STRENGTHENING THE PURCHASING FUNCTION THROUGH RESULTS-BASED FINANCING IN A FEDERAL SETTING: LESSONS FROM ARGENTINA’S PROGRAMA SUMAR

Martin Sabignoso
Leonardo Zanazzi
Susan Sparkes
Inke Mathauer
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By
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The opinions expressed in this document are exclusively those of the authors.
EXECUTIVE SUMMARY

This paper presents a case study of the implementation of Programa Sumar, which was developed by the federal Ministry of Health (MOH) of Argentina beginning in 2004. Detailed evidence based on first-hand experience is analysed to outline the key design features and achievements of Programa Sumar and to then explore the critical features of the implementation process.

Argentina is a federation with 23 autonomous provinces, the Autonomous City of Buenos Aires, and more than 2000 municipalities. The public health system is decentralized; it is managed by provinces, with the responsibility for primary care often devolved to the municipalities. A profound economic crisis in 2001 brought about a significant increase in unemployment and many families lost their formal health coverage. In response, the federal MOH launched a set of policies that were part of the Federal Health Plan (2004-2007) in order to strengthen the public health system that mainly covered the population lacking formal health insurance. Plan Nacer (renamed Programa Sumar in 2012) was one of those key policies implemented by the Federal MOH aiming at improving the effective health coverage of the most vulnerable population groups through a results-based financing (RBF) strategy. Specifically, the federal MOH implemented additional conditional budget transfers linked to results to strengthen the strategic purchasing function in all provinces in order to improve the coverage of a package of prioritized preventive health services, with the ultimate objective of reducing morbidity and mortality. These additional conditional transfers follow a capitation logic on the following basis:

1. Enrolment of the target population in the Program with provision of an essential health service in the last 12 months (60% of the capitation payment); and

2. Attainment of prioritized results relating to health outcomes and outputs (40% of the capitation payment).

Transferred funds can be used only by provincial ministries of health to purchase health services for an explicit package from public providers for the enrolled population. Since 2009, provinces also are obliged to co-finance a predefined share (15%) of the capitation transfers from their own resources.

Using the additional conditional funds, provinces pay public providers through fee-for-service for the defined package. These fee-for-service payments, which come on top of budget allocations to providers aim to incentivize both increased quantity and quality of prioritized services at the provider level.

The programme specifically set out to contribute to the development of the strategic purchasing function within each provincial MOH. The programme allows providers to decide how to use the remuneration they receive for providing services included in the health service package.

The programme has shown that transfers linked to results can become powerful drivers of health system transformation. By investing less than 1% of the average annual provincial health budgets for the capitation transfers, Programa Sumar has made significant contributions to the improvement of both the organizational performance of the health system and health outcomes between its inception in 2004 and 2018. Programa Sumar has also helped strengthen
the stewardship function of the federal MOH and improved coordination with subnational governments.

Although Programa Sumar has made great contributions to the government health sector, important challenges remain. A better understanding of the strategic purpose of the programme is needed among provincial ministries of health, as well as improved coordination with provincial budgetary policies. The support of the World Bank has been key to initiating and sustaining the process of change, however, true institutionalization requires the country to ensure effective financing mechanisms, including public financial management systems, are in place that can support programme implementation using domestic revenues.

The programme can continue to evolve by incorporating into the health service package secondary prevention services for noncommunicable diseases, which cause some 80% of the burden of disease in the country. This will require carefully revising the provider payment mechanism to create appropriate incentives to encourage integrated and continuous care. The federal MOH and the provinces should also consider incorporating changes in the way hospitals are paid by introducing strategic purchasing at this level.

In conclusion, Programa Sumar has shown that it is possible to reconcile the immediate needs of the poor, while introducing ambitious innovations in the health financing system of a federal country through conditional budget transfers based on the idea of results-based-financing. As such, this analysis provides important lessons for other countries working to implement health financing reforms in highly devolved or federal settings and, more specifically, in designing intergovernmental transfers to improve the performance and capacities of subnational jurisdictions.

**ABBREVIATIONS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>GDP</td>
<td>Gross domestic product</td>
</tr>
<tr>
<td>IMR</td>
<td>Infant Mortality Rate</td>
</tr>
<tr>
<td>IT</td>
<td>Information technology</td>
</tr>
<tr>
<td>MMR</td>
<td>Maternal Mortality Rate</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOF</td>
<td>Ministry of Economy and Public Finances of Argentina</td>
</tr>
<tr>
<td>NSSI</td>
<td>National Social Security Insurance</td>
</tr>
<tr>
<td>PAMI</td>
<td>Institute of Social Services for Retirees and Pensioners</td>
</tr>
<tr>
<td>PIP</td>
<td>Production and Investment Plan</td>
</tr>
<tr>
<td>PSSI</td>
<td>Provincial Social Security Insurance</td>
</tr>
<tr>
<td>PPP</td>
<td>Purchasing Power Parity</td>
</tr>
<tr>
<td>RBF</td>
<td>Results-based financing</td>
</tr>
<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
</tr>
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</table>
Efforts to achieve universal health coverage (UHC) have become increasingly important to government agendas, with a range of initiatives promoted and analysed over the past decade. However, the pursuit of UHC in countries where decision-making powers in the health sector are devolved (i.e. shared between federal and sub-national levels) has received little attention. One critical aspect relates to the role of intergovernmental transfers in enabling a central or federal government to make fund allocation conditional on achieving health outcomes, i.e. linking conditional transfers to results along the logic of results-based financing (RBF). While there is a body of literature on the design of RBF mechanisms to establish appropriate provider-level incentives through payment mechanisms, conditional transfers based on a RBF logic in federal or devolved contexts are much less documented and understood.

Relevant policy questions include:
- What are common policy and implementation challenges related to health financing reforms in federal or devolved contexts and how can they be addressed?
- How can intergovernmental fiscal transfers linked to results drive a transformational process towards improved purchasing to improve performance within the health system?
- How can central governments (federal or not) empower subnational governments to improve health systems by placing conditions on decision-making and resource allocation?

This paper presents a case study on Programa Sumar, which was introduced by the federal Ministry of Health (MOH) of Argentina beginning in 2004 (initially called Plan Nacer). Programa Sumar aimed to develop the strategic purchasing function in all 23 provinces of the country and the Autonomous City of Buenos Aires in order to improve effective coverage of a package of prioritized health services, and ultimately to contribute to reduce morbidity and mortality rates. The paper analyses and discusses detailed evidence based on first-hand implementation experience. This analysis provides important lessons for other countries that seek to implement health financing reforms in highly devolved or federal settings and, more specifically, design intergovernmental conditional transfers linked to results to improve the performance subnational jurisdictions and health providers.

Argentina is a middle-income country in which decision-making powers are shared between central (federal) government and the provincial governments. Since provinces were established before the federation, they have retained much of their original autonomy. The government health system is managed by provincial MOHs and it provides free health coverage primarily to the poorest segments of the population. Prior to the introduction of Programa Sumar, these provincial MOHs provided input-based

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1 In this report, the term “intergovernmental” refers to relations between the central Federal Government and the provincial governments.
2 According to Musgrove (2010), RBF “is any program that rewards the delivery of one or more outputs or outcomes by one or more incentives, financial or otherwise, upon verification that the agreed-upon result has actually been delivered”. 
budget allocations to government health providers in their province. This has led to discrepancies between provinces in terms of budgetary processes, regulations and results. The Federal Government holds the stewardship role to coordinate policies and promote equity in access to health care but has no authority to determine how provincial health systems are organized.

Programa Sumar and its predecessor, Plan Nacer, provide an example of how national-level policies introduced in a devolved country were able to make significant progress towards UHC. This paper argues that the federal MOH’s implementation of conditional transfers based on RBF to leverage improved health system performance within provincial health systems was a critical enabler of this progress.

The paper has five sections. After this introduction, Section 2 outlines Argentina’s federal system along with an overview of its health system. Section 3 describes Programa Sumar and the context in which it was designed and implemented. Section 4 provides in-depth analysis of the institutional design and implementation arrangements. Section 5 discusses the challenges and new opportunities for this federal policy and presents the main lessons learned.
2. CONTEXT: ARGENTINA’S FEDERAL STRUCTURE AND HEALTH SYSTEM

2.1. FEDERAL SYSTEM OF GOVERNMENT

Argentina has a population of approximately 44 million people, spread unevenly across a large territory.\(^3\) As a highly urbanized country, most of its population is concentrated in the Buenos Aires Metropolitan Region and in a few other urban centres. As in most Latin American countries, income distribution is highly unequal.\(^4\) Table 1 presents summary socioeconomic statistics.

