit packages from the different schemes.
- Any costing studies and reference prices from related agencies like medicines agencies, other public schemes, etc.
- Cost-effectiveness data and evidence on common packages relevant to the burden of disease in the country or state. This may be local evidence or from global reference databases or literature reviews.
- The data on burden of disease in the country.
- Claims and utilization data from pre-existing schemes that may guide the selection of packages to inform rationalization efforts by removing overlaps and/or redundancies.

The key steps in the process of defragmentation of the packages include:

- The benefits rationalization team should review the data on the disease burden as it pertains to the population eligible for the new scheme. This will include reviewing the trends in disease burden in the country or state, the review of data for claims and utilization of the schemes to determine disease patterns and patterns of use. Depending on the scope of service coverage defined by policy, the team would then select the relevant diseases and conditions to be covered.
- The team then selects a list of interventions by condition or disease according to the financial and service coverage scope. The list of topics/interventions will then be subjected to appraisal through Health Technology Assessment (HTA) or through adaptive HTA, which can be carried out using any of the following methods. The level of detailed analysis will depend largely on the policy window for designing the reforms as well as the cost of the process and the team and skills available. In many instances the reform team will include all the packages or interventions that were in the previous packages and then rationalize these, subject to a budget constraint.

Adaptive HTA is a means of rapid appraisal of different policy options to determine the relative cost effectiveness of the options. Given the constraints in adopting and institutionalizing HTA in many LMICs, including limited financing and technical capacity, many countries use rapid appraisal methods including leveraging adapting available international data, models, economic evaluations and/or policy decisions from established HTA agencies, for example, UHC compendium¹ or the Cost-effectiveness Analysis (CEA)

¹ UHC Compendium: Health Interventions for Universal Health Coverage: <https://www.who.int/universal-health-coverage/compendium>

² CEA Registry: <https://cevr.tuftsmedicalcenter.org/databases/cea-registry>

Registry which includes 10,000 cost-utility analyses on various diseases and conditions published from 1976 to date².

- In addition to cost-effectiveness criteria other criteria should be considered for determining inclusion of interventions in the benefit package. These include equity, affordability as well as a supply side assessment to ensure that included services in the benefit package can be provided through empanelled facilities. This is especially relevant in cases like India wherein some of the packages or interventions are reserved for public sector facilities.
- Once price rationalisation is finalised, the team will also need to conduct a fiscal sustainability analysis and budget impact assessment of the proposed budget. This will be discussed in the next section.
- Once the list of services is developed, the team should present the proposed package to the steering committee for feedback, amendment, and/or approval.

e. Provider payment rate standardization

The price is the financial amount that a purchaser (that is, health insurer) or individual pays to a provider to deliver a service. Many health schemes have a price schedule. This is a detailed list of prices for all providers and hospitals, usually by a coding system for a list of services or interventions as defined by the payment mechanism adopted in the scheme.

Sometimes schemes included in the defragmentation process may have different price rates. It is essential to harmonize the rates when combining the schemes to have one price rate for interventions including in the new package and scheme. This must be done that all stakeholders included in the process and affected by the price changes will be satisfied with the process and outcome.

The critical stakeholders included in this process are the new insurer and the Ministry of Health and the providers empanelled in the scheme. Thus, an open and interactive process is critical for the legitimacy of the process and the final rates to be accepted by the stakeholders. The price points are an important part of the providers participating in the scheme. The team must include representation of the providers in addition to the experts earlier highlighted. The local context is a key issue in the price-setting process. Factors such as local costs, costs of the procedures under earlier schemes, and reference costs from public and private hospitals are often considered to inform such decisions.

Therefore, common data inputs in this case are:

- Unit cost data in the case of existence of cost surveillance systems.
- Market surveys in the country or in the case of decentralized contexts at the subnational level (state, province, region, or district). This involves conducting systematic data collection from public and private providers and insurers to determine the price ranges in the local context.
- Price schedules of the erstwhile schemes should also be reviewed including any costing studies that were used to determine those prices.

Rate determination:

The process of determining the final rates may differ with context depending on the time available for the reform. Time limitations may mean that quantitative analyses cannot be done to determine the optimal prices for the package. Further, limited cost data may also limit the conduct of an analysis for the rates of the benefit package.

If data and time constraints exist during the reform process the team should:

- Conduct a rapid market survey of the prices of the interventions in the package. This includes private and public schemes and providers. This should be used to compare with price schedules submitted by the schemes. The team should deliberate and agree on the optimal prices, considering geographical variations in input costs as well as other influencing factors (hospital size, remoteness, etc.)
- The team should conduct a rapid estimate of the cost of the new package of costs factoring in projections on utilization of the services within the scheme, the burden of disease and the enrolment rates that are envisaged in the first 2-3 years of the scheme.
- Once this has been done the impact of the new cost of the package on the budget of the new scheme should be analysed. This analysis can be conducted with two or three policy scenarios on service coverage and scenarios on price rates to determine the possible budget impact of different policy scenarios. In countries like India where the costs of the insurer or Third Party Administrator (TPA) must anticipated, these must be included in the modelled scenarios to determine the budget impact. Additionally, due consideration should also be given to the risk of fraud within certain packages and adequate checks and balances should be put in place to mitigate any such potential issues.
- The team should present the policy scenarios of the package and rates therein as well as the budget impact analyses to the steering committee for review. The review should consider the budget impact as well as other considerations including feasibility and sustainability of the package and the rates. The evidence of the inputs from relevant stakeholders should be considered as well before a final decision is arrived at.

