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## Increasing Utilization of Health Care Services among the Uninsured Population: The Plan Nacer Program

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**Argentina**  
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the Uninsured Population: The Plan Nacer Program**

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## **The World Bank’s Universal Health Coverage Studies Series (UNICO)**

All people aspire to receive quality, affordable health care. In recent years, this aspiration has spurred calls for universal health coverage (UHC) and has given birth to a global UHC movement. In 2005, this movement led the World Health Assembly to call on governments to “develop their health systems, so that all people have access to services and do not suffer financial hardship paying for them.” In December 2012, the movement prompted the United Nations General Assembly to call on governments to “urgently and significantly scale-up efforts to accelerate the transition towards universal access to affordable and quality healthcare services.” Today, some 30 middle-income countries are implementing programs that aim to advance the transition to UHC, and many other low- and middle-income countries are considering launching similar programs.

The World Bank supports the efforts of countries to share prosperity by transitioning toward UHC with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, successful implementation requires that many instruments and institutions be in place. While different paths can be taken to expand coverage, all paths involve implementation challenges. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Study Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the *nuts and bolts* of programs that have expanded coverage from the bottom up—programs that have started with the poor and vulnerable rather than those initiated in a trickle-down fashion. The protocol consists of nine modules with over 300 questions that are designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following: (a) manage the benefits package, (b) manage processes to include the poor and vulnerable, (c) nudge efficiency reforms to the provision of care, (d) address new challenges in primary care, and (e) tweak financing mechanisms to align the incentives of different stakeholders in the health sector. To date, the *nuts and bolts* protocol has been used for two purposes: to create a database comparing programs implemented in different countries, and to produce case studies of programs in 24 developing countries and one high-income “comparator,” the state of Massachusetts in the United States. The protocol and case studies are being published as part of the UNICO Studies Series, and a comparative analysis will be available in 2013.

We trust that the protocol, case studies, and technical papers will provide UHC implementers with an expanded toolbox, make a contribution to discussions about UHC implementation, and that they will inform the UHC movement as it continues to expand worldwide.

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UNICO Studies Series Task Team Leader  
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## **Abbreviations**

FESP	Essential Public Health Functions
GDP	gross domestic product
MOH	Ministry of Health
PBS	Package of Basic Services
PIU	Provincial Implementation Unit
PMU	Project Management Unit

## Executive Summary

With the Argentine economic crisis in 2001, the population living in poverty increased dramatically, inequity worsened, and more people became medically uninsured. As a result, health indicators, including child and maternal mortality rates, deteriorated sharply in the poorest regions, and national averages worsened. In response, the Government of Argentina implemented the innovative Maternal-Child Health Insurance Program, known as *Plan Nacer*, which helped to introduce innovative changes in Argentina's health system. Plan Nacer became a powerful tool in increasing coverage of basic services among the uninsured population and improving the governance and efficiency of the health system.

Plan Nacer aimed to reduce the maternal and child mortality of uninsured pregnant women and children through highly innovative results-based financing mechanisms at the national, provincial, and provider levels. Specifically, the program links funding to the achievement of three types of results indicators: enrolment in the program, effective delivery of priority health services, and health outcomes. In addition, Plan Nacer contributed to strengthening the governance and stewardship function of the national government in a federal context where health services provision is decentralized at the provincial level. These instruments comprise legally binding contracts between the national government and the provinces and between the provinces and health service providers, and encompass a robust monitoring and evaluation framework, which includes external and internal audits and an impact evaluation strategy.

Interim results from an impact evaluation study conducted in Misiones and Tucuman provinces indicate positive outcomes during the program's first years of operation. Specifically, the study found that the program increased the probability of a first prenatal care visit before week 13 and week 20 of pregnancy. The number of prenatal visits increased, and women also benefited from an improved quality of care, measured by increases in the likelihood of vaccinations and ultrasounds. The improvement in the quantity and quality of services translated into healthier births, an increase in average birth weight, and a decrease in the likelihood of children being born with very low birth weight. Finally, for children under five, the program raised the likelihood of well-baby checkups.

Drastic reforms were not the key to the success of the program. Instead, the major contributing factors were the strategic use of financing to enroll and maintain contact with the target population, contracts with built-in enforcement mechanisms, and a results-based approach that provided incentives for desirable results. All were within the framework of an existing health care network that had previously failed to function effectively for the uninsured population.

In the future, programs supporting the universal health care strategy in Argentina will need to consider the remarkable lessons of Plan Nacer. The shift from a traditional, input-based financing scheme to a results-based financing approach helped increase access to basic health services and strengthen governance of the entire public health system. However, these will have to be complemented with the development of sound health information systems, monitoring and evaluation tools to assess health sector performance, clinical protocols, addressing issues of program sustainability, equity across provinces, and the need to establish a standardized process for setting priorities that includes clinical and cost-effectiveness studies and social validation mechanisms.





## 1. Introduction

This paper describes the functioning and performance of Argentina's Provincial Maternal and Child Health Investment Program, commonly referred to as *Plan Nacer*. The program is aimed at increasing access—for uninsured pregnant women and children under six years old—to a basic set of health services known to effectively address the main causes of maternal and child mortality, while improving the effectiveness and efficiency of the health system. The program supports the development and implementation of publicly funded provincial maternal and child health insurance and the introduction of highly innovative results-based financing mechanisms at the national, provincial, and provider levels. Since its launch in November 2004, Plan Nacer has provided health coverage to more than 4.5 million pregnant women and children and has funded more than 35 million health services delivered to program beneficiaries. By April 2012, the number of beneficiaries was around 1.84 million, representing 89.7 percent of the eligible population. Thus, the program has substantially contributed to expanded health coverage among the most vulnerable.

Plan Nacer was designed to respond to some of the consequences of the devastating 2001 economic crisis, which resulted in a considerable rise in the number of vulnerable people without explicit health coverage. The 2001 economic crisis substantially affected the health status of the vulnerable and uninsured population, the demand for health services, and the capacity of the health system to deliver these services. This situation created the opportunity for the national government to strengthen its stewardship role under a decentralized framework where provinces are responsible for providing health services within their jurisdiction.

The program sought to increase the demand for health services through a public sector that has suffered from efficiency challenges, and where health indicator performance was worsening. As a result of the crisis, gross domestic product (GDP) fell by 18.3 percent from 1998 to 2002, and the number of poor people grew dramatically by up to 20 percentage points. With rising unemployment and job layoffs, up to 12 percent of workers lost their health insurance coverage. The drastic drop in employment left roughly 60 percent of the population outside the social health insurance system, considerably increasing the financial and service provision burden on provincial governments through the public health sector. The crisis also made more evident the systemic problems underlying Argentina's health sector.

Even before the crisis, Argentina performed below other middle-income countries in the region despite higher health expenditure levels (World Bank 2011). In addition, the sharp fall in income and rise in poverty caused by the crisis resulted in the deterioration of health indicators, as illustrated by a reversal in the declining trend in infant mortality that rose from 16.6 per 1,000 in 2000 to 16.8 per 1,000 in 2002. This situation was even worse in the more relatively disadvantaged provinces located in the north of the country, where the infant mortality rate was 25 per 1,000. Alarming, studies revealed that most infant and maternal deaths in Argentina could have been avoided through timely prevention, diagnosis, and treatment.

The Government of Argentina prioritized investments in the health sector as part of its strategy of poverty alleviation. The national Ministry of Health (MOH) allocated resources to the expansion of access to and quality of health services to vulnerable populations using Plan Nacer

as a key instrument for improved health coverage and results, and improvements in efficiency in the health sector system. The program's first objective was to halt increases in infant mortality, and then to further reduce it by 20 percent at the national level and by at least 30 percent in the Northern provinces within 10 years. The second objective was to modify the dynamics of financing and providing health care services at the provincial level, primarily by changing the incentive structure associated with federal funding to provinces, given that provinces are responsible for delivering health care services within their jurisdiction and managing their own budgets and resource allocation.

The Maternal-Child Health Insurance Program was one of the central pillars of a broader and integrated package of pro-poor policy reforms intended to increase the availability of health care services and effectiveness of public subsidies directed to the uninsured. To achieve this objective, Plan Nacer introduced results-based financing mechanisms that promoted a new incentive framework for financing and providing health care services that rewards providers for increased health care coverage, delivery, and staff productivity. Thus, by moving away from a traditional health care system based on inputs and fixed budgets to one geared toward outputs and results, the program contributed to improved health service utilization and health status of the eligible population. This success suggested a promising model of incentives to be considered for other priority areas of the Argentine health care system and the rest of the world.