Table 1. Argentina: selected indicators

<table>
<thead>
<tr>
<th>Indicator name</th>
<th>Date of measurement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population*</td>
<td>2018</td>
<td>44,494,502</td>
</tr>
<tr>
<td>Annual average population growth (%)</td>
<td>2015</td>
<td>10.7</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>2008–2010</td>
<td>75.34</td>
</tr>
<tr>
<td>GDP per capita (US$)‡</td>
<td>2017</td>
<td>14 402</td>
</tr>
<tr>
<td>GDP per capita PPP (US$)‡</td>
<td>2017</td>
<td>20 787</td>
</tr>
<tr>
<td>Gini Index‡</td>
<td>2016</td>
<td>42.4</td>
</tr>
<tr>
<td>Population with unsatisfied basic needs (%)</td>
<td>2010</td>
<td>12.5</td>
</tr>
<tr>
<td>Infant mortality rate (IMR) (per 1 000 live births) •</td>
<td>2016</td>
<td>9.7</td>
</tr>
<tr>
<td>Maternal mortality rate (per 10 000 live births) •</td>
<td>2016</td>
<td>3.4</td>
</tr>
<tr>
<td>Population not covered by the health insurance system (%)</td>
<td>2017</td>
<td>35.3</td>
</tr>
<tr>
<td>Total health expenditure as % of GDP *</td>
<td>2015</td>
<td>9.23</td>
</tr>
<tr>
<td>Health expenditure per capita (US$) *</td>
<td>2017</td>
<td>1,391</td>
</tr>
<tr>
<td>Out-of-pocket payments (as % of total health expenditure)</td>
<td>2014–2015</td>
<td>18.3</td>
</tr>
<tr>
<td>Provincial and municipal expenditure as % of consolidated public health care expenditure ‡</td>
<td>2015</td>
<td>79.5</td>
</tr>
<tr>
<td>Doctors per 10 000 inhabitants</td>
<td>2004</td>
<td>32.1</td>
</tr>
</tbody>
</table>

Source: Indicadores básicos 2017 (basic indicators) of MOH and Pan American Health Organization (2017), except where indicated.

\(^*\) Estimate from INDEC (National Institute of Statistics and Census): http://www.indec.gov.ar/nivel4_default.asp?id_tema_1=2&id_tema_2=24&id_tema_3=84


\(^\bullet\) http://www.deis.msal.gov.ar/index.php/tabulados-2/

\(^\sim\) Estimate based on Programa Sumar’s internal information.

\(^\ast\) Authors’ estimate based on several sources.\(^5\)

\(^\dagger\) Authors’ estimate based on https://www.minhacienda.gob.ar/datos/

\(^3\) With 2 780 400 km\(^2\), Argentina is the eighth largest country in the world and, with approximately 16 people per km\(^2\), is among the lowest in population density.

\(^4\) Figure 5 in the Annex shows the map of Argentina.

\(^5\) It should be noted that the estimate of out-of-pocket expenditure has been made ad hoc for the present paper, since the available estimates are understood to be insufficiently consistent. In particular, out-of-pocket expenditure as a proportion of private expenditure is taken from the World Bank (http://data.worldbank.org/country/argentina, accessed 27 February 2018). See Figure 6 in the Annex.
The country is also characterized by fragile political institutions and remarkable macroeconomic fluctuations. The economy has experienced frequent inflationary episodes and overwhelming crises. The most recent major political and economic crisis lasted from 2001 to 2004, pushing over half of the population below the poverty line and triggering a set of public policies aimed at mitigating the consequences.

2.2. FINANCING SYSTEM OF THE FEDERAL GOVERNMENT AND THE PROVINCES

Argentina is a federation composed of 23 autonomous provinces, the Autonomous City of Buenos Aires (ACBA) and more than 2,000 municipalities. It is characterized by an economically strong Federal Government. The government system is built on the upward delegation of some powers from provinces to the federation. There is further devolution within provinces to the municipal levels in some jurisdictions. There are large differences across provinces in terms of demographic, geographical and socioeconomic characteristics.

The existing federal arrangement has been a source of conflict between the provinces and the federation due to the distribution of revenues amid frequent political and socioeconomic crises. Challenges associated with this system include: (i) the centralization of tax revenue collection at the federal level, (ii) a lack of clear guidelines for equitably distributing funding across provinces, and hence iii) financial difficulties at the provincial levels.

There have been divergent trends in revenue raising authority as compared to expenditure responsibility between the Federal Government and the provinces in recent years, with more emphasis on the fiscal balance at the federal level rather than at the province-level. Revenue-raising has been centralized, currently accounting for almost 75% of the country’s total government revenues.6,7 Provinces have preserved modest tax powers by which they raise, on average, only half of their total revenues.8 Besides umbrella legislation that restricts the taxation powers of the provinces, there is a large burden of federal taxes, thus narrowing the provinces’ tax collection possibilities.9 However, consistent with the federal constitution, provinces have a lot of spending responsibilities. Provinces’ expenditure accounted for over 35% of government expenditure in 2013 (see Figure 1 below).10

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6 The National Constitution of Argentina defines the tax competencies of the federation and the provinces in an ambiguous way. It focuses more on provinces’ incomes (through the revenue-sharing system) than on their powers of taxation.
7 For more detail on the destination of each tax collected by the Federal State, see the referenced report of the Ministry of Economy and Public Finances of Argentina (MOF, 2016a).
8 And only one fifth of revenues collected via taxation by the Federal State. See: Artana D et al. (2015). On non-financial public administration, see the report of Ministry of Finance (MOF, 2016b). In any case, as noted by Cetrángolo O, Jiménez JP (2004), for reasons of efficiency and equity there are few taxes that could be decentralized.
9 Argentina has the highest tax burden in Latin America and the second in the Americas (after Cuba). The tax-to-GDP ratio amounted to 32.1 in 2015; it has almost doubled in the last 25 years (s OECD 2017). Moreover, given the significant tax evasion suffered by Argentina’s fiscal system, effective taxpayers should really bear a higher burden.
10 2015, authors’ estimation based on data of Ministry of Economy and Public Finances of Argentina (MOF, 2015).
The asymmetry between taxation powers and revenues on the one hand and expenditure responsibilities on the other hand puts the provinces in a situation of persistent fiscal imbalance. The share of provincial revenue in total revenue for the public sector has not evolved along with the increase in their spending responsibilities (Figure 1). In fact, over the last 50 years the provinces’ share of expenditure has increased from 21% to 39% while their share of revenue raising through provincial taxation has diminished.\(^{11}\)

Transfers from the Federal to province-level are based on a system that was intended to be temporary, but the current automatic tax revenue-sharing regime dates from 1988.\(^{12}\) It specified a first-step distribution (the proportion that the Federal Government transfers to the provinces as a block grant) and a second-step distribution (the coefficients of distribution across provinces).\(^{13}\) Other transfers to provinces have for decades been a product of bilateral negotiations and transitional measures based mainly on political arrangements. The amount of these transfers is considerable, thus giving the Federal Government a powerful tool to align provincial governments with the policies of the Federal Government in power.

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11 For details, see: Cetrángolo O, Jiménez JP (2004).
12 There is also joint participation within the provinces with regard to the municipalities.
2.3. MAIN FEATURES OF THE HEALTH SYSTEM

Total health expenditure is around 9% of GDP in recent years (9.23% in 2015), which is among the highest in the region.\(^\text{14}\) In 2015, of the total 3.02% of GDP allocated by the public sector to health, 62.6% was provincial and 16.8% municipal, with the rest coming from the federation.\(^\text{15}\) The Argentinian health system is based on three main health financing pillars that are segmented according to people's incomes and employment status: 1) government-funded health-care provision (through the provincial health systems), covering 35.3% of the population; 2) social security system, covering 64% of the population; and 3) voluntary health insurance, covering 9% of the population. There is no connection between the different parts of the health financing system. This partly explains why there is a significant number of people with double coverage (around 2 million people have social health insurance and voluntary health insurance).

With respect to government-funded health care provision, each province is responsible for taking care of its residents' health. Each has its own health authorities and network of provincial and municipal health-care providers. They provide health coverage to 15.7 million Argentinean residents (particularly those in the lowest income quintiles) who are not affiliated with social security or voluntary health insurance schemes. However, anyone can receive health care free of charge from the public sector. The provincial MOH decides on resource allocation and health care provision.\(^\text{16}\) The federal MOH is responsible for sector coordination through the Federal Health Council, which is the institutional forum for consensus-building, setting goals, and adopting common policies and decisions with provincial authorities. The public health providers’ network consists of over 8,500 health facilities funded through historical budgets that are commonly defined by annual incremental adjustments.

