



Health Benefit Plans in Latin America

A regional comparison



Inter-American Development Bank
Social Protection and Health Division

Health Benefit Plans in Latin America

Editors:

Ursula Giedion
Ricardo Bitrán
Ignez Tristao

scl-sph@iadb.org
www.iadb.org/health

May 2014



Cataloging-in-Publication data provided by the
Inter-American Development Bank
Felipe Herrera Library

Health benefit plans in Latin America: a regional comparison / Ursula Giedion,
Ricardo Bitrán, Ignez Tristao, editors.

p. cm.

Includes bibliographic references.

ISBN 978-1-59782-177-3

1. Medical care—Latin America. 2. Medical policy—Latin America. I. Giedion, Ursula.
II. Bitrán, Ricardo A. III. Tristao, Ignez. IV. Inter-American Development Bank. Social
Protection and Health Division.

RA410.55.L29 P43 2013

IDB-BK-122

JEL Codes: I1, I13, I18, H51

The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the Inter-American Development Bank, its Board of Directors, or the countries they represent. The unauthorized commercial use of Bank documents is prohibited and may be punishable under the Bank's policies and/or applicable laws.

Copyright © 2014 Inter-American Development Bank. All rights reserved; may be freely reproduced for any non-commercial purpose.

{ Contents

Foreword	5
Acronyms and Abbreviations	7
Introduction	
Making the Implicit Explicit: An Analysis of Seven Health Benefit Plans in Latin America	9
Part 1: Universal Health Benefit Plans	
Chapter 1. Chile: Explicit Health Guarantees (GES)	43
Chapter 2. Colombia: The Compulsory Health Plan	76
Chapter 3. Uruguay: The Comprehensive Health Care Plan (PIAS)	110
Part 2: Health Benefit Plans with Coverage for the Poor	
Chapter 4. Mexico: The Universal List of Essential Health Services and the Catastrophic Health Expenditure Fund	140
Chapter 5. Peru: The Essential Health Insurance Plan (PEAS)	166
Part 3: Health Benefit Plans Focused on Mother and Child Care	
Chapter 6. Argentina: Plan Nacer	195
Chapter 7. Honduras: The Basic Health Package (PBS)	221

Annexes

The annexes to this publication are available at <http://goo.gl/Mi3lep>

{ Acknowledgments

Health Benefit Plans: A Regional Comparison is a product of the Inter-American Development Bank (IDB) and was carried out under the guidance of Ferdinando Regalia, head of the Division of Social Protection and Health. This volume was edited by Ursula Giedion, senior health economist, Ricardo Bitrán, senior health economist, and Ignez Tristao (IDB), senior health and social protection economist. The three editors, along with Oscar Cañón, are also the main authors of the introduction, in which the results of the case studies in this book are analyzed. Ignez was responsible for the overall coordination of the production of this book, while Ursula was in charge of technical direction.

We, the editors, would like to thank Amanda Glassman from the Center for Global Development (CGD) for bringing this project to life, sharing her initial vision, and launching the first dialogue on the design, implementation and adjustment of health benefit plans. We also wish to thank Norbert Schady, who worked on the review panel for this publication, for his guidance and input.

We are also grateful to Daniela Philipp (IDB), Dorota Raciborska and Adriana Ávila for their collaboration in and dedication to the coordination and management of this project, Agustín Cáceres (IDB) for his editorial input, and Oscar Cañón, co-author of the introduction and the chapter on Colombia, for his technical input during the final editing of this book.

Many organizations presented their priority-setting policies and strategies as well as their design, implementation and adjustment processes for health benefit plans. They generously devoted time to filling out forms, submitting documents and answering questions from the researchers. We have learned from all of you. Thank you so much.

Lastly, we would like to thank Ignacio Camdessus and Sonia Jalfin of Sociopúblico, Kathryn Metz, and Círculo Salvo Comunicación for their dedication to the work of editing, translation, graphic design and production of this book.

{ Foreword

Guaranteeing the right to health care under equal conditions for all is a goal that every society desires to achieve, particularly in a region as unequal as Latin America and the Caribbean. Universal coverage is an important objective for most countries; however, the context for attaining universal coverage is difficult, as the pressure on health spending mounts with each passing day. The rapid development of medical technology, epidemiological changes and an aging population are some of the factors that lead countries to increase health spending. In addition, as a result of better living conditions and access to medical information, people have ever-increasing expectations of what the health system should offer them. At the same time, health care resources have not kept pace with demand, which has led to a widening gap. “No healthcare system in the world has sufficient resources to provide all its citizens with the highest possible quality of care; and anyone who believes otherwise is living in ‘cloud cuckoo land,’” says a recent article by Sir Michael Rawlins, president of the National Institute for Health and Care Excellence (NICE), a public institution in the United Kingdom that has been a pioneer in explicit decision-making on the funding of medical technologies by the British public health system.

Since there are not enough resources to offer all medical services to all those

who need them, their provision must be restricted; in other words, countries end up deciding, either explicitly or implicitly, who receives what services and with what resources. Many countries, both in the region and elsewhere, continue using implicit mechanisms: waiting lists, “dilution” of the quality of service, denial of services at the point of care, and high out-of-pocket payments. These mechanisms do not always favor the most vulnerable groups or the most pressing health issues.¹ For this reason, some countries consider implicit rationing to be rather inequitable and inefficient, and they have adopted health benefit plans that explicitly define the services to be covered by public funds.

These plans are emerging in the context of new social policy and international human rights paradigms. These explicit benefit plans may well be regarded as a realization of the right to health. Basic universalism—the guiding principle of social policy in the region, furthered by the Inter-American Development Bank (IDB) and other international organizations—promotes universal coverage, which includes the universal right to a set of essential benefits that will vary according to the possibilities and definitions established by each country.² These explicit, guaranteed and enforceable rights should be part of a new social pact to achieve universal social protection in the region, as maintained by the

¹ Gottret, P. and G. Schieber. 2006. *Health Financing Revisited. A Practitioner's Guide*. Washington, DC, World Bank.

² Filgueira F., C. G. Molina, J. Papadópulos and F. Tobar. 2006. “Universalismo básico: una alternativa posible y necesaria para mejorar las condiciones de vida en América Latina,” in C. G. Molina (ed.) *Universalismo básico: una nueva política social para América Latina*. Washington, DC and Mexico City, IDB and Planeta.

Economic Commission for Latin America and the Caribbean (ECLAC). Explicit and enforceable health plans are seen as an instrument to promote the enforceability of these rights and to address funding problems and coverage inequities.³ The scope of services offered by health systems is one of the three dimensions used to measure progress toward universal coverage⁴; a benefit plan can give an idea of the depth of coverage, provided that it is effective.

Renewed interest in benefit plans is confirmed by the position they currently occupy in sector debates. How have the countries in the region designed and adjusted these explicit plans? What methodologies have been used for this purpose? What difficulties have they faced? What lessons have they learned from this experience? As shown in the introduction to this book, several countries in the region have defined explicit health benefit plans and the number is on the rise, mirroring a trend being seen around the world.⁵ Yet despite the rich experience of many countries, attempts to systematize these experiences are still few and far between, especially in low- and middle-income countries.

In 2011, the IDB implemented a regional knowledge transfer project on explicit health benefit plans, including methodologies for priority setting, costing, budgetary impact assessment and monitoring, as well as lessons on the processes and institutions necessary for the plans to be technically and politically viable. Within the framework of this project, the IDB organized an

international workshop on benefit plans in Santiago, Chile in October 2010. The interest demonstrated by participating countries exceeded all expectations and highlighted potential synergies and the need for knowledge at the regional level. The seminar was also a starting point for a regional study in which seven Latin American countries analyzed their experiences with explicit benefit plans under a single methodology. Its results are summarized in the introduction of this book. From there, useful lessons can be drawn for other countries interested in adopting explicit benefit plans, or expanding and adjusting them.

Explicit benefit plans are not limited to lists of prioritized services, and they require significant, systematic and continuous methodological efforts from robust institutions and, last but not least, a sustained political commitment to turn priorities into reality. If this occurs, benefit plans may become the cornerstone of universal coverage.

Our hope is that this publication will serve as a guide for health managers in Latin America and the Caribbean, as well as other regions, in their mission to provide the best care to the greatest number of people using limited resources, while ensuring the technical and financial sustainability of the system. We sincerely hope you enjoy it and find it useful.

Ferdinando Regalia

Head of the Social Protection
and Health Division
Inter-American Development Bank

³ Giedion U., G. Panopoulou and S. Gómez. 2009. "Diseño y ajuste de los planes explícitos de beneficios: el caso de Colombia y México." ECLAC-SIDA.

⁴ World Health Organization. 2010. *Informe sobre la salud en el mundo. Financiación de los sistemas de salud: el camino hacia la cobertura universal*. Geneva, WHO.

⁵ Glassman A., K. Chalkidou, U. Giedion, Y. Teerawattananon et al. 2012. "Priority-Setting Institutions in Health." *Global Heart*, 7(1): 13-34.

{ Acronyms and Abbreviations

ASSE	National Health Services Administration (Uruguay)
AUGE	Universal Access with Explicit Guarantees (Chile)
AUS	Universal Health Insurance (Peru)
CABEME	List of Medical Benefits (Mexico)
CASES	List of Essential Health Services (Mexico)
CAUSES	Universal List of Essential Health Services (Mexico)
CMET	Medicines and Technology Evaluation Committee (Colombia)
CNPSS	National Commission for Social Protection in Health (Mexico)
CNSSS	National Council on Social Security in Health (Colombia)
CPU	capitation payment unit (Colombia)
CRES	Health Regulatory Commission (Colombia)
DGSP	Directorate-General of Health (Peru)
ENAHO	National Household Survey (Peru)
EPS	health promoting enterprise (Colombia)
FISSAL	Intangible Solidarity Fund for Health (Peru)
FNR	National Resource Fund (Uruguay)
Fonasa	National Health Fund (Chile)
FONASA	National Health Fund (Uruguay)
FOSYGA	Solidarity and Guarantee Fund (Colombia)
FPGC	Catastrophic Health Expenditure Fund (Mexico)
GDP	gross domestic product
GES	Explicit Health Guarantees (Chile)
GP	health service management provider (Honduras)
HBP	health benefit plan
HIV/AIDS	human immunodeficiency virus/acquired immunodeficiency syndrome
HSRP	Health Sector Reform Program (Honduras)
IAMC	not-for-profit health plan (Uruguay)
IDB	Inter-American Development Bank
IETS	Health Technology Assessment Institute (Colombia)
IHSS	Honduran Social Security Institute (Honduras)
IMAE	specialty hospital (Uruguay)
IMR	infant mortality rate
IMSS	Mexican Social Security Institute (Mexico)
INSSJyP	National Social Services Institute for Retirees and Pensioners (Argentina)

IPS	health care provider institution (Colombia)
Isapre	private health insurance institution (Chile)
ISS	Social Security Institute (Colombia)
ISSSTE	Government Workers' Social Security and Services Institute (Mexico)
JUNASA	National Board of Health (Uruguay)
LGS	General Health Law (Mexico)
LPIS	Prioritized List of Health Interventions (Peru)
MBMC	low/medium-cost medication (Uruguay)
MINSA	Ministry of Health (Peru)
MSP	Ministry of Public Health (Uruguay)
MSPS	Ministry of Health and Social Protection (Colombia)
PBMC	low/medium-complexity, low/medium-cost diagnostic and therapeutic benefit (Uruguay)
PBS	Basic Health Package (Honduras)
PEAS	Essential Health Insurance Plan (Peru)
Pemex	Petróleos Mexicanos (Mexico)
PIAS	Comprehensive Health Care Plan (Uruguay)
PN	Plan Nacer (Argentina)
PNME	National Essential Medicines List (Peru)
POS	Compulsory Health Plan (Colombia)
POS-C	Compulsory Health Plan – Contributory Regime (Colombia)
POS-S	Compulsory Health Plan – Subsidized Regime (Colombia)
PPP	purchasing power parity
PRIESS	Program for Institutional Reorganization and Expansion of Basic Health Sector Services (Honduras)
PyMAC	high-specialization, high-cost diagnostic and therapeutic benefits and high-cost, high-economic-impact medications
SESAL	Ministry of Health (Honduras)
SGSSS	General System of Social Security in Health (Colombia)
SIS	Comprehensive Health Insurance (Peru)
SISFOH	Household Targeting System (Peru)
SNIS	National Integrated Health System (Uruguay)
SPS	provincial health insurance fund (Argentina)
SPSS	System of Social Protection in Health (Mexico)
SUNASA	National Health Insurance Superintendency (Peru)
UECF	Coverage Expansion and Funding Unit (Honduras)

Introduction



Making the Implicit Explicit: An Analysis of Seven Health Benefit Plans in Latin America

Ursula Giedion, Ignez Tristao, Ricardo Bitrán, Oscar Cañón

“No country, no matter how rich, is able to provide its entire population with every technology or intervention that may improve health or prolong life,” states the World Health Organization (WHO, 2010). The growing gap between available financial resources and the actual cost to governments to guarantee the provision of health services for the entire population, including all existing health technologies, constitutes one of the greatest public policy challenges of the 21st century. This book analyzes the adoption of explicit health benefit plans (HBPs) in seven Latin American countries as a way of prioritizing health spending in the face of limited public resources.

The rapid growth of health care spending is no longer the sole concern of health sector stakeholders; indeed, it has also come to worry those responsible for ensuring countries’ fiscal stability. In the United States, where close to 17.9% of the GDP is spent on health care (according to 2011 data from WHO’s Global Health Observatory), the government has indicated that a high level of health care spending is the main determinant of public debt and long-term deficits (Rettenmaier, 2009).¹ Furthermore, in some countries, there is a growing concern that increased health expenditure

is crowding out spending in other areas (Jackson and McDermott, 2004) and affecting the overall economy (Office of the Assistant Secretary for Planning and Evaluation, 2005; Auerbach and Kellermann, 2011).

Evidence shows that the main determinant of growth in per capita health spending in recent decades has been the diffusion and use of new medical technologies (Bodenheimer, 2005; Kaiser Family Foundation, 2007; Giedion, Muñoz and Ávila, 2012).² In the United States, for example, it has been estimated that new health technologies³ account for between 33% and 50% of the increase in health spending (Mohr and Mueller, 2001; Newhouse, 1992). Today, there are already a dozen drugs on the market that cost more than US\$200,000 per patient per year (FiercePharma Manufacturing, 2013), and in 2012, for the first time, a marketing authorization was granted for a genetic drug with an expected cost of €1 million per treatment. These extremely expensive health technologies will have an increasingly significant impact on the financial sustainability of health systems. The Latin America and the Caribbean region has not been immune to this problem. A recent Pan American Health Organization

¹ In the United States, about US\$8,233 per capita was spent on health in 2010 (OECD, 2012). It is projected that the sector will absorb about one-third of the country’s revenue in the next 26 years.

² According to some studies, new prescription drugs should lower the total cost to society by reducing the number of hospitalizations (Zhang and Soumerai, 2007). This has been called the drug-offset effect.

³ Health technologies include devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives.

(PAHO) resolution notes that health technologies “are critical to the quality of care, yet their growing budgetary impact may threaten the sustainability of health systems” (PAHO, 2012). In addition, new technologies do not always offer a clear therapeutic advantage over those already on the market (Olfson and Marcus, 2013), which, in turn, illustrates how important it is for governments to subject these technologies to detailed scrutiny before financing them.

In the context of the situation described above, the question no longer centers on whether governments should make decisions about what to fund but rather how to make these decisions. How do governments direct limited public resources toward the health services that most benefit the population in a world where health technology evolves so rapidly and the medical possibilities and needs seem endless? With the resources that are available, who and what should be covered and under what circumstances? Answering these questions proves particularly difficult in low- and middle-income countries, since the medical community’s access to information on technological innovations in the health sector is the same regardless of the financial capacity of the health systems in which they operate, yet the availability of resources to fund these technologies varies widely, thus creating difficult-to-manage tensions between what is medically possible and what is financially feasible. High-income countries allocate approximately eight times more public resources to health on average (US\$3,240 PPP) than countries in Latin America and the Caribbean (US\$385 PPP) (2011 data from WHO’s Global Health Observatory). This disparity highlights the inability of the region’s governments to finance the same health care coverage as high-income countries, especially when considering that the region still faces equity issues, with a significant portion of the population lacking access to even basic health services. For example, data from demographic and health surveys shows that many poor women with a low level of education do not access

hospital-based labor and delivery care in several countries in the region, and in many countries, only a small percentage of those diagnosed with diabetes or hypertension receive adequate treatment (Giedion, Muñoz and Ávila, 2012).

When needs outweigh available resources, some form of rationing is bound to exist. Many countries within and outside the region are still operating exclusively with implicit rationing mechanisms such as waiting lists, cumbersome authorization procedures, denial of services at the point of care, etc. (Klein, Day and Redmayne, 1996). However, a growing number have adopted explicit priority-setting tools. These countries make explicit decisions about which health technologies to finance (or not) with public funds. There are two types of mechanisms to handle this, which many countries apply in a complementary fashion: the institutionalization of explicit priority-setting processes (for example, with the help of institutions dedicated to the evaluation of the costs and benefits of new medical technologies) and/or the adoption of an HBP that explicitly defines which services are to be financed with public funds.

The adoption of an HBP has become a trend in many countries, regardless of income level. For instance almost all European health systems financed by payroll taxes have explicit health benefit plans (Busse, Schreyögg and Gericke, 2007). In addition, most countries explicitly define drug benefits covered by their health systems no matter what type of system they have (Vogler et al., 2008). The question of whether to adopt more explicit benefit plans is even being discussed in some systems that are financed by general taxes. For example, there is a debate in the United Kingdom over whether the national health system should move from implicit rationing to a more explicit benefit plan (Rumbold, Smith and Alakeson, 2012). Low- and middle-income countries have been part of this trend as well. According to Glassman and Chalkidou (2012), at least 63 low- and middle-income countries in

all regions of the world—with or without insurance systems, with or without the participation of private stakeholders—now have explicit HBPs. In Latin America and the Caribbean, a growing number of countries have adopted explicit benefit plans to cover the entire population or target groups with comprehensive or limited-scope plans. In addition, several countries allocate a significant portion of their public resources to the funding of an explicit HBP. Colombia already channels more than 70% of its public resources into the funding of the Compulsory Health Plan (POS), while Uruguay allocates 72% (2008), Chile, 46% (2009), and Mexico, 28.1% (2011). Thus, explicit benefit plans are determining the allocation of public resources to an increasing extent, and they are becoming important instruments of efficiency and equity in health spending.

Policies on health benefit plans are nothing new. Perhaps the pioneer in this area was the state of Oregon in the United States, where an HBP was designed and implemented in the late 1980s to address the lack of full insurance coverage for the poor under the Medicaid system (DiPrete and Coffman, 2007). The criteria and methodologies used to adjust this HBP have evolved, but Oregon still updates and publishes an explicit list of covered services on an annual basis.

In 1993, in its World Development Report *Investing in Health*, the World Bank proposed that developing countries adopt explicit health plans financed with public funds, as this would allow scarce available resources to be directed toward interventions with greater impact on health (World Bank, 1993). More recently, under the concept of universal coverage promoted by WHO, explicit benefit plans or packages have received renewed interest. According to the well-known universal health coverage “cube,” coverage is defined in three axes or dimensions: the population covered by social security, the services covered, and the proportion of costs covered. A series of recent studies by the World Bank that analyzes 22 countries that have made

progress toward universal coverage found that 80% of them have an explicit benefit plan (World Bank, 2013).

The region already has numerous and varied experiences in the field of design and implementation of explicit benefit plans, but these experiences have not been systematically documented. Even international literature on the subject is scarce (Schreyögg et al., 2005; Stolck and Rutten, 2005; Mason, 2005). This accumulated knowledge is not easily accessible to policymakers and others interested in the subject, as it is dispersed among government agencies, specialized professionals, research institutes and consulting firms. This book seeks to systematically document the experience of seven countries in the region that have adopted explicit benefit plans.

The remainder of this chapter begins by presenting different definitions of what is meant throughout the book by the term “health benefit plan” or HBP. Following that section, the guidelines used to select and document the seven case studies are presented. Next, the countries’ main motivations for designing and implementing an HBP, the context in which these processes occurred, and the characteristics of their plans are examined. Then, the most innovative aspects and major challenges of each of the seven HBPs are highlighted, and, lastly, the main conclusions of the experiences explored in this book are analyzed.

Definitions

There is no consensus on the definition of an HBP. Many attempts to describe it have resulted in a circular definition; they define an HBP as a health benefit plan with certain characteristics. Therefore, in this section, instead of attempting a definition, the definitions in use are presented and the most relevant characteristics of the HBPs are described in order to outline the aspects that differentiate them from other health plans.

According to Tarimo (1997), HBP are “health service interventions that are considered important and that *society decides* [authors’ emphasis] should be provided to everyone.” According to Schreyögg et al. (2005), “The benefit basket refers to the totality of services, activities, and goods *covered by publicly funded statutory/mandatory insurance schemes or by national health services* [authors’ emphasis].”

According to Wong and Bitrán (1999), an HBP meets the following three characteristics: “1) It typically contains a limited subset of all health care interventions made possible by today’s medical technology; 2) Interventions are not randomly assigned to the package; rather, they result from a prioritization process to achieve specific technical and/or social objectives; and 3) Interventions are not independent from each other within the package. In fact, many are chosen specifically to complement or reinforce each other so that there is synergism among them.” As a complement to this definition, Rumbold, Smith and Alakeson (2012) describe three elements that form part of a benefit plan: i) the categories of services funded, i.e., the treatments and services that are defined as eligible for funding under the rules of the health system; ii) the appropriate use of services as defined by rules and protocols; and iii) financial constraints, which dictate the HBP services to be provided free of charge versus those that require a payment, as well as how this payment will be defined.

The above definitions and descriptions highlight several core features of an HBP:

1) *A minimum set of explicit guarantees...*
 The HBPs provide a minimum of services that must be guaranteed for all individuals on grounds of equity. No society, not even the wealthiest, can provide unlimited financing for all health services for the entire population. For this reason, an HBP sets explicit boundaries on the services, activities and goods covered. This contrasts with the traditional functioning of health

systems in Latin America, where there is generally a universal public supply of health services but with budget and resource constraints. An HBP defines what is covered in a positive manner. From this perspective, the negative lists used by some countries (for example, the United Kingdom) would not be considered an HBP.

2) *...financed with public resources...*
 These benefit plans are funded with public resources. From this perspective, plans financed by private funds through the payment of premiums would not be considered HBPs. However, benefit plans financed by compulsory payroll contributions would be HBPs regardless of whether the insurer is public. For example, the benefit plan that operates in Chile (AUGE), which is guaranteed by the country’s private insurers (Isapres), would be classified as an HBP since it is funded with compulsory payroll contributions, while the health plans offered by private insurers in Brazil to supplement the coverage provided by the Brazilian Universal Health System are not considered HBPs because they are financed with private funds.

3) *...and linked to the needs or social preferences of the population to be covered.*
 This means that there is no single ideal HBP for every country. The contents of the HBPs, in principle, should reflect the values of each society, whether defined through broad social participation (as in the case of Chile’s AUGE) or through a priority-setting or deliberative process by the government, based on its analysis of the population’s needs (as in the case of Mexico’s CAUSES). The process of defining the HBP’s content varies from country to country. In this regard, Klein (1995) writes, “What conclusions can be drawn from this international experience? Firstly, drawing up a set of principles [governing priority setting] is extraordinarily difficult. [...] contrast Sweden’s rejection of a cost-benefit approach with New Zealand’s use of the value-for-money criterion.”

Study Guidelines

In order to perform a comparative analysis of their HBPs, the case studies contained in this book have all followed the same guidelines (Giedion, Raciborska and Bitrán, 2010). The different stages of the HBPs were analyzed: the motivation behind their creation, the definition and costing of their contents, their operation, the evaluation of outcomes, and their adjustment. The following aspects of each HBP are addressed:

1. Reasons for its adoption
2. Priority-setting methods and costing of interventions
3. Main features: scope of services, population coverage, cost, use of guidelines and protocols, etc.
4. Funding sources and institutional arrangements for service delivery
5. Critical aspects of the implementation
6. Evaluation and monitoring
7. Methods and institutional arrangements for the periodic adjustment of coverage and financing

Every case in this book has been studied by a team of experts from each country and has undergone an international peer review.

There appears to be scant international literature on HBPs and even less at the regional level. Obtaining information for this book involved a difficult research and data collection effort, for which a combination of sources was used:

- National and international literature on the subject of priority setting and benefit plans
- Gray literature, signed by institutions and stakeholders that have participated in the design, adjustment and implementation of HBPs

(government documents, consultant reports, etc.)

- Structured interviews with key stakeholders

Priority-setting Mechanisms: To Ration or Not to Ration Is No Longer the Question

Since countries' health needs are greater than the resources available to health systems, rationing of some sort—whether explicit or implicit—is unavoidable. This section analyzes both mechanisms of rationalization. The first part demonstrates that an HBP can be a good tool for rationing by way of explicit priority setting. However, it should be noted that to reap the benefits promised by the adoption of an HBP, other conditions must fall into place, such as consistency between an HBP's cost and its budget allocations or the availability of human, technological and physical resources, among others. The second part of this section compares the advantages and disadvantages of an explicit benefit plan versus implicit rationing. The last part compares the pros and cons of adopting an HBP or negative lists, which identify the interventions or technologies that are not covered rather than the ones that are.

Potential advantages of an explicit benefit plan

Mentioned below are the objectives to which an HBP can contribute, sorted from the most strategic and fundamental in nature (to guarantee the right to health and promote equity) to the most operational (to serve as a management tool and ensure comprehensive care).

Realize the right to health. By explicitly defining a minimum set of services to be provided to all, HBPs allow for the realization of the right to health.

Furthermore, since an HBP publicly establishes the system's obligations to the citizens, this explicit definition becomes a commitment. By making the rights of citizens known and making available the legal instruments to demand these rights, an HBP can improve accountability and citizen empowerment. Citizens become aware of the specific benefits to which they are entitled. In many countries in Latin America and the Caribbean, the state's obligation to its citizens to guarantee universal and equitable access to health care is enshrined in their constitutions⁴ or health systems. However, in practice, inadequate public resources have resulted in the rationing of care and breach of that which is established by law. Those creating an HBP often seek to move from a sweeping and unattainable promise to an explicit, narrowed, achievable and affordable definition of services to which all should have access. This motivation to make explicit what was once implicit was cited as one of the reasons for creating an HBP by virtually every country included in this book.

Improve equity in health. By making explicit a universal set of minimum services, HBPs can improve health equity. Roberts, Hsiao, Berman, and Reich (2008) propose two notions of equity: absolute equity, under which any difference in access to health care among individuals is considered unacceptable, and relative equity, for which differences are acceptable to the extent that all individuals have access to a minimum set of services. Under the concept of relative equity, an HBP could serve as that socially-acceptable minimum. This idea has regained relevance in the context of the current universal coverage movement that seeks "access to key health interventions to promote, prevent, cure and rehabilitate all members of society at an affordable cost" (Guerrero, Arreola-Ornelas and Knaul, 2010). Many countries have chosen to explicitly define what these key interventions will be.

Most of the countries in this book invoke equity as one of the main reasons that led them to define an explicit benefit plan. The clearest example illustrating the potential for an HBP to serve as a mechanism to achieve a real improvement in equity is that of Mexico. The definition of CAUSES made evident the resources required to offer an essential plan to both the insured and uninsured populations. This mobilized the resources needed and led to a more equitable distribution of available resources to people with or without formal social security (Frenk, Gómez-Dantés and Knaul, 2009).

Align health goals and resource allocation to maximize impact on health. The World Health Organization (2010) and Roberts et al. (2008) argue that countries should have three policy goals: improving health status, meeting the expectations of the population, and providing financial protection. With regard to the first goal, an HBP allows spending to be redirected toward the most effective interventions and *maximize their impact on health* by explicitly defining which services are financed with the available public resources. An HBP would then serve to improve efficiency in health spending. In this regard, a World Bank report maintained that the introduction of an HBP is one of the three strategies required for public policies to improve health conditions in developing countries; an essential minimum set of cost-effective interventions could prevent 71% of the disease burden among children under 15 and 50% of the disease burden in adults (World Bank, 1993). The countries included in this book, with the exception of Chile and Mexico, have rarely articulated and applied explicit cost-effectiveness criteria when defining or adjusting the contents of their HBPs. Colombia attempted to do so with the help of internationally renowned experts; however, it failed after proving unable to handle political considerations (Plaza, 1996).

⁴ For example, the Haitian Constitution says: "The State has the absolute obligation to guarantee the right to life, health, and respect of the human person for all citizens without distinction...The State has the obligation to ensure for all citizens in all territorial divisions appropriate means to ensure protection, maintenance and restoration of their health."

In addition, countries have recognized the importance of the other two policy goals put forth by WHO, and they have considered including high-cost interventions with low impact on overall health status in the HBP to provide people with *financial protection*. Explicit plans to cover catastrophic or high-cost events in Peru (FISSAL), Mexico (FPGC) and Uruguay (FNR) also illustrate the desire to capture in a benefit plan services that would create an undue financial burden on households if they were not covered by public funds. Countries have included services that are not cost-effective but are *benefits that people want to receive*; therefore, they aim to direct health spending toward the second goal proposed by WHO, as mentioned above. For example, Chile's AUGE included oral health interventions as a result of public consultation. Striking the right balance in the allocation of public resources for these three goals is a challenge. It must be considered that without explicit criteria or mechanisms to define resource use, it is likely that resources will be allocated on the basis of pressures from system stakeholders, especially those with a greater capacity for involvement and coordination. Thus, it is highly likely that the most expensive and profitable technologies will replace the least expensive and profitable ones. This can be detrimental because the most profitable technologies are not necessarily those most capable of effectively resolving the population's health problems.

Increase rationing's social legitimacy by making it explicit. The implicit rationing of services that countries are compelled to adopt leads to discontent among citizens; however, an HBP can increase rationing's social legitimacy by making it explicit. In the creation of an HBP, the method and criteria for developing the plan are agreed upon in advance.

In contrast to the potential benefits of explicit priority setting associated with

the implementation of a benefit plan, the implicit rationing of services is carried out through the denial of services based on ad hoc criteria, the referral of patients to other providers, delayed care, and the provision of incomplete or low-quality services, also called dilution.⁵ These mechanisms are illegitimate given that they lack a methodology or publicly-accepted criteria and that their basis lies in the judgment and discretion of different agents, whose intentions are unknown, following procedures that are rarely participatory or appealable.

Improve the management of planning, financing and delivery of services. An HBP is a *management tool* in all health systems in which the government has delegated the insurance function to a third party. In these circumstances, the government establishes the amount to be paid to either a public or private third party in exchange for guaranteed delivery of a set of explicit benefits. Today, most health systems in Latin America that have adopted a universal insurance scheme to structure their health systems have explicit benefit plans (Colombia, Chile, Mexico, Peru, Uruguay and others).⁶

Besides the fact that an HBP defines insurance-related obligations, it also facilitates budgeting and greater transparency in terms of resource allocation. This is possible because in order to implement an HBP, it is necessary to calculate a premium or per capita value for the services to be rendered. It also allows for expectations from the health supply to be specified and expressed, thereby serving as a tool in the planning and development of services. The HBP indicates to all sector stakeholders which services must be offered.

Promote comprehensive care and improve the quality of care. The HBP is expected to facilitate the delivery of comprehensive care since HBP benefits are often structured around health problems,

⁵ For a description of the different forms of implicit rationing, see Klein, Day and Redmayne (1996).

⁶ Nonetheless, there are countries whose public systems are intended for the uninsured, which continue to operate with traditional supply-side subsidies alongside an explicit benefit plan. This is the case for Argentina's Plan Nacer and Honduras' benefit plan.

pathologies or the lifecycle (see the cases of Chile and Peru as an example). Furthermore, when the services listed in the HBP are accompanied by instructions regarding their use in the form of protocols or clinical practice guidelines, the plan can simultaneously promote and guarantee a minimum standard of quality. Protocols and guidelines associated with HBP benefits are in use in several of the countries described in this book. For example, when CAUSES was defined in the context of Seguro Popular, one of the main reasons for implementing the plan was for it to serve as a quality assurance tool, and it was designed to guarantee that all necessary services were provided according to standardized protocols (Frenk, Gómez-Dantés and Knau, 2009).

The advantages of implicit rationing

Although an increasing number of countries are making explicit the benefits they guarantee to their population (Schreyögg et al., 2005), some countries have chosen to follow the path of implicit rationing and/or have adopted negative lists instead of positive ones to define what is covered and what is not.

Implicit rationing neither defines nor prioritizes a set of benefits. Within this framework, the health system would be obliged to provide everything a citizen needs, when he needs it; however, since the needs of the population are greater than the available resources, it is impossible to satisfy all of the demand. So, as the sector's resources are gradually depleted, waiting lists are generated, services are denied at the point of care, and it becomes more difficult to obtain authorization for procedures.

Supporters of implicit rationing reject explicit rationing on ethical and political grounds. Their argument is that any type of rationing or limitation placed on the judgment of the treating physician is unacceptable and restricts medical autonomy and that explicit priority setting runs contrary to the right to health (Malagón Oviedo et al., 2010).

They worry that an HBP limits the technologies that professionals have at their disposal to address their patients' health problems. In Colombia, the president of the Colombian Association of Scientific Societies stated that "maintaining a health care scheme in the form of a list (of diseases, technologies and drugs) is not a remedy to illness; all it does is perpetuate the system's difficulties." He went on to say that the health system should provide "what the person needs for as long as he needs it" (Camargo, 2011). As seen in the case study, this position largely explains why Colombia is about to abandon its explicit benefit plan.

In addition to these arguments made on principle, other assertions in favor of implicit rationing make reference to the great challenges and technical issues involved in defining and adjusting an HBP. These challenges are threefold: i) the difficulties in defining, implementing and adjusting an HBP; ii) the possibility of political manipulation and the undesirable results that can arise from an open discussion; and iii) the limitation on the autonomy of local authorities and providers (Mechanic, 1997; Garpenby, 2003; Rumbold, Smith and Alakeson, 2012). As to the first argument, the development of an evidence-based HBP using explicit priority-setting criteria is not an easy task because, at least in theory, the contents of the HBP should be the result of a thorough technical cost-benefit analysis of all health technologies (Chalkidou, 2012). For this reason, some authors believe it may be a disproportionate task (Rumbold, Smith and Alakeson, 2012). Furthermore, the process of defining an HBP necessarily implies clarity with regard to the cut-off points that will be used to decide whether a service or technology should be included in the benefit plan. Defining cut-off points is complex because it involves choosing selection criteria and assigning importance to each one, and then deciding when to include a benefit or not (Chalkidou, 2012). As will be seen in this book, the technical design of HBPs based on a rigorous application of evidence and

explicit criteria has not been the norm in the region, at least in the countries studied here.

As to the second argument, vulnerability to political manipulation and undesirable results from an open discussion, an HBP should be defined through a participatory process that confers legitimacy. However, if this process is not handled properly, interest groups may cause the HBP to favor the diseases and technologies that have the most impact on public opinion through the media, which are not necessarily those with the greatest impact in terms of the health system's efficiency and equity.

At the international level, several countries have preferred implicit rationing for one or more of these reasons. This is the case in the United Kingdom, where one study found that the disadvantages of implementing an HBP in this country outweigh the advantages of combining implicit rationing with other measures (Rumbold, Smith and Alakeson, 2012). Perhaps the most important takeaway from this study is that implicit rationing can be a valid approach as long as it is accompanied by other policy measures to address the gap between available resources and demand, such as the evaluation of technologies, the introduction of incentives to provide services that have a greater impact on health, or the provision and dissemination of explicit recommendations about the benefits and costs of adopted technologies.

Of the countries studied in this book, only Colombia is considering the possibility of distancing itself from its comprehensive, detailed benefit plan and attaching greater importance to implicit rationing by introducing a negative list of services that will not be funded. In June 2013, this country passed a framework bill that lays the groundwork for a negative list (Ministry of Health and Social Protection, 2013). This was largely the result of a change in the tide of system stakeholders' political power, in which doctors have grown more assertive

in the defense of their medical autonomy in the face of an insurance sector responsible for guaranteeing the provision of an HBP that is increasingly discredited in public opinion. The Colombia chapter elaborates on this topic.

Lastly, several countries included here have chosen what might be called a third path, with the explicit prioritization of certain services considered of utmost importance coexisting alongside implicit rationing. Theoretically, in these systems all services are guaranteed, but some receive preferential treatment. This avoids the political cost of explicitly denying some services.

Implicit rationing or adoption of an HBP

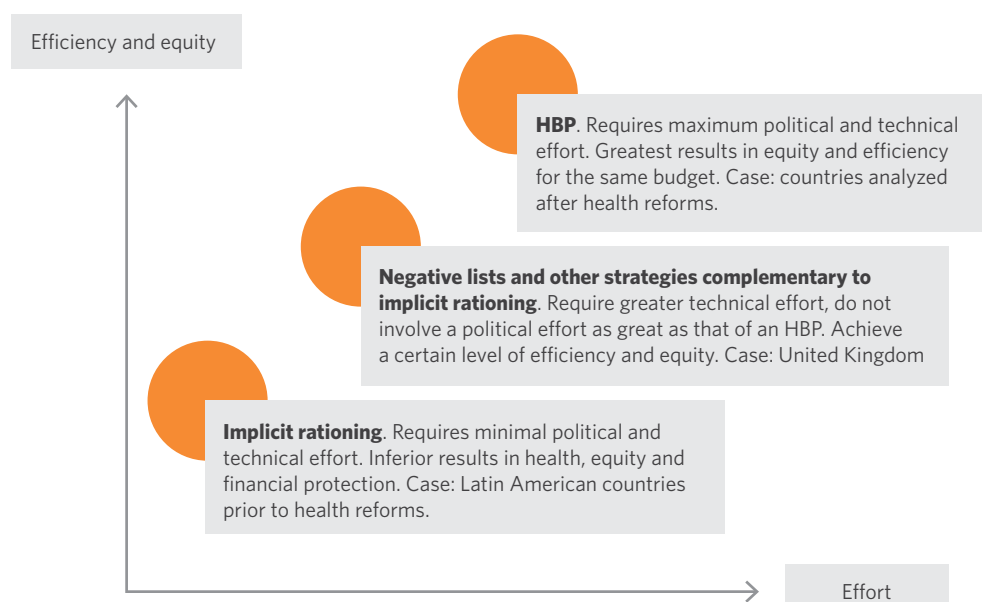
Policymakers are torn among three alternatives: assume full implicit rationing; adopt an HBP that explicitly defines what the government will guarantee; or split the difference by adopting negative lists. These alternatives are outlined in figure I.1.

Full implicit rationing requires minimal technical and political effort. Resources within the system are allocated according to spending by service providers and the political influence of each region, population group, institution, or interest group. In other words, it is an approach that allows the system's agents to vie for resources, and those that are strongest, both politically and economically, receive the lion's share.

In contrast, an HBP involves a major technical as well as political effort to define and periodically adjust a set of services that satisfies previously agreed-upon, explicit criteria, which seek to maximize ex ante social welfare using available resources.

With the intermediate alternative, several strategies make the realization of the right to health more explicit, and they improve efficiency and equity in resource allocation without defining

Figure I.1. Dilemmas between effort and efficiency-equity



Source: Developed by the authors

an explicit and comprehensive HBP. Among these are the adoption of negative lists of technologies that are excluded and mechanisms that promote the use of technologies that contribute the greatest value to health systems, such as the design of copayments that discourage the consumption of non-cost-effective technologies (Thomson, Schang and Chernew, 2013), regulation of prices based on drugs' therapeutic value (Taylor, 2010), outcome-based payment, strengthening of primary care, and encouragement of generic drug use. Technically speaking, these mechanisms are less difficult to implement than the design and adjustment of an evidence-based HBP and, above all, they are more easily managed from a political standpoint; however, their potential to direct health spending toward more efficient technologies is not as clear. Choosing this other path also depends on the context of the health system. For example, insurance systems that transfer risk management to third parties in exchange for a premium must clearly establish this financial risk, either

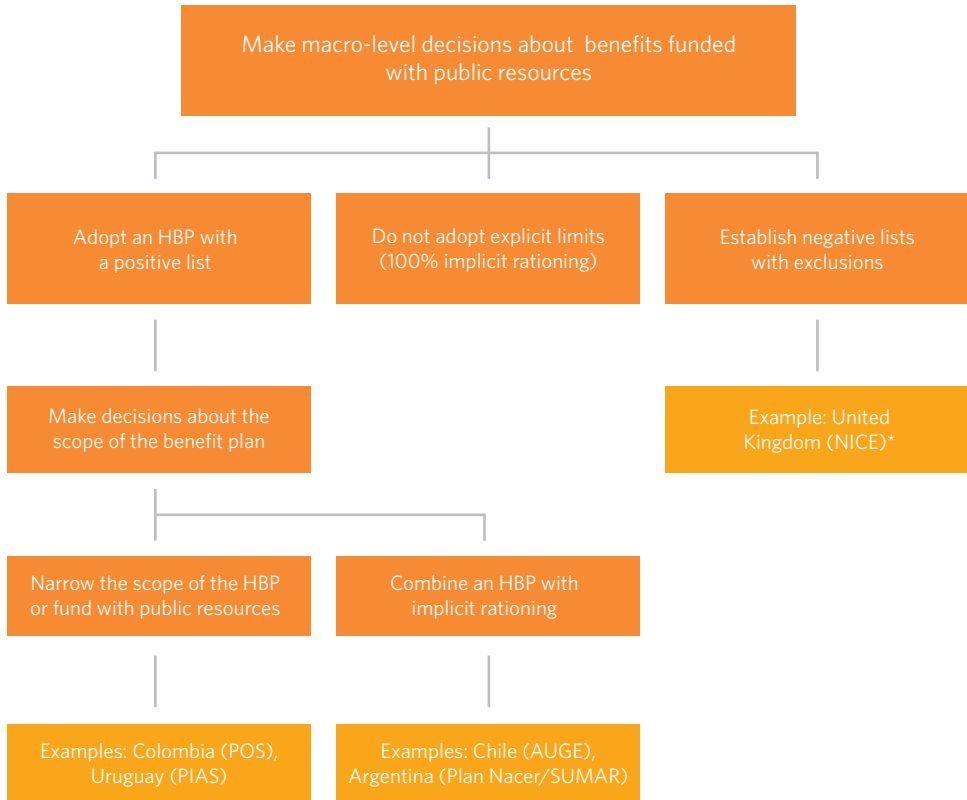
through an explicit benefit package or risk limits.

Positive or negative list

Once countries decide to make explicit what they will or will not cover through their health systems, a second design decision comes into play. Should these decisions be reflected in a positive list, a negative list, or a combination of both types of lists? There is no systematic review of this topic; however, it is known that almost all countries in the European Union have turned to positive lists (88%), though they are often limited to drugs only (80% of those using positive lists). Some combine positive and negative lists (8%), while a small group of countries (12%) uses only negative lists (Carone, Schwierz and Xavier, 2012).

At first glance, it would seem that it makes no difference whether a country opts for a positive list or a negative one, since the act of defining one establishes the other. Nevertheless, each option has different technical and political implications. In

Figure I.2. Key decisions



Source: Developed by the authors

*Note: Both negative and positive lists are in use in the United Kingdom.

principle, under the assumption that what is excluded encompasses a smaller universe than what is implicitly included, a negative list would be easier to create than a positive one, since it is understood that all of the content in a positive list has been evaluated in some way (Rumbold, Smith and Alakeson, 2012). A positive list may require an intense amount of work, since each technology must be evaluated, as well as any new technology that is later added (Dukes, Haaijer-Ruskamp, de Joncheere and Rietveld, 2003). In terms of the delivery of health services, a negative list grants greater autonomy to providers, since they can freely decide which technologies to use as long as they are not part of the negative list (Rumbold, Smith and Alakeson, 2012). Alternatively, a positive list can prove a useful mechanism

to counter the pressure to include new and costly technologies, since it only finances those items that have been explicitly included. This is more difficult with a negative list because all new technologies are automatically included unless an explicit decision is made to not fund them. Furthermore, explicitly stating what is not covered affects the interests of certain groups and, therefore, can be politically costly, especially if they manage to mobilize public opinion (Dukes, Haaijer-Ruskamp, de Joncheere and Rietveld, 2003).

Some countries have tried to get the best of both types of lists by combining them. This is the case with the Netherlands and the United Kingdom, which have found it beneficial to manage several lists,

especially for drugs. One list specifies the drugs that must be guaranteed to any patient to whom they are prescribed, and the other details those that must be supplied only in certain circumstances (for example, after having tried other medications). A third list contains drugs that will not be funded under any circumstances (Giedion, Muñoz and Cañón, 2013).

Lastly, the context of each health system influences the suitability of either a negative or positive list. For example, if certain stakeholders are responsible for insuring the population, it is unlikely that they will accept the risk of offering “everything except some explicit exclusions” in exchange for a limited premium. It is precisely this issue that forms part of the discussion in Colombia about whether to abandon the policy of an explicit HBP.

When deciding between one type of list or the other, the following should be considered: the political capacity of the regulatory entity to address different advocacy groups, the technical capacity to define the contents of the HBP, and consistency with the health system, among other factors.

Policymakers are faced with different alternatives to address the problem of rationing. First, they must decide whether to explicitly prioritize benefits at the macro level. If so, they must then decide how to go about translating these decisions into policy, whether through an HBP, negative lists, or a combination of an HBP and implicit rationing mechanisms. These key decisions are represented in figure I.2. This book focuses on the left side of the figure, experiences with HBPs.

Comparative Analysis of the Basic Characteristics of the HBPs

This section compares the main features of the seven HBPs analyzed in this book.

First, it describes the socioeconomic context of the HBP and its health system. It then goes on to describe the time period when the HBP was adopted and the reasons supporting the decision. Next, the service and population coverage of the HBP are discussed, as well as their importance to the total health expenditure as a potential strategic purchasing tool. This section also examines how countries have begun to introduce guarantees in their HBPs that go beyond the list of services that can be accessed by beneficiaries. Lastly, the common denominators among the HBPs of the countries analyzed are presented.

Socioeconomic and health system context

The seven cases in this book have very different characteristics (see table I.1). Honduras, for example, is a country with a low income level, high poverty, a large rural population, scarce public resources to finance health care, and many challenges in terms of reproductive health and the prevention and treatment of infectious diseases. In contrast, Uruguay is a country with an upper-middle income level, low poverty, and a mostly urban population, with greater availability of resources to finance health care, and a health status in which chronic diseases predominate. These differences pose distinct challenges in the definition and implementation of benefit plans. All countries would like to offer their citizens coverage and quality guarantees for health services; however, socioeconomic conditions influence the scope or depth of the HBP that a country is able to offer. Uruguay's benefit plan is very broad and similar in scope to that of high-income countries, while Honduras is limited to offering a basic plan restricted to maternal and child health care.

Nonetheless, the countries share many of the same design challenges. For example, they must all decide on the size of the benefit plan, its target population, and the methods for purchasing the services included in the HBP and for allocating

Table I.1. Some socioeconomic and health indicators

Country	Population (in millions)	Per capita income, US\$ PPP	Health spending (HS) per capita, US\$ PPP	Public HS per capita, US\$ PPP	HS (% of GDP)	Out-of-pocket spending (% of total HS)	IMR
Argentina	40	17,130	1,434	408	8.2	25	14
Chile	17.1	16,330	1,292	455	7.5	37	9
Colombia	46.3	9,560	618	345	6.1	17	18
Honduras	7.6	3,820	193	92	8.6	48	21
Mexico	113.4	15,390	940	296	6.2	47	16
Peru	29.1	9,440	496	145	4.8	38	18
Uruguay	3.4	14,640	1,210	669	8	13	10

Source: WHO database

Note: Data from 2011, except for population figures, which correspond to 2010
 PPP: purchasing power parity; IMR: under-five mortality rate per 1,000 live births

resources. In addition, they all face permanent political pressure to expand plan content, limited empowerment and public knowledge of the benefits offered, and difficulties in monitoring that the plan is really being delivered and is not just an empty promise.

The HBPs analyzed in this book fall into three types of health systems according to their level of segmentation: i) systems that segment access by socioeconomic status and type of employment relationship, with minimal coordination between systems (this group includes Argentina, Honduras, Mexico, and Peru); ii) systems that are segmented but unified in key aspects, such as the existence of a single benefit plan and common governance and regulation (this group includes Chile and, to a large extent, Colombia); and iii) unified systems, which, besides having just one health plan and equal regulatory structure for all, manage resources through a common fund that is supported by defined contributions based on the ability to pay and that finance a single plan (Uruguay, with its National Integrated Health System [SNIS], is the only country

studied that fits in this group). These differences are important to the extent that the system's level of segmentation correlates to that of the benefit plans. The highly-segmented health systems (the first group) offer broad plans for formal-sector workers and their immediate family members, while more restricted plans are available to the rest of the population (in Mexico and Peru, those unaffiliated with the social security system; in Argentina and Honduras, the mother and child population). Colombia (since 2012) and Chile offer a single benefit plan that is the same for all, but access to the health system differs depending on the individual's ability to pay. The benefit plan is mainly delivered through the public network for individuals enrolled in Fonasa (Chile) or the subsidized regime (Colombia), while the rest of the population—those with higher socioeconomic status (Colombia and Chile) and lower risk (Chile)—access this plan through a mixed network. Furthermore, in Chile, the contribution made by Isapre enrollees to finance AUGE does not depend on their ability to pay but instead is determined by the cost of providing the plan.⁷ Only

⁷ See analysis by Chile's Superintendency of Health on variations of the AUGE premium in the Isapre system at <http://www.lanacion.cl/prima-auge-isapres-aumentaron-precio-promedio-en-33-9/noticias/2013-05-28/130803.html>.

Table I.2. Central motivations for adopting an HBP

Year of adoption	Country Name of HBP	Motivation
1993	Colombia POS	Establishment of an insurance framework with separation of duties and resource mobilization to improve equity and ensure a minimum level of coverage for all
2003	Argentina Plan Nacer	Economic and social crises as a catalyst for establishing more explicit guarantees
2003	Honduras PBS	Part of a decentralized management framework with separation of duties that required the definition of services to be delivered
2003	Mexico CAUSES and FPGC	Mobilization of resources for greater equity; quality assurance tool designed to ensure that the necessary services were provided according to standard protocols; and empowerment of the insured population, making individuals aware of their rights
2005	Chile AUGE/GES	Public dissatisfaction that led to the need to provide health care services with explicit guarantees
2006	Uruguay PIAS	Equity in access to explicit and enforceable benefits
2009	Peru PEAS	Equity; the desire to provide a minimum level of coverage for all citizens as part of a universal insurance plan

Source: Developed by the authors on the basis of the case studies

in Uruguay are all individuals entitled to the same benefit plan, financed by a single pool of resources to which citizens contribute according to their ability to pay. Lastly, the provision of differential plans by segment and population group also reflects the considerable differences in resources available to each of the segments. This situation generates inequality, since the most vulnerable population with the greatest needs often has more limited coverage than the wealthier population.

Year of adoption and motivation behind the adoption of the HBPs

The case studies in this book reveal important commonalities and differences in terms of the motivations that led the countries to adopt an explicit benefit plan (table I.2). In Colombia and Honduras, the central motivation—though not the only one—was eminently practical; by delegating the management of health care services to a third party, a contractual relationship was generated that required a definition of the amount that would be paid in return for providing a set of benefits. Almost all of the other countries

cited increased equity in financing and access as a central reason for adopting an HBP. In Chile and Argentina, dissatisfaction with a system that, theoretically, promised everything but that operated with obvious restrictions in terms of access was the main catalyst to explain at least a portion of the services that the system must provide.

The countries studied in this book have adopted explicit plans at different times. Colombia was the pioneer back in 1993, when the concept of basic packages promoted by the World Bank was at its peak. The country decided to introduce an insurance program for its entire population that came with the need to define exactly what the insurer was going to cover in exchange for a premium. The other countries then followed suit, with Peru as the last to join. As discussed in this book, depending on the years of experience that each country has with its HBP, some processes will be more mature than others, so much so that even the very idea of an explicit benefit plan could be called into question. For example, Chile, eight years after implementing its AUGE plan, has begun to design a framework to institutionalize health

Table I.3. Scope and coverage of the benefit plans

Country	Target population	Population coverage	Coverage of services	Estimated annual cost per capita (in nominal US\$)
Name of the HBP				
Argentina Plan Nacer	Population without social security, emphasis on maternal-child group with gradual increase of target population (currently, all women up to age 64 and adolescents)	63% of the population without explicit insurance (23% of total population) (2012)	Maternal and child services at the primary care level with gradual expansion to other services such as surgeries for congenital heart disease	US\$4 (additional marginal cost) (2010)
Chile AUGE/GES	Entire population	97% (2011). The rest were covered by other social security systems in health	80 health problems (2013) whose treatment is estimated to cover 60% of the national burden of disease	US\$168 (2013)
Colombia POS	Entire population	92% (2012)	Comprehensive package, all levels of care, the same for all Colombians as of 2012	US\$374 (POS-S) and US\$418 (POS-C) (2013)
Honduras PBS	Rural poor population, with emphasis on maternal-child group	10.7% of the total population, 16.8% of the poor population, and 25% of the rural population (2012)	Maternal and child services at the primary care level, with emphasis on health promotion and prevention	US\$25 (2004)
Mexico CAUSES and FPGC	Population without social security	Approx. 45% of the total population	CAUSES provides low- and medium-complexity services while the FPGC covers catastrophic events	US\$200 (2012)
Peru PEAS	Entire population	67.3% of the target population	140 insurable conditions (e.g., gestational diabetes). Services account for +/- 65% of the country's burden of disease, with an emphasis on pediatric and obstetric and gynecologic conditions	US\$174.70 (MINSAL), US\$199.70 PRAES and SIS. Variable cost US\$104 (2011)
Uruguay PIAS	Entire population	95% (2012). The rest were covered by other social security systems in health	Very broad coverage of all services, from preventive care to curative care and rehabilitation	No costing study. Annual premium is US\$650 per beneficiary (2011)

Source: Developed by the authors on the basis of the case studies

technology assessment, thus informing its coverage decisions for the plan. After a decade with explicit benefit plans, Mexico recently introduced legislation that stipulates that the inclusion of any technology in the Health Care Formulary and Supply Catalog must be accompanied by an economic evaluation study that

demonstrates the technology's advantages over the options that are already included. In Colombia, the region's pioneer in explicit benefit plans, many stakeholders are wondering whether the best path is to adopt an explicit benefit plan with a positive list detailing each service to be covered.

Service and population coverage and cost of the health plan

Defining *who* and *what* to cover are key decisions when opting for an HBP. Answering these questions forms an essential part of a health system's strategic purchasing decisions (in addition to deciding how and from whom to purchase) (Busse, Figueras, Robinson and Jakubowski, 2007). The cases included in this book made different decisions regarding which population would be covered by the explicit health plan (see table I.3). For example, Uruguay's PIAS is aimed at the country's entire population, while the Honduran benefit plan focuses solely on poor maternal and child populations in rural areas. Different levels of health coverage are also observed, from modest coverage in Honduras and Peru, to near-universal coverage in Chile, Colombia, Mexico and Uruguay. Regarding the scope of the health plans, there is a very broad range, from Honduras, with its focus on maternal and child health services to Uruguay, with its broad and comprehensive plan. There are also differences in cost; Argentina only earmarks US\$4 per beneficiary to finance the additional cost of improving the maternal and child services offered by Plan Nacer (data from 2010), while Uruguay allocates US\$650 per beneficiary for its plan (data from 2011). A country such as Uruguay, which invests US\$669 in public resources per capita annually—the highest amount of the cases in this book—can offer a much broader health plan and cover a larger swath of the population than Honduras, which only spends US\$90 in public resources per capita annually (data from 2011). However, the decision of what and whom to cover does not depend only on available resources, as shown, for example, in the differences between Argentina and Colombia. Argentina, with a public expenditure per capita of US\$408 per year, operates a small benefit plan that costs US\$4, while Colombia, which has a similar public investment per capita (US\$345 in 2011), has decided to finance a broad health plan that costs about US\$374 PPP for the subsidized regime and

US\$418 PPP for the contributory regime (2012). Defining the scope of the health plan is also a political decision, for which some prefer to provide only a subset of services to the population (Argentina, Chile and Honduras) while others aspire to include almost any service in their benefit plans that their citizens may require (Colombia, Uruguay and Mexico).

Expenditure channeled into the provision of the HBPs

The countries analyzed here have assigned very different proportions of their public resources to fund the explicit benefit plans. In Uruguay and Colombia, most public spending is allocated to benefit plans that operate in the context of universal health insurance systems, while in Argentina, Honduras and Peru, the resources allocated to the HBP represent less than 10% of the total public health expenditure. These differences reflect, in part, that the HBPs matured differently following their implementation. In Peru, PEAS is still in the pilot phase and covers only small pockets of the population. Argentina's Plan Nacer/SUMAR benefit plan is in the process of gradually increasing benefits and adding beneficiaries. Chile is a special case since it has a consolidated universal health insurance system, yet it has decided to allocate only 46% of its total public resources to funding an explicit list of illnesses considered priorities. The remaining public resources are allocated through implicit rationing. Prioritized illnesses benefit from priority access, and comprehensive, quality care and timely diagnosis and treatment are guaranteed, along with financial protection. In other cases, it is possible to access services without explicitly stating the benefits and without providing guarantees. This is an interesting option in countries where it is politically very difficult to specify the exclusion of some services or where there is the risk of legal action, such as in Colombia and, increasingly, Uruguay (Iunes, Cubillos-Turriago and Escobar, 2012; Guerrero, Arreola-Ornelas and Knaul, 2010), where citizens demand

Table I.4. Public expenditure channeled through the HBP

Country	Name of HBP	% of total public health expenditure to fund HBP	Observations
Peru	PEAS	There are no known estimates of public expenditure on PEAS	Only includes variable costs; fixed costs are financed by historical budgets
Honduras	PBS	2.61% of total Ministry of Health expenditure and 1.8% of total public health expenditure	Only includes poor rural areas. The rest is financed by the historical budget
Argentina	Plan Nacer	0.9% of provincial health expenditure	Only includes the cost to improve quality and coverage of prioritized services. The rest is financed by the historical budget
Mexico	CAUSES and FPGC	28.1% of public health expenditure (2011)	FPGC only covers variable cost; fixed costs are financed by historical budgets
Chile	AUGE/GES	46% of Fonasa health expenditure (2009)	
Uruguay	PIAS	72% (2008)	
Colombia	POS/POS-S	74% (2007)	

Source: Developed by the authors on the basis of the case studies

services not included in the HBP via judicial mechanisms.

With the exception of Colombia and Uruguay, it is difficult to determine the amount of resources channeled toward the HBPs since there are often no mechanisms that link provider funding to the HBP and its cost.

Organization of the HBPs and level of detail

As this book shows, there are different ways of organizing and describing health services. The services can be organized around different axes: types of technology (such as services, devices and medications), diseases, pathologies, levels of care, or by type of health condition or illness. The countries analyzed here have chosen different paths. The HBPs of Argentina, Chile, Mexico and Peru are structured around pathologies or health problems, and they describe, within each of these problems or diseases, the services required for comprehensive, quality care. Colombia, Honduras and

Uruguay organized their HBPs by type of technology (interventions and procedures organized by level of care and medications organized separately from interventions).

Regarding the level of detail with which the benefits are described, there is some variation between countries, with Chile, Colombia and Peru employing the highest level of detail—even specifying the type of medication and maximum number of services—while Argentina, Honduras, Mexico and Uruguay define benefits more generally. The level of detail included in the HBP catalog depends in part on whether it is explicitly accompanied by institutionalized clinical guidelines, where the rest of the necessary detail will be defined, as in the case of Mexico and Uruguay. Furthermore, it also appears that in countries where delivery of plan services is the responsibility of third parties or the financing function is separated from service delivery, the detail of the HBPs is greater.

The optimal level of detail has been the subject of debate in some countries. For example, in the context of health care

Box I.1. Beyond simple lists: definitions of explicit guarantees

Peru: PEAS is defined on a “cascade” basis, starting with a prioritized list of 140 insurable conditions (such as normal pregnancy, delivery and postpartum recovery). Four elements are included in the detail of each insurable condition: 1) definition of the condition, 2) ICD-10 codes of the corresponding diagnoses, 3) specific clinical management, and 4) the list of services to be funded. The latter includes the type and level of care, the standardized medical procedure code, a simplified description, event coverage (amounts) and observations. Guarantees: guarantees of timeliness and financial protection are being developed.

Chile: AUGÉ is defined around 80 diseases with guaranteed treatment (2013). The resolution of health problems is divided into four stages, called “types of health interventions”: suspicion, diagnostic confirmation, treatment and follow-up. For each of these, a set of specific services is defined and detailed in an explicit list of services that make up part of AUGÉ. Likewise, each AUGÉ condition has a corresponding clinical practice guideline. Guarantees: each condition comes with a set of explicit and enforceable guarantees of access, timeliness, quality and financial protection.

Mexico: CAUSES is defined on a “cascade” basis and begins with a list of six groups (e.g., surgeries or hospitalizations) within which the interventions (e.g., splenectomy) are described. Each intervention carries a description, clinical indications (e.g., splenectomy; cases in which a heart attack and splenic rupture occur, which do not respond to conservative management) and relevant regulations in force, as well as covered medications (e.g., cefotaxime, injectable solution of

1 g in 4 ml) and ancillary diagnostic tests (e.g., CBC). Explicit guarantees: none.

Colombia: The POS (Decree 29/2011) is structured around a general definition of coverage followed by a detailed listing of covered drugs and interventions. In some cases these lists are accompanied by a clarification (e.g., trastuzumab, covered in the treatment of early breast cancer with overexpression of HER2+ and metastatic breast cancer with overexpression of HER+, upon confirmation of HER2+ status). Guarantees: Colombia does not provide explicit guarantees of timeliness, quality and financial protection as Chile does. However, it is perhaps the country where the legal enforceability of what is stated in the benefit plan is more real, given the writ of protection that makes it possible, through smooth and rapid proceedings, to demand the services outlined in the benefit plan.

Uruguay: All high-cost services and drugs have coverage guidelines, standards or regulations that explicitly state the indications or specific conditions, as well as inclusion and exclusion criteria. With regard to low- and medium-complexity services included in the PIAS, these are categorized into two groups: practices included without normatization and those with normatization. The former include those for which it is understood that there is sufficient evidence of their effectiveness and for which it is not possible or cost-effective to implement coverage limitations (practices with low utilization/low cost, whose range of indications has little variability; practices for which it is not possible from a clinical standpoint to clearly define limitations on the scope of

their indications; practices for which, even if it were possible to limit their indications, it would not be practical or cost-effective to implement control

measures). The latter include practices with normalization, whose use should be restricted to specific populations and indications.

reform in the United States in 2011, the level of detail was a topic widely discussed by the committee responsible for defining and adjusting an essential health benefit plan (Ulmer, McFadden and Cacace, 2012). After reviewing the evidence, the committee recommended that the HBP have a high level of specificity: “If we want the contents of essential health plans to be guided by scientific evidence, we need more specific definitions and descriptions of what is included and excluded, consistent with the way in which scientific evidence is structured.” However, this discussion apparently did not include the idea that, in practice, the scientific evidence is much less definitive and clear. There are differences in clinical practice and among patients that affect health outcomes, so it is important to strike a balance between detail and freedom for doctors to be able to adjust their approach and treatment according to the circumstances and needs of each case.

In addition to deciding on the organization and level of detail of an HBP, countries may choose to accompany the plan with protocols or clinical practice guidelines. As shown in box I.1, the countries included here have begun to specify under which conditions and for which patient subgroups the services would be covered, especially the most expensive ones. The case of Uruguay is quite illustrative. It indicates that part of PIAS’s services were “normalized,”⁸ because “it is considered that use of these practices should be restricted to specific populations and indications, namely, practices for which there is sufficient evidence of their effectiveness,

yet it is necessary to define the clinical indications in which their use would be recommended, as these may be highly variable depending on clinical, demographic, financial, cultural, and geographical factors, among others. These are practices for which, because of their utilization rates or cost, it would be justified to implement control mechanisms. [...] The scope of coverage for the practices included in this group must be defined within the context of a systematic review of scientific evidence and the development of guidelines and recommendations. By limiting in this way the clinical situations in which the practice should be covered, its use can be significantly scaled back and its proper use guaranteed in order to reduce inappropriate variability.”

Guarantees beyond a list of services

Chile has been a pioneer, at both a regional and international level, in defining a list of services to which the population has the right to access and linking them with a series of legally enforceable guarantees: i) a financial protection guarantee (the right under which copayment amounts are determined according to the ability to pay); ii) a timeliness guarantee (the right to receive care within defined time limits, in the manner and conditions established for each health problem); and iii) a quality guarantee (the right to receive care that meets established standards of quality). Uruguay, Peru and Colombia have begun to emulate Chile’s AUGE with explicit guarantees of access, timeliness, financial protection and quality.

⁸ Normalization is the process to define norms and standards for health services that include information on when and how these services have to be applied, who will be the responsible provider and who may benefit from these health services. One of the expected results of the normalization process is the standardization of a health technology/health service.

Segmentation of coverage by type of contingency

There can be different levels of coverage under the same HBP with respect to its definition, adjustment, management and financing, depending on the contingency covered. In Colombia (POS) and Chile (AUGE), all types of services (medications, interventions, treatments) for all levels of complexity are included in a single HBP that insures the entire population. In Mexico, CAUSES focuses on low- and medium-complexity services, the Catastrophic Health Expenditure Fund (FPGC) offers complex, high-cost care for all, and Health Insurance for a New Generation offers coverage for children for anything not covered by CAUSES or the FPGC. In Peru, PEAS covers low- and medium-complexity services as well as high-frequency, complex care, while the Intangible Solidarity Fund for Health (FISSAL) covers some high-cost, low-frequency illnesses. In Uruguay, the split of PIAS management between two entities, the Ministry of Public Health and the National Resource Fund (FNR), is a coordination challenge for both institutions. This specialization of functions may be beneficial, as it facilitates management within entities, each of which can focus on managing a certain level of contingencies; however, it can also lead to coordination difficulties and an overlapping of functions. Nonetheless, it is worth asking whether a policy of segmented HBPs is always beneficial for the population, if greater integration and coordination of these various HBPs should be sought or, at least, whether common guidelines should be laid out when it comes to defining and adjusting them to improve coordination.

Despite the diversity in the design and implementation of the HBPs, all of the countries' plans share certain characteristics. The most important is a common thread at their inception: before implementing the HBP, the public system already offered most of the services, but that offer was not explicit or accompanied by guarantees of access, quality or financing. The decision of these

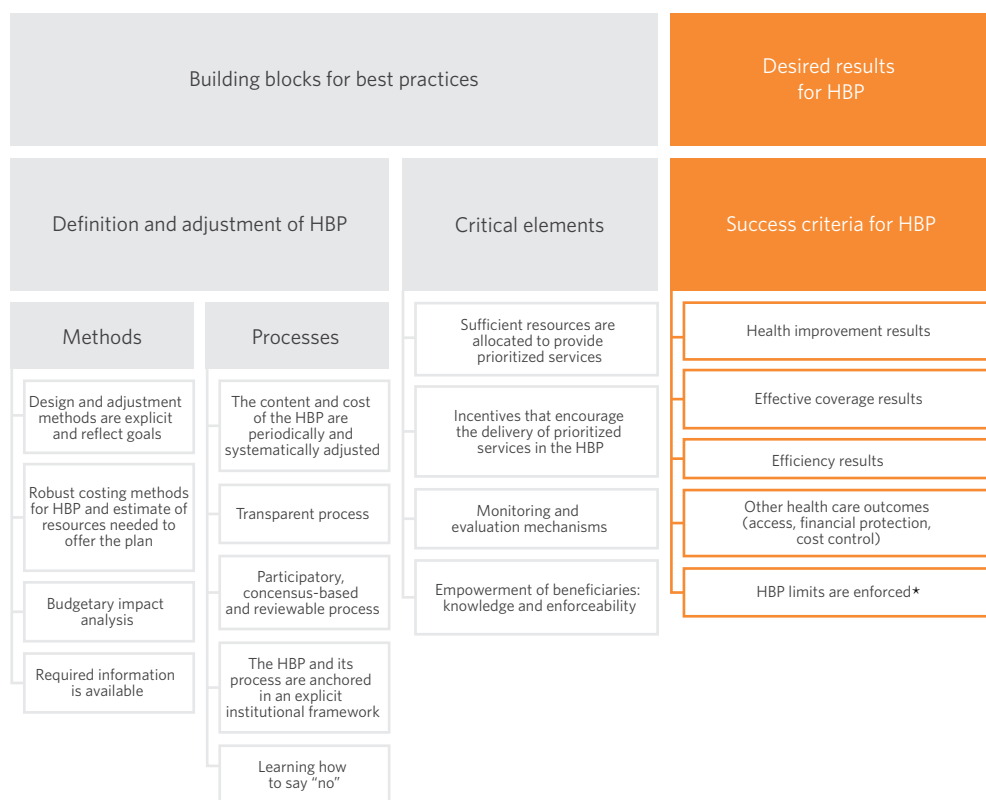
seven countries to adopt an explicit HBP with guarantees for beneficiaries reflects a common desire to end the ambiguity, uncertainty and inequality arising from an uncertain supply, which ended up as a “broken promise” of universal coverage.

HBP Outcomes and Best Practices

Conceptual model to analyze HBP outcomes and best practices

Despite the large number of countries that have adopted explicit benefit plans, and despite the renewed interest they have aroused, there is currently no conceptual framework to facilitate analysis. However, the literature provides several studies that have tried to identify the best practices central to the HBPs: the coverage decision process. Drummond et al. (2008) identified 15 elements of best practice in making coverage decisions based on the *evaluation of health technology*. Chalkidou et al. (2009) reviewed the literature to identify six structural, technical and process principles, which required the use of evidence on comparative effectiveness as input for decision making. For their part, Daniels and Sabin (2008) identify the four key elements required for the *explicit priority-setting process to be legitimate and fair*. Sibbald, Singer, Upshur and Martin (2009) systematically analyze stakeholders' opinions on what would be the 10 key elements of a successful explicit priority-setting process. Some shared principles emerge from the aforementioned analyses, such as the importance of technical robustness or participation and transparency in decision-making. These serve as references and provide useful elements for the analysis of the HBPs, but they are not a tool to analyze the degree of success or best practices of the HBPs. This is a much broader issue, in that it is not limited to the analysis of coverage decisions; it also includes the institutional framework and processes to design the plan and keep it updated with effective coverage for the target population. In light of the

Figure I.3. Conceptual model of the HBP



Source: Developed by the authors

* Countries that use the HBP to define what can be comprehensively provided to each person with the given resources.

above, an initial conceptual framework is proposed in figure I.3, based on outcomes and best practices of the HBPs. It starts by asking what the results of a successful HBP policy would be (right side of the figure). The left side of the framework organizes the best practices that facilitate the attainment of positive results with the HBP policy. These are divided into two groups: i) the practices directly related to *defining and adjusting* the HBPs in both technical and process dimensions, which should help the benefit plan to achieve its objectives and be recognized as a legitimate rationing mechanism; and ii) *the enabling factors* that ensure that what is prioritized in the benefit plan does not remain a mere “statement of services” but instead becomes effective coverage of prioritized services.

