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

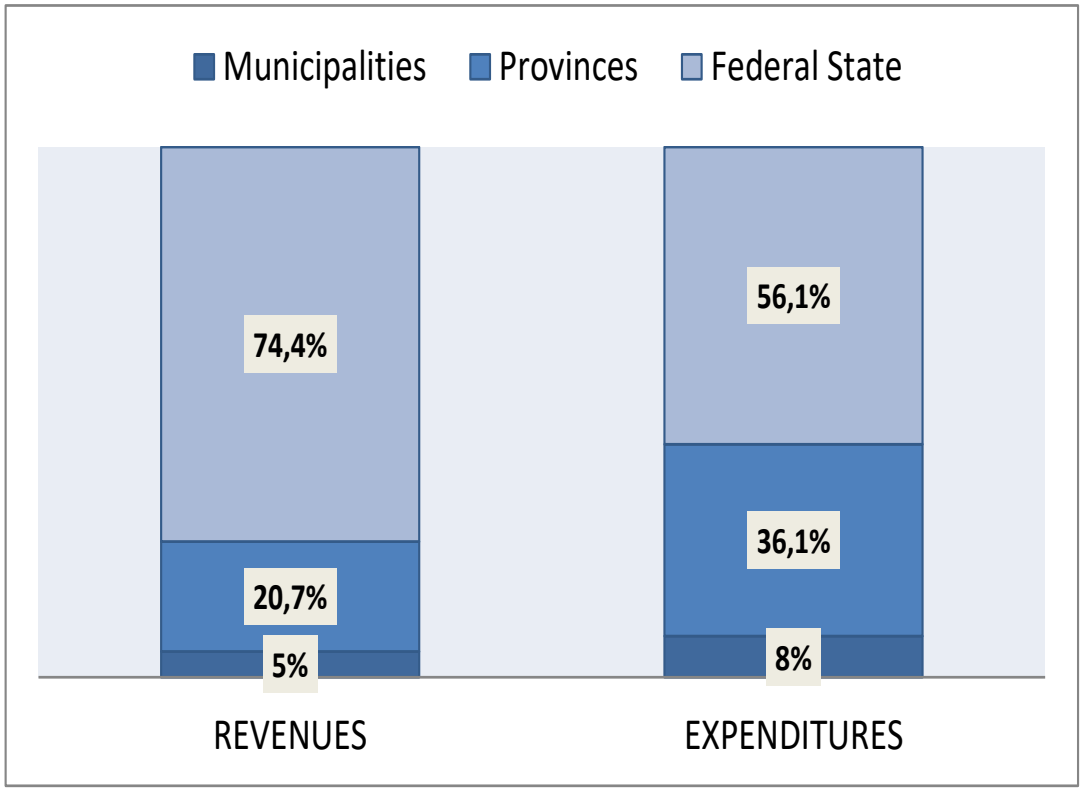
3. Achievements, challenges and main learnings of Programa Sumar