Social health insurance provides coverage to formal-sector employees and their families. It also covers retirees and their dependents (through the Institute of Social Services for Retirees and Pensioners, or also known as PAMI). It is funded by compulsory contributions from employees and employers and currently provides coverage to more than 27 million affiliates.\(^\text{17}\) This is a highly fragmented sector with over 300 federal and 24 provincial social health insurance schemes (obras sociales) that purchase health services for their beneficiaries. Some insurers operate their own facilities where beneficiaries access health services. The benefit package is governed by the Plan Médico Obligatorio (mandatory medical plan)\(^\text{18}\) which defines essential health services and medications that must be covered. Over time, the number and range of benefits covered have increased, and the catalogue is today one of the most inclusive of the Americas region.

Voluntary health insurance is chosen by the wealthiest people to obtain access to private providers and covers almost 4 million beneficiaries.\(^\text{19}\)

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\(^\text{14}\) Figure 6, in the Annex, shows an illustrative chart of the distribution of health expenditure.

\(^\text{15}\) Authors’ estimate based on MOF (2015).

\(^\text{16}\) For more details on the distribution of decision-making powers in the health sector between the Federal State and the provinces, see Table 5 in the Annex.

\(^\text{17}\) Number of affiliates according to coverage is calculated (updated to 2017) on the weights presented by Cetrángolo O (2014: 176).

\(^\text{18}\) The Mandatory Medical Plan is mandatory for the National Social Insurers and Private Insurers.

\(^\text{19}\) Adapted from Cetrángolo O et al. (2011: 42).
The health status of the Argentine population has improved in recent years. The infant mortality rate (IMR) fell from 20.8 in 1995 to 9.7 in 2015 and life expectancy increased. Moreover, the gap in infant mortality rate between Northern provinces (the poorest) and the rest of the country decreased. However, the maternal mortality rate (MMR) has remained high at around 4 deaths per 10,000 live births and much more effort is needed to achieve equity in health indicators across provinces. In 2015, the infant mortality rate and maternal mortality rate of the most disadvantaged province was 2.3 and 4.3 higher, respectively.

The distribution of decision-making and regulatory powers between the Federal State and the provinces prevents any of them from having sufficient powers to carry out profound reforms to the health system. Each sector, including health, is organized according to its own laws and regulatory frameworks. The management of the government health sector shows important heterogeneities across provinces.

Although each province organizes and finances its public health-care network, no province had a financing system that used RBF as a payment method for its public providers prior to the introduction of Programa Sumar. During the second half of the twentieth century, the management and funding of most public hospitals were decentralized from the Federal State to the provinces, adding burden to the fiscal accounts of the latter. On the other hand, some provinces, particularly the largest ones, have decentralized the management of health services (mainly primary care services) to the municipal levels.

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20 Specifically 4.4 in 1995 and 3.9 in 2015 according to Dirección de Estadísticas e Información de Salud (DEIS, 2016a).
21 IMR: Autonomous City of Buenos Aires, 6.4; Corrientes, 14.5. IMM: Autonomous City of Buenos Aires, La Pampa & Santa Fe, 1.9; Salta, 8.1. Source: Dirección de Estadísticas e Información de Salud (DEIS, 2016a). Despite considerable gaps, these figures show progress in respect of the health situation at the beginning of the century.
22 For instance, there are three provinces (Buenos Aires, Córdoba and Santa Fe) where the provision of primary health services has been partially delegated to the local authority (municipalities).
23 The results of the process do not seem positive in health terms. Analysts agree that such decentralization has been a consequence of a need for federal governments to alleviate their tax burden rather than of federalist convictions.
3. OVERVIEW OF PROGRAMA SUMAR

3.1. STARTING POINT AND OBJECTIVES

Plan Nacer was launched in 2003, i.e. in the aftermath of one of Argentina’s deepest economic crises in 2001. Unemployment of around 20% led many families to lose their social health insurance coverage. Some 48% of the population did not have social health insurance coverage and the most affected segment were children, 65% of whom had no social health insurance coverage. The crisis also highlighted the lack of federal stewardship and intergovernmental coordination, poor performance at the primary care level, and a general misallocation of resources.

The Federal Health Plan 2004–2007 pointed out that primary care facilities did not play their intended role as entry points to the health system. Instead, people opted to seek care in hospitals, with varying degrees of quality. There were shortages of equipment, infrastructure and inputs. Although by 2003, health indicators began to improve; many remained unsatisfactory. Maternal and child health were the main concerns; the national averages of maternal and infant mortality remained high compared to those in neighbouring countries with similar levels of development and lower health spending. Most of these deaths would have been avoidable through timely prevention, diagnosis and treatment.25

Through Resolution No. 198/2003 of the MOH26, Plan Nacer was created in 2003 and, beginning in 2004, was rolled out in phases with financial assistance from the World Bank. In 2012, Plan Nacer turned into Programa Sumar with the aim of contributing to the reduction of morbidity and mortality rates among persons under 65 years of age without social health insurance coverage.27,28 It sought to strengthen the existing system and respond to the urgent health access needs of the most vulnerable population by introducing an innovative mechanism to link funding to results as a means to ensure access to a set of essential services. This RBF mechanism embedded in conditional transfers from the federal to provincial levels was accompanied by policy, institutional, organizational and managerial improvements. It was designed by the Federal Government in close consultation with provinces through the Federal Health Council.

26 Presidential decrees were required at the federal level to approve loans taken with the World Bank (usual procedure).
27 Uninsured persons over 64 years of age are covered by the Institute of Social Services for Retirees and Pensioners.
28 It was part of the set of programmes and initiatives of public health launched by the government in response to the crisis and was framed in the Federal Plan of Health 2004–2007.
3.2. KEY DESIGN FEATURES, INSTITUTIONAL CHANGES AND ACHIEVEMENTS OF PROGRAMA SUMAR

EXTENSION OF SERVICES AND POPULATION COVERAGE

At the outset, Plan Nacer was implemented in the nine provinces of northern Argentina that had the highest level of poverty, the largest number of people without social health insurance coverage, and the highest rates of maternal and child mortality in the country. The focus of the health services package was on promotive and preventive services at the primary care level. In 2007, Plan Nacer was launched in the remaining 14 provinces and the Autonomous City of Buenos Aires.

In transforming into Programa Sumar in 2012 children aged 6–9 years, adolescents aged 10–19 years and women up to 64 years of age were all incorporated. In 2015, coverage was extended to men up to 64 years of age, reaching the entire population under 65 without social health insurance coverage. Figure 3 provides a visual overview of this population and service coverage extension process.

This expansion process began as of 2010 when the programme began to include more complex health services, including coverage for the treatment of congenital heart disease, high-complexity perinatal health conditions (in 2012) and several congenital malformations (in 2015) (see Section 4 for more details). Overall, the programme’s scope is now broad and it is implemented by 7,734 public health facilities (91% of the total), and reinforces coverage for the entire population without social health insurance coverage under 65 years of age (about 35% of the total population).

Figure 3. Expansion of population coverage under Plan Nacer and Programa Sumar

INTERGOVERNMENTAL TRANSFERS AND PURCHASING OF HEALTH SERVICES THROUGH RBF

The federal MOH transfers resources to the provinces through capitation payments, considering additional equity criteria and provinces’ performance in terms of health output and outcome indicators. The provinces, in turn, transfer resources to health-care providers through fee-for-service payments for a set of prioritized preventive health services for the population enrolled in the programme. As such, the RBF mechanism is applied at two levels: in relation to the conditional budget transfers, and as part of provider payment of public providers.

The Programme provides additional, albeit relatively limited, resources to the health system (less than 1% of the total provincial public health expenditure for the capitation transfers).29 The capitation payment amounts to approximately US$ 4 per month and covers the incremental cost of the health service package. This way, Programa Sumar implemented RBF within the structure and budget allocations of the public health system. Figure 4 visualises the funding flows.

Federal Government investments to the programme totaled US$ 700 million between 2004 and 2017. Since 2009, the provinces have co-financed implementation of the strategy with more than US$ 100 million. The Northern provinces started co-financing the programme in January 2009 and the rest of the provinces in January 2011. The federal MOH initially planned to finance the capitation payments along the following schedule: 100% during the first three years, 70% in the fourth year, 40% in the fifth year, and thereafter the provinces would fully finance the programme. However, after the first two years, the federal MOH realized that it was critical to remain the main financier in order to sustain the capacity to coordinate improvements in provinces. Since then, the federal MOH has financed at least 70% of the capitation payment.

29 The fiscal burden of Programa Sumar is modest, representing around 0.03% of Argentina’s GDP.
Because Programa Sumar now covers the treatment of complex pathologies (see Box 1 in Section 4.3), the programme created a Solidarity Reassurance Fund for Catastrophic Diseases (hereafter the Catastrophic Fund) that is entirely financed by the federal MOH.