The three axes of the proposed model are described in greater detail below: expected results, defining and adjusting the HBP (methods and processes), and enabling factors.

Achievements and Challenges in Light of the Conceptual Framework

Results

Above all, an HBP is a strategy to obtain the best health or welfare results possible with the resources available. This should be reflected in better health indicators and greater effective coverage of the prioritized services and, at the same time, should

lead to an increase in efficiency and an improvement in other health indicators (access, financial protection, etc.). Moreover, in countries where the HBP defines health services financed by public funds (e.g., Colombia and Uruguay), the implementation of an HBP is successful insofar as it is able to enforce its limits. If people massively access excluded services, the rationale for the HBP is de-institutionalized,⁹ and the policy cannot be considered successful.

HBPs are often implemented as part of a *package* of policies, so it is difficult to isolate the impact of the plans reviewed in this book on equity, efficiency and health. To do so, health outcomes are indirectly measured. It is estimated that in Mexico, CAUSES covers 95% of the reasons for outpatient visits; in Peru, PEAS covers 65% of the burden of disease; and in Chile, AUGE covers 60% of the burden of disease. However, these calculations predate the implementation of the HBPs and only estimate their potential effect. It would be more important to evaluate whether the prioritized services are really being provided adequately and to everyone who needs them; however, in most of the countries reviewed here, there is no institutional framework for monitoring and evaluation to find out whether what the HBP promises is actually provided to the population. Argentina and Chile are exceptions in this regard.

The evaluations referenced in the case studies are scarce and do not estimate the impact of the HBPs on the efficiency and allocation of health spending, even though improving the allocation of resources is one of the main reasons for adopting an HBP. Little is known about the impact of the HBPs on the performance of health systems.

Defending the legitimacy of benefits excluded from an HBP is perhaps the

greatest challenge that Latin American countries face in trying to implement a benefit plan. This challenge seems more difficult in the region's wealthier countries with universal HBPs and attractive markets for high-cost technology companies. This is the case with Colombia and Uruguay, which have faced heavy pressure from interest groups to finance expensive technology excluded from their HBPs. They have resorted to the judicial system or exceptional mechanisms to have their demands met. In Colombia, these pressures have resulted in a diversion of up to 26% (2010) of the contributory regime's resources (for people with the ability to pay) to services not included in the HBP (mainly high-cost drugs), which de-institutionalizes the spirit of the HBP to improve resource allocation. These legal battles, along with technological pressure and the defense of physician autonomy as a guarantee of adequate care, have brought the country to the point of eliminating its benefit plan.¹⁰ While Uruguay has faced similar problems (although to a lesser extent), Mexico, the country with the highest GDP of all of the countries studied but whose HBP only covers the lower strata of the population, has not faced the same level of legal pressure. In Colombia, the request for non-prioritized services is concentrated among the higher strata of the population. The question then arises as to whether difficulty in terms of enforcing the limits of an HBP increases not only with the wealth of a country but also with its target population's income.

Definition and adjustment of the HBP

A. Methods

The methods contain the elements that make the HBPs technically robust. The methodological aspects detailed below are shown in figure I.3.

⁹ Not all countries are looking to establish every individual service that people can receive in the HBP, as shown in the cases of Argentina, Chile and Uruguay.

¹⁰ In June 2013, the Colombian Congress approved the Statutory Health Law, a framework law in which the notion of the HBP is removed. The law is under review by the Constitutional Court.

The design and adjustment methods are explicit, and they reflect the plan's goals. If these methods do not address the goals to be achieved, there is no way to ensure the plan's consistency. Furthermore, if the methods are not explicit, there is no way to monitor and determine whether the methodology was implemented in accordance with equitable principles or if, instead, it served individual interests.

In general, the plans of the countries studied here demonstrate serious limitations in terms of the explicit criteria and methods that have been used to define the inclusion or exclusion of technologies. In addition, the methods that have been applied are poorly documented. The countries use multiple criteria, often including burden of disease or cost-effectiveness evaluations; however, the case studies show that countries rarely utilize robust and systematic methods to define and—much less—adjust the HBPs. They are adjusted sporadically, sometimes by external consultants, with rules that change with each new round of adjustments. In many cases, criteria are announced whose practical application is unclear. One exception is Chile, which has created and applied an algorithm that combines different criteria and includes social preferences. As demonstrated by Vargas and Poblete (2008), this is applied fairly consistently.

Costing methods must be robust in order to estimate the resources (human, infrastructure, etc.) required to provide the services set forth in the HBP. These methods must make it possible to estimate the cost of providing the plan, with an acceptable level of certainty. This task is technically complex, since it involves numerous factors and uncertainties, and the available fiscal budget is a point of political contention. If the actual cost of the plan is underestimated, resources will be insufficient; if the cost is overestimated, in addition to wasted resources, the profitability of some agents could be greater than originally envisaged, which could undermine public support for the HBP. In addition to estimating

the *economic* resources required, it is necessary to calculate the needs of other resources such as human talent, technology and physical infrastructure. Chile and Colombia have the most advanced costing methods, and they apply them more systematically. In Chile, for example, costing is done periodically within a regulatory framework, while in Colombia, annual actuarial calculations are made to determine and adjust the premiums paid to insurers providing the HBP.

As for other resources, in almost all cases, the deliberations to define or adjust the benefit plans considered the infrastructure and human resources available to provide the HBP. In Honduras, the evaluation of the feasibility of the HBP in remote rural areas led to a supply adjustment in some situations. However, in most cases, there is no explicit link between HBP content and the planning and adjustment of the supply of physical and human resources.

In addition to knowing how much the HBP costs, it is necessary to establish its budgetary impact. This ensures that the plan is not only cost-effective or that it complies with priority-setting criteria but that it can also be financed (Mauskopf et al., 2007).

The required information must be available. Even with sound methods, results will not be technically robust without the proper data. Much of this information has to be local in order to make the right decisions. For example, it is very risky to extrapolate cost-effectiveness information from other countries' data without making adjustments to it (Goeree et al., 2011).

In general, the case studies show that the available information, including the most basic data—for example, epidemiological profile or cost of interventions—is limited. Thus, it is difficult to rigorously apply explicit priority-setting criteria. How can cost-effectiveness criteria be determined in the absence of reliable information on the epidemiological profile and demand of the population? How can the financial

impact be analyzed when the cost of interventions is not known?

B. Process

The elements of the *process* that enable an HBP to be seen as a legitimate instrument are shown below (see figure I.3). These are based on the case studies and the literature reviewed.

Periodic and systematic adjustments through explicit methods. HBPs require periodic adjustments due to the dynamic nature of health systems. Health problems, available technology, and the cost and demand of services change as well, necessitating adjustments to the HBP. These should be consistently made using agreed-upon methods, rather than changing the methods in an arbitrary fashion or with each new government administration. Most of the countries studied here have failed to establish and institutionalize periodic adjustment processes or to define the content of their plans and determine the value of premiums or allocated resources. Substantial effort is made at the beginning, often with external support, but this effort is not institutionalized in order to be able to periodically adjust the HBP. For example, in the case of Mexico, there are still no systematic adjustment processes for CAUSES or FPGC benefits. In Colombia, the lack of a regular update caused the HBP to lose legitimacy and to be strongly criticized by the Constitutional Court. An exception to this lack of institutionalization is Uruguay with its FNR, which is responsible for defining and adjusting the HBP in relation to high-cost benefits. The FNR has implemented systematic and institutionalized adjustment processes. Another example is Chile, which has managed to institutionalize its costing processes and social participation in AUGE.

Transparency. When discussing the requirements of a legitimate explicit

priority-setting process, perhaps the greatest level of consensus exists on the topic of transparency (Goeree et al., 2011). It is essential that information about the methods and their application, as well as discussions around the development of the HBP and its outcomes be documented and publicly available. Access to information, a key tool for participation and an essential input for accountability and transparency in government (OAS, 2013), is perhaps even more important in the context of a controversial topic like explicit priority setting. In order for the definition of the HBP's contents and its adjustments to be robust, the processes performed must be explicit, documented and publicly available.

Most countries included in this book have had limitations in terms of explaining processes and making them transparent, in addition to a lack of documentation. In Colombia, the original technical priority-setting studies used to design the HBP were lost. In other countries studied here, information was available, although not to the general public. In the case of Uruguay, there were very few official, public documents on the methods and processes used to define the PIAS that could be cited in the literature. A similar situation occurred with Mexico.

Participatory processes to define and adjust the HBPs. Key stakeholders and the general public must be able to learn about, provide information about and participate in the process of defining and adjusting the HBP. Participation can be organized in many ways, from collecting information from different parties to the possibility of involving them in decision-making.¹¹ Nevertheless, there is no consensus on how this involvement should take shape, particularly with regard to how the public should participate (Mitton et al., 2009). Decision-making criteria accepted by individuals with regard to coverage should be established.¹²

¹¹ A discussion on participation in health technology assessment institutions can be seen in Giedion, Muñoz and Cañón (2013).

¹² See the criterion of relevant reasons proposed by Daniels and Sabin (2008).

Participation also involves the ability to review the results when parties identify errors in the process.

In most of the countries studied, key stakeholders' participation has been very limited, but Chile is the exception. In this case, an institutionalized process anchored in the law is used to incorporate citizens' preferences into the decisions about the design and adjustment of the HBP. Limitations on participation may be one of the reasons why countries fail to successfully manage political pressure. In all cases, it was found that the development and adjustment of an HBP faces strong pressure from all key stakeholders (health care professionals, patient groups, etc.), since the adjustment of an HPB is not just a technical issue but a political one as well. In Chile, "The president of that organization [the Chilean Medical Association] during the legislative deliberation of the GES admitted in an interview that the Chilean Medical Association did everything possible to block the reform, but it failed because of the strong support that the reform garnered from the public and political parties." From the above remarks, it can be inferred that a proper participatory process helps the HBP to obtain the necessary political support.

Institutional and policy support to define and adjust the HBP. HBPs require institutional support, with standards that establish their operation and consistent application over time, and that ensure sufficient resources such as human talent, technological capabilities, etc.

In many cases, institutional support is poor. In Peru, during the development of PEAS, a prior plan—the Prioritized List of Health Interventions (LPIS)—was not taken into consideration, which made a subsequent update necessary. This shows that an HBP is not always developed within a clear institutional framework. In Honduras, the structures that manage, hire and pay HBP service providers are seen as programs external to the Ministry of Health rather than an integral part of the institution. The opposite

occurs with the high-cost component in Uruguay, where an independent technical institution, the FNR, defines which technologies are funded, based on a standardized and systematic evidence evaluation process. The FNR also manages and monitors provision of the high-cost technologies included in the HBP.

Learning how to say "no." The experience of countries with a more advanced HBP implementation has shown that the lack of a strategy for handling requests for excluded technologies can erode the plan, so this must be defined from the start. Knowing how to manage services excluded from the HBP can be as important as defining those that are included.

Countries face different kinds of pressures when implementing their HBPs. The experience collected in this book identifies three key aspects that make it difficult to refuse requests to include technologies in the HBP.

1. A limited understanding of *medical autonomy* by health professionals. Medical autonomy is regarded as the state's obligation to fund any treatment prescribed to a patient, without restrictions, and without any concern for the resources that remain available to other patients. This was one of the main arguments used by the Chilean Medical Association to oppose the HBP.
2. *Political pressure to "inflate" the plan's contents.* Politics tend to promise more than what can be financed by the HBP. In Chile, the gradual broadening of AUGE's scope reduced fiscal pressure during the HBP implementation.
3. *Pressure for acquired rights.* When the plan reduces benefits for a group, this creates pressure that is very difficult to manage. In Peru, the insured poor received the LPIS, which offered more extensive coverage than the first version of PEAS. This pressure made it necessary to supplement PEAS to

bring its coverage in line with that of the LPIS.

It seems that the resistance to “no” is greater when the HBP seeks to be comprehensive, as in Colombia and Uruguay. Less resistance is offered when 1) there is a coexisting plan with a public-sector supply system tied to implicit rationing mechanisms (Chile, Argentina and Mexico), or 2) benefits are very basic, as in the case of Argentina, with a plan focused only on pregnant women, or in the case of Honduras, with a plan limited to the rural population.

C. *Enabling factors*

In addition to methods and processes, an HBP requires some enabling conditions in order for the prioritized services to actually be provided. These conditions are described below.

Allocation of sufficient resources to provide prioritized services. The costing of the HBP must be reflected in the allocation of resources, so that the agents responsible for organizing and providing services can do so. Otherwise, an implicit rationing system is generated, which is exactly what governments hope to avoid.

One of the biggest challenges is the lack of consistency between the cost of the plan and the resources allocated to it. The situation is extreme in the case of Peru, where the government only provides 25% of the estimated standard variable cost of PEAS to the Comprehensive Health Insurance program. Furthermore, the case studies in this book make reference to strong pressure to expand the HBPs without a proportional increase in resources, as in Peru, with the adjustment of PEAS to include the services provided by the LPIS. In Colombia, the premium fell from US\$512, calculated when the plan was introduced in 1993, to US\$370. To quote an official at one of the insurance companies that was supposed to offer the HBP: “...three months in and the CPU was no longer 140,000 pesos but 121,000. Period, that’s it. That’s how the Minister of Finance put it to us, without

any content adjustment. Policy decisions went in opposite directions, and the market has taken it upon itself to bring them together. For example, by adjusting the rates for the provider network. The market has united the CPU and the POS but at the cost of technology” (Giedon et al., 2007). Ensuring that the cost, the budgeted amount, and the amount actually transferred all coincide is an indispensable prerequisite for effective delivery of the HBPs.

Incentives that encourage the delivery of the HBP’s prioritized services. The incentives that influence the behavior of agents that from part of health systems must encourage the provision of the prioritized services set forth in the HBP. For example, if health care professionals have the same incentives to provide prioritized services as they do those outside of the HBP, it is unlikely that they will give priority to the former.

The alignment of incentives with the HBP’s objectives has not been an explicit goal of all of the countries studied. Nevertheless, in Argentina, resources are allocated on the basis of prioritized services and the outcomes obtained. The management agreements signed between the National Board of Health and comprehensive health care providers establish goals and quality criteria for the services included in the HBP, indicating that Uruguay is also moving in this direction. In Mexico, the lack of an explicit link between the plan’s cost and content and the resources received by providers has limited their incentives to provide the prioritized services.

For the most part, the countries’ *monitoring and evaluation systems* are just getting off the ground. Sometimes the results of the HBP can be assessed indirectly through national demographic and health surveys or assessments that are not specific to the HBP but that refer to national health indicators. However, attempts to systematically evaluate whether the prioritized services reach the target population are still in their infancy. Some countries have made

progress in this area. Chile has monitored services within and outside the HBP, while Argentina has created a monitoring system for Plan Nacer/SUMAR, which includes verification visits, a dashboard tool and concurrent external audits.

Empowerment of beneficiaries and legal enforceability. HBP beneficiaries are essential to ensuring that prioritized services are actually provided. For this to happen, they must be empowered; they must be aware of the benefits to which they are entitled as well as the guarantees of timeliness or financial protection that accompany these benefits. In addition, they must have mechanisms to fall back on when guarantees are not met.

Almost all of the countries analyzed have disseminated information about the benefits contained in their HBPs; however, awareness of the existence of the HBPs is usually not as widespread as governments would like. This lack of awareness has reduced citizen empowerment, since an unknown right is impossible to demand. Few countries have mechanisms to ensure the plan's enforceability. For example, Colombia has a legal mechanism called a writ of protection that allows individuals to quickly and effectively petition for health care services. Through this mechanism, in 2010, a total of 89,762 writs of protection were presented to demand services not included in the HBP (Office of the Ombudsman, 2011).

Conclusions

It is generally agreed that resources, which are always scarce, are insufficient to provide all of the technologies available to all those who need them, and that the gap between what is medically possible and financially feasible grows over time. Thus, countries are faced with the inevitable rationing of health care services.

The question, therefore, is not if there must be rationing but how to ration. In many countries in Latin America

and the Caribbean, this gap between supply and demand has been addressed by implicit rationing. Under this model, the government assumes neither a commitment nor a clear position on the services that will be provided to the population, such that the services that reach the population will depend on contingent and discretionary factors, such as geographic location, the socioeconomic group to which an individual belongs, or the supply of available resources when an individual requests services. This type of rationing comes with problems of efficiency in spending allocation, unequal access and a high level of out-of-pocket spending.

Despite the diversity of the countries analyzed in this book and the different options they selected when defining their benefit plans, they all opted for an explicit HBP, even though they already had public systems that, in theory, offered all of the services required by the population. However, that offer was neither explicit, nor was it accompanied by guarantees of access, quality or financing. The decision of these seven countries to adopt an explicit HBP with guarantees for beneficiaries reflects the common desire to put an end to ambiguity and uncertainty and to reinforce the government's commitment to its citizens and key stakeholders. Consequently, the HBPs did not come about as a transition from not delivering health services to providing a minimum package financed with public funds (as might be the case for some low-income countries in other regions) but rather as a transition from implicit to explicit.

In general, the potential advantages of an HBP are many, including the possibility to improve efficiency and equity in the allocation of spending. Furthermore, the HBP can be used as a coordination tool. The main functions of the entire health care system are organized around an HBP, including financing, purchasing and provider payment, the organization of service delivery, the regulation of insurers and providers, and the inducement of consumers, insurers and health care

service providers. An example of this is Argentina's Plan Nacer/SUMAR. The cases of Mexico and Colombia illustrate the HBP's ramifications for financing and equity. In Mexico, calculating the cost of CAUSES made it possible to quantify and leverage additional public resources to fund the HBP for the uninsured in order to reduce inequality. The definition and costing of a benefit plan in Colombia made it possible to quantify and mobilize additional financial resources to cover the cost of prioritized services for the poor. Implementing an HBP also facilitates purchasing and provider payment because the explicit formulation of the HBP's contents contributes to the simplification and transparency of service purchase contracts between funders and providers. An HBP can also become a cornerstone for organizing providers; the explicit definition of the plan and each of its benefits makes it possible to gauge the human and physical resource requirements to provide the covered services. In addition, in some cases, each HBP service is accompanied by a care protocol, which specifies the conditions under which each health care service should be offered and how it should be performed. Lastly, an explicit HBP—accompanied by guarantees for the target population—increases accountability. This consists of disseminating information about beneficiaries' rights and obligations regarding health care, so as to encourage citizens to demand them.

The study of these seven countries shows that implementing an HBP presents significant challenges on both a technical and political level. At the technical level, the main problem facing Latin American countries is the overall lack of resources: *economic resources* to develop the plan,

human talent qualified to conduct the various technical studies that support the plan, *information*, and even *time* limitations, since HBPs must often be implemented during a presidential or legislative term. At the political level, the major challenge is defending the legitimacy of the choice not to fund the provision of some available technologies, or in other words, managing the implications of saying no.

The case studies show how environmental factors can affect the implementation of prioritized services. In their absence, the HBP would only be a statement of benefits that could be provided, without much difference from the oft-heard promises in systems without explicit priority setting. Resource allocation consistent with the contents of the plan and, in particular, with its estimated cost stands out from among the aforementioned factors. In addition, the system must encourage the provision of HBP services. Without incentives, it would be unreasonable to expect agents to be concerned with providing the HBP. It is necessary to evaluate the plans and track them according to objectives and established targets. Monitoring and evaluation systems to accurately assess the results of the HBP have not been implemented in the countries studied, with the exception of Argentina and Chile.

Lastly, the case studies show that there is a third option that involves implementing an HBP in combination with implicit rationing. The cases of Chile (AUGE) and Argentina (Plan Nacer/SUMAR) illustrate this path. This alternative could be especially attractive in the Latin American context, where it is very difficult to deny the services excluded from an HBP.

References

- Auerbach D. I. and A. L. Kellermann. 2011. "A decade of health care cost growth has wiped out real income gains for an average US family." *Health affairs (Millwood)* 30(9), 1630-6.
- Bodenheimer T. 2005. "High and rising health care costs. Part 2: technologic innovation." *Annals of internal medicine* 142(11): 932-937.
- Brosa M., R. Gisbert, J. M. Rodríguez and J. Soto. 2005. "Principios, métodos y aplicaciones del análisis del impacto presupuestario en el sector sanitario." *Pharmacoeconomics - Spanish research articles* 2(2): 65-78.
- Busse R., J. Figueras, R. Robinson and E. Jakubowski. 2007. "Strategic Purchasing to Improve Health System Performance: Key Issues and International Trends." *Healthcare Papers* 8 (supplement): 62-76.
- Busse R., J. Schreyögg and C. Gericke. 2007. "Analyzing changes in health financing arrangements in high-income countries. A comprehensive framework approach." HNP discussion paper, World Bank.
- Camargo M. P. 2011. "¿Por qué los médicos se oponen al nuevo POS?" *Semana*. December 7.
- Carone G., C. Schwierz and A. Xavier. 2012. "Cost-containment policies in public pharmaceutical spending in the EU." *European economy. Economic Papers* 461. Brussels, European Union.
- Chalkidou K. 2012. "Establecimiento de prioridades en base a evidencia: la teoría y la práctica." Policy note.
- Chalkidou K., S. Tunis, R. Lopert, L. Rochaix, P. T. Sawicki, M. Nasser and B. Xerr. 2009. "Comparative effectiveness research and evidence-based health policy: experience from four countries." *The Milbank Quarterly* 87(2): 339-67.
- European Commission. 2013. "Social Investment Package: Investing in Health." European Commission staff working document. Available at: http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf. Accessed: October 2013.
- Corte Constitucional de Colombia. 2008. Sentencia T-760.
- Daniels N. and J. E. Sabin. 2008. "Accountability for reasonableness: an update." *British Journal of Medicine* 337: a1850.
- Defensoría del Pueblo de Colombia (Office of the Ombudsman of Colombia). 2011. *La tutela y el derecho a la salud 2010*. Bogotá, Imprenta Nacional de Colombia.
- Dinarte Mendoza M. J. and L. Bolaños. 2012. "La voluntad no basta." Entry for the blog Priorización y planes de beneficios en salud. 21 February. Available at: <http://www.redconocimientopbs.org/profiles/blogs/la-voluntad-no-basta>. Accessed: October 2013.

- DiPrete B. and D. Coffman. 2007. "A Brief History of Health Services Prioritization in Oregon." Health Services Commission.
- Drummond M. F., J. S. Schwartz, B. Jönsson, B. R. Luce, P. J. Neumann, U. Siebert and S. D. Sullivan. 2008. "Key principles for the improved conduct of health technology assessments for resource allocation decisions." *International Journal of Technology Assessment in Health Care* 24(3): 244-58.
- Dukes M. N., E. M. Haaijer-Ruskamp, C. P. de Joncheere and A. H. Rietveld (eds.). 2003. *Drugs and Money. Prices, Affordability and Cost Containment*. Seventh edition. IOS Press and WHO.
- FiercePharma Manufacturing. 2013. Chart "The World's Most Expensive Drugs." Available at: <http://www.fiercepharmamanufacturing.com/pages/chart-worlds-most-expensive-drugs>. Accessed: October 2013.
- Frenk J., O. Gómez-Dantés and F. M. Knaul. 2009. "The democratization of health in Mexico: financial innovations for universal coverage." *Bulletin of the World Health Organization* 87: 542-8.
- Garpenby P. 2003. "The priority setting process. A macro perspective." Stockholm, National Center for Priority Setting.
- Giedion U. et al. 2007. "Entrevistas estructuradas a actores claves. Documento sobre diseño, ajuste e implementación de los planes de beneficios en el Sistema General de Seguridad Social en Salud." Bogotá, Ministry of Social Protection-ARS reform support program.
- Giedion U., A. L. Muñoz and A. Ávila. 2012. "Introducción a la serie de priorización explícita en salud." Series of technical notes on priority-setting processes for health care. IDB.
- Giedion U., A. L. Muñoz and O. I. Cañón. 2013. "Lecciones emergentes de entidades de evaluación de tecnologías en salud en cuatro países de América Latina y el Caribe y en cuatro países de ingresos altos." Series of technical notes on priority-setting processes for health care. IDB.
- Giedion U., G. Panopoulou and S. Gómez-Fraga. 2009. "Diseño y ajuste de los planes de beneficios: el caso de Colombia y México." *Development Financing Series*. Santiago, Chile, United Nations.
- Giedion U., D. Raciborska and R. Bitrán. 2010. "Guía metodológica para la elaboración de estudios de caso sobre el diseño, ajuste e implementación de paquetes o planes explícitos de beneficios de salud."
- Glassman A. and K. Chalkidou. 2012. *Priority-Setting in health building institutions for smarter public spending*. Center for Global Development. Washington, DC, Communications Development.
- Goeree R., J. He, D. O'Reilly, J. E. Tarride, F. Xie, M. Lim and N. Burke. 2011. "Transferability of health technology assessments and economic evaluations: a systematic review of approaches for assessment and application." *ClinicoEconomics and Outcomes Research* 3: 89-104.

- Guerrero R., H. Arreola-Ornelas and F. M. Knaul. 2010. "Breadth and depth of benefit packages: lessons from Latin America." WHO.
- Iunes R., L. Cubillos-Turriago and M. L. Escobar. 2012. "Universal Health Coverage and Litigation in Latin America." Washington, DC, World Bank.
- Jackson H. and A. McDermott. 2004. "Health Care Spending: Prospect and Retrospect." Analytical note. Available at: <http://www.medicare.ca/wp-content/uploads/2009/05/finance-note2.pdf>. Accessed: October 2013.
- Kaiser Family Foundation. 2007. "Snapshots: How Changes in Medical Technology Affect Health Care Costs." Available at: <http://kff.org/health-costs/issue-brief/snapshots-how-changes-in-medical-technology-affect/>. Accessed: October 2013.
- Klein R. 1995. "Priorities and rationing: pragmatism or principles? Time for Britain to follow the Netherlands, New Zealand, and Sweden's lead and get serious." *British Medical journal* 311(7008): 761-2.
- Klein R., P. Day and S. Redmayne. 1996. *Managing scarcity: priority setting and rationing in the National Health Service*. Buckingham Open University Press.
- Kutzin J. 2000. "Towards Universal Health Care Coverage. A Goal-oriented Framework for Policy Analysis." HNP discussion paper, World Bank.
- Malagón Oviedo R., M. Hernández Álvarez, J. M. Díaz-Granados Ortiz, N. Paredes Cubillos, N. Alvis Guzmán, J. Orozco Africano and M. Torres Tovar. 2010. "La sentencia T-760: alcances y limitaciones." Cuadernos del Doctorado. Bogotá.
- Mason A. 2005. "Does the English NHS have a 'health benefit basket'?" *European Journal of Health Economics*, s1(6): 18-23.
- Mauskopf J. A., S. D. Sullivan, L. Annemans, J. Caro, C. D. Mullins, M. Nuijten and P. Trueman. 2007. "Principles of good practice for budget impact analysis: report of the ISPOR task force on good research practices - Budget impact analysis." *Value in Health* 10(5): 336-347.
- Mechanic D. 1997. "Muddling through elegantly: finding the proper balance in rationing." *Health Affairs* 16(5): 83-92.
- Ministerio de Salud y Protección Social de Colombia (Colombian Ministry of Health and Social Protection). 2013. Proyecto de ley 210 de 2013. Available at: <http://senadorjorgeballesteros.com/wp-content/uploads/2013/03/Proyecto-de-Ley-Ordinaria-Salud.pdf>. Accessed: October 2013.
- Mitton C., N. Smith, S. Peacock, B. Evoy and J. Abelson. 2009. "Public participation in health care priority setting: A scoping review." *Health Policy* 91: 219-28.
- Mohr P. E. and C. Mueller. 2001. "The impact of medical technology on future health care costs: final report. The Project Hope Center."
- Newhouse J. P. 1992. "Medical care costs: How much welfare loss?" *The Journal of Economics Perspectives* 6(3): 3-21.

- OAS (Organization of American States). 2013. "Culminates the regional seminar on access to public information and transparency organized by OAS." *Regional Seminar on Access to Public Information and Transparency*. San Salvador.
- OECD (Organization for Economic Cooperation and Development). 2012. Health policy database. Available at: <http://www.oecd.org/els/health-systems/oecdhealthdata2012-frequentlyrequesteddata.htm>. Accessed: October 2013.
- Office of the Assistant Secretary for Planning and Evaluation. 2005. *The 2005 HHS poverty Guidelines*. ASPE.
- Olfson M. and S. C. Marcus. 2013. "Decline in placebo-controlled trial results suggests new directions for comparative effectiveness research." *Health Affairs (Millwood)* 32(6): 1116-25.
- Ontario Ministry of Health and Long-Term Care. 2008. "Priority Setting. The Health Planner's Toolkit." Module 7 of Health Systems Intelligence Project – 2008. Ontario.
- PAHO (Pan American Health Organization). 2012. Evaluación e incorporación de tecnologías sanitarias en los sistemas de salud [Health Technology Assessment and Incorporation into Health Systems]. 28th Pan American Sanitary Conference. 64th Session of the Regional Committee. Washington, DC.
- Plaza B. 1996. "Cost effectiveness and priority setting case study." Washington, DC, World Bank.
- Rettenmaier A. J. 2009. "Health care spending forecast." Available at: <http://www.ncpa.org/pub/ba654>. Accessed: October 2013.
- Roberts M., W. Hsiao, P. Berman and M. Reich. 2004. *Getting health reform right: a guide to improving performance and equity*. New York, Oxford University Press.
- Rumbold B., P. C. Smith, and V. Alakeson. 2012. *Rationing health care: is it time to set out more clearly what is funded by the NHS?* Nuffield Trust.
- Schreyögg J. et al. 2005. "Defining the 'Health Benefit Basket' in nine European countries. Evidence from the European Union Health BASKET project." *European Journal of Health Economics*, s2-10.
- Sibbald S. L., P. A. Singer, R. Upshur and D. K. Martin. 2009. "Priority setting: what constitutes success? A conceptual framework for successful priority setting." *BMC Health Services Research* 9(43): 1-23.
- Stolk E. A. and F. H. Rutten. 2005. "The health basket in the Netherlands: A contribution to Work Package II of the EU funded research project 'HealthBASKET': Description of benefits, entitlements, actors and decision making processes in the Dutch health care sector." Institute for Medical Technology Assessment.
- Superintendencia de Salud de Chile (Chilean Superintendency of Health). 2012. Resolución exenta SS n.º 801. Available at: [http://webserver.superdesalud.gob.cl/bases/SistemaSanciones.nsf/8d89ce51a9c911ed842571e700700d9a/3ebd31c347ba33448425797a007afc58/\\$FILE/ATTRFJ2G.pdf/Res.ex.SS.801.pdf](http://webserver.superdesalud.gob.cl/bases/SistemaSanciones.nsf/8d89ce51a9c911ed842571e700700d9a/3ebd31c347ba33448425797a007afc58/$FILE/ATTRFJ2G.pdf/Res.ex.SS.801.pdf). Accessed: October 2013.

- Tarimo E. 1997. "Essential Health Service Packages: Uses, abuse and future directions." *Current Concerns* 15. WHO.
- Taylor D. 2010. "Implementing Value Based Pricing for Medicines. An introduction."
- Thomson S., L. Schang and M. E. Chernew. 2013. "Value-Based Cost Sharing in the United States and Elsewhere Can Increase Patients' Use of High-Value Goods and Services." *Health Affairs* 32(4): 704-12.
- Ulmer C., B. McFadden and C. Cacace. 2012. *Perspectives on Essential Health Benefits*. National Academy Press.
- Vargas V. and S. Poblete. 2008. "Health prioritization: the case of Chile." *Health Affairs (Millwood)* 27(3): 782-92.
- Vogler S., C. Habl, C. Leopold, I. Rosian-Schikuta, K. de Joncheere and T. L. Thomson. 2008. *Pharmaceutical Pricing and Reimbursement Information Report*. Vienna, Gesundheit Österreich / Geschäftsbereich ÖBIG.
- WHO (World Health Organization). 2000. *Informe sobre la salud en el mundo. Mejorar el desempeño de los sistemas de salud*. [World health report. Health systems: improving performance.] Geneva, WHO.
- _____. 2010. *Informe sobre la salud en el mundo. Financiación de los sistemas de salud: el camino hacia la cobertura universal*. Capítulo 2: "Más dinero para la salud." Available at: http://www.who.int/whr/2010/10_chap02_es.pdf. Accessed: October 2013.
- Wong H. and R. Bitrán. 1999. "Designing a benefits package." Module 5 of *Flagship course on Health sector reform and sustainable financing*.
- World Bank. 1993. *Informe sobre el desarrollo mundial. Invertir en salud*. [World Development Report. Investing in Health.] Washington, DC, World Bank.
- _____. 2013. Universal health coverage study series. Available at: <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/0,,contentMDK:23352920~pagePK:210058~piPK:210062~theSitePK:282511,00.html>. Accessed: October 2013.
- _____. 2013. *El proceso de participación en el establecimiento de las prioridades explícitas en salud: la experiencia chilena*. Available after free registration at: <http://www.redconocimientopbs.org/page/resumenes-de-pol-ticas-2>. Accessed: October 2013.
- Zhang Y. and S. B. Soumerai. 2007. "Do Newer Prescription Drugs Pay for Themselves? A Reassessment of the Evidence." *Health Affairs* 26(3): 880-6.

Chapter 1



{ Chile: Explicit Health Guarantees (GES)

Liliana Escobar and Ricardo Bitrán

Summary

Context. In 2005, Chile adopted a health benefit plan (HBP) interchangeably referred to as the Explicit Health Guarantees (GES) Plan or Universal Access with Explicit Guarantees (AUGE) Plan. Today, this HBP covers 80 diseases selected according to various priority-setting criteria. The coverage and guarantees defined in this plan apply to the social security health system, including beneficiaries of the state-run provider known as the National Health Fund (Fonasa), which currently covers about 80% of the population, as well as beneficiaries of private health insurance institutions (Isapres), entities that cover about 17% of Chileans.

The health coverage offered to Fonasa and Isapre beneficiaries is not limited to the contents of the AUGE health benefit plan. If beneficiaries suffer from an illness not included in the HBP, they can still obtain coverage through a supplemental health plan available through Fonasa or their respective Isapre. In the case of Fonasa, it is possible that the services required will not be immediately available; the beneficiary will have to wait days, weeks or months for care, in addition to paying a copayment, if the plan requires it, at the time of service. In the case of the Isapres, if the supplemental plan provides coverage for the required services, the beneficiary can obtain them immediately, paying the copayments stipulated by the plan.

Prior to the reform, Chile already had nearly universal social health insurance coverage, but AUGE placed the base guarantees of public insurance on par with those of private insurance, while improving access for the public subsystem and financial coverage for Isapre beneficiaries.

Key elements of the GES. One of the most important aspects of the GES was the introduction of four explicit guarantees that go beyond a mere list of covered services. These guarantees are as follows:

1. **Access:** the obligation of Fonasa or the Isapres to ensure the provision of health benefits covered by the GES regime.
2. **Timeliness:** maximum wait times for the provision of health benefits covered by the GES, in the manner and conditions specified by the respective decree (reviewed annually).
3. **Quality:** the provision of guaranteed health benefits by a provider duly accredited by the Superintendency of Health.
4. **Financial coverage:** the contribution or copayment to be made by the insured individual per benefit or set of benefits must not exceed 20% of the value determined by the regime's fee schedule, established for this purpose. However, Fonasa's indigent

and low-income beneficiaries pay neither copayments nor deductibles.

A second noteworthy aspect is related to the fact that Chile chose to include just a subset of health problems in the HBP, which aims to cover approximately 60% of the country's burden of disease. Thus, the initiative to develop a legally binding priority-setting process for the GES used the absence of explicit priorities for health problems and medical benefits excluded from the plan as a starting point. Those excluded health problems maintained their previous status, remaining—in the public sphere—subject to rationing by waiting lists. In the case of its large public insurer, Fonasa, Chile has decided to maintain an implicit rationing system for the benefits excluded from the GES and, simultaneously, to prioritize the subset of benefits that are included in the plan. 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 supply is considered ethically and socially unacceptable.

A third element worthy of highlighting is the institutionalization of two fundamental processes associated with the adjustment of an HBP: costing and the identification of social priorities. With regard to costing, the law states that any modification to the contents of the GES must first undergo a rigorous actuarial study commissioned by the Ministry of Health. In terms of the identification of social priorities, the formulation of the first version of the GES in 2005 was preceded by an extensive public consultation process that included groups of experts, interest groups, public, municipal and private workers, and the general public.

A final key element to emphasize in the case of Chile is the government's decision to gradually expand the GES. In 2005, the first 25 prioritized health problems were added to the regime, and a year later, another 15 prioritized conditions

were included. In 2007, 16 more were incorporated for a total of 56 illnesses and conditions. The list has since been expanded two more times, growing to 69 prioritized conditions in 2010 and arriving at a total of 80 in 2013. This strategy of gradually incorporating health problems over time eased the fiscal impact of the reform, as well as its funding requirements and the challenges of its implementation.

Outcomes. Evaluations of the GES are scarce and limited in scope, but the few that do exist reveal important achievements. For example, Bitrán, Escobar and Gassibe (2010) showed that the GES allowed for greater access to care, better coverage, and a reduction in hospitalization and mortality rates for various diseases (acute myocardial infarction, type 2 diabetes, hypertension, epilepsy, depression, and cervical cancer). A recent evaluation by Bitrán & Asociados (Ministry of Health, 2012) showed that out of a set of health services selected for study and linked to the GES, the majority experienced an increase in provision. Furthermore, in the first five years of the reform, public spending (Fonasa) per beneficiary on GES benefits grew 34% in real terms.

Challenges. Standardization of the GES adjustment process is one of the major unresolved challenges, since the process has yet to be clearly established. For example, the relative importance of each of the priority-setting criteria used by the GES advisory committee, the body responsible for updating the HBP, is unknown. There are also no established criteria or rules governing the committee's decisions. The recent initiative by the Ministry of Health to develop a health technology evaluation system in the public health sector promises to contribute to the transparency and institutionalization of the future priority-setting process for public health spending.

While the utilization of GES benefits has increased, the waiting lists for services not included in the plan have grown as

well. The Ministry of Health has openly declared that resolving the waiting list issue will take years due to limited public health resources. However, the reality is that, during the 2005-09 period, public spending on non-GES benefits, expressed in real terms per beneficiary, increased as much as GES spending. An apparent consequence of the GES would

be the establishment of a civic culture that would make its health benefits enforceable, regardless of the legal basis of those demands. It remains to be seen whether the GES will have an impact on the composition of public spending by increasing the proportion of spending allocated to prioritized benefits.

Basic Elements of the Explicit Health Guarantees Plan

Name of HBP	Explicit Health Guarantees (GES) Plan, previously known as the Universal Access with Explicit Guarantees (AUGE) Plan
Year plan began operations	2005
Central motivation	Significant differences in quality and access between the care received by the users of the National Health Fund (Fonasa) and the users of private health insurance institutions (Isapres)
Target population	Entire population
Service coverage	Services have been defined for the care of 80 health problems of varying nature and complexity, including nearly two-thirds of the country's burden of disease. These include ambulatory, inpatient, and surgical services as well as medications
Financial coverage	There are copayments with an annual limit per household equivalent to 43 monthly contributions and a limit per event equivalent to 29 monthly contributions. Indigent and low-income Fonasa beneficiaries do not pay copayments or deductibles
Population coverage	Ninety-seven percent of the country's population is covered by the social security health system and so, by extension, is a GES beneficiary, either through the public insurer, Fonasa, (80%) or private insurers known as Isapres (17%). The remaining 3% is covered by other health insurance systems (e.g., the Armed Forces) or has no insurance
Estimated annual cost per capita	For the 80 health problems, the cost stood at US\$168 in July 2013
Percentage of public health resources channeled to HBP funding	Forty-six percent of Fonasa spending on health care (2009)
Provision of non-prioritized services	They are provided based on availability, with longer wait times and higher copayments
Principal innovations	<p>The HBP defines explicit and enforceable guarantees of access, quality, timeliness and financial protection for covered diseases</p> <p>The combination of an explicit benefit plan for prioritized health problems with implicit rationing for the care of other conditions</p> <p>Institutionalization of the HBP costing process and the incorporation of social priorities; costing anchored in the law and based on a rigorous actuarial methodology grounded in population, epidemiological and cost data; identification of social priorities and the impending formalization of a health technology evaluation process</p> <p>Gradual implementation of the HBP; only 25 conditions were covered at the outset (2005), but by 2012, 80 conditions were covered, reducing the reform's tax burden in the short term</p>

Lastly, the explicit guarantees of the GES have forced Fonasa to increasingly turn to private providers in areas where public providers lack sufficient supply. As a result, there has been pressure to increase Fonasa's budget because private providers generally charge prices far above the costs of public provision.

Reasons for the HBP and the Adoption Process

Background

Chile has a long track record in public health, beginning with the creation of the National Health System in 1952. With health sector reform in 1981, during the military dictatorship, private health insurance institutions (Isapres) were created and the operation of primary care facilities was transferred to municipalities. These changes generated a mixed public-private health system, which is still in effect today.

Over the course of decades, the Chilean health system—along with other sectors that also influence the health of individuals, such as education, nutrition, and housing—has achieved a substantial improvement in the health of citizens. As a result, Chile's maternal and child health indicators are as high as those of developed countries, even though Chilean health spending is comparatively low.

With the restoration of democracy in 1990, the leadership of the leftist ruling coalition, known as Concertación, initiated a discussion about health reform. However, other priorities, such as the need for education reform and fear of the political cost of health reform, meant the process was postponed until 2005, when President Ricardo Lagos (2000-06) decided to tackle health reform. According to the former Minister of Health under Lagos, Pedro García, there were several

unresolved issues at the beginning of the 1990s, including the regulation of private sector insurers (Isapres) to prevent abuse and improve financial coverage, as well as to improve the financial solidarity of the social security system.

According to a survey conducted in 2000, Chileans mentioned health care among their top three concerns, along with employment and poverty. In the public subsector, the shortcomings observed by the population pertained to difficulties of access, manifested in waiting lists and poor quality of care. In the private system, people reported feeling inadequately protected by Isapre coverage and unsatisfied with the pricing policies of those insurers. Along with the public's concerns, health sector authorities were troubled by the increase in health care prices above the general rate of inflation. These factors also helped lay the groundwork for reform.

The Lagos government devised and supported health sector reform and helped it take shape with two important elements: the definition of the health targets for that ten-year period and for overall health reform. Some foundations and motivations for the reform emerged from these health targets, such as demographic and epidemiological changes, inequality, and the level of citizen dissatisfaction with health care. The 2005 Chilean health reform contains five legally differentiated elements,¹ one of which relates to the definition of a health benefit plan known as AUGE, later called GES. This HBP is the centerpiece of the reform and the subject of this chapter.

The Chilean health system

Chile relies upon the social security health system to provide near-universal coverage to its almost 17 million inhabitants. The public insurance

¹ The components of the reform are the Health Authority Law, the regulation of the Isapres based on two laws, the rights and duties of individuals, and the Regime of Explicit Health Guarantees (GES or AUGE).

system, Fonasa, far and away the largest insurer in the country, covers 80% of the population, including the poor, whose care is fully subsidized by treasury funds. Several private health insurance companies, known as Isapres, compete for the coverage of about 17% of Chileans. Other systems, such as those of the Armed Forces, cover the remainder of the population. Fonasa beneficiaries mainly use public health providers, although non-poor Fonasa beneficiaries are entitled to health care through private providers by paying a modest coinsurance rate. Isapre beneficiaries mainly use private health providers (figure 1.1).

The national health care system has mandatory and voluntary components with respect to the choice of insurer and the amount of the contribution. In principle, individuals can freely choose to enroll in Fonasa or with an Isapre, but in practice, salary is the main determinant of choice. Upper-middle- and high-income individuals tend to choose an Isapre in order to obtain services above and beyond those provided by the GES through additional contributions, whereas middle-, lower-middle- and low-income individuals usually choose Fonasa because with their contributions, they could not obtain a better level of coverage with the Isapres. The law requires formal workers to contribute a compulsory health insurance premium equal to 7% of their income, up to a monthly income cap of about US\$1,500; it also allows those who choose to enroll with an Isapre to make voluntary contributions above this 7% in return for services supplemental to those of the GES. Both Fonasa and the Isapres require copayments.

During their first 10 years of existence, from 1981 to 1991, the Isapres were free from government control since there was no regulatory body responsible for overseeing their operations. During that decade, these insurers grew rapidly, reaching nearly two million beneficiaries (enrollees plus their dependents). In 1990, the government created the Superintendency of Isapres under the jurisdiction of the Ministry of Health. Up

until that time, the Isapres could freely select which risks to cover, allowing them to build a portfolio of wealthier, younger and healthier beneficiaries than that of Fonasa. The Isapres' coverage continued to expand until 1997, when they reached nearly four million beneficiaries or 25% of the market. Since then, their coverage has declined; they currently cover only 2.7 million Chileans or 17% of the population, as a result of a significant migration of beneficiaries from Isapres to Fonasa.

The significant differences in the quality and accessibility of care between Fonasa and the Isapres led the government to design the AUGE plan in 2005, a health system reform whose centerpiece was the creation of a minimum benefit plan, common to both Fonasa and the Isapres. That same year, the government created the Superintendency of Health, an agency responsible for regulating and monitoring Fonasa and the Isapres, as well as public and private providers.

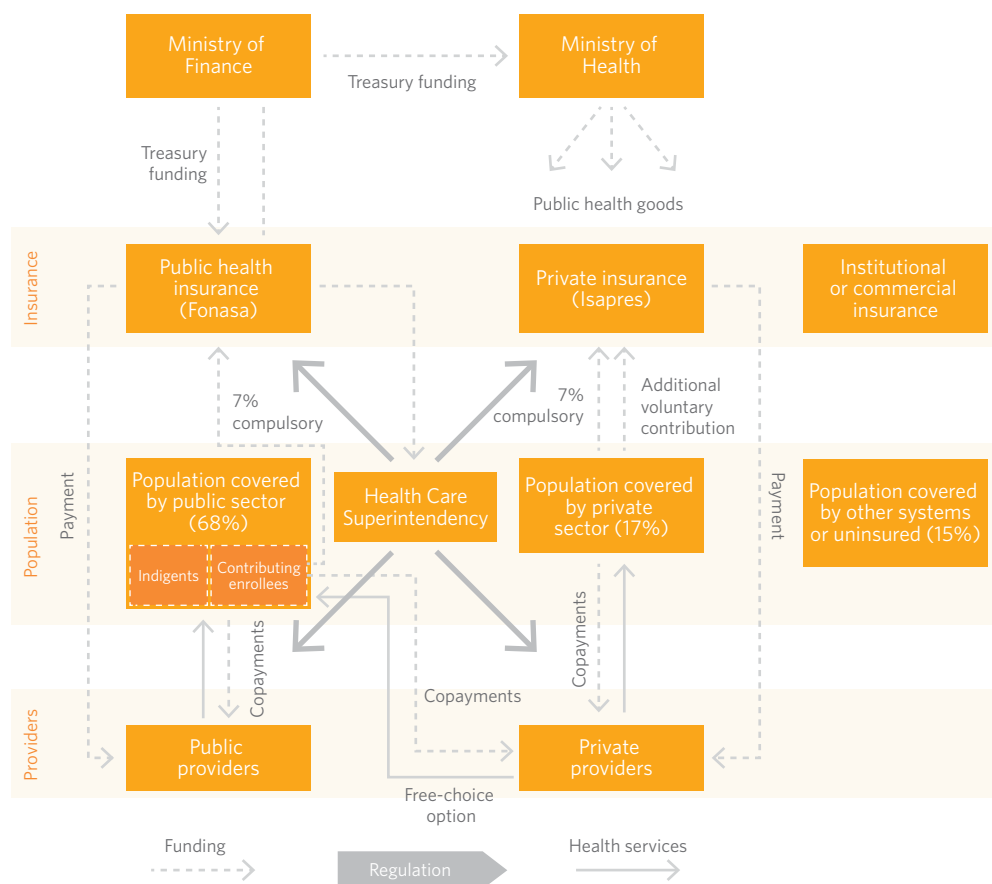
Objectives of the reform

The objectives of the 2005 reform were similar to the health targets set by the government for the 2000-10 period: i) improve on the public health gains made in the 20th century; ii) reduce inequity; iii) meet the new challenges of an aging population and changes in society's vision of health care; and iv) provide services that meet the expectations of the population.

In this way, the reform sought to provide adequate responses to an aging, more educated population with greater awareness of its rights than in the past. As discussed later in this chapter, the main instrument underpinning the reform was a set of explicit health guarantees supported by legal instruments available to consumers in order to ensure compliance with those guarantees.

Until 2005, Fonasa beneficiaries lacked coverage with explicit guarantees, and access to health care was subject to the

Figure 1.1. The Chilean health system



Source: Developed by the authors

availability of supply. In contrast, Isapre beneficiaries had contracts establishing explicit coverage through these private insurers.

Deliberation and negotiation of health care reform and the GES

The development of this HBP required technical expertise, public consultation and political leadership. A powerful opposition to the reform emerged from medical associations, politicians of different persuasions, and even some sectors within the Ministry of Health itself. Nevertheless, President Lagos's unconditional support for the initiative

and his skillful political maneuvering of the process neutralized the opposition.

In early 2000, President Lagos launched a Health Commission to define the reform, led by his right-hand man Hernán Sandoval. According to the account of former Undersecretary of Health during the Lagos administration, Antonio Infante, "this commission requested that an external firm conduct an opinion poll among stakeholders at the national level, using a focus-group methodology. The 'concerns' of those groups were distilled from the results and were used as the basis for a survey administered to families about the need for reform, health priorities, priority groups [...]. In

other words, there was a scientific basis that drew upon the perspective of the public and reflected its needs. [...] Later, workshops were held that addressed different issues with various groups of experts, issues that led to discussion with a variety of interest groups including politicians, professional associations, the ministry, etc. Lastly, progress in the design was brought up for discussion at the community level with social leaders (with a certain degree of bias because the call for participation was made by the health sector). The Chilean Medical Association participated in these activities.”²

In parallel to the work of the Health Commission, the then-minister, Michelle Bachelet (who went on to become Chile’s president), organized other roundtables to discuss the rights and duties of patients. These roundtables were aiming for a very different reform from the one that Sandoval had been designing. Consequently, this parallel effort generated conflict that resulted in the end of the Health Commission’s work, Sandoval’s resignation, and Bachelet’s departure from the Ministry of Health. President Lagos subsequently reestablished the Health Commission under the leadership of Sandoval.³

During that time, the Chilean Medical Association expressed fierce opposition to the reform. One of its main arguments was that the reform would violate medical autonomy by establishing which health problems would be covered by the new HBP and that it would impose the adoption of care protocols. Despite this opposition, Sandoval’s team and the Ministry of Health continued making progress on the formulation of laws for the GES, which would be submitted for review by the Chilean Congress.⁴ During the legislative process, led by the Chamber of Deputies Health and Finance Committees and the Senate

Health Committee, there was a great deal of controversy and public debate with opposing political and professional groups. However, as expressed by Ulises Nancuante,⁵ “throughout the reform process, the steadfast support of former President Lagos—who was convinced of and committed to the idea of reform—was crucial, a fact made evident each time he personally intervened when internal conflicts arose; thanks to his political might, it did get passed...”

The public also participated in the lengthy debate. Several surveys conducted in the country revealed that the vast majority of Chileans, of all political parties, considered health sector reform to be essential (Cegades, 2002).

One component of the reform, the Regime of Explicit Health Guarantees (Law No. 19,966), was included in a supreme decree in 2005, which allowed for implementation of the GES Law. This decree outlined a set of 56 prioritized health problems whose treatment would be explicit and guaranteed by law for all social security health beneficiaries in the country. In defining the content of the HBP, Law No. 19,966 states that “the preparation of the Explicit Health Guarantees proposal will allow for the development of studies in order to determine a list of health priorities and interventions that give consideration to the health status of the population, the effectiveness of the interventions, their effect on extending or improving the quality of life and, where possible, their cost-effectiveness. To this end, epidemiological studies shall be conducted, including burden of disease, systematic reviews of effectiveness, economic evaluations, potential demand, and supply capacity of the Chilean health system.”⁶ Additionally, Article 14 states that “taking into consideration the studies indicated in the preceding article,

² Authors’ interview with Ulises Nancuante (2011).

³ Bitrán and Escobar (2008) describe the political economy of the reform.

⁴ Composed of representatives from the Ministries of Health and Finance and the Superintendency of Health.

⁵ Former auditor for the Superintendency of Health and co-author with Andrés Romero of the book *La reforma de la salud* (2008).

⁶ See Régimen de Garantías en Salud [Regime of Explicit Health Guarantees], September 3, 2004. Available at: <http://www.redsalud.gov.cl/archivos/guiasges/leyauge.pdf>.

as well as national and international scientific evidence and experience, a list of diseases and their associated services will be developed, with the obligation to discard all those for which a benefit in terms of the survival or quality of life of those affected is unsubstantiated. To the same extent, the cost of incorporating them into the regime must be estimated, in accordance with the supply capacity of the public and private sectors and the potential demand for such interventions.”

The initiative to develop a legally binding priority-setting process for the GES used the absence of explicit priorities for health problems and medical benefits excluded from the plan as a starting point. Those excluded health problems maintained their previous status, remaining subject to rationing by waiting lists within the public sphere. This situation worried GES detractors, including the Chilean Medical Association, but it held no major consequences for the design of the reform.⁷

To avoid excessive pressures on health spending, the GES provided for the gradual addition of health problems to the list, guaranteed over a period of three years, beginning with 25 conditions in 2005 and reaching 56 in 2007.

The following lessons emerged from the reform described above:

- The creation of a reform commission external to the Ministry of Health gave its technicians the autonomy to develop a design that would be free from both interference by the prevailing problems of that entity, and contamination by the political forces represented in the figure of the health minister.

- Support for the reform in Congress was made possible by the deft political maneuvering of President Lagos and his allies (including the health ministers who succeeded Bachelet), obtaining majority backing from representatives of both the left and the right.
- The provision of legal health guarantees for citizens was a key element of the reform, which received broad political support.
- The gradual implementation of the HBP reduced pressures on the health system associated with such a drastic reform, incorporating guaranteed coverage of new health problems over time for the population. In addition, this method facilitated financing of the plan and the progressive adoption of new procedures by insurers and providers.
- President Lagos and his advisor, Sandoval, successfully appealed to the people in order to defeat the opposition of the Chilean Medical Association through public opinion. The president of that organization admitted in an interview that the Chilean Medical Association did everything possible to block the reform during legislative deliberation of the GES, but it failed because of the strong support that the reform garnered from the public and political parties.⁸

GES Design

Priority-setting methods

Article 11 of Law No. 19,966 concerns the determination of the explicit guarantees under the Regime of Health

⁷ In 2005, waiting lists for non-AUGE health problems started to grow. They reached a peak of several tens of thousands of people waiting for a procedure or surgery not included in AUGE. This became the subject of national discussion as Chileans sought answers from the Ministry of Health and Fonasa, which eventually formulated a plan to reduce the waiting lists. This issue continues to be a topic of debate, and the waiting lists persist. A reform initiative promoted by former President Sebastián Piñera sought to expand health guarantees beyond the AUGE health benefit plan so that there would be no exclusions. It is unclear how President Piñera hoped to achieve this objective, given the natural limitation on financial resources and the broad and growing health needs of the population.

⁸ Authors' interview with Juan Luis Castro, former president of the Chilean Medical Association.

Guarantees. It states that these will be developed by the Ministry of Health, in accordance with the procedure established by that law and in the regulations, and they shall be approved by supreme decree of the aforementioned ministry and endorsed by the Minister of Finance.

As mentioned above, the law states that the preparation of the GES proposal must allow for the performance of studies in order to determine a list of priorities and interventions that give consideration to the health status of the population, the effectiveness of the interventions, and their effect on extending or improving the quality of life. In addition, when possible, cost-effectiveness and the public's preferences and priorities must be considered. As stated in the law, the HBP proposal must undergo a verification process for the expected cost per beneficiary through a study commissioned for that purpose, to be directed and coordinated by the Ministry of Health.

Based on the results of the study, the Ministries of Health and Finance must submit the proposal for consideration by the Advisory Council. Once those procedures have been completed, both ministries must issue a decree corresponding to the new explicit guarantees. This means that priority setting was chiefly conducted on the basis of the evaluation of health problems according to the parameters set by the law, and then, associated benefits were defined for each one. This final definition was based on the clinical practice guidelines created for this purpose and developed using evidence-based medicine. In addition, policymakers had to consider whether health providers across the country could indeed offer the health guarantees and whether they were financially sustainable. One example of a service that was not included as a guarantee is the placement of a stent as treatment for a myocardial infarction,

because the National Health Care Service did not have enough surgeons available throughout the country with the necessary skills to perform this procedure.

In operational terms, legislators gave structure to the organization of the GES through the Advisory Council, composed of a group of experts. They prioritized health problems and their respective interventions according to the aforementioned criteria, discarding those that were unsubstantiated, i.e., services that did not increase survival or improve the quality of life of those affected.

The health problems submitted for initial evaluation to determine their possible inclusion in the GES came from two lists: the list of priorities defined by the Ministry of Health and the list of health problems included in Fonasa's Catastrophic Illness Program, which contained about 20 conditions.⁹ As previously mentioned, multiple priority-setting criteria were adopted to define the contents of the HBP with respect to that original list, as illustrated in figure 1.2.¹⁰ For that reason, it is not possible to systematize or mechanically formulate the procedure used by the members of the Health Commission to apply the aforementioned priority-setting criteria. This is attributable to the fact that the application of these criteria did not obey strict formulas. Instead, the criteria were considered as a whole, without assigning a specific weight to each one, resulting in a procedure that is difficult to describe or generalize.

Lastly, once the expected cost associated with each guaranteed health problem is known, the financial feasibility of its inclusion is evaluated. A global indicator of the GES plan's expected cost to the health system has been the annual expected cost per beneficiary, a figure also known as the GES premium. Table 1.1 presents the development of

⁹ Bitrán and Escobar (2008) describe the political economy of the reform.

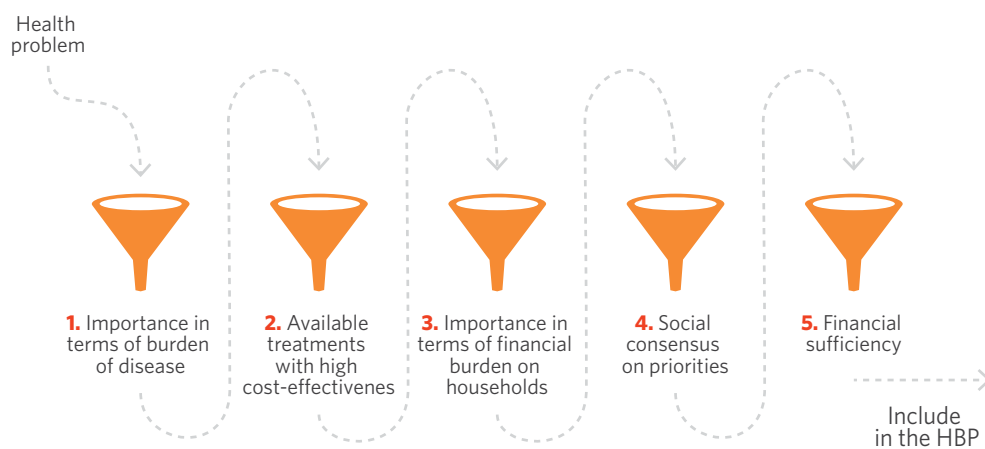
¹⁰ The priority-setting criteria that led to the selection of the 56 prioritized health problems in the AUGE plan were analyzed in Vargas and Poblete (2008).

this premium over the 2005-10 period. Financial aspects of the GES are addressed in greater detail later in this chapter.

Vargas and Poblete (2008) analyzed the previous priority-setting process and concluded that the dominant selection criteria were burden of disease and social preferences. In fact, of the 56 health problems that were initially prioritized, 42 of them figured on the list developed by the Ministry of Health and were linked to the health targets for the 2000-2010 period. Of those, 26 formed part of Fonasa’s Catastrophic Illness Program. Other noteworthy findings from Vargas and Poblete (2008) include the following:

- Of the 56 health problems, 21 of them account for half of Chile’s disease burden (measured in disability-adjusted life years), including conditions such as congenital malformations, many types of cancer, diabetes mellitus, accidents, some neurological and mental health problems, vision and hearing loss, acute respiratory infections, and oral health problems.
- Forty-five percent of the health problems presented significant socioeconomic inequities in terms of access.

Figure 1.2. GES priority-setting criteria



Source: Bitrán and Giedion (2008)

Table 1.1. Annual universal GES premium per beneficiary, by year of application (Ch\$ and US\$ in 2010)

Year	Number of health problems	Ch\$	US\$
2005	25	21,965	46.40
2006	40	43,929	92.80
2007	56	65,894	139.20
2010	66	72,784	153.80

Source: Developed by the authors

- Two-thirds of the prioritized health problems were explicitly included in the social preference studies, whether related to life-saving treatments (cancer and diabetes) or interventions for prioritized groups (children and the elderly).
- Slightly more than half of the health problems selected are of a catastrophic nature, according to the annual cost ceiling used (over US\$1,900). Two out of three health problems in this category were already part of Fonasa's Catastrophic Illness Program.
- Most of the health problems selected have treatments with moderate or high effectiveness.
- With regard to the priority-setting criteria, the analysis showed that half of the health problems are associated with a high burden of disease, high social preference or they belong to the group of high-cost interventions. Among those, 10 health problems are also associated with highly cost-effective treatments.
- In contrast to what is recommended in the literature, the criterion of cost-effectiveness was included for a subset of health problems in the first round of priority setting and was also used in the selection of interventions (treatments for health problems already selected).
- The priority-setting process for the health problems and contents of the benefit plan had a pronounced technical character, an aspect that prevailed over political or other considerations. The role of the Ministry of Health was central to the priority-setting process, because even when the institution commissioned some studies from external sources, it played a role as an active and decisive partner in the outcomes of those studies. Furthermore, Fonasa also contributed to the analysis, providing background information on the health problems that were the focus of special programs, such as the Catastrophic Illness Program and Health Care Opportunity Program (which prioritized wait times for certain health problems considered critical by the Ministry of Health). In addition, the experience gleaned from pilot testing in the public system's network also contributed to the selection of health problems included in the GES.
- The selection of benefits that constitutes the list of treatments was based on the content of the clinical guidelines developed using evidence-based medicine. This was the result of collaboration between staff from the Ministry of Health and representatives from scientific societies dedicated to specific illnesses. These guidelines explicitly state the scientific rationale behind each recommendation, and based on that, the list of benefits associated with each health problem is developed, explicitly defining the guarantees up to that level.¹¹ This implies a clear prevalence of technical elements over any other consideration in the selection of benefits, although, in the end, some benefits included in the guidelines are not among those guaranteed. The reasons for this include insufficient public supply (for example, stenting in acute myocardial infarction or bone marrow transplant in adult leukemia) or financial resources. One example from the clinical guidelines is the case of arterial hypertension, for which the guidelines define the professional consultations required by the patient, as well as laboratory tests, procedures, and the active ingredients of the medications to be prescribed.

¹¹ Grading the quality of evidence and the strength of recommendations with the GRADE system. See <http://www.fisterra.com/guias-clinicas/la-evaluacion-calidad-evidencia-graduacion-fuerza-recomendaciones-sistema-grade/>.

- The guidelines cover the situation that occurs most often, which means that for cases unsuited to standard management, the required treatment is provided with the usual guarantee instead of the “explicit” guarantee. This means that each insurer, whether public or private, will provide coverage according to the health care and financial benefits of each plan.

The benefit selection mechanism already described was also used to define the medications included in the GES (active ingredients).

In summary, the priority-setting process was strengthened by the methodology used, and it was supported by data from recent studies of a varied nature (burden of disease, social preference surveys, and others), the parallel development of clinical practice guidelines with an evidence-based methodology, the creation of an institutional structure for the GES (Advisory Council), and the alignment of the priority-setting process with health targets set by the Ministry of Health for the 2000-2010 period.

Legitimacy

The legitimacy of the process is based on the use of a priority-setting method that includes the most relevant variables designed to fulfill the objectives of the reform and the established guarantees. Furthermore, this method included data from the user population obtained by various means and also allowed for the involvement of groups of specialists, as in the case of the health reform roundtables and the development of clinical guidelines. Nevertheless, the Chilean Medical Association openly expressed its disapproval of the GES and vigorously opposed the reform at every turn, because its leadership considered the plan a

threat to its livelihood and professional autonomy.

Main Features of the GES

As already stated, this HBP consists of a list of prioritized health problems (80 as of July 2013), representing about 60% of the country’s burden of disease, along with an explicit set of guaranteed treatments. In addition, the HBP contains a list of benefits belonging to the “preventive medical examination” group.¹² The preventive medical examination is the means of conducting secondary prevention through early diagnosis and timely treatment of selected pathologies. Unfortunately, figures show that the greatest interest and demand from the public are focused on curative measures.

The GES provides beneficiaries with four types of explicit guarantees:¹³

- *Access.* The obligation of Fonasa and the Isapres to ensure the provision of health benefits covered by the GES regime.
- *Timeliness.* Maximum wait times for the provision of guaranteed health benefits, in the manner and conditions specified by the respective decree, reviewed annually.
- *Quality.* The provision of guaranteed health benefits by a registered or accredited provider.¹⁴
- *Financial coverage.* The direct contribution or copayment to be made by the insured individual per benefit or set of benefits must not exceed 20% of the regime’s fee schedule, established for this purpose. This applies to all Isapre

¹² See the benefits of the preventive medical examination at http://www.redsalud.gov.cl/gesauge/ges_examen.html.

¹³ Details on these guarantees are contained in the supreme decrees. The current decree is Supreme Decree No. 4 of February 5, 2013, available at <http://www.minsal.cl>.

¹⁴ This guarantee will be enforceable once the Superintendency of Health’s certification, accreditation and registration systems enter into force.

beneficiaries and Fonasa high-income beneficiaries. To limit the beneficiary's out-of-pocket spending on GES copayments, the law also calls for a deductible, which corresponds to the amount of out-of-pocket payments that a beneficiary must make each annual period. The law establishes that the deductible is equal to 29 monthly contributions (7% of income) or approximately US\$5,500. Once the beneficiary has reached the deductible, the insurer must fully cover all treatment costs above that value. Indigent and low-income Fonasa beneficiaries do not pay copayments or deductibles.

Detailed characteristics of the HBP are set forth annually in a supreme decree that supplements the guarantees and allows for their implementation. Since the inception of the GES in 2005, the government has issued five supreme decrees, each of which contains a definition of the health problem, a list of the conditions incorporated (diagnoses), and a description of the four guarantees.¹⁵ It also contains an annex entitled "List of Specific Benefits," which explicitly details each of the health problems and their corresponding guaranteed benefits. Thus, each supreme decree establishes a concise and explicit framework within which to address the guaranteed health problems (Superintendency of Health, 2008).

The law states that insurers must ensure that GES benefits are granted through a network of preferred providers. In the case of Fonasa, this network corresponds to the National Health Care Service, while the Isapres utilize the network designated by those insurers. These preferred GES providers constitute a closed system of

care aimed at containing the health system's costs. To ensure Fonasa's compliance with the guarantees, the Ministry of Health has developed an equipment and infrastructure investment plan for its National Health Care Service provider network.

Nomenclature

As previously mentioned, the GES includes an explicit list of health problems defined by their respective diagnoses,¹⁶ based on the International Classification of Diseases, 10th Edition (ICD-10).

The annex to this chapter details the 80 health problems covered as of July 2013. The clinical guidelines that direct the management of each case have been defined for each of these health problems. Based on these guidelines, explicit guarantees have been defined regarding the benefits to be provided, which in turn have been differentiated into the following four stages of addressing a health problem: suspicion, diagnostic confirmation, treatment and follow-up. Two of these, suspicion and diagnostic confirmation, are grouped together in the stage called diagnosis. Comprehensive care management of these health problems is embodied in and implemented through this approach, which is illustrated in figure 1.3.

These stages or phases of the health care process correspond to what are termed "types of health interventions" in GES nomenclature, and specific health interventions, some of which are complementary or alternative, have been defined for each health problem.¹⁷ In

¹⁵ On July 1, 2005, Decree No. 170 took effect, under which guaranteed coverage was granted for 25 health problems. On July 1, 2006, Decree No. 228 took effect, which established coverage for 40 health problems. On July 1, 2007, Decree No. 44 took effect, which established coverage for 56 health problems under the Regime of Explicit Health Guarantees. On July 1, 2010, Decree No. 1 took effect, which established coverage for 66 health problems, and on July 1, 2013, Decree No. 4 took effect, which established coverage for 80 health problems.

¹⁶ For example, the surgical treatment of scoliosis in individuals under the age of 25 includes diagnoses of the following types of scoliosis: congenital, infantile idiopathic, juvenile idiopathic, adolescent, thoracogenic, neuromuscular, associated with bone dysplasia, associated with any syndrome, secondary, and kyphoscoliosis.

¹⁷ For example, in the case of breast cancer (health problem number 8), health interventions include treatment in the form of surgical intervention (with or without breast reconstruction), chemotherapy (different regimens depending on the stage of the disease), curative radiation therapy, palliative radiation therapy, and hormone therapy.

turn, each health intervention has a set of specific services that are detailed in the explicit list of benefits that forms part of every decree. Figure 1.4 shows what was described above.

In all cases, the benefits associated with each health problem and the preventive medical examination for each population group are clearly identified, hence the “explicit” label. In the case of medicines, active ingredients are defined.

With regard to health services, for easy identification and understanding on the part of users and providers, codes based on Fonasa’s fee schedule are used, since this list is well known and widely used throughout the country.

Medical coverage

Among the 80 current health problems covered since July 2013 are i) cancers: cervical, breast, leukemia, lymphoma, prostate, stomach, testicular, and all childhood cancers (in children under age 15); ii) cardiovascular problems: heart attack, stroke; iii) surgical disorders: scoliosis, congenital heart disease, neural tube defects, hip replacement, cataracts, cholecystectomy, etc.; and iv) problems involving high-cost treatment such as kidney transplant, HIV/AIDS, heart surgery, etc. (See the full list in the annex to this chapter.)