Box 2: Differential pricing in provider payment rate setting

Several countries base their payment rates on a multitude of factors. This helps surmount variations in input and operating costs across facilities of different kinds. Such differential pricing is usually informed by the factors that play an important role in these variations within a country or state setting. As an example, the health scheme Badan Penyelenggara Jaminan Sosial (Social Insurance Administration Organization, BPJS) in Indonesia pays hospitals for services provided to its members using a prospective payment system based on Indonesian Case Mix-Based Groups (INA-CBGs)(7). The insurance scheme has developed a system of updating the DRG prices annually to adjust for inflation and economic growth. Health-care costs vary according to region and hospital class with the insurance scheme making top-up payments for only special cases using a cost-to-charge ratio(8). INA-CBGs pay the same rate for either public or private hospitals. The INA-CBGs also include costs for drugs and medicines. The government has divided the country into four regional JKN service areas based on differences in the cost-of-service delivery and distance resulting in differences in rates of up to 7% for medical consumables.

An important consideration is that the above process relates to the base rates of the interventions in the benefit package. In decentralized contexts, actual prices may be adjusted

based on epidemiological factors as well as other factors related to economic status of the geographical regions or districts. Furthermore, other health-system related factors including the type of health provider (whether a teaching hospital or level of care) and others also play a key role in determining these rates.

The technical work can be coordinated by the technical team but conducted by a local technical partner like an academic institution.

Box 3: Defragmentation and the price setting process in Indian states

This box includes two case studies in which rate revisions have been conducted. One case study is in a state where the rates were revised to harmonise payment rates to providers for procedures common in the benefit packages of the two schemes. In this instance the schemes are separate, but the procedure rates are similar for common procedures. In another case study the schemes were merged and as such a rate revision exercise was conducted to ensure one price list.

Kerala: The KBF scheme had developed a list of procedures with bundled case-based payment rates. However, it appeared that hospitals could charge as per their own estimates of treatment costs, therefore, the reimbursements for the same treatment procedure varied from one hospital to the next. This was one of the reasons that motivated the senior leadership to consider the defragmentation of this scheme with those in which payments were ‘closed-ended’. This was standardized when the KBF scheme was integrated into Karunya Arogya Suraksha Padhathi Ayushman Bharat PM-JAY (KASP-PMJAY) (2, 9). A technical committee was established under the leadership of the Health Secretary and included the Department of Health Services, Directorate of Medical Education, Planning Board members, general taxation and health financing experts, medical officers from Comprehensive Health Insurance Agency of Kerala (CHIAK) and Karunya Benevolent Fund (KBF) scheme to deliberate the rates under the PMJAY benefits package (HBP 2.0) and state-specific considerations based on the earlier schemes. The Directorate of Medical Education had circulated all the packages and procedures among different specialists and super specialists in medical colleges and asked them to recommend the rates. Some of the final rates adopted were higher than pre-integration and some were lower. However, the process of integration of schemes had standardized the payment rates and methods across all empaneled providers under the integrated scheme, for all services provided.

Assam: Bundled case-based payments (referred to as package rates) were used in both Atal Amrit Abhiyan (AAA), Assam’s state-specific health insurance scheme for the poor and vulnerable, and PMJAY-empaneled providers (2, 10). AAA covers treatments for 12 specialties.³ National Health Mission initially developed these packages after studying examples from other states. Under PMJAY, in the beginning Health Benefit package (HBP) 1.0 was adopted. It had 1393 packages representing eight medical specialties and 16 surgical specialties. It was observed that there were many procedures common to PMJAY and AAA, however, the reimbursement rates to providers differed. The concern was felt that the hospitals that are included in both schemes would prefer to provide service under a higher paying scheme, which may lead to denial of treatment or balance billing for the beneficiaries in the lower paying scheme. It was also observed that AAA rates were higher for some packages than PMJAY or vice versa. Hence after HBP 2.0 was launched, the mapping of all the procedures in both schemes was initiated. HBP 2.0 had 1578 packages/procedures. Out of these 732 procedures were matched with AAA. Only 57 procedures could not be mapped because of technical differences in defining the packages. After mapping the procedures, rates of the common 732 procedures were standardized. In the process, rates of PMJAY were adopted primarily, except for a few procedures wherein AAA rates were found to be more appropriate and were adopted with justification.

f. Defragmentation of provider payment mechanisms

Schemes may also vary in the provider payment mechanisms (PPM). In some cases, these are fee for service payments; in others, they may be case-based groups or any other type. See box below for types of provider payment mechanisms.

Payment method	Unit of service	Type	Incentive created
Line-item budget	Functional Budget categories	Either	Little flexibility in resource use, cost control of total cost, poor incentives to improve productivity.
Global budget	Health Facility	Prospective	Not always linked to performance indicators, cost-shifting possible if global budget covers limited services, rationing may occur
Per diem	Per day	Retrospective	No incentive for improving allocative efficiency or quality within the health facility setting
Case-based (“DRG”)	Per case or episode	Retrospective	Incentives to reduce services per case but increase number of cases, incentives to improve efficiency per case
Fee-for-service	Per unit of service	Retrospective	Incentives to increase units of service
Capitation	Per capita	Prospective	Incentives to undersupply, strong incentives to improve efficiency that may cause providers to sacrifice quality, rationing may occur, improves continuity of care

Adapted from Barnum et al(11).

Table 2. Provider payment mechanisms

When pools are merged with different payment systems, the process for selecting the appropriate payment mechanism may result in potential losers and gainers. Therefore, the process should be as transparent as possible. This should be facilitated by participatory consultation with relevant stakeholders and evidence of the PPM’s effectiveness, feasibility, cost-effectiveness, affordability, and acceptability.

Stakeholders in this process include the team that is leading the technical work, ministry or department of health, the purchasing agency, and the providers. Providers are a critical

³. Six critical care specialties: Cancer, Heart disease, Kidney disease, Neurological disorder, Neonatal diseases and Burns; additional Vistarita specialties include ICU Packages, Trauma, Critical Care Paediatrics, Paediatric Surgery, Japanese Encephalitis and Acute Encephalitic Syndrome and Supplementary Procedure (Bone Marrow Transplantation is also covered under AAA)

stakeholder because the PPMs' success depends on the providers understanding the rationale for them and accepting them.