The program operates within the existing institutional framework, with federalism as the main pillar. The relationship between the national government and provincial governments in terms of provision and funding of health services through the public sector has not been substantially modified due to the implementation of Plan Nacer. Provinces continue to be responsible for delivering (and funding) health services within their jurisdiction, while the national government is in charge of health system coordination. Likewise, before and after Plan Nacer, public health providers are funded by the provincial governments through a line item budget that covers salaries, medical supplies, and equipment and maintenance, as well as other relevant operating costs.

With the introduction of Plan Nacer, public health providers receive additional funds based on the number of health services provided to the program's beneficiaries. Thus, the program operates on top of the system promoting innovative features that are aimed at improving the utilization of basic health services for the poor. Specifically, the program introduces a chain of incentives that includes all the main stakeholders involved in the provision of health services in the public sector, giving the right incentives to pursue the program objectives and introducing, for the first time, payment mechanisms (linked to results).

This document is organized as follows. Section 2 provides an overview of the Argentine health care system, including a description of public health, primary care, and supply-side efforts, to put in context the implementation of Plan Nacer. Section 3 presents a detailed description of the main features of the program, including the institutional architecture; the targeting, identification, and enrolment of beneficiaries; the management of the program's funds and benefits package; and the information environment of Plan Nacer. Section 4 provides a discussion of the highly innovative results-based financing mechanisms included in the design of the program. Section 5 draws some conclusions on the pending agenda and challenges ahead.

## **2. General Health System Overview**

The Argentine health system is highly fragmented both horizontally and vertically. It is composed of social security and the public and the private subsystems that provide health services. Formal workers, retirees, and their families have health insurance through the social security subsystem, while people who can afford the payment of a voluntary health insurance premium are covered through the private sector. The public sector's services are aimed at all inhabitants of the country, although it is used mostly by people without social or private health insurance (commonly the poor). Each of the subsystems is organized and operates differently, since they are ruled by their own specific regulations. The social security subsystem is further fragmented into hundreds of insurers. Most of them are National Social Health Insurance Organizations (Obras Sociales Nacionales), which are regulated by the Health Insurance Superintendence. However, provinces regulate the Provincial Health Insurance Organizations (Obras Sociales Provinciales) for civil servants and their families within their jurisdiction.

In addition to this horizontal fragmentation, Argentina's federal structure assigns responsibilities related to health service provision to the provinces. While this allows for greater efficiency and local adaptation in the delivery of individual health services, it has posed a complex challenge for national health policy formulation and implementation. The national MOH is responsible for sector coordination through the Federal Health Council, setting and enforcing quality standards and regulations, as well as the traditional areas of national public health. In the last decade, the MOH has succeeded in developing tools such as Plan Nacer to influence provincial policy from the national level, and thereby offset its limited legal and administrative capacity to achieve objectives.

### **Financing and Delivery Mechanisms**

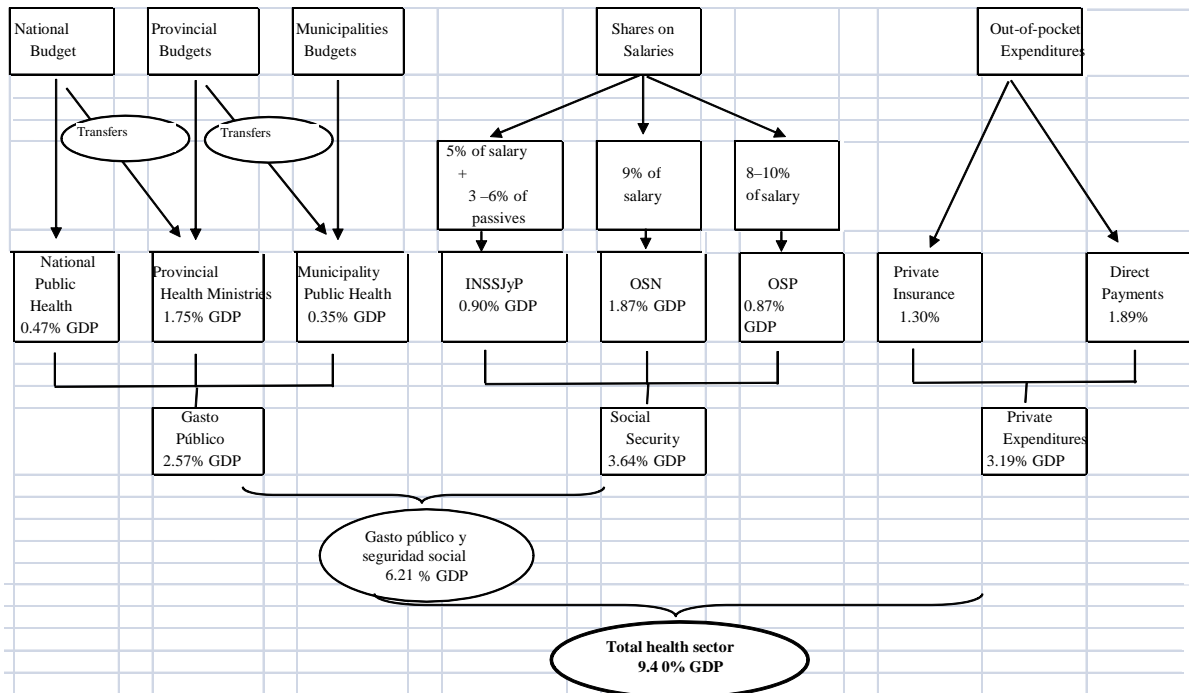
Health sector expenditure is financed by households, social security, and the public sector. According to a United Nations Development Programme estimation (Argentina UNDP-OPS-CEPAL), total health expenditure represents 9.4 percent of total GDP, of which 33.9 percent is funded by households, 38.7 percent is financed by the social security sector, and the remaining 27.3 percent is financed by the national, provincial, and local public sector (Cetrángolo and Goldschmit 2012) (table 1). Households finance health service provision through out-of-pocket expenditures, which are mainly directed to drugs, copayments, or private health insurance. Social security is funded mainly through payroll taxes from formal workers, while the public sector finances health service delivery with budgetary resources from general taxes. Given that provinces are responsible for health service provision, provinces account for 68 percent of the public expenditure on health, while the national government funds around 18 percent (figure 1). Although Argentina's tax structure consists of taxes collected from the national level, a substantial portion is transferred to provincial governments through different distribution schemes, as established by the Federal Sharing Regime Tax (Cetrángolo and Jimenez 2004).

**Table 1 Health Expenditure, Argentina, 2009**

	<b>% of GDP</b>	<b>%</b>
<b>Public Health Expenditure (1)</b>	<b>2.57</b>	<b>27.3</b>
National	0.47	
Provincial	1.75	
Local	0.35	
<b>Obra Social Expenditures (2)</b>	<b>3.64</b>	<b>38.7</b>
<i>Obras Sociales Nacionales</i>	1.87	
Institute of Social Services for Retirees and Pensioners (INSSJyP)	0.90	
<i>Obras Sociales Provinciales</i>	0.87	
<b>Public Sector and Obras Sociales Subtotal (1)+(2)</b>	<b>6.21</b>	<b>66.1</b>
<b>Private Health Expenditures (3)</b>	<b>3.19</b>	<b>33.9</b>
<b>Total Health Expenditures (1) + (2) + (3)</b>	<b>9.40</b>	

Source: Cetrángolo and Goldschmit 2012.

**Figure 1 Health Sector Financing and Organization in Argentina (in % GDP; in % total sources)**



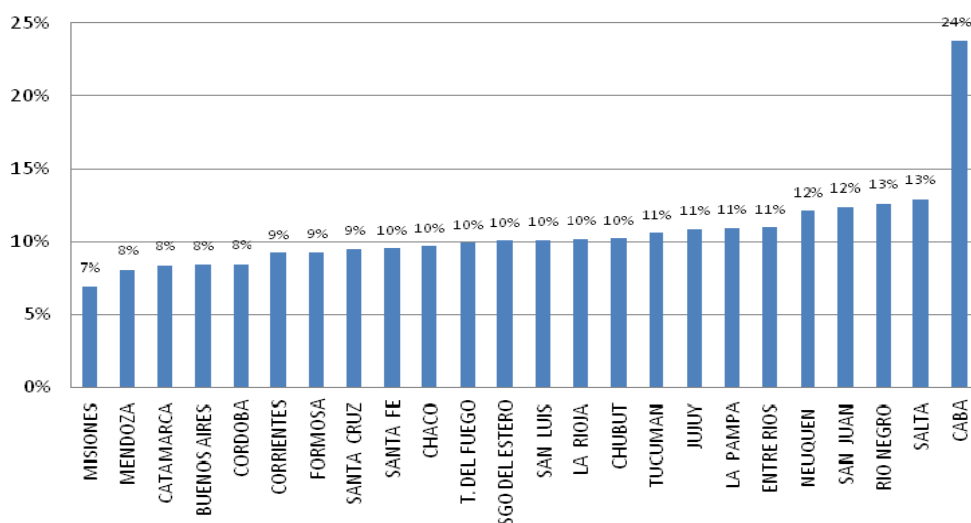
Source: Cetrángolo and Goldschmit 2012.

