Webinar on Governance for strategic purchasing: implementing result-based financing in a decentralized setting. Lesson’s from Argentina’s Programa Sumar

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Key questions to be addressed

- How can intergovernmental fiscal transfers linked to results become key levers to boost a transformational process of the health system in a highly decentralized country?
- What are the main learnings offered of Programa Sumar?

Structure of the Presentation

1. Argentina’s federal structure and health system
2. Programa Sumar institutional design and implementation arrangements
3. Achievements, challenges and main learnings of Programa Sumar
1. Argentina’s federal structure and health system
Argentina’s federal organization

- Argentina is a federal middle income country (23 Provinces and the Autonomous City of Buenos Aires).

- The **Federal State** is in charge of the **vast majority** of tax collection (almost 75%). Federal transfers to Provinces are partially defined by Law and the Federation has **wide discretion** to allocate funds.

- Provinces and municipalities are in charge of almost 80% of health public expenditure. The **asymmetry** between taxation powers and expenditure responsibilities places provinces in a situation of **permanent fiscal imbalance**.

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**Share of revenues and expenditures, by level of government (2013)**

<table>
<thead>
<tr>
<th></th>
<th>Municipalities</th>
<th>Provinces</th>
<th>Federal State</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REVENUES</strong></td>
<td>5%</td>
<td>20,7%</td>
<td>74,4%</td>
</tr>
<tr>
<td><strong>EXPENDITURES</strong></td>
<td>8%</td>
<td>56,1%</td>
<td>36,1%</td>
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The health system is composed of 3 sectors (public, social security and private) that in practice are segmented according to people’s incomes.

The public sector is highly decentralized and it’s managed by the provincial and municipal levels and provides free health coverage mainly to the poorest segment of the population. It’s funded by input-based budget allocations, there are remarkable inequities among provinces.

The Federal MOH holds the stewardship role and has a modest participation in terms of financing.
2. Programa Sumar institutional design and implementation arrangements
### Basic features of Programa Sumar

<table>
<thead>
<tr>
<th>Purpose</th>
<th>To strengthen the purchasing function through an RBF mechanism to improve effective coverage of a Health Services Package (HSP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting point context</td>
<td>The Program was launched after a profound political, social and economic crisis (2001) 48% of the population and 65% of children had no social health insurance coverage.</td>
</tr>
<tr>
<td>Beneficiaries</td>
<td>Uninsured population up to 64 years of age</td>
</tr>
</tbody>
</table>
| Gradual expansion | From 9 provinces to the whole country  
From 80 services to more than 700 services  
From preventive services to high complexity interventions  
From 700 thousand beneficiaries to more than 15 million |
Two-fold RBF mechanism: 1) conditional budget transfers to provinces

Federal MOH

- Additional resources are transferred to **close access and quality gaps** of a HSP that covers more than 700 services.
- The capitation payment amounts to approximately **US$ 4** per month and covers the **incremental cost** of the health service package.
- RBF allowed the **introduction of a HSP** into the public system as a tool to allocate funds.

Capitation Payment

60% Beneficiaries enrolment and EBC (effective basic coverage)

40% Outputs and Outcomes

Province

- Provinces have to **co-finance 15%** as a way to align financial efforts but also to **encourage improvements in Provincial PFM**.
- The EA (private firm) acted as an impartial **third party** (mediator) between the Federation and the provinces.
- Its opinion is **independent** and **binding** for the federal and provincial governments.

External auditor (private firm)
Performance indicators

1. **EARLY PREGNANCY CARE**
   Pregnant women seen before week 13.

2. **PREGNANCY FOLLOW-UP**
   At least 4 prenatal checkups in pregnant women.

3. **EFFECTIVENESS OF NEONATAL CARE**
   Survival of 28 days of children with birth weight between 750 and 1,500 grams.

4. **FOLLOW-UP OF CHILDREN UNDER 1 YEAR OF AGE**
   At least 6 checkups before the first year of age, as scheduled.

5. **INTRAPROVINCIAL EQUITY IN THE FOLLOW-UP OF CHILDREN UNDER 1 YEAR OF AGE**
   It measures equality in terms of health follow-up of children under 1 year of age in the different regions of the same province.

6. **DETECTION CAPABILITY OF CONGENITAL HEART DISEASE IN CHILDREN UNDER 1 YEAR OF AGE**
   Children under 1 year of age with congenital heart disease diagnosis reported to the National Coordinating Referral Center.

7. **FOLLOW-UP OF CHILDREN BETWEEN 1 AND 9 YEARS OF AGE**
   At least 9 checkups between 1 and 9 years, as scheduled.

8. **IMMUNIZATION COVERAGE AT 24 MONTHS**
   Children at 2 who received quintuple and polio vaccines between 1½ and 2 years of age.