Feasibility is critical because of the data needs of the PPM. In situations where data systems are rudimentary or paper based, it is very difficult for more strategic PPMs like DRGs. Thus, many schemes will use fee for service schedules. In cases of mixed PPMs in the health financing system, a mechanism is needed to select the PPM.

- The technical team should review the PPMs that are being used by the schemes that will be merged. This review should identify the information systems required, the human resource and cost components, and what assessments have been done of the PPM's effect on the scheme's objectives including cost containment, efficiency, and quality of care.
- Suppose there are no pre-existing studies of the PPMs. In that case, the technical team should conduct rapid appraisals of the PPMs including conducting key informant interviews with key stakeholders to determine the effects of the PPMs.
- Once the review is complete, the selected candidates should be assessed based on the international evidence of good practice for PPMs.
- The proposals should be presented to stakeholders and deliberated based on the objectives of the scheme as highlighted above. Key stakeholders to engage in this case are the providers that were empanelled by the schemes that will be merged as new provider payment methods will affect how they are reimbursed and the volume therein. Thus, the team must have iterative discussions with providers providing awareness the payment options and the changes that are likely to be incurred with any PPM proposed. This should facilitate discussions related to mitigating any challenges that might arise with the PPM.
- Once stakeholders' feedback has been incorporated, the technical team should present the options to the steering committee for final approval according to the policy legal environment and the political feasibility of the option selected.

Communication:

Once the changes have been made to PPM has been selected the options for PPM and the new rates are communicated to the relevant stakeholders. This could be through a meeting or through official communication.

A system should be put in place to collect stakeholders' feedback on price rates and payment methods. This should be reviewed regularly by the purchasing agency. This is essential for managing the changes associated with the PPMs and mitigating any challenges with the system.

g. Amalgamation of networked healthcare providers

Smaller financial protection schemes in the states have not usually undertaken robust processes for hospital empanelment. Merging into larger schemes calls for the need to develop criteria and processes to ensure that appropriate providers constitute the network, as per the population distribution and benefits package.

The critical stakeholders included in this process are the new insurer and the ministry of health as well as the representatives of providers. Thus, an open and interactive process is critical for the legitimacy of the process and the empanelment criteria.

Inputs in the defragmentation process:

- a) Minimum service standards
- b) Accreditation criteria from national accrediting agencies
- c) Databases of empanelment used in erstwhile schemes
- d) The empanelment criteria of the erstwhile schemes
- e) Normative guidance from WHO and others on service standards

This merger includes the following aspects:

- a) The criteria for empanelment may differ between schemes. Considering this, it is important to agree on the scheme's criteria.
- b) The processes of empanelment may also differ. In some cases, only documentation may suffice; in other schemes, mandatory inspection by the empanelment team is necessary. Therefore, it is critical to agree on the processes that will ensure maximum quality and equity in service delivery.
- c) The database for managing the data related to the empanelment processes may also differ. In some erstwhile schemes in Indian states, empanelment was largely paper based making it cumbersome and tedious. In others including PMJAY the process is electronic. In many cases, transition has been made from paper based to electronic systems. The trade-offs include feasibility and efficiency in processing.
- d) In most instances the providers empanelled may be the same but where differences exist the decision to include or exclude providers will depend on the criteria included.
- e) The empanelment criteria should be communicated through media outlets to ensure that providers interested in participating in the scheme have the relevant information.

Digital integration of purchasing functions:

The respective state must make decisions on the ideal ICT systems to be adopted for supporting defragmentation. When merging with a national scheme, adopting the national ICT system has advantages. A ready platform is available for strengthening purchasing functions. In cases where there are different ICT systems, the system with greatest functionality with reference to the administrative and purchasing functions is adopted. In cases where they are harmonizing schemes and not merging, the option of using APIs to integrate across schemes is often adopted.

h. Audit, fraud, and grievance management

A key benefit of defragmenting smaller financial protection schemes into larger ones was the adoption of systematic processes for key purchasing functions like audits, fraud, and grievance management, which are usually already a part of such larger schemes. Often, smaller schemes lack these processes and systems.

The team will include experts in anti-fraud and abuse management, the purchasing team, and ICT experts.

The inputs to be considered are:

- Anti-fraud and abuse guidelines used in erstwhile schemes
- Normative guidance on anti-fraud and abuse systems
- The list of triggers used in each scheme

Process of merging the measures:

- The larger and ICT-based schemes often have superior anti-fraud and abuse measures. Thus, in merging the schemes this will be adopted.
- The team will review the various systems in previous schemes and the international guidance on best practice. They will review the systems in terms of their effectiveness to detect and mitigate fraud, the cost of running the systems, the cost-effectiveness, and the feasibility of implementation, including a systematic comparison of procedural and technical strengths and weaknesses of each system and areas for redressal.
- The team will also review the range of fraud management strategies that have been employed across the dimensions of prevention, detection, and management of fraud. This will include a review of the measures for verification of fraud and enforcement of penalties.
- The most cost-effective and feasible measures will be selected and presented to stakeholders for feedback. These include providers and Ministry of Health and Finance and in cases where their party administrators are operating, these may be included.
- The final list of measures is presented to the steering committee for review and approval.

3.2 Decision-making for the defragmentation reform

This phase may be depicted later in the policy cycle, but the experience is that it is a non-linear process that in many cases may start at the beginning of the policy formulation phase but consultation with stakeholders continuously refines the decision-making process.

3.2.1 Stakeholder engagement

This is a critical element of the reform process. This is a useful element of the process as it fosters the reform's legitimacy with critical stakeholders including the providers, beneficiaries, TPA in the contexts where these are used, civil society organizations (CSOs), academia, media and more.

