Programa SUMAR
Moving forward towards effective universal health coverage though RBF

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5 introductory concepts

1. Argentina is a **federal country**.
2. Health coverage in Argentina is **universal**. However, this is an implicit universal coverage.
3. The **2001 crisis** brought about an increase in unemployment and this situation imposed a heavy burden on the public provincial systems.
4. In 2004 the National government implemented **Plan Nacer** to improve access and quality of prioritized services (Explicit Health Benefit Plan) through a **Results-Based Financing** strategy.
5. Programa **SUMAR** is the **expansion** of Plan Nacer including new population groups.
RBF - Virtual Separation of functions

Capitation payment based on performance (#)

Enrollment (monthly payment)

Health outputs/ outcomes (every four months)

Per capita value is co-financed 85% Nation and 15% Province

Fee for Service

Autonomy in the use of funds

The facility may self-manage its own account or it may be managed by a third party (hospital, local secretariat, municipality)

Incremental approach. Only includes the cost to improve quality and coverage of prioritized services. The rest is financed by the historical budget.

Funder

Provincial Purchaser Unit

External Auditor

External Auditor

60%

40%

NATION

PROVINCE

HEALTH PROVIDER
Gradual implementation

Children 0-5
Pregnant women
North Region

Children 0-5
Pregnant women
Country

Children 6-9
Adolescents
Adult women

Adult men

2004
700,000

2007
2 MILLIONS

2012
10 MILLIONS

2015
15 MILLIONS
<table>
<thead>
<tr>
<th>Performance Indicators</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EARLY PREGNANCY CARE</strong></td>
<td>Pregnant women seen before week 13.</td>
</tr>
<tr>
<td><strong>PREGNANCY FOLLOW-UP</strong></td>
<td>At least 4 prenatal checkups in pregnant women.</td>
</tr>
<tr>
<td><strong>EFFECTIVENESS OF NEONATAL CARE</strong></td>
<td>Survival of 28 days of children with birth weight between 750 and 1,500 grams.</td>
</tr>
<tr>
<td><strong>FOLLOW-UP OF CHILDREN UNDER 1 YEAR OF AGE</strong></td>
<td>At least 6 checkups before the first year of age, as scheduled.</td>
</tr>
<tr>
<td><strong>INTRAPROVINCIAL EQUITY IN THE FOLLOW-UP OF CHILDREN UNDER 1 YEAR OF AGE</strong></td>
<td>It measures equality in terms of health follow-up of children under 1 year of age in the different regions of the same province.</td>
</tr>
<tr>
<td><strong>DETECTION CAPABILITY OF CONGENITAL HEART DISEASE IN CHILDREN UNDER 1 YEAR OF AGE</strong></td>
<td>Children under 1 year of age with congenital heart disease diagnosis reported to the National Coordinating Referral Center.</td>
</tr>
<tr>
<td><strong>FOLLOW-UP OF CHILDREN BETWEEN 1 AND 9 YEARS OF AGE</strong></td>
<td>At least 9 checkups between 1 and 9 years, as scheduled.</td>
</tr>
<tr>
<td><strong>IMMUNIZATION COVERAGE AT 24 MONTHS</strong></td>
<td>Children at 2 who received quintuplet and polio vaccines between 1½ and 2 years of age.</td>
</tr>
<tr>
<td><strong>IMMUNIZATION COVERAGE AT 7 YEARS OF AGE</strong></td>
<td>Children at 7 who received triple or double viral, triple and polio vaccines between 5 and 7 years of age.</td>
</tr>
<tr>
<td><strong>FOLLOW-UP OF ADOLESCENTS BETWEEN 10 AND 19 YEARS OF AGE</strong></td>
<td>At least one annual checkup between 10 and 19 years of age.</td>
</tr>
<tr>
<td><strong>PROMOTION OF SEXUAL AND/OR REPRODUCTIVE HEALTH RIGHTS</strong></td>
<td>Adolescents between 10 and 19 and women up to 24 who take part in sexual and/or reproductive health workshops.</td>
</tr>
<tr>
<td><strong>PREVENTION OF UTERINE CERVICAL CANCER</strong></td>
<td>Women between 25 and 64 with high degree lesions or uterine cervical carcinoma diagnosed in the last years.</td>
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<tr>
<td><strong>BREAST CANCER CARE</strong></td>
<td>Women up to 64 with breast cancer diagnosed in the last year.</td>
</tr>
<tr>
<td><strong>EVALUATION OF THE ATTENTION PROCESS OF THE CASES OF MATERNAL AND INFANT DEATH</strong></td>
<td>It evaluates the attention process of maternal and infant death cases.</td>
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</tbody>
</table>
Health Benefit Plan