**SYSTEM CHANGES AND NEW INTER-GOVERNMENTAL RELATIONSHIPS**

In addition to the introduction of federal budget transfers for health using a RBF logic, Programa Sumar has also made substantial changes in key health system elements such as the stewardship function of the Federal Government at sub-national levels, intergovernmental coordination, provider autonomy, management capacities, information systems, provider payment mechanisms and local management autonomy. The programme also created new ways of interaction between federal and provincial governments; prioritizing rules and predictability in decision-making on the basis of clear goals and expectations, reciprocity and a cooperative and planned agenda. The programme also contributed to a more informed and frequent dialogue between provincial MOHs and their public providers. Some of these aspects are outlined in more detail in Section 4.

The programme created management agencies at the federal and provincial MOHs, called the central executive unit at the federal level and provincial management units. The provincial management units,30 within the provincial MOHs, are in charge of purchasing health services from public providers using the resources received by the programme, and as such operate like a health insurance agency within the provincial MOHs.31 The federal MOH not only provided additional funds and agreed on goals with the provinces, but even more importantly, Programa Sumar strengthened the purchasing function in the provincial MOHs.

Another key element is the introduction of the first explicit health service package into the public health system through Programa Sumar, leading to clear entitlements by the population. Moreover, the health service package has also become a useful instrument for coordination across vertical programmes at the federal level, which often had worked in parallel with the subnational levels (provinces and municipalities). In this way, the Programme contributed not only to better alignment of provincial strategies with federal priorities but also to better alignment across vertical programme activities managed by the federal MOH.

Furthermore, the Programme has deepened decentralization by transferring decision-making authority to health facilities and fostering real change in the organizational culture. Now, all public health providers and their staff are able to participate in fund allocation decisions. The facility is the owner of and decides on the use of the funds it generate, and it bills the health services for the package of health services included in Programa Sumar. This allows for more discretionary allocation decisions at the facility level, and this dynamic is supposed to have a positive impact on their motivation.

Finally, Programa Sumar has enhanced the managerial capacities of provincial governments and health care providers. From a human resources perspective, new profesional profiles have been established, including economists, accountants, process engineering experts, among others, that all support a more strategic approach to financing. It also promoted the definition of areas of intervention and responsibility by developing the first federal roster of people.

30 Regarding the regulatory requirements, the provinces had to create the programme and its management unit at the provincial MOH. This was generally done through ministerial resolutions.
31 In the following, we will refer to them as provincial health insurance agencies.
The programme carried out a broad impact evaluation, assisted by the World Bank in 2011, covering not only service utilization and quality but also the impact on the health status of the beneficiary population. In terms of service utilization, studies have shown a number of improvements for beneficiaries. For instance, the probability of receiving the first prenatal care before the 13th week increased by an average of 8.5% throughout the provinces, and there was a rise of 17.6% in the probability of having the first prenatal care before the 20th week for pregnant women enrolled in the programme. For pregnant women enrolled by the programme, the number of prenatal check-ups increased by 17.3%. The likelihood of receiving the first three medical check-ups established by medical guidelines increased by 32.7% for infants of 45–70 days of life, by 21.5% for infants aged 70–120 days, and by 18.2% for infants between 120 and 200 days. More than 10,000 children and adolescents received surgery for congenital heart disease between 2010 and 2017, with a reduction in waiting times of 80% compared with 2009.

Moreover, the impact evaluation showed that the programme has had significant impacts on health status. For instance, the average infant birthweight increased by 70 g for those with programme coverage. The number of very-low-birthweight infants (lower than 1500 g) reduced by 26% and APGAR test scores improved. These achievements reduced early neonatal deaths, as the death risk for children covered by Programa Sumar fell significantly. At large maternity facilities, there was a reduction of 32% of newborn mortality, a decrease of 19% in the incidence of low birthweight (newborn babies of beneficiary mothers) and a decline of 74% in neonatal death (newborn babies of beneficiary mothers). The prevalence of stunting for children younger than 5 years was reduced by 45%, and prevalence of underweight decreased by 38%.

In terms of cost-effectiveness, evaluations of Plan Nacer’s phase concluded that it was highly cost-effective in the Argentine context, with an estimated cost per DALY of US$ 814, which is well below the GDP per capita of more than USD $6,075 over the period under analysis (2004-2008).

Finally, it is worth mentioning that during its inception in 2003 and 2015 the national IMR fell over 40% (from 16.5 in 2003 to 9.7 in 2015) and the IMR gap between the Northern provinces and the national rate was reduced by more than 35%. Programa Sumar was one of a group of national and provincial health policies that helped to achieve these positive results.

IMPROVED SERVICE UTILIZATION AND HEALTH OUTCOMES

that are only covered by the public system. It has improved the quality of clinical records and encouraged the development of electronic information systems to facilitate real-time monitoring of the use of health services by beneficiaries. Other new instruments that previously did not exist in the public health system include management and performance agreements, an explicit health service “basket” to allocate funds, costing exercises, audits and evaluation tools (which are further elaborated in Section 4).

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35 Authors’ estimate based on data from Dirección de Estadísticas e Información de Salud (DEIS, 2005, 2016b).
Programa Sumar operates within the existing institutional framework and federal arrangement and did not require a law to reassign decision-making rights between the federal and provincial levels.

The Programme developed its own regulations that were constantly updated, adapted and refined as the strategy evolved. The procedures of the Programme were carefully and clearly designed for strong internal consistency. The central executive unit has made continuous efforts to harmonize the different rules of the operations manual, in terms of definitions and supervision for example, to achieve a common interpretation of the rules and protocols across provinces, municipalities and their facilities, as well as by the external auditors.

In order to find the right balance between a set of fundamental and uniform rules for all provinces and the flexibility that every province should have to adapt the implementation of the programme to its particular context, the legal framework implemented by the federal MOH has two major components applying to each province:

1. **Umbrella Agreement:** This contract is non-negotiable for the provinces and defines clear rules and detailed procedures that comprise all key technical, financial, administrative and fiduciary roles and responsibilities. The umbrella agreement covers a five-year period to allow provinces sufficient predictability of the conditional budget transfers to develop the strategic purchasing function within the provincial MOH. For each phase of the Programme, the federal MOH defines a set of organizational, regulatory and health performance requirements to be met by each province as a condition for concluding the umbrella agreement with the Federal Government. These eligibility conditions were established to ensure a solid basis for the appropriate implementation of the programme. For instance, a province could expand the programme to adolescents and adult women so long as, among other pre-conditions, the province could demonstrate good health results for children and pregnant women and an adequate financial performance.

2. **Annual Performance Agreement:** This is the operational agreement and includes annual targets for the tracer system, enrolment, communication activities, training for providers, fee for service payment rates for the health service package as well as the workplan to improve health services for indigenous populations. These targets are negotiated province-by-province, allowing provinces to tailor the Programme implementation to their particular situations.
Table 2 summarizes the main functions and processes related to the interaction between the different Programme levels.

Table 2. Division of responsibilities and tasks between the different actors involved in programme implementation

<table>
<thead>
<tr>
<th>PROCESS</th>
<th>FEDERAL MOH</th>
<th>PROVINCE</th>
<th>PROVIDER</th>
</tr>
</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 rates (with the technical assistance of the central executive unit)</td>
<td>Provision and billing of health services</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 digitalization</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Definition of the tracer matrix</td>
<td>Monitoring provider performance</td>
<td>Self-assessment</td>
</tr>
<tr>
<td></td>
<td>Monitoring the financial and health performance of the Provincial Health Insurance and the participating providers</td>
<td>Consolidation of service data and elaboration of the performance report</td>
<td></td>
</tr>
<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>
</tr>
</tbody>
</table>

4.2. WELL-DEVELOPED CONDITIONS AND INSTITUTIONAL ARRANGEMENTS FOR THE RBF MECHANISM

BASIS OF DETERMINING THE TRANSFER AMOUNT AND CONDITIONS FOR THE USE OF FUNDS

A core element of Programa Sumar is the distinctive conditional results-based budget transfer arrangement between the federal MOH and provinces. The transfer amount
from federal to provincial levels is determined on the basis of: (1) enrolment and effective basic coverage (60%); and (2) achievement of health outcomes and outputs. These are further outlined in Table 3.