Medical and dental benefits, bed days, surgeries, diagnostic and therapeutic procedures, laboratory tests, imaging and anatomic pathology, specific therapies, supplies and medications are included among the explicitly guaranteed benefits. For this last item, the GES defines the active ingredient and each insurer selects the pharmaceutical product, whether generic or brand name, to include in its formulary. In addition, the authority has defined an average frequency for each benefit, which is only meant to serve as a reference for the application of the guarantees and is relevant to the estimation of costs. This means that the utilization level of each benefit is defined by the treating physician according to his criteria and the condition of each patient.

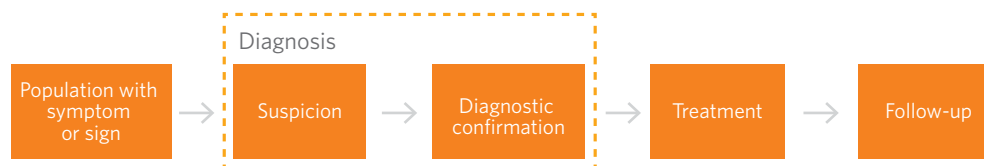
Clinical practice guidelines

Each one of the current health problems has an associated clinical guideline—available in the public domain—which was developed by a professional team using evidence-based medicine.¹⁸ Some of these guidelines have already been updated, so the guarantees of several previously valid health problems were modified as of July 2010.

Population coverage

The GES is defined as a plan for beneficiaries of both the public (Fonasa)

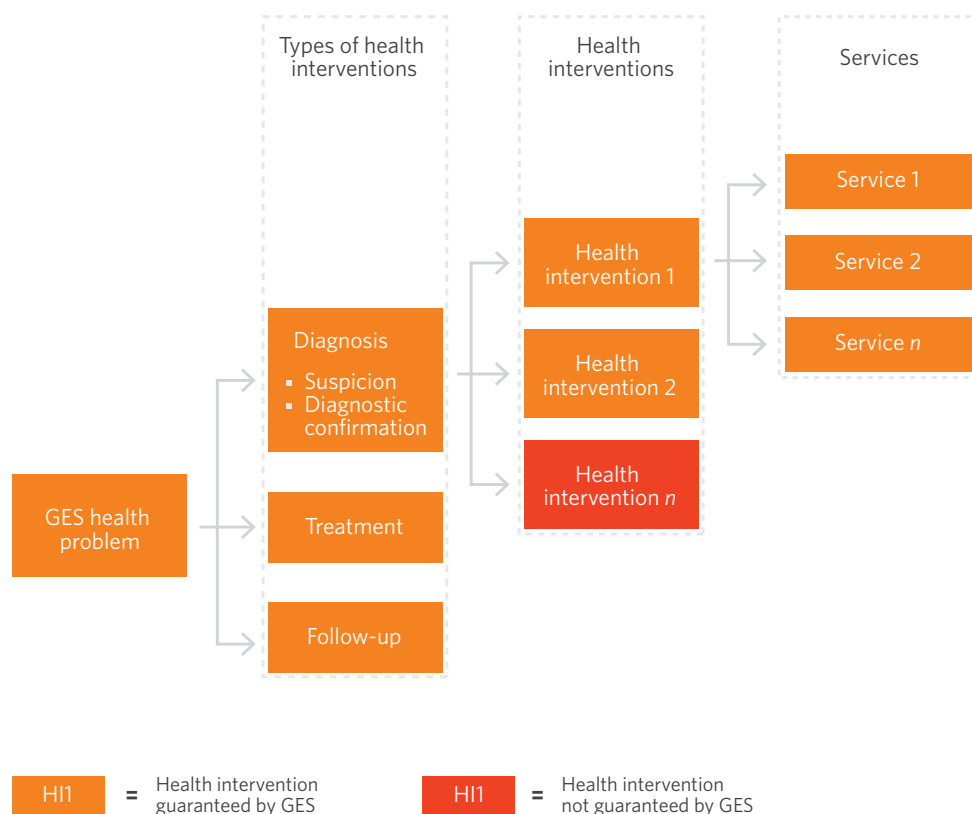
Figure 1.3. Stages of resolution of GES health problems



Source: Developed by the authors

¹⁸ See the Ministry of Health’s website at <http://www.minsal.cl>.

Figure 1.4. Health problems, interventions and services



Source: Developed by the authors

For each of the 80 health problems currently included in the GES, four types of health interventions exist, namely 1) suspicion, 2) diagnostic confirmation, 3) treatment and 4) follow-up. Each of these four types of interventions has, in turn, one or more specific health interventions. These interventions, in their own right, include one or more health services. Some health interventions are guaranteed by law while others are not.

and private (Isapres) subsystems. Together these account for 97% of the population, meaning GES beneficiaries total more than 15 million people. The remainder of the population is served by another health system (Armed Forces or Police), works in the informal sector and has private health insurance, or is uninsured.

Chile already had nearly universal social health insurance coverage before the introduction of the GES, but this HBP placed the base guarantees of public insurance on par with those of private insurance, while improving access for the public subsystem and financial coverage for Isapre beneficiaries.

Access to excluded services

All diseases or health problems excluded from the GES are included under the regular coverage offered by Fonasa and the Isapres. In these cases, Fonasa beneficiaries must cope with waiting lists and Isapre beneficiaries face higher copayments, but no one goes without coverage. One exception to this rule is that high-cost outpatient medications are not covered for Isapre beneficiaries, and some diagnostic or therapeutic technologies are unavailable in the public sector. Under the Isapres, the characteristics of those benefits depend on each health plan.

Similarly, Fonasa beneficiaries can access care for non-prioritized health conditions. The considerable difference from GES care is that the care offered for non-GES benefits is not accompanied by legal guarantees, which translates to difficulties in access (longer wait times and waiting lists) and/or increased out-of-pocket spending.

There is also a highly developed private market for voluntary supplemental health insurance, which offers medical coverage in addition to that of Fonasa and the Isapres.

Financing, Insurance and Service Delivery

Financing

For Fonasa, GES financing comes from two sources: beneficiaries' contributions (compulsory and equivalent to 7% of salary) and general taxes. With respect to taxes, the legislative process included a pronouncement (initially temporary but which later became permanent) for a one percentage point increase in the value added tax, which rose from 18% to 19% in 2005. As shown in graph 1.1, a growing proportion of Fonasa spending is financed with resources from the Treasury (i.e., with tax money), while the mandatory 7% social security contributions are declining in importance. This trend existed before the adoption of the GES (since at least 2002), so it does not appear to be attributable to the adoption of the HBP.

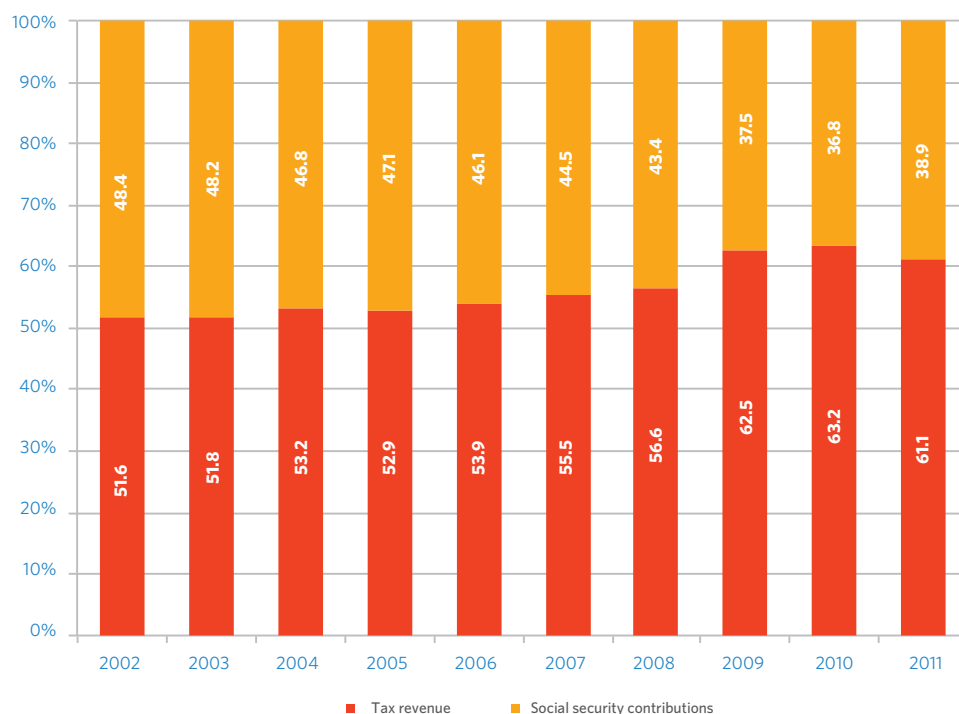
In the case of the Isapres, they are empowered by law to collect an additional 7% compulsory health care premium. The law made a provision for that premium so the Isapres would be able to cover any incremental cost resulting from the adoption of the GES. The various Isapres have adopted different premiums and have followed a variety of policies for their annual update. Some believe that the premiums charged for the GES by certain Isapres exceed the actual incremental cost imposed on these insurers by the HBP;

however, only a systematic study could shed light on this issue. In any event, although the Isapres sell many insurance plans and charge different premiums for each of these plans (which beneficiaries fund with the 7% contribution by law plus additional voluntary contributions), each Isapre charges a single premium for the GES. In other words, the Isapres finance the GES with a kind of pooled premium, while they finance the rest of their benefits with differential premiums based on the actuarial risk of each insured individual.

Successive cost studies on the GES commissioned by the Ministry of Health in 2005, 2006, 2007, 2010 and 2012 have sought to estimate the cost of the GES for Fonasa and the Isapres. However, the calculated cost matches neither the total cost nor the incremental cost of the GES for those insurers. This is because the methodology defined by the Ministry of Health for the calculation of this cost states that the figure that must be calculated is the cost faced by the insurer when a beneficiary decides to address a health problem through the GES preferred provider network, chosen by Fonasa or the Isapre, respectively. In the case of Fonasa, it is estimated that over 80% of beneficiaries choose to receive care through the GES option rather than the free-choice option provided by that insurer. Therefore, for Fonasa, the calculated cost is similar to, but somewhat less than, the total cost of providing medical benefits for the health problems included in the GES. For the Isapres, the situation is quite different. On average, it is estimated that only 20% of beneficiaries opt to receive care from the Isapre's preferred GES providers, with the remaining 80% preferring to do so through their free-choice coverage. Consequently, for the Isapres, the cost studies commissioned by the Ministry of Health yield a result that represents a small fraction of the true cost of prevention and treatment of GES conditions.

Casting aside for a moment these important clarifications on the

Graph 1.1. Fonasa revenue structure, 2002-11 (%)



Source: Bitrán, Debrott and Arpón (2013)

interpretation of the costs calculated by the Ministry of Health, the cost estimates are intended to ensure that the weighted average cost per beneficiary for these two insurers does not exceed the maximum set by law. That legal maximum, known as the universal premium, seeks to limit fiscal impact, in the case of Fonasa, and the impact on private financing, in the case of the Isapres. The value of the universal premium is calculated annually by the Ministry of Finance, using the country’s wage index as the basis for the update.

The Ministry of Health has also been interested in learning what fraction of Fonasa’s total cost is allocated to the financing of GES benefits and what remaining portion finances the benefits not guaranteed by the regime. A recent study commissioned by the Ministry of Health estimated that GES benefits represent 46% of total spending on

benefits financed by Fonasa, as shown in graph 1.1 (Ministry of Health, 2012). Since most current GES benefits were already offered by Fonasa, without guarantees, prior to the implementation of the GES in 2005, for the years preceding 2005, the figure also shows the proportion of Fonasa spending represented by those benefits that would later be guaranteed by the GES.

Financial coverage

The following aspects stand out from among the parameters established by the GES law:

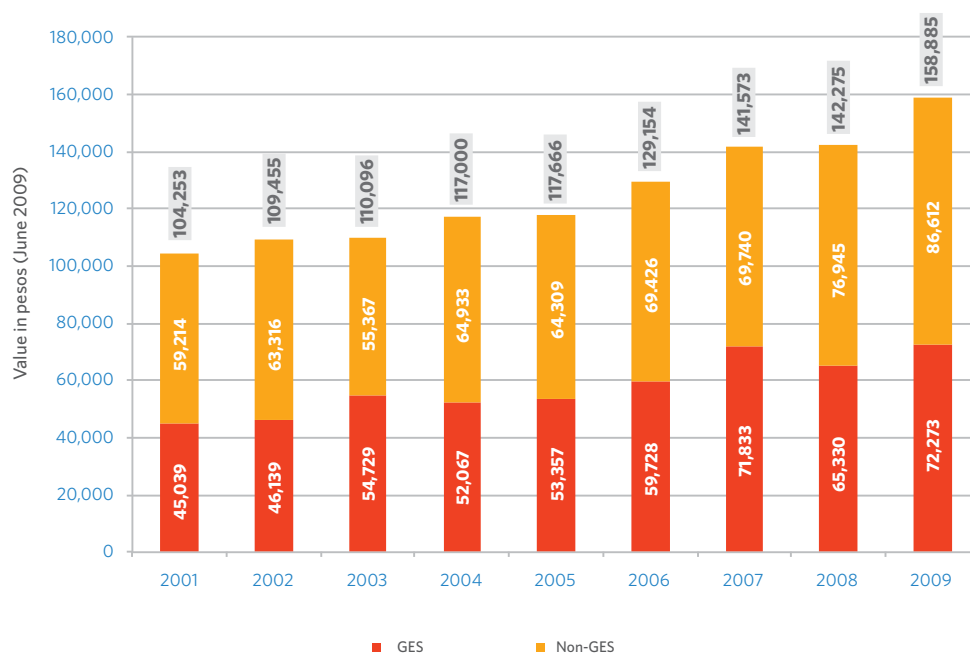
- Copayments for services are established, which are applicable to higher-income beneficiaries of both Fonasa and the Isapres. These are capped at 20% of the value listed in the GES regime’s fee schedule.

- Health events are managed on an annual timetable, which means copayments based on the fee schedule accumulate over the course of a year until the deductible is met.
- Catastrophic coverage known as “additional financial coverage” also exists, which covers 100% of the amounts exceeding the defined copayments.
- The annual deductible for high-income beneficiaries of Fonasa and the Isapres is equivalent to 29 monthly contributions per event, where one contribution equals 7% of the beneficiary’s salary.¹⁹ In the case of a family, the deductible is set at a maximum of 43 monthly contributions. If a family requests benefits for more than one health problem included in the GES, the total deductible remains at the annual maximum of 43 contributions rather than a sum of the deductibles for the individual benefits.
- The accumulation of copayments toward the deductible does not include benefits unrelated to the protocols or those that have been provided outside the network (except in the case of life-threatening emergencies, reported within 72 hours).

Costs

The GES Law states that “the proposed selection of health problems will undergo a cost verification process for

Graph 1.2. Estimated Fonasa spending per beneficiary, GES and non-GES (in Chilean pesos, June 2009)



Source: Developed by the authors

¹⁹ The monthly contribution is defined as the 7% salary deduction that the beneficiary must make to obtain coverage for himself and his family. A monthly cap of approximately US\$2,500 is applied to the beneficiary’s salary, such that the contribution does not exceed the amount of US\$175.

the expected cost per beneficiary for the set of prioritized conditions with explicit guarantees, through a study commissioned for that purpose, to be directed and coordinated by the Ministry of Health.” In accordance with this requirement, there have been a total of five cost studies performed on the GES (Ministry of Health, 2006, 2007 and 2010). These studies are available in the public domain and can be accessed through the Ministry of Health website.

These cost verification studies served as the basis for the Advisory Council to better organize the implementation of solutions to the health problems between 2005 and 2007. Later, they were used in 2010 to select 69 health problems from among the 85 that had been costed, and more recently, to estimate the cost of the 80 current health problems.

Macro-financial equilibrium of the health system

Without differentiated financial records, it is difficult—if not impossible—to empirically establish whether a financial equilibrium exists for some of the insurers. Supply deficits in the public sector have resulted in many cases of non-compliance with GES provision guarantees. This situation has helped Fonasa to contain the cost of the GES, but it has affected compliance with the law. Fonasa has remained in this irregular situation by way of legal maneuvering, thus managing to avoid an audit by the Superintendency of Health and the application of fines or penalties. This limitation on the public supply of services is not necessarily due to a lack of financial resources but instead is driven by an occasional shortage of personnel at public facilities. The situation is more critical in certain specialties and has worsened over time as the private provider system has grown.

Although there are no estimates, there is a sense that a financial equilibrium exists among the Isapres, since each one sets the GES price when there are changes

to the HBP. In fact, in some cases it has been suggested that the increase in GES prices generates a surplus large enough to compensate for the rising limits of the supplementary health plans offered by the Isapres.

The purchasing of plan services

Among the strategies used by insurers for cost containment is the network of preferred providers, with which prices and payment mechanisms have been negotiated. In the case of Fonasa, as the sole purchaser of services, the entity unilaterally sets the amounts to be transferred to public sector providers. When purchasing services from the private sector, Fonasa calls for bids that allow it to select the most inexpensive providers. In the case of the Isapres, each one negotiates rates and contracts with private providers from around the country to obtain the supply of GES services it requires. When purchasing GES medications, both public providers as well as the Isapres solicit bids that allow them to contain costs.

The payment mechanisms that Fonasa and the Isapres have adopted include various options, ranging from fee-for-service payments to payments associated with diagnoses or service packages. In the case of Fonasa, adopting one form of payment over another helps encourage and promote compliance with the guarantees. When Fonasa wants to promote the supply of a service, it reimburses providers using fee-for-service payments; when it expects to share the financial risk with providers (e.g., in the case of high-complexity services), the package payment is used.

These payment mechanisms are not new to the system. Fonasa has been utilizing them for the implementation of special programs such as the one for catastrophic illness, the reduction of waiting lists, and others since the 1990s. In parallel, each Isapre must assemble its own GES provider network, as by law the Isapres cannot own health service provider

institutions. In practice, this is relative, as most of the Isapres or the financial holding companies to which they belong also own providers or provider networks at different levels (ambulatory or inpatient), and therefore intra-holding relationships do occur. The Isapres also instituted a negotiation process that includes payment mechanisms such as service packages. Providers have had to join this system, although at the beginning they balked at sharing risks with the insurer and offering competitive rates.

Relevance of the GES to the Health Care System

According to the 2010 cost verification study, the total expected cost of 85 health problems that year was Ch\$1.233 trillion (US\$2.458 billion), when adding the expected costs of Fonasa and the Isapres.²⁰ This value represented 1.3% of the gross domestic product (GDP) projected for 2010 (Central Bank of Chile, 2010). A 2012 study estimated that for the 80 health problems that currently constitute the GES, the total cost to the country was US\$2.729 billion, equivalent to 1% of the GDP for that year.

Implementation

The implementation of the GES has been gradual, because although a total of 56 health problems were defined and costed at the plan's inception, only 25 took effect the first year (2005). In 2006, the figure reached 40, and a year later, in 2007, the GES included the full 56. Subsequently, in 2010, another 10 health problems were added, and one of the previous health problems was divided into four different conditions, bringing the total to 69. In July 2013, 11 more health problems were included for a current total of 80.

The implementation processes for Fonasa, the Isapres and their respective providers did not occur in parallel. Fonasa began conducting pilots before the official launch of the GES. These pilots allowed the public health system to test the operational level of the HBP before it became a legally enforceable guarantee. For example, in 2009, pilots were conducted for hip dysplasia and comprehensive oral health for pregnant women throughout the entire public provider network. Their objectives included identifying gaps and critical points in the health care process to evaluate whether it was feasible to deliver these guarantees and to redesign them according to the results obtained.

In contrast, the Isapres had to implement an entirely new system, assemble a network of GES providers through agreements, train staff, and inform beneficiaries of the guarantees and the processes to access them.

Additionally, the law called for the formation of the GES Advisory Council, with the role of advising the Ministry of Health on matters related to the analysis, evaluation and revision of the guarantees. The Advisory Council is composed of nine individuals, six of whom are academics nominated by various universities and three of whom are presidential appointees.²¹ Its members receive no remuneration for this role and are barred from any contractual relationship with health sector entities (the Ministry of Health, regional ministerial secretariats, the Superintendency of Health, etc.). The council's mission is to evaluate the proposal developed jointly by the Ministries of Health and Finance and to issue an opinion on the proposal itself and the arguments presented to support it. Operationally, this meant that technicians from the Ministry of Health, the Superintendency, and organized groups from scientific societies would be involved in the definition of GES content.

²⁰ The average exchange rate for December 2009 was Ch\$501.42 to the US dollar. Available online at <http://www.sii.cl>.

²¹ The Advisory Council is composed of nine members of recognized expertise in the fields of medicine, public health, economics, bioethics, health law and related disciplines.

Throughout the six years of the GES plan's operation, the council has debated—sometimes publicly—the inclusion or exclusion of health conditions from the HBP, whether due to lack of consensus on their priority status or supply-side restrictions on services in the country. According to Dr. Hernán Sandoval, the approval of various international entities was sought during the GES plan's long development process. “In 2000, the GES was presented at an activity organized by the Rockefeller Foundation in Bellagio [Italy] to academics from the London School of Economics and Political Science, who gave strong support to this initiative that conditions a health budget to the use of protocols or clinical guidelines.” Sandoval adds, “We also worked with Norman Daniels (an expert on public health ethics at Harvard University), and we gathered ethical arguments that supported the frequency and severity criteria for priority setting (concentrating there the majority of problems that contribute to the burden of disease) but with the safeguard of leaving resources available to treat other diseases.”²²

Oversight

The oversight body as defined by law is the Superintendency of Health. This institution, created in 2005 on the basis of the Health Authority Law, has focused its efforts on monitoring the Isapres rather than Fonasa, even though most of the population is covered by the latter. This is because Fonasa has resisted oversight by the Superintendency, arguing that the General Comptroller of the Republic serves as its oversight body. Multiple audits have not identified serious compliance issues among the private insurers, although there is indeed evidence of non-compliance, particularly on the part of Fonasa, in terms of the timeliness guarantee (Sánchez, 2009).

Quality control

The Superintendency of Health replaced the Superintendency of Isapres. In addition to handling the functions previously performed by the Superintendency of Isapres, the Superintendency of Health oversees the newly created Office of Health Provider Oversight. This office is charged with authorizing individuals and companies that wish to provide GES services. In order to fulfill this function, the office registers, qualifies and evaluates these individuals and companies as GES providers, based on an accreditation process with previously agreed-upon standards. The accreditation process has already been defined, as well as the regulations governing its application, but it is still in its infancy. This is because many of the public providers do not meet the established criteria, and for that reason, the accreditation requirement is not yet enforced. The only requisite for providing the HBP that has been enforced is provider registration. To date, only 18 institutions have been accredited: seven high-complexity hospitals (only one public) and 11 ambulatory care facilities (all private).

Dissemination of information and public knowledge about the GES

Several mechanisms exist to educate the public about GES benefits. First, the law states that when diagnosing or monitoring a patient suffering from a health problem included in the GES, every health professional must 1) inform the patient of his benefits and explain them and 2) document this action through a form created by the Superintendency of Health, which the patient must sign. This documentation is subject to audits by the Superintendency of Health, particularly among private providers, since the private system's beneficiaries must actively request their benefits from each Isapre. In contrast, the public system's patients

²² Interview by one of the authors of this chapter with Hernán Sandoval in 2008.

are treated within the National Health Care Service network and, therefore, automatically receive those benefits.

Since 2006, the Superintendency of Health has been commissioning population surveys (the Adimark surveys) to assess the public's level of knowledge about the GES.²³ In 2006, the survey (with a nationally representative sample) found that 53% of respondents knew about "some" health conditions included in the GES, and the primary means of dissemination was television. In 2009, an equivalent assessment showed that between 28% and 38% of the population claimed to know "all" of the health problems included in the GES. A 2010 survey conducted with Fonasa beneficiaries under treatment for cervical cancer showed that 57% were unaware that their health condition was part of the GES (Urrutia, Villegas and Poupin, 2010). The latest assessment performed in 2011 (2011 Adimark survey) showed that 80% of Isapre beneficiaries reported a sense of protection, compared to 54% of Fonasa beneficiaries (this figure stood at 50% in 2010), while 50% of the total number of respondents claimed to know little or nothing about the GES.

The surveys conducted by the Superintendency of Health in 2009 on the public's perception of whether the GES had improved health care in Chile showed that 60% felt it had, up from 50% of the population in 2007.

Dissemination of information about the GES has largely fallen to the insurers, although the Ministry of Health and the Superintendency of Health have gotten involved through the use of written and visual media. In the case of the Isapres, they were required to send informational letters to their beneficiaries at the beginning of each contract period, so that their enrollees would be familiar with the benefits and how to access them. In addition, enrollees may request verbal or written information at these insurance

companies' customer service centers, and they can also access this information online. These processes are supervised by the Superintendency of Health. It is worth noting that detailed information about the HBP's benefits and form of operation is available in a set of official documents. These include the supreme decree that establishes the health conditions each year and their guarantees; details on copayments and maximum wait times; GES technical standards, which facilitate the understanding and application of the guarantees; the specific list of services for each condition and health intervention; and clinical guidelines, among others.

In summary, the results of the aforementioned surveys indicate that one of the weakest aspects of the reform has been the dissemination of its benefits and form of operation.

Resources available to provide services

At the conclusion of President Lagos's term, the Ministry of Health conducted an inventory of the public supply of health services and sought to strengthen it by investing in equipment and improving hiring terms to attract specialists, thus taking the necessary steps to meet GES demand. With this, the ministry looked to prevent an increase in public health spending, which would occur if public providers were unable to absorb all of the GES demand, thus forcing Fonasa to purchase GES services from private providers at higher prices. Evidence shows that Fonasa demand outstripped the public system's supply, which led to non-compliance with GES timeliness guarantees on the part of Fonasa and generated waiting lists for some non-GES health problems in the Santiago Metropolitan Region, with an even more serious situation in the other regions. This situation prompted an initiative to create the GES voucher, spearheaded by former president Sebastián Piñera.

²³ Most of these surveys have been conducted by the company Adimark, and they are known as Adimark surveys. See <http://www.adimark.cl>.

Universal Access with Explicit Guarantees (AUGE) voucher

On January 10, 2011, the country's public sector procurement website (<http://www.mercadopublico.cl>) posted the bidding conditions for the implementation of a policy known by the generic name of AUGE voucher, through which Fonasa would consign the provision of medical benefits for public sector GES users to private health entities for an amount set at Ch\$3 billion (US\$5.9 million), denoting a significant budget increase (75%) for purchases from private providers.

Table 1.2 presents the number of services that Fonasa had purchased from the private sector through the AUGE voucher system by the end of 2011. Salud un Derecho, a political and social movement that seeks to restore solidarity as a fundamental pillar of the Chilean health system, performed an analysis on the bids submitted for the solicited services that shows that they are overpriced in comparison to the reference values used by Fonasa to reimburse public providers. "This means that with those same resources, many more patients could be served at public hospitals, provided that there is political will to carry out improvements to their management, which include more and better incentives for specialized staff at public institutions, more investment in infrastructure and equipment, and improvements to the management systems for waiting lists, in other words, the political will to strengthen the public sector" (Salud un Derecho, 2011).

To demonstrate the previous point, Salud un Derecho presents a costing exercise with five health conditions, specifically, five services solicited and bid on with varying magnitudes of difference. Table 1.2 presents the number of services that could be provided in the public sector compared to the private sector, assuming

that the Ch\$3 billion that Fonasa allocated to bids on the GES voucher over 36 months were equally distributed among these five conditions. The purchase prices for private services under the AUGE voucher far exceeded the fees paid by Fonasa to the public providers for the same benefits (graph 1.3).

It would be necessary to complement the previous analysis with the cost entailed by making the aforementioned modifications to the public system, not to mention that the Fonasa fee defined for many of the GES benefits does not cover the public sector's costs. One argument in that regard is that Fonasa has commissioned a cost study on the benefits, based on the need to update those values and consider costs that are not included, and which may be responsible, at least in part, for the debt held by public hospitals. The National Confederation of Municipal Primary Health Care Workers presents the following conclusions after evaluating the government's first bid solicitation for health problems included in the GES: "In this bid solicitation, Fonasa dismissed public facilities as potential bidders, which seems absurd. Furthermore, the bidding conditions lack means of validating the quality of private providers, the establishment of a cap on the value of each service, and the requirement that the bid include the cost of transporting patients when they must travel far from home to receive care. Lastly, the bid solicitation does not take responsibility for the comprehensive and complete resolution of health problems, especially surgical, oncological and chronic conditions, since Fonasa patients treated through this modality would be able to receive timely services at the private facilities under agreement, but they will not have continuity of care, as they must return to their referring or local facilities for comprehensive resolution of their health problem."²⁴ Comprehensive care would be provided for eye care and hip replacement surgery due to arthritis.

²⁴ Statement by Vivianne Bachelet on Salud un Derecho. Available at http://economia.terra.com.mx/noticias/noticia.aspx?idNoticia=201101181302_INV_79483645.

Table 1.2. Number of services purchased by the National Public Health Procurement Office in order for Fonasa to comply with GES guarantees, and provision of those benefits in the public sector, 2011

Service solicited	Number of private sector treatments	Number of public sector treatments
Cervical cancer	533	3,443
Testicular cancer	664	2,626
Stomach cancer	121	323
Detached retina, surgery	796	3,552
Schizophrenia, treatment	833	14,570
TOTAL	2,947	24,514

Source: Salud un Derecho, based on data from Chile's public sector procurement website (<http://www.mercadopublico.cl>)

Of the difficulties observed over the years with this HBP's operation, the most significant has been the lack of compliance with the guarantees, which, although low in percentage terms (between 1% and 2%), should strictly be held to zero given that the plan has legal backing. This situation has been observed to a greater extent in Fonasa than in the Isapres, which are closely monitored by the Superintendency of Health and their own users. Monitoring of these cases has been hampered by record-keeping problems, mainly in the public system, since the information system designed for this purpose (SIG-GES) does not provide complete information in a timely manner. This occurs because there are no incentives that encourage proper record-keeping, making it difficult to assess the level of compliance with guarantees. In addition, supply shortfalls of both a qualitative (lack of specialists) and quantitative nature have become evident in the public system, which leads to non-compliance.

Evaluation and Monitoring

Evaluation

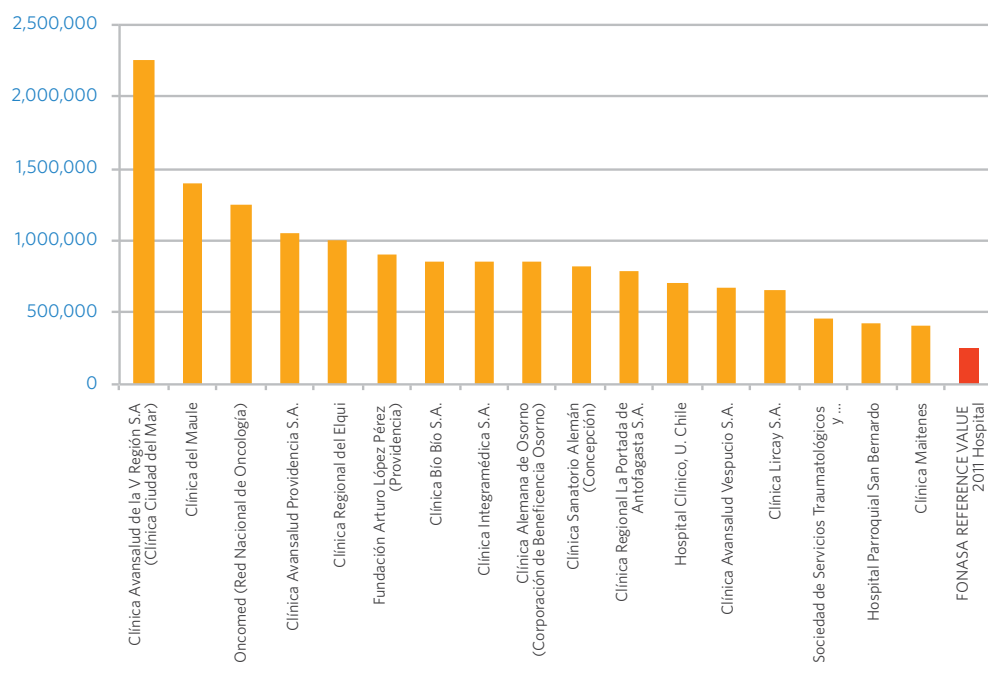
Under current law, the Superintendency of Health is responsible for ensuring that

Fonasa and the Isapres comply with the obligations imposed on them by law, particularly the provision of the GES.²⁵ This institution defined a methodology to evaluate the implementation of the reform and its impact on beneficiaries. The monitoring and evaluation system placed some emphasis on the GES, particularly the functioning of the Isapre system, since in 2005, along with the implementation of the GES, Congress also enacted legislation known as the Short Law on Isapres, consisting of a set of rules to correct various aspects of the functioning of these insurers. Among them were the rules for annual adjustments to insurance premiums, including the restriction that they remain within a price band; the regulation of the factor table used by the Isapres to establish changes in premiums based on the beneficiary's age and sex; and the operating methodology of an inter-Isapre risk compensation fund (Superintendency of Health, 2007).

Consistent with the reform's objectives, the criteria to assess its performance should include access to health services, utilization rates of the guarantees, level of out-of-pocket spending and impact on financial protection, health impact, and level of satisfaction among beneficiaries.

²⁵ For further information on the functions and powers of the Superintendency of Health, please consult <http://www.supersalud.gob.cl/portal/w3-propertyname-571.html>.

Graph 1.3. Comparison between prices paid by Fonasa under the AUGE voucher and the standard Fonasa fee (in Chilean pesos)



Source: Salud un Derecho

The available evidence on these aspects is presented below.

Access to health services. As of October 2013, neither the Ministry of Health nor the Superintendency of Health has conducted a systematic study of the GES plan’s impact on health care access; however, both institutions do have statistics available on the number of individuals who have used these guarantees through Fonasa and the Isapres. A quantitative study using secondary sources showed that access to care for six chronic health problems increased, along with coverage for that care (Bitrán, Escobar and Gassibe, 2010).

Utilization of guarantees. In March 2011, almost six years after the introduction of the reform, the cumulative number of GES cases reached 11.8 million, of which 95% corresponded to Fonasa beneficiaries (Superintendency of Health, 2011). This means that each Fonasa beneficiary has

made use of the GES an average of one time throughout its years of operation. These figures include various types of health problems. In some cases, they correspond to acute episodes that may recur in the same individual over a period of time (e.g., acute respiratory infections in children under 5, outpatient dental emergencies, acute myocardial infarction) or chronic conditions (hypertension, diabetes mellitus type 1 and type 2, chronic obstructive pulmonary disease, etc.), as well as multiple episodes. With chronic health problems, the statistics may include utilization of guarantees associated with cancer that, depending on its progression, requires prolonged treatment (breast cancer, cancer in children under 15 years of age, prostate cancer, etc.). This implies that the cumulative number of cases is not representative of the active cases that are permanently demanding health care services.

Another factor that has influenced the progressive increase in the number of GES cases over time has been the gradual increase in the number of guarantees. Another possible explanation for the growing number of cases has been the public's increasing awareness of the guarantees and empowerment to demand these rights, thereby boosting demand for services.

Out-of-pocket spending and financial protection. Since one of the GES guarantees consists of providing financial protection to beneficiaries, one of the priority-setting criteria for the Chilean HBP was the high cost of certain medical benefits (hemodialysis, kidney transplant, surgery for congenital heart disease, treatment of different types of cancer, etc.), which demanded high out-of-pocket spending for patients and their families. While the law established copayment amounts for every group of benefits according to the insurer's financial coverage for each Fonasa or Isapre beneficiary, Fonasa has not collected these copayments due to operational difficulties. To that end, when the GES was initially implemented (2005), the Ministry of Health issued a regulation rendering these health care services exempt from the copayments. Despite being contrary to the spirit of the law, there has been no audit or calculation of the revenue lost by the public system for waiving the collection of the copayment. Given this fact, it is possible to state that copayments and, therefore, out-of-pocket expenses have declined for Fonasa beneficiaries with this reform. Cid and Prieto (n.d.) showed that between 1997 (pre-GES) and 2007 (post-GES), the proportion of the GDP corresponding to out-of-pocket health spending remained constant at about 2.8%, while out-of-pocket spending, in real terms, increased by 23% per household and 40% per individual over that period (Cid and Prieto, n.d.). According to Román (2000), out-

of-pocket health spending in Chile, including copayments, medications and other direct costs, totaled US\$1.48 billion, corresponding to about one-third of the sector's financing. In the Isapre system, the average out-of-pocket spending between 2001 and 2004 represented approximately 13% of taxable income.²⁶

Another way to assess the GES plan's financial impact is by gauging the opinion of the beneficiaries themselves. In a study by the Superintendency of Health, 55% of respondents felt that the GES covered the majority of the cost of care for a defined set of diseases (Superintendency of Health, 2011). Among Isapre beneficiaries, the figure was slightly higher at 59%.

Health impact. No systematic studies have been conducted on this topic. This shortage of studies may be attributable to problems with the data, including the lack of a clearly established baseline and the deficient information system that was designed to monitor the GES (SIG-GES).

Bitrán, Escobar and Gassibe (2010) demonstrated that in-hospital mortality declined for six chronic health problems. From a qualitative perspective, the Ministry of Health published a 2009 study that revealed that the mortality rate for various cancers (testicular, breast and gallbladder) fell from 125.8 per 100,000 inhabitants in 2005, before the GES, to 114.5 per 100,000 inhabitants in 2007, two years after the introduction of the reform (Ministry of Health, n.d.). Another report from that institution showed that there was an increase in the early detection of cervical and breast cancer (Ministry of Health, n.d.). A study by the Chilean Society for Cardiology and Cardiovascular Surgery revealed that the GES led to a substantial and statistically significant drop in mortality from acute myocardial infarction, falling from 12% in 2004 to 8.6% in 2008, thanks to the guarantee of timely diagnosis and access

²⁶ Taxable income is a fraction of the revenue on which the percentage of the health contribution, pensions and occupational risks are calculated. It corresponds to 80% of annual gross income, without deductions. See <http://www.previsionsocial.gob.cl/cotizacion-honorarios/pagina3.html#ancla32>.

to medical treatment (thrombolysis; see the reference at the bottom of table 1.3).

While there are several studies that analyze different aspects of the GES, especially those that focus on specific diseases, studies are needed to examine the health impact of these guarantees as a group of synergistic actions rather than isolated ones. This shortage is partly explained by the fact that the entity responsible for this function has still not been defined. The Superintendency of Health is responsible for monitoring compliance with GES guarantees (access, timeliness, financial coverage and quality of care), which it does through periodic audits, but not the impact on population health.

Level of satisfaction among beneficiaries. One of the motivations of the reform was the desire to improve Chileans' satisfaction with their health system. In the decades leading up to the implementation of the GES, health satisfaction surveys consistently revealed dissatisfaction among beneficiaries, particularly in terms of access for Fonasa beneficiaries and financial coverage for Isapre beneficiaries.

A study commissioned by the Superintendency of Health, in which 2,327 people over the age of 18 were interviewed, showed that about half of the population gave the GES a top score, based on personal experience or testimonials from acquaintances (2011 Adimark survey). The percentage of beneficiaries who awarded this rating varied slightly depending on their insurer (46% of Fonasa's poor beneficiaries and 49% of Isapre beneficiaries). Satisfaction was higher among those who had used GES services (versus the general population).

Other aspects. A study commissioned by the Ministry of Health is currently getting underway, with the goal of evaluating the GES plan's impact on the provision of health care services and the public health system's financial burden.

Monitoring

Monitoring carries implications beyond the scope of an audit, as it refers to a system of indicators produced and evaluated on a recurring basis. As already mentioned, the Superintendency of Health defined a methodology for evaluating the progress and performance of the reform; however, it has not defined a system for the *periodic* evaluation of compliance with GES guarantees on the part of Fonasa and the Isapres. This function has only been fulfilled by occasional audits focused on specific topics. In addition, it has been restricted to the Isapres for the reasons cited earlier in the chapter.

These audits found nearly full compliance with the guarantees among the Isapres. With Fonasa, there is evidence that 2% of beneficiaries who have sought care for one of the health problems covered by the GES have not received the service within the time limits established by the law.

Audit reports for the public sector—composed of Fonasa as the insurer and the decentralized facilities of the National Health Services System as providers—are issued on an occasional basis, with a separate report for each of the 30 health facilities. This stands in contrast to the private sector audits of the Isapres, which the Superintendency performs on a systematic and simultaneous basis for each Isapre. Numbers-wise, this makes the oversight efforts for the public sector appear more rigorous.

In short, the Isapres have demonstrated a good level of compliance with the GES guarantees evaluated in the private sector. However, with regard to private providers' responsibility to notify each person suffering from a health problem included in the GES about his condition and rights, the level of compliance has not been good.

With regard to the public system, Fonasa has demonstrated compliance issues with the guarantees on timeliness and availability of medications at the primary

Table 1.3. Mortality due to acute myocardial infarction, pre- and post-GES, Chile (%)

Period	Thrombolysis	Angioplasty	No intervention	Men	Women	Total
Pre-GES	10.6	14	14	9.4	19.8	12
Post-GES	6.8	6	12	7.5	11.8	8.6

Source: Multicenter Study Group of Acute Myocardial Infarction, 2009

care level (access to treatment). The first problem prompted the introduction of the AUGE voucher to improve compliance with the timeliness guarantee, as already described in this chapter.

To date, the evaluation of the AUGE voucher has been positive in terms of improved performance by Fonasa regarding compliance with timeliness guarantees. However, neither the Superintendency of Health nor Fonasa has publicized the impact this measure has had on the public insurer's spending.

In summary, better compliance with the defined guarantees has been observed for Isapre beneficiaries than for Fonasa beneficiaries, although Fonasa's performance has improved over time, partly due to the implementation of the GES voucher system, which subsidizes the demand for care through private providers. There is evidence of improvements in health care, both quantitative (improved access and coverage) and qualitative (earlier diagnosis for some types of cancer and decreased mortality in cases of acute myocardial infarction).

Adjustment

As already explained, the GES was initially defined for a total of 56 diseases, which were gradually incorporated between 2005 and 2007. The previous adjustment process included an update of the clinical practice guidelines, an extension of the guarantees or benefits for 20 of the 56 initial guaranteed health conditions, and the incorporation of new health

conditions (there are currently 80 guaranteed conditions).

The GES Advisory Council is the entity responsible for making adjustments to the plan, based on the material prepared periodically by the Technical Secretariat of the GES, a body of the ministry. This entity receives and analyzes requests from different sectors of society (organized community groups, such as patient advocacy groups, scientific societies, pharmaceutical companies and others) to incorporate new benefits into the health benefit plan of the GES. The Advisory Council has considered diverse priority-setting criteria similar to those initially adopted in the GES priority-setting process: background information presented and fiscal impact. For the latter, the Secretariat has access to the results of cost verification studies, which must be opened to public bidding each time the Council considers updating the guarantees. To date, there are four verification studies, which contain cost estimates for each health problem included in the GES. During the 2009 adjustment process, 24 potential health problems to be included among the GES guarantees were analyzed, and the Council decided to provide guarantees for 10 them as of July 2010.

There are no explicit criteria or set rules governing the GES adjustment process; therefore, it is impossible to know with any certainty whether a request for the inclusion of a new guarantee in the GES will be accepted. The amount of public funds available to finance new guarantees is not known publicly beforehand, nor is

the relative importance assigned by the Advisory Council members to each of the multiple priority-setting criteria they consider when reviewing new requests for the inclusion of guarantees.

Legal context

Article 19, No. 9 of the Chilean Constitution grants all people the right to the protection of health as a fundamental guarantee. Additionally, Article 12, No. 1 of the International Covenant on Economic, Social and Cultural Rights, to which Chile is a signatory, declares: “The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” and to ensure the fulfillment of this right, it instructs in the same Article 12, No. 2 (d), “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

The Latin American Association of Social Medicine raises the point that the Constitution does not guarantee the people the right to universal and equal access to health care as a responsibility of the state (Alames, n.d.). The issue boils down to ensuring the right to demand access to public or private services, which remains subject to a supposedly free decision by the user.

The Chilean health system includes two subsystems: Fonasa and the Isapres. Each one is subject to legislation that mandates its operation and the rights of its beneficiaries. Furthermore, the health reform included several legal elements, including the Health Authority Law; the regulation of the Isapres based on two laws; the rights and duties of individuals; and the Regime of Explicit Health Guarantees. All were passed, with the exception of the rights and duties of individuals, which was postponed indefinitely in Congress.

Regarding the HBP, its associated law defines the explicit guarantees in great

detail in order to clearly describe which guarantees are equally enforceable by beneficiaries, in both the public and private systems.

In addition to this law, supreme decrees have been issued by the Ministry of Health, which mandate and operationally define these guarantees for each of the health problems included in the GES. Along with these decrees, a list of benefits associated with each guarantee is issued together with a technical standard that clarifies the operation and scope of these guarantees.

In short, this HBP is supported by clear and robust laws and regulations held in common for both subsystems and applied equally throughout the entire country. Fonasa and the Isapres are responsible for carrying out the plan, using a predetermined network of health service providers.

Conclusions

The reform significantly altered the Chilean health system by introducing, for the first time, a single benefit plan for both the public insurer and the private insurers tied to social security. This HBP established a base of precise, explicit benefits for a wide range of conditions, which were formulated in terms of health benefits to which beneficiaries are entitled, maximum wait times, standards for the quality of care, and caps on out-of-pocket spending.

Despite strong opposition to the reform by the medical community and even some officials from within the Ministry of Health itself, the reform moved forward thanks to the skillful political maneuvering of the Chilean president and his advisers.

Few studies have evaluated the impact of the reform, although the limited evidence available is favorable. The GES has greatly minimized and even eliminated the once prevalent rationing of care for many of the population’s health problems, a result

of the HBP's explicit guarantees and the tools that the reform gives beneficiaries to make these guarantees enforceable.

Although the GES mandates that Fonasa and the Isapres comply with these legal guarantees, evidence has shown that Fonasa has failed to comply in some cases. The crux of the compliance issue rests on Fonasa beneficiaries who do not receive the care included in the GES within the timeframe prescribed by law. In late 2011, the Ministry of Health declared that it had put an end to all compliance problems related to the GES guarantees, but the evidence proving that it actually did so is lacking. The Isapres, however, have complied with all of the HBP's guarantees.

The asymmetric compliance seen between Fonasa and the Isapres is mainly due to the lopsided supervision provided by the Superintendency of Health with regard to these two types of insurers. The Superintendency has used a firm hand in the auditing of the Isapres, and it has exercised all of its legal powers to make the rights of the beneficiaries of private insurers enforceable. Fonasa, however, has resisted oversight by the Superintendency, exploiting legal loopholes that are not in the public domain. Consequently, Fonasa has failed to comply with GES guarantees. A solution to the problem of asymmetric regulation is essential in order to preserve clear rules regarding the HBP and to further improve health equity in Chile.

One consequence that seems to have emerged as a result of the adoption of the GES is waiting lists for health care problems not covered by the HBP. It is possible that these waiting lists already existed before the reform, but since the culture of legally enforceable explicit guarantees introduced by the GES was not yet instituted, perhaps people did not make claims and/or Fonasa did not record them. Moreover, the prioritization of public spending on GES benefits within Fonasa may have shifted public spending away from non-GES benefits, which, in turn, may have generated waiting lists for care that previously

enjoyed greater availability. Currently, the Ministry of Health is working to firmly establish an information system to keep track of the waiting lists for health problems not included in the GES and to direct the policies to reduce those lists. However, the ministry has already stated that resolving the waiting list issue will take, in some cases, years due to limited resources and the fact that compliance with the guarantees included in the GES (as opposed to non-GES benefits) has the highest political priority.

The adoption of the GES has required substantial investment to address institutional changes and to fund increased volumes of care in the public sector. Public expenditure on health, which represented 3.5% of the GDP in 2005, increased by nearly one percentage point, reaching 4.4% in 2010. The GES has also required the creation of various management and policy tools in the public sector to enable its operation. Among these tools are the creation of clinical practice guidelines by the Ministry of Health in order to regulate the provision and quality of care included in the GES; the development of accreditation systems for providers under the Superintendency of Health; the development of new laws and regulations; the documentation of waiting lists and non-compliance with guarantees in the ministry; the adoption of new payment systems by Fonasa for public and private health care providers included in the GES; and the establishment of contracts between the Isapres and private health care providers across the country in order to comply with GES guarantees.

The expected outcome of all of these investments is an improvement in health care access for the population as a result of the GES and, eventually, an improvement in the health status of the Chilean people. It is a public policy priority to evaluate the performance of the GES, so that there can be an understanding of the consequences that the effort detailed above has had on the population's wellbeing.

References

- Alames (Latin American Association of Social Medicine). n.d. *Derecho a la salud. Situación en países de América Latina*. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo, y Alames.
- Banco Central de Chile (Central Bank of Chile). 2010. GDP Forecast. Santiago, Chile, Banco Central de Chile.
- Bitrán R. and L. Escobar. 2008. "The Politics of the AUGE Health Reform in Chile. A Case Study prepared for the Results for Development Institute." Bitrán & Asociados.
- Bitrán R. and U. Giedion. 2008. *Designing Benefit Packages*. Estudio para el curso sobre reforma del sector salud y financiamiento sostenible del World Bank Institute. Santiago, Chile, Bitrán & Asociados.
- Bitrán R., D. Debrott and P. Arpón. 2013. *Opciones de reforma a la seguridad social en salud en Chile*. Santiago, Chile, Espacio Público.
- Bitrán R., L. Escobar and P. Gassibe. 2010. "Después de la reforma de la salud en Chile: aumento de la cobertura y acceso, reducción de las tasas de hospitalización y mortalidad." *Health Affairs* 29, No. 12.
- CEGADES (Centro de Estudios y Gestión para el Desarrollo). 2002. Encuesta de opinión pública. El plan AUGE desde las encuestas de opinión pública.
- CEP (Centro de Estudios Públicos). 2000. *Estudio de Opinión Pública*, No. 39.
- Cid C. and L. Prieto. n.d. "Inequidad en el financiamiento de la salud y su impacto en la distribución del ingreso en Chile." Unpublished paper.
- Engel E., A. Galetovic and C. Raddatz. 1999. "Impuestos y distribución del ingreso en Chile: ¿es regresivo el IVA?" *Perspectivas en Política, Economía y Gestión*, 2. Universidad de Chile, Departamento de Ingeniería Industrial.
- GfK (Growth from Knowledge). 2011. "Estudio opinión usuarios del sistema de salud. Conocimiento y posicionamiento de la Superintendencia de Salud, GES-AUGE y otros aspectos de la reforma." Santiago, Chile, GfK.
- Ministerio de Salud (Ministry of Health). 2004. *Ley 19966. Establece un régimen de garantías de salud*. Santiago, Chile, Ministerio de Salud.
- _____. 2006. "Verificación del costo esperado por beneficiario del conjunto priorizado de problemas de salud con garantías explícitas 2007." Elaborado por la Facultad de Economía y Negocios de la Universidad de Chile.
- _____. 2007. "Verificación del costo esperado por beneficiario del problema de salud con garantías explícitas: Atención del parto." Elaborado por Bitrán & Asociados.

- Ministerio de Salud. 2010. *Estudio verificación del costo esperado individual promedio por beneficiario del conjunto priorizado de problemas de salud con garantías explícitas - 2009*. Santiago, Chile, Subsecretaría de Salud Pública.
- Ministerio de Salud. 2012. Impacto de las Garantías Explícitas en Salud en producción y en gasto en la Red Asistencial de Salud. Santiago, Chile, Bitrán & Asociados.
- Ministerio de Salud. n.d. Presentación “GES AUGE...su historia.” Ministerio de Salud de Chile.
- Nancuante U. and A. Romero. 2008. *La reforma de la salud*. Santiago, Chile, Biblioteca Americana.
- Olivares-Tirado P., E. Salazar and C. Castillo. 2008. *Comportamiento financiero de las Garantías Explícitas en Salud en el sistema Isapres*. Santiago, Chile, Ministerio de Salud de Chile y Sistema Integral de Salud.
- Román A. 2000. Presentation “Fondo Nacional de Salud.” Available at: https://www.google.com.co/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&ved=0CCoQFjAA&url=http%3A%2F%2Fwww.eclac.org%2Fmujer%2Fnoticias%2Fnoticias%2F4%2F8274%2Falfredo_roman.ppt&ei=rhAPUuzOHvL9yAGI64Aw&u sg=AFQjCNHTri8SD1lUADCU92zWmgNXh850Mw&bvm=bv.5076. Accessed: September 2013.
- Salud un Derecho. 2011. “Comunicado Bono AUGE.” Available at: <http://www.saludunderecho.cl/archivos/2011/08/Tercer-Comunicado-Bono-AUGE-Agosto-2011.pdf>. Accessed: September 2013.
- Sánchez H. 2009. “Incumplimiento de las garantías AUGE.” *La Tercera*, 1 de noviembre.
- Superintendencia de Salud (Superintendency of Health). 2007. *Evaluación de la reforma de salud y situación del sistema Isapres. Diseño metodológico y definición de líneas basales*. Santiago, Chile, Superintendencia de Salud.
- Superintendencia de Salud. 2008. *Comportamiento financiero de las Garantías Explícitas en Salud en el sistema Isapres*. Santiago, Chile, Superintendencia de Salud.
- Superintendencia de Salud. 2010. *Estadísticas financieras de las Isapres a diciembre de 2010*. Santiago, Chile, Superintendencia de Salud.
- Superintendencia de Salud. 2011. *Casos GES (AUGE) acumulados a diciembre de 2010*. Santiago, Chile, Superintendencia de Salud.
- Urrutia M. T., N. Villegas and L. Poupin. 2010. “Garantías Explícitas en Salud: conocimiento y fuentes de información en un grupo de mujeres del programa AUGE Cáncer Cérvico-uterino.” *Revista Chilena Gineco-Obstetricia* 75, No. 4: 221-26.
- Vargas V. and S. Poblete. 2008. “Health Prioritization: The Case of Chile.” *Health Affairs* 27, No. 3.

Chapter 2



Colombia: The Compulsory Health Plan*

Ursula Giedion, Oscar Cañón

Summary

Context. Colombian health reform, passed in 1993 through Law 100, has been well documented internationally as a result of the profound changes it prompted. It proposes two insurance structures: a contributory regime for the population with the ability to pay (especially the formal sector population) and a subsidized regime for the population without the ability to pay (largely the informal sector population). Insurance coverage currently reaches 92% of the population. In both regimes, funding comes from general taxes as well as payroll contributions. In general, the contribution is made according to the ability to pay, and all enrollees receive the same benefit plan called the Compulsory Health Plan (POS). Both regimes operate with public and private insurers that pledge to guarantee the POS in exchange for a premium. This system is currently undergoing a deep process of reform; under consideration is a move from a model with an explicit benefit plan (positive list) to one that combines implicit rationing with a negative list.

Achievements. Today, the entire insured population enjoys the same benefit plan regardless of socioeconomic status and ability to pay. This constitutes an enormous achievement in the face of the significant equity gaps in the region.

Among Latin American countries with an explicit health benefit plan (HBP), only Colombia, Uruguay and Chile have made as much progress in this regard.

The POS allowed the country to coordinate different health system stakeholders, funding sources, and policies that universalized the explicit guarantees of rights for the population in a fiscally sustainable manner. By establishing rights and benefits through the POS and paying for them with the capitation payment unit, the country was able to respond to different setbacks, such as rising unemployment, with the tax and macroeconomic adjustments necessary to maintain the financing of the health care system. In addition, it has created a direct link between the cost of the HBP and the allocation of resources to service providers, something that rarely happens in the region.

Challenges. Placing the benefit plan for individuals without the ability to pay (those enrolled in the subsidized regime) on equal footing with the plan for individuals with the ability to pay (those enrolled in the contributory regime) was one of the main challenges faced by Colombia in the first 20 years of the POS. Under pressure from the Constitutional Court and on behalf of the principle of equality, in 2008 an equalization process began that culminated in 2012 with

* This chapter is based on Giedion, Panopoulou and Gómez-Fraga (2009).

identical plans and very similar premiums in both regimes. This created a significant tax burden, the management of which remains under discussion.

Another challenge to the sustainability of the POS has been the management and financing of services excluded from the plan. An extremely detailed explicit benefit plan, together with the availability of funds to finance excluded services, generated incentives for insurers to request authorization for services not

included in the benefit plan, considering this income over and above the premium they receive. This situation, in addition to the legal and administrative mechanisms that facilitate the request for excluded services and the pressure of technological innovation, has led to an explosion of financing for services that have not been prioritized in the HBP. In 2010, one-fifth of payroll taxes earmarked for health were allocated to the payment of services not included in the POS. The effectiveness of many of these services is questionable,

Basic Elements of the Compulsory Health Plan

Name of HBP	Compulsory Health Plan
Year plan began operations	1993
Central motivation	The adoption of an insurance framework that separates the financing function from the insurance function requires the definition of guaranteed services based on a premium. In addition, the desire to move from a system that offers, in theory, everything to everyone through a framework of supply-side subsidies, to another, based on demand, that would render explicit the services that the country could guarantee its population
Target population	All those enrolled in the health insurance system
Service coverage	Health promotion and prevention, diagnosis, treatment and rehabilitation for all conditions
Financial coverage	There are copayments and sliding-scale fees for some services and populations, with annual caps
Population coverage	System coverage stands at 92.02%, with 42.82% under the subsidized regime and 48.37% under the contributory regime. The remaining percentage was insured through special regimes (military, teachers, etc.) (2012)
Estimated annual cost per capita	US\$418 in purchasing power parity (PPP) terms for the contributory regime and US\$374 PPP for the subsidized regime (2013)
Percentage of public health resources channeled to HBP funding	Seventy-four percent of public health spending is allocated to the Compulsory Health Plan (Barón, 2007)
Provision of non-prioritized services	Prior to receiving funding, services not included in the benefit package are subject to an administrative process, either presentation before a scientific technical committee or an expedited judicial process (10 days) known as the writ of protection
Principal innovations	<p>First country in the region to define an explicit and legally enforceable plan for the entire population</p> <p>Integration of the priority-setting process for all types of technologies and the entire population, with a defined institutional structure concerning who evaluates and decides</p> <p>One of the first countries in the region to offer the same comprehensive benefit plan to the entire population (and the first to seriously consider eliminating this explicit plan)</p> <p>Budget allocation is based on the cost of the plan and on the insured population, something that many countries have struggled to achieve</p>

and equity of resource distribution has been affected (Uprimny, 2013), since a positive correlation is observed between income level and the number of requests made.

The implementation of institutionalized, systematic, robust and transparent processes to decide which benefits to include in the POS is another major challenge facing Colombia. There is a consensus among stakeholders that progress in this area will be key for the POS to be seen as a legitimate rationing tool. However, the Colombian medical community has increasingly questioned the idea of an explicit benefit plan on the grounds that this idea runs counter to the concept of medical autonomy and stands in opposition to health care that responds to the specific needs of patients. Furthermore, the atmosphere of constant judicial and administrative confrontation with the POS in order to obtain excluded services, in disputes often lauded by the media, has led to the POS being perceived as illegitimate. The elimination of a positive list of benefits is now a real possibility. If the replacement of the POS by a negative list is approved, Colombia's major challenge in the coming years will be to ensure the financial sustainability of the system, as well as efficiency and equity.

Colombia is an ideal case from which to learn why explicit benefit plans can fail; it was the first country in the region to adopt a universal plan, and it is the first to move decisively toward its elimination. This case study shows that politics and the definition of what is included in or excluded from an HBP can be much more important determinants of the legitimacy of an explicit benefit package than the technical aspects involving its definition and adjustment.

Introduction¹

In 1993, the General System of Social Security in Health (SGSSS) was created

in Colombia through Law 100. The SGSSS is a universal health insurance system providing family coverage. It is administered by health-promoting enterprises (EPSs), which are insurers that must offer a predefined benefit package in return for a premium. They are in charge of contracting with health care provider institutions (IPs) for the services included in the Compulsory Health Plan. The premium or monetary value that the government pays the EPSs to provide the POS is called a capitation payment unit (CPU). The SGSSS is composed of two regimes—the contributory regime and the subsidized regime—each with different target populations and funding sources. The contributory regime is aimed at workers and pensioners with the ability to pay, while the subsidized regime focuses on the poor. In the beginning, each regime had a different HBP (POS-C for the contributory regime and POS-S for the subsidized regime); however, since 2012, the plans of the two regimes have been identical. Figure 2.1 summarizes the structure of the Colombian health system.

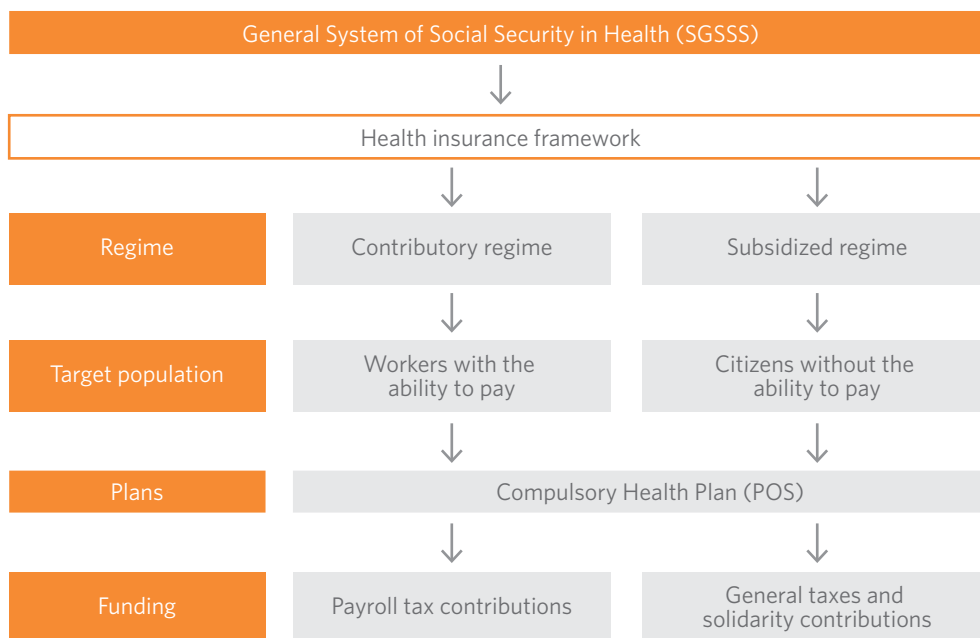
Reasons for and Process of Adoption

Background and motivation

The explicit benefit plans of the contributory regime (POS-C) and subsidized regime (POS-S) with which the SGSSS began its operations are framed in a very specific historical context that encompasses more than just the health sector: i) a new constitution (1991) that defined broad social rights and enforcement mechanisms, such as writs of protection; ii) economic openness and the adoption of reforms that sought to eliminate state monopolies, which explains the emphasis of the SGSSS on efficiency and private sector involvement in insurance and the provision of health care services; and iii) a thorough process of decentralization of functions

¹ The following section is based on the Inter-American Development Bank's health sector note on Colombia (Pinto, 2010).

Figure 2.1. The Colombian health system



Source: Adapted from Giedion, Panopoulou and Gómez-Fraga (2009)

and resources at the territorial level (departments and municipalities). Within the implementation framework of the POS-S, decentralization meant a clash between the principle of a single, equal plan for all, established at the national level, and the significant resource disparities that existed across different regions of the country (Giedion and López, 1996).

Thus, the benefit plans were the result of a specific context and process that had begun many years before the new health care system would be configured in 1993.

The creation of the POS mainly came about for two reasons: 1) to adopt an insurance system that would separate the role of financing (the responsibility of the public sector) from the role of insurance

provision (the responsibility of the EPSs) and that would have to define the services insurers would guarantee in exchange for a premium and 2) to switch from a system that offers, in theory, everything to everyone through a framework of supply-side subsidies, to one that would render explicit the services that the country could guarantee its population.

As in other countries, the policy introduced by the 1993 reform did not clearly reflect the objectives and outcomes expected of the POS, opting instead to state them in a very general fashion.² Subsequent regulations indicate that the POS is envisaged as a tool that is meant to improve the health of Colombians and guarantee the right to health care with efficiency.

² "It will afford comprehensive protection to families for maternity and general illness at the stages of health promotion and prevention, diagnosis, treatment, and rehabilitation for all conditions, in accordance with the intensity of use and the levels of care and complexity that are defined" (Art. 162) (Congress of the Republic of Colombia, 1993).

Deliberation and negotiation: POS design

Once the reform was passed in December 1993, the Ministry of Health had six months (before the change of administration) to set forth its regulations, including the contents of the POS. Two teams from the ministry worked independently: one focused on the subsidized regime's benefit plan (POS-S) and the other on the contributory regime's benefit plan (POS-C). The proposal of the first team was accepted without great opposition by the National Council on Social Security in Health (CNSSS).³ It did not generate extensive debate in Congress or the CNSSS, nor was concern expressed that the benefit plan for the subsidized regime was much more limited than that of the contributory regime.⁴

A team of world-class experts was assembled to design the POS-C based on cost-effectiveness criteria. This team faced strong opposition during the process of drafting the law and further defining the contents of the POS. In the House of Representatives, the confrontation led to a modification of the original proposal of the law (see footnote 2) to include an article that stated that the POS-C must include, at the very minimum, all of the contingencies that had been offered by the Social Security Institute (ISS) in the past. By using general wording, which referred to "contingencies" as opposed to "services," the ministerial team working on the definition of the benefit package attempted to maintain a technical approach to defining the POS-C, based on cost-effectiveness criteria. However, when the technical POS-C proposal was presented to the decision-making body (CNSSS), it was rejected for containing fewer benefits than those that had been previously provided by the ISS and for doubts about the robustness of the data that had been utilized to design it. As a

result, in a record time of less than two months, a new proposal was drafted, based on the contents of the ISS fee schedule.⁵ This new proposal for the content of the POS-C was approved by the CNSSS.

As the aforementioned shows, despite having a highly-trained technical team with substantial financial resources, the ministry failed to approve an HBP based on technical criteria, and it never managed to consolidate or approve a methodology to guide subsequent POS adjustments.

POS Design

Priority-setting methods

The approved POS-C did not undergo a technical priority-setting process since the ISS fee schedule served as a template for the plan's design, on the premise of avoiding a reduction in the services already provided. The initial technical proposal was based on an analysis of the disease burden and on cost-effectiveness criteria. From there, packages of therapeutic options were assembled for each of the prioritized diseases. The cost of these options was estimated from available data, and the effectiveness of each treatment was calculated in terms of DALYs gained, allowing for the proposed POS to include all of the diseases in a cost-effective manner (Plaza, 1996).

The POS-S was an expanded version of the health plans and services already offered by the public sector. The experience and information from previous Ministry of Health prevention and promotion programs were used as a reference, and the explicit benefit plan of the Health Solidarity Enterprises Program, implemented as a pilot in 1993 by the ministry, was taken as the basis for the POS-S. That plan offered a minimum

³ Regulatory body for the health system, composed of representatives of the major stakeholders from the system and the political sphere, which was replaced by the Health Regulatory Commission (CRES) in 2009.

⁴ The POS-S was equivalent to 50% of the value of the POS-C and focused on the primary level of care and care for catastrophic illnesses.

⁵ In Decree 1650, Art. 4 of 1977 (Office of the President of the Republic of Colombia, 1994).

package of health care services to the most vulnerable populations. The main criteria for analysis and priority setting used in the implementation of the POS-S were the data available on morbidity and mortality. Based on the analysis of the epidemiological profile, primary level interventions required to address health issues were established, and data on the frequency and costs of treatment were sought.⁶ The initial list of interventions was expanded to include catastrophic illnesses.

Costing

Using information from the ISS and other institutions,⁷ the team from the Ministry of Health estimated the cost of the contributory regime's benefit plan CPU at US\$512⁸; however, the Ministry of Finance indicated that it only had US\$370 per capita available. The POS-C began operating with this amount of funding, without adjusting its content in light of the reduced availability of resources (CNSSS, 2003). In this regard, an official from an EPS commented that over the course of three months, the CPU plummeted from COL\$140,000 to COL\$121,000, and the then-minister of finance confirmed that there were no more funds and that no adjustment would be made to POS content. Policy decisions, the official added, went in opposite directions (POS and CPU), and the market has sought to bring them together, for example, by adjusting rates for the provider network. The market has united the CPU and the POS but at the cost of technology. As a result, stakeholders must decide whether to stay or exit the market. If they decide to stay, in order to maintain expected financial performance, they are forced to find new

strategies, such as reducing the rates charged and adjusting the frequency of use.⁹

The costing of the POS-S was conducted based on information from health departments on the Ministry of Health's prevention and health promotion programs. The CPU was estimated at US\$216, which was later adjusted to US\$185 due to the budget limit set by the Ministry of Finance (Ministry of Health, CNSSS, 1994a).

Legitimacy of the initial design

For the initial design of an HBP to be legitimate, it needs i) to be backed by the use of technically robust priority-setting methodologies, ii) to include an extensive consultation process with different population groups, and iii) to disclose information about the content and process.

As shown earlier, the initial proposal for the POS-C was not adopted, despite using technically robust methodologies. There was no consistency between the POS-S and the POS-C in terms of methods or criteria, so it is difficult to make the claim that the implementation of the POS fulfilled the first condition of legitimacy mentioned.

The technical proposal for the costing of the premium was replaced by a political definition. The process lacked extensive consultation and social participation, and while the CNSSS discussions included representatives from various sectors, relevant stakeholders were not involved nor was there disclosure of the process or its contents. As proof of the aforementioned, there is no

⁶ The burden of disease and cost-effectiveness studies prepared for the POS-C were never taken into consideration, because the plan was approved before they were finalized.

⁷ Based on an interview with Dr. Luis Gonzalo Morales, advisor for the POS-C design.

⁸ Monetary values are expressed in 2013 U.S. dollars adjusted for purchasing power parity, unless otherwise indicated.

⁹ The verbatim quote: "...three months in and the CPU was no longer COL\$140,000 but COL\$121,000. Period, that's it. That's how the Minister of Finance put it to us, no content adjustment. Policy decisions went in opposite directions, and the market has taken it upon itself to bring them together. For example, by adjusting the rates for the provider network. The market has united the CPU and the POS but at the cost of technology. There's that decision of 'am I in or out?' and then, if I'm in—in a way—the expected financial performance, we had to look for a reduction in fees to pay, a frequency adjustment" (Giedion et al., 2007).

documentation that explains the process to define the initial content of the POS and the CPU.