The stakeholders' engagement mode must be tailored to the contexts in which the reform is being conducted and the stakeholders that are being consulted. It will in some cases also differ with the thematic area that is being discussed. Some thematic areas are very technical and will require engagement towards the end of the process while for some thematic areas, the consultation may commence much earlier in the process to shape the development of the options for reform that are being considered. While mechanisms of engagement vary with context, topic and stakeholder, the following principles apply in general:

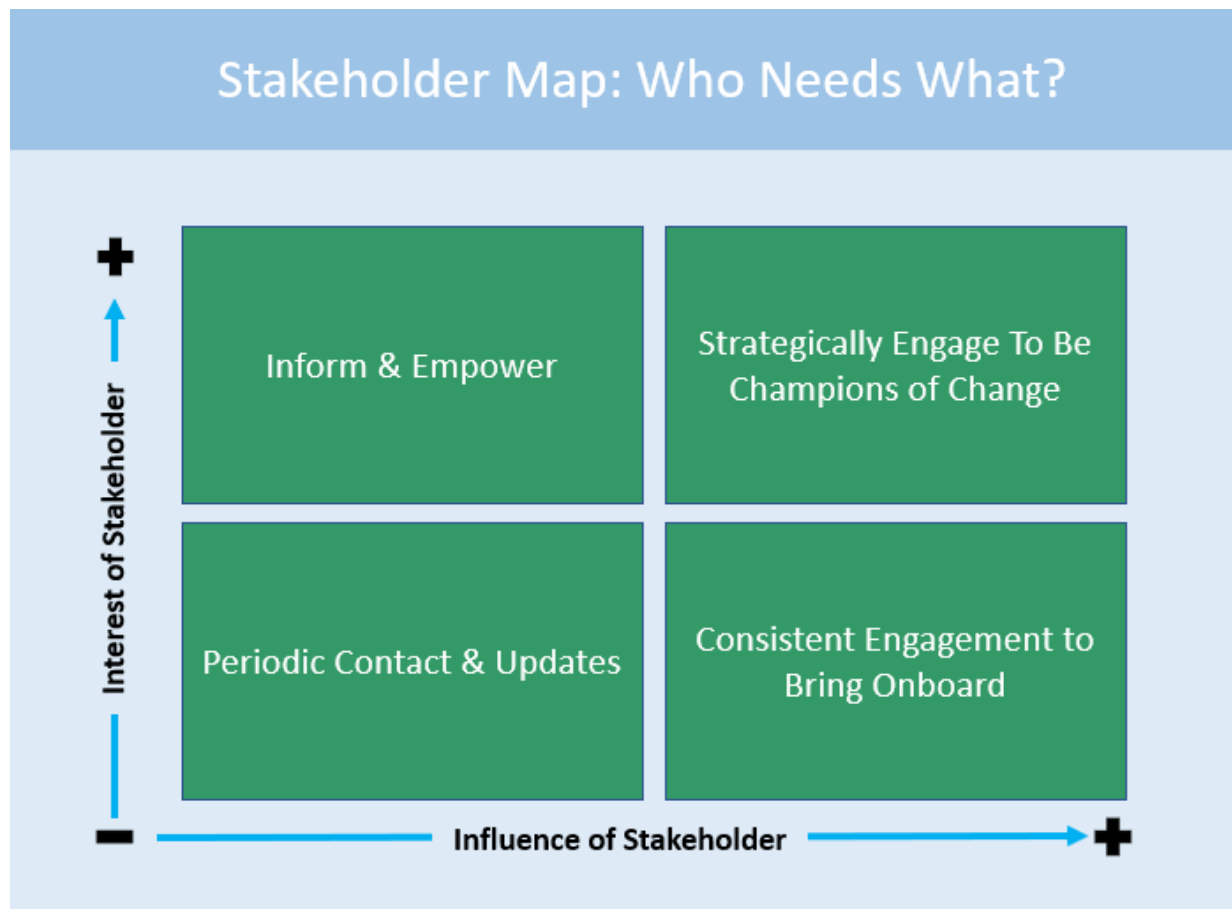
- A) **Stakeholder analysis:** a systematic analysis of the stakeholders in the sector is critical to design a deliberate stakeholder engagement strategy. With every policy change there is a loser and a gainer. These necessarily mean that each policy reform stakeholders will be affected differently. This generates interests amongst stakeholders on the outcome of the reform and, therefore, different positions that the stakeholders depending on the interest.

Considering this, a deliberate stakeholder engagement strategy is informed by mapping the positions of different stakeholders in the sector and their interests on the reform. It also considers the level of influence that the stakeholders have in the sector and with key stakeholders to cause shifts in positions of other stakeholders.

The key questions that the stakeholder engagement team should ask are:

- i. Who are the key stakeholders in this policy reform process?
- ii. What is each stakeholder's interest and what is the level of interest in this reform?
- iii. What is the level of influence of the stakeholders on the policy decision?

A mapping within a matrix should be done as in Fig. 4. below to enable the team to determine each stakeholder group's level and mode of engagement.



Adapted from: Mendelow, A. L. (1981). *Environmental Scanning-The Impact of the Stakeholder Concept*. ICIS 1981 Proceedings, 20. <https://aisel.aisnet.org/icis1981/20>

Fig. 4. Stakeholder mapping matrix

From the matrix above some stakeholders will require regular one-on-one engagement while for others they can comfortably be consulted in a group meeting. Therefore, consultations with stakeholders on the different thematic areas include:

- As part of the technical working group, the stakeholders included in the thematic TWG will generally be those with technical experience and implementation level experience. For instance, for the health benefit package area, the team from the purchasing agency or ministry will include public and private health care providers, with specialist expertise to inform the development of the options for the benefit package.
- One-on-one engagement as a bilateral engagement to seek their input in the reform design. This may be done for particularly influential stakeholders to gain insight on their position on the policy issue without disclosing to the stakeholder the current options on the reform. This is done to mitigate resistance early in the reform process while the reform team is canvassing support from other stakeholders.
- Lastly, the consultations can be done as part of a larger group. These may be done to get input from the public and all stakeholders. The main goal is to collectively review proposed strategies proposed by the thematic TWGs and to provide the feedback into the reforms. At the least, two such engagements across the cycle should be considered

with the first engagement geared towards soliciting input and the last geared towards validating the reforms that the supervisory committee and the TWGs have proposed.