Note: INSSJyP = Institute of Social Services for Retirees and Pensioners; OSN = National Social Health Insurance Organizations; OSP = Provincial Health Insurance Organizations.

Total public expenditure on health on the provincial level increased proportionally between 2003 and 2009. In nominal terms, expenditure on health increased substantially, from US\$7.3 billion in 2003 to US\$30 billion in 2009. Health expenditure remained the second-most-relevant investment, after education. On average, around 16 percent of total provincial expenditure was dedicated to health during 2003–09. There are major differences in the portion of total

expenditure directed toward health between the provinces: the city of Buenos Aires spent an average of 24 percent of its budget on health between 2002 and 2009, while Misiones spent only 7 percent. The remaining provinces varied from 8 percent to 13 percent (figure 2).

**Figure 2 Health Expenses as Percentage of Total Health Expenditures  
(Excludes expenditures from Obras Sociales)  
Average 2002–09**



Source: Sanguinetti 2012.

Provincial public expenditure on health covers expenses for personnel, goods and services, and other (mostly administrative) costs. In 2010, personnel expenses represented 61 percent of total provincial expenditure on health. Around 27 percent was spent on goods and services, and the remaining was spent on other costs. To fully analyze resource allocation, it is necessary to decompose the spending of a number of entities in the past several years: the City of Buenos Aires, and the provinces of Buenos Aires, Santa Fe, and Córdoba. The number of medical workers did not change largely between 2007 and 2010. However, there were substantial increases in salaries for medical workers during the same period. Between 2007 and 2010, the increase in health expenditure per province can largely be explained by an increase in employee salaries (Sanguinetti 2012).

Health service delivery is carried out by the three subsystems. The public sector finances and provides health services through the 24 provincial ministries of health and that of the Autonomous City of Buenos Aires, plus the national MOH. The first level of care is managed mainly at the provincial level, but also by local authorities, though to a lesser extent. Notwithstanding this, there are three provinces (Buenos Aires, Córdoba, and Santa Fe) where the provision of health services has been delegated to the local authority. Public providers that deliver second and third level services are essentially managed by the provincial governments, while a small number of these are managed by the national government.

The social security sector is made up of 291 National Social Health Insurance Organizations, 24 Provincial Health Insurance Organizations, and the Institute of Social Services for Retirees and Pensioners (INSSJyP). These organizations provide health services through their own providers, but mainly through private providers. Finally, the private sector is composed of health care providers, insurance companies, laboratories, companies that produce medical supplies and equipment, pharmacies, and diagnostic centers. These three subsystems have strong relationships in terms of funding and providing health services and coordinating health service provision.

**Table 2 Coverage and Average Expenditures of Subsectors**

	<b>Public Sector</b>	<b>National Social Health Insurance Organizations (OSN)</b>	<b>Institute of Social Services for Retirees and Pensioners (INSSJyP)</b>	<b>Provincial Health Insurance Organizations (OSP)</b>	<b>Private Insurances</b>
<b>Targeted Population</b>	Total Population	All workers under payroll with the direct family members contributing to the OSN, including retirees	Retirees and pensioners, wife and their children	Provincial Public employees and retiree who contribute to the POS	All people who decides to enroll voluntarily
<b>Population</b>	40.091.359	18.685.052	3.334.599	5.500.000	3.600.000
<b>Population (%)</b>	100%	47%	8%	14%	9%
<b>Monthly per capita Expenditure (2009)</b>	US\$61	US\$96	US\$259	US\$151	N/A

*Source:* Cetrángolo and Goldschmit 2012.

*Note:* N/A = not applicable.

Each level of care is provided through the three subsectors (public, social security, and private) (table 2). Unfortunately, the information available does not allow for the differentiation of providers among levels of care. However, it is possible to present a distribution of providers by subsystems, taking into account whether they have inpatient services.

According to the Integrated Health Information System of the national MOH, in 2012 there were around 12,360 providers without inpatient services, which are distributed among the three subsectors as follows: (a) health care facilities (including public primary care centers, urgent care, and vaccination centers) are managed by the national (15 facilities), provincial (4,877 facilities), and local (3,010 facilities) governments; (b) 4,188 private primary providers including medical clinics, ambulatory surgery, urgent care, and vaccination centers, but not doctor's offices<sup>2</sup>; and (c) around 270 facilities owned by the social health insurance organizations.

There are 3,118 providers with inpatient services: (a) 1,275 providers, 8 managed by the national government, 930 managed by the provincial authorities, and 337 managed by the local governments. They comprise both general and specialized hospitals (including maternal and child, pediatric, psychiatric, trauma, and rehabilitation hospitals); (b) 1,789 private medical

<sup>2</sup> There is no information on the number of private doctor's offices.

clinics (including maternal and child, pediatric, psychiatric, trauma, and rehabilitation clinics, among others); and (c) around 50 hospitals or clinics that are owned by both national and provincial social health insurance organizations. There is no available information on the number of medical specialists providing services through private doctor's offices. In addition, there are 2,083 imaging centers and medical laboratories, which are mainly private (98 percent). There are 85,743 hospital beds in the public sector and 99,185 in the private sector (Sanguinetti 2012).

### **Brief Description of Public Health, Primary Care, and Key Supply-side Efforts**

The public health subsector is aimed at providing first, second, and third level health care to all inhabitants of Argentina. Primary care attention is widespread throughout the country, although there are challenges to reaching vulnerable populations and achieving efficiency gains at the health network levels. Public services delivered by the provincial MOH are used by those without private or social health insurance, who are commonly the poorest (37.9 percent of the total population [INDEC 2010]). The public health care subsector of Argentina is composed of the health subsystems implemented in the 23 provinces and the Autonomous City of Buenos Aires. Each subsystem is organized according to its own laws and regulatory frameworks, although most are structured around health networks related to health regions. These health regions have a primary health care network, which consists essentially of primary care providers (Primary Care Centers) and secondary and tertiary providers (hospitals of second and third level of care).

The provincial governments generally provide first level care through the network of Primary Care Centers, and secondary and tertiary care services through second and third level hospitals. However, the national MOH has verified that these networks do not function as such, nor do primary health services function as a gateway to the health care system. Furthermore, no scheme exists to guide the continuation of care, that is, to facilitate and instruct the referral of patients who require it. This situation is more pronounced in the rural areas, where a lack of human resources and medicines presents supply challenges. In this respect, development, innovation, and implementation of organizational units of referral and counterreferral of care are still limited and uneven.

The absence of coordinated and relevant standardized processes of referral and counterreferral between the first and second levels of care prevents health networks from fulfilling their basic functions. Moreover, management of Primary Care Centers proves inefficient when getting appointments scheduled by the second level. The task of coordinating interjurisdictional public health systems in Argentina falls under the jurisdiction of the Federal Health Council. Provincial and national health ministers fulfill the role of coordination and reaching consensus on health initiatives, especially those related to increased efficiency of health networks.

The government is working to improve the performance of existing networks, thereby increasing the quality and quantity of services delivered. In this context, projects recently launched by the national MOH—the *Sumar* Program and the Essential Public Health Functions II (FESP II)—will promote better organization of the public health system by focusing not on the existing health facility structure, but on the health needs of the population as the only way to ensure an equitable response. Specifically, the *Sumar* Program continues supporting the development and

implementation of a congenital heart disease network, while the FESP II supports the implementation of two pilots at the provincial level to foster the development of health care provider networks for noncommunicable diseases.

### **3. Plan Nacer Description**

#### **Institutional Architecture and Interaction with the Rest of the Health System**

Plan Nacer's main objectives are to increase access to health care services for uninsured pregnant women and for children under six years old, and to improve efficiency in the use of public health funds through the introduction of a results-based chain of incentives. Since the provision of health care services in the country is free, Plan Nacer is aimed at effectively increasing health coverage and making access to services explicit. To achieve these goals, the program is comprised of a range of activities at the national, provincial, and health provider levels, as described below.

First, Plan Nacer supports the development and implementation of publicly funded provincial maternal and child health insurances, which are built around a prioritized package of basic health services (PBS) to be delivered to program beneficiaries. The program promotes a noncontributory insurance scheme, which includes the following elements: (a) capitation payments, (b) actuarial calculations and risk assessment for the definition of the capitation payments, (c) national and provincial health insurance purchasing units, (d) nominalization of beneficiaries, (e) a list of child and maternal health services, (g) prices for each individual health service, (g) explicit agreements between each province and health care providers within its jurisdiction, and (h) payment mechanisms (from a province to its health providers) based on fee-for-service.