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**

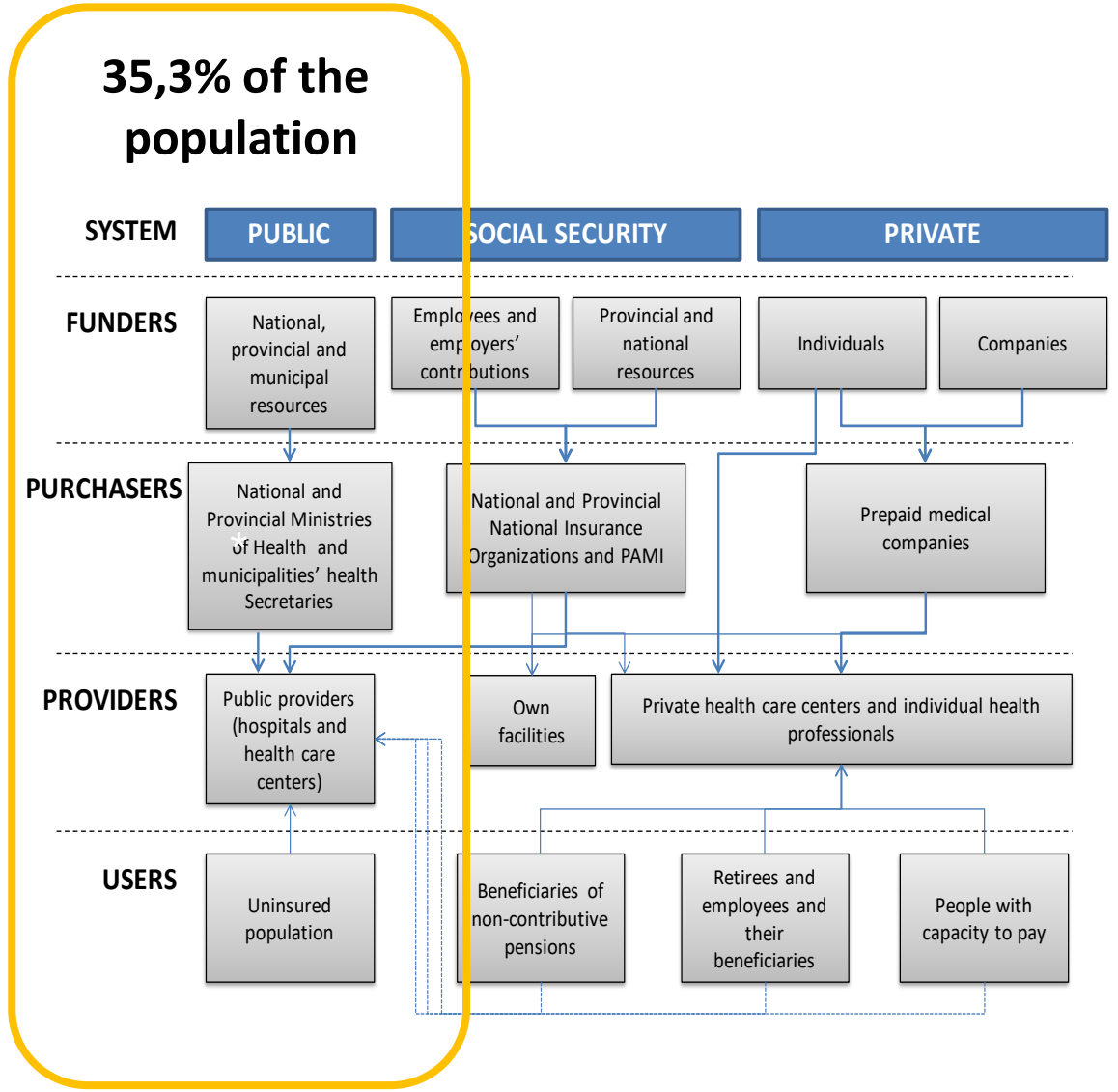
Share of revenues and expenditures, by level of government (2013)



Source: Expenditures: authors' presentation based on Ministry of Economy and Public Finances of Argentina (MOF, 2015). Resources: Instituto Argentino de Análisis Fiscal (Argañaraz N, Devalle S, Mir A, 2014).

Structure of the health system in Argentina

- 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

Purpose	To strengthen the purchasing function through an RBF mechanism to improve effective coverage of a Health Services Package (HSP)
Starting point context	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.
Beneficiaries	Uninsured population up to 64 years of age
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