Table 3. Bases for budget transfer from the federal MOH to the provinces

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>VERIFICATION PROCESS</th>
<th>FINANCIAL PENALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Enrolment &amp; effective basic coverage:</strong></td>
<td>• Internal verification is done monthly, ex ante, and by electronic data validation of all records; no field visits are included.</td>
<td>• Debits and fines (20% of the debited amount) for all types of errors or inconsistencies (beneficiaries with explicit health coverage, duplication, incomplete data or inconsistent data).</td>
</tr>
<tr>
<td>• 60% of the transfer is based on the enrolment rate of the eligible population and to the provision of at least one essential health service in the last 12 months to each beneficiary.</td>
<td>• Counter-verification is conducted every 2 months, ex post, by an external auditor. Electronic data validation is done of all records and a risk-based sample is selected to ensure the existence of enrolment forms and the effective provision of the essential health service through which basic effective coverage is provided.</td>
<td></td>
</tr>
</tbody>
</table>

| Health outputs & outcomes:                    | • Internal verification is done monthly, ex ante, and by electronic data validation of all records; no field visits are included. | • Debits and fines (20% of the debited amount) for all types of error in the registry at the provincial level: duplication, incomplete data, inconsistent data, non-beneficiary population. |
| • 40% of the transfers is linked to the attainment of the 14 tracers measured every 4-month period. | • Counter-verification is conducted ex post every 4 months. Data validation is conducted for all records, and a risk-based sample of health facilities is selected (primarily facilities with higher numbers of patients). | • If a province does not meet the minimum threshold for 4 tracers, the federal MOH can suspend transfers and declare the province in violation of the Umbrella Agreement. |
| • Each tracer is specified by a set of mandatory indicators to assess the quality of the health service to be reported for each beneficiary. |                                                                                 |                                                                                     |
| • A linear, flexible and continuous payment function with thresholds is used, and different compensation levels are defined for each tracer on the basis of the complexity and effort required for its achievement. |                                                                                |                                                                                     |

Furthermore, the Federal MOH places conditions on how these transferred funds can be used and in relation to the role of province-level financing (see Table 4 for details). First, funds can only be used to purchase a specific set of health services (Health Service Package) provided from public facilities on a fee-for-service basis. Second, as of 2009, provinces have to co-finance 15% of the total capitation payments from their own resources.
The Programme’s RBF mechanism has been implemented in a dynamic manner, in line with what international experience suggests. Notably, the federal MOH has constantly evolved and improved its policy instruments to bring about changes in the management model and in the health services provided. The expansion of the programme in 2012 entailed several improvements in design to promote better results. Another key improvement is the requirement that provinces must both enroll the eligible beneficiaries to get the 60% of the capita tion on payment (as with Plan Nacer), and report at least one essential health service provided in the previous 12 months (effective basic coverage).

**REGULAR READJUSTMENT IN THE DESIGN AND IMPLEMENTATION**

The Programme’s RBF mechanism has been implemented in a dynamic manner, in line with what international experience suggests. Notably, the federal MOH has constantly evolved and improved its policy instruments to bring about changes in the management model and in the health services provided. The expansion of the programme in 2012 entailed several improvements in design to promote better results. Another key improvement is the requirement that provinces must both enroll the eligible beneficiaries to get the 60% of the capitation payment (as with Plan Nacer), and report at least one essential health service provided in the previous 12 months (effective basic coverage).

**TRACER MATRIX TO MEASURE PERFORMANCE**

The tracer matrix by which the Programme measures provincial performance had ten indicators in the Plan Nacer phase. With Programa Sumar, a new and more complex matrix was introduced using 14 tracers with the following features:

- **More demanding indicators**: Early detection of pregnancy is now measured before week 13 (with Plan Nacer it was measured at week 20).
- **New outcomes**: The programme has introduced an indicator to evaluate the

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**Table 4. Condition for budget transfer mechanism from the federal MOH to the provinces**

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>VERIFICATION PROCESS</th>
<th>FINANCIAL PENALTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Specific use of capitation transfers:</strong></td>
<td>• No internal verification.</td>
<td>• Debits and fines (20% of the debited amount) for each service purchased that does not fulfil the mandatory requirements.</td>
</tr>
<tr>
<td>• The funds can be used only by the provincial MOH to purchase from public facilities on a fee-for-service basis for the provision of a set of health services that are included in the health service package defined by the federal MOH.</td>
<td>• Counter-verification is conducted every 2 months. Data validation is conducted for all records, and a risk-based sample of health facilities is selected (primarily facilities with higher numbers of patients).</td>
<td>• Fine of 0.15% for each day of default.</td>
</tr>
<tr>
<td>• Providers must bill the services and provide bills to the Provincial Health Insurance within 4 months from the date of Service provision.</td>
<td>• Internal verification is done monthly through audits of all provincial bank accounts.</td>
<td></td>
</tr>
<tr>
<td>• Payments to providers must be made within a specified period (50 days after receiving the invoice from the facility).</td>
<td>• Counter-verification is conducted every 2 months for all provincial bank accounts.</td>
<td></td>
</tr>
<tr>
<td><strong>Co-financing:</strong></td>
<td>• Internal verification is done monthly through audits of all provincial bank accounts.</td>
<td>• Fines (0.1% out of the provincial transfer amount for each day of delay) and, if the delay exceeds 60 days, eventual suspension of transfers until the province transfers the default.</td>
</tr>
<tr>
<td>• The provinces have the duty to co-finance a predefined share (15%) of the capitation transfers with provincial resources.</td>
<td>• The provinces have to make their disbursement within 15 days after the transfer from the federal MOH has taken place at the specific bank account of the Provincial Health Insurance.</td>
<td></td>
</tr>
<tr>
<td>• The provinces have to make their disbursement within 15 days after the transfer from the federal MOH has taken place at the specific bank account of the Provincial Health Insurance.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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37 For a broader approach, see: Cashin C et al. (2014).
38 See Programa Sumar’s current tracers in Table 6 of the Annex.
survival of premature newborns with birthweight between 750 and 1500 grams.

- **Intra-provincial equity:** The programme now measures and rewards equity in connection with achieved coverage across the different regions in each province.

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**CO-FINANCING TO STRENGTHEN OWNERSHIP**

On an annual basis, the central executive unit of Programa Sumar revises the value of the per capita amount to be transferred to provinces.\(^39\) As said, the programme has also introduced a co-financing element, in that the provinces must pay 15% of the capitation transfers.\(^40\) As such, Programa Sumar is the first health programme in Argentina to be jointly financed by provincial and federal funds, and the aim of the federation and provinces is to align investments to reach common goals, and achieve sustainability and policy continuity.

The co-financing arrangement is verified periodically and penalties are applied if a province does not contribute accordingly. Penalties include an interest charge and potentially the suspension of transfers until the province complies, as outlined in Table 4. Some provinces find it difficult to comply with this obligation in a timely manner because of bureaucratic financial rules. However, in view of its financial incentives and the penalties that can be applied for noncompliance, Programa Sumar is less vulnerable to budget delays or cuts than other programmes.

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39 For the measurement of quality gaps, the methodology verifies the real use of the inputs defined by guidelines or the effective service provision by qualified human resources or by facilities that have the necessary equipment or technology.

40 For details on technical issues of the programme, see: Sabignoso M, Silva H, Curcio J (2014).
USE OF INTERNAL AND EXTERNAL AUDITS

Given the importance of provider performance verification in a RBF mechanism, the Programme introduced internal and external audits at both federal and provincial levels. The audits can be of three types: financial and legal audits, enrolment audits, and clinical audits. One of the key functions of audits is to recommend to the central executive unit the implementation of monetary penalties (i.e. debits and fines) in the programme’s rules. The monetary sanctions introduce further incentives to improve the quality and reliability of the information reported by the provinces and their providers while also helping to prevent opportunistic behaviour of providers.

The Programme’s external concurrent auditor is a private firm, hired by the federal MOH, whose opinion is independent and binding for the Programme at both federal and provincial levels. The participation of the external auditor has greatly contributed to building a strong control environment and transparency in the provinces. A distinctive feature of the audits is that they take place regularly and in parallel with Programme implementation. The external auditor acts as an impartial third party between the federation and the provinces.

It has fulfilled a fundamental role not only to guarantee the transparency of the Programme but also to legitimize the commitments between the federation and the provinces regarding implementation of the Programme. Although auditing fees can be high (approximately 6% of capitation transfers) they compensate for any deductions that may be applied to the provinces in terms of debits and fines. Beyond financial oversight, the audit function has broader positive externalities for the Programme, including:

- strengthening controls on the proper use of programme resources and preventing opportunistic behaviours;
- verifying and promoting the use of federal guidelines among healthcare providers;
- identifying opportunities to refine the regulatory framework;
- encouraging a two-way dialogue between programme implementers (federal and provincial MOHs) and health-care providers;
- acting immediately to make corrections in a more effective and timely manner; and
- mediating differences between the federation and the provinces.