- Prevention, diagnosis and beginning of treatment of breast, cervical and colorectal cancer
- NCD research, identification of risk level and follow-up
- Care of low and high-risk pregnancy
- Care of childbirth and its complications in safe Maternities
- Health promotion and risk prevention actions
- Family planning
- Care of alcohol and other substance consumption
- Care of suicide attempt

- Neonatal care
- Treatment of NB in critical condition
- Treatment of CHD and congenital malformations
- Control of vaccine-preventable diseases
- Care of respiratory infections
- Diagnosis and treatment of overweight and obesity
- Control of vaccine-preventable diseases
- Immunoprevention of HPV
- Diagnosis and treatment of overweight and obesity
- Care of alcohol and other substance consumption
- Care of suicide attempt

- More than 700 services covered
- Focus on preventive services
- Quality requirements
**Main contributions of the concurrent and independent verification**

1. It strengthens **control environment**
2. It promotes **quality standards** of care among health providers
3. An important opportunity for a **two-way dialogue** between the purchaser and providers about current performance
4. As it is done shortly after the processes have occurred, it allows **more accurate and effective corrections** to be made
5. It has functioned as a **mediator** to settle differences between the actors
## Balance between regulation and autonomy

<table>
<thead>
<tr>
<th>Process / Tool</th>
<th>Nation</th>
<th>Province</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td>- It sets capita value annually</td>
<td>In charge of 15% of capitation transfers</td>
<td>No co-payments</td>
</tr>
<tr>
<td></td>
<td>- In charge of 85% of capitation transfers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provincial Purchasing Unit staff</td>
<td>- It defines profiles</td>
<td>- It selects staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- It financed 100% of the Provincial staff 2005-2014</td>
<td>- It has undertaken to incorporate staff from 2015-2017</td>
<td></td>
</tr>
<tr>
<td>Health Benefit Plan</td>
<td>Design (with the participation of the Provinces)</td>
<td>It sets Prices (with the technical assistance of the Nation)</td>
<td>Provision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option: to pay higher prices to rural providers</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>It sets standards and provides technical assistance</td>
<td>It develops IT tools</td>
<td>Digitalizes data</td>
</tr>
<tr>
<td>Allocation of capitation funds</td>
<td>No rules</td>
<td>It defines eligible expenditure categories</td>
<td>Decides which specific goods or service to purchase</td>
</tr>
</tbody>
</table>
Changes in the retribution scheme of tracers

Incentive payments function “All or nothing”

Disadvantages
- Full compensation for partial achievement
- Opportunistic behaviour of provinces (under-reporting to avoid high goals)

Continuous function with 3 thresholds

Advantages
- Incentives for all provinces, every improvement counts
- Partial retribution “for partial achievement” always promoting the optimal result
- Balance any baseline deficit
100% of children were enrolled but 27% had not reported a health service in the previous year.

Adaptative implementation

60% Capitation Payment

Enrollment + 1 service provided in the last 12 months

Basic Effective Coverage
The importance of autonomy and flexibility

It favours the building of new skills

“Programa SUMAR has changed our way of thinking and doing things, we all became managers”
Patricia García, Health Center of the Province of Salta.

It improves equity

A health facility of San Juan bought motorbikes to provide services in hard-to-reach rural areas

It encourages creativity

A health center of La Pampa draws bicycles (purchased with Programa SUMAR funds) for all those children whose vaccines and checkups are up to date
Health Facilities share their investments and improvements with their communities

Province of La Rioja “Islas Malvinas” Health Center

Province of La Rioja “Jardín Residencial” Health Center
Focus on “what” and “how”