Main Features of the POS

Medical coverage

The principle of comprehensive care governs the scope of the POS. The POS-C and POS-S offer comprehensive care that includes activities, interventions and procedures for contingencies of “[...] maternity and general illness at the stages of health promotion and prevention, diagnosis, treatment and rehabilitation for all conditions [...]” (Art. 162) (Congress of the Republic of Colombia, 1993). The benefits of the POS-C were defined on the basis of this principle, which included benefits for health promotion, disease prevention, diagnosis, treatment and rehabilitation at all levels of complexity. Procedures, interventions, activities and medications are included for each of the aforementioned. Until 2010, the POS-C covered all levels of care while the POS-S only provided coverage at the primary level and for catastrophic events, with the exception of care for children under age 1 and pregnant women, who were always entitled to the same coverage, regardless of the regime in which they were enrolled. In 2012, that changed radically when both regimes began covering the same health care services. However, lingering differences exist for other social benefits, such as maternity and sick leaves.

Financial coverage

Sliding-scale fees and copayments were introduced with the adoption of the SGSSS.¹⁰ Sliding-scale fees are designed to regulate access and promote demand for highly effective or necessary services without creating significant financial barriers. These fees depend solely on the beneficiary’s ability to pay, and their price ranges from US\$1.60 to US\$16.50

(the same amount is charged for all services). Similarly, maximum limits are established for the payment of sliding-scale fees per event and per year. Only contributory regime enrollees pay sliding-scale fees when using ambulatory services. Copayments were introduced to “help co-finance the system” (CNSSS, 2004). They correspond to a portion of the fee that the EPS has agreed upon with the IPS, and they apply to medical, dental, and surgical treatments, hospitalizations and diagnostic tests. The design of the copayments seeks to avoid barriers to access and promotes the use of the most necessary or effective services. For example, there are no copayments for services such as labor and delivery and health promotion and prevention.

Population coverage

In 1993, only 25% of the population was insured. The rest depended on the public network within a health care model that suffered from serious problems of equity, efficiency and quality (Ministry of Health and Health Reform Support Program, Harvard University, 1996). According to population projections and the SGSSS report on enrolled individuals, coverage reached 92.02% in 2012. Of this percentage, 42.82% belonged to the subsidized regime and 48.37% to the contributory regime. The remaining percentage was insured through special regimes (military, teachers, etc.). As these figures indicate, Colombia has achieved almost universal coverage. Without ignoring the importance of this accomplishment, it is worth noting that there is an increasing number of stakeholders and analysts who want to move toward greater protection for effective access to health services. For example, it has been stressed that “[...] it is not just about having insurance coverage above 90%, as the country currently does. It is about guaranteeing the right to health for 90 people out of every 100. To that end, it is also important

¹⁰ Decree No. 260 of 2004 of the CNSSS defines the set of rules for copayments and sliding-scale fees in Colombia.

to examine the quality of services provided to the population” (University of the Andes, 2012).

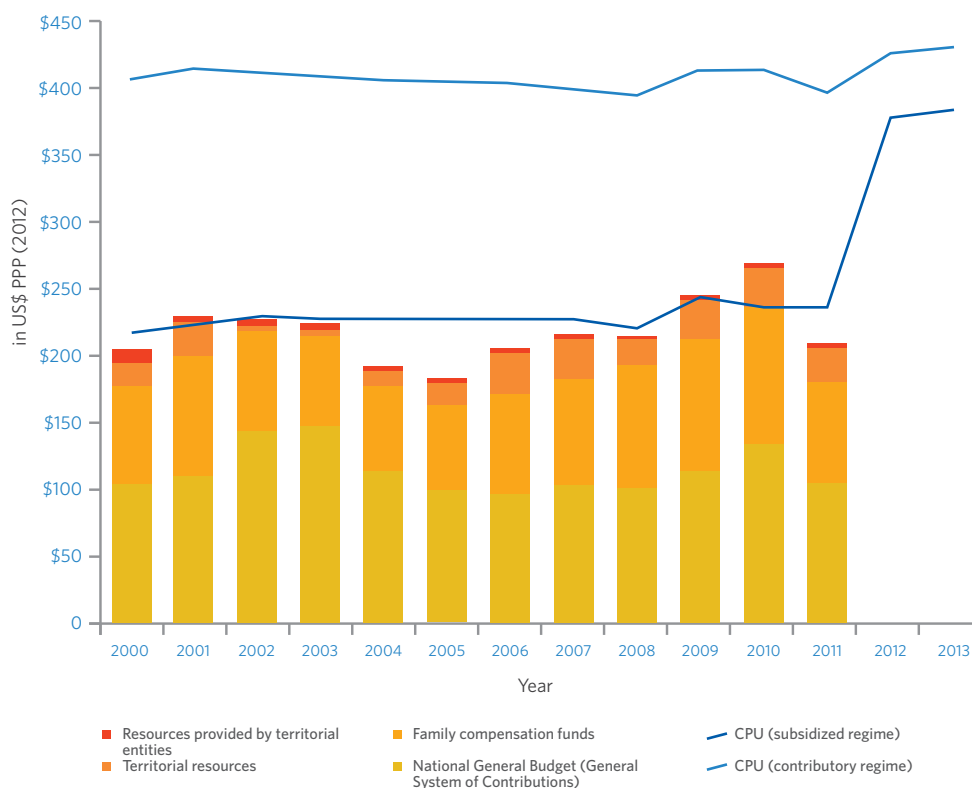
POS financing and premiums

The subsidized regime is primarily financed with resources from the general budget at the national and territorial levels, and with some funds from payroll contributions made by enrollees in the contributory regime (graph 2.1).¹¹ This last mechanism, known as the solidarity contribution, is a unique method of

financing that has been criticized by some and defended by others.¹² The solidarity contribution corresponded to 1.5% of earnings until 2011, when it was decreased to 0.17%.

The POS-C is financed mainly with payroll tax contributions. The health care contribution equals 12.5% of the salary of workers with an employment contract, while the self-employed pay 5% of the amount of their contracts. The minimum contribution is based on the legal monthly minimum wage (US\$441),¹³ while the maximum contribution is 25 times the

Graph 2.1. 2000-13 CPU and per capita income in the subsidized regime



Source: Ministry of Social Protection (2010a) and Núñez et al. (2012)

¹¹ Constituted thusly: 0.17 points (1 for pensioners) (Ministry of Social Protection, 2011) and 5% of funds collected from family compensation funds, which receive 4% of the wages of workers with an employment relationship (Congress of the Republic of Colombia, 1982).

¹² Critics claim that Colombia’s high contribution levels are partly responsible for the high degree of informality in the labor market. Proponents of this financing mechanism argue that it gives substance to the principle of solidarity in financing in a country with a low tax base, which makes it difficult to mobilize higher levels of equitable, general taxation (e.g., income tax).

¹³ The current legal monthly minimum wage in Colombia for 2013 is COL\$589,500.

minimum wage (US\$11,017) (Ministry of Social Protection, 2008).

For 2013, the CPU was US\$418 for the contributory regime and US\$374 for the subsidized regime. This is the average amount of resources each EPS receives yearly per enrollee. The CPU value for the POS-C differs by age group and gender. It is greater for newborns and the elderly and lower for young men. An additional percentage is received for the residents of certain areas, mainly those with a scattered rural population, where higher costs are anticipated because of transportation, but also in urban areas, where a higher than average frequency of health service use is expected. In addition, some of the contributory regime's EPSs receive an additional percentage for having a greater number of high-cost patients (CRES, 2011c). Aside from the CPU, the EPSs collect sliding-scale fees and copayments. Although no study has analyzed their impact on POS financing, the Ministry of Health estimates that the total collected does not exceed 4% in the contributory regime and 5% in the subsidized regime.¹⁴

Nomenclature

The POS contains general coverage descriptions linked to a list of medications and procedures. The list is described using two nomenclatures:¹⁵ the Anatomical Therapeutic Chemical (ATC) Classification for medications and the Health Procedure Code for procedures, based on the chapter on procedures in the International Classification of Diseases, 9th Edition (ICD-9). For illnesses and medical devices, other nomenclatures are specified.¹⁶

Despite this effort to communicate unambiguously, conflicts of interpretation surrounding the POS do arise, since the EPSs have incentives to follow a restrictive interpretation of what is covered by the benefit package, while the government and users push for a broader one. These disparities, which may undermine the legitimacy of the plan,¹⁷ increase transaction costs for stakeholders, create legal uncertainty, interfere with costing, and foster conflicts between stakeholders. However, no benefit plan can be formulated in language precise enough to avoid arguments about its interpretation. Thus—particularly in systems where the provision of the HBP is delegated to a third party in exchange for payment of a premium—it is important to formulate the plan's content as precisely as possible (Eddy, 1996)¹⁸ and to establish mechanisms to monitor interpretations and clarify conflicting ones.

Guarantees

Many countries believe that it is not sufficient to simply list the benefits of a benefit plan; instead, the plan must specify under what conditions and with what guarantees the benefits will be provided. For example, Chile has attached guarantees of timeliness, quality and financial protection to its HBP.

In Colombia, maximum wait times have been defined by service type. For example, it is stipulated that the wait time for a pediatric consultation should be five days or less. These times do not imply an obligation/individual right but instead serve as institutional indicators and are calculated as averages. In other words, some individuals may wait longer for

¹⁴ Data from the Ministry of Social Protection (December 2010a).

¹⁵ Nomenclatures and classification systems eliminate synonyms and polysemy and allow for accurate identification of a specific element within a set (Martínez Tamayo and Valdez, 2009).

¹⁶ For example, Article 50 of CRES Decree 029 makes reference to arterial hypertension, but it does not specify the appropriate ICD-10 code, I10.

¹⁷ On this issue, the Constitutional Court of Colombia states (Decision T 760/2008) "...many of the writs of protection filed to request access to services stem from the existence of doubts regarding what is included or excluded from the POS and the absence of institutional mechanisms within the Social Security Health System to overcome this uncertainty."

¹⁸ As mentioned in the comparative chapter of this book, the team responsible for the design of the essential benefit plan known as Obamacare has arrived at similar conclusions in the United States.

a consultation because the obligation is linked to the average length of all wait times to obtain a consultation (Supersalud, 2007). In the case of a general medical consultation, there does exist an individual right to obtain the consultation in a maximum of three days (Office of the President of the Republic, 2012b); however, there are no effective mechanisms to make this right enforceable (Silva, 2012).

Clinical practice guidelines

The Colombian Ministry of Health has adopted an increasing number of clinical practice guidelines during the last decade. These guidelines have influenced the benefit plan in four ways: i) by helping to define the content to be covered in terms of health promotion and prevention; ii) by linking the coverage of medications to the specific conditions and situations established in the clinical practice guidelines; iii) by defining the scope of health technology coverage, since, in the case of some medications, the EPSs are only required to cover them under the conditions set forth in the guidelines; and iv) by providing input for the prioritization of technologies when adjusting the HBP. In this regard, in 2011, from among the 996 technologies considered for potential inclusion in the benefit package (as input for the decision on their inclusion in the POS), 538 came from care guidelines (CRES, 2011b). Nevertheless, there is no explicit and formally established link between the recommendations in the guidelines adopted by the government and the definition of the contents of the POS. This implies that the guidelines adopted by the government sometimes include technologies that are not being covered by the HBP. Also, unlike in other countries, the clinical practice guidelines have not played an important role as

input for the costing of Colombia's benefit plan, since the adoption of national guidelines does not imply that the contents will be incorporated into the POS.¹⁹

Access to excluded services²⁰

Access to health services excluded from the benefit package through judicial mechanisms is an important issue in the context of Colombia. There are two mechanisms for requesting these services: a writ of protection presented before a judge or a request made before the scientific technical committee of an EPS. Under the first mechanism, through smooth and rapid proceedings (a maximum of 10 days), Colombians can bring a claim before a judge for the immediate protection of their fundamental constitutional rights when they fear that these may be violated or threatened. If the judge rules in favor of the citizen, the EPS must provide care at the government's expense, specifically using resources from the SGSSS fund known as the Solidarity and Guarantee Fund (FOSYGA). Under the second mechanism, a request is submitted to the scientific technical committee of the EPS, which decides whether the service is indicated in this specific case. In 2010, the government allocated an amount equivalent to 26% of each CPU in the contributory regime to finance these services that do not form part of the benefit package (Núñez et al., 2012; Ministry of Social Protection, 2010a).

A combination of various factors led to exponential growth in FOSYGA funding for services excluded from the POS, thereby distorting the meaning of an explicit and limited benefit plan and threatening the sustainability of the Colombian health system. Some of the factors behind this explosion of requests

¹⁹ Article 9 of Decree 29, 2011: "[...] in this decree concerning the inclusion of technologies in the Compulsory Health Plan, neither the official adoption of the Clinical Practice Guidelines nor hospital protocols automatically results in it, but instead the explicit or express inclusion enacted by the Health Regulatory Commission, following the evaluation of each health technology contained in the respective guidelines or protocols" (CRES, 2011e).

²⁰ Some of the ideas presented here correspond with the pharmaceutical policy of the National Council on Economic and Social Policy (National Planning Department, 2012).

for services excluded from the HBP are as follows:

Existence of expeditious judicial and administrative mechanisms. Writs of protection and the decisions of scientific technical committees allow patients to request non-POS services, with reimbursement to the EPSs for the provision of these services through FOSYGA. These requests are made by invoking the right to health and are based on the treating physician's appraisal of medical need.

Incentives. SGSSS stakeholders have had many incentives to request services not included in the benefit package and too few to keep these requests in check. For the EPSs, reimbursements have been a growing source of additional income, accounting for 23% of resources in the contributory regime in 2010.²¹ Since each non-included service requested by providers and physicians signifies revenue for the EPSs, they lack incentive to audit and reject them. The medical technology industry and drug producers and distributors regard the reimbursements as an opportunity to sell technologies that are not part of the POS at the prices and quantities they want, with limited monitoring, while providers regard the reimbursements as an additional source of income without having to negotiate rates with insurers, as is the case for services covered by the HBP.

Insufficient governance. Although in the 1990s there was already recognition of the writ of protection's potential impact on the system, no measures were taken to prevent it.²² It was only when the reimbursements increased to the point that a deficit was projected for the contributory regime, that the government began to react with various measures, such as the declaration of a

social emergency in late 2009, which sought to limit reimbursements by fining doctors who strayed from protocols and allowed people to use their mandatory unemployment savings accounts (a form of severance) to pay for non-POS services (Office of the President of the Republic, 2009).²³ The absence of governance has been particularly evident with respect to medications, which are the main component of reimbursements for services not included in the benefit package (87% in 2009). Of this expenditure, 50% corresponds to 36 pharmaceutical products, chiefly those that are high cost (Tocaruncho Ariza, 2011), such as biotechnology products (Zapata, Pinto and González, 2010). In the past three years, eight of the 10 most frequently reimbursed medications have been biotech drugs. Furthermore, it has been noted that the prices paid for the reimbursements are quite high in comparison to other countries (Núñez et al., 2012; Cañón et al., 2012). The Health Regulatory Commission (CRES), responsible for making adjustments to the POS until 2012, found no scientific evidence of efficacy for some of the most heavily reimbursed drugs not included in the benefit package.²⁴

In health care systems, multiple agents participate, each seeking to fulfill its objectives based on the incentives and constraints of the system. In cases such as those of the reimbursements for high-cost drugs not included in the benefit package, the system's configuration leads agents to behave opportunistically in favor of their interests and counter to what the system expects of them. Identifying conditions that may steer the system away from its objectives, such as the existence of perverse incentives, and intervening in a timely manner should be a central task of the governing body.

²¹ COL\$2,328,431,887,847 in reimbursements and COL\$10,238,400,000,000 in funds from the contributory regime (from Robert Steiner, 2011).

²² For example, in the late 1990s, the CNSSS is on record as stating that "...the costs not covered by the CPU, through court decisions arising from writs of protection that mandate the delivery of costly services [...] threaten to upset the balance of the system..." (Giedion, Panopoulou and Gómez-Fraga, 2009).

²³ This measure aroused substantial indignation among physicians and was later declared unconstitutional.

²⁴ For example, the use of anti-thymocyte immunoglobulin (rabbit-derived) in treating aplastic anemia (CRES, 2011).

Relevance of the Compulsory Health Plan

The POS is one of the cornerstones of the Colombian health care system, not only for the magnitude of the resources mobilized to finance it, but also for its role as the government's primary tool for strategic purchasing in order to decide which services to offer the population, according to its needs (Giedion, Panopoulou and Gómez-Fraga, 2009).

Share of the budget

The POS serves as the main guide for health expenditure allocation. In 2011, the total health expenditure was US\$36.631 billion (6.1% of the GDP), of which 74.8% corresponded to the public health expenditure. Seventy-four percent of this public spending is used to pay for the POS (Barón, 2007), a much higher percentage than what is observed in most countries in the region. The situation is different with regard to medications. In 2010, 76% of the total value of pharmaceutical companies' sales corresponded to non-POS drugs (public and private resources) (Econometría SA, 2011). In 2011, about 51% of public spending on medications was directed toward these drugs.²⁵ It is worrying that the majority of spending on medications occurs through administrative and judicial mechanisms and without a priority-setting instrument that directs resources toward those technologies with proven efficacy and safety.

Share of service delivery

A large part of health service delivery in Colombia is directly related to provision of the POS. This is reflected in the data from the 2007 National Health Survey,

which shows that the vast majority of consultations and hospitalizations provided in the country are financed by the EPSs of the contributory and subsidized regimes and, therefore, coincide with the services included in the HBP (table 2.1).

Adjustment

This section describes the main criteria for adjustment of the POS, the institutional design to conduct it, the adjustments that were made, and the legitimacy of these processes.

Adjustment criteria and the institutional framework

With the creation of the SGSSS, criteria and guidelines were defined to update and adjust the contents of the POS. These have changed over the course of the past two decades and can be grouped around the following topics and criteria: i) health needs: epidemiological criteria of morbidity and mortality, years lost to disability, years lost to premature death, and disease burden; ii) technical possibilities: the technologies available in the country; iii) sustainability: the POS must be sustainable with existing resources; iv) efficiency: the optimal use of resources to obtain a health outcome; v) establishment of guidelines for the technologies that should be considered in the update of the POS, such as those set forth in the clinical practice guidelines; and vi) process: the conditions under which update processes must be performed, e.g., periodicity, citizen participation and transparency.

These last criteria for the adjustment process have become more important than the technical criteria, although

²⁵ If an expenditure of COL\$19.4 billion (2010) is assumed between the subsidized and contributory regimes, calculated based on Steiner (2011), and assuming that the percentage of spending on medications has not changed since 2008, when it was estimated at 11.79% (Núñez et al., 2012). Total public spending on medications is understood as EPS spending on medications (contributory and subsidized regime spending multiplied by the percentage of spending on medications) plus 2010 FOSYGA spending of COL\$2 billion on medication reimbursements (Ministry of Social Protection, 2010b). This last figure is regarded as non-POS spending. This analysis assumes that all spending on medication reimbursements was for non-POS drugs, and it does not take into account the amount paid by the territorial regimes on reimbursements outside of subsidized regime funds.

Table 2.1. Payment by EPS and out-of-pocket spending on medications, per event, 2007

Insured event	Primary EPS pays for event (%)		Out-of-pocket spending on medications per event (%)	
	Subsidized regime	Contributory regime	Subsidized regime	Contributory regime
Hospitalizations	92.3	88.9	13.9	23.6
Outpatient consultations	93.3	91.9	6.9	30.4

Source: Developed by the authors based on data from Cendex, Javeriana University (2009)

at the beginning they were not taken into consideration. For example, more than five years had passed since the POS was first adopted in 1994 before the periodicity of POS updates was established.

Development of the institutional framework

Colombia has gradually changed its institutional framework for adjusting the POS and the CPU, as shown in table 2.2. Phase I relied on a political entity, the CNSSS, which did not have any specific technical support to make its decisions. Subsequently, in phase II, an ad hoc technical secretariat of the CNSSS was created, the Technical Committee on Medicines, which later expanded its role and became the Medicines and Technology Evaluation Committee (CMET). Both committees were coordinated by the Ministry of Health. The CMET established itself as the technical evaluator of proposals for inclusion; however, it lacked the resources to conduct the evaluations and to compensate its members (Giedion, Panopoulou and Gómez-Fraga, 2009).

In phase III, a regulatory body, the CRES, was created for greater autonomy from the ministry and greater technical strength. It was given administrative autonomy and sufficient resources to conduct its own evaluations, but the CRES failed to gain proper autonomy from the Ministry of Health (Guzmán Paniagua, 2012b), for which it was

heavily criticized and its technical capacity questioned. It was said that rather than acting as independent technicians, the CRES commissioners acted in favor of the sectors that nominated them (Lewin, 2012). Furthermore, the Constitutional Court found that the POS update performed by the CRES during the 2008-09 period (Resolution 03 of 2009) did not meet established technical requirements (Cortés Castillo, 2009).

During phase IV, in 2012, Law 1438 was passed, which established the Health Technology Assessment Institute (IETS), an entity that issues technical opinions about technologies that should be included in the POS. The IETS coexisted with the CRES on the assumption that the former would be responsible for providing independent technical recommendations while the latter would remain in charge of decision-making.

In 2012, Colombia's president announced the dissolution of the CRES as part of a package of measures to manage the health sector crisis (Office of the President, 2012a), without specifying the reasons that led to this decision (Guzmán Paniagua, 2012a). Thus began phase V. Under this approach, the IETS would be responsible for assessing the technologies to be included in the POS and for making technical recommendations to the Ministry of Health, which would then make final decisions about the adjustment of the benefit package (IETS, 2012; Ministry of Health and Social Protection, 2012a). With this, control of the POS adjustment would fall squarely on the

Table 2.2. Development of the institutional framework for the adjustment of the POS and the CPU

Entity/phase	Phase I 1994-96	Phase II 1997-2008	Phase III 2009-11	Phase IV 2012	Phase V 2013-...
Ministry of Health, executive-level entity	The minister forms part of the CNSSS		The minister forms part of the CRES		Defines benefits and the CPU
Ministry of Finance, executive-level entity	The minister forms part of the CNSSS and has the right to veto the establishment of the CPU (University of Antioquia, 2007)		The minister forms part of the CRES		
CNSSS (Law 100 of 1993), oversight entity composed of the 14 principal public, private, and labor union stakeholders as well as users	Defines the POS and the CPU		De facto elimination		
CTM (Resolution No. 51, 1997), eight-member ad hoc committee		Provides technical input to CNSSS	Becomes the CMET in 2002		
CMET (Resolution No. 232, 2002) from the CNSSS), technical entity composed of seven ad honorem members appointed by the Minister of Health			CMET begins to function in 2002	In 2006, CMET establishes itself as the technical evaluator of inclusions	De facto elimination
CRES (Law 1122, 2007), commission with administrative and budgetary autonomy. Composed of the Minister of Health, Minister of Finance and five experts nominated by various sectors and appointed by Colombia's president			Defines the POS and the CPU. In addition, it performs the corresponding technical analyses		Eliminated
IETS (Law 1438, 2011), autonomous and independent public-private entity. Four of its five board members include the Minister of Health and three directors of other entities, all appointed by Colombia's president			It makes technical recommendations about inclusions in the POS, but it is unclear whether it also does so for the calculation of the CPU		
Recommendations for inclusion based on evidence and HTA					

Source: Developed by the authors based on Giedion, Panopoulou and Gómez-Fraga (2009), Law 100 of 1993, Law 1112 of 2007, Law 1438 of 2011, CNSSS Resolution 51 of 1997, CNSSS Resolution 232 of 2002 (University of Antioquia, 2007) and Decree 2560 (Ministry of Health and Social Protection, 2012)

Ministry of Health. Some stakeholders questioned the measure: “It would mean handing all control of the system back to the Ministry of Health, with no other entity to monitor it. The new law should grant the commission [CRES] genuine autonomy and place it on a higher technical and scientific level” (Paniagua Guzman, 2012b).

Despite the long road and many attempts to identify an institution to take charge of providing technical recommendations and decision-making with regard to the adjustment of the POS and CPU, there is still no national consensus on which would be the best institutional framework to achieve legitimacy in coverage decisions. Also lacking is a decision on how to divide the responsibilities for the update to the benefit plan and how to coordinate the entities involved.

Recently, in phase V, the institutional framework changed significantly. In June 2012,²⁶ a statutory law was enacted that removed the foundations on which the POS was built. The law states that individuals are entitled to any health services they require, with some exceptions: i) services performed purely for aesthetic reasons; ii) treatments for which there is no evidence of their efficacy, effectiveness and safety; iii) experimental treatments; and iv) treatments that lack the necessary health agency approval for their commercialization in the country and technologies that must be loaned from abroad (Congress of the Republic, 2013). The benefits that meet the aforementioned criteria must be excluded, and it is expected that, within the current regulatory framework, the Ministry of Health will issue a negative list based on IETS assessments. Thus, Colombia is on the verge of shifting from explicit rationing through an HBP to a system that combines implicit rationing with a negative list for some services.

Adjustments and rules

Adjustments made to the HBP according to the phases indicated in figure 2.2 are presented below, followed by an analysis of the adjustments to the CPU premium.

Phase I. The first POS adjustments. When the system was introduced, the CNSSS made the first adjustments to the POS for the contributory regime and the subsidized regime. It included high-cost illnesses under the subsidized regime and performed the first update on the drug manual.

Phase II. Evaluation committees. The CNSSS has relied on the technical support of the Technical Committee on Medicines (CTM) since 1997 and the Medicines and Technology Evaluation Committee (CMET) since 2002. With this technical support, a total of 15 modifications were made to the POS: eight to the POS of both regimes, six to the POS-S, and one to the POS-C. These modifications, like those made in phase I, were characterized by the absence of a periodic methodology for priority setting, disinterest on the part of the CNSSS in performing its role as policy leader for the POS, the growing influence of judicial and legislative powers on the definition of the POS, and the lack of priority-setting criteria for the services included in the POS of the subsidized regime (Giedion, Panopoulou and Gómez-Fraga, 2009). The subsidized regime lacked a vision of how to handle the expansion of its benefit package and its convergence with the larger benefit package of the contributory regime that, according to law, was slated to be finalized by 2001. For example, photon external-beam radiation therapy and laparoscopic cholecystectomy were added before a consultation with a specialist or the majority of medium-complexity services (Ariza, Giedion and Pulido, 2007). The legal framework indicated that expansion of the benefit plan in the subsidized regime should primarily follow a criterion

²⁶ As of October 14, 2013, this law has yet to be reviewed and approved by the Constitutional Court in order for it to take effect.

of disability-adjusted life years (DALYs). Under this principle, the inclusion of high technology should have been deferred in favor of low-complexity services, yet just the opposite happened.

In 2006, guidelines were developed for chronic kidney disease and HIV/AIDS. They were used to update the POS, which favored the adoption of a more comprehensive and disease-oriented approach, in contrast to the “one-off” approach used in the previous year.

Phase III. The CRES updates the POS. In 2008, the Constitutional Court ordered a comprehensive update of the POS (Constitutional Court, 2008). The CRES complied and issued Resolutions 03 and 08 of 2009 and 14 of 2010; however, the Court refused to acknowledge that the comprehensive update had been fulfilled by this process, and so it intervened in the POS and made inquiries regarding compliance with aspects of the update, particularly citizen participation (Constitutional Court, 2012).

Passed in January 2011, Law 1438 ordered the POS to be updated by December of that year, using a clear, explicit and participatory methodology. The CRES was required to complete the adjustment within a very short timeframe; as a point of reference, countries with a great deal of experience in this matter evaluate no more than 50 or 60 technologies per year.²⁷ In order to update the POS, 996 potential technologies were identified for inclusion. The CRES did not coordinate with the CMET, which had been in charge of providing technical recommendations for the update of the POS in the past (CRES, 2011b), nor did it build upon existing methodologies.²⁸

The CRES then took five steps: 1) it selected technologies for evaluation, 2) it evaluated them, 3) it analyzed the

exclusion of technologies from the POS, 4) it made the process participatory, and 5) it deliberated and issued the new version of the POS.

With this update, 44 new procedures and 128 new drugs were added to the POS. For the first time in the POS adjustment process, social participation was sought and an explicit methodology for selecting and evaluating technologies was employed.

Phase IV. The CRES establishes equal benefits under the POS for both the contributory and subsidized regimes. This process should have occurred prior to 2001, as was defined when the system was created (Law 100, Art. 162). During the first 14 years, only pregnant women and children under age 1 enjoyed the same benefit plan in both the contributory and subsidized regimes. Given the inequity of providing a lesser plan to the most vulnerable populations, in 2008 the Constitutional Court ordered that the plans be unified and updated urgently (Constitutional Court, 2008). The CRES gradually established equal benefits under both plans, doing so by population group. In 2009, it incorporated children under 18, and two years later, adults over 60. Finally, in 2012, it added the remaining groups. Although the plans for both regimes are now equal, the premiums were not made equal because the CPU of the subsidized regime is 88% of that of the contributory regime. This was justified by pilot data, which showed that the subsidized regime is used less frequently than the contributory regime (CRES, 2011g); however, this type of study has its limitations. For example, it is assumed that frequencies of use can be taken at face value, but this is not necessarily the case if access to services is restricted.

Phase V. The HBP is replaced by explicit exclusions. It is expected that the next

²⁷ The National Institute for Health and Care Excellence (NICE) in the United Kingdom, perhaps the most renowned authority of its kind in the world, spends a minimum of 54 weeks on one evaluation and 36 weeks on a short evaluation. These timeframes may increase if several evaluations are being carried out at once (Drummond and Sorenson, 2009).

²⁸ In particular, the POS proposal developed by the Health Solidarity Enterprises Program and the one by the team of experts, developed on the basis of disease burden and cost-effectiveness studies, should have been considered before accepting the ISS benefits as the basis for the POS.

adjustments to the HBP will be related to the transition from a positive list of benefits to a negative one, even though it is still unclear when and how this process will take place.

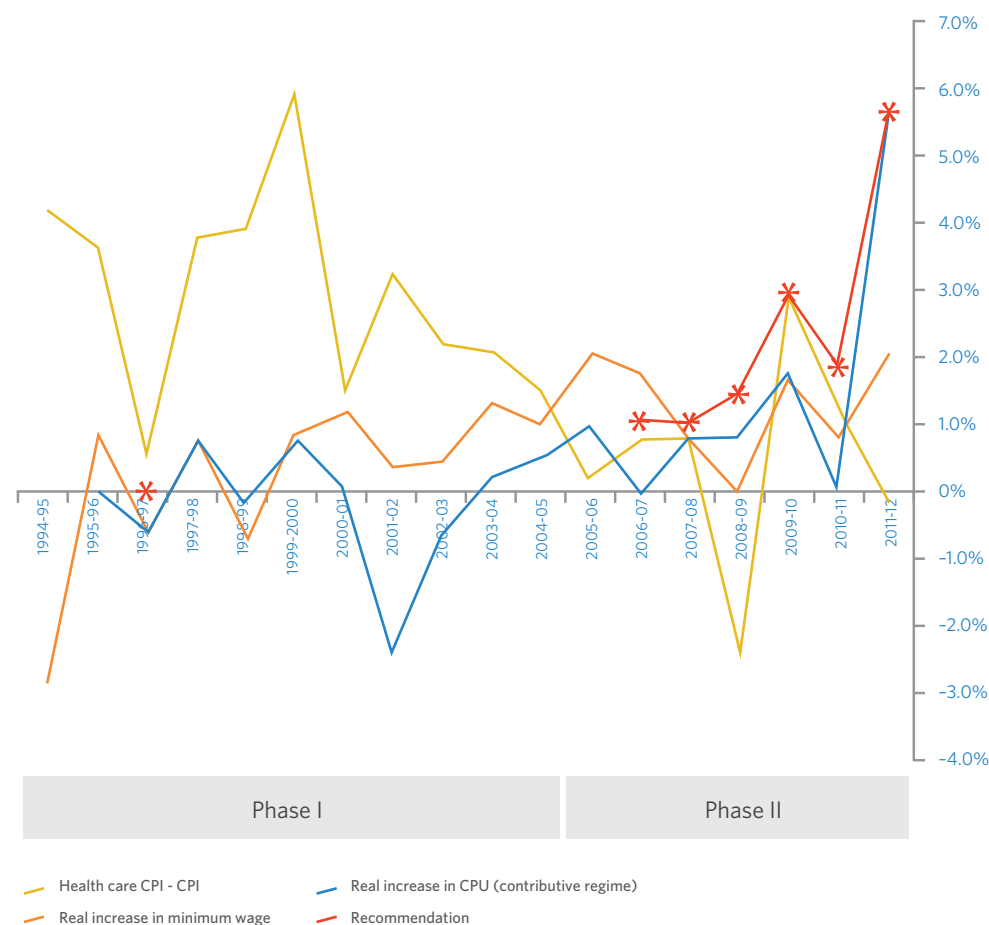
Adjustments to the CPU

After the initial adjustment of the CPU imposed by the Ministry of Finance, as described earlier, a distinction can be

made between two phases, which are presented in graph 2.2.

CPU, phase I. As there was very little information on the demand and service costs for the POS, adjustments to the CPU were based on studies of overall financial stability, and, in the contributory regime, largely on changes in the minimum wage, as they determined the revenue performance of this subsystem. Due to the rise in unemployment—an effect of

Graph 2.2. Real increase in the CPU of the contributory regime, minimum wage, CPI for health care, and technical recommendations



CPI: consumer price index.

Note: The general CPI is subtracted from the CPI for health care.

Source: Developed by the authors based on CRES and CNSSS resolutions (Ministry of Social Protection, 2011a-2011f; Ministry of Social Protection, 2010a; Gerencie, 2011)

the 1999 global economic crisis—it was necessary to make subsequent adjustments below the minimum wage increase and, in some years, below the rate of inflation (Castaño Yepes, 2004), as observed in graph 2.2. In general, adjustments to the CPU completely ignored the change in the cost of providing the benefit package.

CPU, phase II. The analyses of the previous phase showed that it was necessary to have more information to adjust the CPU. In 2005, the Ministry of Health began to request information annually from the EPSs on the previous year's spending, in order to calculate the CPU for the following year. With this information, actuarial research was performed, which served as input for the adjustment of the CPU. The first research study, in 2006, used data from 17% of the contributory regime's EPSs. Thanks to the studies that brought information gaps to light, in 2011 reliable information was available from 52% of the EPSs, which account for 90% of the enrollees in the contributory regime. Meanwhile, the improvement in the subsidized regime has been smaller. For the latest study, information was obtained on just 14% of enrollees.

A recent study analyzes the impact of including new technologies in the POS and estimates the value of the subsidized regime CPU after unification of the plans. The study was based on the demand for services observed during a pilot test (CRES, 2011g). In addition, new techniques of analysis were introduced, such as the use of time series data to predict variables (CRES, 2011b).

Through a systematic and sustained effort, the country increased its technical capacity to analyze the CPU adjustment using quality techniques. However, the recommendations were implemented only in the most recent increase of the CPU.

Legitimacy

The legitimacy of the adjustments to both the POS and the CPU in each of the phases described is discussed below.

Phase I. The technical process of the CNSSS was not robust and lacked technical support and broad-based participation and consultation.

Phase II. Technical support progressively improved, first with the Technical Committee on Medicines and then the CMET. While no progress was made in terms of participation, there was some dissemination of information through the publication and presentation of the guidelines that served as the basis for the updates.

Phase III. Several aspects of the update process were questioned (ISPOR Colombia, 2011; Rossi Buenaventura, Umbacía and Sánchez, 2012; ACEMI, 2011; López G., 2012; working group of the citizen participation project to define the methodologies and proposals for the update of the POS and establishment of the CPU in Bogotá, 2010; and the Colombian Medical Federation's drug observatory). With regard to technical strength, there were quality issues and variability in the assessments, and they did not all follow the same format. In addition, in several cases, laboratories requesting the inclusion of a technology in the benefit package also provided most of the information for the assessments. With regard to transparency, the reason the CRES deviated from the technical recommendations in some instances was not disclosed. For example, some non-prioritized medications with low impact on health, such as esomeprazole, were included in the POS, even though they had not even been evaluated. Furthermore, the details of the methodology for estimating budgetary impact were not disclosed in advance. With regard to participation, patient organizations demanded full participation in the definition of the adjustment methodology, training on POS adjustment methodologies, and a meeting with the group at the National University of Colombia that created one of the methodologies. They also expressed that the time they were given to study the documents was insufficient.

Phase IV. The technical robustness of the equalization process was called into question when the POS-S and the POS-C were made equal but a disparity remained between the premiums, and yet again when the EPSs of the subsidized regime experienced financial problems (see balance between the POS cost and financial allocation). The technical justification for equalization has not been sufficiently substantiated.

Phase V. The financial significance and number of non-POS services introduced by requests to scientific technical committees or by legal proceedings in the form of writs of protection began to increase. At the same time, the media sided with patients trying to gain access to excluded services, which turned public opinion against the POS. Furthermore, ministry technicians ceased to acknowledge the plan as a measure to prioritize spending, since both included and excluded services were being financed. In this context, no political entity recognized the advantages of an HBP.

Analysis

The country has made progress in the technical robustness of its adjustment processes—beginning with the technical strengthening of the CMET—in the definition of guidelines, and in its process for adding new benefits. Later, transparency and participation criteria were implemented by court mandate (Constitutional Court, 2008) and the 2011 health care system reform (Law 1438). However, even the latest adjustment of the POS elicited numerous criticisms on each of the factors of legitimacy, partly because national capacity is overwhelmed by the timeframes imposed by the Court. As a result, some degree of technical robustness, transparency and participation was sacrificed along the way, as noted by a few stakeholders.

It is troubling to note how the judiciary triggered the two most significant

adjustments of the POS: equalization and the comprehensive update. The Constitutional Court assumed an oversight role with respect to the POS, a situation not seen in other countries. This points to the plan's lack of legitimacy, at least in the eyes of the entity charged with protecting the constitution. In this context, the idea of medical autonomy as an unrestricted power gained a foothold, and it was defended by medical associations (Camargo, 2011), repeated by the media, and accepted by large segments of society. That led to the only politically feasible action, which was to forego rationing through the HBP and adopt implicit rationing, with only a few technologies excluded by a negative list.

Implementation

The successful implementation of an HBP requires much more than an explicit, technically-robust, and consensual definition of the benefit plan. In the case of Colombia, six conditions for success have been identified, which are discussed below.

Macro-financial equilibrium

The clearing account of the contributory regime has generally maintained positive surpluses except for two times: the first in the wake of the global economic crisis of 1999, when it was necessary to adjust the CPU to a level below the increases of both the minimum wage and the inflation rate (Castaño Yepes, 2004) and the second in 2010, when there was a deficit of US\$485 million. To cover it, the government mainly resorted to reserves accumulated in previous years (Muñoz, 2012). Recent projections simulated the impact of some measures to reduce the risk of deficits in this regime. For example, decreasing the contributory regime's solidarity contribution to the subsidized regime from 1.5% to 0.17% of income generates a surplus for the regime between 2011 and 2015; otherwise, the system would face a US\$641 million deficit in 2012, equivalent to 6% of the revenue

collected from payroll contributions. These measures were adopted through Resolution 477 of 2011, which decreases the contributory regime's solidarity contribution. In addition, in 2012 the National Council on Economic and Social Policy established that the reimbursement for services not included in the POS but requested through judicial mechanisms should be reduced to less than US\$377 million by 2012 to maintain the system's financial equilibrium (National Planning Department, 2012).

Subsidized regime. During the last decade, there has been concern about the financial sustainability of the subsidized regime, the tax burden generated by universal health coverage and, more recently, the equalization of the POS-S and POS-C. Recent simulations show that by equalizing the POS, the subsidized regime will run a deficit between 2011 and 2015 (Núñez et al., 2012; Ministry of Social Protection, 2010b).

Studies paint a difficult picture for the SGSSS. It must generate new resources and control spending on reimbursements for services not included in the benefit package in order for the system to maintain universal coverage and the equalization of the POS. Another option is to slow the increase of the CPU; however, if this measure is insufficient, it will result in barriers to access, which would constitute an economic adjustment at the expense of users.

Balance between POS cost and financial allocation

Periodic studies to estimate the cost of providing the POS and, therefore, the value of the CPU (Ministry of Social Protection, 2010a; Castaño Yepes, 2004; Ministry of Social Protection, 2010b) found the following four main limitations:

1. Great variability in the *quality of information* reported by the EPSs. Although the trend is leaning toward more consistent data, serious

problems persist in the subsidized regime. In 2010, there was a setback, to the point that it is reported that “these studies reveal inconsistencies in the information reported by the EPSs [...] and, therefore, hinder decision-making...” (Ministry of Social Protection, 2011c; Ministry of Social Protection, 2011d; Ministry of Social Protection, 2011e).

2. Since EPS revenues depend on the amount of the CPU, it is in their interest for it to increase. They have the ability to influence the value of the CPU, as the adjustment is mainly calculated based on frequencies of use and the costs reported by the EPSs (Ramírez Moreno, 2011).
3. On several occasions, CPU adjustments have been lower than technicians' recommendations.
4. It is assumed that the observed frequencies of use are at the necessary levels to ensure effective access. These studies only allow the conclusion that the CPU is sufficient for the provision of the POS *as it has been provided in the past* with adjustments based on demographic variables and “timely” inclusions, instead of the real needs of the population and its demographic and epidemiological profile. It is, perhaps, revealing that 38.9% of doctors have reported restrictions on the provision of services (Office of the Ombudsman, 2007a). While it is impossible to know from the available information whether these access restrictions are caused by an insufficient CPU, it is problematic that this value is calculated on the basis of frequencies of use in an environment with restricted access.

According to a system stakeholder, “... if the actual cost of the POS is not reflected in a CPU value that allows for the continuation of the supply chain, each stakeholder will either exert pressure on the next link or exit the system and, at the end of the line, the one most

affected will be the patient” (Giedion et al., 2007). This can be observed in the subsidized regime, where several EPSs have decided to withdrawal after the plans were equalized but not the CPU values.

Quality control

The quality of POS services is evaluated in the context of the Mandatory Quality Assurance System, which sets standards of timeliness, safety, appropriateness, continuity and accessibility, supervised by the National Health Superintendency, territorial authorities and the EPSs (supervision of their own network of IPSs). In addition, minimum operating requirements (accreditation) are defined for the IPSs or EPSs. These include scientific and technological, equity and financial, and technical and administrative capacities (Office of the President of the Republic, 2006).

This system has limitations in terms of ensuring that the POS is provided with the desired level of quality. Many health providers start offering health services by simply completing a provider authorization form, without having received a verification visit.²⁹ Additionally, when an IPS or EPS is the only provider of a service in a particular region, closing it down proves problematic. Lastly, territorial health departments are in some way responsible for the public IPSs in their region (the hospitals), and they are also in charge of disciplining them, which places them in a difficult situation (Montoya, 2003).

While the quality system has allowed for the creation of a provider registry, the definition of criteria that providers must follow, and monitoring of indicators, in practice, the Mandatory Quality Assurance System cannot yet guarantee adequate provision of the POS (Echavarría Aguirre, 2004).

Knowledge of benefits and mechanisms in order for the population and stakeholders to be able to demand their rights

One of the determinants of the impact of the POS is the public’s knowledge of the benefits to which individuals are entitled and the mechanisms available to demand those benefits. Only 53% of people are aware of the POS, with those at lower socioeconomic levels registering lower awareness (32%) than those at higher levels, where it reaches 75% (Gestarsalud; National Consulting Center, 2009). According to a study by the Ministry of Health, the information provided to the public is “limited, confusing and offered by the EPSs [...]. The information delivered by the EPSs is basic, limited and incomplete” (Bonilla, 2009).

Three types of mechanisms make the delivery of POS services enforceable:

1. The primary mechanism is the *writ of protection*. The significant number of writs of protection that have been brought before the court in the area of health, for services both included and excluded from the benefit plan, attests to the fact that more than just mere lip service is being paid to the enforceability of the right to health in the Colombian case. Additionally, there is the right of petition (Article 23 of the Constitution of 1991), which obligates entities to respond to written requests made by individuals within 15 days. In the absence of a response, it is understood that the request has been approved. People have been using the right of petition as a means of requesting access to services, in writing, from the EPS, and they send copies to different monitoring entities. Sometimes they do succeed with this approach and the services are provided to them; otherwise, the request serves as evidence for a writ of protection.

²⁹ The regulation states that each year, only 25% of the service providers registered in the four-year period must be visited (Resolution 1043 of 2006).

2. *Specific mechanisms.* Other mechanisms do exist, such as the jurisdictional function, the conciliation function, and denial of service, for which the National Health Superintendency (Supersalud, 2007) is responsible, but in practice they are rarely used (Supersalud, 2009).
3. *Support mechanisms* that seek to advise people on accessing health services and using the mechanisms mentioned above. Support mechanisms have emerged as consumer protection offices at various institutions, including the National Health Superintendency (Law 1122, Art. 42), some territorial health departments (Bogotá Mayor's Office, Capital District, 2007), the EPSs and several NGOs. Since these mechanisms are provided by entities engaged in activities that generate a conflict of interest, situations may arise where consumers require protection from the very place they have gone to for help.

Infrastructure and human resources available to provide POS services

The supply of infrastructure and human resources required to provide the POS is available in most medium and large cities. However, there has been no systematic study to determine whether POS services are offered across the country, taking into account capacities and needs. It is known that there is great heterogeneity across the country in terms of available infrastructure, the number of beds, the number of services, and human resources, which would indicate that the supply of POS services is quite unequal, as shown in map 2.1. The problem is more serious in areas with greater population dispersion, shown as dark areas on the map. These departments should have a greater number of medical transport services for the transfer of their patients. The difference in physician density is enormous; while Bogotá has 326 doctors per 100,000 inhabitants, four

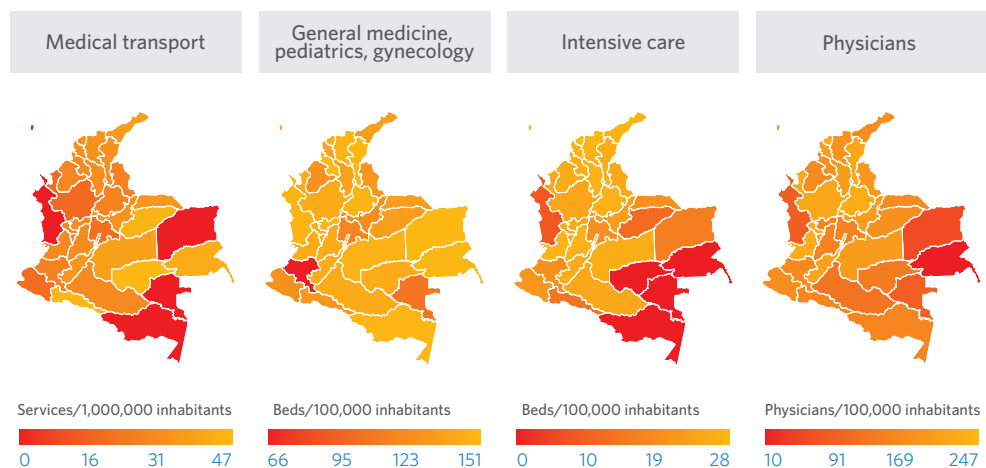
of the poorest departments (Chocó, Guainía, Vaupés, and Vichada) have fewer than 30 doctors (Ministry of Social Protection, 2009a). This data supports the importance of geographic location for access to the benefit plan, as reported by Ruiz Gómez et al. (2008).

Three strategies have been tested in order to provide the POS throughout the country: i) a 10% more expensive CPU for remote departments, ii) medical air transport services, and iii) telemedicine (Ministry of Health and Social Protection, 2012c). However, offering the same access to services included in the HBP to everyone poses significant challenges, especially in places where the population is small and scattered, where there is a lack of good road access to all cities, and where transportation on waterways or by air is unaffordable for most people.

Institutional capacity to monitor and verify compliance with objectives

Benefit plans inherently facilitate accountability by explicitly stating the services to be rendered. However, to date there are no published studies that quantify whether all POS services are delivered according to the conditions established. While some indicators show improved implementation, there is no evaluation system to determine the impact of the POS on the population. As a general objective or guiding principle, it was established that the POS would ensure the inclusion of services that improve the health of Colombians. However, no systematic analysis of any sort has been performed on the relevance of the POS to the country's morbidity and mortality profile (Giedion, Panopoulou and Gómez-Fraga, 2009), nor has the impact of POS services been evaluated. On another matter, since the specific objectives of the POS were never formulated, it is difficult to establish to what extent the plan has fulfilled its mission. This is a problem for evaluating the performance of institutions and for planning public policy. The lack of goals was evident during the 2011 POS update.

Map 2.1. Density of services, beds (2012) and physicians (2009) by department



Source: Developed by the authors based on the registry of accredited providers (Ministry of Health and Social Protection, 2012c), population projections from the National Administrative Department of Statistics (DANE, 2012) and Ministry of Social Protection, 2009a

One would have expected the Ministry of Health to be the first in line to adjust the contents of the HBP according to the needs of Colombians.

Lessons and Recommendations

The following lessons and recommendations can be drawn from Colombia’s experience.

- Benefit plans have not only a technical dimension but a political one as well. In Colombia, political arguments about acquired rights overshadowed technical arguments when it came time to design the HBP, even though a “dream team” of international experts in priority setting had been assembled. Similarly, given the non-technical limitations, the government chose to set a premium well below the actual cost of the benefit plan. Therefore, in addition to defining and adjusting the HBP and its cost from a technical perspective, it is necessary to construct a solid institutional framework where participatory, transparent and systematic processes take priority. Otherwise, the government runs the risk of defining and adjusting the benefit plan using criteria that respond more to the political situation or interests of a few, rather than the real needs and capabilities of the country.
- Any gap or ambiguity in the HBP coverage or in the handling of excluded services that is not resolved by government health entities will be resolved by other stakeholders, whose objectives do not necessarily match those of government health entities. That is what occurred when the judiciary intervened with respect to the entities responsible for updating the POS. Although these

- court interventions have sought to uphold individual rights, they make management of the system difficult because they consider neither defined priorities nor fiscal constraints.
3. Several technical tools guide and strengthen the development and adjustment of benefit plans. Colombia has increasingly relied on clinical practice guidelines and techniques in health technology assessment. A clear and explicit methodology encourages stakeholders to trust and believe in the process.
 4. Authorities must systematically and consistently follow adjustment methodologies. In Colombia, the inclusion of medications in the POS that had not been subjected to the explicit assessment methodology put forward by the CRES, the entity responsible for adjusting the HBP at that time, placed the entire adjustment process under scrutiny. Some critics have even called for these decisions to be declared invalid since they did not follow due process. Acknowledging and justifying decisions—in an explicit and transparent manner—when it was necessary to deviate from the methodology strengthens the formulation and adjustment processes of an HBP.
 5. The adjustment of an HBP requires significant time and financial resources as well as capabilities. Making ad hoc adjustments without the necessary resources will expose coverage decisions to criticism and detract from their legitimacy.
 6. Judicial and exceptional mechanisms to access services not included in the HBPs, together with the lack of an explicit strategy to manage these uncovered services, form an explosive combination for health systems. In Colombia, public spending on non-POS drugs has skyrocketed and threatens the system's sustainability and legitimacy. The design and adjustment of an HBP must be accompanied by an explicit policy on how to handle the services excluded from the plan as well as a clear policy on pharmaceuticals.
 7. A benefit plan favors universal health care; it makes provisions for a system that separates the functions of financing (responsibility of the government) and insurance (responsibility of the EPSs). In Colombia, a benefit plan was a necessary step to incorporate the EPSs as insurers. The POS established the obligations of the EPSs, while the CPU defined the obligation of the government to the EPSs. Quantifying the cost of care enabled the country to determine the scope of and appropriate the necessary resources to provide universal health insurance.
 8. The fact that a benefit plan is legitimate and well-designed is not enough to ensure successful implementation. Other factors are required: a micro- and macro-financial balance, mechanisms to ensure the quality of care provided, dissemination of information to the public, mechanisms for people to demand their rights with regard to the plan, and sufficient physical and human resources to provide the plan. If any of these factors are absent, the population will experience problems accessing the benefit plan.
 9. There are no studies that can say with absolute certainty that the CPU will be sufficient to provide the POS under adequate conditions of access and quality. The withdrawal of several insurers from the subsidized regime after the two plans were equalized in terms of their coverage (POS) but not in terms of the premium received by the insurers (CPU) might indicate that the allocated resources are insufficient, at least in the subsidized regime. The geographic distribution of human resources and the installed capacity is very unequal and places conditions on the possibility of

delivering POS services to the entire population. This underscores the need to reconcile economic resources with the services the government seeks to guarantee.

10. Studies to determine the calculation of the premium must be performed even though the data is problematic. By highlighting flaws and information needs, studies could improve data availability and quality, leading to a virtuous cycle.
11. Among the factors that have undermined the legitimacy of

the POS, the following stand out: incentives to access excluded benefits, the illusion that anything clinically effective has the potential to be funded, and the idea that medical autonomy is unconstrained. These same elements could undermine the HBPs of countries in similar situations. Perhaps this is the most important lesson of the Colombian case and a great opportunity for other countries to learn from the failure of the POS.

References

- ACEMI (Colombian Association of Comprehensive Medical Providers). 2011. "ACEMI se pronuncia sobre el valor de la UPC anunciado por el Gobierno." Press release. Available at: <http://www.acemi.org.co/images/documentos/ACEMI%20sobre%20ajuste%20de%20la%20UPC.pdf>. Accessed: September 2013.
- Alcaldía (Bogotá Mayor's Office), Distrito Capital. 2007. Decreto 122 de 2007. 29 de marzo.
- Ariza J. F., U. Giedion and A. Pulido. 2007. *Hitos centrales en el diseño, implementación y ajuste del POS*. Bogotá, Programa de Apoyo a la Reforma de Salud (PARS), Ministerio de la Protección Social.
- Barón G. 2007. *Cuentas de salud de Colombia 1993-2003*. Bogotá, Ministerio de Salud.
- Barraza Llorens M. 2012. *Política farmacéutica y priorización en salud: el caso de México*. Mexico DF, IDB.
- Bonilla J. 2009. "El derecho a la información en la sentencia T760. Revisión de la sentencia T760 de la Corte Constitucional." Dirección de Aseguramiento, Ministerio de la Protección Social, Bogotá.
- Camargo M. del P. 2011. "¿Por qué los médicos se oponen al nuevo POS?" *Semana*. Available at: <http://www.semana.com/nacion/articulo/por-que-medicos-oponen-nuevo-pos/250467-3>. Accessed: September 2013.
- Cañón O. I., L. A. Daza Castillo, M. P. Gómez, I. Moreno and J. S. Rodríguez. 2010. "High-cost medications in 10 countries: A cross-sectional comparative study." *Value in health*, A123 PMS8.
- Castaño Yepes R. 2004. *Elementos fundamentales del equilibrio financiero del sistema general de seguridad social en salud, que inciden en las decisiones de ajuste del POS y/o de la UPC*. Bogotá, Fundación Corona.
- Cendex (Centro de Proyectos para el Desarrollo). 2006. Encuesta Nacional de Salud 2005.
- CNSSS (National Council on Social Security in Health). 2003. Acta n.º 142. 23 de diciembre.
- _____. 2004. Acuerdo n.º 000260 de 2004. Por el cual se define el régimen de pagos y cuotas moderadoras dentro del Sistema General de Seguridad Social en Salud.
- Congreso de la República. 1982. Ley 21 de 1982.
- _____. 1993. Ley 100. Por la cual se crea el sistema de seguridad social integral y se dictan otras disposiciones.
- _____. 2010. Ley 1393 de 2010.

_____. 2011. Ley 1438. Por medio de la cual se reforma el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones.

_____. 2013. Ley estatutaria de salud.

Corte Constitucional (Constitutional Court). 2008. Sentencia T-760.

_____. 2010. Sentencia C-252.

_____. 2012. Auto 064 de la sala especial de seguimiento.

Cortés Castillo C. 2009. "El Plan Obligatorio de Salud: antes no; ahora, tampoco." *La Silla Vacía*. 1 de octubre. Available at: <<http://www.lasillavacia.com/historia/4554>>. Accessed: September 2013.

CRES (Health Regulatory Commission). 2011a. Actualización integral del Plan Obligatorio de Salud 2011. Anexo 9: "Fichas de supresión de medicamentos."

_____. 2011b. Actualización integral del Plan Obligatorio de Salud 2011. Anexo 1: "Metodología para la actualización integral del Plan Obligatorio de Salud del Sistema General de Seguridad Social en Salud."

_____. 2011c. Acuerdo 30 de 2011.

_____. 2011d. *Actualización integral del Plan Obligatorio de Salud del Sistema General de Seguridad Social en Salud*.

_____. 2011e. Acuerdo 29 de 2011.

_____. 2011f. "Efectividad, seguridad y análisis económico de la inmunoglobulina antitimocítica (equina y leporina) en el tratamiento de la anemia aplásica." Available at: <http://www.minsalud.gov.co/salud/POS/Documents/CRES/Actualizacion%20POS%202011/Inmunoglobulina%20Antitimoc%3%ADtica%20%20Anemia%20Apl%3%A1sica%20Informe.pdf>. Accessed: September 2013.

_____. 2011g. "Estimación del valor de la unidad de pago por capitación de los regímenes contributivo y subsidiado." Bogotá, unidad administrativa especial de la CRES.

Cubillos Turriago L. and J. Castrillón Correa. 2009. *Condiciones médicas priorizadas para la realización del primer grupo de guía de atención integral -GAI- para la actualización del los planes obligatorios de salud -POS*. Bogotá, Ministerio de la Protección Social.

DANE (National Administrative Department of Statistics). 2012a. Population estimates 1985-2005. Available at: http://www.dane.gov.co/files/investigaciones/fichas/Metodologia_estimaciones.pdf

_____. 2012b. Proyecciones de población 2005-2020 nacional y departamental desagregado por área, sexo y grupos quinquenales de edad. Statistical information. Database available at: http://www.dane.gov.co/files/investigaciones/poblacion/proyepobla06_20/VisorCertificaPPO_Oct11.xls. Accessed: September 2013.

- Defensoría del Pueblo. 2007a. *Autonomía médica y su relación con la prestación de los servicios de salud*. Bogotá, Imprenta Nacional de Colombia. Available at: http://www.defensoria.org.co/red/anexos/publicaciones/aut_med.pdf. Accessed: September 2013.
- _____. 2007b. *La tutela y el derecho a la salud*. Período 2003-2005. Bogotá. Available at: http://www.defensoria.org.co/red/anexos/publicaciones/tutela_salud.pdf. Accessed: September 2013.
- Departamento Nacional de Planeación (National Planning Department). 2012. *Política farmacéutica nacional*. Documento Conpes social 155. Bogotá, Consejo Nacional de Política Económica y Social. Available at: <http://www.minsalud.gov.co/Documentos%20y%20Publicaciones/Politica%20Farmac%C3%A9utica%20Nacional.pdf>. Accessed: September 2013.
- Drummond M. and C. Sorenson. 2009. "Nasty or Nice? A perspective on the use of health technology assessment in the United Kingdom." *Value in health*, 12 (Supplement 2), S8-S13.
- Echavarría Aguirre M. 2004. "Evaluación de la calidad técnica en prestación de servicios de salud. Ojo con la calidad en salud, porque no todo es lo que parece." *El Pulso. Periódico para el sector de la salud*, año 6, n.º 68, mayo.
- Econometría SA. 2011. Producto 2A. Diagnóstico de la situación 2011. Parte A - Medicamentos. Final report.
- Eddy D. M. 1996. "Clinical decision making: from theory to practice. Benefit language: criteria that will improve quality while reducing cost." *JAMA*, vol. 275, n.º 8: 650-7.
- Flórez C. E., V. E. Soto, O. L. Acosta et al. 2007. *Avances y desafíos de la equidad en el sistema de salud colombiano*. Bogotá, Fundación Corona.
- Gerencie. 2011. "Histórico del salario mínimo y del auxilio de transporte en Colombia." Available at: <http://www.gerencie.com/historico-del-salario-minimo-y-del-auxilio-de-transporte-en-colombia.html>. Accessed: September 2013.
- Gestarsalud and Centro Nacional de Consultoría. 2009. "Reforma propuesta al sistema de salud." Available at: <http://gestarsalud.com/logrosycriterios/images/PDF/postura%20reforma%20a%20la%20salud.pdf>. Accessed: September 2013.
- Giedion U. and Á. López. 1996. *Heterogeneidad financiera territorial y homogeneidad en la política de salud*. Harvard University (Health Reform Support Program) and World Bank (Municipal Systems Program).
- Giedion U. et al. 2007. "Entrevistas estructuradas a actores claves." Documento sobre diseño, ajuste e implementación de los planes de beneficios en el Sistema General de Seguridad Social en Salud. Bogotá, Ministerio de la Protección Social, Programa de Apoyo a la Reforma de Salud.
- Giedion U., G. Panopoulou and S. Gómez-Fraga. 2009. *Diseño y ajuste de los planes de beneficios: el caso de Colombia y México*. Santiago, Chile, United Nations. (Development Financing Series).

- Giedion U. and M. Villar Uribe. 2009. "Colombia's Universal Health Insurance System." *Health Affairs*, vol. 28, n.º 3: 853-63.
- Glassman A., M. L. Escobar, U. Giedion and A. Giuffrida. 2009. *From few to many: a decade of health insurance expansion in Colombia*. Washington, DC, IDB and Brookings Institution.
- Grupo de trabajo del proyecto participación ciudadana para definir las metodologías y propuestas de actualización del POS y fijación de la UPC en Bogotá. 2010. Comunicado enviado a la CRES el 9 de diciembre.
- Guzmán Paniagua H. 2012a. "Gobierno insiste en acabar con la CRES." *El Pulso. Periódico para el sector de la salud*, año 14, n.º 168, septiembre. Available at: <http://www.periodicoelpulso.com/html/1209sep/debate/debate-14.htm>. Accessed: September 2013.
- _____. 2012b. "Promotor de la CRES dio apoyo crítico." *El Pulso. Periódico para el sector de la salud*, año 14, n.º 168, septiembre. Available at: <http://www.periodicoelpulso.com/html/1209sep/debate/debate-16.htm>. Accessed: September 2013.
- Hsiao W. and P. Shaw. 2007. *Social health insurance for developing nations*. Washington, DC, World Bank.
- IETS (Health Technology Assessment Institute). 2012. Estatutos. Bogotá.
- ISPOR Colombia (International Society for Pharmacoeconomics and Outcomes Research). 2011. "Observaciones metodológicas generales del proceso de evaluación." Unpublished document.
- Iunes R., L. Cubillos-Turriago and M. L. Escobar. 2012. "Universal Health Coverage and Litigation in Latin America." Washington, DC, World Bank.
- Lewin J. E. 2012. "Al autorizar el Misoprostol, la CRES le da otro golpe al Procurador." *La Silla Vacía*, 5 de octubre. Available at: <http://www.lasillavacia.com/historia/al-autorizar-el-misoprostol-la-cres-le-da-otro-golpe-al-procurador-36406?page=3>. Accessed: September 2013.
- López G. J. J. 2012. "Los medicamentos inútiles del POS." *UN Periódico*, n.º 152, 11 de febrero. Available at: <http://www.unperiodico.unal.edu.co/dper/article/los-medicamentos-inutiles-del-pos-1.html>. Accessed: September 2013.
- Martínez Tamayo A. M. and J. C. Valdez. 2009. *Indización y clasificación de bibliotecas*. Buenos Aires, Alfagrama.
- Ministerio de la Protección Social (Ministry of Social Protection). 2005. *Guía para el manejo de VIH/SIDA basada en la evidencia Colombia*. Bogotá, Fedesalud.
- _____. 2008. Resolución 01747. Por la cual se modifica la resolución 634 de 2006. 21 de mayo. Bogotá. Available at: <http://www.alcaldiabogota.gov.co/sisjur/normas/Norma1.jsp?i=30469>. Accessed: September 2013.
- _____. 2009a. Composición de la oferta de profesionales de medicina en Colombia 2009. Bogotá. Available at: <http://www.minsalud.gov.co/salud/documents/observatorio%20talento%20humano%20en%20salud/>

- composici%3%93n%20oferta%20de%20profesionales%20en%20colombia.pdf. Accessed: September 2013.
- _____. 2009b. Decreto 4975 de 2009. 23 de diciembre. Bogotá. Available at: http://www.secretariassenado.gov.co/senado/basedoc/decreto/2009/decreto_4975_2009.html. Accessed: September 2013.
- _____. 2010a. *Estudio de suficiencia y de los mecanismos de ajuste de riesgo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2011*. Bogotá, Ministerio de la Protección Social. Available at: http://www.minsalud.gov.co/salud/POS/Documents/sitio/Estudio_Suficiencia_POS_UPC_2009_Def.pdf. Accessed: September 2013.
- _____. 2010b. *Sostenibilidad de la subcuenta de compensación del FOSYGA y financiación del régimen subsidiado*. Bogotá. Available at: <http://www.minsalud.gov.co/Normatividad/Acuerdo%20019%20de%202010%20-%20Anexo%206%20-%20Sostenibilidad%20del%20Fosyga%20-%20R%20C3%A9gimen%20subsidiado.pdf>. Accessed: September 2013.
- _____. 2011a. *Estudio de la suficiencia y de los mecanismos de ajuste de riesgo para el cálculo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2006*. Colección Estudios de Suficiencia UPC-POS. Bogotá, Ministerio de la Protección Social. Available at: <http://www.minsalud.gov.co/salud/POS/Documents/sitio/Estudio%20de%20Suficiencia%20UPC-POS%202006.pdf>. Accessed: September 2013.
- _____. 2011b. *Estudio de la suficiencia y de los mecanismos de ajuste de riesgo para el cálculo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2007*. Colección Estudios de Suficiencia UPC-POS. Bogotá, Ministerio de la Protección Social. Available at: <http://www.minsalud.gov.co/salud/POS/Documents/sitio/Estudio%20Suficiencia/Estudio-suficiencia-UPC-POS-2007.pdf>. Accessed: September 2013.
- _____. 2011c. *Estudio de la suficiencia y de los mecanismos de ajuste de riesgo para el cálculo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2008*. Colección Estudios de Suficiencia UPC-POS. Bogotá, Ministerio de la Protección Social. Available at: <http://www.minsalud.gov.co/salud/POS/Documents/sitio/Estudio%20de%20Suficiencia%20UPC-POS%202008.pdf>. Accessed: September 2013.
- _____. 2011d. *Estudio de la suficiencia y de los mecanismos de ajuste de riesgo para el cálculo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2009*. Bogotá. Ministerio de la Protección Social. Colección Estudios de Suficiencia UPC-POS. Bogotá, Ministerio de la Protección Social. Available at: <http://www.minsalud.gov.co/salud/POS/Documents/sitio/Archivos/Estudio%20de%20Suficiencia%20UPC-POS%202009.pdf>. Accessed: September 2013.
- _____. 2011e. *Estudio de la suficiencia y de los mecanismos de ajuste de riesgo para el cálculo de la Unidad de Pago por Capitación para garantizar el Plan Obligatorio de Salud en el año 2010*. Bogotá, Ministerio de la Protección Social. Colección Estudios de Suficiencia UPC-POS. Bogotá, Ministerio de la Protección Social. Available at: <http://www.minsalud.gov.co/salud/POS/Documents/sitio/ACTUALIZACI%3%93N%20POS%202012/Estudio%20de%20Suficiencia%20UPC-POS%202010.rar>. Accessed: September 2013.

- _____. 2011f. Resolución 477. Por la cual se define el monto de la cotización obligatoria de los afiliado al régimen contributivo que se destina a la financiación de la subcuenta de solidaridad del FOSYGA.
- Ministerio de Salud (Ministry of Health). 2000. Resolución 412 de 2000.
- Ministerio de Salud and Programa de Apoyo a la Reforma de Salud (Health Reform Support Program), Harvard University. 1996. *La reforma de salud en Colombia y el Plan Maestro de Implementación*. Health Reform Support Program-IDB.
- Ministerio de Salud and CNSSS (National Council on Social Security in Health). 1994a. Acuerdo n.º 009 de 1994.
- _____. 1994b. Acuerdo n.º 011 de 1994.
- Ministerio de Salud y Protección Social (Ministry of Health and Social Protection). 2012a. Decreto 2560.
- _____. 2012b. Boletín de prensa n.º 311. 3 de octubre. Available at: <http://www.minsalud.gov.co/Paginas/Creacion-de-Fondo-unico-para-recaudar-todos-los-recursos-de-la-salud.aspx>. Accessed: September 2013.
- _____. 2012c. Registro especial de prestadores de servicios de salud. Available at: <http://201.234.78.38/habilitacion/>. Accessed: September 2013.
- _____. 2012d. Respuesta a cuestionario realizado por el presidente de la Comisión séptima del Senado de la República. Proposición 20, 21 y 28.
- Molina C. G. and U. Giedion. 1994. *Distribución del gasto público en salud en Colombia*. Bogotá, Fedesarrollo.
- Montoya C. M. 2003. “Continúan tropiezos en verificaciones de habilitación de IPS.” *El Pulso. Periódico para el sector de la salud*, año 5, n.º 60, septiembre. Available at: <http://www.periodicoelpulso.com/html/sep03/general/general-09.htm>. Accessed: September 2013.
- Muñoz M. N. 2012. “Política de precios de medicamentos.” 19.º foro farmacéutico ANDI. Cartagena, Ministerio de Salud y Protección Social.
- Núñez J., J. G. Zapata, C. Castañeda, M. Fonseca and J. Ramírez. 2012. *La sostenibilidad financiera del sistema de salud colombiano. Dinámica del gasto y principales retos de cara al futuro*. Bogotá: Fedesarrollo.
- Observatorio del Medicamento, Federación Médica Colombiana, Colegio Médico de Cundinamarca. 2010. “Una muestra de factores antihemofílicos VIII y IX incluidos en el POS que habrían sido recobrados como ‘No POS’ por más de Col\$ 15.000 millones.” *Boletín Informática & Salud - Boletín del Consumidor de Medicamentos*, año 20, n.º 44, 25 al 31 de octubre. Available at: http://www.med-informatica.net/BIS/BisBcm44de2010_25a31oct10.htm. Accessed: September 2013.
- Pinto D. 2010. Estrategia del BID con Colombia: 2011-12. Nota Sectorial: “Sistema general de salud.” IDB.