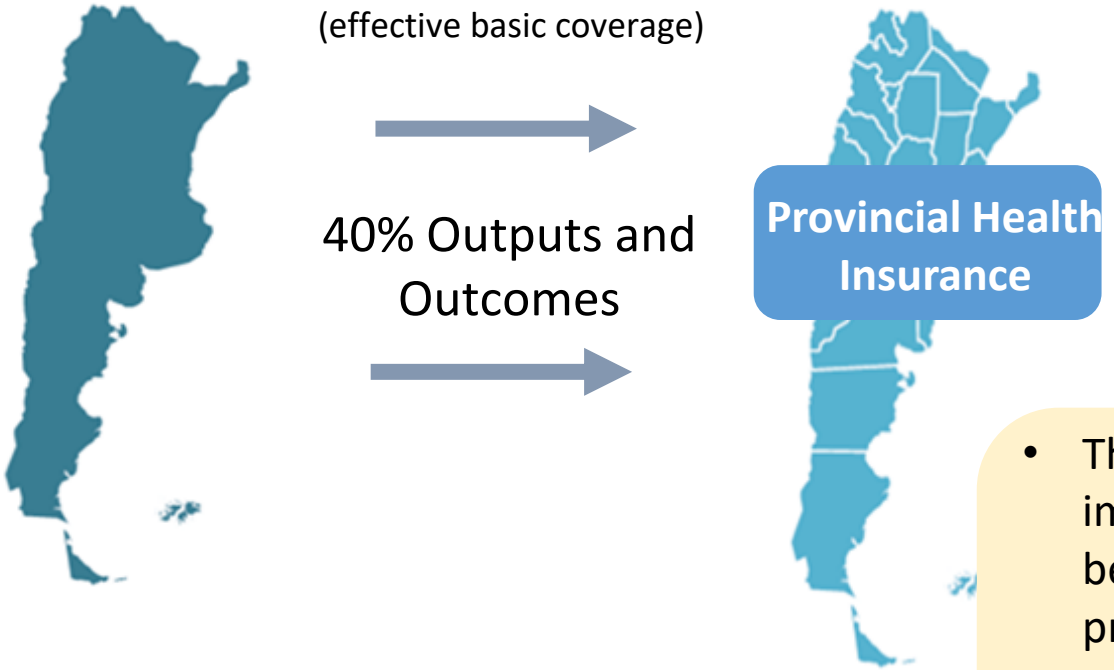
Federal MOH

- 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



External auditor (private firm)

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

Performance indicators

EARLY PREGNANCY CARE
Pregnant women seen before week 13.

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

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

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

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.

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.

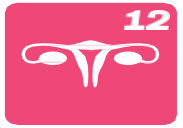
FOLLOW-UP OF CHILDREN BETWEEN 1 AND 9 YEARS OF AGE
At least 9 checkups between 1 and 9 years, as scheduled.

IMMUNIZATION COVERAGE AT 24 MONTHS
Children at 2 who received quintuple and polio vaccines between 1 ½ and 2 years of age.

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.

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

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.



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

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

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

Provincial MOH
(Strategic Purchaser)

- 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

Province

Fee for service to purchase the HSP

Provider

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)

External auditor
(private firm)