Provincial Performance Index

<table>
<thead>
<tr>
<th>Province</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tucumán</td>
<td>65.4%</td>
</tr>
<tr>
<td>Misiones</td>
<td>61.3%</td>
</tr>
<tr>
<td>Santiago del Estero</td>
<td>59.2%</td>
</tr>
<tr>
<td>Córdoba</td>
<td>59.0%</td>
</tr>
<tr>
<td>Entre Ríos</td>
<td>57.6%</td>
</tr>
<tr>
<td>La Rioja</td>
<td>56.6%</td>
</tr>
<tr>
<td>Jujuy</td>
<td>55.8%</td>
</tr>
<tr>
<td>Mendoza</td>
<td>55.5%</td>
</tr>
<tr>
<td>San Luis</td>
<td>54.7%</td>
</tr>
<tr>
<td>La Pampa</td>
<td>54.5%</td>
</tr>
<tr>
<td>Salta</td>
<td>53.7%</td>
</tr>
<tr>
<td>Corrientes</td>
<td>52.9%</td>
</tr>
<tr>
<td>Río Negro</td>
<td>50.9%</td>
</tr>
<tr>
<td>Chaco</td>
<td>48.9%</td>
</tr>
<tr>
<td>Chubut</td>
<td>48.7%</td>
</tr>
<tr>
<td>San Juan</td>
<td>47.8%</td>
</tr>
<tr>
<td>Santa Fe</td>
<td>43.2%</td>
</tr>
<tr>
<td>Neuquén</td>
<td>41.1%</td>
</tr>
<tr>
<td>Buenos Aires</td>
<td>40.3%</td>
</tr>
<tr>
<td>Formosa</td>
<td>38.6%</td>
</tr>
<tr>
<td>Tierra del Fuego</td>
<td>35.0%</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>28.8%</td>
</tr>
<tr>
<td>CABA</td>
<td>23.3%</td>
</tr>
<tr>
<td>Catamarca</td>
<td>22.4%</td>
</tr>
</tbody>
</table>

June 2015

Exceeds the expected performance
Around the expected performance
Near the expected performance
Distant from the expected performance

63.6% EXPECTED VALUE
48.1% COUNTRY AVERAGE
# An integrated and integrating strategy

<table>
<thead>
<tr>
<th>Dimension of Integration</th>
<th>Starting point</th>
<th>What we developed</th>
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</table>
| Evaluation and Research  | Epidemiological analysis and health status assessment | - Costing  
- Measurement of supply side capacity and gaps  
- User satisfaction surveys  
- Survey on the motivation of health teams |
| Financing                | Historical budget modality and strong centralized fund allocation scheme | - Pay for performance  
- Decentralized scheme  
- Alignment of financial sources (national and provincial) |
| Health Beneficiary Rosters | National Social Security Roster | - Building of the Provincial Social Security Roster (condition for capitation transfers)  
- Nomination of people without formal health insurance |
| Health Services          | Clinical guidance and protocols | Explicit Health Benefit Plan with quality standards requirements |
| Information Systems      | Perinatal Information System (PIS) at Maternities | - Online systems for billing/reporting health services to be used by Hospitals and Health Centers  
- 2016 Pilot: encouraging the utilization of Electronic Clinical Record at the Primary Health Network through RBF |
## An integrated and integrating strategy

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<th>What we developed</th>
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</table>
| Organizational Structure and Professional Profiles at the Provincial Ministries of Health | - Traditional budgeting areas  
- Provincial Ministries mainly managed by physicians and accountants | - Creation of the Strategic Provincial Health Purchasing Units  
- Multidisciplinary approach |
| Training | Mainly related to clinical issues | New subjects: Financial Planning, Evaluation, Costing and Pricing, Leadership, Persuasive and effective communication, Change Management, etc. |
| Roles and Functions of key players | Norms | Network of Management Agreements |
| Accreditation of public providers | Norms | Tie the fulfillment of accreditation requirements to financing |
| Joint Agenda between the Public & Provincial Social Security Sectors | Emerging dialogue | Operational agreements in all provinces to harmonize Health Benefit Plans and strategic purchasing schemes |
How does Programa SUMAR encourage behavioural changes?

- Transfers (+)
- Debits and Fines (-)
- Increased Autonomy
- Better work environment
- Training opportunities

**MONETARY INCENTIVES**

**NEW TOOLS**

**EMPOWERMENT**

**LEADERSHIP**

- Performance indicators
- Performance Feedback
- Management instruments
- Long-term goals
- Integration
- Bench-learning
Learnings from implementation

- Programa Sumar investment represents 0.5% of the average provincial expenditure but has strengthened national and provincial leadership and reoriented the management and care model.

- RBF is not an end in itself. It plays a supporting role. It requires strong stakeholder collaboration. The explicit Health Benefit Plan developed by the Program has been a fundamental coordination tool.

- Targeting the poorest among the poor and achieving similar levels of performance among provinces is still a challenge.
Learnings from implementation

• RBF programs are “managerial reforms” that demands ad-hoc training approach at all institutional layers. Smart sequencing maximizes the chances of project success.

• Programa Sumar demonstrated that providers can manage resources and that it was possible to introduce RBF within Provincial Health and Finance Ministries.

• The 2001 crisis enabled the change process because it helped the provinces to "let their guard down". But the key factor that drove change was the strong leadership role of the Health Ministry.