4.3. DYNAMIC DEVELOPMENT OF THE HEALTH SERVICE PACKAGE

The capitation payments finance the incremental cost of the health service package, which is designed to ensure a minimum level of services for all the population without social health insurance coverage. The health service package is

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41 For further information, see: Perazzo & Josephson (2014).
42 As a general rule, the opinions issued by the firm are considered binding by the authorities of the programme, although there are a few exceptions such as an explicit error by the firm’s representative regarding a sanction on a province, or the submission by the province of a report justifying that the sanction requested by the firm is not appropriate. The third-party verifier’s report is written every two months (results of tracer verification are reported in every other report). There is regular discussion of the third-party verifier’s reports. Provinces involved can potentially participate in the clarification of the points established by the third-party verifier by submitting requests for clarification in accordance with the programme’s operations manual. The operations manual also states that the central executive unit can evaluate the opinions stated by the firm and act as the firm’s technical counterpart.
core to the RBF mechanism. A well-defined health service package facilitates the provider payment design, the development of performance indicators, costing, design of audit instruments, and identification of the human resources and infrastructure to be met by providers.

Box 1:

**The development of the first high-complexity federal network: integral coverage of congenital heart disease**

The sound implementation of Plan Nacer enabled its scope to be expanded in 2010 by including the full treatment of congenital heart disease, which is the one of the leading causes of infant mortality by birth defects in Argentina. This was an important milestone in the evolutionary process that was followed up by Programa Sumar.

Prior to 2010, financial and organizational barriers prevented nationwide access to timely and equitable treatment for congenital heart disease in the public sector. Interventions were insufficiently financed by many provinces; the lack of coordination led to unused capacity in some public hospitals and long waiting lists in others, especially in Buenos Aires. The goal of guaranteeing nationwide effective coverage to all patients required interprovincial coordination.

The federal MOH created a network of 16 surgical public hospitals (located in eight provinces), more than 50 diagnostic hospitals (at least one in each province), coordinated by a Federal Referral Coordinating Center. The complex heart disease surgeries are fully financed by the federal MOH through the Catastrophic Fund created and managed by Programa Sumar, while less complex surgeries are co-financed by the provinces. The need for a national solution to guarantee universal access required the provinces to delegate the selection of providers and the definition of rates to the federal MOH.

The main characteristics of the congenital heart disease care are:
- the creation of an explicit network with a Referral Coordinating Center;
- interprovincial agreements;
- performance-based contracting;
- transfer of additional resources based on the number of interventions;
- mandatory investment planning for participating surgical hospitals (to ensure that funds are effectively used to increase their productivity);
- implementation of a monitoring scheme that systematically measures organizational performance, productivity, outcomes and patient satisfaction.

The impact of the programme on improving congenital heart disease coverage was remarkable. Between 2010 and 2016, its diagnosis increased by 70% and in the neonatal subgroup by 100%. The average age at diagnosis was 30 months in 2011 and decreased to an average of 6 months in 2016. The surgeries increased by 70% and the average surgical age decreased from 11 to 6 months. Furthermore, population surveys showed high satisfaction with the services supplied by the federal network.

In a decentralized and heterogeneous health system as the Argentinian, universal coverage of complex and high-cost treatments can only be achieved if the Federal MOH intervenes to ensure sufficient funds while incentivizing a sustained collaboration among all subnational governments.

*Source: Authors’ estimate based on information from the Federal Referral Coordinating Center, November 2017.*

*44 For more information, see: Programa Sumar & FCE UNLP (2013) and Programa Sumar (2015a).*
Programa Sumar initially focused on a small number of prioritized services for pregnant women and children and then expanded coverage gradually by adding new population groups and health services. Currently, the Programme covers more than 700 health services organized in 52 care pathways, with each health service backed by clinical guidelines approved by the federal and provincial MOHs.

Although the federal MOH defines the health service package, Programa Sumar’s central executive unit has created mechanisms to negotiate with provincial counterparts about the scope and structure of the package. Revision of the package is undertaken through dialogue with stakeholders in the public sector, enabling the package to serve as a guide for agreements between the different institutional levels (federation, provinces, municipalities and providers), for design of a monitoring system and for greater accountability of stakeholders.

### 4.4. STRENGTHENING THE STRATEGIC PURCHASING FUNCTION OF THE PROVINCIAL MOHS

Prior to 2004, the provinces were passive purchasers who financed public services through input-based budget allocations that covered personnel, goods, services and other (mostly administrative) costs. To change this logic, the Programme complemented provincial budgets to health service providers with a fee-for-service payment in order to increase the provision of prioritized and underserved preventive services. To this end, the provincial management units enter into a management agreement with each public provider whose structure and scope are defined by the operational manual of the Programme.

While the provincial budget allocations are the main source of funding to public providers to provide the health service package, Programa Sumar provides additional resources to improve the quality and effective provision of those services. The provinces define the fee-for-service payment rates of the services included in the package and can revise them every six months. The central executive unit of the federal MOH provides provinces with technical guidance and useful information (e.g. the relative cost of package services to ensure that incentives are right) and is in charge of the final approval of payment rates (although this has generated tensions at times).

Provinces usually set higher fee rates for specific activities and health services such as the notification of risk factors or timely referral of high-risk pregnancy to higher level care maternities. The Programme also

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45 Argentina through Programa Sumar and Chile through AUGE-GES have explicitly prioritized certain services considered of the highest importance that coexist along with the traditional implicit rationing. In theory, in these systems all services are guaranteed, but some receive preferential treatment. This approach of explicitly guaranteeing certain benefits without explicitly denying others seems attractive in political terms, especially in Latin America, where constitutional law guarantees access to health and the explicit rationing of the offer is considered unacceptable from an ethical and social point of view.

46 This progressive expansion contrasts with other countries such as Mexico, where the “Seguro Popular” benefits package was, since its introduction, quite broad and comprehensive.

47 A care pathway is a comprehensive set of health services (promotion, prevention, treatment and rehabilitation) related to a specific disease (e.g. anemia, cancer or HIV) or health situation (e.g. pregnancy or malnutrition).

48 For the health service package Programa Sumar experience in perspective, see Sabignoso M, Silva H, Curcio J (2014).

49 See Programa Sumar (2014).

50 In 2010, personnel expenses represented on average 61% of total provincial expenditure on health.
allows the provinces to pay differential fees when certain quality attributes are met. For example, if the first prenatal care is provided before the 13th week, or if a pediatric check-up provides information on weight, height, percentiles, blood pressure and body mass index, the provider is paid a higher fee rate. Provinces are also allowed to pay rural providers a double rate in order to channel more resources to providers who are often underfunded.

Fee rates are an important tool, but certain conditions must be met by the providers, for example with respect to service provision, clinical training and billing and reporting. Inadequate fulfilment of these conditions by providers in some provinces has prevented the provinces from using fee-for-service payment as an effective tool to incentivise providers to increase the volume and quality of priority health services. An important lesson is that the fee-for-service payment method should go hand-in-hand with a more comprehensive strategy that considers administrative, motivational, training and communication aspects. Payment rate incentives can be undermined by poor communication of fee-setting policies, or contradictory messages from vertical programmes. The formulation by the provinces of their payment rate policies is still a managerial challenge for the programme. Several provinces have had policies with erratic criteria and have changed rates abruptly, sending confusing signals to healthcare providers.

Since fee-for-service payment may encourage the overprovision of unnecessary services, the Programme took measures to limit the number and frequency of each service of the health service package, based on protocols, with electronic billing systems automatically making this validation to prevent over-reporting. It also ensured strong control through audits and applied monetary penalties (debits plus fines) firmly.

At the outset of the Programme, providers were also paid a per capita fee for each beneficiary during his/her first year of enrolment in the program. The main reasons for this were to incentivise the identification and enrolment of the target population, to make resources flow rapidly to health facilities (and create confidence in the Programme) and to give provinces and providers time to develop the tools and capacities to report services.

### 4.5 STRENGTHENING ORGANIZATIONAL AND MANAGERIAL CAPACITIES IN THE PROVINCES

As said, dedicated management units were created within each province for operational and technical support to drive the process of change and manage intergovernmental relations. This enabled a degree of institutional autonomy at provincial level which helps explain how the Programme has been able to function for over a decade with a degree of insulation from administrative and political instability.51

The provincial management units are multidisciplinary teams whose main responsibilities are to identify and enroll beneficiaries, contract public providers, set payment rates, control the technical quality of care, audit and monitor the performance of providers, and ensure that the programme is financially sound. These units have also been instrumental in developing and implementing electronic billing systems, which have helped to prevent over-reporting and ensure accurate payment of fees.51

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51 While these arrangements ensured a more expedient process, they also could have isolated Plan Nacer from the federal and provincial MOHs. Although this seems to have been true during the early stages, the central executive unit at the federal level is now fully integrated with those areas of the federal MOH where overlap exists, such as the Maternal and Infancy Directorate. Further, the plan has become an important tool for these Ministry of Health areas to promote federal policies at the provincial level.
of services, and audit providers’ fulfilment of Programme rules. Between 2005 and 2015 the provincial management units were fully financed by the federal level. As of 2017, the federal MOH financed 50% of the staff and, as of 2018, provinces began to fully finance their units. However, transferring financial responsibility to the provinces poses challenges in terms of sustainability, because the provinces usually pay lower wages, which can affect morale and lead to attrition.