Intergovernmental transfers based on results

Basis for budget transfers

Conditions 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

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

Solid legal and procedural framework

Legal framework

- 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

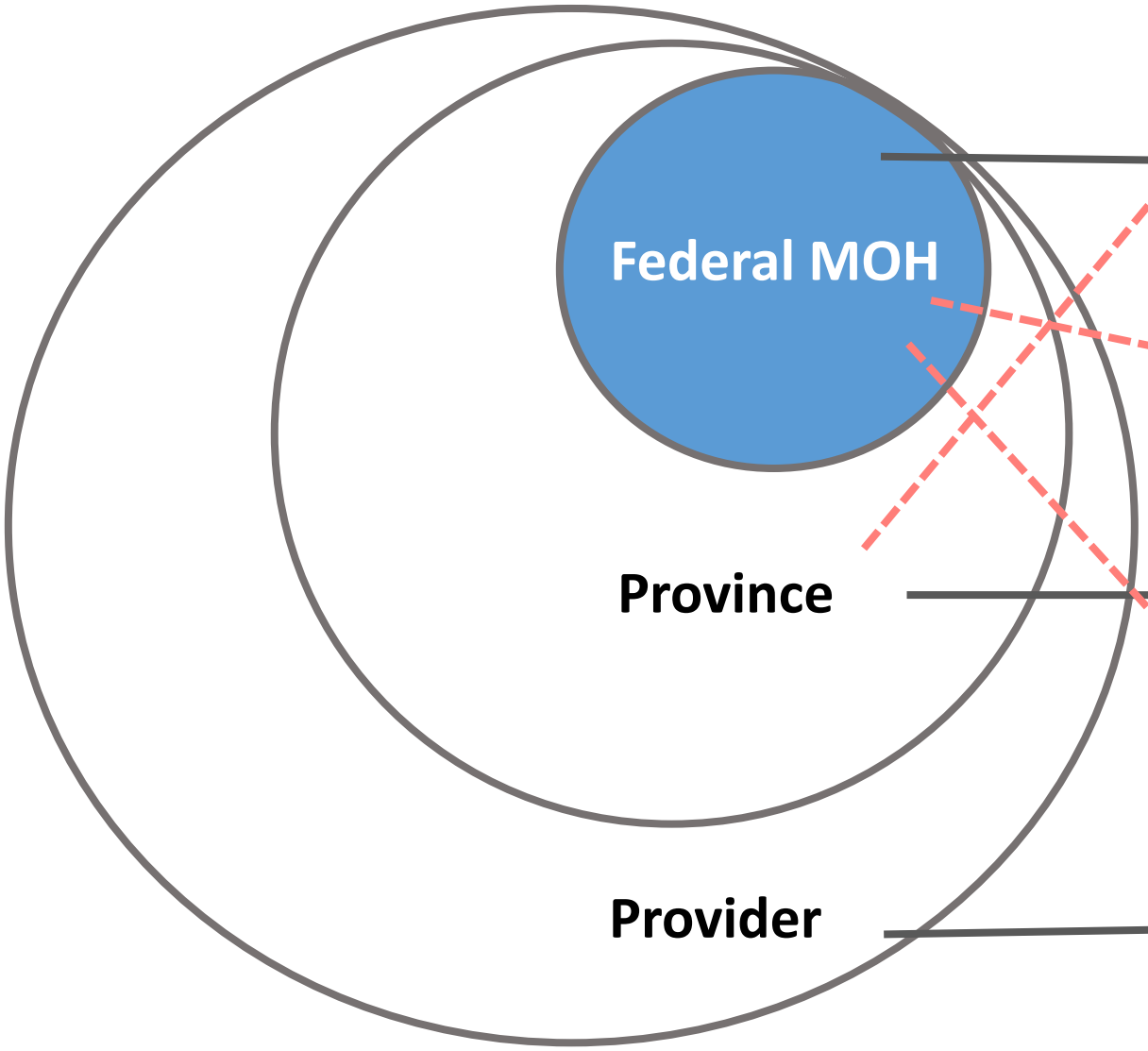
Umbrella Agreement (non-negotiable)

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

Annual Performance Agreement (flexible)

- 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



Open participation in the definition of the HBP

- It defines the HBP and set standards
- It establishes the financing mechanisms
- It determined provider autonomy

Technical assistance

- It defines HBP fees and provider expenditure categories
- It develops its own IT tools
- IT deploys its strategy to implement the Program

Managements tools

- It adapts the provincial strategy to its local context
- It allocates funds to satusfy its specific needs