Second, the program provides additional resources to finance a gap in terms of coverage and quality in the provision of the PBS under a results-based financing mechanism, thereby complementing the provincial budgetary funding. These funds are transferred from the national MOH to the provincial MOH through a capitation payment (per beneficiary enrolled in the program) adjusted for performance. These payments are only used by the provincial MOHs to reimburse providers for the services included in the PBS that are delivered to Plan Nacer's beneficiaries. The design of the program allows each health provider to decide how to use these resources, empowering personnel and promoting staff productivity. The autonomy in the use of the resources retained by the health provider has become a powerful incentive to increase service delivery, while adding flexibility to resource allocation in the health care system at the provider level. Therefore, Plan Nacer provides funds linked to the achievement of three types of results: enrolment, improvements in health performance as determined by 10 health indicators called tracers, and health care service delivery and quality (figure 3).

Third, the program provides financing support to strengthen the supply capacity of the health care facilities, which includes medical, transportation, and communication equipment and training. It also fosters health service demand through the financing of activities that increase knowledge of the effects of PBS among the beneficiaries of the program.



Plan Nacer was originally designed by the national government—in close consultation with provinces through the Federal Health Council—as a means to address consequences of the economic crisis that struck Argentina in 2001, reducing inequalities and promoting national MOH stewardship and coordination within the health sector. It was created in 2003 through Resolution No. 198/2003 of the national MOH. The program was rolled out in two phases with the assistance of two Adaptable Program Loans from the World Bank. The first phase was launched in 2004 in nine provinces in northern Argentina that were most afflicted by poverty and poor health indicators. In 2007, it was implemented nationwide, in the remaining 15 provinces. After the first phase closed in 2010, implementation of the program in all participating provinces was supported through the second phase program loan.

Plan Nacer is a national program, coordinated by the national government and implemented by the provincial governments. The national MOH is responsible for meeting Plan Nacer's performance targets, while provinces have the operational responsibility to implement the program and reach provincial level performance targets. To achieve these targets, the national MOH provides additional funding (capitation transfers) to provinces that complement the existing provincial health budgets. This structure enables the national MOH, which is legally responsible for coordinating health policy and programs throughout Argentina, to have influence over health in a decentralized context. The provinces transfer resources to the health provider through fee-for-service payments applied to a PBS.

The coordination function of the program is carried out by the Project Management Unit (PMU) created within the scope of the Secretariat of Promotion and Sanitary Programs of the national MOH. The PMU reports directly to the latter and is led by the Promotion and Sanitary Programs Secretary who serves as the National Director of Plan Nacer. In addition, the program has a National Executive Coordinator in charge of operational issues. Both the National Director and National Executive Coordinator are appointed by Nation's Minister of Health. Whereas the PMU is responsible for working with the provinces in implementing the program, provinces are directly responsible for purchasing services from providers that deliver the PBS to Plan Nacer's beneficiaries. The PMU is also responsible for ensuring that all technical, financial, and administrative aspects of the project implemented by the provinces meet agreed upon quality standards in a timely manner. The PMU is supported by the International Finance Unit (UFI-S) of MOH in managing the financial and procurement requirements.

The provincial MOHs are responsible for ensuring health care in their jurisdictions and for providing health care to the uninsured. Plan Nacer implementation is conducted by the Provincial Implementation Units (PIUs), created within the scope of the provincial MOHs as part of the structural reforms being introduced in health financing. These units are led by a Provincial Executive Coordinator appointed by the Provincial Minister of Health. The PIUs run the Maternal-Child Health Insurance Program and act as the health services purchasing agency of the provincial MOH. Their main responsibilities are identifying and enrolling beneficiaries and mobilizing their participation; identifying, authorizing, and contracting service providers to deliver PBS to the beneficiaries; and controlling the technical quality of services, financial management, and procurement at the provincial level.

The relationship between the national MOH and the provincial MOH, and between the provincial MOH and health care providers, is governed by legally binding management agreements, which refer specifically to Plan Nacer's insurance scheme and financing. These are voluntarily legal contracts that define roles and responsibilities of each party and ensure accountability. The first type of agreement, signed between the national MOH and the provincial MOH, is known as the umbrella agreement. It covers all permanent technical, financial, administrative, and fiduciary aspects of provincial participation in the program and provides for Plan Nacer's funds to be transferred to the provinces based on the number of beneficiaries enrolled and the achievement of specific tracer targets.

In addition, the national MOH and the provincial MOH annually negotiate enrolment and tracer targets, work programs, and resource requirements, which are included in another type of contract called the Annual Performance Agreement. The agreement signed between the provincial MOH and the health care provider is called the management contract, and it guides the provision of PBS and its pricing; quality standards and control measures; payment mechanisms; expected results; maintenance of clinical and financial records; and modalities for supervision and inspection. It also defines providers' responsibilities, which include enrolling beneficiaries, delivering the PBS, and billing the province. All providers that are able to deliver the PBS<sup>3</sup> are eligible for signing a management contract to be part of Plan Nacer, although most of them are public.<sup>4</sup>

The structural changes promoted by the program in the health system were introduced through the signature of these legally binding agreements, involving a shift in the way the national government provides health sector funding to the provinces and in how payment to health providers is made. Thus, Plan Nacer funding, which is linked to the achievement of results in terms of beneficiary enrolment, health outcomes, and health services delivery, comprises the following aspects:

- A capitation payment in the amount of US\$3.86 (Arg\$17) per month per beneficiary enrolled in the program. This capitation payment can be seen as the value of a health insurance premium, which entitles Plan Nacer beneficiaries to receive services from providers under contract to supply certain services for an agreed capitated rate. Seventy percent of this payment is transferred by the PMU to the PIUs, through the International Finance Unit responsible for managing the financial and procurement requirements of the program at the national level.

National contributions are funded by the World Bank, and the remaining 30 percent is transferred by provincial governments to the provincial PIUs. These payments are exclusively used by the PIU to reimburse providers for health services delivered to Plan Nacer beneficiaries. In addition, the capitation transfer is paid in two installments, both

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<sup>3</sup> For the provision of the PBS under Plan Nacer, providers do not need to be approved or accredited by anyone. Conversely, for the provision of the Congenital Heart Disease Package, which comprises high-complexity interventions and was implemented in 2010, providers are required to be assessed and accredited by the National Directorate of Maternity and Childhood of the national MOH.

<sup>4</sup> Private providers are allowed to participate in Plan Nacer, but since the fee-for-service under Plan Nacer does not cover the full cost of the services, there is no incentive for private providers to participate in the program. The capitation amount only covers the cost of closing the gap in terms of quality and quantity of priority health services.

driven by results. The first installment, 60 percent, is disbursed immediately after the provinces send the roster of Plan Nacer enrollees, and it is verified by the PMU. The second installment, up to 40 percent, is disbursed every four months after verification and certification that the province actually met targets for the 10 health indicators (tracers) (Annex 1).

Currently, tracers and targets are equal for all provinces. Each tracer has a set of targets with three thresholds to be met in each four-month period. Provinces can receive 2 percent, 3 percent, or up to 4 percent of the capitation payment for each tracer, based on the threshold level achieved. The targets are included in the annual performance agreements signed between the national and provincial MOHs.

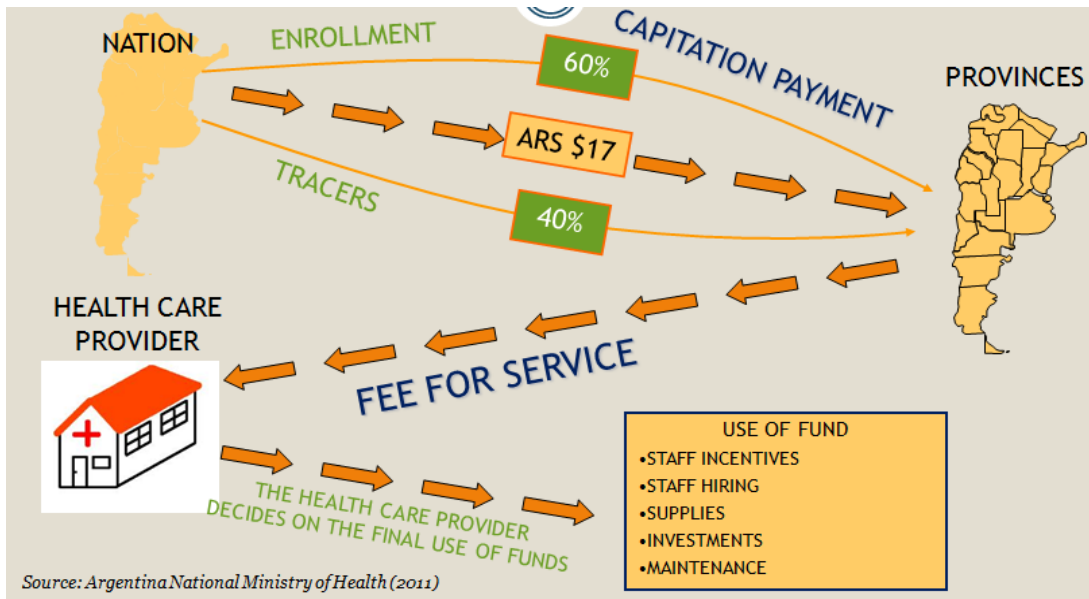
- Fee-for-service payments from the PIUs to health care providers are contracted by Plan Nacer based on the number of services delivered to the program beneficiaries. Given that prices are set by the provincial government in coordination with the national government, increasing the value attached to each of the health services included in the PBS means that PIUs signal providers on which services are needed to increase utilization to achieve tracer targets or give response to a particular health context within a province.<sup>5</sup> Provider managers have autonomy to decide how to use these funds within broad categories defined by the provincial MOH. There are a small number of provinces that allow providers to use Plan Nacer's funds to reward staff for their performance. The fee-for-service mechanism is revised twice a year. Provinces assess the type and number of health services included in the Package of Basic Services that was provided to the beneficiaries, and they can adjust their prices to ensure financial sustainability of the province if needed. Within a province, the fee-for-service scheme is the same for all levels of facilities.