Nonetheless, these management units are one of the key strategic elements for Programme implementation. The Programme promotes a change in the management model, which entails hiring people that are specifically in charge of the strategic purchasing function. From the outset, the federal MOH was aware that improving the purchasing function depended on the development of new skills and competencies for the provincial MOHs and their providers. Although RBF can encourage improvements in the organizational culture, targeted action and support is needed to ensure all competencies within the system are built. To this end, the Programme developed an ambitious training programme for provincial teams and health providers. Between 2004 and 2015, over 110,000 people were trained throughout the country. Additionally, the central executive unit deployed supervisory teams to monitor and support the implementation process in the provinces and to sustain a close dialogue with provincial teams. Several regional and federal meetings are held each year to evaluate progress, adjust the implementation plan and encourage a cross-learning process between provinces.

The sustainability of the two-fold RBF mechanism requires strong and qualified provincial teams as well as coherent integration with the rest of the organization. Every year each provincial management unit has to develop a joint workplan with other health programmes as a mandatory component of the Performance Annual Agreement jointly agreed with the federal MOH.

4.6 BUILDING THE INFORMATION MANAGEMENT SYSTEMS

At the design stage, the central executive unit assessed the routine information systems of all provinces to ensure compatibility with the Programme’s data requirements. However, no mechanisms were available for the timely collection of digitalized data from the primary health care network in any of the provinces. Through its incentives, the Programme was the key enabler for the development of IT systems to track the effective coverage of preventive health services in the public network. The strategy of the federal MOH was to define a clear and manageable set of data, to respect local IT developments without imposing specific tools, and to place the right incentives at the provider level to encourage the collection and timely reporting of the required data. Provinces were offered technical assistance and there was a concerted effort to align data entry with that of other federal MOH programmes.

52 The central executive unit created different instruments to track the implementation process of the programme in each province. This is the case of the Provincial Performance Index that has three components or dimensions (financial, organizational and health performance) and more than 20 indicators.
Providers need to have some say in management decisions in order to respond to incentives and meet people’s health needs more efficiently. Accordingly, Programa Sumar is flexible with respect to how provider can use the resources they receive. Funds can be used in a flexible way across broad budget categories defined by the provincial MOH or the municipality (such as equipment, infrastructure, inputs, human resources or monetary incentives). The facility is the “owner” of the funds it generates by providing and billing for the health package services. The only rule set by the federal MOH is that spending on staff incentives cannot exceed 50% of the total funds. Currently, 14 provinces allow providers to use Programme funds to reward staff on the basis of performance.

The facility may manage its own accounts or may have them managed by a third party. In the latter case, an agreement must be signed between the provincial management unit, the provider (in all cases a primary health centre), and the third party (a public institution, such as a hospital, the municipality or the provincial MOH) that administers the funds. The administrator carries out the procurement of goods and services that the provider defines. This task is performed free of charge (i.e. the administrator cannot charge any commission). The third-party administrator can use the funds only with the explicit written authorization of the provider. Noncompliance can result in the suspension of transfers and potential termination of the agreement. Nonetheless, this process

4.7 EXPANDING FINANCIAL AUTONOMY TO PUBLIC HEALTH PROVIDERS

The creation of an IT department within each provincial management unit was crucial to the development of the electronic billing system in all provinces. Initially, the billing process was paper-based, but over time each province developed its own IT system for billing with technical assistance from the central executive unit. Today almost 95% of services are billed online. This system has enabled real-time monitoring of effective coverage levels for each beneficiary of Programa Sumar. The Programme has successfully created a culture to generate, use and analyse data on health service utilization across provinces. However, there is still room to further develop the interoperability with other information systems implemented by traditional vertical programmes so as to reduce the administrative burden on providers.

As a result, the Programme developed a rich health database with timely information on service utilization in all provinces. For instance, on the basis of systematic collection of anthropometric data, the federal MOH can regularly follow-up the nutritional status of all children enrolled in the Programme. The Universal Child Allowance (a conditional cash transfer system for children and adolescents) uses the information of Programa Sumar to verify the fulfillment of health requirements such as check-ups and vaccinations.

often faces challenges as provinces may find ways to limit the financial autonomy of providers by placing additional bureaucratic procedures on them.

In recognizing challenges faced by providers in explicitly defining eligible expenditure categories in accordance with priority goals and budget execution, the central executive unit created a management tool, that is the “Production and Investment Plan” (PIP). The PIP is meant to support providers in using their resources more efficiently. With this tool, health facilities can plan their health service production, estimate their revenues and prioritize fund allocation. The tool allows health teams to keep up to date on the contents of the health service package and its rates of payment. In addition, the PIP serves as an institutional communication tool that enables dialogue on productivity, health performance and financial management between the provincial MOH and its public provider network. Despite some positive feedback by provinces on this tool, its use is still modest as it is not mandatory and entails a demanding training process and close support for its proper use by providers.
5. CONCLUSIONS

5.1 LESSONS LEARNED

Programa Sumar has shown that intergovernmental transfers linked to results can make significant contributions to improve the institutional performance and outcomes of a health system. The federal MOH pursued this process of transformation in the provinces by providing additional resources linked to results, creating stable and predictable incentives, defining accomplishable rules, and offering autonomy and technical assistance to strengthen local decision making.

By implementing a RBF mechanism, the Programme helped strengthen the stewardship function of the federal MOH and led to better coordination with subnational governments. The Programme also strengthened the role of provincial MOHs as purchasers and established conditions for decision-making and resource allocation. The effectiveness of this system depends, to a large extent, on the implementation of a robust auditing scheme that guarantees the veracity of reported results and ensures equity and transparency across provinces.

A key lesson is that intergovernmental transfers should define some basic conditions for the use of resources in order to ensure that subnational governments allocate them in line with the intended results. This has to be done in a way that does not affect provincial managerial autonomy, and hence allows different strategies to be taken to improve their performance.

Engaging provinces in the design phase of Plan Nacer was important for developing a framework that could be easily adapted to match the distinctive features of the different provinces. It helped to foster a sense of ownership by provincial authorities, which facilitated and accelerated implementation. An intense implementation process by the Federal MOH was also needed to support provincial management units (in particular in low-performing provinces), to verify compliance with Programme rules and to allow for adaptive and evolving change.

Programa Sumar expanded incrementally, allowing the federal MOH to learn from experience and adjust its strategy to an ever-changing context. The Programme’s principle of defining some core rules while providing flexibility has enabled the federal MOH to manage provincial diversity effectively.

Provider autonomy to allocate funds was one of the most critical changes that the Programme introduced. The promise of additional financial resources facilitated the acceptance by provincial MOHs to devolve this authority. The new power of providers to decide how to use the funds has proven essential in increasing the volume and quality of priority health services as health facilities have more influence over the processes they manage. This also enhanced provider motivation. Nonetheless, provider autonomy should be clearly delineated and supervised by the provincial MOHs to ensure
alignment with local priorities and budget policies.

An important accomplishment of Programa Sumar is its rigorous evaluation agenda that has served as a guide for improving its design and implementation. In the near future, the Programme should broaden the scope of its evaluations by combining different methodologies to assess, for instance, the effect of the health service package fee rates in provider decision-making, the different models of financial incentives for health teams, and the programme’s impact on untargeted services.54

In conclusion, federal transfers can help to equalize resources, incentivize better performance and strengthen essential functions of the health system. Programa Sumar showed that it is possible to meet the immediate needs of the poor while introducing ambitious innovations in a federation’s financing system through conditional transfers based on RBF.

5.2 CHALLENGES AND NEW OPPORTUNITIES FOR PROGRAMA SUMAR

While Programa Sumar has made great contributions to the government health sector in Argentina, there remain some important challenges.

In particular, provincial MOHs could improve their understanding and use of the strategic purpose of the Programme. In some cases, it is still seen as one a federally-driven programme that transfers resources to provinces, rather than as a policy that pursues a new financing architecture. There are two main reasons for this: first, provincial MOHs generally still do not see themselves as purchasers and, second, improvements in payment methods are demanding, both institutionally and technically. Further high-level and strategic discussions about the intended purpose of the Programme are needed and, to this end, the Federal Health Council is the ideal arena to broaden the debate. In the federal context of Argentina, policy coordination and sustainable improvements cannot be achieved without a common and shared vision.

Additionally, there needs to be better coordination of the Programme with the budgetary policies of the provincial MOHs.55 Two initiatives that could be encouraged are: (i) the incorporation of additional health services into the health service package to complement it, fully financed with provincial resources; and (ii) the definition of a single, strategic investment framework for both budgetary resources and the additional funds provided by the Programme.