9. **IMMUNIZATION COVERAGE AT 7 YEARS OF AGE**
   Children at 7 who received triple or double viral, triple and polio vaccines between 5 and 7 years of age.

10. **FOLLOW-UP OF ADOLESCENTS BETWEEN 10 AND 19 YEARS OF AGE**
    At least one annual checkup between 10 and 19 years of age.

11. **PROMOTION OF SEXUAL AND/OR REPRODUCTIVE HEALTH RIGHTS**
    Adolescents between 10 and 19 and women up to 24 who take part in sexual and/or reproductive health workshops.

12. **PREVENTION OF UTERINE CERVICAL CANCER**
    Women between 25 and 64 with high degree lesions or uterine cervical carcinoma diagnosed in the last years.

13. **BREAST CANCER CARE**
    Women up to 64 with breast cancer diagnosed in the last year.

14. **EVALUATION OF THE ATTENTION PROCESS OF THE CASES OF MATERNAL AND INFANT DEATH**
    It evaluates the attention process of maternal and infant death cases.
Two-fold RBF mechanism: 2) PPM of public providers

- The PHI’s role is to purchase on a fee for service basis the HBP that complements provincial budgets (the underlying PPM).
- Every year the PHI enters a Performance Management Agreement with each public provider or with Municipalities.

Increased financial autonomy

- The province or municipality defines the expenditure categories.
- The facility decides which specific goods or service to purchase and it may self-manage its own account or it may be managed by a third party (hospital, municipality or province).

Provider

Fee for service to purchase the HSP

Province

External auditor (private firm)
Intergovernmental transfers based on results

**Basis for budget transfers**

1. **Enrollment**
   - 60% linked to enrollment of eligible population (poor people without formal coverage)
   - **Equity**
2. **Health outputs & outcomes**
   - 40% linked to the attainment of the 14 tracers (four-month period)
   - **Effectiveness**

**Conditions for budget transfers**

3. **Specific use of capitation transfers**
   - Additional funds can only be used by the provincial MOH to purchase a HBP on a fee-for-service basis
   - **Provider empowerment**

4. **Co-financing**
   - Provinces have to co-finance 15% of the capitation payment
   - **Sustainability**

**Multiple purposes**

- To introduce a common Health Benefit Package (HBP) focus on primary health care
- To equalize funds and create incentives for the effective provision of HBP (pro-poor)
- To encourage the creation of the Strategic Purchasing function in the provinces
- To eliminate OOP payments for services included in the HBP
- To broaden the financial autonomy of providers
The Program operates within the existing institutional framework and federal set up.

The Program has its own regulatory framework (Operational Manual) that has been constantly refined.

It defines few core rules and provides Provinces with broad autonomy to adapt its implementation to each particular context.

Every rule defined by the Federation, is systematically verified by Internal and External Auditors and linked to a specific monetary penalty.

- Core rules
- Defines technical, financial, administrative, and fiduciary roles and responsibilities
- 5 year duration

- Operational Plan: enrollment and health goals strategies, communication, training, monitoring activities, etc.
- Annual targets
- HBP fees and expenditures categories for providers
Few central rules and broad local autonomy

- It defines the HBP and set standards
- It establishes the financing mechanisms
- It determined provider autonomy
- It defines HBP fees and provider expenditure categories
- It develops its own IT tools
- IT deploys its strategy to implement the Program
- It adapts the provincial strategy to its local context
- It allocates funds to satisfy its specific needs

Open participation in the definition of the HBP

Technical assistance

Managements tools
Responsibilities and tasks of the different actors involved in programme implementation

<table>
<thead>
<tr>
<th>PROCESS / ACTOR</th>
<th>FEDERAL MOH</th>
<th>PROVINCE</th>
<th>PROVIDER</th>
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</thead>
<tbody>
<tr>
<td>Financing</td>
<td>Financing 85% of capitation transfers</td>
<td>Financing of 15% of funds of capitation transfers</td>
<td>No application of co-payments by beneficiaries</td>
</tr>
<tr>
<td>Enrolment of beneficiaries</td>
<td>Validation of roster of beneficiaries</td>
<td>Elaboration of the roster of beneficiaries</td>
<td>Identification and enrolment of beneficiaries</td>
</tr>
<tr>
<td>Health Service Package</td>
<td>Design of the list of services and setting of the quality requirements</td>
<td>Setting of fee for service payment rates</td>
<td>Provision and billing of health services</td>
</tr>
<tr>
<td></td>
<td>(with the participation of provinces)</td>
<td>(with the technical assistance of the central executive unit)</td>
<td></td>
</tr>
<tr>
<td>Information Management</td>
<td>Setting of standards and provision of technical assistance</td>
<td>Development of information technology tools for the enrolment of beneficiaries and billing process</td>
<td>Data collection</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Definition of the tracer matrix</td>
<td>Monitoring provider performance</td>
<td>Self-assessment</td>
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<td></td>
<td>Monitoring the financial performance and health outcomes/outputs</td>
<td>Consolidation of health service data and elaboration of the performance report</td>
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<tr>
<td>Auditing</td>
<td>Financial and clinical audits</td>
<td>Clinical audits (adopting the methodology developed by the central executive unit)</td>
<td>Facilitation of the audit process</td>
</tr>
<tr>
<td>Final use of funds at provider level</td>
<td>No rules. Exception: incentives personnel are capped at 50%</td>
<td>Definition of eligible expenditure categories</td>
<td>Decision of which specific goods or service to purchase</td>
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Dedicated teams and cooperative relationships