For the first time in Argentina, the national and provincial governments are linking funding to results. To be able to effectively link funding to results, the government has developed and implemented many instruments that were not previously common in the public sector, including management and performance agreements, tools for managing the production and application of funds, pricing, monitoring, auditing, and evaluation systems. These structural changes in the health financing model are changing the incentives framework, encouraging efficiency, and including the poor in the public health system. Plan Nacer is the first program in Argentina to ensure that funding is received directly by health providers, meaning that the staff decides on the investment. This achievement has had a significant impact on the level of empowerment and motivation of health teams in the public health sector.

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<sup>5</sup> Since the provincial MOHs continue to pay for most health care costs, including the public health workers' salaries, these fee-for-service payments do not cover the full cost of the services covered, just the incremental cost.

**Figure 3 Institutional Arrangements: Plan Nacer's Payment Mechanisms**



### Targeting, Identification, and Enrolment of Beneficiaries

Plan Nacer has been aimed at targeting the poor and most vulnerable groups. Given the lack of a unique national system to identify the poor, the program specifically targets uninsured households where people are often unemployed or work in the informal sector and therefore are much more likely to be poor than in insured households. In addition, the program is directed to benefit pregnant women and children, who tend to be the most vulnerable groups among the uninsured.

The target population is people without explicit health coverage (including social security coverage or private coverage) within the following groups: children under six years old, pregnant women, and women up to 45 days after delivery or miscarriage. Special attention is given to the indigenous population, a traditionally poor and excluded group, through the inclusion of specific outreach activities.

The program initially targeted the most vulnerable children and pregnant women through operating in the country's poorest provinces. The program was launched in 2004 in the nine Northern provinces with the highest level of unsatisfied basic needs and highest infant mortality rates. This region is also home to 75 percent of Argentina's indigenous population. In 2007, the program was expanded to the rest of the country. To identify Plan Nacer's target population, the program has had to design and build its own system to determine eligibility. The PMU estimates and periodically reviews the target population using available data on health coverage and population of children under six years old from the census, national household surveys, and newborn registers. In 2012, the estimated target population was around 2 million people. The PIUs are responsible for identifying, enrolling, and verifying that potential beneficiaries fulfill the eligibility criteria. The PIUs have delegated the first two activities to the providers, as agreed in the management contracts. However, given that the PIUs are responsible for ensuring that the

eligible population has access to enrolment even in scattered geographic locations and low-density areas in each province, they have also had to implement strategies to find and enroll the target population (for example, health workers visiting poor neighborhoods). After enrolment is completed, the PIUs crosscheck the information of new enrollees against an employer-based coverage database called *Padrón Único Consolidado Operativo*, created from the Social Security registers. This helps ensure that they do not have explicit health coverage.

Plan Nacer requires that potential beneficiaries who meet the eligibility criteria are voluntarily enrolled in the program. To achieve this objective, the program provides different incentives both to the PIUs and the health care providers. The provincial insurers have direct incentives to enroll beneficiaries since enrolment accounts for 60 percent of capitation payments made from the national government to each participating province, whereas providers have only indirect incentives, since they can bill only those health services delivered to people enrolled in the program. In addition, the design of the program de-incentivizes the enrolment of ineligible people, given that compliance with enrolment requirements is audited internally and externally and the enrolment of those who do not meet the eligibility criteria results in monetary penalties. This situation has led to a low number of erroneous beneficiaries. According to audit reports from 2008 and 2009, only 0.25 percent of beneficiaries in the nine Northern provinces were erroneously included in Plan Nacer's register.

Enrolment as a percentage of the target population has grown steadily, despite ups and downs. By April 2012, the number of beneficiaries was around 1.84 million, representing 89.7 percent of the eligible population. The program benefited from implementation of the Universal Family Allowance Policy<sup>6</sup> in November 2009, which made enrolment in Plan Nacer a requirement to access this benefit. Consequently, enrolment increased substantially after a period of extremely low growth. In fact, two years after implementation of the Universal Family Allowance Policy, enrolment increased by 46 percentage points in Centro, Patagonia, and Cuyo provinces, and 9 percentage points in the Northern provinces. Although it is unclear why the growth curve tended to flatten, two possible explanations are that the remaining eligible population is much harder to reach and that the program did not devote enough resources to communications and outreach activities.

### **Special Topics Related to the Management of Public Funds in Plan Nacer**

Plan Nacer does not represent a substantial amount compared to provincial budgets. According to the latest available data, in 2009, Plan Nacer funding was around 0.66 percent of public health spending excluding expenditures for social security, 0.04 percent of the public expenditure, and 0.017 percent of GDP.<sup>7</sup> Taking into account that provincial governments are responsible for providing health care services within their jurisdiction, it is important to consider Plan Nacer's relative weight compared to the provincial health budget. Although Plan Nacer funding was around 1.12 percent of the provincial public health spending excluding expenditures for provincial social security in 2008, there were substantial differences among provinces. For

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<sup>6</sup> This policy targeted poor families with children, providing US\$50 a month per child to the family.

<sup>7</sup> Prepared by the author based on data supplied by the national MOH and the Ministry of Economy and Public Finance.

example, in Misiones it was 4.3 percent of provincial public health spending, while in Neuquén it represented only 0.1 percent (Sanguinetti 2010).

The program's resources are money on top of existing budgets. Plan Nacer spending is subject to the amount of money set for implementing the program: US\$435.8 million from 2004 to 2012, plus a small amount of resources provided by the provincial governments. Before the program, the provision of health services in the public sector at the provincial level was exclusively funded under the traditional input-based scheme. In this context, Plan Nacer aims to improve coverage and quality of prioritized health services, which are already provided by the provinces through the public sector. To do so, it provides additional resources to finance a gap in coverage and quality in the provision of those services. These additional funds, which cover 50 percent of the cost of providing the prioritized PBS, consist of national government contributions financed with World Bank proceeds (70 percent) and provincial government contributions (30 percent). Both are transferred to the provincial MOHs under a results-based financing scheme. The remaining 50 percent is funded by the provincial MOH through the traditional input-based scheme.

Provinces can adjust prices to regulate the flow of resources to the health providers. If demand for health services from Plan Nacer's beneficiaries is higher than the amount of money that the PIU has available to pay for them, the PIU can cancel the debt at the agreed prices in the following months and, in the meantime, adjust the prices paid to the providers to avoid a similar situation in the future. Given that health service provision is free in the public sector, with or without Plan Nacer, patients are never turned away for lack of funds. For the providers, being part of the Plan Nacer network means that they can receive additional funds on top of what they receive under the traditional input-based scheme and decide on how to use those funds at the health facility level. The amount of these additional funds depends on the number and price of the health services delivered to Plan Nacer's beneficiaries.

Although predictability of financing has not been a serious issue during program implementation, some provinces have experienced difficulties. For example, some provinces had to deal with a shortage or excess of funds to pay providers for the services delivered to Plan Nacer's beneficiaries. To solve this, the PIUs managed the price of health services, either reducing or increasing them as needed.

The provincial legal framework makes it difficult to transfer resources within provinces. For instance, there have been delays in transferring the share of capitation payment that is cofunded by the provincial MOH (30 percent of the capitation payment), which caused the suspension of the remaining 70 percent as established by Plan Nacer guidelines. These difficulties affect all programs at the provincial level and are related to budgetary constraints. However, Plan Nacer is less vulnerable to budget variability cuts than other programs, given that the umbrella agreement signed between the national and provincial MOHs states that the provincial health budget has to be maintained or increased in order to continue receiving Plan Nacer resources.