- Plaza B. 1996. "Cost effectiveness & priority setting case study." Washington, DC, World Bank.
- Pontificia Universidad Javeriana-Cendex (Cendex, Javeriana University). 2009. Encuesta Nacional de Salud 2007. Bogotá, Fundación Cultural Javeriana de Artes Gráficas.
- Presidencia de la República. 1994. Decreto 1650 de 1994.
- _____. 2006. Decreto 1011 de 2006.
- _____. 2009. Decreto 4975 de 2009.
- _____. 2012a. "Declaración del Presidente Juan Manuel Santos sobre el sector salud." 19 de julio. Available at: http://wsp.presidencia.gov.co/Prensa/2012/Julio/Paginas/20120719_06.aspx. Accessed: September 2013.
- _____. 2012b. Decreto ley 19. 10 de enero.
- Procuraduría General de la Nación, Cendex and USAID (U.S. Agency for International Development). 2011. *Financiamiento del Sistema General de Seguridad Social en Salud. Seguimiento y control preventivo a las políticas públicas*. Bogotá, ECOE ediciones. Available at: <http://www.procuraduria.gov.co/portal/media/file/Publicaci%C3%B3n%20-%20Finanzas%20en%20Salud.pdf>. Accessed: September 2013.
- Profamilia. 2000. Encuesta Nacional de Demografía y Salud. Bogotá, Profamilia.
- _____. 2011. Encuesta Nacional de Demografía y Salud 2010. Bogotá, Profamilia. Available at: http://www.profamilia.org.co/encuestas/Profamilia/Profamilia/index.php?option=com_content&view=article&id=62&Itemid=9. Accessed: September 2013.
- Ramírez Moreno J. 2011. "Las instituciones y los mercados en el sistema general de seguridad social en salud." Presentación en 18 Foro Farmacéutico ANDI.
- Red de priorización y planes de beneficios en salud. 2012. IDB.
- Rossi Buenaventura F., L. M. Umbacía and E. Sánchez. 2012. *Inclusiones de medicamentos incorporados en el Plan Obligatorio de Salud (POS) - Acuerdo 029 de 2011*. Bogotá, IFARMA.
- Ruiz Gómez F., L. Amaya Lara , L. Garavito Beltrán and J. Ramírez Moreno. 2008. *Precios y contratos en salud. Estudio indicativo de precios y análisis cualitativo de contratos*. Colección PARS. Bogotá, Cendex. Available at: <http://www.cendex.org.co/GPES/publicaciones/libros/Precios.pdf>. Accessed: September 2013.
- Silva D. 2012. "Denisse Silva, vocero de Pacientes Colombia, denuncia fallas en los servicios de salud. Sandra Camacho, directora de la Asociación Colombiana de Empresas de Medicina, responde." *W radio*, 1 de marzo.
- Steiner R. 2011. "Reflexiones sobre la dinámica del gasto en Salud." XVIII foro farmacéutico de la ANDI. Cartagena, Fedesarrollo.

- Supersalud (National Health Superintendency). 2007. Circular externa 047 de 2007. Circular única, 30 de noviembre.
- _____. 2009. Certificación técnica de calidad en la gestión pública (Norma NTCGP 1000:2004).
- _____. 2012. “Entidades promotoras de Salud. Regimen contributivo y subsidiado. Informe de situación financiera. Marzo de 2012.” Available at: <http://www.supersalud.gov.co/supersalud/LinkClick.aspx?fileticket=dt0XRxDSDgo%3D&tabid=443&mid=1545>. Accessed: September 2013.
- Tocarruncho Ariza, L. H. 2011. “Tecnologías en salud iniciales para evaluación al Plan Obligatorio de Salud.” Informe para la CRES.
- Universidad de Antioquia (University of Antioquia). 2007. “Reforma a la regulación en salud en Colombia: del Consejo Nacional a la Comisión de Regulación.” *Observatorio de la Seguridad Social*. n.º 16: 1-16.
- Universidad de los Andes (University of the Andes). 2012. *El libro blanco de la salud*. Bogotá, Uniandes.
- Uprimny, R. 2013. “La protección judicial del derecho a la salud en Colombia: tendencias, debates y perspectivas.” Seminario a distancia, 25 de junio. World Bank.
- Varela A., G. Carrasquilla and T. Tono. 2002. “Asimetría en la información: barreras para la implementación de la reforma de salud en Colombia.” *Colombia Médica*, vol. 33, n.º 3: 95-101.
- Zapata J. G., D. Pinto and J. L. González. 2010. “Análisis de la dinámica del gasto en salud en Cundinamarca y en los hospitales del departamento.” Fedesarrollo.

Chapter 3



{ Uruguay: The Comprehensive Health Care Plan (PIAS)

Silvia Molins, Lucía Alonso and Jorge Fernández

Summary

Context. Uruguay's health system, known as the National Integrated Health System (SNIS), separates the functions of service delivery and financing. Both public and private providers participate in service delivery. Financing is separated by level of complexity: the National Resource Fund (FNR) finances more complex services, while the National Health Fund (FONASA) finances those classified as low and medium complexity. Uruguay was the first country in Latin America to offer an explicit, comprehensive and equal health care plan for its entire population.

Key elements of the Comprehensive Health Care Plan. The Comprehensive Health Care Plan (PIAS) constitutes a health benefit plan with explicit guarantees (positive list), which clearly and precisely describes the health services to which the population is entitled. One goal of PIAS is to achieve universal and equal access to health care. Despite being financed by different funds, the plan covers almost the entire population.

PIAS has two major components: the national health care programs, which are health promotion and prevention initiatives aimed at specific age groups, and the explicit list of benefits for secondary and tertiary prevention services at all levels of care. The list of benefits consists of the following:

- 1) low/medium-complexity, low/

medium-cost diagnostic and therapeutic benefits (PBMCs); 2) low/medium-cost medications (MBMCs); and 3) high-specialization, high-cost diagnostic and therapeutic benefits and high-cost, high-economic-impact medications (PyMACs). PIAS replaced the approach of specifying exclusions with one that clearly and accurately describes the health benefits to which the population is entitled, such that they constitute an explicit, enforceable and equitable guarantee of availability to all citizens. From a rights perspective, PIAS offers a comprehensive approach, with primary, secondary and tertiary initiatives at all levels of complexity.

In terms of the plan's operations, it is worth highlighting the management contracts between the governing entity, the National Board of Health (JUNASA), and the comprehensive health care providers, which function as health service providers and coordinators. These contracts define goals and quality criteria for the services included in the health benefit plan (HBP). This coordination between the content of the benefit plan and payment mechanisms that reward performance is a characteristic shared only by Uruguay's PIAS and Argentina's Plan Nacer/SUMAR.

Another noteworthy aspect of PIAS relates to the establishment of clinical management standards defined in handbooks, technical guidelines and

corresponding protocols to aid in the selection of prioritized procedures. This links priority setting to the standardization of medical practice.

The comprehensive management of high-cost technologies centralized in the FNR, another PIAS innovation, facilitates the coordination of high-cost interventions, from funding and priority setting to monitoring of the use of these technologies.

Outcomes. As in the other cases reviewed in this book, Uruguay does not have a monitoring and evaluation system specific to HBP performance. However, through the use of management contracts that reward fulfillment of priority health goals (along with the copayment

reduction policy, among other aspects), it is considered that several health care indicators have improved, such as out-of-pocket spending and wait times, as well as some health indicators such as maternal mortality rate.

Challenges. The shared management of PIAS between two entities—the Ministry of Public Health (MSP) and the FNR—presents a challenge to both in terms of coordination. For one, centralizing the management of high-cost interventions in a single autonomous entity such as the FNR is advantageous; however, doubt still remains as to whether shared management may sometimes lead to a duplication of functions. Regardless, the need to strengthen the coordination of both institutions has been identified.

Basic Elements of the Comprehensive Health Care Plan

Name of HBP	Comprehensive Health Care Plan
Year plan began operations	2008
Central motivation	Equity in access to explicit and enforceable benefits
Target population	Universal
Service coverage	Comprehensive coverage of all services, from preventive care to curative care and rehabilitation
Financial coverage	No copayments for hospital benefits or health promotion and prevention services Capped copayments for ambulatory care and some exemptions
Population coverage	Ninety-five percent of the country's total population (2012)
Estimated annual cost per capita	Annual premium of US\$650 per beneficiary (2011)
Percentage of public health resources channeled to HBP funding	Approximately 72% (2008)
Provision of non-prioritized services	Access to services not included in PIAS depends on the purchasing power of the population that demands them or the decision of providers to offer these services at their own risk. In addition, there are governmental and non-governmental organizations that provide non-compulsory benefits, primarily to low-income individuals
Principal innovations	Management contracts for benefit fulfillment
	Establishment of standards for covered services, indicating clinical conditions and subpopulations for which the service is available
	Comprehensive management of high-cost technologies, from explicit priority setting to monitoring
	First country in Latin America to offer an explicit, comprehensive and equal health care plan for its entire population

Health care reform in Uruguay introduced a change in the model of care, which shifted its focus from a curative orientation to a preventive one. However, PIAS does not yet reflect this new approach to the model of care, which underscores the need for the plan to mesh with health system policies.

Introduction

Uruguay ranks as one of the countries with the highest human development index in Latin America and the Caribbean (UNDP, 2009). The country's distribution of income is among the most equitable in the Americas, and its education levels and life expectancy stand above regional averages. With regard to the health care system, Uruguay is the country with the highest per capita public investment in health in the region, equivalent to US\$1,210 in purchasing power parity (PPP) terms.¹ The country has a population of less than four million people, 12.4% of whom fall below the poverty line. Its gross income per capita is the second highest among Latin American countries, with US\$14,640 PPP.² The country is predominantly urban, with 92.4% of its population living in cities, including half in the capital of Montevideo.

In terms of its epidemiological profile, Uruguay's population is rapidly aging. According to 2010 data, the 65-and-over population accounted for 13.9% of the total population, as compared to the regional average of 6.9%. The falling birth rate coupled with increased life expectancy reinforces this trend. The main causes of death are circulatory diseases, while the number of deaths from infectious diseases has declined over

the last two decades (Ministry of Public Health, 2010). The infant mortality rate (IMR) is lower than the regional average, with 10 deaths per 1,000 live births (2011 data), and the maternal mortality rate in 2010 was 29 per 100,000 live births, the lowest in the region.³

With regard to its health care system, prior to the 2007 reforms, Uruguay had a segmented system comprised of two subsectors: 1) a private subsector financed by a contribution based on a sliding scale and assumed by the Social Security Institute⁴ (formerly known as the Social Insurance Bank) for formal workers in the private sector, or by direct payment for those with the ability to pay who were not formal workers and 2) a public subsector⁵ for informal workers and the population unable to pay. The covered health benefits for these populations were not explicitly defined, and variability was observed in the coverage provided by both subsystems. Explicitly-defined exclusions—for example, cosmetic surgery and psychotherapy—established by the MSP only existed for not-for-profit health providers. This led to differences between providers, both in the scope of benefits as well as the copayments they were authorized to charge, a problem that has not yet been fully resolved. In short, prior to the reforms, there was no recognition of true universal access to comprehensive, regulated, planned coverage sustained over time and of equal quality for all.

In 2007, Uruguay reformed its health care system and created the National Integrated Health System (SNIS). The country then became one of the few in Latin America that offers a unified insurance system and an explicit, equal plan for all, which improves upon the

¹ According to the Global Health Observatory (GHO) data repository of the World Health Organization: <http://apps.who.int/gho/data/node.main.75>, Accessed: September 2013.

² World Bank database, health expenditure per capita: <http://datos.bancomundial.org/indicador/SH.XPD.PCAP>, Accessed: September 2013.

³ According to the Global Health Observatory (GHO) data repository of the World Health Organization: <http://apps.who.int/gho/data/node.main.75>, Accessed: September 2013.

⁴ The Social Security Institute contracted with not-for-profit health providers to provide low- and medium-complexity health care services to formal workers from the private subsector.

⁵ The public subsector is represented by the following providers: National Health Services Administration, National Directorate of Armed Forces Health Services, National Directorate of Police Health Services, and the Clinical Hospital of the School of Medicine.

previously segmented health care system that characterizes many countries in the region.

The National Health Insurance (SNS) program was created together with SNIS, based on a foundation of distributive justice in the funding of health expenditures, thus ensuring the equity, solidarity and sustainability of the system. The creation of a link between the entire population and this single insurance system was the institutional basis for the design and implementation of a health benefit plan known as the Comprehensive Health Care Plan, which homogeneously offers a set of explicit health benefits, regardless of citizens' affiliation or socioeconomic status. Institutions accredited as comprehensive SNIS providers must guarantee the HBP to users, either through their own services or those of a third party.

Reasons for and Adoption of PIAS

Background

The fragmentation and segmentation of health care services, along with political reasons and the lack of universal coverage and comprehensive care, generated the need and motivation to reform the health care system and to achieve greater equity in access to benefits.

Nevertheless, the reforms maintained the framework of high-cost, high-complexity benefits which was already explicitly handled and administered by the FNR since its creation in 1980.⁶ The FNR acts as a reinsurance that covers the entire insured population, regardless of individuals' income. It resulted from an initiative led by groups of medical

professionals that encouraged the creation of a special funding mechanism for dialysis treatments, heart surgery, pacemakers and hip replacements. More procedures were added later, and beginning in the year 2000, high-cost drugs, such as those for cancer, were also included.

In 2005, under the first administration of the Frente Amplio party, Uruguay proposed health care reforms, which included the creation of the SNIS. In December 2007, the outline of the overall system architecture was finalized in the form of Law No. 18,211 (which established the SNIS). The reform was comprised of three central themes:

- *Changes to the financing model:* principles of equity and solidarity were guaranteed through the National Health Insurance program, which is administered by JUNASA (composed of representatives of the Ministry of Public Health, Social Insurance Bank, Ministry of Economy and Finance, providers, beneficiaries and workers) and financed by a single, compulsory, public fund known as FONASA for low/medium-complexity, low/medium-cost benefits. This framework is complemented by the FNR for high-complexity, high-cost benefits.
- *Changes to the management model* in order to make it more democratic, efficient, and participatory and to ensure transparency. Although these changes have yet to be implemented, social participation is the key focus of these reforms, with SNIS beneficiaries and workers participating in JUNASA, the health care system's highest governing body, while private and public providers are included at the micro level (consultative and advisory councils at private providers

⁶ Created in 1980 by Law No. 16,343, the FNR is a reinsurance system for high-complexity, high-cost health technologies used in the treatment of "catastrophic illnesses." Catastrophic illnesses are defined as very serious health problems that involve a significant monetary outlay relative to household income or in excess of a normal threshold. They generally have a strong impact, and they create a state of temporary or permanent financial insolvency. WHO (2009) defines catastrophic illnesses as those diseases whose treatment involves an out-of-pocket payment greater than or equal to 40% of household income. The role of the FNR is to provide financing for the services that meet these characteristics, which are provided by highly-specialized medical institutions.

and participation on the board of the National Health Services Administration).

- *Changes to the model of care*, which occurred with the help of the following:
 1. A comprehensive health care plan (PIAS) that equalizes the quality and quantity of benefits through an explicit definition enforceable against the health authority
 2. The health care contributions that FONASA transfers to each provider responsible for ensuring PIAS service delivery. These contributions have two components: risk-adjusted capitation (by age and sex) and payment for health care goals. This type of provider payment recognizes the health needs of the population, as well as the differential costs associated with its care
 3. Management contracts between JUNASA and providers, a performance-management tool that aims to incentivize providers to carry out specific activities and achieve the objectives established in the context of health care reform

Since PIAS was created in the context of sector reform, guaranteed comprehensive benefits could be clearly established in return for payment of the health care contribution, with separation of the financing and service delivery functions.⁷

The National Health Insurance program operates within a social insurance framework in which individuals contribute according to their economic

capacity, and they receive care according to their health needs. In addition, FONASA redistributes financial resources from the population groups using health services the least (lowest risk) to the groups requiring more intensive use of services (highest risk). The FNR was included in the reforms and continued operating as it did before.

The comprehensive providers⁸ that compose the SNIS are i) private non-profit institutions (not-for-profit health providers [IAMCs], mutual associations, medical cooperatives, and not-for-profit, physician-owned health facilities); ii) comprehensive private insurance plans authorized by the MSP; and iii) the public provider known as the National Health Services Administration (ASSE). These FONASA providers are paid a premium called the “health care contribution” to provide HBP services considered low/medium-cost and complexity.

High-complexity benefits⁹ financed by the FNR are provided by specialty hospitals (IMAEs). IMAEs are public or private providers authorized by the Ministry of Public Health to offer services covered by PIAS. Each IMAE specializes in an area of medicine, with facilities dedicated to cardiology, orthopedics (hip and knee replacements), dialysis, kidney transplants, etc.

The general architecture of Uruguay’s health care system can be appreciated in figure 3.1.

Goals

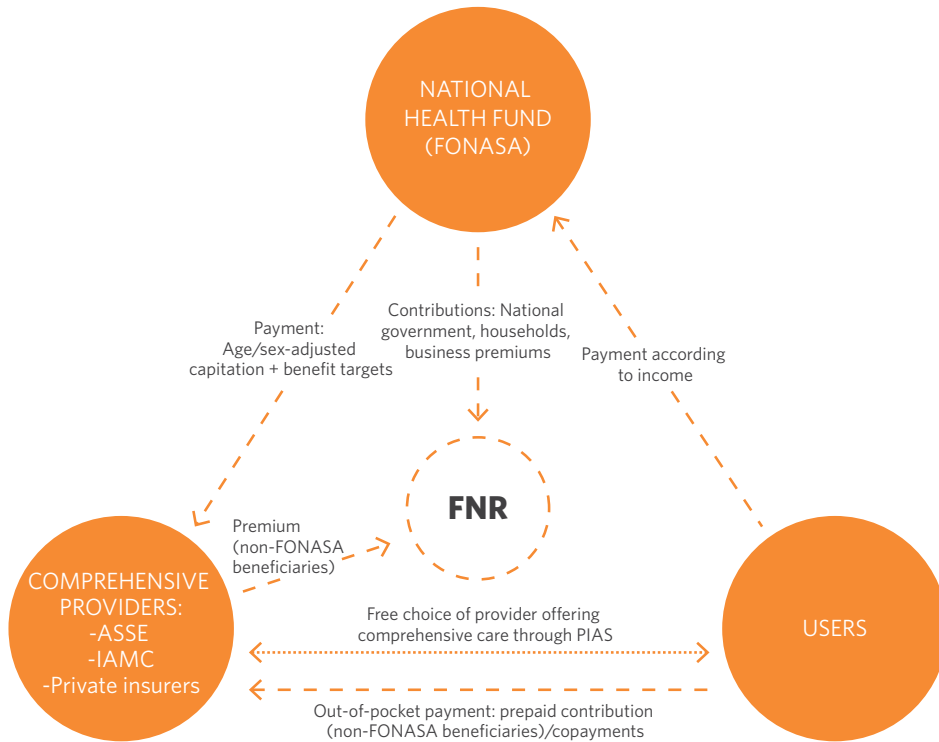
The goals of PIAS are as follows: i) to provide universal access to health care, ii) to ensure equity of benefits, iii) to guarantee a quality of care acceptable to society, iv) to ensure the participation

⁷ The health contribution is comprised of an age- and sex-adjusted capitation payment plus a supplemental payment for compliance with health care goals established as priorities by the national health authority, for example, prenatal check-ups.

⁸ The comprehensive health providers required to comply with the HBP are those public and private institutions that have signed management contracts with JUNASA.

⁹ According to an opinion expressed by the School of Medicine at the University of the Republic (Uruguay), highly-specialized medicine requires a high concentration of human and material resources for a small number of patients for whom a vital or functional prognosis is at stake, coordinated in a manner that allows for excellence in care.

Figure 3.1. National Health Insurance



ASSE: National Health Services Administration; IAMCs: not-for-profit health providers; FNR: National Resource Fund; PIAS: Comprehensive Health Care Plan

Source: Adapted from Ministry of Public Health data

of organized society, and v) to establish a system of universal and equitable financing. These objectives fall within the principles of the SNIS.

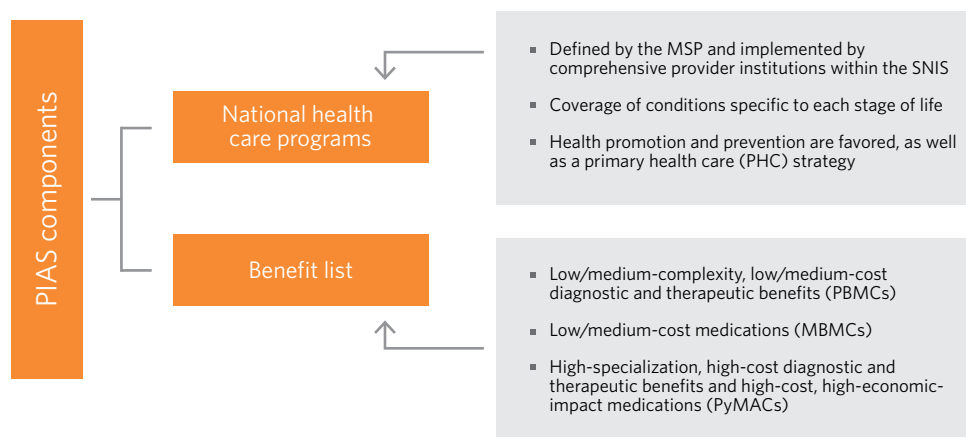
Main Features of PIAS

PIAS has two major components: 1) the national health promotion and prevention programs, defined by the MSP, whose guidelines must be applied by SNIS comprehensive provider institutions to their beneficiaries¹⁰ and 2) a benefit

list (see figure 3.2). In this second component—unlike other countries such as Chile and Peru—the HBP does not detail the conditions to be covered but instead specifies the benefits necessary for diagnosis and treatment, as well as rehabilitation of health problems. In addition, the benefits included in the list are formulated as a positive list of services covered, divided into three subcomponents: PBMCs, MBMCs and PyMACs. Low-, medium- and high-cost medications are consolidated into a list called the therapeutic drug formulary. PyMACs are a legacy of the pre-reform

¹⁰ The programs defined to date are the National Children’s Health Program, National Women’s Health and Gender Program, National Adolescent Health Program, National Health Program for the Elderly, National Oral Health Program, National Mental Health Program, National Disability Program, STI-AIDS Priority Program, National Nutrition Program, National Program for Treatment of Drug Abuse, and the National Tobacco Control Program.

Figure 3.2. PIAS components



Source: Developed by the authors

health care system; since 1980, Uruguay's health care model has explicitly identified some high-cost benefits to meet the needs of the population, benefits which are financed by the FNR.

Population coverage

All persons who reside in the country and have formalized their right to health care through one of the National Health Insurance program's comprehensive provider entities can access the benefits included in PIAS regardless of the type of enrollment.¹¹ Ninety-five percent of the country's population is enrolled in the National Health Insurance program, and an additional 2% access services through the National Directorate of Armed Forces Health Services (DNSFFAA) or the National Directorate of Police Health Services (DNSP). Individuals who are unable to pay receive services from the ASSE. Formal workers and their families, as well as those enrolled in FONASA and able to pay, receive services from IAMCs. In addition, formal workers who make an extra contribution or those who are

not enrolled in FONASA but who make the corresponding payments may receive services from private insurers (see table 3.1). Institutions excluded from the National Health Insurance program, such as the DNSFFAA and the DNSP, pertain to subsystems that cover very specific population groups. Health coverage provided by these institutions spans the entire range of PIAS benefits and, in some cases, includes additional benefits. It is estimated that nearly 100,000 people (i.e., 3% of the population) do not have formal coverage; however, they do have access to the services of the public provider. All public or private health care institutions that have signed management contracts with JUNASA are obligated to comply with the list of benefits.

The scope of coverage

Health care reform in Uruguay shifted the country's curative model of care to a preventive one, with a focus on the primary care level. This created the need to *harmonize the HBP's design with strategic health care planning*. As a result,

¹¹ Institutions providing coverage to beneficiaries of the National Health Insurance program that have a valid management contract with JUNASA (ASSE, IAMCs, comprehensive private insurers) are considered comprehensive SNIS providers.

Table 3.1. Users of the National Health Insurance program by provider type for 2006, 2007, 2008 and 2010

Provider	Target population	Dec. 2006	Dec. 2007	Dec. 2008	Dec. 2010
ASSE	Population without the ability to pay	1,440,264	1,308,593	1,203,702	1,200,000
IAMCs	FONASA: formal workers and their families, retirees				
	Non-FONASA: population with the ability to pay on an individual basis	1,450,867	1,491,874	1,806,750	1,900,000
Private insurers	FONASA: formal workers and their families plus retirees, who access the system by making a supplementary, out-of-pocket prepayment (population with greater income)	64,995	69,167	74,789	80,000
	Non-FONASA: population with greater income (individual payment)				
Total number of National Health Insurance users		2,956,126	2,869,634	3,085,241	3,206,228
% of country's population		91%	89%	95%	95%*

Source: Directorate-General of the SNIS-MSP (2011)

*Note: The National Statistics Institute estimated the country's population in 2010 at 3,356,584.

PIAS turned out to be a very broad HBP intended to cover virtually all of the needs of the population. The compulsory benefits included in PIAS allow for medical exams, diagnosis and treatment of all diseases and health problems in accordance with the technologies available in the country (low/medium-complexity, low/medium-cost diagnostic studies, therapeutic procedures and medications).¹²

While the national health care programs cover conditions specific to each stage of life and favor aspects of health promotion

and prevention of diseases or certain health conditions, the benefit list covers secondary and tertiary prevention at all levels of care and complexity for acute and chronic diseases.

Organization and clinical practice guidelines

Nomenclature used in the benefit list

The benefits that constitute PIAS coverage are grouped into different chapters within the benefit list: 1) types of medical care

¹² For details about PIAS, see <http://www.fnr.gub.uy/cobertura>.

(e.g., inpatient care at all levels, from basic to intensive care; ambulatory care, both office and home visits; facility-based urgent and emergency care, or ambulatory surgery), 2) medical or other professional and technical specialties for health monitoring and recovery, 3) diagnostic procedures, 4) therapeutic and rehabilitation procedures, 5) oral health, 6) medications and vaccines (therapeutic drug formulary), and 7) medical transport. In each of these chapters, the benefits are presented in sections by alphabetical order (e.g., clinical analysis laboratory), type (e.g., imaging), or organ system (e.g., cardiovascular system), as in the case of both diagnostic and therapeutic surgical procedures.

To date, the use of a unique coding system has not been proposed. The only benefits that are coded are surgical interventions, based on the International Classification of Diseases, 9th Edition, whose nomenclature does not correspond to Uruguay's clinical practices, thus proving impractical for the user in many cases. Despite that fact, there have been no problems in terms of misinterpretation or lack of coverage for these procedures, since questions posed by health professionals are quickly resolved by the MSP. However, it may be unclear to patients as to whether an intervention prescribed by a doctor is included on the list, as these interventions are not usually coded.

Standards, guidelines and rules that accompany the plan

All of the PyMACs financed by the FNR are accompanied by coverage standards, guidelines and rules specifying indications or conditions and their criteria for inclusion or exclusion. These evidence-based tools are designed to rationalize the

indications of the benefits covered and to avoid unjustified indications with their attendant risks and costs. In addition, management contracts between JUNASA and comprehensive providers state that providers must develop clinical practice guidelines for conditions prioritized by the MSP, such as hypertension, diabetes, cancer and smoking.

For the PBMCs, considering that their use must be restricted and standardized, the MSP should have a standard or protocol for the list of procedures. However, to date, none of the established benefits has been regulated.

Financial coverage

The Comprehensive Health Care Plan's PBMCs related to hospital care are free and do not require copayments. Providers may only charge sliding-scale copayments (known as *tasas moderadoras*)¹³ for services rendered as part of ambulatory care (vouchers for prescription drugs and medical orders [consultations, studies and procedures]), with a maximum authorized amount for each provider. However, for each adjustment authorization, the current policy of the Ministry of Economy and Finance is to maintain these values below UYU\$1,000 (approximately US\$50). To promote health monitoring and prevention, the government adopted a policy aimed at reducing economic barriers to access, based on the waiver of some copayments and a discount for others,¹⁴ which have a defined flat payment that does not vary according to the socioeconomic status of each beneficiary and no deductibles. In general, the public provider does not charge copayments while private providers do. However, they may waive or discount copayments for large segments of the enrolled population as a means of

¹³ The *tasas moderadoras* are a particular system of copayment, consisting of a fixed amount per service based on income.

¹⁴ These include a) exemption from payment of the medical consultation voucher for well visits for children and adolescents up to age 17, according to guidelines; b) exemption from payment of the voucher for certain paraclinical studies during prenatal check-up, according to guidelines; c) exemption from payment of the voucher for some blood glucose regulators; d) exemption from payment of the voucher for oncologic colposcopy (Pap smear) and mammography, according to guidelines; e) discount on voucher for certain medications to control high blood pressure and certain antipsychotic drugs; and f) free routine analysis for FONASA retirees: basic biannual routine including complete blood count, blood glucose, creatinine, total cholesterol and HDL, urine test, X-ray and annual electrocardiogram.

competition to attract beneficiaries. In the case of benefits that fall under the FNR's financial coverage, beneficiaries do not pay sliding-scale fees (copayments) under any circumstances.

Cost

The annual value assigned to cover low- and medium-complexity benefits and medications is approximately US\$590 per beneficiary. This value corresponds to the 12 monthly installments (capitation payments plus fulfillment of health care goals) that FONASA pays to the comprehensive provider institutions, and it corresponds to the comprehensive health benefit coverage of the PBMCS, according to the Health Economics Division of the MSP. In addition, the average annual cost per capita of the benefit plan funded by the FNR amounts to about US\$60, bringing the FNR's annual budget to US\$15 million. Taking both payments into account, PIAS is estimated to have an annual value of about US\$650 per beneficiary. This value is higher than that of the other cases in this book, reflecting the breadth of Uruguay's HBP coverage and the level of public investment in health undertaken by the country.

Financing

The two types of benefits covered by PIAS, targeting different health contingencies (high-cost and low- or medium-complexity), have different funding sources and are managed by different stakeholders. The low- or medium-complexity PIAS is financed through public sources (general and departmental taxes and compulsory monthly contributions from FONASA contributors, proportional to income and family structure) and private sources (copayments for ambulatory services and prepaid contributions for those individuals who do not contribute to FONASA). The high-complexity PIAS is funded exclusively by the FNR through

public sources (gaming taxes and compulsory contributions through a flat capitation payment). Table 3.2 details the main sources of PIAS financing. To date, there has been no change or policy proposal in terms of the coexistence of these two systems of financing.

A key aspect of the system that allows for adequate financial protection is the disconnect between the contribution and the benefit received. As shown in table 3.2, beneficiaries make contributions in line with their income and they receive services as needed, regardless of the value of their monthly contribution.

Relevance of PIAS to the health care system

In Uruguay, PIAS is seen as a strategic policy tool for the provision of cost-efficient services, which ensures access to health benefits in line with the demographic and epidemiological profile of its population.

This relevance is also explained by the role that the explicit benefit plan has in terms of directing the country's spending. As noted in the analysis of health expenditures for the 2008 fiscal year (the only data available to date), it is estimated that 72% of health expenditures are allocated to the provision of PIAS services (table 3.3).

Furthermore, PIAS plays a major role in service delivery (MSP and PAHO, 2010); it is estimated that 90% of all services available on the market correspond to benefits included in the plan, according to data provided by the Health Economics Division of the MSP.

PIAS Design

Priority-setting method

The fact that the low/medium-complexity and high-cost, high-complexity components of PIAS are independent

Table 3.2. PIAS funding sources

Sources of financing			Types of benefits	
			Low/medium-complexity and cost	High-cost, high-economic-impact (catastrophic)
Public	Taxes	General, departmental	Funds are fully allocated to public institutions (ASSE, National Directorate of Armed Forces Health Services [DNSFFAA], National Directorate of Police Health Services [DNSP]) to finance the compulsory benefits of those who do not contribute to FONASA or those who are unable to pay	
		On gaming		Approx. US\$1,000,000. Represents just 0.7% of the FNR's total funding
	Compulsory contributions		To FONASA: contributors make a compulsory monthly contribution; percentage of salary based on income level and family structure	To the FNR*: fixed capitation payment (equivalent to US\$5). This contribution corresponds to FONASA beneficiaries and non-FONASA contributors with the ability to pay (IAMC affiliates or comprehensive, for-profit private insurance). For beneficiaries from the public subsector (non-FONASA contributors or those without the ability to pay), the Ministry of Economy and Finance (MEF) pays the FNR a fee for service, as agreed upon between the FNR, MEF and the IMAEs, as reimbursement for medical services provided to its users from the ASSE public subsector. The DNSFFAA reimburses medical services provided to its beneficiaries (fee)
Private	Individuals (households)	Prepaid contributions	Non-FONASA contributors with the ability to pay; fixed monthly premium	
		Out-of-pocket payments (approx. 13% of national health expenditure)	Only for ambulatory care	PyMACs do not have copayments
	Sale of services		Sale of services to other institutions and individuals. Income from the IMAEs (specialty hospitals)	

Source: Developed by the authors

*The FNR operates as a reinsurance system with national coverage and compulsory enrollment for the entire population.

Table 3.3. Relevance of PIAS (2008)

Category	Value in millions of US\$
Integrated Health Service Providers	1,653
ASSE	463.5
IAMC	1,071.1
Private insurers	118.4
FNR*	122
PIAS expenditure	1,775
Total health expenditure	2,464
% total expenditure allotted to PIAS	72%

*Includes US\$25.4 million in IAMC spending, with the FNR as the financing agent
Source: MSP and PAHO (2010)

from a financial, hierarchical, and managerial standpoint has led to a situation where the priority-setting processes of these two components are not unified, despite forming part of the same HBP. In the definition and priority setting of the PBMCs, a methodology with practical criteria that combined various sources of information was used: records from previous working groups, reference benefit lists, analysis of the available evidence, government regulations and expert opinions. In addition, some services were subject to deliberation using a modified Delphi consensus method over several consecutive stages (figure 3.3), a process led by the Directorate-General of Health and the Health Economics Division of the MSP, with technical advice from Argentina's Institute for Clinical Effectiveness and Health Policy.

a) Preparation of the PIAS base list. To prepare the base benefit list, a benefits basket proposed by the Mutual Union of Uruguay was used.¹⁵ The list was expanded based on other national and international references (figure 3.4), and so, with then-

current lists from multiple entities in Uruguay and even Argentina, an inventory of available benefits was compiled, which identified 4,420 possible benefits.

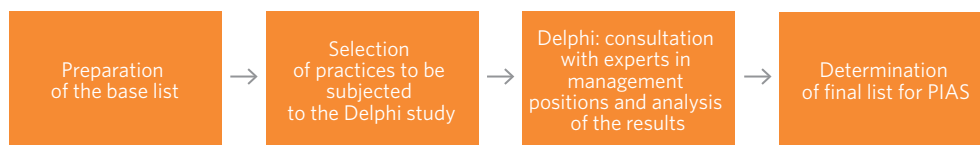
b) Selection of practices to be considered in the Delphi study. Practices considered appropriate for specific analysis were selected. Included on this "priority" list for the Delphi study were i) all practices found on the list of doubts, ii) some of the practices from the list of exclusions, iii) benefits that are not part of common medical practice in the country, iv) techniques that—although originally included in the plan—were little used in practice, and v) practices whose normatization¹⁶ of use would provide a benefit. The final number of practices selected by the Delphi study for expert analysis totaled 163.

c) Consultations with management experts using the modified Delphi consensus method and analysis of the results. The variables used to analyze the 163 benefits selected included the following: i) the level of evidence to support the

¹⁵ The Mutual Union of Uruguay (UMU) was founded in 1988 by its three current members, the First Spanish Mutual Aid Association, the Evangelical Hospital Mutual Aid Society and Casa de Galicia, and it is a member of the International Association of Mutual Benefit Societies and the Mutual Assistance Alliance of America.

¹⁶ Normatization is the process to define norms and standards for health services that include information on when and how these services have to be applied, who will be the responsible provider and who may benefit from these health services. One of the expected results of the normatization process is the standardization of a health technology/health service.

Figure 3.3. Stages of the priority-setting process



Source: Developed by the authors

effectiveness of the practice; ii) cost-effectiveness; iii) budgetary impact; iv) the need or potential benefit of standardizing its use or restricting it to special populations; v) the availability of the technology in Uruguay or the ability to make it accessible through adequate distribution; vi) the feasibility of implementation, considering the socio-political context; and vii) potential coverage in terms of the ability to reach all possible beneficiaries based on equity criteria.

In accordance with the responses of the experts consulted, the benefits were grouped into the following categories: 1) agreement to incorporate practices, 2) agreement not to incorporate practices, 3) no agreement on practices, and 4) practices with inadequate assessment.

d) *Determination of the final list for PIAS.* All benefits in the draft version of PIAS not subject to the consensus recommendations of experts and the interagency working group were included in the compulsory coverage, without requiring normalization. Following the consensus discussion held by the interagency working group, the benefits submitted for evaluation were classified into two main groups: practices to be included and not included. This resulted in the following four categories of practices.

Category 1. Practices included without normalization. Those practices for which it is understood that sufficient evidence exists about their effectiveness and for which it is not possible or cost-effective

to implement limitations on the scope of this coverage, including i) low-utilization, low-cost practices; ii) practices whose spectrum of indications has little variability; iii) practices for which it is not possible, from a clinical perspective, to clearly define limitations on the scope of their indications; and iv) practices for which, while it would be possible to limit their indications, it would not be practical or cost-effective to implement control measures.

Category 2. Practices included with normalization at a later stage. It is considered that use of these practices should be restricted to specific populations and indications, namely, practices for which there is sufficient evidence of their effectiveness, yet it is necessary to define the clinical indications in which their use would be recommended, as these may be highly variable depending on clinical, demographic, financial, cultural, and geographic factors, among others. These are practices for which, because of their utilization rates or cost, it would be justified to implement control mechanisms. Defining the scope of coverage would, on the one hand, ensure their proper use in all clinical situations where there is sufficient evidence of their benefits and, on the other hand, allow for their use to be avoided when there is no precise indication. The scope of coverage for the practices included in this group must be defined within the context of a systematic review of scientific evidence and the development of guidelines and recommendations. By limiting in this way the clinical situations where the practice should be covered, its use

Figure 3.4. National and international references used for the PIAS base list



Source: Developed by the authors

can be significantly scaled back and its proper use guaranteed in order to reduce inappropriate variability.

Category 3. Practices not included on the initial list but with priority status in the evaluation to consider their inclusion. Practices for which it is necessary, initially, to critically analyze the compulsory nature of their coverage due to one or more of the following characteristics: 1) sufficient evidence exists as to their effectiveness but there

are other more readily available diagnostic and/or therapeutic alternatives that are more widespread or cost-effective, such that the scope of coverage for the practice should be analyzed in this context; 2) sufficient evidence exists as to their effectiveness, but they are based on specific technologies and/or skills and it cannot be guaranteed that all providers offer them; 3) sufficient evidence exists as to their effectiveness in specific clinical situations, but they are not widely available throughout the

country; 4) sufficient evidence exists as to their effectiveness but they are very limited in scope or appropriate only in very specific clinical situations, such that their inclusion should consider a proper limitation on their indications.

Category 4. Practices not included on the initial list since there are doubts about their efficacy and their cost-effectiveness, which will be analyzed in the period following the consideration of the prior group to define their inclusion. They possess one or more of the following characteristics: the evidence regarding their efficacy is limited, other more effective diagnostic and/or therapeutic alternatives are available, they may be considered obsolete according to current standards, or there is sufficient evidence to advise against their use.

Detailed Delphi methodology was not applied to MBMC priority setting because that process occurred prior to the creation of PIAS.

With regard to PyMACs, these benefits were defined prior to the creation of the National Integrated Health System, which led to their inclusion in PIAS without modifications. The processes of priority setting and costing for the FNR are independent of those corresponding to the low- and medium-complexity benefits (PBMCs and MBMCs) under the MSP. The FNR has total financial independence from the MSP but only partial organizational independence, given that its honorary administrative commission (which makes decisions regarding the inclusion of financed benefits) is presided over by the MSP. Nevertheless, the MSP participates on the commission as a minority and, therefore, its decision-making power is that of a minority as well. The fact that both benefit plans (low/medium-complexity and high complexity) are independent from a financial, hierarchical, and managerial

standpoint has led to a situation where the priority-setting processes of these two components are not unified, despite forming part of the same benefit plan (PIAS), nor is there a true superior hierarchical level held in common by these two bodies.

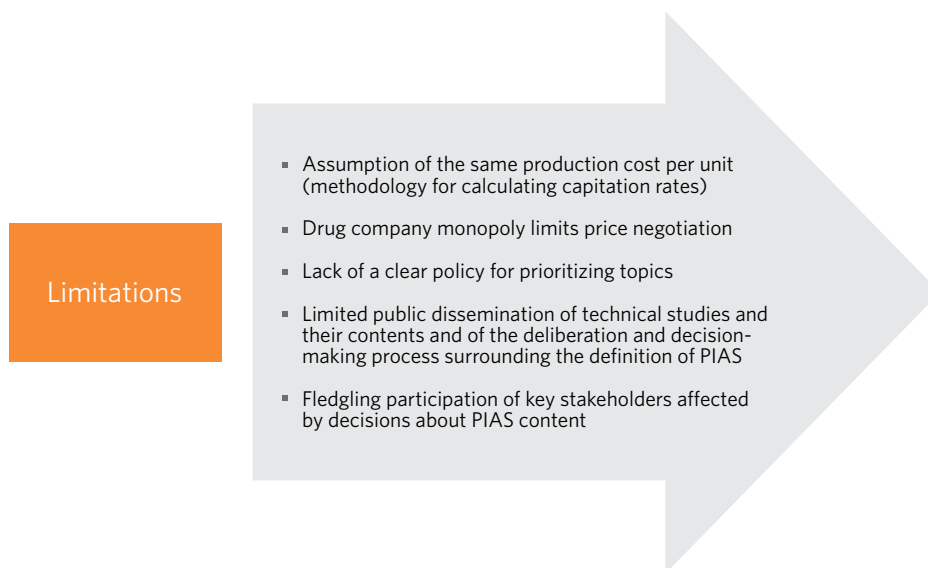
Costing

The total cost of PIAS in relation to the PBMCs and MBMCs was not determined since they are mainly composed of services that had already been covered by the not-for-profit health providers (IAMCs) prior to the reforms. In any event, it was necessary to define the amount of resources that would be transferred to participating SNIS insurers in order for them to provide the interventions included in PIAS. To do so, per capita expenditures reported by the IAMCs were drawn upon, based on the assumption that these figures were indicators of the resources required to provide the HBP. A costing exercise was never performed for the prioritized list of benefits. One limitation of this calculation methodology is that it assumes that the costs and frequencies of the IAMCs are those desired and that the service cost is the same regardless of the beneficiary's characteristics.¹⁷

Currently, the associated studies on production costs and the calculation of fees for the PyMACs are being conducted, taking into consideration the necessary human and material resources, the number of hospital days required, the types of potential complications, and the use of operating rooms when appropriate. Based on this information, the cost of production is defined as well as the budgetary impact, according to the estimated prevalence. However, this costing process has been criticized for failing to consider aspects of efficiency in terms of scale, meaning that the

¹⁷ It is assumed that a consultation costs the same, regardless of whether the service is for a child or an elderly person, a man or a woman. Therefore, we proceeded to multiply by a correction factor that gave less weight to consultations, looking for them to be representative of the expense they generate (the correction factor is 0.5). The expense distribution excludes "administrative and sales expenditures," which are distributed linearly among all users of the institutions, without weighting the use of each segment.

Figure 3.5. Limiting factors for PIAS costing



Source: Developed by the authors

rates reflect the situation of the high-complexity service providers (the specialty hospitals) with better conditions of scale. The technical report from these studies is the tool used to negotiate rates between the FNR, the Ministry of Economy and Finance, and the group of specialty hospitals. In the case of medications, the prevalence and annual incidence of the condition being treated are examined, and prices are negotiated with the supplier through an internally-managed process in an *ad hoc* committee composed of the FNR and Ministry of Economy and Finance. The existence of single suppliers for medications (monopoly) is a limiting factor in the negotiation of purchase prices. Furthermore, these cost studies are not publicly available.¹⁸

Process of deliberation and negotiation of benefits

The process of deliberation and negotiation of benefits included in PIAS

was split, according to the type of benefit, into PBMCs, MBMCs and PyMACs, as described below.

Low/medium-complexity, low/medium-cost diagnostic and therapeutic benefits (PBMCs). The deliberation process began with the formation of an interagency working group, composed of representatives of the MSP (the leader of this process), the FNR (with a very important role), and the Social Security Institute.¹⁹ The group received technical support from Argentina's Institute for Clinical Effectiveness and Health Policy, and clinical experts in various specialties and benefits management were consulted as well. The main discussions focused on technical and economic aspects of accessibility and availability of different health technologies to establish benefits provided in a homogeneous manner by all health care institutions. While advances were made in terms of coverage extension (universalization), this resulted in the loss of some grandfathered services or benefits

¹⁸ Interview with the technical director of the FNR, Álvaro Haretche, in 2010.

¹⁹ The Social Security Institute (formerly the Social Insurance Bank) is the entity responsible for administering Uruguay's social security programs, among which are disability, old age, sickness and unemployment benefits.

that a few institutions provided up to that point with the collection of the respective fee. In this regard, manifestations of dissatisfaction on the part of the affected population were not systematically identified.

Low/medium-cost medications (MBMCs).

There is a commission on medications under the MSP, responsible for the deliberation process that includes—or excludes—medications under compulsory coverage.

High-specialization, high-cost diagnostic and therapeutic benefits and high-cost, high-economic-impact medications (PyMACs).

Deliberation with regard to these high-cost interventions is of a technical and political nature. The FNR's honorary administrative commission is responsible for deciding whether to include technologies under its coverage through a recommendation report with technical support from doctors and public accountants who evaluate data and provide guidance. Requests to review potential benefits for inclusion can come from groups of doctors, politicians, the MSP, and proposals from the FNR based on new technology with proven effectiveness, adopted in other countries. Regardless of the source of the request for review and incorporation into PIAS, the principal negotiation tool for decision-making is the scientific evidence regarding the technology's effectiveness, safety and financial sustainability. Decisions and negotiations are conducted in close connection with political authorities.²⁰

Mechanisms for adjusting PIAS

Adjustments to the HBPs serve to restore the financial balance of the system or to incorporate new technologies and remove obsolete ones.

In terms of the P BMCs, Law No. 18,211 (art. 5) states that the MSP will periodically adjust these comprehensive plans based on scientific, demographic and epidemiological evidence of the Uruguayan population and on the financial viability of the health care system. Its financing will depend on an increase of the health care contribution or some other measure, in the case of ambulatory care services (copayment). These adjustments are made according to the following steps: a) *correction of omissions, clarifications, classifications, and nomenclature* of commonly-used practices not included, elimination of obsolete techniques or substitution for others of greater effectiveness, safety, accessibility and lower cost; b) *benefit normalization*; c) *evaluation of the inclusion of new benefits* (benefits selected for evaluation, systematic search for evidence, benefit costing, and determination of financing). This adjustment process draws on suggestions and requests from users in order to choose the benefits with the most demand, those which give rise to the greatest pressure from interest groups, and those excluded during the Delphi study but given priority during the evaluation and search for more evidence of effectiveness.²¹ Benefit normalization is the most advanced step of the three defined above, since guidelines and cost estimates must be brought before the respective authorities for their consideration.²² The adjustment process requires a stable group of trained professionals dedicated to this task. However, even though there are professionals trained in health technology assessment who are familiar with the process of creating PIAS and have the support of academia (School of Medicine), the public provider (ASSE) and clinical experts, these professionals

²⁰ Interview with the technical director of the FNR, Álvaro Haretche.

²¹ Practices with any of the following characteristics are included: sufficient evidence of effectiveness but diagnostic and/or therapeutic alternatives are available; sufficient evidence exists as to their effectiveness, but they are based on specific technologies and/or skills that cannot be guaranteed by all providers; sufficient evidence exists as to their effectiveness in specific clinical situations, but they are not widely available throughout the country (in these cases, compulsory coverage should be critically considered and adequate mechanisms for every case anticipated in order to avoid asymmetries and inequities in terms of the economic impact that their inclusion could cause); sufficient evidence exists as to their effectiveness but they are very limited in scope or appropriate only in very specific clinical situations, such that their inclusion should consider a proper limitation on their indications.

²² This includes the collection of evidence on the selected technologies, consultation with clinical experts, and the prevalence survey.

do not work full-time on this task, which limits the adjustment process.

Adjustments to the PyMACs, financed by the FNR (which is a coverage system, not a system for financing innovation), are carried out by selecting benefits according to scientific evidence about objective changes in disease progression, disability-adjusted life years and quality of life, plus evidence from studies by the National Institute for Health and Care Excellence (NICE) in the United Kingdom. Based on this information, the technical advisory committee on highly-specialized medicine prepares a technical report that also contains cost-effectiveness studies. The technical advisory committee consists of a representative of the MSP, another from the School of Medicine, and a third designated by the honorary administrative commission at the suggestion of the national health body. The recommendations of the technical advisory committee are not binding. The report is delivered to the FNR's administrative committee for its approval, which requires a quorum of five members to hold a meeting. Decisions of the administrative committee on the inclusion or exclusion of technologies or drugs in the FNR are made by simple majority vote. If no decision is reached, then voting is repeated, and the vote of the MSP counts twice. The honorary administrative committee has the power to authorize the expenditures required to meet the objectives of the FNR. Decisions of the administrative committee may be appealed by interested parties within a period of 20 days, and the committee must respond within 30 days following the filing of the complaint.

Adjustments related to the MBMCs are supported by the review of evidence, safety and cost-effectiveness analysis, pharmacoepidemiological analysis, their place on the therapeutic list, and the costs to the SNIS, among other aspects that fall under the responsibility of the Therapeutic Drug Formulary Unit of the Directorate-General of Health. The therapeutic drug formulary is under permanent review, and it is updated

annually in accordance with regulations, although if the situation warrants it, additions may be made prior to the one-year mark of the last incorporation (the update and adjustment process is represented graphically in section 8 of the annex to this chapter). Requests to incorporate medications into the therapeutic drug formulary must be submitted in writing by national health programs, department chairs and services of the School of Medicine, or scientific or other societies, and they must be based on aspects such as the place on the therapeutic list, evidence of safety and efficacy, comparative costs, etc. Each health care program analyzes the set of medications that forms part of its scope, and it falls to the Therapeutic Drug Formulary Unit to make a decision or obtain adequate support from the School of Medicine, scientific societies or national reference groups.

In the more than four years since PIAS was implemented, the benefit list has been adjusted, with benefits added and removed, but this process occurred in a different manner for each category of services and medicines.

Legitimacy

Although PIAS was developed and updated in line with certain criteria and standards, detailed below are factors that would help improve PIAS's legitimacy. These are mainly related to the participation of different stakeholders in the stages in which benefits are defined and adjusted.

The Delphi method was used to determine the PBMCs, while the FNR used a systematic assessment of the evidence and an estimate of budgetary impact for the PyMACs. The lack of a clear policy on priority setting—the selection of candidate technologies for assessment—is limiting, because, to date, it mainly responds to the demands of social, academic and business organizations.

With respect to technical advice, the selection criteria for academic experts are neither explicit nor publicly divulged, both in the case of the FNR and the rest of the PIAS benefits. One example is the selection of participants from medical symposiums. The FNR maintains an implicit policy of selecting professionals with acknowledged professional standing and an independent profile as expert consultants.

The participation of key stakeholders affected by decisions on PIAS content is just getting underway. Although groups of experts and academics were consulted in the definition of the PBMCs, other sectors of civil society such as doctors' unions, patients, and politicians were not. Participation by professional groups, academia and providers that sell services was limited to the submission of requests for inclusion in the plan, particularly medications. As for the legitimacy of the adjustments made to PIAS, so far there is no clearly-defined consultation or participation phase for beneficiaries. Although a participatory process does exist, it has not been conducted with any sort of regularity up to the present time. The following factors limit this process: i) turnover among MSP authorities; ii) the prioritization of greater population coverage over greater benefits coverage; iii) the lack of institutionalization of health policies, developed without the influence of the authority in power; and iv) a health agenda affected by political fluctuations.

Lastly, one weakness of PIAS is the limited public dissemination of its technical studies and the deliberation and decision-making process about the benefit plan.

Implementation

This section describes the following aspects of PIAS implementation: the purchasing of plan services, the adequacy

of financial resources, quality control, users' knowledge of benefits, physical and human resources available for the delivery of plan services, the ability to monitor and verify plan compliance, and lastly, barriers and implementation issues.

The purchasing of plan services

The coexistence of two types of plans within PIAS, with different administrators and funding sources, means that the purchasing mechanisms for services are not unified. The purchasing mechanism of each plan is described below.

PBMCs. JUNASA signs management contracts with all providers authorized to provide services for PIAS. These contracts have been one of the most important aspects in the context of PIAS and health care system reform; by directing the conduct of providers, they are a powerful tool to ensure that the benefits included in PIAS translate into good health. The management contracts²³ define the following obligations:

a) *Guarantee the provision of PIAS according to a defined scope of benefits and meet health care goals as a condition for access to resources.* As a result, it is hoped that providers will have incentives to direct spending toward health promotion and prevention activities with greater impact.

b) *Management:* establish the conditions of access to benefits (maximum wait times for consultations and elective surgical procedures), primary care office hours, methods for scheduling consultations (e.g., the ability to make appointments by phone). Obligations concerning information and customer service are also defined, and means of communication, mandatory information about rights and responsibilities, prices, and a list of professionals are established, as well as the obligation to conduct satisfaction surveys.

²³ Available at: http://www.msp.gub.uy/ucjunasa_5816_1.html.

c) *Financing*: form of payment for the health contribution and penalties in the event of non-compliance with the aforementioned obligations, such as the total or partial, temporary or permanent suspension of the payment of health contributions.²⁴

PyMACs. The FNR pays the IMAEs on a fee-for-service basis. It conducts centralized purchasing of drugs and certain devices and prosthetics through calls for bids. The FNR's financial autonomy is critical when scheduling and finalizing purchases. This model gives the FNR significant purchasing power; however, Uruguay's market volume does not afford the government strong bargaining power, as in other countries in the region (Tobar, n/d).

Adequacy of financial resources

An HBP must be accompanied by sufficient resources; otherwise, access to the plan may be restricted or the financial stability of providers may be jeopardized. In the case of Uruguay, resources have been sufficient, and different strategies have been employed to manage the frequency of use of health services.

PBMCs and MBMCs. According to an analysis of the economic and financial situation of the institutions that comprise the IAMC subsector in the National Integrated Health System, between October 2007 and September 2008,²⁵ the estimated amounts for financing of these types of benefits were sufficient to satisfy PIAS benefits with proper quality and access, without

spillovers caused by increases in demand or other reasons. The government regulated accessibility through provisions related to wait times for elective surgeries and medical consultations, health care goals,²⁶ and the sliding-scale copayment policy,²⁷ among other measures. Additionally, the government established that all newly incorporated benefits would receive specific financing through increased capitation rates or copayments.²⁸ Although it was understood that the (non-explicit) benefits provided prior to the definition of PIAS were financed with the monthly contribution, an analysis of whether the contribution was disproportionately small or large was not performed.

PyMACs. Current FNR funding appears to be sufficient to cover high-complexity, high-cost benefits, despite new prescription drug coverage benefits and the fact that neither significant increases in funding sources nor reductions to the benefits portfolio have been reported.²⁹ One of the strategies used by the FNR has been outreach and professional development focused on coverage standards and indications for covered procedures and medications, so as to reduce the number of requests from physicians at health care institutions, without increasing the number of rejections from the FNR. Another strategy has been to offer activities and supplies to prevent certain diseases, thereby reducing or delaying their onset and lowering future health care costs.³⁰

Lastly, the micro-financial equilibrium between the planned allocation (contributions) and the actual cost of the HBP is expected to be maintained

²⁴ Although there is no accessible public record, in practice it is known that there are rarely sanctions or financial penalties.

²⁵ The IAMC system reported no relevant changes to the structure of revenues, costs or expenditures that jeopardized its profitability (Ministry of Public Health, 2009b).

²⁶ Prenatal check-ups, well-child care, choice of referring physician.

²⁷ Ban on creation of new copayments since 2005; establishment of a cap and copayment waiver for certain benefits.

²⁸ As an example, it is possible to cite the inclusion of tubal ligation and vasectomy in 2011 under the compulsory coverage, which was financed by an increase in the capitation payment.

²⁹ Since its creation, only three benefits have been dropped—extracorporeal lithotripsy, percutaneous lithotripsy, and radio-guided neurosurgery—which were transferred to the compulsory coverage of the IAMCs by increasing the respective contribution.

³⁰ For example, the cost of providing a daily 100-mg dose of acetylsalicylic acid (aspirin) as an antiplatelet agent in patients with high cardiovascular risk is substantially lower than stenting, an intervention appropriate for an advanced state of cardiovascular disease. The medication that the FNR distributes in one year to 288 patients in heart disease prevention programs is financed with resources that would cover less than two heart surgeries (FNR, 2010).

through periodic adjustments to the capitation payments that FONASA makes to comprehensive provider institutions. These values are adjusted every six months according to price variations in several categories, with salaries for health care personnel accounting for the most significant portion (64.8%). For this calculation, a parameter is applied to obtain the price adjustments for individual and collective contributions and FONASA capitation payments (see section 3 of the annex to this chapter).

Quality control

The MSP is responsible for authorizing both the IMAEs and the not-for-profit health providers that participate in the health care market. Although accreditation is not required, there are minimum requirements in terms of the physical plant, infrastructure, equipment, licensed personnel, and hospital waste management procedures.³¹

Through its coverage decisions, the FNR has sought to establish appropriate indications that conform to scientific evidence and take into account patients' quality of life and risk assessment. This is a cost rationalization strategy that seeks internal economies without diminishing the quality of services and their accessibility. It includes the review after the patient is admitted to the facility and when medical interventions are performed. The procedure performed is evaluated to determine whether it conforms to the FNR's regulations. If deemed necessary, some cases are escalated to a group of external evaluators or for consideration in a symposium. Generally, the medical review culminates in payment authorization (Rodríguez, Fernández and Haretche, 2008).

Knowledge of benefits and mechanisms in order for the population and stakeholders to be able to demand their rights

Whether the population effectively accesses prioritized services depends in part on its ability to demand benefits and, therefore, on its knowledge of those benefits. This also applies to providers. The only means used to disseminate the contents of PIAS and coverage standards are the websites of the MSP and the FNR. These mechanisms are not accessible to the entire population, so it is necessary to implement other communication mechanisms to maximize understanding of PIAS benefits, coverage standards, copayment amounts, and accepted wait times for not-for-profit health providers. In addition, a communication strategy contributes to a decrease in judicial actions.

Physical and human resources available to provide services

On the whole, the promises made by the benefit plan and the institutional, economic, and epidemiological reality of the country seem to be consistent with what the plan is actually capable of offering. However, although all providers cover the same low- and medium-complexity benefits, beneficiaries residing outside the Uruguayan capital must sometimes travel there due to the uneven supply of health technology, which often constitutes an economic barrier to access.³² To alleviate this situation, a national rural health program is in development, which would reach residents in towns with fewer than 5,000 inhabitants and the scattered rural population. It is anticipated that a network of services will be created, which will coordinate services between public and private providers with the necessary referral and counter-referral mechanisms for patients.

³¹ The authorization is granted for a maximum period of five years, after which time the institution must reapply for authorization to continue as a comprehensive SNIS provider.

³² For ambulatory care, the patient pays his own transportation costs. If the patient is hospitalized, ambulance service is included in the coverage.

Institutional capacity to monitor and verify compliance with objectives

PIAS compliance is verified through health care goals, which are monitored by a specific division of the MSP that reports to JUNASA. It also monitors compliance with wait times for outpatient doctor visits and surgical interventions through the National Information System, under the Health Economics Division of the MSP, and through the Audit Department, under the Directorate-General of Health. The MSP has no regular mechanism for monitoring, surveillance and control of the coverage of the other compulsory benefits.

Law No. 18,211 established that public and private entities that constitute the SNIS are required to provide their users with the comprehensive benefit programs approved by the MSP (one of the two major components of PIAS). Failure to do so would result in immediate intervention on the part of the MSP to ensure the right to health care. The MSP serves as the oversight entity, as there is no superintendency of health services. The scope of monitoring includes control mechanisms that evaluate whether system stakeholders fulfill their obligations in a way that guarantees the rights of users, as well as overseeing the quality and suitability of benefits. In this context, wait times are defined for certain benefits,³³ which verifies that functional, geographic and economic access parameters are fulfilled, while data sent to the National Information System from provider institutions is monitored. Although there have been occasional audits by the MSP, they are not systematic.³⁴

The FNR guarantees the quality of health care through a system of prospective and retrospective evaluation that, firstly,

periodically inspects the IMAEs to assess aspects of their structure, facilities, physical plant, equipment and processes, and beyond that, it performs monitoring, evaluation and follow-up of the results of the benefits provided. This monitoring of results allows for, among other things, periodic assessment of whether it is appropriate to continue covering each of the treatments. It also tracks the IMAEs, as they are required to report certain medical complications or alterations of parameters.³⁵

Barriers to and problems in implementation

The main challenges that arose in the implementation of PIAS are summarized in figure 3.6. Two of these challenges relate to benefits that are *not* included in the HBP, which generate claims and litigation by beneficiaries. It should be noted that the MSP does not require health care institutions to cover services not included in PIAS. For example, the benefit list does not specify the medical/surgical supplies required for the provision of the benefits defined, since, in theory, capitation payments and contributions should finance the full benefit plan, including necessary supplies. However, in practice there are problems with certain high-cost devices that have more economical alternatives.³⁶ This raises questions as to what level of detail is required of the HBP.

Sliding-scale fees (copayments) for ambulatory care pose another problem. The amounts of certain copayments restrict some citizens' access to benefits.³⁷ For this reason, the MSP implemented a sliding-scale copayment policy, which provides exemptions.³⁸

³³ These were selected after identifying quality indicators from health systems that prioritize their users' needs, product of a technical working group. Claims and complaints from SNIS users were also considered.

³⁴ The MSP has a customer service office that receives and processes all complaints made by SNIS beneficiaries. For the time being, there is no published data about the type and frequency of complaints.

³⁵ For example, pulmonary embolism following a hip replacement; disease outbreak; fever and chills during dialysis.

³⁶ For example, the port-a-cath® for chemotherapy treatments.

³⁷ For example, the same procedure may have different copayment amounts at each of the health care institutions, ranging from US\$0 to US\$300.

³⁸ Exemption from the sliding-scale copayment for some blood glucose regulators, Pap smears (oncologic colposcopy) and mammograms (Pap from age 21 to 65, every three years; mammogram from age 40 to 59, every two years), and diagnostic studies for

Some users feel that the maximum wait times allowed³⁹ for medical consultations and elective surgeries must be reduced and that maximum wait times for certain diagnostic studies and benefits that are currently unregulated should be defined as well.

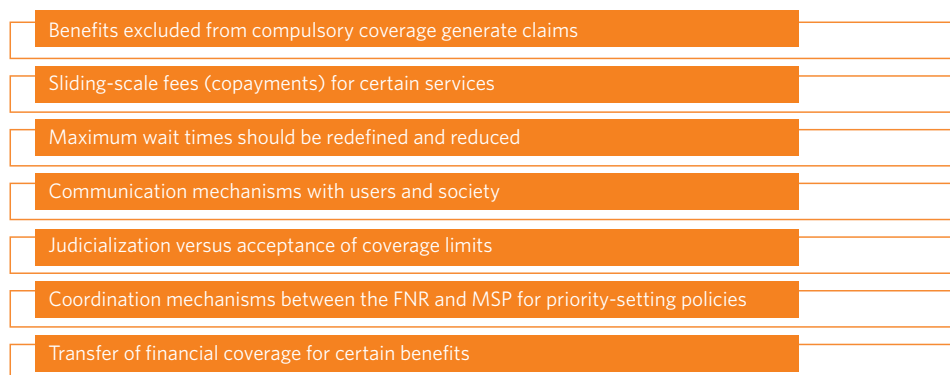
It is important to improve communication with users and society as a whole about PIAS benefits, authorized sliding-scale copayments and accepted wait times. Dissemination of information about compulsory coverage through the FNR and its protocols must also be improved, as it would help reduce lawsuits.

The judicialization of medicine, motivated by a reluctance to accept coverage limits, is an obstacle to health care planning, since it creates pressure for the incorporation of benefits “on demand,” which do not arise from an analysis of efficacy or cost-effectiveness. In Uruguay, most of this pressure has been focused on drug coverage for the

treatment of catastrophic illnesses (e.g., cancer) or indications that have not been standardized by the FNR. In many cases, judges order the FNR to provide coverage, despite having no solid evidence of efficacy to support their decisions. Therefore, the FNR must adopt a priority-setting policy that addresses, with transparency and financial equilibrium, the growing problem of requests to incorporate new high-cost drugs, while simultaneously ensuring the right to health care.

There are judges who rule in favor of the plaintiffs, thereby assigning responsibility for coverage of the requested benefit to the MSP, despite available technical studies that demonstrate its lack of efficacy at the population level. The MSP is not a provider, and it lacks resources allocated for that purpose. To hold the MSP responsible as a provider may threaten the financial stability of the system. Each writ of protection is on an individual basis—to protect a “violated” right—which imposes the concept of

Figure 3.6. PIAS challenges



Source: Developed by the authors

low-risk pregnant women (according to guidelines); a fixed copayment for certain blood pressure medications; and a fixed copayment for general medical consultations, pediatrics (not check-ups, which are exempt), and obstetrics and gynecology. These measures are targeted at health promotion and prevention and the treatment of prevalent diseases, and their goal is to reduce heterogeneity and ensure equity of access. The aim is for fees to be truly of a sliding-scale nature.

³⁹ Wait times established by Decree 359/07 for general medical consultations, pediatrics and gynecology, within 24 hours; general surgery, within 48 hours; and for medical and surgical specialties, within 30 days of the request. For elective surgery, the timeframe is 180 days from the date of its indication by the treating physician.

displacement (“take from everyone and give to one person”) to the detriment of a macro view of the system and of health care planning. While this phenomenon is just beginning to occur, its impact is significant since it mainly deals with high-cost medications.

The lack of clear, explicit *mechanisms of coordination* shared between the FNR and the MSP in order to define compatible priority-setting policies for benefits to be provided has created gaps and unresolved gray areas. Such is the case with a cochlear implant device for children under 7 with profound sensorineural hearing loss: the FNR covers the device, but the surgical implantation procedure is not explicitly included in the compulsory coverage provided by the IAMCs.

The FNR has incorporated and now funds prevention programs for chronic non-communicable diseases with high-cost procedures. Although this approach is justified as a way to contain the FNR’s costs, there is clearly some policy overlap with the MSP’s Department of Strategic Health Planning. Both would benefit from more harmonious coordination of objectives and methods.

Transferring financial coverage of certain benefits from the FNR to the IAMCs has brought with it a negative consequence in terms of accessibility for the population. This was proven in the case of extracorporeal lithotripsy procedures, to which the IAMCs apply more restrictive policies than those previously employed by the FNR.

Monitoring, Evaluation and Results

Monitoring and evaluation

Although the MSP only has a PIAS monitoring study, the National Information System keeps track of several indicators.

Objectives and indicators. The National Information System, under the MSP, collects indicators to evaluate the performance of the HBP’s low- and medium-complexity benefits (see section 6 of the annex for this chapter): utilization of services in ambulatory care and hospitalization; coverage; and the measurement of accessibility, quality and change in the model of care. With regard to benefits with financial coverage from the FNR, the indicators related to complications, infections and mortality are not made public, but the FNR uses this information in reviews and decision-making.

Studies performed. The only study conducted by the MSP was the User Satisfaction Survey (2010) on primary health care services. The survey revealed details about treatment during care, accessibility, facilities, information about rights and obligations, and the quality of care. The results show higher levels of dissatisfaction at the administrative level and with access to information about rights and obligations. Each year, the FNR analyzes results from the IMAEs (specifically dialysis, angioplasty, heart surgery and hip surgery), and it publishes them on its website. The FNR compares the results from each IMAE with the national average. For some variables, a limit of acceptability was established, which considers recommendations from specialized academic literature and the national context (quality of the procedure, adverse events, mortality, etc.). The FNR also evaluates certain programs on an annual basis: nephroprotection, hemodialysis, cardiovascular, and smoking cessation. This review provides valuable information for decision-making, which is still not being used as a tool to empower the FNR and the population (for example, to help select one IMAE over another).

Outcomes

Although the impact of PIAS has not been studied, out-of-pocket spending and economic access barriers have decreased

since the passage of health care reform. This occurred in two ways: 1) a reduction in direct health care spending for previously uninsured households and 2) the policy for the reduction of sliding-scale copayments for IAMCs, driven by the MSP for certain benefits and prioritized medications for ambulatory care. The relative weight of medical orders and vouchers reimbursed to the IAMCs went from 2.6% and 9.5% in 2004, respectively, to 2.4% and 7% in 2008 (Directorate-General of the SNIS-MSP, 2011). The data collected by the health care module of the National Information System⁴⁰ allows for a determination of the average wait time for an appointment at the polyclinic, consultations per enrollee per year, revenue per 1,000 enrollees, and surgeries performed. Additionally, a marked decrease in the IMR stands out during the period, which is now close to achieving the Millennium Development Goals (MDG) target rate. Compliance with prenatal check-ups and well-child care, using guidelines established in the health care goals, was a prioritized policy during the period and may have been one of the factors that contributed to the decline in the IMR.

Lessons and recommendations

The design and implementation of PIAS—within the framework of the launch of the SNIS—involved challenges and a need to make adjustments on the fly to ensure the coordination of the system. The most relevant lessons from this process are identified, and some recommendations are made below.

It is important to *harmonize the design of the HBP with the country's strategic health planning*. Health care reform in Uruguay changed the model of care, with an emphasis on primary care. Remarkably, this change was not accompanied by a sharp rise in primary care benefits. Instead, to date, the majority of health

services continue to be provided at the secondary and tertiary levels of care.

The *management of the HBP is split* according to the complexity and cost of its benefits (the MSP manages the PBMCs and the MBMCs, while the FNR manages the PyMACs), and strong coordination mechanisms are lacking. However, the differential management of high-cost, high-complexity benefits by a specialized body, with budgetary and hierarchical independence, offers a distinct advantage or strength because it facilitates the comprehensive management of benefits.

The case of PIAS shows that the *normalization or formalization of benefits* carries implications beyond the mere identification of a list of benefits. Normalization applies to i) the use of technologies restricted to populations and practices whose efficacy is duly established when associated with certain clinical indications or ii) when its utilization rate or cost justifies formalization or further definition.

Defining the scope of coverage would ensure proper use of health services in clinical situations where their benefits are sufficiently tested. It would also avoid their use when there is no precise indication. By reducing the variety of scientifically-unsupported treatments for the same condition (inappropriate variability), the system becomes safer and more efficient, which offers technical legitimacy.

When designing an HBP, it is vital to establish a nomenclature in keeping with local designations, which facilitates users' experience. The International Classification of Diseases, 9th Edition (ICD-9) nomenclature has made consultations more complicated for users (the general population, doctors and agents).

⁴⁰ The public provider ASSE joined in 2010, so the 2009 data only reflects private providers. As a result, the information cannot be extrapolated to the system in general.

Priority-setting policies are strengthened and legitimized when *society gets involved and the applied methodology is made public*. In Uruguay, there was no organized, collective social participation process, with the ability to influence strategic decisions, as the consultation with and participation of users could have been. Furthermore, the supporting documentation for PIAS's design is not a matter of public record but instead is meant solely for internal use.