**Federal MOH**
- The Program is managed by dedicated multidisciplinary teams at the Federal and Provincial MOH.
- Exclusive task forces at both levels were key to manage intergovernmental relations effectively.

**Province**
- Provincial Management Unit structure and HR profiles are defined by the Federation.
- Between 2005-2015, PMUs were 100% financed by the Federation. Today, the Provinces finance 50% of the staff and in 2020 will finance the whole unit.

**Cooperative relationship**
1. Two-way dialogue
2. Technical assistance
3. Close supervision
4. Training programs
5. Cross-learning dynamics

Planned joint effort with vertical programs
Greater autonomy to public health providers

- Provider autonomy in the use of funds was key to close the incentive chain and to promote changes in the healthcare model.

- Provider autonomy should be clearly delineated and supervised by the provincial MOHs to ensure alignment with local priorities and budget policies.
How much do the resources transferred by the Sumar Program represent on provincial health expenditure?

Participation of Programa Sumar’s funds in Provincial Public Expenditure on health (2014)

Country average = 0.9%
3. Achievements, challenges and main learnings of Programa Sumar
Institutional achievements

- The Programme provided the Federation with stronger influence over the provinces and facilitated a better coordination and dialogue among Federal and Provincial Governments.

- It initiated the agenda for developing the strategic purchasing function in the Provinces and it has broken the status quo associated with historical budget and centralized allocation.

- It has developed the first federal roster of people covered by the public system and the richest data asset that enables real-time monitoring of health service utilization.

- It empowered public providers to play a totally novel role, fostering a real change in the organizational culture of the public system.

- It introduced new tools and management modalities (performance agreements, an explicit HBP to allocate funds, audits and evaluation tools, etc.).

- It has had positive impact results on health service utilization and on the health status of beneficiaries.

With less than 1% of the average provincial health budget...
How has the Program strengthened intergovernmental governance?

<table>
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<th>Key ingredients of good governance</th>
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<td><strong>Transparency</strong></td>
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<tr>
<td>• Clear, rigorous and uniform criteria to transfer resources</td>
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<td>• Independent verification of provincial performance</td>
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<td><strong>Participation</strong></td>
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<tr>
<td>• Engaging provinces from the design phase</td>
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<tr>
<td>• Well aligned Incentives and broad autonomy to adapt the programme strategy to local context</td>
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<tr>
<td><strong>Accountability</strong></td>
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<tr>
<td>• Institucional and performance agreements</td>
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<tr>
<td>• Ongoing monitoring of financial performance and health outputs/outcomes</td>
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<tr>
<td><strong>Capacity</strong></td>
</tr>
<tr>
<td>• Improving local decision-making (strategic purchasing)</td>
</tr>
<tr>
<td>• Close supervision and technical assistance</td>
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<td>• Multiple benchmarking activities among the provinces</td>
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The federal and provincial MOHs should also consider incorporating changes in the way hospitals are paid and explore better ways to purchase services from providers with limited capacity who are located in disadvantaged areas.

Provincial MOHs generally still do not see themselves as purchasers. Further high-level and strategic discussions about the intended purpose of the Programme are needed.

Better coordination of the Programme with the budgetary policies of the provincial MOHs.

Achieving similar levels of performance across provinces remains a challenge.

The federal and provincial MOHs should also consider incorporating changes in the way hospitals are paid and explore better ways to purchase services from providers with limited capacity who are located in disadvantaged areas.
Main learnings

Federal transfers can help to equalize resources, incentivize better performance and strengthen essential functions of the health system.

Intergovernmental transfers should define some basic conditions for the use of resources in order to ensure that provinces allocate them in line with the intended results.

The effectiveness of this system depends on a robust auditing scheme that guarantees the Federation the veracity of the reported results and that insures the provinces the equanimity and transparency of the model.

Financial incentives are not enough to improve local decision making, it's also crucial to offer provinces sufficient autonomy and technical assistance and to develop a strong performance monitoring system.
Thank you!