In all instances the supervisory committee must be fully in control of the reform process and consultations.

3.2.2 Discussion on state budget transfer and financial coverage of the scheme

One area of note for final decision-making will be the financial coverage for the scheme. This critical discussion will inform other sectors other than health, particularly the ministry of finance. The negotiations between the health sector and the ministry of finance will be partly informed by the policy proposals made on other areas of the reform including the size of the benefit package, the population coverage within the scheme and the prices agreed on in the scheme. The proposed financial package will also in part inform the design and assumptions considered in the policy scenarios for these themes. In reality, the subsidy determined will be determined by iterative consideration of the policy proposals in these thematic areas.

The main issues that will be discussed will include:

- **The determination of the degree of subsidization of the scheme members:** Often, universal schemes will have the same subsidy application to all. In the case of schemes where populations have been targeted, the subsidy may be full or partial for all beneficiaries, full subsidy for some population groups (usually the poorest and the most vulnerable), or partial subsidy for wealthier groups in the scheme.

This step will be facilitated in part by the fiscal sustainability analysis as different population coverage scenarios are included in the analysis including the extent and nature of financial coverage. It includes the analysis of the impact of co-payments for all or part of the beneficiaries as well as the inclusion of premiums for some population groups. The results of the analysis must be assessed within the broader macro-economic framework and other dynamics like poverty levels as well as the degree of informality in the economy and an evidence-based decision is made on what subsidization policy will be for the scheme members.

- **Calculation logic to determine the amount being transferred:** This policy discussion is determined by the financing team's fiscal analysis. These can be included as scenarios in the revenue module of the analysis. In this case possible scenarios include whether some or all the costs could be covered based on regular contribution levels for some or all, minimum or average wages, specific percentage of the government budget, etc., and what the budgetary implications of different levels proportions or scenarios. Based on discussion with the Ministry of Finance and other stakeholders, for example, representatives of the employees' associations, insurance regulatory authority, etc., to determine the most viable mechanism.
- **Coverage limits are not commonly seen in countries other than India.** For schemes involving contracted insurance companies for risk management, this applies so that premiums are decided based on the sum assured per policy. The amount of money spent by the government is usually determined by government budget and actuarial estimates in many countries. In India, decisions on the financial coverage limit for the integrated

scheme can differ across states usually driven politically.

The financial coverage limit will set the budget constraint for the scheme and limit the scope of the benefit package and the premium payable to the insurance company or any other third-party administrator where such arrangements exist. Thus, it is important that the team handling the rationalization of the benefit package conducts a fiscal impact analysis based on the utilization patterns and the new price rates for the interventions in the package to determine whether it is affordable based on the budget constraint. Details of this process are included in the sections below.

- **A relevant discussion in the manner revenues will be collected and then transferred:** The revenue collection differs by the source of the revenue. Government revenue from taxes would be collected by the tax authority and pooled in a consolidated funds. Premium rates for voluntary enrollees are often difficult to collect and may be a deterrent to enrolment. This easily resolved by digital financial management and payment systems that can be co-opted such as Google pay, PayPal, etc. It can also be specifically developed for the scheme with applications that enable self-enrolment to make it easier. Employee and employer contributions are usually collected as part of social security collections or payroll taxes. The decision on what collection mode is used should factor in elements such as the ease and costs of administration and the costs to the beneficiary in making that contribution.
- **Type of transfer mechanism:** Individual-based (a specific amount is being paid for each exempted individual) or lump-sum (a lump sum transfer for the entire exempted population is made). This is often set following the fiscal space analysis and the steering committee determines a probable per capita rate. The representation of Ministry of Finance is key in this discussion. The “per capita” rate must include the administration cost.

3.3 Implementation of the reform

The success or failure of reforms depends on how well the reform has been designed, that is, whether the policy options are based on evidence of what works and is feasible in that context and secondly; on how well implemented the reform is. The fidelity of implementation to the policy design will determine the outcomes realized. Many factors can undermine the best designed policies including the level of capacity within the system to implement the reform. This capacity includes skills, competencies, and the adequate numbers of personnel to implement the reform. Furthermore, a lack of adequate financial investments to implement the reform can undermine its outcomes. In addition, confusion as to the role and responsibilities of the different actors can frustrate even the best designed reforms. This may result in some functions being neglected and thus having gaps in performance while in some cases many players are implementing one aspect that is not duplicating efforts and is inefficient but may create coordination challenges.

Lastly, reform results in changes that may benefit some stakeholders and may negatively impact others. A strategic communication and engagement plan is critical to ensure buy-in from stakeholders, manage and answer any questions around the process and the reform, and provide beneficiaries with necessary information about their new rights and obligations. The sections below discuss these in detail.

3.3.1 Institutional capacity building

Once the review of the purchasing mechanisms is complete, it is important to immediately embark on a functional review of the entire purchasing agency. This functional review ensures that the agency can deal with any new tasks that it is taking on and deal with the new workload that comes in from changes in beneficiary population size or changes in systems. The following section details the steps for a functional review of the purchasing agency and how the institutional capacity of the purchasing agency should be built up.