### **Management of Benefits Package**

Plan Nacer's prioritized PBS is aimed at addressing the main causes of infant and maternal mortality in Argentina, including diarrhea, acute respiratory diseases, malnutrition, and

inadequate prenatal care in the case of infant mortality, and hemorrhage and infections linked to unsafe deliveries and complications from unsafe miscarriage in the case of maternal mortality. The PBS also includes interventions for primary health care promotion and prevention and for reproductive health care after deliveries or miscarriages. The PBS originally encompassed 80 health services. Later, it was expanded to include outpatient treatments and high-complexity health services, to continue reducing the infant mortality rate by tackling some of the leading causes of death, especially those that are difficult to prevent or very costly to treat (for example, congenital heart disease surgery and neonatal intensive care services).

The PBS was designed by the national MOH in coordination with the Federal Health Council. The process of building the PBS involved a set of relevant theoretical and conceptual bases (of health policy, the health economy, and governance), which took into account the basic constitutional mandates of the “right to health” and the “country’s federal organization,” and equity as a central objective.

The prioritization process to build the PBS began with the selection of the target population and was followed by the decision to launch the program in the poorest provinces (in the north of the country) as a means to reduce inequity. Then, to identify which health services to include in the PBS, the national MOH conducted studies to assess health needs using available data sources, including vital statistics, burden of disease studies, epidemiological statistics, and health surveys, among others. Once the health services were selected, the national MOH carried out a cost-effectiveness analysis of the PBS.

The prioritization process faced initial difficulties related to the lack of critical information, which made it hard to provide credibility and objectivity. For example, available data on the epidemiological profile of Argentina’s population was limited, hampering analysis and definitions related to definition of the PBS. In addition, this situation hindered accurate estimations of gaps in terms of coverage and quality associated with the provision of the PBS. The lack of information on the delivery capacity of the public health systems and costs led the national MOH to conduct its own studies at a later time.

The process of setting priorities evolved during program implementation. The design of a new PBS, under the expansion of Plan Nacer to the new *Sumar* Program, incorporated broad mechanisms of institutional deliberation involving various levels of government. The process ends in a national and provincial consensus on a single list of health services for the entire country. The inclusion of public consultation mechanisms is still pending.

Plan Nacer only covers gaps in coverage and quality in the provision of PBS, to allow providers to offer a selected set of health interventions at adequate levels of quality and coverage. Therefore, the capitation value<sup>8</sup> was defined through a basic actuarial calculation. The initial budget for implementing Plan Nacer was defined based on the estimated target population and a capitation value to cover a share of the cost of providing the PBS. As mentioned in section 2, Plan Nacer complements provincial government funding for providing health services through

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<sup>8</sup> The calculation of the capitation value was done through analysis of the costs of the component parts of each health service included in the PBS, accounting for the prices that prevail in the markets for medical goods and services, technology improvements and efficiency standards, and expected economies of scale.

the public sector. As such, the provincial MOHs were already funding the prioritized health services covered by Plan Nacer, but offering them in quality and utilization levels lower than desired. The actuarial calculation took into account (a) the estimated target population, (b) the current provincial spending for provision of the prioritized PBS to the target population, and (c) expenditures required to fully finance the PBS when provided at adequate levels of quality and coverage. The difference between the cost of providing the PBS at the current levels of coverage and quality compared to the cost of providing the PBS at desired levels is what Plan Nacer funds. Currently, additional Plan Nacer funding represents 50 percent of the cost of providing prioritized PBS. The capitation value was initially estimated by the program in 2004 and later recalculated in 2010. The first study resulted in an incremental capita per enrolled person of AR\$12<sup>9</sup> per month, whereas the result of the second study was an incremental capita of AR\$17.3<sup>10</sup> per month.

As explained in section 2, the provincial MOH sets the prices of each health service included in the PBS. Therefore, the cost of providing the PBS is managed through price administration at the provincial level. This is the only cost containment measure used by the program.

### **The Information Environment**

The results-based financing mechanism promoted by Plan Nacer requires a complex amount of information to effectively link funding to the achievement of results in terms of enrolment, health outcomes, and service delivery. Plan Nacer includes indicators to track the level of program coverage with respect to the eligible population and tracers to monitor the effectiveness of the health services included in the PBS. As mentioned in section 2, these indicators are also used to determine the capitation payment for each province. The information flow required by the program begins at the provider level, starting with the enrolment of beneficiaries. Providers send this information, along with information on service delivery, to the PIU. Once information is audited and approved, the PIU calculates payments to the providers based on a fee-for-service mechanism. Simultaneously, the data from providers about the services they delivered determines the extent to which the tracer targets are achieved. That data, together with information on beneficiary enrolment, determines the amount of the capitation payments to be paid by the PMU to the PIU.

The implementation of the monitoring and evaluation system of the program has required an upgrade and expansion of existing information systems, and the development of new mechanisms. Although most of the health providers contracted by Plan Nacer had functioning medical records systems to generate basic data on beneficiary numbers and services rendered, the program funded the development of roster management and tracer systems to respond to the specific health needs of the provinces. Currently, the PMU is working on the development and implementation of electronic enrolment and billing systems to continue improving the information environment of the program.

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<sup>9</sup> Equivalent to approximately US\$4, taking into account a nominal exchange rate in December 2004 of (AR\$2.98/US\$).

<sup>10</sup> Equivalent to approximately US\$3.86, taking into account the nominal exchange rate in June 2012 of AR\$4.5/US\$).



Plan Nacer has also provided support to strengthen the national and provincial MOH capacity to monitor, evaluate, and audit performance. Monitoring and evaluation mechanisms are a cornerstone of programs that include results-based financing mechanisms, since the fact that funding is at stake introduces incentives to overstate the accomplishment of the results defined by the program. In this case, the provincial MOHs and providers have incentives to overstate the number of beneficiaries enrolled in the program, the volume of services delivered to them, and the level of tracer targets achieved. For these reasons, Plan Nacer comprises a comprehensive monitoring and evaluation scheme that includes independent external audits, both financial and technical, and internal oversight. These mechanisms help to prevent fraud, hold the recipients of funds accountable, and ensure that funds are used according to the program's guidelines.

The financial audit is conducted annually by the Argentine Supreme Audit Institution (*Auditoría General de la Nación*), and the technical audit is carried out bimonthly by an independent, external firm. The latter verifies the project results in terms of enrolment, improvements in health conditions as determined by the tracers, and health care service delivery and quality, and thereby determines whether and how much of the funds are transferred to the provincial MOH and the health care providers. In addition, the technical auditors assess provincial compliance with the program's standards and report their findings to the PMU, proposing sanctions and recommending ways to solve identified problems. Then, the PMU, through the Internal Oversight area, reviews the auditors' findings, applies the debits and fines suggested by the audit, and designs and supervises action plans to correct deviation and improve critical situations.

The auditing process is an essential element of the program. It has led to improvements in performance, as illustrated by the reduction in the number of erroneous beneficiaries included in Plan Nacer,<sup>11</sup> and has contributed to increased health system governance. The provision of an independent external opinion on the results reached by the provinces facilitates the relationship between the national and provincial MOHs in a federal context and improves registration of services and results. This has led to an increase in accountability, the generation of quality improvement processes, and institutional capacity building, among other things.

In addition, Plan Nacer includes an impact evaluation strategy to generate evidence on the impacts of the program and to inform key program design and implementation decisions. The evaluations include (a) an impact evaluation randomized at the provincial level to measure the program's impacts on maternal and child health outcomes, and (b) a series of provider-level experiments to test alternative design features of the Plan Nacer model. The impact evaluation was rolled out in the nine Northern provinces included in the first phase. The evaluation strategy involved the creation of baselines, with medical, socioeconomic and community information, for a representative sample of the three measurable universals: women and children, health care agencies, and pregnant women and children served by primary health care providers. With respect to the first phase, information was gathered from each of the nine participating provinces of Phase I of Plan Nacer and from a control group from four other provinces. However, due to the expansion of the program to the rest of the country in 2007, the comparison group for the Phase I provinces were contaminated. In light of the changes to the impact evaluation design and

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<sup>11</sup>According to audit reports, in the Northern provinces, the number of errors in beneficiary enrolment identified each month dropped from 22 percent in December 2006 to 11 percent in December 2009.

delays in contracting the survey firm to conduct the follow-up, alternatives strategies for generating interim results were sought to further support the policy dialogue.<sup>12</sup>

The alternative consisted of interim results using available sources of administrative data. The government has made an extra effort, supported by the World Bank, to measure the impact of the program even when the original identification strategy had been invalidated. With the use of administrative data (Phase I), the team exploited the panel data structure and used a fixed effects strategy to control for all time-constant factors at the provider level. It applied instrumental variables using the participation status of the provider in the program, and preprogram population characteristics to estimate treatment status. In two provinces, Misiones and Tucuman, data sources identified included health services provided at public sector Primary Care Centers and maternity clinics. This included data on prenatal care, delivery care, and well-child care outcomes (World Bank 2012).