Additionally, the lack of mechanisms to gauge user satisfaction with the performance of the SNIS constitutes another weakness. Information of this nature would allow users to report aspects for improvement, which would be of great value during the HBP adjustment process.

Defining an *effective strategy for communication and dissemination of information about the benefits* included in the HBP allows people to assert their rights and raises awareness among health personnel and agents regarding the health technologies included in the

compulsory coverage. In Uruguay, except for the publication of PIAS on the MSP website and the benefit plan funded by the FNR on its site, the HBP has not been actively disseminated. This means that neither users nor physicians had a clear understanding of the benefits included in the compulsory coverage, leading to multiple queries to the MSP and delays in health care.

Uruguay's health care reform established management contracts between JUNASA and the comprehensive provider institutions as *mechanisms of control and efficient, timely evaluation of PIAS benefits*. Nonetheless, the audit process has been quite variable, mostly due to limited material resources and personnel for the task. The health care goals that form part of these contracts are a financial incentive for providers to meet priority health goals. A good example is the reduction of the IMR, one of the lowest in Latin America.⁴¹ This *pay-for-performance mechanism* contributed to the change, as it is aimed toward health promotion and prevention activities at the primary care level.

⁴¹ This achievement was based on, among other things, defined goals such as obtaining a given percentage of pregnant and nursing women under medical supervision, a given percentage of the pediatric population with a current vaccination record, a mandatory home visit for newborns, etc.

References

- Arana D. and H. Laca. 2011. "Sistema de salud de Uruguay." *Salud pública de México* vol. 54, suplemento 2.
- Dirección General del SNIS-MSP (Directorate-General of the SNIS-MSP). 2011. *Transformar el futuro: Metas cumplidas y desafíos renovados para el Sistema Nacional Integrado de Salud*. Montevideo, Ministerio de Salud Pública.
- Economic Commission for Latin America and the Caribbean. 2012. *Anuario estadístico de América Latina y el Caribe 2012*. Santiago de Chile, Economic Commission for Latin America and the Caribbean. Available at: <http://www.eclac.org/publicaciones/xml/2/48862/AES2012EstadisticasSociales.pdf>. Accessed: September 2013.
- FNR (National Resource Fund). 2010. *Política y gestión de la cobertura de medicamentos de alto costo: Programa de Seguimiento del Fondo Nacional de Recursos*. Publicación técnica n° 13, Montevideo, FNR. Available at: http://www.federicotobar.com.ar/nf_pdf2/Politica%20y%20gestion.pdf. Accessed: September 2013.
- _____. 2006. Texto Ordenado de Normas Regulatorias del FNR. Available at: <http://www.fnr.gub.uy/formularios-normativas>. Accessed: September 2013.
- JUNASA (National Board of Health). 2010. Rendición de cuentas ejercicio 2009. Available at: https://www.google.com.co/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=0CDQQFjAB&url=http%3A%2F%2Fwww.msp.gub.uy%2Fandocasociado.aspx%3F4193%2C18888&ei=H9A5UrO0CibI9QTh1IGwDg&usg=AFQjCNFzl_mNqtghOLPHOwdfCHw8yvWFg&sig2=YOqC_fjzyVLPMt53909x4Q&bvm=bv.52288139,d.eWU. Accessed: September 2013.
- MSP (Uruguayan Ministry of Public Health). 2009a. *La construcción del Sistema Nacional Integrado de Salud. 2005-2009*. Montevideo, MSP. Available at: http://www.psico.edu.uy/sites/default/files/cursos/nas_la_construccion.pdf. Accessed: September 2013.
- _____. 2009b. Primer ejercicio cerrado luego de la creación del SNIS el 1 de enero de 2008. Informe sistema mutual. Ejercicio 2007-2008. División Economía de la Salud, MSP. Available at: <http://www.msp.gub.uy/andocasociado.aspx?3056,17014>. Accessed: September 2013.
- _____. 2010. Datos sobre mortalidad en Uruguay, 2010. Available at: http://www.msp.gub.uy/ucepidemiologia_6490_1.html. Accessed: September 2013.
- _____. 2013. "Mortalidad infantil, Uruguay 2012." Montevideo, MSP. Available at: http://www.msp.gub.uy/ucepidemiologia_6487_1.html. Accessed: September 2013.
- MSP and PAHO (Pan American Health Organization). 2010. *Cuentas nacionales de salud 2005-08*. Montevideo, MSP-PAHO. Available from: <http://www.msp.gub.uy/andocasociado.aspx?5650,21507>. Accessed: September 2013.

- PAHO (Pan American Health Organization). 2003. *Conjunto de prestaciones de salud. Objetivos, diseño y aplicación*. Washington, DC, PAHO.
- Rodríguez A., G. Fernández and A. Haretche. 2008. “Gestión de la utilización de procedimientos de alta especialización médica en Uruguay.” Cuadernos del Centro de Estudios de la Salud del Sindicato Médico de Uruguay nº4. Available at: <http://www.smu.org.uy/elsmu/organismos/ces/cuadernos/cuadernos4/art8.pdf>. Accessed: September 2013.
- Sindicato Médico del Uruguay. El sector salud: 75 años de un mismo diagnóstico. Available at: <http://www.smu.org.uy/publicaciones/libros/turenne/index.html>. Accessed: September 2013.
- Tobar, F. “Medicamentos en la reforma de salud del Uruguay.” Available at: http://www.federicotobar.com.ar/nf_pdf2/Medicamentos.pdf. Accessed: September 2013.
- UNDP (United Nations Development Program). 2009. *Informe sobre desarrollo humano 2009. Superando barreras: Movilidad y desarrollo humano*. New York, UNDP. Available at: http://hdr.undp.org/en/media/HDR_2009_ES_Complete.pdf. Accessed: September 2013.

Chapter 4



Mexico: The Universal List of Essential Health Services and the Catastrophic Health Expenditure Fund

Giota Panopoulou, Ursula Giedion and Eduardo González-Pier

Summary

Context. The health system in Mexico is segmented. The services received by the population depend on individuals' employment status and ability to pay. Access to services is differentiated into four population segments: i) individuals with the ability to pay, who access private insurance covering all levels of care; ii) workers, pensioners and their families enrolled in social security through entities such as the Mexican Social Security Institute (IMSS), the Government Workers' Social Security and Services Institute (ISSSTE) and *Petróleos Mexicanos* (Pemex), among others; iii) individuals without social security, covered by *Seguro Popular*; and iv) a small population that is not yet covered by *Seguro Popular*.

The aforementioned social security institutions have not defined an explicit health benefit plan (HBP) for their enrollees. However, individuals enrolled in *Seguro Popular*, introduced in 2003, are entitled to the services of two explicit benefit plans: the Universal List of Essential Health Services (CAUSES) and the List of High-Cost Interventions (CIAC), financed by the Catastrophic Health Expenditure Fund (FPGC). These two benefit packages,¹ which currently cover approximately 45% of the

population, are the subject of analysis in this chapter.

Key elements of CAUSES and the FPGC package. The benefit plans under *Seguro Popular* have explicitly stated the health care services to which enrollees are entitled. This has resulted in two important consequences: i) by demonstrating the financial requirements to provide these packages, the availability of resources earmarked for *Seguro Popular* enrollees has increased and ii) with this increase in resources, the gap between *Seguro Popular* enrollees and social security enrollees has been reduced.

Outcomes. In 2012, nearly 53 million Mexicans had access to CAUSES and the FPGC package through their enrollment in *Seguro Popular*. CAUSES coverage has progressively expanded and currently includes 284 interventions focused on the primary and secondary levels of care. The CIAC covers 20 disease groups associated with 61 interventions.

While no specific evaluations of CAUSES have been conducted, the 2005-06 evaluation of the System of Social Protection in Health (SPSS) found that *Seguro Popular* has protected beneficiaries from catastrophic expenses, specifically households that reported use of ambulatory care and inpatient

¹ The word "package" is commonly used in this context in Mexico and refers to what is known as a plan throughout most of Latin America and the Caribbean.

services. Furthermore, the results of the evaluation indicated that Seguro Popular enrollees were more likely to use health services than non-enrollees. An increase in the effective coverage of services for arterial hypertension, breast and cervical cancer screening, labor and delivery, and management of preterm births was also noted. The evaluations conducted thus far have not reported significant changes in terms of health status.

Challenges. At present, the main challenge is to institutionalize the process of priority setting and adjustment for both HBPs. While significant progress has been made, the process has yet to be formalized and documented. Another pending task is to publicly disclose the information that supports the costing of the packages. This would allow for an analysis of the theoretical and empirical costs to determine if the available resources

are sufficient and, if not, to justify a request for additional resources. The next challenge, since population coverage has already been achieved, is to increase the plans' service coverage, which would involve bringing the resources allocated per person under Seguro Popular in line with social security levels. It is also necessary to improve transparency with regard to Seguro Popular's sources and use of funds, thus establishing a clear link between benefit package services rendered and payment mechanisms, as currently there is concern about the use of funds and the efficiency achieved with the available resources.

In the future, if Mexico decides to move toward a comprehensive, universal health system, it will face major challenges and pressures to introduce a universal HBP that will likely be based on CAUSES and the FPGC package. Included in

Basic Elements of the Seguro Popular Benefit Plans

Names of HBPs	Universal List of Essential Health Services List of High-Cost Interventions financed by the Catastrophic Health Expenditure Fund
Year plans began operations	2003
Central motivation	Demonstrate the resources necessary to serve the population without social security, improve equity and efficiency of health spending, empower the enrolled population by making its rights explicit
Target population	Population without social security
Service coverage	Universal List of Essential Health Services: low- and medium-complexity services Catastrophic Health Expenditure Fund: high-cost interventions
Financial coverage	No copayments
Population coverage	Approximately 45% of the total population (2012)
Estimated annual cost per capita	US\$200 for both plans (plus budgets already allocated to the states for the delivery of health services [2012])
Percentage of public health resources channeled to HBP funding	28.1% of total health expenditure (2011)
Provision of non-prioritized services	Public network under the traditional framework of supply-side subsidies and historical budget
Principal innovations	The services that Seguro Popular enrollees are entitled to were made explicit The issue of priority setting for health services was placed at the center of health sector discussions The need for more resources for the population without social security was shown, which facilitated the mobilization of additional resources and helped close the gap in funding equity between the population with social security and the population without

these challenges and pressures are fiscal pressures and constraints, political groups, pressure from unions, physical infrastructure capacity, and availability of human resources in health care, among others.

Introduction: Seguro Popular

This chapter discusses the design and implementation of the health benefit plans of the System of Social Protection in Health (SPSS), known as Seguro Popular.² This is a public insurance program aimed at individuals who are not enrolled in social security, and it covers 52.9 million people (2012 data), a figure equivalent to 45.2% of the population.³ The benefits offered through Seguro Popular are mainly embodied in two explicit plans: a low- and medium-complexity plan called the Universal List of Essential Health Services (CAUSES) and a list of high-cost interventions, financed by the Catastrophic Health Expenditure Fund (FPGC). In 2007, a program called Health Insurance for a New Generation (now known as 21st Century Health Insurance) was created to expedite and expand coverage to children under 5 born after December 1, 2006. This program offers 131 additional interventions beyond those included in CAUSES and the FPGC, all related to rare diseases affecting children under 5. This chapter will only examine CAUSES and the FPGC.

Like most of the studies presented in this book, Mexico is characterized by a segmented health system, which divides the population into subsectors according to their economic capacity and type of

employment relationship (figure 4.1). First, there is a private subsector aimed at the higher-income population. Second, there is a public insurance subsector, Seguro Popular, which provides health care coverage to the population not covered by social security. Third, there is a social security subsector fragmented along lines of different types of employment relationships: the Mexican Social Security Institute (IMSS) for private sector workers and their families; the Government Workers' Social Security and Services Institute (ISSSTE) for federal government workers and their families; as well as plans covering specific sectors, such as oil industry workers (Pemex) and members of the Mexican Army (Ministry of Defense) and Navy (Ministry of the Navy) (see figure 4.1).⁴ The three main segments of public insurance (IMSS, ISSSTE and Seguro Popular) do not enjoy the same benefits. IMSS and ISSSTE enrollees are entitled to a broader set of health care services as compared to Seguro Popular enrollees;⁵ however, the long-term objective is the universalization of Mexico's system of social protection in health, placing the IMSS, ISSSTE and Seguro Popular on the same level, both in terms of funding and covered health benefits (González-Pier, Gutiérrez-Delgado, Stevens et al., 2006). According to administrative data, in 2012, 52.1% of the Mexican population was insured by the IMSS, 44.9% by Seguro Popular and 10.6% by the ISSSTE. Other plans such as those offered by Pemex, the Ministry of Defense, the Ministry of the Navy, and state governments covered 1% of the population, while 1.8% of the population had private insurance.⁶ According to these figures, Mexico has achieved universal coverage of the population.⁷

² This case study is based on Giedion, Panopoulou and Gómez-Fraga (2009).

³ Calculation based on the national population projection from the 2010 National Population and Housing Census for 2012. It can be referenced at <http://www.conapo.gob.mx/es/CONAPO/Proyecciones>.

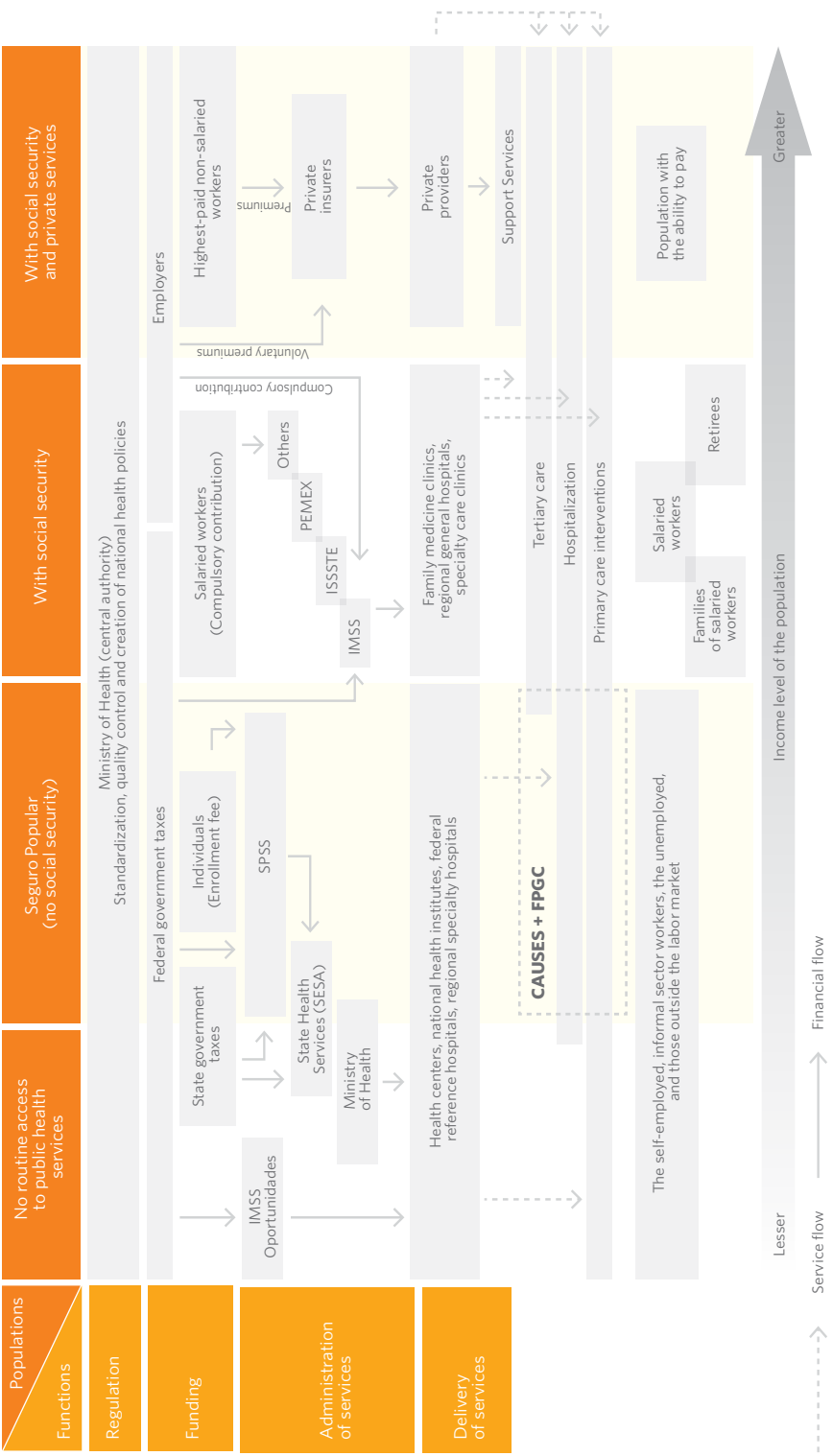
⁴ For a detailed description of the Mexican health system and Seguro Popular, see Ministry of Health (2006a) and OECD (2005).

⁵ IMSS and ISSSTE services are not defined in an explicit package, but instead they are described in a general manner, for example, ambulatory care, hospitalization, rehabilitation, etc., in the respective laws of the two institutions (Congress of Mexico, 1995; ISSSTE, 2007).

⁶ The sum of the enrollees in the different insurance programs is greater than the total Mexican population (117,724,402 people) as a result of duplication of coverage. For example, many people are simultaneously enrolled in Seguro Popular and the program Oportunidades. Sources: IMSS (2012 and 2013), ISSSTE (2012); SPSS, 2012 performance report; National Statistics and Geography Institute, 2010 Population and Housing Census.

⁷ It is estimated that only a very small proportion of the population remains unaffiliated with an insurance program and must rely on Ministry of Health and state health service providers to receive care as part of the "open" or uninsured population.

Figure 4.1. The health care services system in Mexico



Source: Finance Division, IMSS

Objectives and the deliberation process for CAUSES and the FPGC package

The study *Economía y salud* (Economics and Health), conducted by FUNSALUD (the Mexican Health Foundation), was the first to define a health care plan designed using national data on the estimation of the disability-adjusted life years (DALYs) indicator and cost-effectiveness calculations for the interventions (Frenk, Lozano, González-Block et al., 1994). Based on this study, in 1996, the Ministry of Health began implementing the Coverage Expansion Plan (PAC) with a strong emphasis on health promotion and prevention, directed especially at the rural poor. In 1997, this package was integrated into the conditional cash transfer program Progresá (Program for Education, Health and Nutrition), which was later renamed Oportunidades.

Although the PAC was an important precedent for CAUSES, it quickly became apparent that the interventions it covered were limited in the context of Seguro Popular. The result was that, during the implementation of the first pilot phase of Seguro Popular (2001-03), a much broader benefit plan focused on low- and medium-complexity care was selected, known as the List of Medical Benefits (CABEME). The PAC was used as a reference in building CABEME, in addition to information on the frequency of use of services offered by the Ministry of Health's and state health services' network of public providers. Most of these services were already financed by the Ministry of Health's budget and relied on formal regulations, which established procedures for the prevention, diagnosis and treatment of diseases such as hypertension and diabetes, as well as care management for childbirth and cesarean section, among others.

In 2003, the Mexican Congress approved a reform of the General Health Law (LGS), creating the SPSS with Seguro Popular as the operational arm for personal health care services. In this context, two explicit health care packages were approved: i) the List of Essential Health Services (CASES), which included a set of low- and medium-complexity medical interventions and ii) the FPGC's List of High-Cost Interventions, a high-complexity, high-cost health care package, whose need became evident during the pilot phase.⁸ CASES was the direct successor of CABEME, which operated during the 2001-03 pilot phase, and was in turn replaced by CAUSES in 2006.

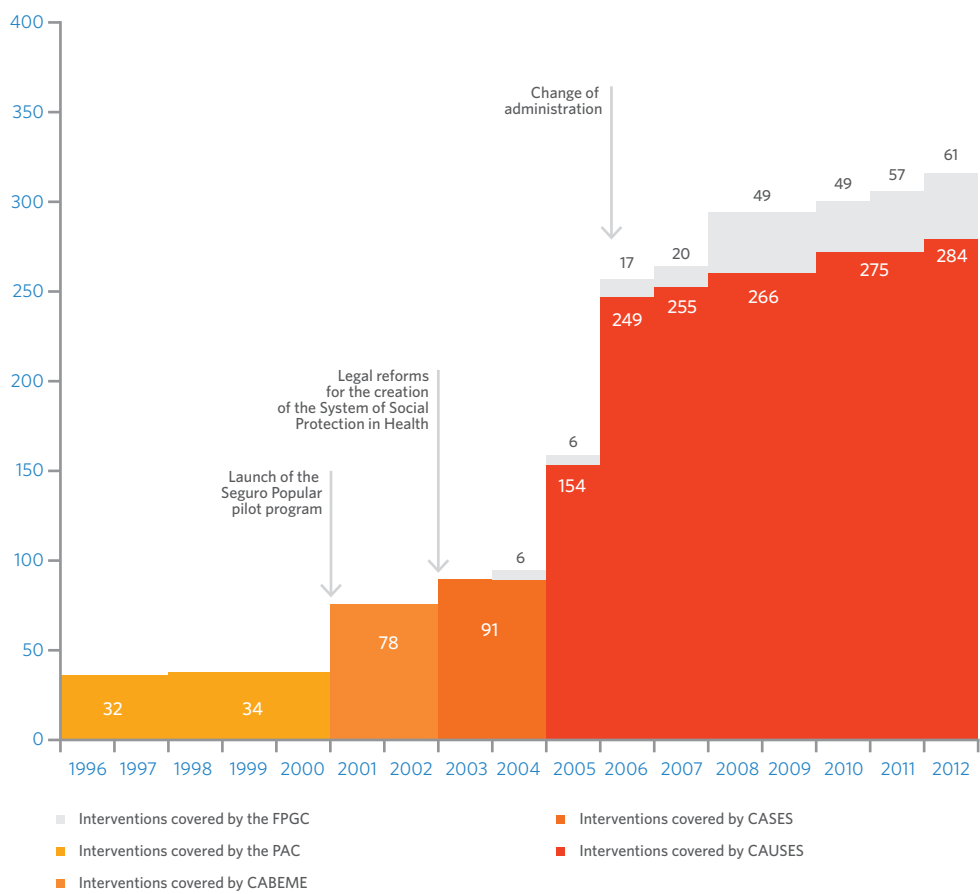
Graph 4.1 is a schematic representation of the names and packages during the period from 1996 to 2012 and shows how Seguro Popular has gradually expanded its scope. For example, FPGC coverage grew from six interventions in 2004 to 61 in 2012.

Goals

The 2003 reform of the LGS, which gave rise to CAUSES and the FPGC package, does not explicitly state its goals; however, the document accompanying CAUSES 2008 (CNPSS, 2008b) suggests that the goal of prioritizing the interventions is "...to use the resources allocated to health care in a manner that generates the greatest possible benefits in terms of the health conditions of the population." According to another publication, the goal of the list is "to define the composition and scope of each of the services or procedures to which the enrolled population is entitled" (CNPSS, 2009b). Perhaps even more significant is a publication by Frenk, Gómez-Dantés and Knaul (2009), which mentions three fundamental reasons for the implementation of the CAUSES package: 1) to serve as the basis for calculating the resources required to provide health care

⁸ A third package of community-focused interventions (vaccination campaigns, epidemiological surveillance, vector control, etc.) rather than individual-focused interventions was also adopted. Known as the List of Community Services, it was aimed at all Mexicans, not just Seguro Popular enrollees, as with CASES and the FPGC.

Graph 4.1. Development of Seguro Popular benefit plans, 1996-2012



Source: Adapted from graph 2 of González-Pier et al. (2006)
 PAC: Coverage Expansion Plan; CABEME: List of Medical Benefits; CASES: List of Essential Health Services; CAUSES: Universal List of Essential Health Services

services to the uninsured; 2) to be used as a quality assurance tool designed to ensure that all of the necessary services are provided according to standard protocols; and 3) to empower the enrolled population by making individuals aware of their rights.

The LGS defines the goal of the FPGC but not its HBP. In accordance with Article 77 bis 29, the fund’s objective is “... to support the financing of health care, primarily for SPSS beneficiaries suffering from high-cost diseases that lead to catastrophic expenses...”

In addition, one of the central motivations for the formulation and costing of an explicit benefit plan was to improve equity in the financing of the health care system between social security enrollees and the uninsured. Prior to the reform, public health spending per insured individual (primarily on social security) was 2.3 times greater than public health spending per uninsured individual (figure for 2002) (Ministry of Health, 2006a). The introduction of the HBPs intended to remedy this imbalance by guaranteeing the allocation of a specific amount of public funds per

enrolled family and, subsequently, per Seguro Popular enrollee, for the financing of personal medical services. In the process of determining the plans' content and cost, the resource requirements per enrollee became clear, which, in turn, helped mobilize additional resources. The explicit list of interventions allowed coverage gaps to be identified in urban and rural areas across the country, in order to guide investment decisions on infrastructure, equipment, and training of human resources, thus progressively guaranteeing effective access to services. As a result, in 2010, public health spending per capita for the insured declined to a rate 1.2 times the figure for the uninsured (Knaul, González-Pier, Gómez-Dantés et al., 2012).

Deliberation process

Seguro Popular launched its operations with the health benefit plan CABEME during its pilot phase (2001-03). It covered primary care interventions, ambulatory care and hospitalizations but not high-cost interventions. The deliberation and negotiation process through which interventions were selected was led by the Ministry of Health and was the result of broad consensus among different branches of this entity and the involvement of professionals from various disciplines, including doctors and economists (a description of the priority-setting and costing methods is found below). Furthermore, the analyses and discussions of the Ministry of Health were supplemented with consultations and recommendations from the health authorities of the five states where the pilot was launched (Jalisco, Colima, Tabasco, Campeche and Aguascalientes).

During these discussions, participants sought to design a benefit package that would meet both technical criteria and

other requirements. This package needed to i) be financially viable, which meant that its per capita cost for expected coverage could not exceed the budget ceiling for its implementation; ii) have the technical response capacity to provide services that conform to minimum quality criteria, which depended on the equipment, infrastructure and human resources already available; and iii) be associated with a drug formulary whose supply could be guaranteed, taking into account the expected population of enrollees. As in other cases discussed in this book (Colombia, Peru, Honduras, and Uruguay), citizens and other key stakeholders (e.g., medical associations) did not explicitly and systematically participate in the initial process to define CABEME. The National Commission for Social Protection in Health (CNPSS), the operational entity of Seguro Popular at the federal level, was designated by law as the body responsible for updating the list of essential services and for costing the interventions included therein.

Analyses prior to the introduction of Seguro Popular showed that uninsured households suffered from catastrophic and impoverishing expenses caused by out-of-pocket health spending (Ministry of Health, 2006a). It then became clear that it was necessary to supplement the coverage of low- and medium-complexity services offered in CABEME with coverage for some catastrophic health events. The LGS defined nine categories of health problems that would be the target of the FPGC's initial funding.⁹ Furthermore, the LGS and its regulations (published in April 2004) designated the General Health Council¹⁰ as the entity responsible for defining the diseases, treatments, medications and associated materials targeted for FPGC funding. From there, the General Health Council established an initial list of 60 possible diseases to be included. Lakin and Daniels (2007)

⁹ The diagnosis and treatment of cancer, cardiovascular conditions, cerebrovascular diseases, serious injuries, long-term rehabilitation, HIV/AIDS, neonatal intensive care, transplants, and dialysis (provisional article 14 of the LGS reform decree). There are discrepancies in the terminology used to define the categories since, in some cases, the name of the category is defined as the suggested treatment, e.g., dialysis and neonatal intensive care, while in other cases, it takes the name of the illness, e.g., cancer and cerebrovascular diseases.

¹⁰ Created in 1917 by constitutional mandate, it reports directly to the president and is responsible for the planning, regulation, coordination and organization of the national health system.

provide a detailed description and analysis of this priority-setting process, which is summarized in the following two paragraphs.

Nine general categories were selected based on technical and political criteria. In technical terms, the categories were defined based on criteria of cost-effectiveness, DALYs, budgetary impact and total cost considerations. In political terms, consideration was given to existing programs, such as the antiretroviral program for HIV/AIDS patients. Likewise, importance was placed on the considerations of Congress with regard to equity and the rights of women and children. The list of 60 potential diseases resulted from the discussions of nine groups of medical experts convened by the General Health Council. These groups also defined protocols for the care of these diseases, which were used to calculate the average annual cost of care for a subset of conditions that were considered leading candidates for inclusion under the FPGC in its first year of operation.

The FPGC initially covered four conditions: antiretroviral therapy for HIV/AIDS, cervical cancer, neonatal intensive care, and acute lymphoblastic leukemia in children and adolescents (under the age of 19). Antiretrovirals for HIV/AIDS patients were selected because these patients formed a strong interest group that had supported the reform in 2003. Furthermore, since they were funded through a vertical program administered by the National Center for the Prevention and Control of HIV/AIDS, their inclusion in the FPGC involved no additional financial cost. Similarly, some neonatal treatments were already offered to the population without social security through the Equal Start in Life program created during the Fox administration to reduce maternal and infant mortality. The inclusion of neonatal care and acute lymphoblastic leukemia was largely influenced by the growing evidence from families with members who are suffering from these diseases and facing catastrophic and impoverishing expenses, plus poor outcomes due to the

high treatment dropout rate resulting from a lack of resources. The inclusion of cervical cancer benefited the female population, bringing attention to a health problem that has been a leading cause of premature death in women for some time. In addition, the public sector had the ability to identify new cases rather reliably, but it lacked the necessary funds to finance their treatment.

Interviews with various sector stakeholders confirmed the important role played by the then-health secretary in making decisions about the diseases covered by the FPGC (Giedion, Panopoulou and Gómez-Fraga, 2009). Given the circumstances as well as the political and time pressures, it was noted that the diseases selected for coverage were sound choices.

By and large, the period of deliberation and negotiation of the Seguro Popular packages did not present any serious challenges, mainly because the reform did not intend to bring the IMSS and ISSSTE benefit packages in line with Seguro Popular. As a result, the process did not affect the acquired rights of the population.

Like other countries documented in this book (Colombia, Uruguay, and Peru), the design of the Seguro Popular packages displays a gradual development process, determined by supply responsiveness and associated budget availability. In this sense, the Mexican HBPs conform to the national reality rather than reflecting an outside technical proposal. Furthermore, as in Uruguay and Peru, the low- and medium-complexity services were developed separately from the high-cost or catastrophic services.

Main Features of CAUSES and the FPGC Package

This section describes three dimensions of the two plans analyzed: their population coverage, the scope of services they provide, and their financial coverage

in terms of the contributions made by beneficiaries (copayments) (WHO, 2008).

One of the most significant challenges of the reform introduced by Seguro Popular was to provide insurance to over 50 million Mexicans without social security, most of whom are poor. The implementation of Seguro Popular was gradual; the program launched its operations in 2001 in five pilot states, with coverage of 59,500 low-income families (Ministry of Health, 2006a). By December 2012, Seguro Popular had grown to cover approximately 52.9 million people, roughly 45% of Mexico's population (table 4.1).

The scope of services covered by CAUSES was established at the national level for the first time in 2004, and by 2012, it had grown to offer 284 interventions focused on the primary and secondary levels of care. Similarly, the FPGC package, aimed at high-cost illnesses, has been increasing its coverage from the top down, starting with the most catastrophic events.

The structure and content of CAUSES includes a description of the diagnosis and treatment of each intervention, rehabilitation measures, necessary medications, laboratory tests and diagnostic imaging that may be indicated by the treating physician. The interventions or services are categorized into six groups: i) 27 preventive health interventions; ii) general practice/family medicine or specialty consultations corresponding to 110 interventions for the diagnosis, treatment and rehabilitation of chronic non-communicable diseases and infectious diseases that can be addressed at the primary and secondary levels of care; iii) seven dental services; iv) 25 emergency services; v) 49 inpatient interventions;

and vi) 66 surgical interventions for the most frequently diagnosed digestive, gynecological, obstetric, dermatologic, and orthopedic disorders (CNPSS, 2012b).¹¹ The organization of CAUSES into these six groups follows hierarchical logic and, as noted in the 2008 list of services, it is intended to “allow for continuity of care, facilitating the referral and counter-referral of the enrollee once the differences in complexity between each health center and the health care needs of all SPSS users have been identified.” This is in spite of the present-day challenges that remain in terms of referral and counter-referral procedures between different levels of care.

For its part, by 2012, the FPGC package covered 20 disease groups composed of 61 interventions (see the annex to this chapter).¹² Unlike CAUSES, the FPGC does not describe the procedures, interventions or medications included for each of the covered events; however, since the beginning of operations, care protocols have been in place that define inputs and services that represent the variable costs of each intervention (medications, laboratory tests, etc.). These protocols are used to calculate the average cost but do not define in detail the benefits covered.

For conditions not covered by either of the two packages, Seguro Popular enrollees may receive services financed through resources from the federal and state budgets, separate from those of Seguro Popular.

In terms of financial coverage, the LGS leaves open the possibility of introducing copayments for certain services and/or medications, in order to reduce superfluous demand and prevent unnecessary prescriptions. However, to date, copayments have

¹¹ The annex to this chapter presents an excerpt of the list, where each of the six groups is illustrated with an example of an intervention, the organization, and the structure of the benefit plan.

¹² Among the diseases financed by the FPGC are cervical cancer, HIV/AIDS treatment, neonatal intensive care, different childhood and adolescent cancers, bone marrow transplants, breast cancer, testicular cancer, non-Hodgkin lymphoma, corneal transplants, lysosomal diseases in children under 10, hemophilia in children under 10, acute myocardial infarction in adults under 60, prostate cancer, kidney transplants in children under 18, hepatitis C, colorectal cancer, malignant ovarian cancer, and 17 congenital and surgical disorders and acquired diseases that form part of Health Insurance for a New Generation.

Table 4.1. Seguro Popular coverage, 2004-12

Year	Number of families enrolled	Number of individuals enrolled	Number of family members
2004	1,563,572	5,318,289	3.4
2005	3,555,997	11,404,861	3.2
2006	5,100,000	15,672,374	3.1
2007	7,293,539	21,925,654	3.0
2008	9,146,013	27,176,914	2.9
2009	10,735,500	31,132,949	2.9
2010	15,542,400	43,518,719	2.8
2011	19,932,044	51,823,314	2.6
2012	20,349,235	52,908,011	2.6

Source: System of Social Protection in Health, performance reports, 2005-13

not been implemented. As mentioned in the section on financing, the only contribution made by families enrolled in Seguro Popular is the family contribution at the time of enrollment, which forms part of the insurance premium.

Priority-Setting, Costing and Adjustment Methods

Priority-setting methods

The selection of CABEME interventions was based on those that already had recognized effectiveness and support in federal programs, those that were regulated, and, in many cases, those that already had financing. The following sources were used in the selection process: i) service plans already offered by other programs such as the PAC and the Program for Quality, Equity and Development in Health; ii) federal programs and their interventions; and iii) the study *Economics and Health*, which proposed three essential health service plans (ordered from the least to greatest

number of interventions) based on the cost per DALY gained per beneficiary per year.¹³

The selection was also based on a number of criteria: i) interventions needed to be highly cost-effective according to data from previous studies, ii) they had to address important health problems in terms of burden of disease (measured in DALYs), and iii) there needed to be a reasonable response capacity to avoid a problem with expectations in the short term. In addition to these components, demand was analyzed based on hospital admissions and records of primary care visits. Based on this data, it was possible to select interventions for CABEME that covered 95% of the reasons why people sought outpatient care and 66% of the causes of hospital admissions recorded by the Ministry of Health's services nationwide. On the basis of the aforementioned, two plans were formulated, one with 78 interventions and a broader one with 105 interventions. Some 15 high-cost medical interventions were considered as well, although the FPGC was not functioning during the

¹³ One DALY can be thought of as one lost year of healthy life. Measuring the burden of disease with this indicator would define the gap between the current health status of a population and the ideal, in which each member of that population would reach old age free from disease and disability.

pilot phase. The selection and design process for CABEME was described in the book *Estimación de costos de producción de servicios clínicos para la prevención, diagnóstico y tratamiento médico* (Cost Estimate of the Production of Health Services for Prevention, Diagnosis, and Medical Treatment) (Ávila-Figueroa, Herrera-Basto, Sousa-Fragoso et al., 2002), which is the only published source detailing how the essential services plan was created.

One point that was not clearly defined at the time of priority setting is the concept of catastrophic illness. Economic studies developed before and during the reform consider that a household faces a catastrophic expense whenever it spends over 30% of its disposable income (total income minus food costs) on medical expenses (Knaul, Arreola-Ornelas, Méndez-Carniado et al., 2006). However, a more operational definition was needed to define the high-cost interventions. Currently, experts convened by the General Health Council define a catastrophic illness according to the duration of the illness, the different stages of treatment, and its economic cost.

Costing methods

To define the cost of the interventions covered by Seguro Popular, two types of costing were performed. The first was a bottom-up (microcosting) method, for which the production function of each intervention was determined, considering all of the inputs required to offer it (infrastructure, human resources and equipment). Decision trees were designed for the illnesses with various clinical options, and the average cost of basic functions such as an outpatient consultation, one day of hospitalization, one day of intensive care, one hour of operating room time, medications, supplies, studies, etc., was determined (Ávila-Figueroa et al., 2002). From there, the cost of each intervention was defined, classified as fixed or variable.

The second type of costing was performed using a top-down (macrocosting) method based on a budget ceiling, with the implicit understanding that the financing for the Seguro Popular packages should not exceed that ceiling. The population without social security—Seguro Popular’s target population—and the estimated demand for each intervention (incidence) were considered, and from there, a per capita cost per intervention was estimated. The sum of the annual costs of the interventions that formed the package could not exceed the total cost per capita defined as the budget ceiling.

In the case of the FPGC package, the same bottom-up costing exercise was performed, except only variable costs (the marginal cost of the interventions) were considered, since the institutions that provide these types of services—primarily specialty hospitals—already received resources to finance fixed costs (salaries, capital costs, and general services).

In both cases, probably the greatest difficulty was the availability and reliability of information from the Ministry of Health’s services in order to perform the calculations, so sometimes information was used from other health sector institutions or even other countries.

Adjustment of CAUSES and the FPGC package

Adjustment of CAUSES

The initial selection and design exercise for CABEME was not repeated in subsequent years with the introduction of the SPSS, although several adjustments were made to the HBP as described below.

During the 2004-08 period, the adjustment of CAUSES was based on an exercise led by the National Commission for Social Protection in Health (CNPSS), which drew upon several sources, including the costing of interventions that were not initially included in CAUSES, as well as the opinion and experience of the states that proposed interventions

to include according to the demand on state services. From there, potential interventions were listed annually on the basis of a consensus among different areas of the CNPSS and taking into account both clinical and economic criteria similar to those considered in the design of the first package: budget adequacy, response capacity, and technical capacity, among others. However, this process was not systematized, institutionalized or documented.

Between 2004 and 2008, the number of interventions covered by CAUSES grew from 91 to 266, an increase of 192%. The changes not only reflect new interventions that were added or interventions already included that were disaggregated, but there were also interventions that were excluded due to low demand or limited therapeutic effectiveness, according to information from the states.

During this same period, the increase in interventions was accompanied year after year by a moderate real increase in financial resources (see table 4.2), with no clear relationship between the increase in interventions and increase in resources.

Taking into account the need to update the cost of interventions, beginning in 2008, the CNPSS defined technical protocols for all CAUSES conditions and conditions considered for inclusion. The protocols were transformed into spreadsheets through a standardized methodology, with information similar to that used for the first costing: the epidemiological profile of the diseases and utilization data, including hospital admissions. This update showed that the original calculation overestimated the demand for certain interventions, which explains the budgetary slack in the per capita cost of CAUSES. The fact that the per capita resources allocated to CAUSES were more than sufficient to fund its operations allowed new interventions to be included in 2010 and 2012.¹⁴

Adjustment of the FPGC package

In addition to the first four diseases covered by the FPGC package, cataracts, bone marrow transplants, other types of childhood and adolescent cancers, breast cancer, and 17 diseases from Health Insurance for a New Generation were included (see the annex to this chapter). In 2011, the FPGC introduced coverage for testicular cancer, prostate cancer, lysosomal diseases and hemophilia in children under 10, corneal transplants, acute myocardial infarction in adults under 60, and expanded coverage for non-Hodgkin lymphoma and bone marrow transplants in adults over 18. In 2012, kidney transplants in children under 18, hepatitis C, malignant ovarian tumors, and colorectal cancer were included.

Consistent with the comments made above in the case of the first four diseases, the inclusion of these new diseases in the FPGC results from a priority-setting approach in favor of vulnerable groups such as children and the use of a gender-based approach, as noted with testicular and prostate cancer, or breast and cervical cancer. For most types of cancer, the process gave priority ranking to those that generate high costs, and in order for them to be included, clinical cost-effectiveness was considered. However, a search of the General Health Council's minutes, which document the criteria and processes applied to the different diseases included in the package, produced no results. Many of the discussions and decisions on the selection of illnesses occurred in meetings that went undocumented.

The case of cataracts is interesting, because it does not seem to be a condition that generates catastrophic expenses. Lakin and Daniels (2007) connect this case to pressure from non-governmental organizations. In particular, they mentioned that Fundación Gonzalo Río Arronte wanted to donate Mex\$50 million to increase the number of

¹⁴ Interventions/diseases related to emergency obstetric care, mental health, drug treatment programs, vaccination, delayed diseases, eating disorders, and diabetes, among others.

cataract surgeries performed in the country, but since the foundation's grants mainly cover equipment, it asked the Ministry of Health to contribute another Mex\$50 million to cover personnel costs. The resources allocated for these surgeries were included in the fund, and consequently, the intervention became part of the package. Other stakeholders mention that the health sector had fallen behind on cataract surgeries, noting that the public sector had not performed them in over 15 years. Although they did not represent a catastrophic expense at the individual level, these surgeries could have posed a catastrophic expenditure for the public sector due to high demand from the population without social security.

This example and others, such as the financing of vaccines through the fund and the diseases from Health Insurance for a New Generation that were included in a very short period and without care protocols, show that on several occasions the FPGC has been used to finance interventions that do not necessarily generate catastrophic expense at the personal or family level. The FPGC has a trust fund with no budgetary limit, which means that at the end of each year, unspent funds are not returned to the Federal Treasury.

Driven by the need to institutionalize the process of inclusion of catastrophic illnesses in the FPGC package, in the summer of 2006, the General Health Council began to develop a manual for priority-setting activities. Four working groups were created: clinical-epidemiological evaluation, economic, ethical evaluation, and social acceptability. Based on the first manual for priority setting, it was determined that the four working groups would have similar status/importance. Each group would use indicators relevant to its topic in order to evaluate the diseases (Lakin and Daniels, 2007). Then, each group's evaluations would be translated into a composite index that would allow the various illnesses to be ranked, thus determining their inclusion. This first draft of the manual was followed by other

drafts, but the change of administration in late 2006 and early 2007 brought about personnel changes and led to a hiatus that continued until early 2009. Although work on the manual resumed, many of the original questions that had been raised remained unanswered. The most difficult questions to answer fell to the ethical evaluation and social acceptability working groups, for example, the type of criteria and indicators to be taken into account, or who should be a member of these groups. Although the creation of the manual allowed for better ranking of the list of illnesses to include in the fund, it failed to institutionalize the priority-setting process.

To date—nine years after implementing the reform—there are no formal, institutionalized processes for the adjustment of CAUSES and the FPGC package. During this period, there have been isolated attempts to define the priority-setting process for the two packages, without result. Now, having achieved universal coverage, there is an opportunity to focus efforts on formalizing priority setting for the Seguro Popular packages and adding transparency and credibility to the process.

Financing

The financial mechanism of Seguro Popular reflects the intention of its creators to combine new and existing funding sources in one virtual basket without having to change the prevailing financial structures at the time of the reform, for example, the resources historically allocated to the states through the Health Care Contribution Fund or the resources for programs such as Oportunidades. This strategy, known as alignment of resources, avoided a duplication of resources and laid the foundation for the states to direct the funds they receive for health toward the SPSS in the future.

This section describes the sources of financing for the Seguro Popular packages, the development of the

budget allocation per person, and these resources' share of the total public health expenditure.

Sources of financing

Seguro Popular financing consists of three components, as shown in figure 4.2: federal contributions from the central level, state contributions and family contributions. CAUSES and the FPGC package are financed by a pool of money composed mostly of national resources (74.4%), supplemented with state-level resources (25.5%) and, to a much lesser extent, family contributions (0.1%) (2012 data). Almost 90% of these resources are used to fund the low- and medium-complexity services of CAUSES, with less than 10% funding the catastrophic illnesses and services included in the FPGC.

The contributions from federal resources are divided into two parts:

- a. The *social contribution* per beneficiary, which is equivalent to 3.92% of the current general minimum daily wage in the Federal District. The annual social contribution in 2012 amounted to US\$66.80 per person.¹⁵
- b. The *federal solidarity contribution* per enrollee averages 1.5 times the amount of the social contribution but varies according to the income level of each state. It is greater in the poorest states at the expense of the richest ones (in accordance with a formula that considers factors such as the number of enrolled families, health needs, the performance of health care services, etc.). The average annual federal solidarity contribution nationally in 2012 was US\$100.20 per person. The federal government only transfers as a federal solidarity contribution the portion of funds that remains after considering the

budgets of programs that existed before Seguro Popular (existing resources).

The state solidarity contribution comes from state resources. It is the same for all states, and it was set at half the value of the social contribution. In 2012, the annual state solidarity contribution was equivalent to US\$33.40 per person.

Family contributions are payments required of families enrolled in Seguro Popular, with the exception of the poorest segments of the population (income deciles I through IV). The contribution is collected annually per family and depends on the level of family income. It varies between US\$157 (for decile V in 2012) and US\$864 (for decile X) (CNPSS, 2013). These contributions are collected directly by state governments. They aim to create a culture of shared responsibility and payment in advance, but they have never been considered a significant source of financing for the packages.

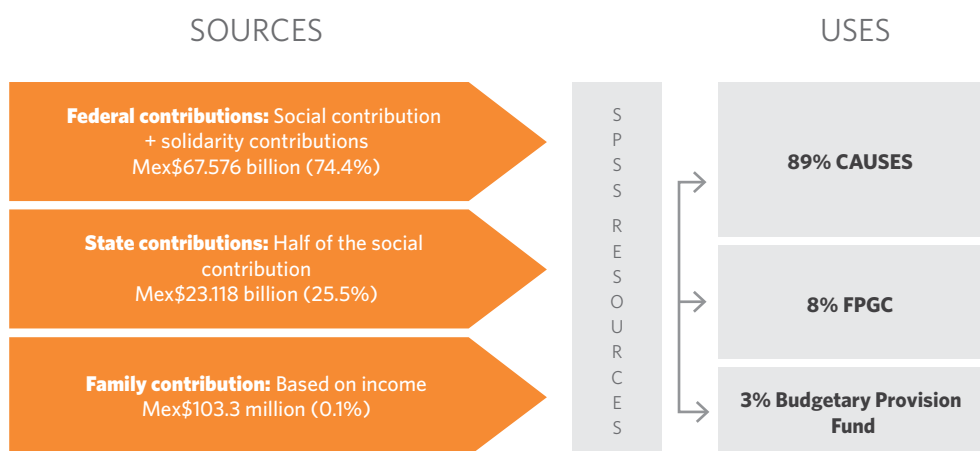
Development of the budget allocation per person

In 2012, the budget allocation per person for CAUSES and the FPGC package was, on average, about US\$201. Table 4.2 shows the development of the budget allocation for the 2004-12 period, taking into account that the system's funding changed in 2009 from a family allowance to an individual one. Figures indicate that during the 2005-09 period, real growth of the resources allocated to Seguro Popular was positive but declining. In 2010, per capita funding decreased 27% due to the transition from a family allowance to an individual one, while in 2011 and 2012, it remained stable in real terms.

The change in funding unit was aimed at balancing the finances of Seguro Popular, as there was evidence that the average family size was less than the 3.4

¹⁵ It was calculated only once in January 2009, and it has been adjusted periodically for inflation. The annual average exchange rate in 2012 was 13.17 Mexican pesos to the dollar (source: Bank of Mexico).

Figure 4.2. Sources and uses of SPSS funding, 2012



Source: Developed by the authors using data from the 2013 performance report for the System of Social Protection in Health

Note: Resources from the Budgetary Provision Fund finance infrastructure and equipment, and they cover the unexpected differences in the demand for interstate health service delivery.

members established when the plan was launched.¹⁶ This occurred in part because the states manipulated the number of enrolled families by separating the people who lived in a single dwelling into multiple families, thereby increasing the federal funding they received. As a result, the states with greater resources and smaller family size received more funding per person in comparison to poorer states with larger families (CNPSS, 2009a). The change from family to individual funding boosted enrollment, which recorded a peak of 12.4 million additional enrollees in 2010. It is expected that the states with more enrollees will benefit.

In the case of the FPGC, only the marginal cost of the interventions (variable costs) is covered, since the institutions that provide these services, most of which are specialty hospitals, receive their own budget to cover fixed costs. In 2012, the amount allocated to providers as reimbursement for the

variable costs of providing FPGC coverage was US\$825 million, which divided by the number of Seguro Popular enrollees for that year (52.9 million) yields a per capita marginal cost of approximately US\$12.¹⁷ This cost is included in the budget allocation of US\$200.

Share of the budget

As mentioned at the beginning of this section, Seguro Popular packages are financed by both new and existing resources. In 2011, this set of resources represented 28.1% of public health spending, and new resources accounted for 18.4% (table 4.3). New resources allocated to the financing of CAUSES and the FPGC package increased more than tenfold between 2004 and 2011.

For the 2004-11 period, public health spending on the population without social security grew relatively faster than

¹⁶ Seguro Popular's nuclear family was formed by the head of household, his spouse, children under 18 or students under 25, economically-dependent direct relatives over 64 who live in the same home, persons with disabilities, and dependents of any age.

¹⁷ It is not possible to calculate a total cost for the FPGC package since fixed costs differ among specialty hospitals.

Table 4.2. Seguro Popular budget per capita, 2004-12

Allowance	2004	2005	2006	2007	2008	2009	2010	2011	2012
Family (in current pesos)	7,553	7,881	8,076	8,404	8,720	9,289	-	-	-
Individual (in current pesos)	2,221	2,463	2,605	2,801	3,007	3,203	2,436	2,543	2,641
Individual (in constant pesos, 2012)	3,089	3,293	3,362	3,477	3,550	3,592	2,623	2,648	2,641
Real growth	-	6.6%	2.1%	3.4%	2.1%	1.2%	-27.0%	1.0%	-0.3%
Individual (in constant dollars, 2012)	197	226	239	256	270	237	193	205	201

Source: Developed by the authors on the basis of 2005-13 performance reports from the System of Social Protection in Health

spending on the population with social security. As in Colombia and Uruguay, the Seguro Popular explicit packages define a growing portion of the sector’s resources and have become strategic tools to increase public spending on health in Mexico.

Implementation

The implementation of the HBP involves significant challenges, such as striking a micro-equilibrium among the system stakeholders, procuring prioritized services, monitoring service quality, as well as securing the physical and human resources to guarantee access to the rights that are embodied in the benefit plans. The section below describes these aspects of CAUSES and the FPGC package.

Financial balance

In accordance with the law, the CNPSS conducts an annual financial and actuarial valuation of CAUSES and the FPGC. To date, the results of these evaluations are not public, unlike those of the actuarial valuations performed

for the plans offered by the IMSS and ISSSTE. As a result, there are no public domain sources on which to base an opinion about the financial stability of the SPSS. However, as already mentioned, the costing of CAUSES has been updated, which reveals the existence of budgetary slack in comparison to the original costing.

Procurement of medical services

In the case of CAUSES, there is no direct link between the payment of providers, most of which are public, and the provision of package services. In other words, the providers are not compensated based on the services they provide. Unlike other cases in this book (Uruguay’s PIAS, Chile’s AUGE, Argentina’s Plan Nacer, and Colombia’s POS) where financing and service delivery are separate, in most Mexican states the financial resources manager and the provider coexist under the umbrella of state health services. State resources are still distributed based on previous budgets, without considering the performance of the provider treating the patients, or the quality, complexity, or outcome of the services.

Table 4.3. Public health expenditure, 2004-11*

Public health expenditure	2004	2005	2006	2007	2008	2009	2010	2011
Total	307.294	314.502	329.687	355.399	373.427	397.330	420.581	436.947
Population with social security	206.914	195.147	198.383	209.276	206.201	216.982	233.028	243.261
% of total	67.3	62.0	60.2	58.9	55.2	54.6	55.4	55.7
Population without social security	100.380	119.355	131.304	146.123	167.227	180.348	187.552	193.686
% of total	32.7	38.0	39.8	41.1	44.8	45.4	44.6	44.3
Seguro Popular								
New and existing resources	10.352	24.216	41.015	60.102	78.496	95.148	94.424	122.799
% of total	3.4	7.7	12.4	16.9	21.0	23.9	22.5	28.1
New resources	7.724	15.344	28.334	41.644	52.587	62.918	65.421	80.268
% of total	2.5	4.9	8.6	11.7	14.1	15.8	15.6	18.4

Source: Federal and State Health Accounts System (2012), Directorate-General of Health Information, Ministry of Health; 2013 performance report from the System of Social Protection in Health
 * in billions of constant pesos, 2011

The lack of separation between financing and service delivery is related to the control that the states and state health services wish to maintain over Seguro Popular resources. Although the CNPSS has attempted to acquire information on what and how the states spend Seguro Popular resources, at present there are no regulations regarding accountability or transparency in the use of resources.

In contrast to CAUSES, payments for FPGC package services are linked to their provision. A facility that renders services covered by the FPGC must submit a request to the CNPSS to provide a service covered by the fund; this request is authorized and then paid. The amount paid is defined by a fixed rate that does not change on account of the number and type of studies or interventions performed during the patient's treatment. In other words, providers assume part

of the risk of treatment, and on that basis, they are expected to carry out the procedures necessary to care for the patient.

The separation of funding from service provision is not a prerequisite for the money to follow the patient; however, when the resource manager and the provider belong to the same entity, resources are frequently distributed using criteria different from those for fee-for-service.

Enforceability of medical services

The HBPs of Seguro Popular define a set of explicit interventions that enrollees are entitled to receive. In this way, the right to health protection took shape as defined in the Constitution of the United Mexican States of 1917. Yet neither the Constitution nor the LGS clearly defines

how enrollees may demand that this right be fulfilled. Article 4 of the Constitution states that “...the law shall define the guiding criteria regulating the access to health services and establish concurrent activities to be carried out by the federation and the states in organizing public health services under Article 73, paragraph XVI of this Constitution.” The LGS establishes that enrollees have the right “to make complaints to the State Regimes for Social Protection in Health or to state health services for the inadequate or improper provision of the services established in this instrument, as well as to receive information about the procedures, timeframes and forms in which complaints and inquiries will be addressed, and to be assisted when dissatisfied with the medical care received.”

Furthermore, paragraph 11 of the SPSS operating rules, which corresponds to complaints and grievances, defines the creation of two mechanisms: the Seguro Popular National Customer Service System, consisting of a call center that handles questions, complaints, suggestions and comments from around the country, and a contact email address, where citizens and beneficiaries may submit questions, complaints, suggestions and comments through the Internet. There is also a customer service system to handle citizen grievances, operated by state oversight agencies and the Ministry of Public Administration.

While there is a process for filing complaints, the amount received is quite low compared with the number of Seguro Popular enrollees. The 2012 SPSS performance report (CNPSS, 2013) states that at the national level, 41,819 calls were handled through the call center, of which 8% were complaints (3,127 calls). Of those calls, most complaints were about charges for care (39.6%), poor care (22.2%), denial of service (13.5%) and drug shortage (9%). A total of 2,167 messages were received via the contact email, of which 9% were complaints. The report does not mention complaint resolution, the percentage of complaints

resolved, response time, or follow-up beyond the fact that the complaints were channeled to the states for their attention.

Based on the aforementioned, it follows that the Seguro Popular plans are currently enforceable in theory, but nothing suggests that they are in reality. Mexico’s experience shows that the enforceability of the right to health protection embodied in an explicit benefit plan not only depends on the scope of the plan but also the mechanisms to make it enforceable and the empowerment of its users regarding their rights.

Quality control

In accordance with the LGS, facilities that wish to join Seguro Popular’s provider network must be accredited and guarantee a range of appropriate medical services. The Ministry of Health’s Undersecretariat for Health Sector Integration and Development is responsible for accreditation. The main aspects of accreditation are safety, quality, installed capacity of medical personnel, physical devices, infrastructure and medications.

With regard to CAUSES, health centers, general hospitals, mobile units, and specialty care clinics must be accredited. According to the 2012 SPSS performance report, 10,788 facilities were accredited during the 2004-12 period, representing 84.6% of a universe of 12,743 facilities registered with the SPSS (CNPSS, 2013). To provide the FPGC package, general hospitals, specialty care clinics, regional specialty hospitals, and private hospitals must be accredited. In 2012, there were 1,013 accredited facilities covering all fund interventions.

The accreditation of public facilities serving Seguro Popular enrollees was analyzed during the first SPSS evaluation cycle in 2005-06, although this component was also evaluated in subsequent years. The initial evaluation

emphasized the need to accredit more units in less time, a challenge that seems to be ongoing, given that today more than 15% of the units that provide services for CAUSES are not accredited. Furthermore, the evaluation contended that the main obstacle to accreditation was quality, although facilities did demonstrate satisfactory performance on the safety component. At present, the number of accredited providers is reported annually through the SPSS performance reports, but they fail to provide a qualitative analysis or discuss the challenges of accreditation.

Knowledge of benefits and mechanisms in order for the population to demand its rights

There are few sources of information about the public's knowledge of the benefits included in the Seguro Popular packages. The CNPSS conducts an annual satisfaction survey of Seguro Popular beneficiaries, and the results are published on its website. Through this instrument, system beneficiaries are asked if they received information about Seguro Popular services when they enrolled. The percentage of people responding affirmatively increased from 57% in 2009 to 90.5% in 2011.¹⁸

The 2006 Health and Nutrition Survey reports that three out of four people enrolled have received Seguro Popular's list of medical benefits, while just under three-quarters of enrollees believe that they have sufficient information about their rights and obligations.

Physical and human resources

The availability of physical and human resources is very important, given the sharp increase in the number of enrollees. In 2013, this number represented about half of the country's population. According to data from the National

Health Information System, the levels and rates per 1,000 inhabitants for beds, doctor's offices, doctors and nurses increased in the period from 2000 to 2010 (table 4.4). The increases in human resources have been greater than those in physical infrastructure, and greater for the Ministry of Health as compared to the entire health sector.

Even so, the issue of human resources remains a major challenge, as evidenced by the 2009 SPSS management evaluation (INSP, 2009). To meet the increased demand for medical services, state health services have hired personnel as independent contractors using SPSS resources, without other employment benefits. As this constitutes a precarious hiring practice, there has been significant pressure to hire permanent staff. At the close of 2009, the Ministry of Health estimated that state health services had "regularized" about 70,000 workers at various levels, with SPSS resources used for more than 24,000 of them. Regularization involved granting employment benefits to personnel and extending the life of contracts, which increased resource requirements. According to a 2009 assessment, the number and categories of personnel hired seem to correspond to the services offered by CAUSES and the number of enrollees by state, but the cost of regularization has fallen entirely to the SPSS, limiting the possibility of using system funds to meet enrollment goals, provide medications and other supplies, etc. To bring the situation under control, the CNPSS has capped the amount available to pay personnel hired to provide services at 40% of the system's resources.

In short, although the benefits for the population of the HBPs have been explicitly stated, their implementation still needs to be facilitated. Increasing physical and human resources available to cover the target population and monitoring quality to ensure the efficiency and effectiveness of services are

¹⁸ These surveys gathered samples from about 20,000 people as they exited service provider units (CNPSS, 2009c and 2011b).

challenges. In addition, progress must be made in making beneficiaries aware of their rights so they can demand them.

Evaluation

Since the beginning of the reform in 2003, the importance of monitoring and evaluation has been emphasized. Article 75, paragraph III of the LGS regulations proposed an evaluation model with three components: finance, management and impact. The Directorate-General for Performance Evaluation of the Ministry of Health is responsible for evaluating Seguro Popular. Within this legal framework, assessments covering different aspects of the reform have been made by national and international academic institutions.¹⁹

The initial evaluation of the SPSS—and probably the most complete—was conducted in 2005-06. Between 2007 and 2010, there were other assessments that were more focused on administrative and management processes. The first evaluation analyzed issues relevant to the provision of the packages and their outcomes, including access to and utilization of services, the supply of medicines, effective coverage, health conditions, appropriate treatment and financial protection. According to the results, SPSS enrollees are more likely to use health services than non-enrollees. At the same time, the SPSS protects against catastrophic expenses, especially for the household subgroups that reported use of ambulatory care and inpatient services. The dispensing of prescriptions has improved on account

Table 4.4. Physical and human resources, 2000-10

Year	Beds	Offices	Doctors	Nurses
Total health sector (rate per 1,000 inhabitants)				
2000	0.8	0.5	1.2	1.9
2005	0.7	0.5	1.5	1.9
2010	0.8	0.6	1.7	2.3
Growth rate 2000-10	3.2%	16.1%	41.7%	20.4%
Total health sector (levels)				
2000	77,144	51,492	140,629	190,335
2005	75,992	53,365	155,880	201,036
2010	84,625	65,801	188,909	252,625
Growth rate 2000-10	9.7%	27.8%	34.3%	32.7%
Total Ministry of Health (levels)				
2000	31,487	23,395	54,293	73,502
2005	33,388	26,671	65,575	83,097
2010	37,851	33,015	87,407	115,017
Growth rate 2000-10	20.2%	41.1%	61.0%	56.5%

Source: Statistical information bulletins from the Ministry of Health, 2000, 2005 and 2010

¹⁹ Although many publications evaluate various aspects of Seguro Popular, this section focuses on the evaluations commissioned by the Directorate-General for Performance Evaluation with emphasis on the Seguro Popular packages.

of the SPSS; however, the current level is lower than the one observed in social security clinics. An increase in the effective coverage of services was noted in all of the interventions studied over a period of five years, but particularly in the case of arterial hypertension, breast and cervical cancer screening, labor and delivery, and management of preterm births.²⁰ Similarly, the more effective coverage benefited both those enrolled in the SPSS and those who are not. There were no major changes in terms of health conditions, but this was anticipated given the relative newness of the reform. Some of these outcomes were corroborated by other studies²¹ and the SPSS evaluations from 2008 (Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán [Salvador Zubirán National Institute of Medical Sciences and Nutrition], 2010) and 2010 (INSP, 2010).

In addition, three of the evaluations included aspects related to the FPGC. Those from 2007 (INSP, 2008) and 2009 (INSP, 2009) focused on administrative and managerial aspects of the fund. The results of the last evaluation point out three operational issues: i) difficulties in accrediting hospitals at the state level due to lack of infrastructure and/or lack of resources for accreditation; ii) operational problems in terms of promptly notifying and authorizing cases due to lack of material and human resources; and iii) lack of timeliness in the transfer of resources on the part of the CNPSS. In addition, the 2007 evaluation mentions that a substantial portion of resources continues to be allocated to the purchase of antiretrovirals, which leaves other diseases without much-needed funds. Meanwhile, the use of FPGC resources for the purchase of vaccines to serve a specific health care program is at odds with the strategy of funding an individual care event. The 2010 evaluation analyzed

the effect of the FPGC in patients with cervical cancer and concluded that, although the fund had decreased out-of-pocket spending for patients and their families, it should also encourage early diagnosis, which in turn would facilitate timely treatment and achieve an increased survival rate among patients (INSP, 2010).

The Seguro Popular reform has been extensively evaluated, but given that the evaluation process should be ongoing, there is a need to revisit issues from the first wave of evaluations, such as effective coverage and health outcomes.

Lessons and Recommendations

One of the main achievements of the reform that created the SPSS was to explicitly state the services to which Seguro Popular enrollees are entitled. CAUSES and the FPGC package stand out in Mexico because no other health subsector in the country (IMSS, ISSSTE, Pemex, etc.) has a clearly defined package. Another achievement lies in the fact that the Seguro Popular packages—with all of their shortcomings in terms of deliberation, implementation and adjustment—have made health care priority setting a topic of discussion. A third achievement was its positive effect on the availability of financial resources for the delivery of health care services to the population without social security. This led to a more equitable distribution between the populations with and without social security.

Important challenges still lie ahead. The first and most important one is to institutionalize the priority-setting processes for both packages. Although significant efforts have been made to

²⁰ For the purposes of this evaluation, effective coverage was defined as an intervention that is only provided if needed and that achieves the desired results (quality). For example, in the case of treatment for arterial hypertension, the need was defined based on the target population of adults age 20 or older with a systolic blood pressure level of 140 mmHg or higher; utilization was defined as self-reported use of antihypertensives, while the quality is measured as a reduction of systolic blood pressure due to treatment.

²¹ For a literature review on the effects of the reform, see Knaul et al. (2012).

organize the process, it has not been formalized or documented to date. Second, the lack of public information available on the costing of the packages and the inclusion of new interventions has hindered debate about the level of per capita funding and how it compares with the theoretical and empirical costs of the package. Since population coverage has already been achieved, the next steps should focus on additional service coverage, which requires resources similar to those currently enjoyed by the population with social security. Information on the micro- and macro-equilibrium of the system will enable a case to be made for more resources. A third challenge would be to link the delivery of CAUSES services with payment mechanisms, so that the money follows

the patient across state lines. The lack of transparency at the state level regarding health budget allocation raises serious concerns about the use of funds and the health outcomes to be achieved.

Finally, under the assumption that Mexico is moving toward a comprehensive health care system, the definition of a single package for the population will be important. The Seguro Popular packages may form the basis for a new sectoral package, but the question is how to define its scope considering the differences in coverage between social security and the SPSS. The challenges are many: political maneuvering, pressure from unions, financial constraints, response capacity, technical capacity, and others.

References

- Ávila-Figueroa C., E. Herrera-Basto, A. Sousa-Fragoso et al. 2002. "Estimación de costos de producción de servicios clínicos para la prevención, diagnóstico y tratamiento médico." Mexico, Secretaría de Salud.
- CNPSS (National Commission for Social Protection in Health). 2005. *Sistema de Protección Social en Salud, informe de resultados, tercer trimestre de 2004*. Mexico DF, CNPSS.
- . 2006. *Sistema de Protección Social en Salud, informe de resultados, segundo semestre de 2005*. Mexico DF, CNPSS.
- . 2007. *Sistema de Protección Social en Salud, informe de resultados, segundo semestre de 2006*. Mexico DF, CNPSS.
- . 2008a. *Sistema de Protección Social en Salud, informe de resultados 2007*. Mexico DF: Secretaría de Salud, CNPSS.
- . 2008b. "Catálogo Universal de Servicios de Salud 2008." Mexico DF, CNPSS.
- . 2009a. *Sistema de Protección Social en Salud, informe de resultados 2008*. Mexico DF, CNPSS.
- . 2009b. "Catálogo Universal de Servicios de Salud 2009." Mexico DF, CNPSS.
- . 2009c. Presentation "Estudio de satisfacción de usuarios del Sistema de Protección Social en Salud 2009." Mexico DF.
- . 2010. *Sistema de Protección Social en Salud, informe de resultados 2009*. Mexico DF, CNPSS.
- . 2011a. *Sistema de Protección Social en Salud, informe de resultados 2010*. Mexico DF, CNPSS.
- . 2011b. Presentation "Estudio de satisfacción de usuarios del Sistema de Protección Social en Salud 2011." Mexico DF.
- . 2012a. *Sistema de Protección Social en Salud, Informe de resultados 2011*. Mexico, DF, CNPSS.
- . 2012b. "Catálogo Universal de Servicios de Salud 2012." Mexico DF, CNPSS.
- . 2012c. *Sistema de Protección Social en Salud, informe de resultados, enero a junio de 2012*. Mexico DF, CNPSS.
- . 2013. *Sistema de Protección Social en Salud, informe de resultados 2013*. Mexico DF, CNPSS.
- Congreso de la Unión. 1984. Ley General de Salud. Available at: <http://www.diputados.gob.mx/LeyesBiblio/pdf/142.pdf>. Accessed: September 2013.

- _____. 1995. Ley del Seguro Social. Available at: <http://www.diputados.gob.mx/LeyesBiblio/pdf/92.pdf>. Accessed: September 2013.
- Consejo de Salubridad General. 2009. "Manual para la priorización de enfermedades e intervenciones que ocasionan gastos catastróficos." Version from 19 February.
- Frenk J., O. Gómez-Dántes, F. M. Knaul. 2009. "The democratization of health in Mexico: financial innovations for universal coverage." *Bulletin of the World Health Organization* 87: 542-8.
- Frenk J., R. Lozano, M. A. González-Block et al. 1994. *Economía y salud: propuestas para el avance del sistema de salud en México*. Mexico DF, Fundación Mexicana para la Salud.
- Giedion U., G. Panopoulou and S. Gómez-Fraga. "Diseño y ajuste de los planes de beneficios: el caso de Colombia y México." Serie Financiamiento del desarrollo n.º 219. Santiago, Chile, ECLAC. Available at: <http://www.eclac.cl/publicaciones/xml/8/37988/lcl3131pe.pdf>. Accessed: September 2013.
- Gómez-Dantés O., S. Sesma, V. M. Becerril et al. 2011. "Sistema de salud de México." *Salud pública de México* vol. 53 sup. 2: S220-32.
- González-Pier E., C. Gutiérrez-Delgado, G. Stevens et al. 2006. "Priority setting for health interventions in Mexico's System of Social Protection in Health." *Lancet*. Published online 25 October. DOI: 10.1016/S0140-6736(06)69567-6.
- IMSS (Mexican Social Security Institute). 2012. Informe mensual de población derechohabiente y sistema de acceso a derechohabientes.
- _____. 2013. *Informe al Ejecutivo y al Congreso de la Unión sobre la situación financiera y los riesgos que enfrenta el Instituto Mexicano del Seguro Social, 2012-2013*. Mexico DF, IMSS.
- INSP (National Institute of Public Health). 2008. Evaluación de procesos administrativos 2007. Cuernavaca, INSP.
- _____. 2009. Evaluación de Sistema de Protección Social en Salud 2009. Evaluación gerencial. Cuernavaca, INSP.
- _____. 2010. Evaluación de los efectos del Fondo de Protección contra Gastos Catastróficos en los pacientes con cáncer de mama. Cuernavaca, INSP.
- Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán (Salvador Zubirán National Institute of Medical Sciences and Nutrition). 2010. "Evaluación de efectos del Sistema de Protección Social en Salud 2008." Mexico DF, Secretaría de Salud.
- ISSSTE (Government Workers' Social Security and Services Institute). 2007. "Seguros y prestaciones del ISSSTE." Documento publicado a través de la Subdirección de Atención al Derechohabiente. Mexico DF, ISSSTE.
- _____. 2012. Anuario estadístico 2012. Available at: <http://www2.issste.gob.mx:8080/index.php/mdir-inst-finanzas-anuarios-anos/100-instituto/finanzas/567-dir-finanzas-anuarios-capitulos2012>. Accessed: September 2013.