- **The governance structure of the purchasing agency:** The governance structure of the purchasing agency should be able to conform to the new functions of the agency. One of these entities is the governing board of the purchasing agency. The governing board makes decisions on behalf of the beneficiaries and the government regarding different policy matters related to purchasing of services. It approves new policies, guidelines, changes to functioning of the purchasing agency, new health benefit package. It should be able to reflect:
 - The policy priorities of the agency therefore it should have high-level representation from the Ministry of Health or Health Department as well as the Ministry of Finance or Department of Finance. It should also have representation from citizenry of patient group to ensure their views are expressed. This in some cases can be through civil society organizations. In addition, a representative of the leadership of the purchasing agency usually the CEO or someone in that kind of capacity is included in the governance. Other possible members of the board include representative of providers. In most cases a board of 5-7 members maximum is advised to make decision making and consensus-building tractable.
 - The frequency with which the governing board meets is also reviewed in the functional review. It is important to assess whether the periodicity of meeting hampers decision-

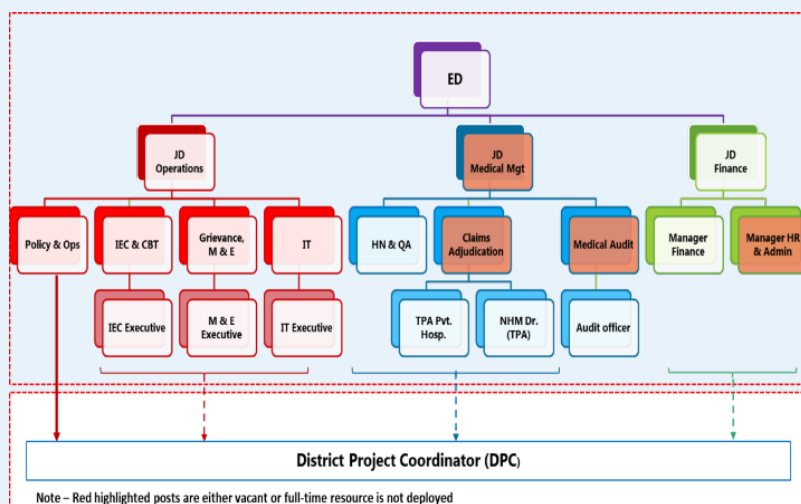
making for policy issues that affect the agency's performance and ultimately affect beneficiaries' access and utilization of services. Furthermore, it is important to review whether there are mechanisms in place to enable ad-hoc meetings that enable the board to meet at exceptional times to facilitate faster decision-making out of the meeting cycles.

- The mechanism of decision-making in the board should also be reviewed to ensure due process or fairness in decision-making for the insurance scheme. This should enable the evidence of proposals to be duly considered and that different stakeholders are fully involved in the decision-making process.
- **The organogram of the purchasing agency:** The organogram spells out the allocation of human resources according to key strategic priorities that have been identified to ensure the functional fit of the purchasing agency. It should necessarily be concluded after the functional review is completed, and the necessary functions (technical and administrative) have been identified. The technical functions will be aligned to the purchasing tasks that are highlighted above and therefore teams are identified accordingly as detailed below. The administrative functions are usually standardized functions found in most organizations including strategic planning, financial management, human resources departments, ICT department, monitoring and evaluation division, capacity building division, etc. These are meant to support the normal functioning of the scheme or agency but are dissimilar from the purchasing functions which are more external process dealing client management.

The organogram spells out the departments from a strategic standpoint, the different sub-units related to each department, and the skills and capacities that are needed in each sub-unit. It also details the roles and responsibilities of each section and the reporting lines within and across levels of the organization. This should be done in a way that includes the different levels of the system that the purchasing agency interacts and has staffed to perform key functions.

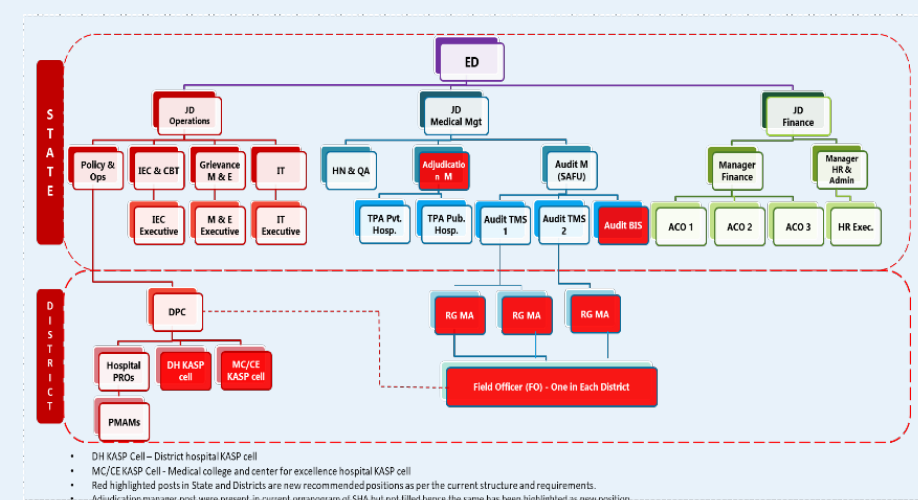
Box 4: Institutional capacity building for SHA Kerala

The State government in Kerala has had a longstanding history with health insurance reform. In 2020, the government merged three pre-existing schemes to form one scheme. The new scheme called KASP PMJAY took an additional charge of families, and the agency covered almost 50% of the state population. The previous organogram of the scheme is shown below:



The State Health Authority commissioned a functional review of the agency owing to the new workload and tasks of the new insurance scheme. The aim was to ensure that the SHA was fit for purpose to ensure successful delivery of the new mandate.