The results of this study show that the program increased the probability of a first prenatal care visit before week 13 of pregnancy by 8.5 percent and before week 20 of pregnancy by 18 percent. Program beneficiaries increased the number of prenatal checkups by 0.5 visits, or 17 percent. Pregnant women also benefited from an improvement in the quality of care, measured by increases in the likelihood of vaccinations and ultrasounds. The improvement in the quantity and quality of services translated into healthier births, including an increase in average birth weight of 69.5 grams (a 2 percent increase over the control group), a decrease of 26 percent in the likelihood of children born with very low birth weight (under 1,500 grams), and a drop in neonatal mortality of 1.9 percent.

Finally, for children under five, the program raised the likelihood of well-baby checkups, as required by the program. These results indicate positive outcomes during the program's first years of operation, and also suggest a promising model of incentives to be considered for other priority areas of the Argentine health care system and the rest of the world (Martinez, Gertler, and Ross 2010). Similar analysis was planned to be completed by the second semester of 2012 for eight provinces from the first phase of the project.

#### **4. Plan Nacer's Results-based Financing Mechanism**

There is no doubt that Plan Nacer is an innovative way to strengthen health systems and is a powerful tool for the national MOH to promote efficiency and effectiveness through incentives at the national, provincial, and health provider levels. Rather than simply funding more health care providers through inputs and fixed budgets, or adjusting existing insurance mechanisms, Plan Nacer provides funding linked to results. In this sense, one of its most novel features is "results-based financing," which refers to the way funds flow to provincial MOH and health care providers, and the incentives it offers. These are intended to encourage each level of the health care system to improve coverage, quality, and results, while increasing governance, accountability, and transparency in health care delivery.

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<sup>12</sup>The baseline for Phase I was conducted in 2006 and for Phase II in 2008. To find valid counterfactuals, variable instrument methodology was applied with randomized promotion. The creation of a Universal Child Allowance in 2009 (which, due to the conditionality of Plan Nacer enrolment, significantly increased enrolment levels), made it impossible to continue with the methodology.

Plan Nacer rewards three types of results: enrolment, improvements in health performance as determined by tracers, and health care service delivery and quality. Specifically, the provinces are given two related incentives. The first involves receiving 60 percent of the capitation payment for each beneficiary enrolled in the program, and the second involves receiving up to the remaining 40 percent based on the achievement of agreed-upon tracer targets. Thus, provinces receive Plan Nacer's funds as long as they succeed in enrolling beneficiaries and improving their health conditions. These funds are transferred from the national MOH to the provinces, where they are used exclusively to pay providers for the delivery of the services included in the PBS.

Providers also have a strong incentive to identify potential beneficiaries, certify that they meet eligibility criteria, and enroll them, even though they do not receive the capitation payment. This incentive is associated to the fact that providers can only bill services delivered to Plan Nacer beneficiaries. After enrolment is completed, another and more powerful incentive comes into play: the services delivered. The more services delivered, the more funds are transferred under the fee-for-service mechanism. Finally, the providers' autonomy to determine how to use funds closes the incentive chain promoted by the program.

Under a results-based financing project, funding is not the only element required to achieve results. The capacity to decide how to use the funds in order to undertake actions aimed at achieving those results has proven to be essential to close the incentive chain. This not only empowers providers' staff, but also adds flexibility to the health care system by allowing providers to direct program funds to correct imbalances caused by the rigid budgetary allocation defined at the provincial level. Despite the fact that the total transfers from the program to the provinces ranges between only 1 percent and 5 percent of total provincial MOH budgets, it has proven to be a powerful tool to promote change, due to its flexibility. The last incentive allowed by some provinces is the introduction of performance payments to providers' staff. According to Plan Nacer guidelines, performance payments cannot exceed 50 percent of the funds received under the program.

As described in section 2, the program includes both internal and external audits aimed at offsetting the overstatement of results in order to receive funds. Jointly with the audits, the existence of a sanctions scheme introduces further incentive to improve health care standards, by recording and recordkeeping at the provider level. Otherwise, if a health provider does not follow Plan Nacer guidelines, fee-for-service payments are reduced, due to the application of monetary penalties. Therefore, health providers are expected not only to offer the services included in the PBS, but also to deliver them according to the national MOH standards.

Beneficiary demand for PBS has been incentivized through the implementation of public awareness campaigns, mailings, and interactions with staff at the health facilities. Beneficiaries learn about the specific services available, their rights, and how to monitor children's health. This has contributed to empowering beneficiaries and has helped create a sense of social accountability that complements the formal accountability obtained through the audits.

Plan Nacer's new mechanisms have locked in many important institutional changes and extended them beyond the scope of the program to other dimensions of the health sector. For example, the

availability of detailed and reliable clinical and programmatic data has been important for monitoring and evaluation of the whole system. Effective participation and active communication between national and provincial governments has promoted more efficient policy making and program implementation than traditional programs that finance only purchases of inputs without focusing on results or enhancing accountability and transparency.

Insurance-based billing and reimbursements not only extended services to the poor, but also enhanced governance and the financial independence of health care providers compared to others outside the program. Furthermore, providers can manage the resources transferred through the fee-for-service from the provincial ministries and choose how best to use those resources. Finally, the results-based financing led by the national MOH has improved its stewardship role and governance of provincial governments in health care delivery. All these changes were funded by just over US\$50 million in annual investments from World Bank loans from 2004 to 2010, which represents up to a maximum of 4.3 percent of the provincial public spending in health.

## **5. Pending Agenda**

Although there is evidence that Plan Nacer has contributed to improved health service utilization and health status of the eligible population, various challenges need to be addressed to ensure the program achieves its objectives and remains sustainable.

For example, the national MOH needs to develop an adequate legal framework that enables the national government to coordinate health policy throughout the country and with the provincial ministries. According to the Argentine federal structure, each province retains all powers and authority not expressly delegated to the national government, as is the case of health services. Provincial governments have their own local laws, norms, and protocols, and have the legal power and ability to organize their own health systems. In addition, most provinces guarantee the right to health in the provincial constitution (Abramovich and Pautassi 2008). Thus, a pending agenda item is a legal framework that allows the national government to steward and coordinate health policies with provincial ministries. Although, Plan Nacer has contributed to a stronger national government stewardship role, the national government still has difficulties enforcing its health strategy. Some examples of pending challenges include the development of sound health information systems and monitoring and evaluation tools to assess the health sector performance and clinical protocols.

The sustainability of the program must be ensured, as should complementarities of Plan Nacer funds to the provincial budgets. Program sustainability to ensure adequate support to the expansion of health coverage is one of the main challenges ahead. Currently, 50 percent of the capitation value to provide the PBS is funded by the provincial MOH through the traditional input-based scheme. The remaining 50 percent is funded by Plan Nacer—70 percent by the national MOH and 30 percent by provincial MOHs—under a results-based financing mechanism. The national MOH contributions are funded with World Bank proceeds. The main issues related to public financing are the following:

- Ensuring the financial sustainability of the program once World Bank funding ends by the national government, the provincial governments, or both. It is relevant to assess whether the provincial governments are willing to provide the necessary resources to the program under a results-based financing mechanism. If the national government decides to continue funding the main share of the cost of the basic health package, a high-level legal instrument will be critical to protect the program from changes in its current administration.
- Strengthen national MOH capacity to ensure that provincial health budgets are not replaced by Plan Nacer funding. Resources from the program should be used to increase access to the Basic Health Package, complementing the provincial budgets.

Equity goals across provinces are still yet to be realized. Even though the percentage of people with health coverage increased to 62.1 percent by 2010, major inequities persist among wealth quintiles. In 2010, only 43 percent of people from the poorest quintile were insured, while 83 percent of people in the wealthiest quintile had health coverage. Furthermore, inequities exist with respect to health services utilization. According to 2010 National Risk Factor Surveys (*Encuesta Nacional de Factores de Riesgo*), 42.1 percent of people visited a doctor in the previous month with a significant variation between the insured and the uninsured: 45.7 percent of the insured population visited a doctor compared to only 34.7 percent of the uninsured.

A similar trend occurs with laboratory tests and medical treatments. In 2010, 20.3 percent of the population received a medical treatment, a lab test, or both, with the percentage as low as 13.4 percent for the uninsured compared to 23.7 percent for the insured portion of the population. In addition, the average out-of-pocket expenditure on health increased to 92 pesos in 2010. This is a real increase of 60 percent relative to 2005, and 83 percent relative to 2003. The main out-of-pocket expenditure components in 2010 were medication purchases (44.1 percent of the total out-of-pocket expenditure), and voluntary insurance coverage (16.8 percent) (Sanguinetti 2012).