There is a question of whether the provincial management units would be better placed within the financing departments of MOHs, rather than as a separate, vertical programme. When the Programme began, the priority for the federal MOH was to coordinate closely with vertical plans, foremost the Maternal and Child Health programme. Nonetheless, this decision could have affected the potential of greater integration with the provincial budgetary policies.

54 Programa Sumar has conducted a broad research agenda. See: Programa Sumar (2013a, 2013c, 2013d, 2013b, 2015b).
55 See: Soucat A et al. (2017).
From the beginning, the financial support of the World Bank was key to initiating and sustaining the process of change. Almost 15 years since it was launched, however, a more profound institutionalization of the Programme requires both domestic revenues, as well as domestic systems, including strong public financial management, to support continued implementation. The role of external financing has meant that the provincial management units have in some ways been established as vertical programmes rather than as integrated parts of the provincial MOH financing arrangements.

Moreover, achieving similar levels of performance across provinces remains a challenge. As a result, federal policies need to focus on provinces with poorer performance by defining ad hoc support plans. To do so, the programme will need help provinces to overcome structural constraints.

Discussions on the scope of the health service package were led by the central executive unit of Programa Sumar. As difficult decisions will need to be made about future expansion, there is an opportunity to formalize the prioritization process and methodology. The programme can continue to evolve by incorporating into the health service package secondary prevention services for noncommunicable diseases, which cause some 80% of the burden of disease in the country. This will require careful consideration of the provider payment mechanism in order to create appropriate incentives to encourage integrated and continuous care. The federal and provincial MOHs should also consider incorporating changes in the way hospitals are paid through the implementation of more strategic purchasing schemes at this level. The programme also needs to explore better ways to purchase services from providers with limited capacity who are located in disadvantaged areas with vulnerable target populations. Currently these providers face constraints due to the level of funding needed to substantially improve the health of their patients.

In conclusion, the implementation of Programa Sumar has been an iterative process entailing gradual expansion, continual readjustment, and careful coordination across levels of government as well as functions of the health system. This step-wise approach that incorporated financing, regulatory, organizational, and service delivery elements with a strong monitoring and evaluation framework underscores the multi-faceted nature of health financing reform. These processes are still ongoing as Argentina works to expand effective coverage to the entire population. The foundation that has been set by Programa Sumar is now considered as a platform for establishing provincial public health insurance schemes with comprehensive benefit packages. As such, the Programa Sumar experience can provide an important model for other countries, particularly with devolved settings, seeking to expand access to quality health services. It is an interesting and insightful case that shows how, through a careful mix of financial levers and regulatory measures, a national-level reform has been effectively implemented by provinces and providers.


Programa Sumar. (2013a). Análisis del proceso institucional de generación de una política social de impacto multisectorial: el Plan Nacer y la Asignación Universal por Hijo y por Embarazo.


7. ANNEX OF FIGURES AND TABLES

Figure 5. Map of Argentina

Table 5. Distribution of fiscal powers between the Federal State, the provinces and the municipalities

<table>
<thead>
<tr>
<th>Expenditures</th>
<th>Decision-making authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>National defence</td>
<td>N</td>
</tr>
<tr>
<td>Foreign affairs</td>
<td>N</td>
</tr>
<tr>
<td>Foreign trade</td>
<td>N</td>
</tr>
<tr>
<td>Macroeconomics</td>
<td>N</td>
</tr>
<tr>
<td>Social security</td>
<td>N-P-M</td>
</tr>
<tr>
<td>Registry of persons</td>
<td>N</td>
</tr>
<tr>
<td>Transportation</td>
<td>N-P</td>
</tr>
<tr>
<td>Interprovincial roads</td>
<td>N</td>
</tr>
<tr>
<td>Provincial roads</td>
<td>P</td>
</tr>
<tr>
<td>Communal and local roads</td>
<td>M</td>
</tr>
<tr>
<td>University-level education</td>
<td>N</td>
</tr>
<tr>
<td>Secondary education</td>
<td>P</td>
</tr>
<tr>
<td>Primary education</td>
<td>P</td>
</tr>
<tr>
<td>Evaluation of education</td>
<td>N-P</td>
</tr>
<tr>
<td>Health services</td>
<td>P</td>
</tr>
<tr>
<td>Internal security</td>
<td>P</td>
</tr>
<tr>
<td>Drugs and narcotics</td>
<td>N-P</td>
</tr>
<tr>
<td>Water and sewerage</td>
<td>P-M</td>
</tr>
<tr>
<td>Recreation and parks</td>
<td>N-P-M</td>
</tr>
<tr>
<td>Fire protection</td>
<td>P-L</td>
</tr>
<tr>
<td>Environment</td>
<td>N-P-L</td>
</tr>
<tr>
<td>Urban services</td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Imports and exports</th>
<th>Tax power</th>
</tr>
</thead>
<tbody>
<tr>
<td>National defence</td>
<td>N</td>
</tr>
<tr>
<td>Incomes</td>
<td>N</td>
</tr>
<tr>
<td>Value added</td>
<td>N</td>
</tr>
<tr>
<td>Private assets</td>
<td>N</td>
</tr>
<tr>
<td>Gasoline</td>
<td>N</td>
</tr>
<tr>
<td>Wages</td>
<td>N</td>
</tr>
<tr>
<td>Gross income</td>
<td>P</td>
</tr>
<tr>
<td>Urban-rural property</td>
<td>P</td>
</tr>
<tr>
<td>Vehicles</td>
<td>P</td>
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<tr>
<td>Stamps</td>
<td>P</td>
</tr>
<tr>
<td>Royalties</td>
<td>P</td>
</tr>
<tr>
<td>Local sales rate</td>
<td>M</td>
</tr>
<tr>
<td>Local property rate</td>
<td>M</td>
</tr>
<tr>
<td>Others</td>
<td>N-P-M</td>
</tr>
<tr>
<td>Co-participation transfers</td>
<td>N-P</td>
</tr>
</tbody>
</table>

N = national;  
P = provincial;  
M = municipality.

Source: Adapted from Asensio (2015).
Figure 6. Distribution of total health expenditures in Argentina (2014–2015)


Source: Adapted from Cetrángolo O (2014).


Table 6. Distribution of decision-making powers in the health sector between the Federal State and the provinces

<table>
<thead>
<tr>
<th>Federal powers</th>
<th>Provincial powers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and design of federal preventive programmes</td>
<td>Administration of hospitals and public health facilities</td>
</tr>
<tr>
<td>Financing and distribution of social assistance programmes</td>
<td>Local administration of federal preventive programmes</td>
</tr>
<tr>
<td>Regulation of federal social insurance organizations</td>
<td>Administration of provincial social insurance organizations</td>
</tr>
<tr>
<td>Coverage of pathologies of low incidence and high cost</td>
<td>Local attention of federal social assistance programmes</td>
</tr>
<tr>
<td>Administration of INSSJyP* in all jurisdictions</td>
<td>Institutional relationships with local provider associations.</td>
</tr>
<tr>
<td>Laboratories of research and production</td>
<td>Regulation of the power of sanitary and bromatology policy</td>
</tr>
<tr>
<td>Regulation of pharmaceutical and technological policy</td>
<td>Regulation of licensing and authorization of private services</td>
</tr>
</tbody>
</table>

* INSSJyP: Instituto Nacional de Servicios Sociales para Jubilados y Pensionados

Source: Arce H (2012).
Table 7. Tracers of Programa Sumar

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>Early pregnancy care</td>
</tr>
<tr>
<td>2</td>
<td>Pregnancy follow-up</td>
</tr>
<tr>
<td>3</td>
<td>Effectiveness of neonatal care</td>
</tr>
<tr>
<td>4</td>
<td>Follow-up of children under 10 years of age</td>
</tr>
<tr>
<td>5</td>
<td>Intraprovincial equity in the follow-up of children under 10 years of age</td>
</tr>
<tr>
<td>6</td>
<td>Detection capability of congenital heart disease in children under 1 year of age</td>
</tr>
<tr>
<td>7</td>
<td>Colorectal cancer prevention</td>
</tr>
<tr>
<td>8</td>
<td>Immunization coverage at 24 months</td>
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<tr>
<td>9</td>
<td>Immunization coverage at 7 years of age</td>
</tr>
<tr>
<td>10</td>
<td>Follow-up of adolescents between 10 and 19 years of age</td>
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<tr>
<td>11</td>
<td>Promotion of health rights and health care</td>
</tr>
<tr>
<td>12</td>
<td>Prevention of uterine cervical cancer</td>
</tr>
<tr>
<td>13</td>
<td>Breast cancer care</td>
</tr>
<tr>
<td>14</td>
<td>Evaluation of the attention process of cases of maternal and infant death</td>
</tr>
</tbody>
</table>

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