Consequently, a review of documents the scheme including national guidance documents and review of practices in other contexts was done. Furthermore, primary data collection was conducted through key informant interviews at all the levels of the state at which the scheme is operated. These KIIs were with functionaries of the scheme and with scheme stakeholders including empanelled providers to determine the gaps in the service delivery of the scheme at each level. The gaps were reviewed against existing guidance and practice globally and within India and recommendations proffered for a new organogram as below. The organogram spelt out new departments and divisions and new roles in each department and division. It also defined new functions at the district level. The new organogram has since been approved and is being used to fill new positions and reconfigure the SHA.



Some actions need to be undertaken to strengthen divisions and departments including:

- Defining roles and responsibilities: There is a need for the agency working together with other stakeholders to have clarity and ownership of roles and responsibilities. Each resource at the highest level of the scheme and at the districts should be aware of his role and responsibility to specific functions. The agency should develop a comprehensive list of activities for each resource to avoid duplication and improve efficiency in the implementation.
- Streamlining operational process – defining the protocols for various activities: Streamlining the day-to-day activities with the pre-defined process, protocols, would be of prime importance to bring efficiency and improve the scheme's performance.
- Defining division level strategy and vision – Short/long term: Divisions should have a complete understanding of their role in improving the overall implementation of the scheme. The division shall develop a short-mid-long-term strategy with the objective of performance improvement, innovations, and policy reforms.

3.3.2 Roles and responsibilities

Key to implementation success of reform is the clear delineation of roles and responsibilities of each stakeholder in the reform. In this kind of reform, changes in the scheme's administration are likely to occur. These may include:

- The formation of one administrator especially so if the schemes have been merged to one scheme or brought under the management of one purchaser.
- A split of the management functions for provision of services and for purchasing of services (purchaser-provider split).
- Integrating and sharing one information system with many functions for beneficiary management, claims management and health care provider empanelment and many more.
- Furthermore, there may be new healthcare providers with new rules of engagement such as some services reserved for provision by a certain provider type or level of provision.
- Institution of new institutional structures or units such as a health technology assessment unit that assists in the definition of subsequent health benefit packages or a cost surveillance unit that oversees monitoring the change in costs of provision to ensure that prices that have been set are able to ensure good quality of service provision.

Spelling out roles and responsibilities is key to attaining UHC objectives as it ensures efficiency in spending scarce resources. The organization or institution with the comparative advantage (human resource skills) and mandate to perform a particular function is best suited to achieve desired results in a particular area than another that has little or no experience. Further it avoids duplications in roles and responsibilities improving efficiency and accountability. It ensures better and more responsive care improving the patient care experience.

The reforms team should clearly spell out the role of each stakeholder in the sector or the reform process related each subfunction of the scheme. A guide developed to map out each stakeholder versus the different thematic areas and the comparative advantages (mandate and skillset) as well as the scope and the terms of reference for each institution or unit that has been identified to play a role in the reform.

3.3.3 Communication

The reforms outlined in this manual have far-reaching consequences on the rights and benefits for several stakeholders and/or their roles and responsibilities. It is important to ensure that all stakeholders know:

- a) That there have been changes in the health financing landscape and what changes have been instituted.
- b) How the changes that have been developed affect the various stakeholders in terms of their roles and responsibilities.
- c) The effect on the changes on the rights or benefits that each stakeholder was enjoying previously including benefits to the beneficiaries, payments to providers and more.

It is therefore important that a communication strategy with clear strategies for management of each stakeholder adapted to the audience and the frequency for communication. It should also include strategies for getting feedback on the early effects and challenges of implementing the reform.

The strategy development should be led by a public health communications expert who can identify the best communication modalities and strategies based on the thematic areas as well as strategies for managing any negative reactions to the reforms.

While each strategy will have to be informed by the contexts and the thematic areas, there are general principles to consider:

- a) General communication of the reform to the public using mass media, social media platforms, infographics and public health champions that communicate the new schemes as well as the rights of beneficiaries. It must include an opportunity for feedback and clarifications from the public. Appropriate language is critical to ensure that the stakeholder understands the reform's implications.
- b) Targeted communication to some stakeholders to ensure that they understand their rights, how the new changes affect their roles and responsibilities, and benefits they were receiving before such as discount schemes, provider payments, etc. these will include one-on-one discussions with the reform team. These may include internal communication channels such as government orders or minutes of meetings with public providers and deliberate stakeholder consultative enjoyments with private providers, for instance.
- c) Employment of a formal and well manned feedback mechanism will be critical to enable the reform team to pick up any early challenges in the perception of the scheme or the understanding of the scheme to refine the communication strategy is key.

The strategy with clear timelines and the means of engagement should be developed, included in the implementation plan, and monitored to ensure full execution. It should be agile to allow some flexibility that may be needed to respond to specific communication needs that arise during implementation.