Currently, Plan Nacer capitation payments per beneficiary enrolled in the program are equal for all provinces. To improve health equity across provinces, it would be desirable to move toward a program design that takes into account these differences and provides a differential capitation payment adjusted to the provincial environment and needs. Although it is clear that this proposed change would generate both political and operational difficulties in the short term, it should be a medium-term goal.

Establishing a standardized process of priority setting that includes clinical and cost-effectiveness studies and social validation mechanisms is necessary. Plan Nacer's PBS responds to the main causes of infant and maternal mortality, and the national MOH has made substantial advances in defining the new *Sumar* Program supported by the World Bank. These efforts have included the Benefit Package production of burden of disease studies, and involve different stakeholders of the national and provincial MOHs in defining the PBS. However, it is necessary to establish a standardized process for setting priorities that includes clinical and cost-effectiveness studies and social validation mechanisms. Under Plan Nacer, clinical and cost-effectiveness studies on the Plan Nacer Benefit Package were conducted by the MOH after defining the PBS.

Health insurance portability should be included in Plan Nacer's design. The program's design includes neither health insurance portability among provinces nor compensation mechanisms to promote it. There have been attempts to introduce such changes, but operational difficulties limited the establishment of agreements among provinces in order to set the necessary compensation schemes. However, improving the efficiency and equity of the health system requires the development of institutional arrangements that promote free choice of providers and that ensure health providers are paid for services they deliver.

Maternal mortality continues to be a challenge. In addition, although national the infant mortality rate declined from 16.5 per 1,000 to 11.9 per 1,000 between 2003 and 2010,<sup>13</sup> maternal mortality remains very high, at 43.7 per 100,000 live births (DEIS 2010). Given that these deaths are mostly related to high-risk pregnancies, the national MOH will soon include specific health services in the new *Sumar* Program's PBS, with the objective of promoting a better organization of health care networks. With more organized networks, pregnant women with high-risk pregnancies can be identified early on and can be referred to a high-complexity health care facility where they can receive adequate follow-up and treatment.

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<sup>13</sup> This reduction in the infant mortality rate is, of course, the result of many factors, including the robust growth rates experienced from 2004 onward, which averaged 7.2 percent per year between 2004 and 2009.

## Annex 1 Plan Nacer's Tracers

No.	Tracer	Description
<b>I</b>	Early detection of pregnant women	Number of eligible pregnant women with at least one prenatal care service before 20th week / number of eligible pregnant women.
<b>II</b>	Effectiveness of childbirth and neonatal care	Number of newborns, from eligible pregnant women, with an "Apgar score higher than "6" at minute 5 / number of newborns from eligible pregnant women.
<b>III</b>	Effectiveness of prenatal care and prevention of premature births	Number of newborns weighing more than 2,500 grams from eligible pregnant women / number of newborns from eligible pregnant women.
<b>IV</b>	Effectiveness of prenatal care and childbirth care	Number of eligible pregnant women who get VRDL (Viral and Rickettsial Disease Laboratory) during pregnancy and antitetanic vaccine previous to delivery / total number of deliveries from eligible pregnant women.
<b>V</b>	Medical auditing of maternal and infant death	Number of medically audited deaths of eligible mothers and children (1 year of age or younger) / total number of deaths of eligible women and children (1 year of age or younger).
<b>VI</b>	Immunization coverage	Number of eligible children less than 18 months old with measles vaccine or triple viral coverage / number of eligible children less than 18 months old.
<b>VII</b>	Sexual and reproductive health care	Number of eligible puerperal women receiving sexual and reproductive health care consultations / number of eligible puerperal women.
<b>VIII</b>	Healthy-child care (1 year old or younger)	Number of eligible children 1 year old or less, with well-child consultations up to date (percentile of weight and height and cephalic perimeter) / total eligible children 1 year old or less.
<b>IX</b>	Healthy-child care (1 to 6 years old)	Number of eligible children 1 to 6 years of age, with well-child consultations up to date and percentile, weight, and height / total eligible children 1 to 6 years of age.
<b>X</b>	Inclusion of indigenous communities	Number of health facilities delivering services to eligible indigenous population in which there are Sanitary Agents (basic health care personnel) especially trained to treat indigenous population / number of health facilities delivering services to the eligible indigenous population.

## Annex 2 Main Stakeholders: Roles and Responsibilities under the Program

	NATION		PROVINCES		HEALTH PROVIDERS
ENROLMENT OF BENEFICIARIES	Consolidate the enrolment list of all provinces and validate its consistency	Umbrella Agreement/ Annual Performance Agreements	Consolidate and validate the registries, check against the social security enrolment list	Management Agreements	Identification and Registration
PACKAGE OF SERVICES	Design		Valorization		Deliver services and generate a bill
TRACERS	Determines the tracers, negotiates the targets with the provinces		Combines data from providers to determine tracer achievements		Reports data on coverage of the tracer services or conditions
FINANCING	Make transfers adjusted by results to provinces per beneficiary (US\$4/month); equivalent to the cost of the premium for a traditional health insurance scheme		Use transfers to pay services to health providers		Uses funds for: <ul style="list-style-type: none"> <li>- Human resources</li> <li>- Equipment</li> <li>- Infrastructure</li> <li>- Supplies</li> </ul>
OVERSIGHT / REGISTER	Internal oversight using systems and field visits of enrolment lists and health services		Internal oversight of registration form and health services		Registration of services in clinical history



### Annex 3 Argentina's Health Sector in Numbers

2009/2010

Population <sup>a</sup>	Millions	40.1
< 5 years old	% population	8.4
< 15 years old	% population	20.1
> 65 years old	% population	10.3
Life expectancy	Years	75

GDP <sup>b</sup>	US\$ per capita	7,472
Poverty <sup>a</sup>	% population under Poverty Line	13.2
Total Health Expenditure <sup>c</sup>	% GDP	9.4
Public Health Expenditure <sup>b</sup>	% GDP	6.2
	US\$ per capita	464
Private Health Expenditure <sup>c</sup>	% GDP	3.2

IMR <sup>d</sup>	% every 1,000 live births	11.9
MMR <sup>d</sup>	% every 10,000 live births	4.4
Health coverage <sup>a</sup>	% population with explicit health insurance coverage	64
Immunization Coverage <sup>d</sup>	Percentage of children 1 year old with coverage of measles vaccine or triple viral	100
Institutional Deliveries <sup>d</sup>	% live births attended by skilled health professional	99.5

Sources: (a) National Statistics and Census Institute (Instituto Nacional de Estadística y Censos) (2010). (b) In current international dollars, 2009; Ministry of Economy and Finance. (c) World Health Organization Health statistics ([www.who.int/nha/en](http://www.who.int/nha/en)) supplemented by country data. (d) National Ministry of Health, Directorate of Statistics and Health Information (2012). Argentine public spending comprises expenditures for health care, national and provincial social security (Obrassociales Nacionales y Provinciales), and the Institute of Social Services for Retirees and Pensioners at the national, provincial, and local levels. Dirección de Análisis de Gasto Público y Programas Sociales, Secretaría de Política Económica, Ministerio de Economía y Finanzas Públicas.

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The World Bank supports the efforts of countries to share prosperity by transitioning toward universal health coverage (UHC) with the objectives of improving health outcomes, reducing the financial risks associated with ill health, and increasing equity. The Bank recognizes that there are many paths toward UHC and does not endorse a particular path or set of organizational or financial arrangements to reach it. Regardless of the path chosen, the quality of the instruments and institutions countries establish to implement UHC are essential to its success. Countries will face a variety of challenges during the implementation phase as they strive to expand health coverage. With that in mind, the World Bank launched the Universal Health Coverage Studies Series (UNICO Studies Series) to develop knowledge and operational tools designed to help countries tackle these implementation challenges in ways that are fiscally sustainable and that enhance equity and efficiency. The UNICO Studies Series consists of technical papers and country case studies that analyze different issues related to the challenges of UHC policy implementation.

The case studies in the series are based on the use of a standardized protocol to analyze the nuts and bolts of 27 programs in 25 countries that have expanded coverage from the bottom up, starting with the poor and vulnerable. The protocol consists of 300 questions designed to elicit a detailed understanding of how countries are implementing five sets of policies to accomplish the following:

- Manage the benefits package
- Manage processes to include the poor and vulnerable
- Nudge efficiency reforms to the provision of care
- Address new challenges in primary care
- Tweak financing mechanisms to align the incentives of different stakeholders in the health sector

The UNICO Studies Series aims to provide UHC implementers with an expanded toolbox. The protocol, case studies and technical papers are being published as part of the Series. A comparative analysis of the case studies will be available in 2013.



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