- Encuesta Nacional de Salud y Nutrición (National Health and Nutrition Survey) 2006. Available at: <http://www.insp.mx/produccion-editorial/publicaciones-antteriores-2010/661-encuesta-nacional-de-salud-y-nutricion-2006.html>. Accessed: September 2013.
- Knaul F. M., E. González-Pier, O. Gómez-Dantés et al. 2012. "The quest for universal health coverage: achieving social protection for all in Mexico." *Lancet*. Published online 15 August. DOI: 10.1016/S0140-6736(12)61068-X.
- Knaul F. M., H. Arreola-Ornelas, O. Méndez-Carniado et al. 2006. "Evidence is good for your health system: policy reform to remedy catastrophic and impoverishing health spending in Mexico." *Lancet*. Published online 25 October. DOI: 10.1016/S0140-6736(06)69565-2.
- Lakin J. and N. Daniels. 2007. "The Quest for Fairness: A case study of the evolution of Mexico's Catastrophic Insurance Fund." Draft paper.
- OECD (Organization for Economic Cooperation and Development). 2005. *OECD Reviews of Health Care Systems: Mexico*. Paris, OECD.
- Presidencia de la República. 2004. Reglamento de la Ley General de Salud en materia de protección social en salud. Available at: http://www.diputados.gob.mx/LeyesBiblio/regley/Reg_LGS_MPSS.pdf. Accessed: September 2013.
- Secretaría de Salud (Ministry of Health). 2007a. "Sistema de Protección Social en Salud. Evaluación de efectos." Mexico DF, Secretaría de Salud.
- . 2007b. "Sistema de Protección Social en Salud. Evaluación de procesos." Mexico DF, Secretaría de Salud.
- . 2006a. "Sistema de Protección Social en Salud. Elementos conceptuales, financieros y operativos." Mexico DF, Secretaría de Salud, Fundación Mexicana para la Salud e INSP.
- . 2006b. "Sistema de Protección Social en Salud. Estrategia de evaluación." Mexico DF, Secretaría de Salud.
- . 2006c. "Sistema de Protección Social en Salud. Evaluación financiera." Mexico DF, Secretaría de Salud.
- World Bank. 1993. *Invertir en salud*. Washington, DC, World Bank.
- WHO (World Health Organization). 2008. *The World Health Report*. "Advancing and sustaining universal coverage," chapter 2. Washington, DC, WHO.

Chapter 5



{ **Peru:** The Essential Health Insurance Plan (PEAS)

Lorena Prieto, Camilo Cid and Vilma Montañez

Summary

Context. Peru has a segmented health system, with one-third of its population uninsured. The Comprehensive Health Insurance (SIS) program covers one-third of the country's population, including the homeless and the poor, while social security (EsSalud) covers 24.8% of the population, which corresponds to formal sector workers. In addition, the social security health system permits the purchase of coverage for low-complexity benefits through health care service providers, and there are also private insurance plans for those with the ability to pay.

Since each population segment has access to different health care coverage, inequalities are found in access to medical care. This inequality was one of the central motivations for proposing a health benefit plan (HBP), called the Essential Health Insurance Plan (PEAS), as part of health system reforms introduced in 2009 under the Universal Health Insurance (AUS) Law. PEAS is the minimum benefit plan for the entire population.

Outcomes. Political agreement has been reached on the utility of an HBP, and its implementation has moved forward through passage of the AUS law as well as the definition and adoption of PEAS and its gradual implementation in pilot areas. Despite technical flaws, the risk of reversing these reforms seems low

considering the political support they receive.

Challenges. The greatest challenge facing PEAS stems from the funding discrepancy between required and allocated resources. According to this case study, the per capita resources allocated amount to just 25.5% of the variable cost of PEAS. Although the SIS only finances the variable cost of PEAS, Peru's Ministry of Health (MINSa) should work to strengthen its negotiation capacity with the Ministry of Economy and Finance in order to make financing of the HBP sustainable for the population enrolled in the SIS. Until the resources required to fund the plan are on par with their actual cost, implicit rationing of these services will continue.

There are also legitimacy issues due to difficulties with the participation of different stakeholders and the technical soundness of PEAS. Health sector experts believe that the priority-setting process lacked transparency and that consultations, both with experts and with the public, were insufficient. Another significant challenge is the institutionalization of the explicit priority-setting process, in such a way that the benefit plan can be systematically and regularly updated to comply with the AUS law. Thus far, the government has chosen to implement supplemental plans rather than update PEAS. Lastly, Peru's experience shows how despite general agreement on the need for a minimum

Name of HBP	Essential Health Insurance Plan
Year plan began operations	2009
Central motivation	Inequalities in access to medical care among different population segments: the homeless and low-income individuals (enrolled in the Comprehensive Health Insurance program), formal workers (enrolled in EsSalud), high-income individuals, and the low-income uninsured
Target population	Universal (gradual implementation in pilot areas)
Service coverage	Comprehensive plan developed on the basis of insurable conditions covering all stages of the lifecycle, for both the healthy and the sick, with an emphasis on prevention. It only covers three catastrophic illnesses (cervical cancer, uterine fibroids and benign prostatic hyperplasia [BPH]). Other catastrophic illnesses and orphan diseases are covered by Plan Esperanza, financed through the Intangible Solidarity Fund for Health (FISSAL)
Financial coverage	No copayments for hospital care or health promotion and prevention activities. There are capped copayments for ambulatory care, but exemptions exist for some services
Population coverage	67.3% of the population has guaranteed coverage under the Essential Health Insurance Plan
Estimated annual cost per capita	MINSA calculation: US\$174.70 in purchasing power parity (PPP) terms. Variable portion of costs: US\$104.82 PPP. Resources actually allocated to the SIS to cover variable costs: US\$24.96 (PPP)
Percentage of public health resources channeled to HBP funding	There are no known estimates
Provision of non-prioritized services	It depends on the institution. EsSalud regularly offers additional services to the Essential Health Insurance Plan. The SIS offers two supplemental plans. FISSAL must cover high-cost conditions (chronic illnesses, cancer, and rare or orphan diseases)
Principal innovations	Passage of the Universal Health Insurance Law (AUS law) and a universal minimum benefit plan as required by law

benefit plan, reforms that should have accompanied its implementation but never did—such as the development of functions within the SIS and the National Health Insurance Superintendency, or an update of the targeting system—can limit the central role that this plan should have.

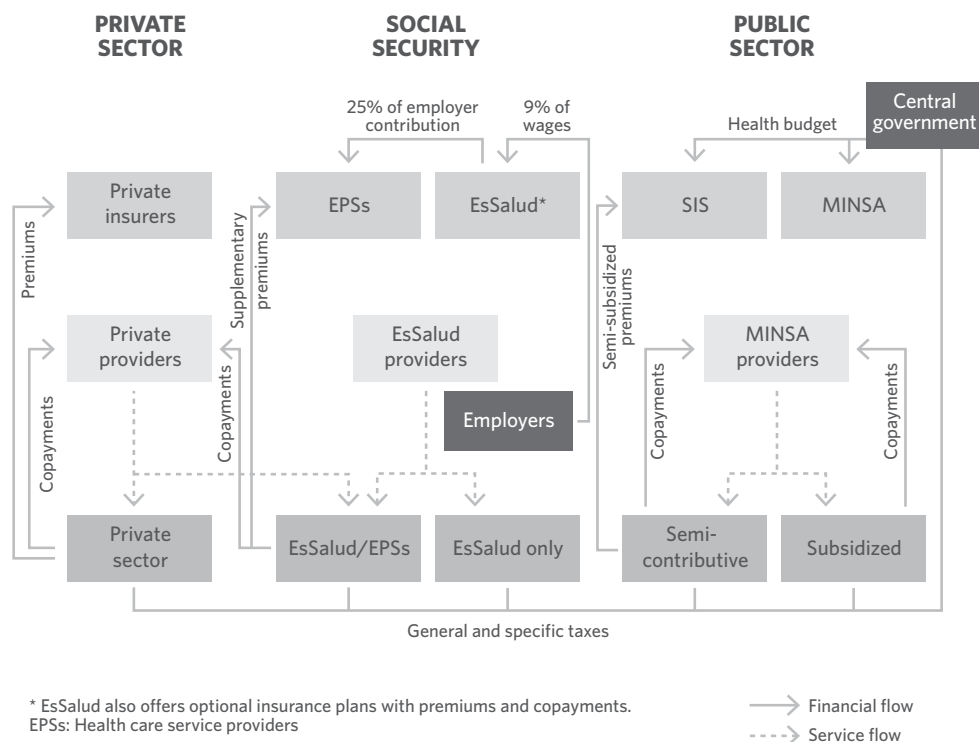
Introduction

This chapter examines the design and implementation of Peru’s health benefit plan, the Essential Health Insurance Plan (PEAS). This plan represents the minimum coverage available to the population through different insurers, whether public or private.

The methodology for the development of this case follows the methodological guidelines described in the introductory chapter of this book. The authors reviewed the available literature on PEAS and its implementation, and they conducted interviews with 19 key health sector stakeholders who participated in the design of PEAS.

It is important to understand the overall structure of Peru’s health system; it is a fragmented system in terms of provision and segmented in terms of insurance, with three main subsectors—private, social security health, and public. Figure 5.1 presents the system’s main financial flows—including direct payments made by beneficiaries to insurers/funders

Figure 5.1. Peru: Health system for the insured population



Source: Prieto (2011)

(premiums), payment of taxes to the government, execution of the health budget, and copayments—and the service flow from providers to beneficiaries.

From top to bottom, figure 5.1 shows insurers and funders, followed by the respective providers and beneficiary groups. From left to right are shown the private, social security, and public subsectors.

The private subsector follows the standard framework of a market composed of insurers and private providers. Generally, the population with the greatest financial resources accesses private insurance through the payment of premiums, and these individuals receive care within the provider network offered by their insurer. Coverage is partial, in terms of both health problems and financial protection, since the insurance policies

contain the standard features for this type of insurance, including deductibles and copayments.

Social security in health offers Social Health Insurance (EsSalud) and coverage through health care service providers (EPSs). Employers pay 9% of their workers' wages to EsSalud to provide health care goods and services through its provider network (Congress of the Republic of Peru, 2006). EsSalud offers broad coverage, under which claims for covered health conditions are paid 100%, but its enrollees must be seen by EsSalud providers. Some employers offer the option to enroll with an EPS. EPSs must offer compulsory coverage known as basic coverage (*capa simple*), which includes ambulatory care, emergency care, maternity care, and dental and vision care. They also offer complex coverage plans (*capa compleja*) with additional

premiums, deductibles and copayments. The EPS system, which was created to reduce the demand on EsSalud for basic care, receives 25% of the employer contribution to EsSalud (corresponding to 2.25% of wages) in order to provide health care services to its enrollees through its own provider network or private provider networks with which it has service contracts. EPSs also offer supplemental coverage to the basic plan for an additional premium, deductibles and copayments. In principle, any care not covered by the EPS is covered by EsSalud.

Lastly, the public subsector has Comprehensive Health Insurance (SIS), which enrolls the poor in order for them to receive care from public providers. The SIS operates with two regimes: 1) a subsidized regime for the uninsured living in poverty and extreme poverty and 2) a semi-contributive regime for the uninsured non-poor. The first group pays no premiums, deductibles or copayments, while the second pays a subsidized premium and few copayments. The SIS is a decentralized public agency under MINSA that has primarily served to fund operating expenses in order to provide coverage to the poor and the extreme poor through its subsidized regime. It later expanded to the non-poor through its semi-contributive regime.

The coverage of services offered by the SIS has expanded since its inception. It currently offers PEAS in the Universal Health Insurance (AUS) pilot areas.

Figure 5.1 does not include the uninsured population, which accounts for 32.7% of the total population (National Institute of Statistics and Informatics [INEI], 2013). The uninsured may access private or public services through out-of-pocket payments for health care. In addition, the uninsured—the vast majority of whom are poor or extremely poor without access to some other type of insurance—may access

the SIS under the following conditions: 1) they must be classified as poor in the Household Targeting System (SISFOH) database and 2) they must register at a health facility.¹

With the introduction of the Universal Health Insurance Law (AUS law) in 2009, SIS coverage also depends on individuals' area of residence (Congress of the Republic of Peru, 2009). The AUS law defined PEAS as the minimum plan that all public and private insurers in the system must offer, although it would be progressively and geographically implemented. In Universal Health Insurance pilot areas, the SIS offers PEAS plus a supplemental plan for the subsidized regime and PEAS only for the semi-contributive regime. In other areas, the Prioritized List of Health Interventions (LPIS) was offered (MINSA, 2007a; MINSA, 2007b); however, the gradual replacement of the LPIS by PEAS was approved at the national level on August 21, 2012 by Presidential Decree No. DS-007-2012-SA (MINSA, 2012b). EsSalud began offering PEAS to the self-employed in 2010, followed by private insurers in 2011.

Graph 5.1 shows how the Peruvian population is distributed by insurance subsector (including the uninsured population) according to 2010 data. In the graph, insurance plans are sorted by average monthly household income per capita of the enrolled population (left axis). The SIS covers 34.4% of the population, whose average income is US\$165.² This population receives an explicit benefit plan (PEAS or LPIS, depending on area of residence, as will be shown later in this chapter). The uninsured population (40.7% in 2010) follows with an average income of US\$281. This population ranges from low-income individuals who may not have enrolled in the SIS to high-income individuals who choose not to insure themselves. EsSalud covers 19.8% of the

¹ Previously, the SIS conducted the economic assessment, but this procedure changed under the regulations of the Universal Health Insurance Law. SISFOH falls under the auspices of the Ministry of Development and Social Inclusion.

² All figures in this chapter are presented in U.S. dollars adjusted for purchasing power parity, according to World Bank data.

population, with an average income of US\$415. In summary, the SIS and EsSalud combined cover 54.2% of the population, while the other insurance plans together cover an additional 5.1%.

The AUS law also states that the Intangible Solidarity Fund for Health (FISSAL) must cover high-cost conditions of SIS enrollees as defined by MINSA and, consequently, it supplements PEAS (Congress of the Republic of Peru, 2009). The law also created the National Health Insurance Superintendency (SUNASA) as the oversight body of the AUS, while MINSA preserves its administrative and regulatory roles.

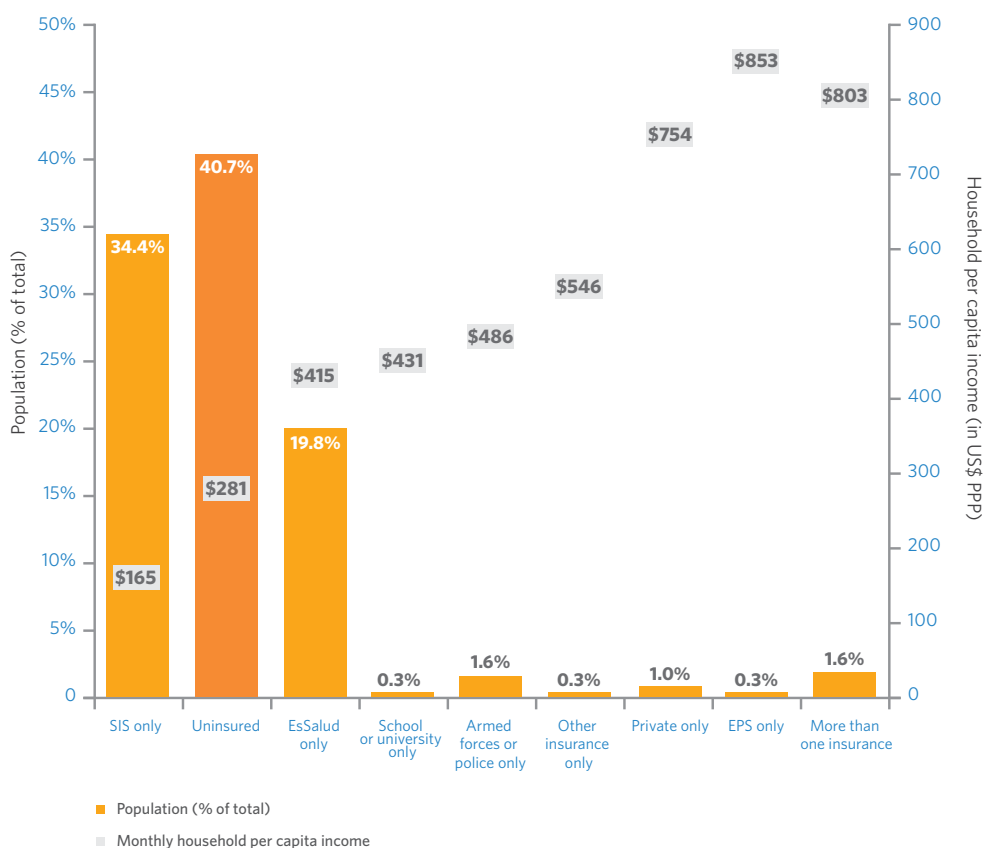
Main Features of the Essential Health Insurance Plan

Approved on November 28, 2009, PEAS is a benefit plan with explicit health guarantees, which contains a list of insurable conditions, interventions and services to be funded. Its main features are described below.

Population coverage

PEAS is a universal benefit plan in terms of population coverage; however, its

Graph 5.1. Insurance plans, population and income, 2010



Source: Developed by the authors with data from the National Household Survey (ENAHO), 2010

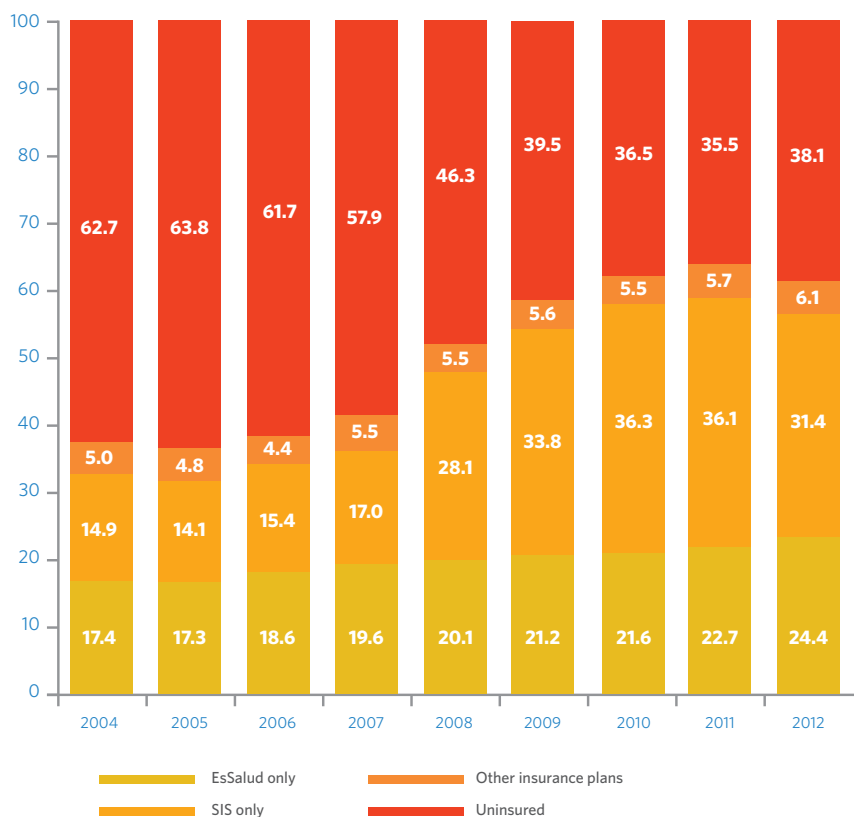
insurable conditions implicitly prioritize pregnant women and children, since 56 of the 140 conditions included in PEAS fall under obstetrics, gynecology and pediatrics.

Since July 2010, PEAS has been available through the SIS in Metropolitan Lima and Callao, with other pilot areas gradually added later.³ In 2012, of the 11,353,562 SIS beneficiaries, 2,810,550 were covered by PEAS, representing 25% of the total beneficiaries (SIS, 2013). Graph 5.2 shows the development of health insurance in Peru from 2004

to 2012. It highlights three important aspects: i) participation in EsSalud and other insurance plans⁴ has been on a slight upward trend since 2007; ii) there has been a significant reduction in the percentage of the uninsured population; and iii) the SIS has managed to increase participation significantly since 2007. These last two points indicate that the AUS is achieving its goal of expanding health insurance.

The distribution of the population covered by PEAS in the SIS is closer to that of the general population than that of the poor

Graph 5.2. The development of health insurance for the Peruvian population, 2004-12(%)



Source: Developed by the authors with data from the National Household Survey (ENAHU), 2004-2012

³ As of 2012, the AUS had expanded to 13 regions, and with DS-007-2012-SA, it expanded nationwide.

⁴ Other insurance plans include private health insurance, insurance for the armed forces and police, university insurance, private school insurance and others.

population, which is the plan's target. This may be due to the fact that the population resides in Metropolitan Lima and Callao, which are higher-income areas in comparison to the rest of the country. The SIS insured population features a higher proportion of children under 9 and a lower proportion of adults ages 20 to 59 in comparison to both the general population and the poor.

PEAS medical coverage

According to the Ministry of Health, PEAS medical benefits cover 65% of the disease burden. The insurable conditions described in PEAS cover the entire lifecycle, for both the healthy and the sick. The PEAS approach is oriented toward comprehensive care, and it emphasizes the preventive aspects of insurable conditions for the healthy population and for different age groups and sexes.⁵

The medical coverage provided by PEAS offers detailed indications for the clinical management of most insurable conditions and services it covers.

PEAS includes benefits at all three levels of care (primary, secondary and tertiary) and specifies the "coverage per event," i.e., the number of services covered. However, it does not explicitly state if this is a maximum, average or recommended number of services. Lastly, the medications covered by PEAS are included on the National Essential Medicines List (PNME).⁶ In cases with specific clinical guidelines, the medications are directly indicated for each intervention and benefit. However, conditions without clinical guidelines lack drug coverage. Presidential Decree DS-016-2009, which approved PEAS, states that "the medications needed for the care of conditions, interventions, and benefits included in PEAS correspond to those included in the PNME." The lack of

clinical guidelines for all conditions makes it difficult to determine or assess whether the PNME's structure complies with the goal of providing comprehensive care.

Nomenclature

PEAS is defined as a prioritized list of insurable conditions, health interventions, health services and procedures with explicit guarantees of timeliness and quality. The insurable condition is defined by population type; for the healthy population, the aim is to maintain its health status while for the sick population the aim is to regain its health status. The intervention is the service or set of services for health promotion, prevention, recovery or rehabilitation, aimed at the management of insurable conditions (the list of 140 insurable conditions is presented in section 6 of the annex to this chapter). Since the total number of existing insurable conditions is unknown, it is difficult to indicate the percentage covered by PEAS.

The detail of each insurable condition includes four elements: 1) the definition of the condition; 2) the corresponding International Classification of Diseases, 10th Edition (ICD-10) diagnostic codes; 3) the specific clinical management; and 4) the benefits covered. The list of covered benefits includes the type of intervention, the level of care, the Current Procedural Terminology (CPT) code, a simplified description, the coverage per event (number of services) and observations.

Clinical practice guidelines

There are clinical management standards for the vast majority of interventions, including those in the areas of obstetrics/gynecology and pediatrics, as well as other conditions included in PEAS (MINSa, 2009a). These standards were not written specifically for PEAS but instead arose

⁵ As mentioned previously, the AUS law contemplates that high-cost catastrophic illnesses will be financed through FISSAL, outside of PEAS coverage.

⁶ The PNME includes 428 active ingredients in 662 pharmaceutical forms and 30 therapeutic drug groups (MINSa, 2010c).

from clinical practices validated by Ministry of Health standards. In cases where there was no MINSA standard, EsSalud standards were consulted and, failing those, international practice guidelines were used. PEAS specifies the standard to be applied when a well-defined MINSA norm exists; when there is no standard, it links to providers' clinical guidelines.

One criticism from both MINSA and other stakeholders is that there are still no guidelines for all of the conditions included in PEAS, or they are too vague or simply unknown. Furthermore, there are differing opinions about the role of clinical guidelines in PEAS care practices; some view them simply as reference documents while others consider their application to be mandatory.

Guarantees beyond the explicit definition of coverage

PEAS includes 34 explicit guarantees tied to 12 insurable maternal and child health conditions, with a total of 22 timeliness guarantees and 12 quality guarantees. The norms required of the different agents involved in the health insurance process will gradually expand until the entire spectrum of PEAS is covered. The PEAS system of guarantees is just now being implemented. On March 27, 2013, lawmakers passed the SUNASA supervisory regulation concerning compliance with the norms governing the aforementioned guarantees. This regulation applies to health insurance fund administration institutions and EPSs (SUNASA, 2013; MINSA, 2013).

Financial coverage

The AUS law does not specify PEAS financial coverage. For example, it does not indicate a minimum cost or maximum copayment that must be assumed by the user for a service, except in the case of enrollees in the subsidized regime of the SIS, where the law specifies that they are not

required to pay premiums, copayments or deductibles. Nonetheless, due to the scarcity of resources at health care facilities, payment for ancillary diagnostic procedures and medications has become a common practice, despite being illegal (Health Forum, 2008; Health Forum, 2009). Those insured under the semi-contributive regime pay premiums and some copayments, and the financial coverage they receive is limited to the maximum benefit amount established by the standards of care.

In addition to exclusions and limits on use, the population enrolled in the SIS without the ability to pay (which is covered by PEAS in the pilot areas and by the LPIS in other areas of the country) must pay at MINSA facilities (table 5.1).

Access to excluded services

The services excluded from PEAS have been significant, especially for the SIS. With the implementation of PEAS, the SIS decided to offer a supplemental plan to enrollees of the subsidized regime in pilot areas, so that they would not notice that PEAS removed some conditions from the benefits already received under the LPIS (SIS, 2010b). Furthermore, the complementarity of FISSAL funding allowed the SIS to cover certain interventions not included in PEAS (for example, cancer, chronic and terminal illnesses, and self-limiting diseases). First they were evaluated by the SIS and then nominated for funding by the FISSAL, which determined support based on available resources. In April 2012, the List of High-Cost Illnesses was approved, and FISSAL moved under the administration of the SIS with public funding from the Treasury (SIS, 2012). In November 2012, Plan Esperanza was approved, which provides coverage for cancer patients with treasury financing (MINSA, 2012c). However, when the service is covered by neither PEAS, nor a supplemental plan, nor FISSAL, nor Plan Esperanza, the SIS enrollee must pay out of pocket for care. As noted above, and as is the case in other countries discussed in this book, different

Table 5.1. Out-of-pocket health expenditure by insurance type and point of care, 2009 (in US\$ PPP, 2010)

	Uninsured	SIS only	EsSalud only	Other insurance	Total
Did not seek health services	7.08	3.00	12.38	21.16	6.72
Pharmacy/drugstore, at home, other	14.18	10.91	16.64	34.60	14.77
MINSA facility (incl. CLAS)	40.40	9.35	36.90	36.58	19.08
EsSalud facility	18.26	14.58	21.51	47.44	22.02
Armed Forces, National Police	-	-	-	43.07	43.07
Private facility	76.98	50.74	77.95	80.26	73.67
Total	19.23	7.44	23.26	43.64	16.62

Source: Developed by the authors with data from the National Household Survey (ENAHO), 2009
CLAS: Local Health Administration Committees

benefit plans coexist for different types of services and contingencies, even for the same benefit population.

Share of the budget

PEAS's share of public spending is unknown, suggesting a gap between its estimated cost and the resources allocated to finance it (this subject is discussed in the section on costing and financing). However, in 2010 MINSA prepared a consolidated estimate of AUS financial requirements, which includes a total of US\$25 million for the payment of services to providers for the care delivered through PEAS to new SIS enrollees in pilot areas (US\$17.84 million for Lima and Callao and US\$7.18 million for all other areas) (MINSA, 2010e). This allocation represents 1.4% of the transfers received by these areas, except in the case of Lima and Callao, which, in 2010, received 9.2% and 2.5% of the total of their transfers, respectively. The volume of PEAS services actually covered could not be verified based on the resources allocated to the regions. Moreover, the resources received

by the SIS are used for all of its enrollees, not just those covered solely by PEAS, since not all people in the pilot areas have completed the PEAS enrollment process.⁷

Reasons and Adoption Processes for the Essential Health Insurance Plan

This section describes the process of discussion and negotiation that took place in Peru to design PEAS and analyzes the methods used in this process.

Events prior to the adoption of the plan

During the political transition from the Paniagua administration (2001), MINSA developed a set of health principles and policies. Among these, the concepts of universal health care and guaranteed social security coverage for all Peruvians and residents were proposed. The creation of a progressively-expanding public health insurance program, in terms of both territory and coverage, was also

⁷ The implementation of PEAS in pilot areas occurs through an enrollment process. In order to enroll, individuals must be classified as poor in the SISFOH. Prior to implementation, there were LPIS beneficiaries in the pilot areas who had to re-enroll in order to choose PEAS. In other words, PEAS enrollment is progressive to the extent that SISFOH classifies the population of the pilot area and that population requests enrollment in PEAS.

proposed as a step toward universality. Lastly, MINSA suggested that the mechanism for formulating and revising health care policies should be based on a social-political agreement: the National Agreement.

In July 2002, now during the Toledo administration, the National Agreement established the need to “guarantee universal access to quality comprehensive health care at no cost and in a timely and ongoing manner, by expanding and strengthening health services, promoting universal access [...] and encouraging the development of a comprehensive, decentralized national health care system” (National Agreement, 2002).

In parallel, the government merged the Free School Insurance and Mother and Child Insurance programs to form the Comprehensive Health Insurance (SIS) program (MINSA, 2001). The SIS was created as a temporary entity, responsible for structuring a new public health insurance program (Congress of the Republic of Peru, 2002). Later, in 2006, 16 political parties signed the Political Agreement on Health, which pledged to define “on the basis of a consensus of national and regional health priorities, a guaranteed benefit plan that includes promotion, prevention, treatment and rehabilitation for major health problems” (Care Peru, UNFPA and NDI, 2006).

Lastly, during Alan García’s presidency, Congress enacted the Universal Health Insurance Law (AUS law) in March 2009, which promotes universal health insurance coverage for the entire population. Thus, PEAS fulfills the National Agreement’s call for a minimum coverage health benefit plan for all Peruvians. The legislature charged MINSA with the creation of PEAS, and it provided guidelines on which it should be based. The design criteria for PEAS excluded catastrophic illnesses, in keeping with its goal of serving as a basic plan. A specific fund (the Intangible Solidarity Fund for Health) was created to cover the excluded diseases.

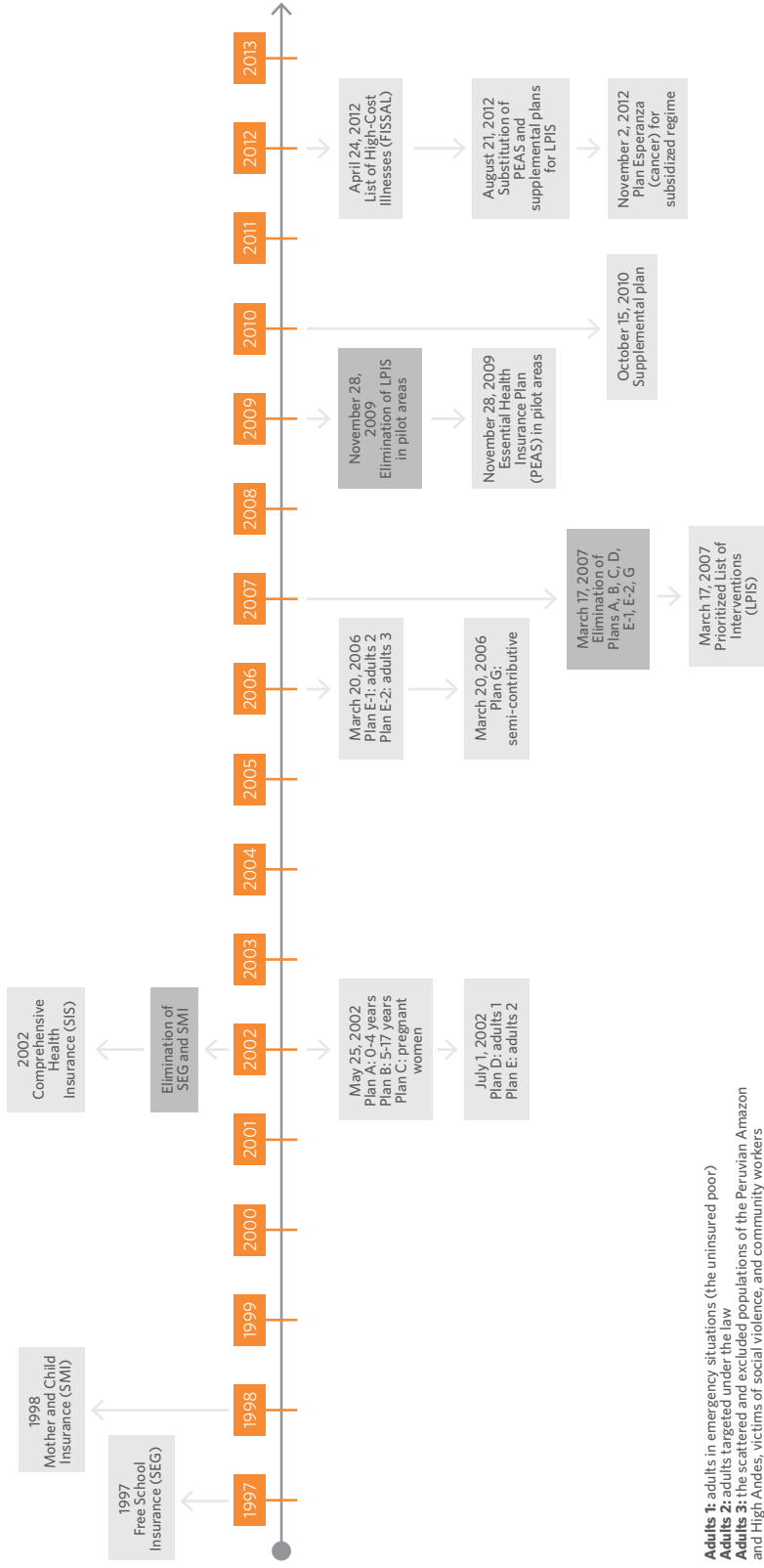
Until 2007, the SIS offered several plans, labeled Plan A through Plan G (see section 2 of the annex to this chapter). These plans were designed for specific population groups that were identified using heterogeneous criteria. Often, there were overlaps with regard to their eligibility criteria and enrollment (figure 5.2), thus complicating SIS management. The system lacked sufficient management tools to track its beneficiaries, resulting in double or triple enrollment of the same person in different plans. In 2007, the SIS developed the Prioritized List of Health Interventions (LPIS) and created more uniform poverty guidelines for enrollment, which were then approved by MINSA and the executive branch. In this manner, management was simplified with one health care plan for all SIS enrollees, even if it was not yet the intention for it to be a plan for the entire system.

PEAS was approved in 2009 with the idea that it would serve as the minimum plan for the entire system, and its implementation in the SIS began later that year in AUS pilot areas. Instead of using the LPIS as a starting point, PEAS’s design was based on criteria defined by the AUS law. Consequently, it left out benefits included in the previous plan, which led to significant resistance when piloted. The readjustment of PEAS over time aims to incorporate LPIS coverage that had been omitted (see section on readjustment).

In addition, although the SIS was required to enroll individuals in PEAS in all AUS pilot areas, at first it could only do so in Metropolitan Lima and Callao since, due to connectivity issues, access to the information system needed to identify the target population for the subsidized component of the SIS (the poor and extreme poor) was limited. This meant that PEAS enrollment was concentrated in Metropolitan Lima and Callao until late 2010, when enrollment began in other pilot areas (SIS, 2011a; SIS, 2010c; SUNASA, 2012b).

All insurers were able to offer PEAS as of April 3, 2011. EsSalud launched the

Figure 5.2. Timeline of Comprehensive Health Insurance (SIS) plans



Adults 1: adults in emergency situations (the uninsured poor)
Adults 2: adults targeted under the law
Adults 3: the scattered and excluded populations of the Peruvian Amazon and High Andes, victims of social violence, and community workers

Source: Developed by the authors

plan EsSalud Independiente for the self-employed, which includes PEAS plus additional coverage financed through the payment of premiums.⁸ In May 2011, private sector insurers launched plans based on PEAS, subject to the payment of a premium with copayments and deductibles.

Goals

The goal of PEAS, according to the AUS law, is to establish a minimum health benefit plan for all residents of Peru. All insurance companies must offer it through public and private health facilities. To ensure comprehensive care for people at different stages of life, PEAS defines 140 health conditions⁹ with a list of benefits and their respective services.

Deliberation and negotiation process

The AUS law charged MINSa with the task of defining PEAS. The creation of the plan did not include an open process of deliberation and negotiation, and there were also coordination difficulties. MINSa asked for technical assistance¹⁰ in the preparation of the first version of PEAS, but since the request was informal, ministry technicians could not give it official approval.¹¹ For this reason, the priority-setting processes for PEAS were not technically justified. This lack of coordination weakened the plan's position, which depended on the ability of its leaders to justify and advocate for PEAS with different stakeholders, such as the Ministry of Economy and Finance, in order for it to be institutionalized within MINSa. For example, MINSa has failed to justify its calculation of financial needs for PEAS to the Ministry of Economy and Finance. This shows the difficulty of establishing proper technical coordination, which in turn may have led

to some gaps in the formulation of PEAS, as noted below.

Furthermore, since PEAS did not take LPIS coverage into consideration, the SIS had to introduce extraordinary coverage to PEAS so that those previously covered by LPIS would not view their benefits as having been reduced.

One of the main improvements that arose from the adjustment of PEAS was the inclusion of professional organizations, such as the College of Physicians and the College of Dentists, representatives of health care service providers, and researchers. Other stakeholders absent during the original PEAS design process were also included. To build consensus around PEAS content, it is important to define the key stakeholders involved in its review. This begins with MINSa, which, as the governing body, should establish an institutional mechanism to carry out this process, using as reference the organizational experience and procedures from other countries to regularly review its plans. Different interested stakeholders, such as providers, insurers, and the Ministry of Economy and Finance, need to participate and, in turn, generate permanent forums for discussion with other sector stakeholders and the public. A formal mechanism ensures institutionality, but it will be the management that defines how the SIS's outstanding issues are resolved, such as the financing of resources necessary for PEAS by the Ministry of Economy and Finance and the application of guarantees to providers. Currently, only representatives of SUNASA, MINSa's Directorate-General of Health, MINSa's General Office of Planning and Budget, the Health Sector Reform Support Program, and the National Institute of Health participate in the AUS evaluation.

⁸ The EsSalud website mentions 236 additional benefits (EsSalud, 2012).

⁹ Health conditions are defined as "...a state of health one seeks to maintain, in the case of the healthy population, or regain, in the case of the sick population, which is eligible to be funded through health insurance plans" (de Habich, Madueño and Sobrevilla, 2011).

¹⁰ Technical assistance was requested from the Promoting Alliances and Strategies (PRAES) project of the U.S. Agency for International Development (USAID).

¹¹ According to officials interviewed from the Directorate-General of Health at MINSa.

PEAS Design

The criteria and methodologies for priority setting and adjustment in order to decide which health conditions and medical procedures are included in PEAS are described below. There is also a general explanation of how its cost was estimated and a description of its funding sources. Lastly, the context into which the design and implementation of PEAS were inserted and the degree of social consensus required to gain legitimacy are mentioned.

Priority-setting and adjustment methods

Priority setting for PEAS followed the trend of other experiences (e.g., Chile's Plan AUGE) of guaranteeing care for health conditions as a comprehensive solution to the issue of access. This contrasts with the approach that guarantees services or benefits without linking them directly to health problems, as has been the case with the LPIS and in countries such as Uruguay and Colombia.

The priority-setting process used to select the 140 health conditions that make up PEAS (see section 6 of the annex to this chapter) followed the general criteria of the AUS law: burden of disease; benefit plans compatible with health priorities; comprehensive patient management; benefits for the healthy population at different stages of the lifecycle; diagnostic and medical procedures for public, private and mixed insurance plans; actual procedures based on scientific evidence and analysis of cost-effectiveness;¹² health system supply capacity; and actuarial analysis and financial estimates. The technical assistance received by MINSA (see footnote 10) performed the priority-setting study in three phases according to different criteria (figure 5.3) (de Habich, Madueño and Sobrevilla, 2011). In the first phase, health conditions were listed, and the diseases were ordered from

highest to lowest burden, until 45% of the total burden of disease was included. Next, conditions requiring hospital care with costs in excess of US\$653.89 per event were included—on the basis that this figure represents 30% of the average annual spending of families in extreme poverty, not including food costs—conditions that account for 60% of hospital admissions. In the second phase, conditions were excluded from the preliminary list if comprehensive care cannot be guaranteed due to restrictions on the health system's response capacity or if they require infrequent hospital care. In the third phase, interventions that were already covered by the SIS and EPSs were identified and included, as well as those that were a public health interest and priority but had been excluded in the first two phases.

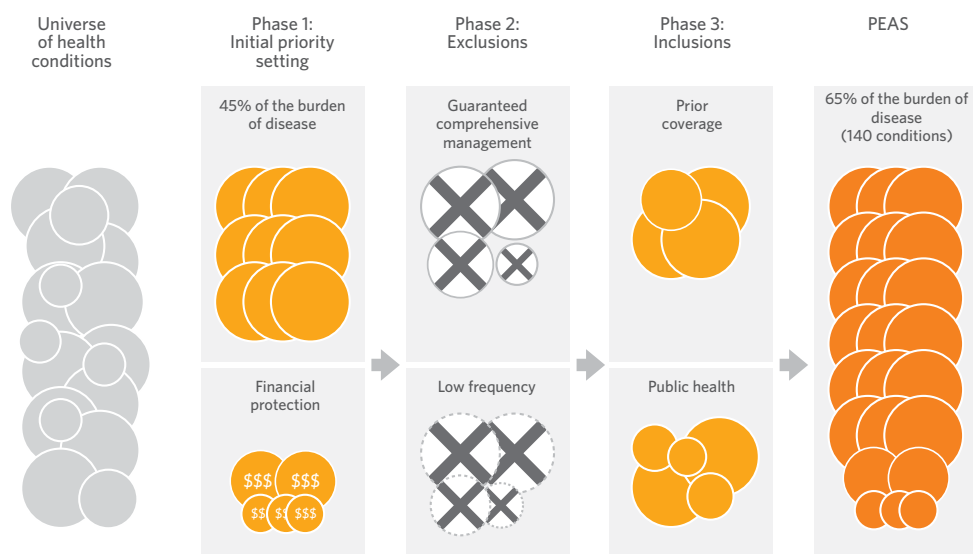
From the start, priority setting excluded high-cost illnesses because the AUS law provides for their funding through FISSAL.

Some weaknesses of the process were reported in interviews:

1. It was carried out in a self-contained manner, without taking into account all of the stakeholders involved. It also failed to consider the burden of disease study prepared by MINSA.
 - a. MINSA technicians reported that they did not allocate the necessary resources to the institutions charged with carrying out the most important studies required to design and adjust PEAS, such as the studies on the burden of disease and costing of the interventions included in the plan.
 - b. Senior staff at MINSA felt that the external technical assistance performed the studies in isolation, when it should have formalized the entire process with the technical teams at

¹² Cost-effectiveness criteria with data from the international literature were used in place of criteria with local data in order to identify interventions that were cost-effective, such as preventive care.

Figure 5.3. The PEAS priority-setting process



Source: Developed by the authors

MINSA, in order for PEAS to be institutionalized and for the capabilities of the governing entity to be strengthened.

2. MINSA technicians believe that the burden of disease cannot be the main or predominant criterion in the priority-setting process and that other instruments should have been used to identify additional social and health criteria.
 - a. The technicians responsible for the burden of disease studies identify lack of protocols and systematization of clinical activity as a crucial element that made priority setting difficult.
 - b. MINSA budget specialists claim that PEAS was designed without considering its financial sustainability and that its primary impetus was the government's political commitment.
 - c. The technicians interviewed also indicated that relevant health

conditions are missing from PEAS, whose exclusion could not be justified by MINSA or the SIS. For example, they mentioned that, according to some sector authorities, it was not politically expedient to exclude from PEAS the coverage that the SIS already offered through the LPIS, in order to keep beneficiaries from feeling that they had lost acquired rights with the implementation of PEAS. Such objections detract from the legitimacy of the priority-setting methodology.

The AUS law states that MINSA should update PEAS every two years and that the update should lead to additions to PEAS rather than reductions. It also says that PEAS can be updated again "... to progressively include more health conditions, according to the availability of funds and the supply of services" (Congress of the Republic of Peru, 2009). This is in line with the aforementioned fact that previously granted rights cannot be taken away from beneficiaries.

However, nothing is specified about possible changes to the interventions and benefits included in PEAS. The law does not address the incorporation of new technologies into treatments for health conditions already included in PEAS or the obsolescence of technologies and medical practices. It also fails to provide clear rules on how PEAS should be adjusted. Instead, it limits itself to defining two cutoff criteria for possible expansion of the conditions: 1) follow the priority-setting methodology for health conditions implemented in the original design and 2) increase the number of insured conditions, as budget and supply allow. The proposal for adjustment to PEAS is framed within the AUS evaluation and does not put forward a specific methodology for reviewing the plan's performance and proposing an adjustment, although it should include one. In addition, the criteria for adjustment are an implicit validation of the priority-setting methodology used in the original design.

The first update should have taken place on November 29, 2011; however, MINSA has not yet submitted a readjustment for PEAS nor has it requested an extension in order to comply with the deadline set by the AUS law. Nevertheless, it did request that the Promoting Alliances and Strategies (PRAES) project of the U.S. Agency for International Development (USAID) review PEAS in early 2011 to verify consistency between insured conditions and their benefits. This work was conducted by the same team that designed the first version of PEAS. During this review, some aspects of the initial design were improved, and MINSA technicians made calculations and conducted a review of the evidence, as a way to transfer capacity from external experts and technicians to the ministry. Although the results have not yet been published, those responsible for the study confirmed in an interview that PEAS would be adjusted, increasing the number of interventions from 1,140 to 1,377. This revision does not involve a change in the insured conditions but instead is meant to check whether the conditions

and their diagnoses are accompanied by the appropriate interventions. It was also stated during the interview that, in a second phase, health policy consultants will revise the cost calculations for PEAS based on adjustments to the interventions.

The PEAS update does not utilize a specific method. The procedure boils down to applying the criteria established by law and repeating the method used when the plan was drafted, with some adjustments in terms of participation. The limitations presented here are reason enough for a review of the PEAS priority-setting methodology.

Costing

MINSA was in charge of costing the interventions included under PEAS. To do so, it requested technical assistance from PRAES, which conducted an initial estimate based on standard costing methodology. It employed probabilities of use based on available historical health data or, when unavailable, expert judgments for each intervention (see section 5 of the annex to this chapter). A cost of US\$199.66 per capita per year was calculated (Escobedo, 2007). This calculation was submitted to MINSA, which then adjusted it to US\$174.70. There is no report available that explains the methodology used to make this adjustment, so it is difficult to understand where the differences arise. In theory, the calculation made by PRAES could be updated and monitored using the SIS database, which contains diagnostic and benefits information with the same coding as PEAS in the case of Lima and Callao.

For its part, the SIS conducted a review of the total standard cost of PEAS and formulated its own estimate, which amounted to US\$199.04 per capita per year. Although the estimates from PRAES and the SIS are almost identical, the official figure for the per capita cost of PEAS is that of MINSA, US\$174.70.

The fixed cost of PEAS is financed through the allocation of public resources to public providers (supply-side subsidies), while the variable cost is financed by the SIS, for both the subsidized and semi-contributive regimes. The SIS finance division estimated that the premium for the semi-contributive regime to cover the variable cost of PEAS is US\$104.82 per year per enrollee (SIS, 2011c). These calculations are rough estimates based on the available budget.

The allocations for PEAS in the pilot areas are not based on previous estimates.

Legitimacy of the process and methods

The legitimacy of both the process and the methods of PEAS has been questioned as a result of several problems that have had consequences for users and public opinion:

- The breadth of PEAS coverage was not based on rights acquired previously by SIS enrollees through the Prioritized List of Health Interventions (LPIS).
- Beneficiaries were not systematically informed of the benefits covered by PEAS.
- The revised enrollment process that accompanied the adoption of PEAS delayed affiliation with the SIS.
- The plan was not initially accompanied by legal rights for beneficiaries to claim the benefits included under PEAS coverage. Although guarantees have been designed to that effect, they have yet to be implemented, as will be discussed below. In March 2013, the SUNASA supervisory regulation was passed (MINSA, 2013a), and a few months later, in June 2013, the implementation period for SUNASA's sanctioning and supervisory functions was extended for one year from the delivery of an implementation schedule from MINSA (MINSA, 2013b).

PEAS has been implemented in pilot areas, but its launch faced problems when individuals and providers noticed that the coverage was different from that of the LPIS. Therefore, the SIS was obligated to devise a supplemental plan with an additional 2,100 diagnoses (broader than PEAS, in these terms) and extraordinary coverage.

Moreover, individuals in pilot areas must re-enroll in the SIS to receive PEAS coverage, as stated in the AUS reform, which also modified the enrollment process and delegated the socioeconomic assessment (classification as poor or non-poor) to SISFOH.

In addition, supplemental provisions were supposed to go into effect, among them the provision of coverage for catastrophic and/or high-cost illnesses, which should supplement PEAS benefits through FISSAL. Beginning in 2012, PEAS coverage was supplemented with cancer coverage through Plan Esperanza. In 2012, FISSAL began receiving treasury funds and being administered by the SIS. It finances all stages of cancer on the List of High-Cost Illnesses, terminal chronic renal failure, and rare or orphan diseases for SIS beneficiaries. Types of cancer not found on FISSAL's List of High-Cost Illnesses are covered by the SIS through its supplemental plan (extraordinary coverage).

Lastly, following the implementation of PEAS, it is unclear what the plan is and is not; it does not offer different ways of accessing services, nor does it provide for different levels of financial protection or quality of care. And, in the end, it fails to address the way resources are budgeted and allocated in the health sector. The combination of all these problems interferes with the legitimacy of the reform. In short, PEAS has not had a discernible impact on the population.

Thus far, the adjustment does not seem to focus on a review of the methodology, which, nonetheless, should be evaluated to determine if it is indeed suitable for the goals of PEAS and if it is sustainable.

The proposed adjustment to PEAS is a unique opportunity for the priority-setting process to be revised and improved and, thus, respond to criticism. For example, it should develop a firmer base of financial and technical sustainability, and MINSA should establish standard procedures to adjust PEAS, which also address medications. Going forward, modifications to PEAS should include an economic and financial analysis as well as a sustainability analysis to address the expected increase in enrollment.

Financing, Insurance, and Service Delivery

The AUS law and its regulations include norms and legal stipulations related to the financing, insurance and provision of PEAS. This section discusses sources of financing and shows that the allocation of resources related to PEAS has not changed substantially. It also reviews the mechanisms implemented for the interventions included in PEAS and their implications for the public, social security and private subsectors.

Financing

The AUS law and its regulations do not define an estimate of requirements or specific sources. The law only states that the SIS must take responsibility for the poor through its publicly-funded budget. As mentioned before, the SIS finances the variable cost of PEAS interventions, while the fixed cost is financed through historical budgets allocated to regional governments, which manage public facilities. EsSalud and the private subsector maintain their pre-PEAS funding sources: contributions from employers and the payment of premiums, respectively.

The national government allocates resources to AUS pilot areas for activities such as the identification of enrollees, information campaigns, supervision of service delivery, improvement of supply, and payment of benefits. However, the

allocation for services offered by the SIS is earmarked not only for PEAS enrollees but also for those of the LPIS. The calculation of the allocation does not consider the variable cost of PEAS but instead bases it on the past SIS budget. This produces a gap between the resources required by PEAS and those it has been allocated.

MINSA estimated the total cost of PEAS at US\$174.70 per year per beneficiary. Despite the lack of reports providing a detailed explanation of the methodology used, it is understood that the calculation was performed using the standard cost method, which represents care under optimal conditions. Of that US\$174.70, the SIS should receive US\$104.82 to cover the variable cost of health benefits, since the regions finance the fixed costs; however, the financial resources supplied by the government are much lower.

Although the per capita expenditure on enrollees with PEAS coverage cannot be identified, if the SIS expenditure is divided by the number of beneficiaries, the result is US\$24.96 per year, which represents only 25.5% of the calculated standard variable cost. This lower expenditure per enrollee may be the product of poor service quality or lower-than-expected utilization. It could also indicate that facilities are charging beneficiaries to cover their costs. For PEAS to avoid requiring an expenditure on the part of its new enrollees, it would be desirable for the SIS to have a per capita budget that would progressively close the gap between the estimated and actual costs.

To maintain the financial stability of the SIS, it is important for resource allocation to be directly linked to the increase in the number of enrollments in AUS pilot areas, since all enrolled individuals, by law, must receive at least the coverage established in PEAS. It would also be important to do a cost study and utilization review of insured conditions at public facilities, as this could create incentives to overuse the better-paid services.

In 2010, the government made its first attempt at financing PEAS in

Metropolitan Lima and Callao for new SIS enrollees, allocating the equivalent of US\$109.64 per capita per year (MINSA, 2010g). However, this money went into a pool of resources available to the SIS, which was not specifically earmarked to fund PEAS care.

In the case of EsSalud, its financial stability has not been affected by the implementation of PEAS because it offers broader coverage, but it is not without its challenges in terms of achieving a balance. In addition, EsSalud offers the EsSalud Independiente plan with an annual voluntary premium of US\$486.68 per person, with no deductibles or copayments but limits on use. This premium is much higher than the MINSA estimate for the standard cost of PEAS. The difference might be due to EsSalud building its inefficiency in service provision into the premium. It could also be because the MINSA calculation assumes that care is provided under optimal conditions or that the utilization of benefits is lower than what EsSalud's past records indicate. In any case, it is important that these estimates are compared and revised.

Alternatively, EPSs offer a basic plan for outpatient consultations or same-day surgeries in exchange for 25% of the mandatory social security contribution for formal workers, corresponding to 2.25% of the worker's wages. However, the EPSs have experienced difficulties in implementing PEAS because their coverage is superior to the basic plan that they agreed to and the contribution they receive has not been reviewed or adjusted.

Implementation

The implementation of PEAS and the progress it has achieved are described below. The purchasing of services is presented first, followed by quality control, dissemination of information about benefits, available resources, monitoring

of objectives, and major obstacles to the pilot implementation.

Purchasing of services

The SIS purchases services included in the benefit plans (PEAS and LPIS) from public providers through three payment mechanisms: advance budget based on agreements, payment for services rendered based on a fee schedule, and costs incurred. The three mechanisms cover only the variable cost of the benefits, and they are used both in pilot areas (PEAS) and the rest of the country (LPIS). When a SIS beneficiary obtains medical care within the MINSA service network, providers report this care to the SIS, which then transfers payment to the implementation units representing the providers.¹³ MINSA has not published a fee schedule for PEAS; however, the SIS adapted the fee schedule for services that it used for the payment of care covered by the LPIS (MINSA, 2011a; MINSA, 2009c).

The SIS is currently establishing purchasing contracts for services with EsSalud and private providers. The SIS provides resources to implementation units through the "grants and transfers" appropriation, which gives regions the freedom to allocate them to any expenditure, even outside the area of health. The end use of grants and transfers appropriations is not regulated or restricted to the reimbursement of PEAS or LPIS services executed by providers. No regulatory mechanism exists for the latitude that regional governments have in terms of resource allocation, indicating a disconnect between the services included in PEAS and service provider purchasing mechanisms.

Quality control

The functions of SUNASA include registration of insurers and authorization

¹³ Implementation units are administrative units responsible, all or in part, for budget implementation (budgetary action).

for them to operate, supervision of compliance with the AUS law, regulation of insurers and providers, and the application of sanctions. With regard to providers, the entity is responsible for ensuring that they meet its quality standards. On March 26, 2013, the SUNASA supervisory regulation was passed, which regulates the quality of insurers and providers (MINSA, 2013); however, SUNASA's oversight tools have yet to be defined. Oversight is still limited to pre-PEAS functions.

Knowledge of benefits and mechanisms in order for the population and stakeholders to demand rights

The dissemination of information about PEAS has been limited to an announcement of the AUS launch in pilot areas. There was no explicit, permanent strategy on the part of MINSA to inform the public about the rights and benefits granted by AUS through PEAS.

SUNASA could measure the public's level of knowledge about its rights as they relate to PEAS through an inquiries and claims system, as the SIS did beginning in May 2010 (SUNASA, 2011) through an online inquiries and complaints system for its beneficiaries. The main criticism received by the SIS was that the system is not easily accessible to most beneficiaries; however, to date there have been no reports or studies on this topic.

Resources available to provide services

There is no study on the sector's capacity to provide PEAS benefits. However, one of the criteria for selecting health conditions established in the AUS law (see section 4 of the annex to this chapter) included a review of the system's capacity to provide comprehensive care for that condition. There is also no report that evaluates the

possible gaps in the Peruvian health care system in order to accommodate PEAS, nor is there a strategy to reduce them in the short or medium term.

The most recent study is that by Madueño et al. (2003), who analyzed supply, demand and gaps in the health care system using data from 1999. The authors concluded that MINSA is the main provider of health care services and that its response capacity, quality of services, levels of investment, and financing arrangements are limited by its budget constraints. This conclusion should be taken into consideration as long as the SIS continues expanding its population coverage and the demand for services and access increases.

With regard to the supply of health care services, the authors came to the disturbing conclusion that it is not based on the needs of the population.

Institutional capacity to monitor and verify compliance with objectives

The ability to monitor and verify compliance with PEAS objectives involves agencies that review planning and monitoring. SUNASA must uphold the AUS law and its promotion, the efficient and timely use of funds allocated to it, and the quality, timeliness, efficiency and effectiveness of service provision.¹⁴ Lastly, according to the SUNASA technicians interviewed, the entity must monitor the provision of the 34 explicit health guarantees and develop its own oversight tools.

MINSA is responsible for supervising, monitoring and evaluating the progress of insurance in the country, and keeping both the public and relevant bodies informed. However, given the system's recent introduction and its gradual implementation in the context of the AUS law, the responsibilities and powers

¹⁴ These obligations are found among the other functions delegated to SUNASA, which are related to the availability of information from agents (and its security) and the mechanisms of reconciliation and arbitration in disputes between users and insurers.

of the Ministry of Health, as well as SUNASA, are still being defined.

Barriers to and problems with implementation

Interviewees' opinions about some of the problems with PEAS's implementation are presented below. A few of them stem from reactions that the plan has generated within professional and social organizations.

For the College of Physicians, the AUS law does not represent a sea change and does not address the issue of social exclusion from health services. The law only approves certain modifications to the SIS. According to Castro (2009), this is an initiative that does not lead to any real improvement of social and financial protection in health. The College of Physicians proposed a "unified public insurance" plan, which envisions the integration of the current public system with EsSalud, without undermining the concept of explicit health guarantees or a benefit plan compatible with health priorities.

According to Health Forum, the AUS originated with a serious problem of financial sustainability, since it has just one-sixth of the necessary resources to care for the SIS program's 12 million beneficiaries (Health Forum, 2012). It also states that the government has not fulfilled its promise to increase health spending from 5% of the GDP to 7%. The lack of planning for PEAS financing gives rise to these and other criticisms.

The Association of Private Clinics views the AUS law as a predominantly positive measure (Joo, 2010). For example, its implementation allows for the organization, control, regulation and monitoring of the health care system. The association emphasizes that the reform could prevent leakage and cross-subsidies and notes the benefit of guaranteeing a basic health plan

that prevents other plans from offering inferior coverage. The association believes that the challenge for the private sector is to understand that with the AUS, profits will be achieved through volume, efficiency and the quality of the services provided, in a new context and with new stakeholders (Joo, 2010). According to the Association of Private Clinics, as long as there is universal enrollment, transparency and efficient targeting of government subsidies, more people will be enrolled and served in the private sector and through EsSalud. These opinions seem natural coming from an entity that operates in the free market. Private clinics foresee greater demand based on the spending of individuals who are currently subsidized in the public sector. In addition, by requiring mandatory insurance, a larger percentage of the population becomes potential private sector clients.

Evaluation

This section describes the PEAS evaluation model, intended as part of the overall assessment of the AUS. Although a working committee drafted a proposal to design the evaluation model (MINSA, 2010e), it has not yet been implemented.

Objectives and indicators

The committee's proposal includes PEAS-related indicators¹⁵ for two outcomes: quality of care and financial protection. There are four quality-of-care indicators for PEAS: 1) effective service delivery, 2) beneficiaries with adequate coverage, 3) percentage of compliance with explicit guarantees, and 4) compliance with clinical practice guidelines. SUNASA serves as the source of the four indicators, which are obtained quarterly.

The effective provision of PEAS is defined as the percentage of facilities that deliver the services included in

¹⁵ See section 11 of the annex to this chapter for the full list of indicators.

PEAS, by category and level of care. This allows for gaps in service delivery to be measured. Adequate PEAS coverage is defined as the percentage of insured patients with a specific health condition who are receiving all the corresponding PEAS benefits. This indicator measures the gap between demand and actual supply. Compliance with guarantees is defined as the percentage of measurable explicit guarantees that are respected. Lastly, compliance with clinical practice guidelines is measured by the percentage of patients whose care is provided in accordance with clinical practice guidelines.

Regarding financial protection, the assessment considers three indicators: 1) insurers' per capita expenditures on care for PEAS services, 2) undercoverage in the subsidized regime of targeted population groups, and 3) leakage in the subsidized regime. Per capita expenditures are obtained annually from insurers. This indicator could be very useful if calculated by insurance type, in order to identify the expenditures of PEAS beneficiaries and plan cost estimates. A larger gap could indicate a greater likelihood of out-of-pocket spending and therefore less financial protection. In the subsidized regime, indicators of undercoverage (type I) and subsidy leakage (type II) errors associated with expenditure targeting were also reviewed. Undercoverage refers to the population that—even without the ability to pay—is excluded from the benefits of the subsidized regime. When analyzing this indicator, it must be considered that PEAS enrollment is subject to the individual applying and being classified as poor in the SISFOH. Leakage refers to the population with the ability to pay, or with another health insurance plan, that is enrolled in the SIS. The analysis of this indicator must consider that there are targeted groups that include the non-poor or those with another type of insurance, and that these individuals are entitled to enrollment in the SIS.

The choice of financial protection indicators did not consider an essential element: measuring households' degree of

protection from out-of-pocket expenses for health events. This information could be captured in a comprehensive manner using Peru's household surveys.

The document containing the assessment methodology for the AUS and PEAS suggests that the outcomes assessment be performed between 2010 and 2015 and does not take into account that it should be done periodically (MINSA, 2010e). Although the methodology was defined after the implementation of the AUS and the subsequent adoption of PEAS, since it suggests using household surveys completed prior to the AUS implementation, baseline information is available for the AUS but not for PEAS because the surveys do not differentiate the type of coverage enrollees receive, only the insurer. In addition, the methodology includes monitoring of the ongoing activities to implement the AUS.

Lessons and Recommendations

This section presents the lessons learned from the design and implementation of PEAS. There is discussion of whether the technical criteria for the plan's formulation were appropriate and what kind of impact they had during implementation. An assessment is also made as to whether the degree of legitimacy of PEAS's design had positive or negative consequences.

The methodology for selecting the 140 conditions that make up PEAS and their respective clinical care interventions have received the following criticisms: i) conditions and interventions were prioritized based mainly on burden of disease criteria without any consideration for other economic criteria (e.g., consideration of cost-effectiveness of the interventions); ii) PEAS's financial sustainability was not considered; and iii) rights secured through the LPIS prior to the SIS were not considered. The main consequence of this methodology is an excessively large plan without financial

sustainability, which could result in claims against the SIS for its lack of compliance. Moreover, in principle, the SIS offers greater coverage than PEAS in the subsidized regime (PEAS plus a supplemental plan and Plan Esperanza) and, therefore, deviates from the original idea of a minimum plan. Lastly, the lack of coherence between the estimated cost of PEAS and the expenditure per SIS enrollee seems to indicate that beneficiaries are not receiving the coverage offered.

The legitimacy of PEAS is primarily limited by a lack of transparency in its priority-setting methodology and poor participation of sector stakeholders, including MINSA, which restricted its involvement to reviewing the proposal of the technical consultants, and the SIS, charged with implementing PEAS.

Enrollment in the SIS with PEAS coverage occurs following classification by the SISFOH. However, since July 2010, it has only been able to grant eligibility in Metropolitan Lima and Callao. This issue results from the fact that the household databases were outdated and that the classification process is under development and has been functioning with difficulties. The regions and districts outside Metropolitan Lima and Callao were gradually incorporated, but only in areas with Internet access and with a focus on impoverished rural areas, even though this runs counter to the plan's operating standard. As a result, new enrollments are slow.

Information about PEAS has not been widely disseminated among the public, even though enrollment requires that individuals come in person to apply. The Ministry of Health's information campaigns have only emphasized universal health care as a right, ignoring the contents of PEAS, so people are unfamiliar with the plan's coverage.

The information available does not allow for an analysis of PEAS's impact on beneficiaries' access to its services. The implementation of PEAS in pilot areas has not gone as anticipated by MINSA, despite the fact that the AUS implementation plan defines the regions and districts to which PEAS would progressively expand (MINSA, 2010f). In practice, PEAS has failed to reach all those places, since it has not allocated the resources necessary to enroll individuals in all of the pilot areas, most of which are poor areas where the primary insurer is the SIS.

Although there is no direct evidence about PEAS, the SIS's annual expenditure per enrollee does not appear to cover the estimated cost, which may translate into higher out-of-pocket spending for beneficiaries. The method for guaranteeing the funding of new beneficiaries—for example, a premium paid by each beneficiary—was never defined. Instead, resources have been added through exceptions. In practice, SIS has maintained its historical budget.¹⁶

Both EsSalud and the private insurers that implemented PEAS calculated premiums comparable to the prices of benefit plans equal to or broader than PEAS, which makes the plan unattractive to them.

Only groups like Health Forum questioned PEAS about the treatment of certain diseases such as chronic illnesses and cancer, but a more complete statement about the plan's insolvencies was never issued.

On another matter, the financing law incorporated FISSAL into the SIS on July 21, 2011, but it did not establish a list of high-cost illnesses, or define what would be covered through which funding source or the procedures that it would implement with the SIS to approve cases for funding. It was not until April 24, 2012 that the List of High-Cost Illnesses was approved and funding allocated.

¹⁶ On July 21, 2011, the Law on Financing of the Subsidized and Semi-Contributive Regimes for Universal Health Insurance was enacted (Congress of the Republic of Peru, 2011).

In light of the problems with the implementation of PEAS, MINSA will have to evaluate whether the commitment to a minimum benefit plan has added something of value to the insurance landscape, and it must rethink how to restore its importance as a priority-setting strategy for health care.

The financial dimension of PEAS has been neglected, not only in terms of costing but also actuarial calculations to establish premiums in the insurance market, administrative institutions for health insurance funds, and of course, financing through the government budget and other sources. The AUS financing law does not address these questions.

The institutions responsible for universal health insurance have not yet been strengthened: the SIS has not become an insurer, SUNASA is still taking

shape and needs to extend its role to the public sector, and the Ministry of Health is struggling to evolve into a neutral governing body. Although the SIS registered as a health insurance fund administration institution in January 2011, it has yet to fulfill all the functions of an insurer.

PEAS's achievement has been its ability to foster political consensus and to move forward with implementation. Despite technical flaws, the risk of reversing these reforms seems low considering the political support they enjoy. Nonetheless, planning and institutional coordination to achieve proper implementation should be stimulated. The challenges ahead include determining the financing needs of the SIS in order to provide PEAS and obtaining political support to negotiate financing with the Ministry of Economy and Finance.

References

- Acuerdo Nacional (National Agreement) 2002. "Acta de Suscripción del Acuerdo Nacional." Available at: <http://www.acuerdonacional.pe/AN/actasuscripcion.html>. Accessed: September 2013.
- Alarcón Espinoza, G. 2009. "Financiamiento del Aseguramiento Universal en Salud: Experiencias internacionales y elementos de decisión para el Perú." Health Systems 20/20 Project. Bethesda, Abt Associates Inc.
- Arróspide, M. (coord.). 2009. "Presupuesto evaluado: Seguro Integral de Salud." Lima, Ministerio de Economía y Finanzas.
- Bitrán R., R. Muñoz and L. Prieto. 2011. "Health Insurance and Access to Health Services, Health Services Use, and Health Status in Peru." In: Escobar, M. L., C. C. Griffin and R. P. Shaw (Eds.) *The Impact of Health Insurance on Low- and Middle-Income Countries*. Bethesda, The Brookings Institution Press.
- Care Peru, UNFPA (United Nations Population Fund) and NDI (Instituto Nacional Demócrata). 2006. "Esfuerzo sin precedentes con miras a un mejor quinquenio 2006-2010: Acuerdo de partidos políticos en salud." Lima, Care Perú.
- Castro, J. 2009. "Hacia el aseguramiento universal en salud en el Perú." *Revista Peruana de Medicina Experimental y Salud Pública* 26 (2): 232-35.
- Congreso de la República. 2002. "Ley del Ministerio de Salud," n.º 27657.
- _____. 2006. "Ley de Modernización de la Seguridad Social en Salud," n.º 26790, que establece modificaciones a la ley n.º 26790.
- _____. 2009. "Ley Marco de Aseguramiento Universal en Salud," n.º 29344.
- _____. 2011. "Ley de Financiamiento Público de los Regímenes Subsidiado y Semicontributivo del Aseguramiento Universal en Salud," n.º 29761.
- CIES (Economic and Social Research Consortium). 2006. "Derecho a la salud: Ejercicio, exigencia y cumplimiento." Lima, CIES.
- Defensoría del Pueblo. 2012. "¿En qué casos puede intervenir la Defensoría del Pueblo? Salud." Lima. Available at: <http://www.defensoria.gob.pe/casos-intervencion.php?tm=5#5>. Accessed: September 2013.
- de Habich M., M. Madueño and A. Sobrevilla. 2011. "El Plan Esencial de Aseguramiento en Salud: Fundamentos técnicos y metodológicos." Health Systems 20/20 project. Bethesda, Abt Associates Inc.
- DGSP (Directorate-General of Health). 2011. "Armonización de componentes de análisis de salud." Presentación en la reunión de discusión sobre el ajuste del PEAS, Lima, Peru, January 6.