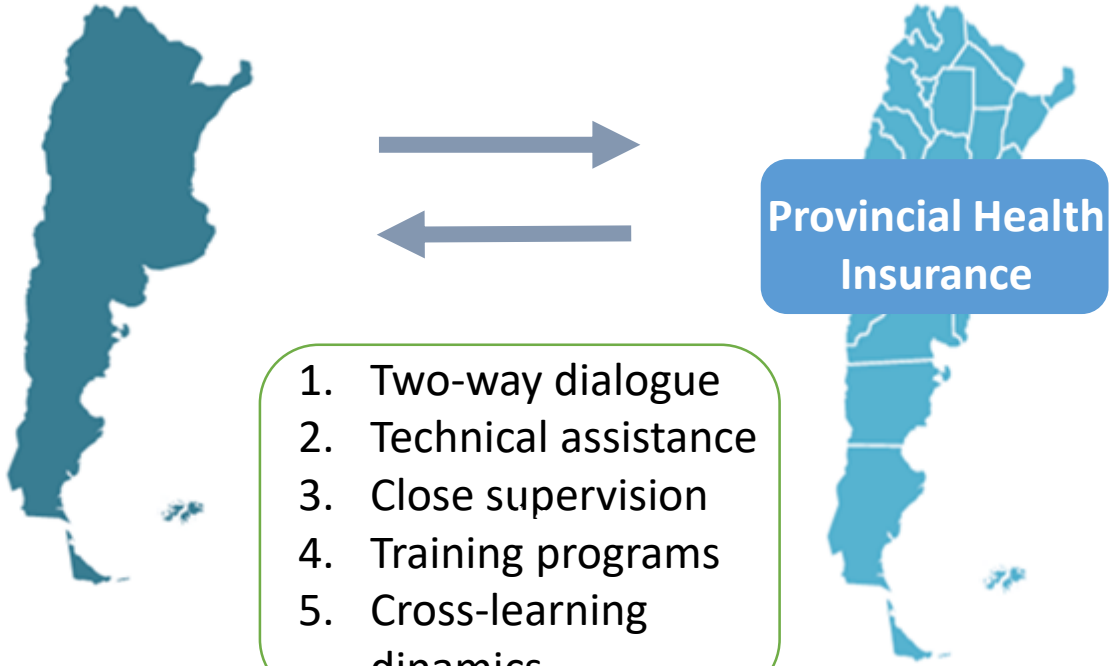
Responsibilities and tasks of the different actors involved in programme implementation

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

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 level was key to manage inter-governmental relations effectively



1. Two-way dialogue
2. Technical assistance
3. Close supervision
4. Training programs
5. Cross-learning dinamics

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.

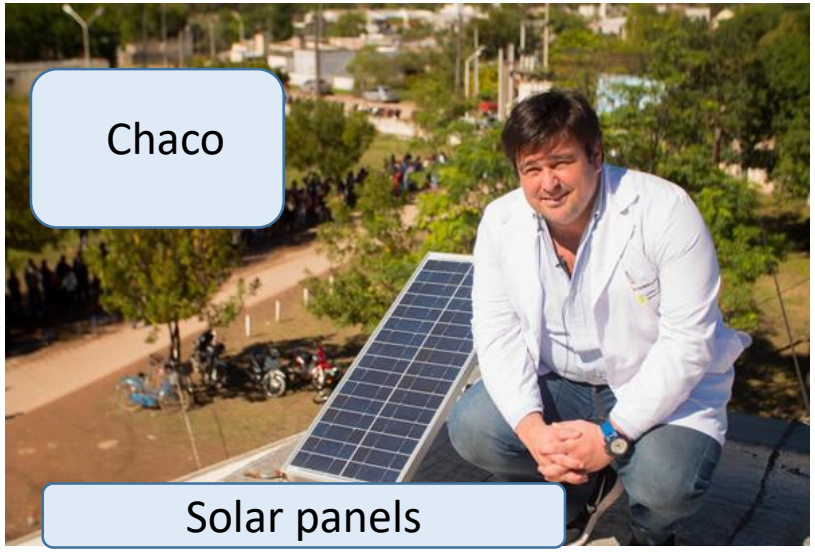
Planned joint effort with vertical programs