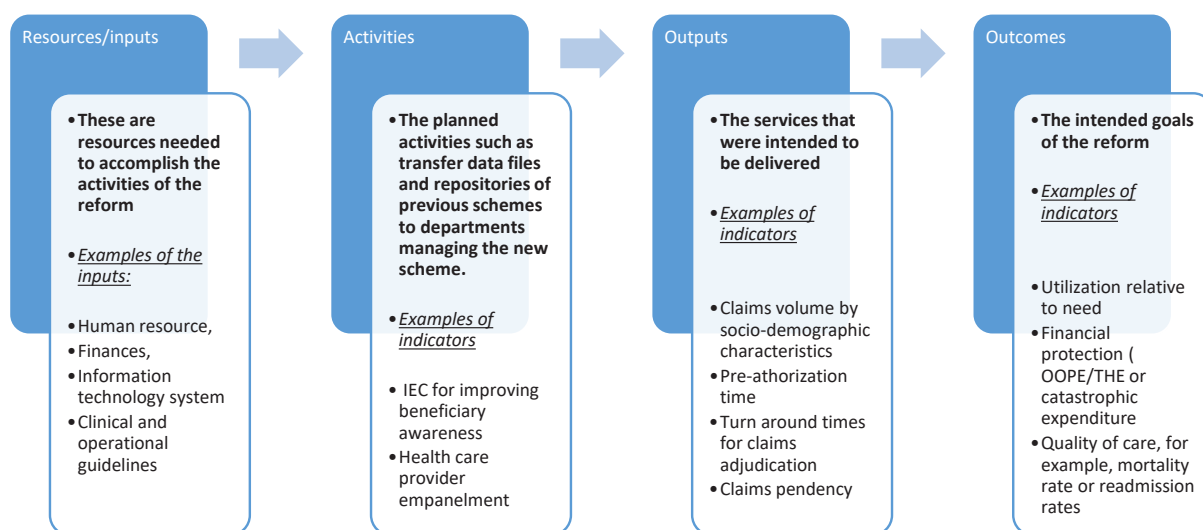
3.4 Monitoring and evaluation

To ensure that the reform is well implemented in an efficient and effective way, it is critical to develop a key performance framework for the short-, mid- and long-term horizon that enables the lead agency to know the progress of implementing the reforms and the effects of the reforms. The M&E framework must include the following considerations:

- a) Identifying the systems needed for routine monitoring as well as for evaluation:
 - i) Routine systems include regular follow up of some indicators daily, weekly, monthly, or quarterly.
 - ii) Evaluation of the scheme including formative evaluation that should guide the formation of early reform proposals, process evaluations that assess key elements of the reform process to ensure that design conforms to the purpose and intended objectives of the reform and lastly impact evaluations that determine the effect of the reform on stated goals of the reform or UHC objective.
- b) The framework should also include identifying the type of data that will be required for the indicators, the data collection mechanism that is cost-effective and feasible for timely monitoring and lastly.
- c) The data systems or databases that can be used including surveys, operational research, routine administrative systems like HMIS, etc.
- d) The reporting and feedback mechanisms for the different indicators including the frequency of reporting. These may include dashboards, newsletters, bulletins, annual reports, operational research reports, etc.

The monitoring framework should be based on the program logic model that includes the following elements illustrated below:

Fig. 5. Program logic model for the monitoring and evaluation framework



A team must lead the Development of the M&E framework with expertise in M&E but must include input from all the thematic TWGs in determining the key indicators that should be included for each thematic area to enable progress and impact to be adequately monitored.

4 Enablers and barriers to defragmentation reforms

Any policy or reform will be affected by the local contextual factors which may have positive or negative consequences. These factors will determine what becomes policy and the effectiveness of those policies in the implementation phase. The identified enablers and barriers have been distilled from global and state reviews. As detailed in the first report, this section provides a consolidated overview of these factors and some of the key considerations to be considered for each of these specific enablers and barriers.

Enablers	Barriers	Key considerations
Political will and feasibility	Resistance from stakeholders	<ul style="list-style-type: none"> While political will is one of the key driving factors for reforms, its feasibility needs to be assessed vis-à-vis the acceptability of such a reform to other stakeholders within the scheme such as beneficiaries and providers. It is often the case that a complete overhaul is too difficult, in which case the reform may need to start with smaller reform with a long-term vision of pool merger
Cross-sectoral collaboration		<ul style="list-style-type: none"> Health reforms cannot be undertaken in isolation. In case of defragmentation, cross-sectoral collaboration is paramount because schemes very often lie outside the health sector. Moreover, a buy in from Ministry of Finance by presenting a case for the efficiency gains defragmentation entails and the need for sustained financing
Institutional technical capacity		<ul style="list-style-type: none"> Institutional technical capacity can ensure that the operationalization stage of reforms is a seamless process with little negative impact on implementation. It should be ensured that a technical gap analysis is done during the defragmentation phase and requisite capacity built for effective implementation
Existence of design implementation guidelines	Data fragmentation and localization	<ul style="list-style-type: none"> The existence of implementation guideline (from other schemes or normative recommendations) can assist in a smooth implementation of the defragmentation process. However, this is often stymied by data localization and fragmentation and requires redressal as an important first step

Reliable data and information systems	Absence of supportive data and information architecture	<ul style="list-style-type: none"> Reliable data and information systems are essential across all areas of reform merger. This ranges from beneficiary identification to hospital database and performance metrics. Absence of uniformity or interoperability across data systems can present a considerable barrier to reforms
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Table 3. Enablers and barriers of defragmentation reforms

The figure below provides an illustrative summary of the factors to be considered as part of a defragmentation process. It is important to note that while operationalization steps do not necessarily progress in a linear manner, an important prerequisite for initiating reforms is the conceptualization (strategy and planning) of reforms and clearly delineating how these reforms address some of the envisioned health system goals a country or state is looking to achieve. Additionally, the importance of political support and sustainable financing for reforms cannot be overstated. While external to technical considerations of reforms, these are perhaps the two most important drivers for ensuring success and sustainability of reform efforts.

5 Conclusion

Defragmentation is an important policy agenda which can facilitate progression to various health system goals. While several countries have gone through the process of consolidating their health insurance schemes, the experiences and learnings from LMICs are, thus far, limited. To that end, this body of work provides the necessary review, conceptualization, and guidance for LMICs and other states in India vis-à-vis their defragmentation reforms. While it is anticipated that such reforms will help countries promote efficiency, equity, quality, and affordability, it is important to reiterate that defragmentation reforms are a means not an end in themselves. Streamlining of such efforts with other health financing and health systems reforms is essential to achieve the desired goals of UHC within a broader framework of systematic health systems reform.

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Notes

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This guidebook builds on an initial ‘Review of defragmentation of PSHI schemes’ undertaken. The guidebook provides recommendations on issues to be considered in the defragmentation and/or evaluation process as well as the processes that can inform defragmentation efforts.