Cooperative relationship

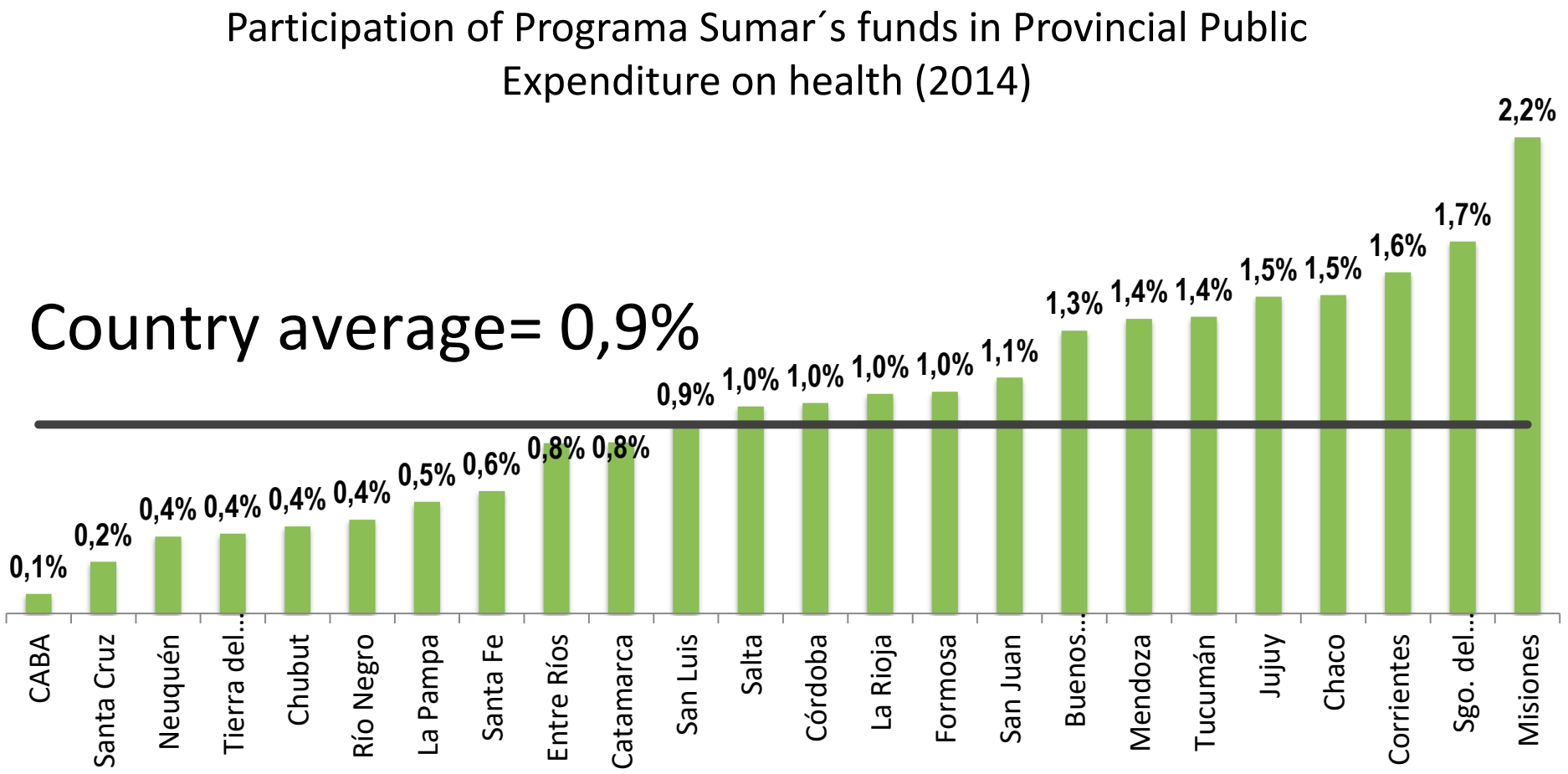
Planned joint effort with vertical programs

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?



3. Achievements, challenges and main learnings of Programa Sumar

Institutional achievements

With **less than 1%** of the average provincial health budget…

- 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

How has the Program strengthened intergovernmental governance?

Key ingredients of good governance

Transparency	• Clear, rigorous and uniform criteria to transfer resources • Independent verification of provincial performance
Participation	• Engaging provinces from the design phase • Well aligned Incentives and broad autonomy to adapt the programe strategy to local context
Accountability	• Institucional and performance agreements • Ongoing monitoring of financial performance and health outputs/outcomes
Capacity	• Improving local decision-making (strategic purchasing) • Close supervision and technical assistance • Multiple benchlearning activities among the provinces

Challenges

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

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.

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

Financial **Incentives are not enough** to improve local decisión making, it´s also crucial to offer provinces **sufficient autonomy** and **technical assistance** and to develop a strong **performance monitoring** system

Thank you!