- Escobedo, S. 2007. "Metodología para la estimación de costos estándar de los procedimientos médicos incluidos en el Plan Universal de Beneficios en Salud." Lima, Ministerio de Salud del Perú.
- EsSalud. n.d. Web page "EsSalud Independiente": <http://www.essalud.gob.pe/essalud-independiente/>. Accessed: September 2013.
- Foro Salud (Health Forum). 2008. "Reporte de la vigilancia ciudadana al Seguro Integral de Salud en establecimientos de salud de Lima Metropolitana." Lima, Foro Salud. Available at: http://www.forosalud.org.pe/Vigilancia_Lima.pdf. Accessed: September 2013.
- _____. 2009. "Reporte de la vigilancia ciudadana al Seguro Integral de Salud Cajamarca 2009." Lima, Foro Salud. Available at: http://www.forosalud.org.pe/Vigilancia_Cajamarca.pdf. Accessed: September 2013.
- _____. 2012. "Los límites y contradicciones del aseguramiento universal." Lima. Available at: http://www.forosalud.org.pe/Nota_ForoSalud_frente_al_aseguramiento_universal.docx. Accessed: September 2013.
- Government of Peru. 1993. The Constitution of Peru.
- INEI (National Institute of Statistics and Informatics). 2009. "Perú: Estimaciones y proyecciones de población urbana y rural por sexo y edades quinquenales, según departamento, 2000-2015." Boletín n.º 19. Lima, INEI.
- _____. 2013. "Boletín condiciones de vida en el Perú, enero-febrero-marzo 2013." Boletín n.º 2. Lima, INEI.
- Joo, C. 2010. Presentation "Estrategias de implementación del AUS en Asociación de Clínicas Privadas." Available at: http://www.bvs.org.pe/local/File/FORO_AUS/EST_DE_IMP_AUS_CLINICAS_PRIVADAS.pdf. Accessed: September 2013.
- Madueño M., J. Alarcón and C. Sanabria. 2003. "Análisis de la brecha entre oferta y demanda de servicios de salud para la programación de la inversión sectorial de mediano plazo." Lima, PHRPlus.
- Mendoza, I. 2006. "El acuerdo de los partidos políticos en salud: Sistematización de experiencias." Lima, Promoting Alliances and Strategies and Abt Associates Inc.
- MINSA (Ministry of Health). 2001. "Por un país saludable. Propuesta de políticas para la salud."
- _____. 2002. "Lineamientos de política sectorial para el período 2002-2012 y principios fundamentales para el Plan Estratégico Sectorial del quinquenio agosto 2001-julio 2006."
- _____. 2002a. Decreto supremo n.º 013-2002-SA "Aprueban reglamento de la Ley del Ministerio de Salud."
- _____. 2002b. "Lineamientos de política sectorial para el período 2002-2012 y principios fundamentales para el Plan Estratégico Sectorial del quinquenio agosto 2001-julio 2006." Segunda edición.

- ____. 2007a. Decreto supremo n.º 004-2007-SA. “Establecen el Listado Priorizado de Intervenciones Sanitarias.”
- ____. 2007b. Resolución ministerial n.º 316-2007/MINSA. “Aprueban norma técnica de salud para implementación del LPIS en el marco del Plan de AUS en los establecimientos del Ministerio a nivel nacional.”
- ____. 2009a. Decreto supremo n.º 016-2009-SA. “Aprueban Plan Esencial de Aseguramiento en Salud.”
- ____. 2009b. Decreto supremo n.º 011-2009-SA. “Crean Comité Técnico Implementador Nacional de la conducción del proceso de Aseguramiento Universal en Salud.”
- ____. 2009c. Resolución ministerial n.º 240-2009-MINSA. “Aprueban el tarifario del Seguro Integral de Salud para los componentes subsidiado y semisubsidiado y definiciones operacionales.”
- ____. 2010a. Decreto supremo n.º 008-2010-SA. “Aprueban reglamento de la ley n.º 29344, Ley Marco de Aseguramiento Universal en Salud.”
- ____. 2010b. Decreto supremo n.º 034-2010-SA. “Aprueban mecanismos conducentes a la afiliación obligatoria del Aseguramiento Universal en Salud.”
- ____. 2010c. Resolución ministerial n.º 062-2010/MINSA. “Petitorio Nacional Único de Medicamentos Esenciales.”
- ____. 2010d. Resolución ministerial n.º 914-2010/MINSA. “Aprueban norma técnica de salud ‘Categorías de Establecimientos del Sector Salud.’”
- ____. 2010e. “Propuesta de diseño para la evaluación de resultados del Aseguramiento Universal en Salud en el Perú.” Lima, Health Sector Reform Support Program II.
- ____. 2010f. “Plan de Implementación del Aseguramiento Universal en Salud.”
- ____. 2010g. “Plan de Implementación del Aseguramiento Universal de Salud en Lima Metropolitana y Callao 2010.”
- ____. 2011a. Resolución ministerial n.º 226-2011/MINSA. “Sustituyen anexos ‘Tarifario del Seguro Integral de Salud para los componentes subsidiado y semisubsidiado’ y ‘Definiciones operacionales’ aprobados por la resolución n.º 240-2009/MINSA.”
- ____. 2011b. Resolución ministerial n.º 464-2011/MINSA. “Aprueba el documento técnico: ‘Modelo de atención integral de salud basado en familia y comunidad.’”
- ____. 2012a. “Transparencia: Normas legales.” Lima. Available at: http://www.minsa.gob.pe/transparencia/dge_normas.asp. Accessed: September 2013.
- ____. 2012b. Decreto supremo n.º 007-2012-SA. “Autorizan al Seguro Integral de Salud la sustitución del Listado Priorizado de Intervenciones Sanitarias (LPIS) por el Plan Esencial de Aseguramiento en Salud (PEAS).” Lima, El Peruano.

- _____. 2012c. Decreto supremo n.º 009-2012-SA. “Declaran de interés nacional la atención integral del cáncer y mejoramiento del acceso a los servicios oncológicos en el Perú y dictan otras medidas.” Lima, El Peruano.
- _____. 2013a. Decreto supremo n.º 003-2013-SA. “Aprueban reglamento de supervisión de la SUNASA aplicable a las instituciones administradoras de fondos de aseguramiento en salud y las instituciones prestadoras de servicios de salud.” Lima, El Peruano.
- _____. 2013b. Decreto supremo n.º 008-2013-SA, que amplía el plazo de implementación de las funciones de supervisión y sancionadoras de la SUNASA establecido en la Quinta Disposición Complementaria Transitoria del Reglamento de la Ley Marco de Aseguramiento Universal en Salud. Lima, El Peruano.
- MINSA (Ministry of Health) and CIES (Economic and Social Research Consortium). 2008. “Cuentas nacionales de salud: Perú, 1995-2005.”
- Montañez V. and E. Chon. 2011. “Financiamiento en Salud: Proyecciones al 2021.” Unpublished report prepared by the World Bank, Lima.
- Murray C. and A. López. 1996. “The Global Burden of Disease: a comprehensive assessment of mortality and disability from diseases, injuries and risk factors in 1990 and projected to 2020.” *Global Burden of Disease and Injury*, vol. 1. Cambridge, MA, Harvard School of Public Health-WHO.
- Portocarrero, A. 2010. “Los retos para financiar el Aseguramiento Universal en Salud.” Available at: <ftp://ftp2.minsa.gob.pe/aus/archivos/foro0ct2010/retosfinanciarAUS.ppt>. Accessed: September 2013.
- Prieto, L. 2011. “Nota sectorial de salud del Perú.” Lima, unpublished document.
- SIS (Comprehensive Health Insurance). 2010a. Resolución jefatural n.º 092-201/SIS. “Aprueban directiva que regula el proceso de afiliación al régimen de financiamiento subsidiado del Seguro Integral de Salud en el marco del Aseguramiento Universal en Salud - ley n.º 29344.”
- _____. 2010b. Resolución jefatural n.º 134-201/SIS. “Aprueban la directiva que establece la cobertura extraordinaria de enfermedades para el régimen subsidiado del Seguro Integral de Salud en el ámbito del Aseguramiento Universal en Salud y sus anexos.”
- _____. 2010c. “Informe de boletín estadístico 2010.” Lima, SIS.
- _____. 2011a. “Informe de boletín estadístico 2010.” Lima, SIS. Available at: http://www.sis.gob.pe/Portal/estadisticas/Estadistica/Informe_BoletinEstadistico_2010_Actualizado.pdf. Accessed: September 2013.
- _____. 2011b. “Estadísticas SIS a diciembre 2010, por regiones y unidades ejecutoras.” Lima, SIS. Available at: <http://www.sis.gob.pe/Portal/estadisticas/index.html>. Accessed: September 2013.
- _____. 2011c. “Seguro semicontributivo.” Lima, SIS. Available at: http://www.sis.gob.pe/Portal/productos/sis-independiente/sis-independiente-aus/cuanto_aporto.html. Accessed: September 2013.

- _____. 2012. Resolución jefatural n.º 143-2012/SIS. “Aprueban los lineamientos de cobertura del Fondo Intangible Solidario de Salud (FISSAL).”
- _____. 2013. “SIS: Número de asegurados al SIS a febrero 2013, por grupo de edad y por distrito de residencia (actualización al 2 de abril 2013).” Lima, SIS. Available at: <http://www.sis.gob.pe/Portal/estadisticas/index.html>. Accessed: September 2013.
- SUNASA (National Health Insurance Superintendency). 2011. “Boletín estadístico al segundo trimestre del 2011.” Año 12, n.º 2.
- _____. 2012a. “Estatuto del Centro de Conciliación y Arbitraje.” Lima, SUNASA. Available at: <http://www.sunasa.gob.pe/ceconar/reglamentos/index.htm>. Accessed: May 2012.
- _____. 2012b. “Boletín estadístico al tercer trimestre 2012.”
- _____. 2013. “Boletín informativo de la Superintendencia Nacional de Aseguramiento en Salud ‘Asegurándonos.’” Año 1, n.º 4. Available at: <http://app3.sunasa.gob.pe/ES/20/256/3/Publicacion-1484.aspx>. Accessed: September 2013.
- Velásquez, A. 2009. “La carga de enfermedad y lesiones en el Perú y las prioridades del Plan Esencial de Aseguramiento Universal.” *Revista Peruana de Medicina Experimental y Salud Pública* 26 (2): 222-231.
- Velásquez A., C. Cachay, C. Munayco, E. Poquioma, R. Espinoza and Y. Seclén. 2008. “La carga de enfermedad y lesiones en el Perú.” Lima, Ministerio Nacional de Salud.
- Wilson L., A. Velásquez and C. Ponce. 2009. “La Ley Marco de Aseguramiento Universal en Salud en el Perú: Análisis de beneficios y sistematización del proceso desde su concepción hasta su promulgación.” *Revista Peruana de Medicina Experimental y Salud Pública* 26 (2): 207-217.

Chapter 6



Argentina: Plan Nacer

Martín Sabignoso, Humberto Silva and Javier Curcio

Summary

Context. Argentina is a federal republic with a health expenditure equivalent to 8.2% of its GDP, a percentage typical of middle- and high-income countries. In 2003, the health outcomes reflected in various indicators revealed the need for a more efficient and equitable use of the resources invested to improve the health of the population. The Argentine health system consists of three subsectors, namely, the private subsector (voluntary), the social health insurance subsector (mandatory for formal workers), and the public subsector (free and universal). The private and social health insurance subsectors have explicit health benefit plans. The Compulsory Health Plan establishes the general framework for these plans, which indicates the services they must guarantee. The public subsector, which should be able to provide health care services to the entire population, mainly through provincial and municipal facilities, does not have an explicit list of prioritized benefits. In this context, the national government implemented Plan Nacer (PN) to guarantee universal access to a set of prioritized health services.

Key elements of the PN. The public health policy known as Plan Nacer aims to improve the health status of individuals without explicit coverage, as well as their satisfaction with the services provided by the public subsector. Initially, primary care services for the most vulnerable

populations (pregnant women or those receiving postpartum care and children ages 0 to 5) were prioritized. The implementation of the PN was conducted in two phases. The first phase began in 2004 in the nine provinces of northern Argentina, and in 2007, the plan was extended to the rest of the country.

The health benefit plan (HBP) implemented a results-based financing mechanism and increased investment in the health sector through the creation of provincial health insurance funds (SPSs) that reinforce existing public coverage.

An important aspect of the program's design and operation consists of a comprehensive plan for monitoring, evaluation and concurrent external audits in order to achieve its objectives and interim targets.

The PN sought to gradually increase population and benefit coverage as well as financial protection for the population. It began with 80 primary health care services for mothers and children, later adding some outpatient curative services. In 2010, high-complexity benefits for the comprehensive care of congenital heart disease were incorporated. High-complexity perinatal care services were included in 2012. That same year, the Ministry of Health and the provinces expanded the PN to new population groups (children and adolescents up to age 19 and women up to age 64 without explicit health coverage) through a set of

400 prioritized benefits. This expansion of the PN launched the program called SUMAR.

Financing of the PN’s health benefit plan represents approximately 0.9% of the funds invested by the provinces in health. The national government provides financing to the provinces through a yearly capitation payment of about US\$4 per enrollee, which is adjusted on the basis of performance indicators. This value represents the incremental cost per capita of the gaps in coverage and quality of prioritized benefits. Sixty percent of the capitation payment is transferred monthly to the provinces based on the identification and enrollment of the

beneficiary population. The remaining 40% is conditional upon compliance with a series of health outcomes measured on the basis of performance indicators called tracers, and the funds are transferred every four months.

The resources obtained by the provinces are deposited in SPS accounts. Their only possible end use is the purchase of prioritized services by the SPS (at prices defined by each province) from facilities within the provincial network that have previously entered into a management agreement. The SPS pay-for-performance mechanism used with facilities is fee-for-service. Lastly, the facilities receive the funds, and their personnel decide how to

Basic Elements of Plan Nacer

Name of HBP	Plan Nacer (now Program SUMAR)
Year plan began operations	2003
Central motivation	Reverse the increase in maternal and child morbidity and mortality rates and provide more explicit guarantees for vulnerable populations
Target population	Pregnant women and children under age 6. In 2012, children ages 6 to 9, adolescents ages 10 to 19, and women ages 20 to 64 without explicit health coverage were added
Service coverage	Maternal and child services at the primary care level with gradual expansion to other more complex services (for example, surgeries for congenital heart disease)
Financial coverage	No copayments
Population coverage	Sixty-three percent of the population without explicit health coverage (23% of the total population) (2012)
Estimated annual cost per capita	Approximately US\$4 (to cover gaps in effective coverage and quality, since facilities continue to receive supply-side subsidies)
Percentage of public health resources channeled to HBP funding	HBP funding represents 0.9% of the resources invested by the provinces in health
Provision of non-prioritized services	The public system provides all other services within the traditional public supply framework, financed by historical budgets
Principal innovations	<p>Explicit benefit plan for a small subset of prioritized services with a gradual increase in coverage for population groups and services</p> <p>Coordination and consistency among prioritized services in the HBP through i) allocation of additional resources to finance measured gaps in quality and coverage; ii) performance-based payment mechanisms for the provinces and facilities; iii) monitoring, evaluation and concurrent external audits; and iv) records on services received by beneficiaries and provincial outcomes</p> <p>Rigorous impact assessment and measurement of user satisfaction and levels of motivation among service provider personnel</p>

spend them, whether on infrastructure improvements, equipment purchases, training, staff recruitment, monetary incentives, or medical supplies.

Initially, 100% of the financing for the PN's capitation payment was the responsibility of the national government, but it later went on to be co-financed by the provinces in a payment scheme, in which 70% of the cost was borne by the national government and 30% by the province. Greater participation in this co-financing scheme on the part of the national government allows it to take a leading role. At the same time, the design and implementation of the program look to strike a balance between the general regulatory framework defined by the national government and the room for autonomy and flexibility required by the provinces to enable the proper evolution of this strategy.

Outcomes. Six main outcomes resulted from the PN: i) implementation and operationalization of a prioritized benefit program and results-based financing in the country's 24 jurisdictions; ii) improvement in the target population's health status, in terms of both interim targets such as early enrollment of pregnant women and the number of prenatal visits, as well as final outcomes such as infant mortality, birthweight and anthropometric measurements; iii) achievement of high levels of satisfaction among beneficiaries and the health teams at facilities, according to surveys conducted; iv) identification of a manageable number of performance indicators (tracers) that allowed for agreements to be institutionalized between levels of government for the attainment of health outcomes through the use of results-based financing; v) coordination with other national policies (universal child benefit and universal pregnancy benefit) that strengthened the institutionalization of the PN; and vi) the incorporation of health services that impact the causes of infant mortality that have proven difficult to reduce, such as comprehensive care for children with congenital heart disease and high-

complexity maternal and neonatal care, among others.

Challenges. This HBP presents multiple challenges: i) determining which aspects of the design or implementation of the program, in general, and of the Health Care Services Plan, in particular, should be adapted in the provinces with different public health characteristics; ii) ensuring the quality of prioritized benefits for new population groups in the various provinces, even when there are no clear guidelines or protocols for the benefits included in Program SUMAR; iii) defining the optimal combination of financing modalities based on budget and outcomes; and iv) maintaining the rigor of PN performance evaluations, which will require greater resources and interdisciplinary contributions.

Introduction

Argentina has 40 million inhabitants, an annual per capita income of US\$17,130 in purchasing power parity terms (2011), and one of the lowest incidences of poverty in the region, with 1.9% of people living on less than US\$2 per day (according to data from the World Health Organization [WHO] and the World Bank). The health status of Argentina's population has improved significantly. In 2011, the country had an infant mortality rate (IMR) of 14 per 1,000 live births (compared to an IMR of 18 per 1,000 live births in 2000) and a life expectancy at birth of 76 years (up from 74 years in 2000) (WHO's Global Health Observatory). These indicators place Argentina among the countries with the best health status in the region. With more than 11% of the population composed of adults over the age of 64 (2013) and chronic diseases becoming increasingly prevalent, Argentina is facing the demographic challenges posed by an aging population. In 2009, cardiovascular diseases and tumors were already responsible for 46% of deaths and 29% of disability-adjusted life years (DALYs) lost by the population under age 70 (Ministry of Health, 2012).

Together with Chile, Argentina has the highest level of public investment in health in the region, with a total health expenditure per capita of US\$408 in purchasing power parity terms (2011), which is above the regional average of US\$385 (according to WHO data).

Argentina has one of the most decentralized and segmented health systems in Latin America and the Caribbean, in which three highly-fragmented subsectors coexist (see figure 6.1.):

1. The private subsector, intended for high-income individuals, with coverage equivalent to 10% of the population.
2. The social health insurance subsector, mandatory for formal workers and their families (social health insurance funds) and pensioners (Comprehensive Health Care Program [PAMI]/INSSJyP). This sector consists of a large number of national social health insurance funds (296 in total) associated with different industrial sectors and provincial social health insurance funds (one for each of the

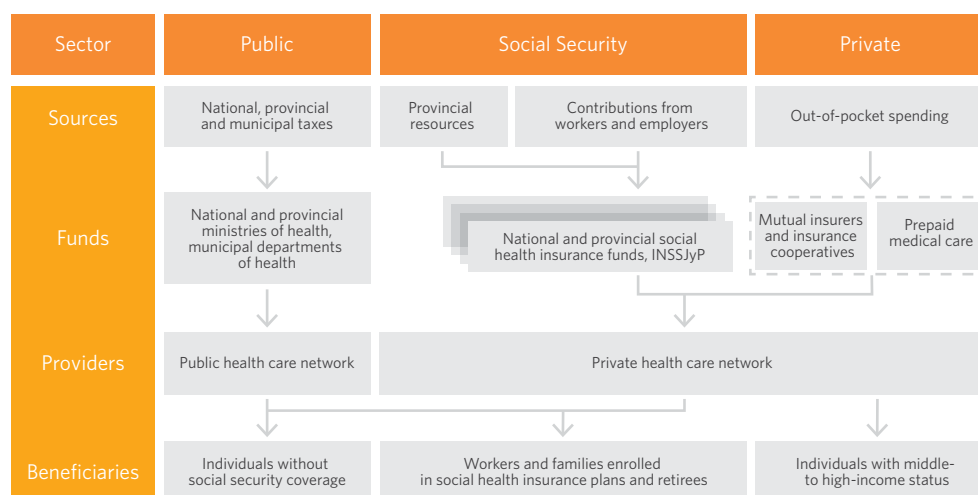
23 provinces plus the Autonomous City of Buenos Aires). Social health insurance funds cover about 54% of the population (2008).

3. The public subsector—composed of national, provincial and municipal agencies under the Ministry of Health and a network of hospitals and public health centers—provides free health care to anyone who demands it, but mostly to those who are not already covered by other social security or private health systems. This sector serves approximately 14.6 million people, or 36% of Argentina’s population.

The public health sector in Argentina is characterized by two features:

- a. *Decentralization and segmentation of the health system.* Argentina is one of the most decentralized countries in the region. Its federal system is composed of 23 provinces and an autonomous city, each with its own ministry of health, independent management of resources, and responsibility for the provision and organization of services.

Figure 6.1. The Argentine health system



Source: Hurtado (2007), with modifications
 INSSJyP: National Social Services Institute for Retirees and Pensioners

The Ministry of Health provides leadership and policy guidance on matters concerning the health care system, but it has little involvement in the allocation of resources at the provincial level. Plan Nacer is a very special case, given that decisions on resource allocation for this program come largely from the national government. Furthermore, the existence of three subsectors offering different coverage and services depending on income level and type of employment relationship demonstrates the segmentation of the health system.

- b. *Universal health system.* Argentina's Constitution states that the public health system must provide free health services to all citizens who demand them, as needed and without exception. Given resource constraints, this means that the system employs implicit rationing. The implementation of an explicit health care plan takes on a very special meaning in this context; instead of explicitly excluding services, the system devotes particular attention (in terms of organization, financing, auditing, etc.) to a subset of services considered priorities.

Reasons for and Objectives of Plan Nacer

In mid-2003, Argentina began to emerge from the deep economic and political crisis that erupted in December 2001, whose devastating effects posed serious challenges at all levels of government. The drastic drop in employment left much of the population without health coverage, thus greatly increasing the burden of service delivery on provincial governments, the entities responsible for public health care in their jurisdictions. This situation made the health sector's underlying systemic problems all the more apparent in a country that, even

before the crisis, demonstrated poorer performance than other middle-income countries in the region with lower levels of health spending (Mesa Lago, 2005; ECLAC, 2006). Moreover, the reduction in income and increased poverty as a result of the crisis translated into the deterioration of several health indicators, for example, the reversal of the downward trend in infant mortality, which in 2003 had dropped to 16.5 per 1,000 live births (Ministry of Health and PAHO, 2007). In 2003, prior to the implementation of Plan Nacer, two-thirds of the country's infant deaths occurred during the neonatal period (Ministry of Health and PAHO, 2007). In turn, six of every 10 newborn deaths corresponded to causes preventable through proper prenatal check-ups, appropriate care during labor and delivery, and early diagnosis and treatment. This situation indicated that there were significant gaps in coverage and quality that needed to be overcome if the country wanted to improve its key health indicators. This assessment, coupled with the government's commitment to meet United Nations Millennium Development Goals, translated into the objectives, design and benefits that would be included in Plan Nacer's health coverage.

The Ministry of Health initiated consensus-building on sectoral and cross-cutting issues that resulted in the 2004-2007 Federal Health Care Plan,¹ in which the design of a new health care model was presented, based on the development of health care networks with primary care as the cornerstone. Thus, in 2003, with consensus reached between the national government and the provinces, the design and implementation of Plan Nacer began. It took shape as a program framed by a health system that offers free, universal, and implicit coverage while prioritizing certain benefits to transform them into explicit and effective coverage. This aspect is reflected in the fact that financing is aimed at gaps in the coverage and quality of benefits prioritized according to health

¹ For more details on the plan and the consensus-building process, see Office of the President (2004).

and clinical effectiveness standards and protocols, rather than the total cost of the prioritized benefits included in the health care plan, which already receive funding through supply-side subsidies. This conceptual framework is graphically represented in figure 6.2.

As defined in its operations manual (Plan Nacer, 2008), the main objectives of the PN consist of the following:

- To explicitly state and improve the health coverage and quality of care provided to mothers and children without social health insurance, through the creation and sequenced development of public health insurance in the Argentine provinces and Autonomous City of Buenos Aires.
- To encourage a cultural shift in the vision and management of health care, in order to prioritize primary health care and promote the effective performance of the public health system.

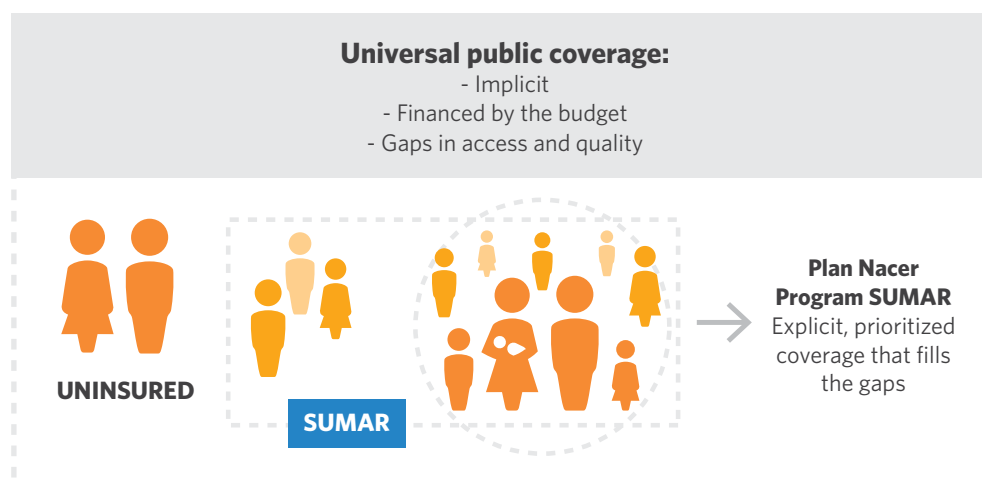
- To contribute to the reduction of maternal and infant morbidity and mortality rates, consistent with the Millennium Development Goals.

The plan promoted the creation and implementation of provincial health insurance funds (SPSs), which would be responsible for purchasing HBP services from authorized facilities (Office of the President, 2004). These insurance funds, as well as the transfer of resources between the national government and the provinces, were defined on the basis of a pay-for-performance model aimed at ensuring effective coverage and maximizing the quality of the HBP prioritized services included in the PN.²

Coverage and Funding Sources

To achieve universal coverage and guarantee universal access to all of the services required, together with social

Figure 6.2. Conceptual framework of Plan Nacer



Source: PN national team

² For more details on the design of the pay-for-performance models in Plan Nacer and their objectives, see World Bank (2003 and 2006).

protection in health, progress must occur in three dimensions (WHO, 2008): i) the breadth of population coverage, ii) the depth or scope of essential services provided to meet the needs of the population, and iii) the level of financial protection (WHO, 2008). This section describes the progress made by the PN in each of these dimensions.

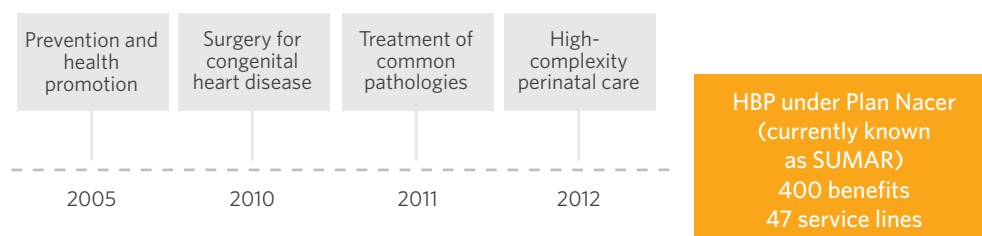
Plan Nacer began with an HBP that was tightly focused on just a few prioritized benefits and population groups, later taking a path of gradual expansion by adding “layers” of new population groups and services. This progressive expansion contrasts with other countries such as Mexico, where the Seguro Popular benefits package was, since its introduction, quite broad and comprehensive. However, as in the case of Chile with its AUGE plan, Argentina has prioritized a small set of health services through an HBP, while still providing other services under the traditional supply model without priority setting. This is an interesting option in countries where it becomes very complex to explicitly deny a service by not including it in an explicit benefit plan. The last part of this section describes the HBP’s funding sources. The PN consumes a very small part of provincial health budgets (0.9% of spending) and is financed by contributions from the national level (70%) and participating provinces (30%).

The scope of covered services

The HBP began with a basic benefit plan consisting of 80 primary health care services for mothers and children, with most services focused on prevention and health promotion. These services were provided in low-complexity facilities and were designed to meet the health needs of women during pregnancy and childbirth and of children under the age of 6. The scope of this health services plan gradually increased as the PN became more established (see figure 6.3). In 2010, a process was initiated to expand the scope of the HBP to include the care of other age groups and to attack the leading causes of death that had proven difficult to reduce. In this manner, comprehensive care services for congenital heart disease, certain ambulatory services, and high-risk pregnancy care along with high-complexity neonatal services were incorporated. These additions for more complex health problems considered the benefits, related services, and medications required for the comprehensive care of each selected condition.

Prioritized services in the HBP are identified in the PN, and they apply to the entire country.³ HBP coverage is organized by a list of medical procedure codes, referred to as the uniform nomenclature, on the basis of age groups and subgroups (e.g., women of childbearing age, pregnant

Figure 6.3. Phase-in of PN benefits



Source: PN national team

³ The list of benefits can be viewed on the Plan Nacer/Program SUMAR website at: <http://www.msal.gov.ar/sumar/images/stories/pdf/nomenclador.pdf>.

women, etc.), the health issue to be addressed (e.g., labor and delivery), and the services to be provided in each case (e.g., prenatal consultation, PAP smear, etc.) (Ministry of Health, 2010c). Selected services are backed by clinical guidelines and protocols approved by the Ministry of Health and provincial health ministries. In addition, the PN's uniform nomenclature is supplemented by a quality matrix linked to the prioritized services and based on protocols and guidelines. This matrix defines quality attributes for each of the benefits included in the HBP, and compliance with these quality standards is required in order for prioritized benefits to be financed by the PN. Compliance is verified by external field audits.⁴ This effort to coordinate different policy elements will be described in detail below, but one of the highlights of Argentina's PN can already be seen here: the HBP is part of a package of coordinated measures that links prioritized services to guidelines, quality indicators, payment mechanisms, and a monitoring and oversight system, among others.

Population coverage and financial coverage

According to WHO (2008), the breadth of coverage—namely, the percentage of the population that enjoys social protection in health—must be progressively expanded to cover the uninsured, which is to say, the groups of people without access to services or social protection against the financial consequences of seeking health care. The PN has helped expand coverage, as it is aimed, first and foremost, at the vulnerable, uninsured population. Just as with service coverage, the decision was made to expand population coverage gradually (see figure 6.4). At first, the PN covered maternal and child populations (pregnant women and children under the age of 6), totaling about two million people. In 2012, the national government and the provinces extended the PN to about 9.4 million people,

including children, adolescents and all women up to age 64, representing 63% of the population without social health insurance or prepaid health care plans and 23% of the country's total population. This expansion of the PN launched the program called SUMAR.

It is important to note in this context that all of these individuals and the services provided to them are being registered in a system, which means that the program not only has information on who is enrolled but also the specific services that each beneficiary has received at any given time. This characteristic sets Argentina apart from most of the other countries included in this book, for which little information exists regarding the services that each beneficiary has received. The mere existence of an HBP does not automatically ensure effective service delivery to the population, even if the plan issues a health insurance ID card to its beneficiaries. It is possible that many people with proof of official enrollment in the program, who are supposedly “covered,” do not access the services they require. With the tracking of benefits, Argentina has taken an important step toward more effective coverage of health services, as this allows the government to analyze the degree of utilization of health services by the PN's target population.

Beginning in 2015, the program plans to expand to cover benefits focused on the secondary prevention of chronic non-communicable diseases in men ages 20 to 64.

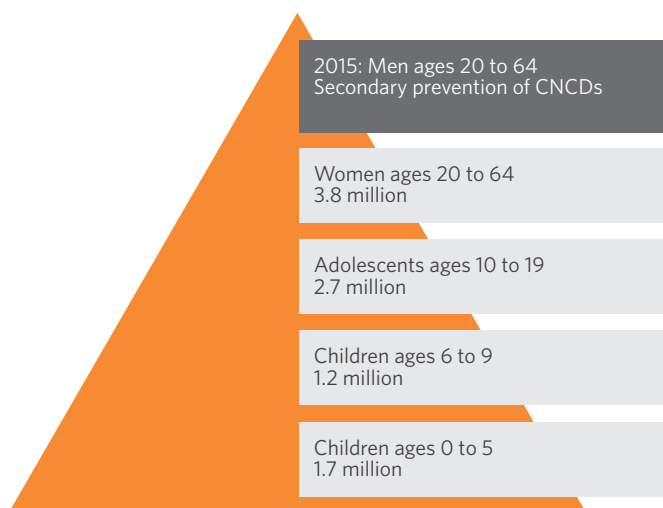
Regarding the financial coverage offered by the program, it is worth noting that PN services—and, in general, all of the services provided by the public network—are free and do not require any copayment.

Sources of financing

Plan Nacer involves a total annual investment of US\$46 million (2010

⁴ The quality matrix can be viewed on the Plan Nacer website at: <http://www.plannacer.msal.gov.ar/>.

Figure 6.4. Plan Nacer population coverage, 2013



CNCDs: chronic non-communicable diseases
Source: PN national team

figure), an amount that is estimated to increase to US\$74 million in 2015 when the program will begin to cover a greater number of people under a broader list of health care services. These amounts are equivalent to approximately 0.9% of the provincial public health care expenditure in 2011. Most HBP financing comes from the national level (76.9% in 2010).⁵ That fact is important in this context, where control over the majority of health care resources lies with the provinces (81.5% of the total in 2010) and where involvement by the national governing body (the Ministry of Health) in the allocation of resources at the provincial and municipal levels is quite limited. It is worth noting that the original design of the PN envisioned ever-decreasing funding by the national government until the plan was fully funded by each province following the fifth anniversary of the program. This plan was modified by the national government on the grounds that as the principal funder, it not only performs one of its governance responsibilities—financial assistance

to the provinces—but it also retains management of the insurance strategy. Its status as principal funder, coupled with results-based financing, provides the national government with greater leverage to introduce enhancements to the management and health care model of the provincial systems in the public subsector. The importance of that argument has to be understood in the context of a highly decentralized health system, in which limited involvement by the national level in the system's governance has been identified as one of the major challenges to overcome.

Priority-setting Methods, Costing and Legitimacy

This section describes the priority-setting and costing process of the HBP that was implemented within the framework of Plan Nacer, as well as the difficulties that were faced. This process contains seven steps (see figure 6.5).

⁵ World Bank loans financed a large share of the resources available at the national level.

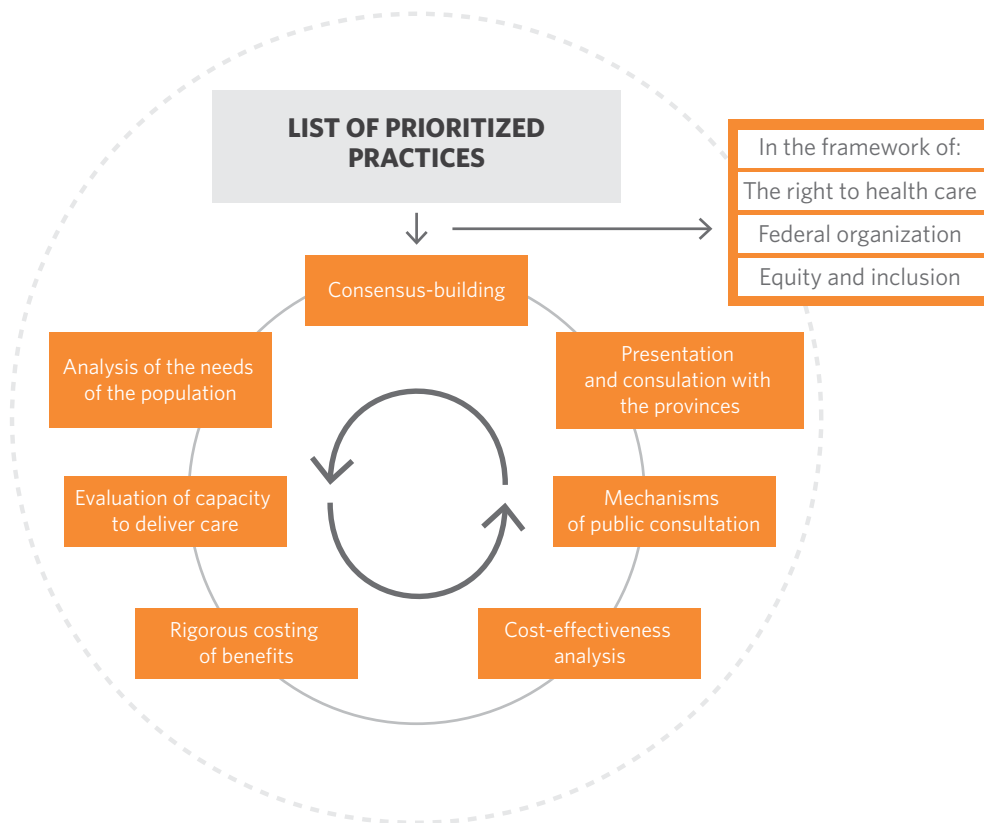
The definition of prioritized benefits for Plan Nacer began and ended with consensus-building among key national and provincial public stakeholders who, in a forum to address priorities, agreed on an initial single list of prioritized benefits for the entire country.

The first step after the establishment of the initial consensus was to analyze the target population and its health needs. One of the characteristics of the PN’s priority-setting process was the explicit consideration of equity criteria that were expressed from both a population and territorial perspective. Thus, in the early stages, the program focused its efforts on the most vulnerable population, namely, pregnant and postpartum women as well

as children under age 6 without explicit health coverage. In addition, it was decided that the strategy would be initially implemented in the nine provinces of the Northeast (NEA) and Northwest (NWA) of the country, where maternal and infant mortality rates were significantly above the national average. In July 2007, the program was extended to the country’s 15 remaining jurisdictions.

The analysis of the main gaps in access to and utilization of health care services by the defined target population was performed on the basis of data collected from a set of sources with significant limitations (vital statistics, disease burden studies, epidemiological statistics, health surveys, etc.), which posed an additional

Figure 6.5. Process of defining prioritized benefits for Plan Nacer



Source: Plan Nacer (2010c)

challenge to this priority-setting exercise. This analysis identified that strengthening of the primary health care strategy represented the approach that yielded the greatest potential impact on health outcomes.

In the beginning, gaps in coverage and quality with regard to clinical practice guidelines and protocols were estimated on the basis of data available for the initial implementation of the public insurance strategy. Later, the program measured gaps in coverage and quality for the services included in the HBP. Having defined the benefits that would constitute the prioritized benefit plan, a financial dimensioning exercise was performed on the coverage and quality gaps. Next, a cost-effectiveness analysis was performed on the benefits to be included in the HBP.

The final steps in the priority-setting process for PN benefits involved opening the plan to public consultation and consultation with the provinces.

The priority-setting process faced numerous difficulties. Initially, the process encountered problems related to a lack of solid information, especially with respect to the epidemiological profile of the Argentine population in all corners of the country, which hampered the analysis and definition of the benefits in question. Consequently, authorities had to make critical and strategic decisions on the basis of partial information.

In addition, there were major constraints in terms of gathering information on the service capacity of the provincial public health systems. Subsequently, field measurements of facilities' service capacity were taken and cost studies on gaps in efficiency and effectiveness were conducted. In addition, the organization of the provincial health systems, the composition of teams, and the existence and application of clinical guidelines and protocols were evaluated.

Implementation

HBPs usually describe a set of health care services that have been prioritized in order to meet the needs—and on occasion, preferences—of a specific population. However, to guarantee coverage for the population, these needs must be coordinated with other health system controls: resource allocation and incentive mechanisms; monitoring, supervision, and evaluation; and the supply capacity to provide these services. Thus, in order for the priority setting established in a benefit plan to be redirected toward the effective delivery of prioritized services, its coordination and consistency with other measures must be promoted. A notable feature of the PN is that it was designed and implemented as a policy in which the benefit plan is linked explicitly to other policy instruments, including three key elements: i) a system that encourages the provision of prioritized services, ii) a monitoring and control system, and iii) resource allocation consistent with the cost of the prioritized benefits. The actions carried out by the PN to implement these three elements and coordinate them with the HBP are briefly described below.

Incentives and payment mechanisms

The monetary incentives introduced by the PN consist of two payment structures split between institutional levels: performance-adjusted capitation payments based on selected health indicators paid by the national government to the provinces (the value of the capitation payment is defined by the Ministry of Health) and fee-for-service from the SPS to the providers (the fee for these services is defined by the SPS). Although the PN is known internationally as a monetary incentive program, these incentives are just one of many elements in a package of coordinated instruments and measures that the plan has to improve the health of the most vulnerable population.⁶

⁶ See <http://www.rbhealth.org/news/item/655/argentina-builds-plan-nacer-evolve-plan-sumar>.

In order for the PN's health benefit plan to translate into real access to prioritized services, a pay-for-performance strategy was designed, which introduced financial incentives aimed at both the provinces as well as the facilities responsible for providing HBP services to the population.

Two principal-agent relationships can be identified among the stakeholders who determine cash flows. The first relationship is between the national government and the provinces, involving a transfer of resources from the national to the provincial level through a capitation payment of approximately US\$4 per enrollee or AR\$17 per year. Sixty percent of that amount is disbursed after identification and enrollment of the target population, and the remaining 40% is disbursed after a series of health targets are met, measured on the basis of 10 performance indicators (tracers) (see table 6.1).

After defining the tracers, payments are determined for each of these indicators, taking into account available information on the achievement of health objectives—both at the national level and within participating jurisdictions—which results in incentives for every jurisdiction to work toward its own specific health target for each indicator. Meeting the target for each tracer entitles the province to a maximum of 4% of the capitation payment. At first, performance was compensated under an all-or-nothing payment rule based on a predefined target. With this incentive structure, no payment was received unless the target was reached, and results that exceeded the target failed to generate any additional payment beyond the maximum of 4% for each tracer, which meant there was no incentive to improve performance upon reaching the goal. This payment rule has since been replaced by a tiered system. In general terms, if the province meets 100% of the established target, it receives 4% of the payment for that tracer. If the established target is not fully met, the percentage of payment is reduced according to a sliding scale.

The tracers are based on the HBP and clinical protocols considered best practices for primary health care. For example, the HBP includes services that guarantee comprehensive care for women during pregnancy, and the list of tracers contains, among others, the following two process and outcome indicators: i) the percentage of eligible pregnant women who attend their first prenatal check-up prior to the 20th week of gestation and ii) newborns with a birthweight over 2,500 grams (5.5 pounds). The capitation payments transferred from the national government to the provinces are deposited into each jurisdiction's SPS account for Plan Nacer. In turn, the provincial health insurance funds use these resources to pay health facilities for the prioritized benefits under the HBP (Gertler, Martínez and Celhay, 2011). The provinces have signed a framework agreement with the national government in which, as a result of the incorporation of this new funding source, they pledge that the additional funds provided by the PN will serve as a complement to the provincial public resources that are already invested in health rather than a substitute (Plan Nacer, 2008). The reason for this is that the gaps identified in provincial health systems not only correspond to inadequate incentive structures in terms of generating better health outcomes but also the need for financial assistance.

In the third quarter of 2010, the provinces met just over half of the established tracer targets, generating an overall payment of 21.5% (with the maximum potential payment set at 40%). In the third quarter of 2012, performance improved to 78% effectiveness in meeting tracer targets, resulting in an overall payment of 31.2%. This variation in the achievement of targets mainly reflects an improved ability to document health care performance on the part of the provinces.

The second relationship, in which a pay-for-performance mechanism is also used, is that between the SPS and the health facilities. The SPSs, which assume responsibility for the implementation of the PN in their territories, transfer funds

Table 6.1. Plan Nacer tracers

Tracer	Health issue assessed	Description of the tracer
I	Early enrollment of pregnant women	Pregnant women attend first prenatal check-up prior to the 20th week of pregnancy
II	Effectiveness of delivery and neonatal care	Newborn with five-minute APGAR score greater than 6
III	Effectiveness of prenatal care and prevention of premature birth	Birthweight greater than 2,500 grams
IV	Quality of prenatal and delivery care	Mothers screened for syphilis (VDRL test) during pregnancy and given tetanus vaccine before delivery
V	Medical auditing of maternal and infant deaths	Evaluation of the care process in cases of maternal death and the deaths of children under the age of 1
VI	Immunization coverage	Administration of the measles or MMR vaccine in children under the age of 18 months
VII	Sexual and reproductive health care	Sexual health and reproductive counseling for postpartum women within 45 days after delivery
VIII	Well-child care (under age 1)	Children under the age of 1 with a complete schedule of check-ups and percentiles for weight, height and head circumference
IX	Well-child care (ages 1 to 6)	Children ages 1 to 6 with a complete schedule of check-ups and percentiles for weight and height
X	Inclusion of indigenous population	Health care providers serving indigenous people, with staff trained in the care of this population

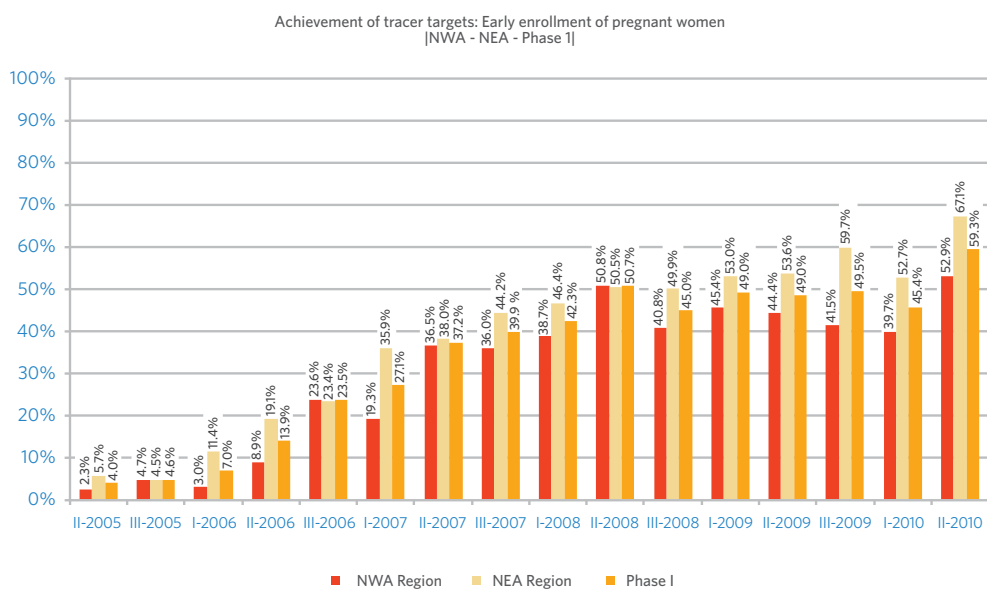
Source: PN national team

to health facilities based on the services they provide to the target population from the plan's list of benefits. Each province sets the prices at which the SPS will purchase HBP services from the health facilities. These prices are used to ensure a balance between the resources received from the national level and the payments made to providers, and they also serve as a tool to encourage the delivery of the HBP services most relevant to each province. Each invoice issued by providers for a service contains the beneficiary's personal information, and only those services included in the HBP and provided to program enrollees may be billed. Thus, through the PN, the SPSs transfer resources to providers as fee-for-service payments. Since the providers themselves are able to invest these funds in certain expenditure categories that have been predefined by the province or municipality, the resources flow directly to the health facilities. This empowers the facilities by allowing them to allocate funds according to their priorities and

needs, while remaining in accordance with the general guidelines defined by the health authority to which they report. Eligible expenditures include incentive payments for staff, hiring of staff, medical supplies, capital spending, and maintenance. The payment mechanisms outlined above are shown in figure 6.6.

Through the aforementioned incentive mechanisms, the Ministry of Health sought to modify the behavior of agents in a way that could not be achieved by traditional means of public sector financing, in which resources are allocated by historical budgets. The term "incentives" should be interpreted broadly since, in addition to monetary or economic inducements, it includes other aspects that are highly valued by health care teams, such as empowerment and autonomy in decision-making and the opportunity to use new management tools. The aspects that motivate key stakeholders are taken into consideration, and a results-based funding mechanism is defined.

Graph 6.1. Level of compliance



Source: PN national team

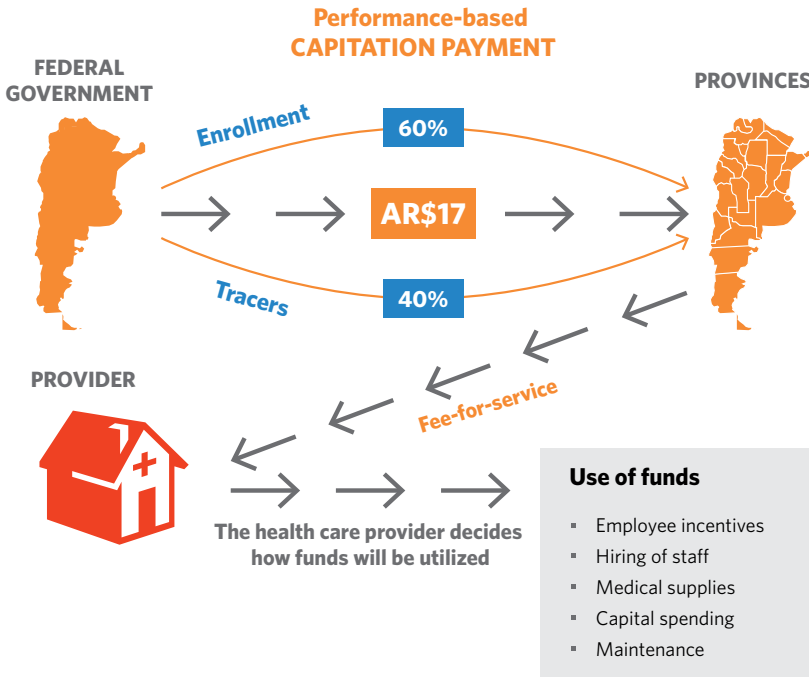
The most straightforward mechanism made possible by the PN is the direct payment of staff at health facilities, although it has only been used on a limited basis by just a few jurisdictions. Alternatively, the most widespread mechanism used to motivate human resources consists of helping staff to link the additional resources received by the facility with the provision of prioritized services in the HBP, and then having the opportunity to participate in the decision on how to use those funds. Studies, including some impact assessments, have shown how these motivational methods have generated improvements in organization and increased production of prioritized services.

Pricing of services

The PN expects the provinces to define the prices of the services included in the HBP. First and foremost, these prices serve as a sign and instrument of priority setting at the provincial level. If a jurisdiction believes that a certain benefit is being underutilized, it may

increase the reimbursement to encourage facilities to provide that benefit and to boost its supply. In the context of a federal system with marked differences in health outcomes among the jurisdictions, allowing every province to establish its own prices serves as a critical program tool so that priority setting of the HBP, a singular plan at the national level, can be tailored to each province's specific situation. Price setting is also flexible because the program allows for a twice-yearly review of prices, which enables the provinces to adjust to different situations by changing reimbursement rates for benefits, in other words, making changes to their objectives and priorities over time. The pricing mechanism for provision of the HBP also functions as an adjustment variable to ensure the financial stability of the SPS. As mentioned, the national government transfers capitation payments to the provinces, which are deposited in a special bank account for the sole use of the PN. To date, price has been the central variable adjusted by the provincial insurance implementation units in order to ensure that sufficient funds are always available. In situations

Figure 6.6. Payment mechanisms defined by Plan Nacer



Source: PN national team

where a large number of services have been provided and, consequently, there exists a high demand for funds from providers, the province may decide to lower the reimbursements for services in order to maintain financial equilibrium. Conversely, in the event of a large surplus of funds in the provincial account, the province may increase reimbursements in order to transfer more funds and reduce the surplus.

Prices are an important tool, but certain conditions must be met in order for them to be effective: strengthening of the structural conditions of service provision and reporting; training on the clinical process; and training on the services available through the PN’s list of benefits, their public health importance, and their billing and reporting mechanisms. The inadequate development of these conditions in some provinces prevented them from using pricing as an effective tool for the promotion and implementation of the HBP and

the resulting improvement of health outcomes, with price primarily used as an adjustment variable. On that basis, the national government is in the process of designing new management tools for the provincial health insurance-health facility relationship. These tools allow for the pricing of services compatible with a health strategy that forms part of a larger, comprehensive strategy to promote benefit coverage that considers health, financial, motivational, training, and communication aspects.

Mechanisms for the Effective Provision of the Plan

One interesting aspect of the PN is the coordination between HBP services and the tracking, monitoring and evaluation system. This framework facilitates the actual provision of the services set forth in the list of benefits and the fulfillment

of program objectives. This monitoring and supervision framework and the PN's outcome evaluation framework are described below.

Monitoring and supervision

The PN incorporated a detailed monitoring and evaluation system into its design, which allows it to quantify the performance of both the relationships between the national government and the provinces as well as the provinces and the health care providers. To this end, the signing of annual contracts between the national government and participating provinces and the provincial governments and health care facilities has been institutionalized. In the agreements between the national government and participating provinces, each province commits to a set of performance and coverage goals. Similarly, the SPSs sign management contracts with participating health facilities, in which the providers commit to periodic progress reports about their activities, such as the benefits provided or the enrolled population. In addition, they agree upon the plan's development goals as outlined in the World Bank's project document on Plan Nacer. These indicators measure aspects such as institutional development, effectiveness of the services provided, and morbidity and mortality rates within the eligible population. The pay-for-performance strategy aims to promote the gradual fulfillment of the targets set in various agreements. Compliance is monitored by the national government through three types of instruments/ actions:

1. *Supervisory visits by teams and auditors from the PN's central implementation unit.* As part of these visits, a progress evaluation is conducted with regard to the fulfillment of the operational objectives defined in the annual contract. Based on these visits, the implementation unit team generates reports and recommendations to

further improve the program's performance.

2. *Dashboard* (tool with management indicators that enables monthly reporting by the SPSs). This dashboard allows for the monitoring of progress in program implementation. It uses indicators on the following dimensions: population and benefit coverage, management of the provider network, and financial and health outcomes.
3. *Binding reports issued by concurrent external audits.* The PN's framework provides for financing of concurrent external auditing processes that verify the degree of compliance with PN standards and critical management processes. These financial and health care audits are conducted bimonthly by independent firms, using a sample of provider institutions and the beneficiary population. External audits focus on several different aspects related to PN management. First, they examine the list of beneficiaries, since the eligibility of enrolled beneficiaries is verified. Second, they scrutinize the transfers to the provinces, which are verified through medical record review to ensure that they are made in relation to eligible beneficiaries and health outcomes that were actually achieved and documented. They also confirm that the funds sent by the national government were successfully transferred to the SPS account and that the payments made by the latter went to services that were actually provided to beneficiaries enrolled in accordance with the rules of the program. Lastly, they examine the quality of benefits, verifying that the payments made by the provinces (SPS) to providers match the quality standards established for each service.

The findings (of a legally-binding nature) of the concurrent external audits are reported, and when appropriate, sanctions such as the refunding of improperly transferred resources and

finer equal to 20% of these amounts are proposed to the central implementation unit. Refunds and fines are provided for in the PN's design, which allows for the application of sanctions for reasons such as the provision of services to non-eligible individuals or the billing of services not included in the PN's list of benefits, among others. The refund is deducted from the province, even if the provider was the one responsible for the error or non-compliance. Later, the province has the power to decide whether to transfer that penalty to the health facility. The audits have played an important role in the context of the PN, not only by verifying that what was promised in the HBP and the contracts was actually carried out and that the payments were justified, but also in terms of the training they have represented for teams at the provincial level and at health facilities. The concurrent external audit generates an environment of control that limits unwanted behaviors from the different participants involved in the PN's transfer mechanisms. It also promotes the application of standards and best practices defined by existing guidelines and protocols. The funds generated by the application of fines and penalties from the concurrent external audit far exceeded its implementation costs.

Evaluation of results

The ongoing evaluation of results has been a major component of the PN since its inception.⁷ It is important to note that evaluation results refer to the program as a whole, since it is impossible to isolate the impact of the HBP from the rest of the tools that have been implemented in coordination with the benefit plan (payment mechanisms, audits, etc.). The impact assessment of the PN brought together several lines of research, which, on balance, yield positive results; the PN expanded coverage and increased the use and quality of services, which

is evidenced, in a general way, by an improvement in the target population's health status. Broadly speaking, three areas of work should be mentioned:

1. *Analysis of administrative records.* The first striking results were obtained through the analysis of benefit data provided by the provinces of Misiones and Tucumán. In order to assess the impact, quasi-experimental methods were applied (fixed-effects instrumental variables).

The results show that for prenatal care, the program increased the early recruitment of pregnant woman, which, in turn, generated a 16% boost in the use of prenatal services. It was also shown that higher-quality services are now provided.

In terms of the use of health services and health status, important evidence on the utilization of prioritized services, the quality of prenatal and well-child care, the health status of the newborn, and the reduction in early neonatal mortality rate was generated through rigorous monitoring and impact assessment mechanisms. These results were verified by an impact assessment during the first phase of the program (Gertler, Martínez and Celhay, 2011), which showed positive results in the provinces, especially in Tucumán and Misiones in the north. A significant increase in the probability of early identification and enrollment of pregnant women, a decrease in the probability of very low birthweight, and a reduction in mortality at birth, among other results, were observed (see table 6.2).

This evaluation also found positive results regarding the IMR (see graph 6.2), showing that the PN managed to narrow the gap with the Millennium Development Goal

⁷ The methodological rigor applied to the Plan Nacer impact assessment has received deserved international recognition, which attracted additional sources of funding, including the Spanish Impact Evaluation Fund (SIEF) and the Norwegian fund known as the Health Results-Based Financing Fund (HRBF).

on child mortality. Furthermore, increased program enrollment, achievement of tracer targets (full 40% payment reached for meeting all health targets) and application of funds were demonstrated, among others.

2. *Comprehensive program evaluation.* Following this line of research, program information gathered at baseline and at follow-up was analyzed. The data has been processed and documented, and there are two types of findings—those that pertain to health and those related to institutional organization. Similarly, other studies were performed using quantitative and qualitative methods that enabled the capture of results that are impossible to substantiate through impact assessments. For example, studies on user satisfaction and the evaluation of the motivational levels of health care teams at facilities are available.

The PN has had a major impact on the capacity of the institutional health care system. For example, it promoted planning at the level of the provincial insurance implementation unit, in a collaborative effort with those who share responsibility for the performance of the health care teams at the facilities. At the same time, it has fostered and invigorated the spirit of teamwork among all public health network stakeholders. Its implementation has allowed for a learning process to occur in each jurisdiction, one that addresses the promotion of health outcomes through the meticulous monitoring of each facility's performance. Plan Nacer's HBP has proven to be a central tool for guidance, directing the actions of health care teams toward the care and management priorities defined by the national and provincial governments.

3. *Randomized experiments.* To date, two randomized experiments have been conducted at over 300 health care

facilities; one assessed the impact of the implementation of results-based payments on prioritized practices at the PN provider level, and the other evaluated the impact that a staff training and care strategy had at health facilities (Plan Nacer, 2010b). The main design feature of these studies consists of dividing the sample into two randomly assigned groups: the experimental group, which receives the intervention under study, and the control group, which is used as the basis for comparison. These experiments provide the highest level of evidence, as controlling for extraneous variables allows researchers to draw conclusions about causality, unlike other methods that only permit the observation of a correlation (see Giedion, Alfonso and Díaz, 2013).

The PN was one of the first programs in Argentina to use a monitoring and evaluation process that included a quantitative impact assessment, which has generated great interest in other areas of the Ministry of Health. Other programs are beginning to view the impact assessment as a way to measure their contribution to society and thus legitimize themselves as part of public policy, as in the case of the Essential Public Health Functions Program and the program Remediar + Redes.

Empowerment

To empower beneficiaries, in 2011, health facilities began distributing an informational pamphlet that explicitly outlines the list of rights provided through enrollment in Plan Nacer. In addition, beneficiaries are given a toll-free number to leave feedback, complaints, questions, comments and/or suggestions about the program. Nonetheless, Plan Nacer still has no specific instruments for individuals to demand access to services in the event of non-compliance. The program intends to expand the mechanisms for users to

access information about their rights and to create formal mechanisms for them

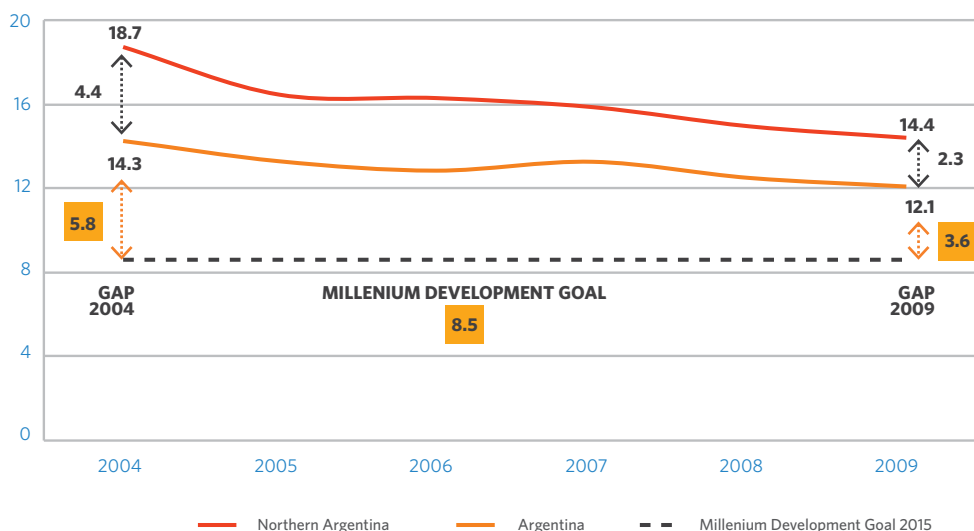
to be able to demand that their rights be upheld.

Table 6.2. Measurement of the impact of Plan Nacer in Tucumán and Misiones (statistically significant results)

TUCUMÁN		MISIONES			
Probability of early identification of pregnant women Weeks 14 to 20					
With Plan Nacer	Without Plan Nacer	With Plan Nacer		Without Plan Nacer	
32.1%	29.7%	59.8%		30.0%	
Probability of very low birthweight					
W < 2.5 kg		W < 1.5 kg		W < 2.5 kg	
With Plan Nacer	Without Plan Nacer	With Plan Nacer	Without Plan Nacer	With Plan Nacer	Without Plan Nacer
1.1%	1.3%	0.1%	1.9%	7.4%	10.5%
Mortality at birth			Number of prenatal checkups		
With Plan Nacer	Without Plan Nacer	With Plan Nacer		Without Plan Nacer	
0%	1%	7.2		3.4	

Source: Gertler, Martínez and Celhay (2011)
Statistical method used: difference in differences with fixed-effects instrumental variables

Graph 6.2. Change in the infant mortality rate (Northern Argentina, the entire country, and the Millennium Development Goal), 2004-09



Source: Developed by the authors based on data from the Ministry of Health and PAHO (2012)

Conclusions

The economic and financial crisis of 2001 increased the number of people dependent on the services provided by the public sector, widening existing coverage gaps and reversing the strides made in reducing the maternal and infant morbidity and mortality rates just a few years before the measurement of the Millennium Development Goals. In view of this situation, the country established explicit coverage for a limited number of health problems and services that were considered priorities and that were clearly not being provided at adequate quality and coverage levels.

Design option: a limited benefit plan within a free and universal health care system, with a gradual increase in coverage. Plan Nacer is a program that prioritizes a small subset of benefits for certain priority groups in the population, and it consumes no more than 0.9% (2011) of all public resources spent by the provinces on health. All other services are provided without explicit priority setting (implicit rationing), within the traditional framework of financing through historical budgets. The case of Argentina features an explicit priority-setting option and HBP design that contrast with the broad, comprehensive benefit plans that other countries have chosen to offer (Colombia, Mexico and Uruguay), but the plan is similar to what Chile has done, in terms of prioritizing health care for a subset of conditions while still providing services for non-prioritized health problems. In addition, Argentina opted for a strategy of progressive HBP coverage expansion toward new population groups and more complex benefits. The strategy launched by the PN implied profound institutional and managerial changes to the public subsector, so a sequenced, gradual expansion enabled a more effective and robust implementation.

Additionality of funding. Unlike the financing arrangements described by the other cases in this book, the total cost of the HBP is not financed. Instead, funding is only required to cover the gap between

current quality and coverage levels and the optimal levels defined by existing guidelines and protocols.

The benefits plan as part of a package of coordinated measures to improve effective coverage. The PN not only adopted a benefit plan that brought awareness and explicit guarantees to national priorities in the field of health, but it was also accompanied by a package of coordinated measures: 1) it linked prioritized services to clinical practice guidelines and protocols; 2) it included the necessary resources to guarantee that the prioritized services could actually be provided; 3) it designed payment mechanisms that encouraged service delivery of the HBP; 4) it implemented monitoring and auditing mechanisms to verify the effective provision of HBP benefits and the allocation of resources, in accordance with the standards and objectives of the program; and 5) it implemented a research program to evaluate the impact of the plan. At the regional level, an evaluation as rigorous as the one performed on the PN is the exception rather than the rule. As noted in other cases in this book, policies are rarely subject to such rigorous monitoring and evaluation. The PN, one of the pioneers in this area, became a point of reference and consultation for programs interested in conducting their own evaluation.

An HBP as a policy coordinator in a decentralized system. Argentina's highly decentralized public health system grants provincial institutions the autonomy to make decisions on the organization of services and allocation of resources, while leaving the national government with little room to manage the system. The PN has offered new possibilities for governance in this context by i) designing a single, equal benefit plan for the entire country; ii) using common ground rules for the allocation of resources; iii) implementing a single framework for monitoring and auditing; and iv) defining a set of health indicators and policy goals with an incentive structure that encourages compliance. In turn, the different components of the

program's design respect the country's federal structure, establishing formal and informal mechanisms for consensus-building between levels of government and within the provinces. The PN set a first precedent for Argentine public policy by having the national government and the provinces self-impose explicit health targets relating to a health benefit plan.

Furthermore, the evolution of the PN—from its initial phase up through the current coverage expansion and strengthening of the SPSs—allowed the program to become involved in functions that were not originally anticipated. The process of defining the HBP was not limited to the determination of a list of benefits; it also helped redefine, or more explicitly state, the functions of the provincial ministries of health. Based on the definition of an explicit HBP, the ministries of health (through the SPSs) began to supervise, monitor and analyze the performance of the PN's authorized service providers, a role they were not previously accustomed to performing.

The HBP as a tool to improve the health conditions of the population and to achieve health goals. The PN succeeded in improving the health status of the target population, in terms of end results such as infant mortality, birthweight and children's anthropometric measurements, as well as interim goals such as the early enrollment of pregnant women in the program and the number of prenatal visits. For example, for the provinces that participated in phase I, there is preliminary evidence that the probability of low birthweight was reduced by 8%, thanks to the implementation of the PN. In addition, according to survey results, beneficiaries and the health care teams at facilities are highly satisfied with the PN, reporting a satisfaction score of 7 on a 10-point scale (for both users and health care teams), with greater satisfaction found among beneficiaries with higher levels of benefit utilization and those who received care at facilities where the program was more tightly integrated. Also, the PN has been institutionalized and coordinated with other programs

such as the universal family benefits policy.

The PN has served as a very valuable experience with important lessons for other countries. The program has also faced significant challenges, some of which were overcome with adjustments while others are ongoing.

Lessons. The gradual expansion of the program, as well as the constant process of internal evaluation that distinguishes the PN, made it possible to recognize lessons and experiences that motivated the introduction of changes to the program's design to provide the most powerful tools possible for insurers, in order to achieve the sought-after coverage results. Most of the modifications made were to the incentive system, by adjusting performance indicators, reformulating them and increasing their targets, including health impact indicators. In addition, a differential payment was introduced that hinges on the complexity of achieving each goal. This change looked to promote equity among the provinces, providing greater reward to those that achieve consistent performance within their territory.

In its own right, the monitoring and evaluation strategy employed throughout the history of the program, from implementation through to the expansion of population and service coverage, has made it possible to identify and present these challenges:

1. It will be necessary to determine which aspects of the program's design or implementation must be adapted to the particularities of provinces that are organized differently.
2. Expansion of the program will require greater technical skills and expertise to effectively set priorities for the health care services contained within the HBP.
3. The program's visibility and recognition of its ability to generate

health outcomes may make it vulnerable to excessive demands, including expansion decisions or requirements that are beyond the capabilities of the tools in its design.

4. The expansion of the HBP's contents will impose greater technical requirements on the program, particularly in the creation of explicit provider networks for high-complexity perinatal care, the adaptation of services to guarantee adolescents' access to priority benefits under the conditions required by the program's initial standards, and the management of chronic diseases such as type 2 diabetes and hypertension.
5. The expansion of the program will create a new challenge regarding the definition of the optimal combination of financing modalities based on budget and outcomes.
6. The expansion process for results-based financing will require greater fiscal contributions from the provinces and the national government.
7. Maintaining the rigor of the PN performance evaluations will require greater resources and interdisciplinary contributions. The initial evaluation strategy, focused on quantitative methods and causal analysis, has been broadened to a more comprehensive view of the evaluation process,

considering other methodological approaches that capture and document relevant program performance that cannot be captured with the methods initially used.

8. As the program expands, it will be necessary to determine how the health care facilities will behave once they begin to receive increasing revenue from the PN. Will they be steadily more interested in the benefits paid by the PN, to the detriment of the health services funded through the traditional system of historical budgets? How will the network and payment systems coordinate with each other when the new HBP benefits require the transfer of a patient to the referral and counter-referral system, encompassing providers at different levels? Do the public providers have the supply capacity to meet PN beneficiaries' demand for new benefits, or will it be necessary to contract with private providers? These are all questions that must be answered in the new phase of this policy.

The priority-setting process for benefits that was defined and institutionalized with the PN is beginning to stimulate institutional priority-setting processes within other policies and strategies. This is possibly one of the most important lessons from Argentina's Plan Nacer.

References

- Belló M. and V. Becerril Montekio. 2011. "Sistema de salud de Argentina." *Salud Pública Mexicana*, vol. 53, n.º 2: 96-108.
- CEOP (Centro de Estudios de Opinión Pública). 2007. Formulación de la línea de base de evaluación del APL I. Diseño e implementación de la investigación. Preparado para la Unidad de Financiamiento Internacional de Salud (UFI-S). Préstamo BIRF n.º 7225-AR- PNUD ARG/04/023.
- _____. 2009. Formulación de la línea de base de evaluación del APL II. Diseño e implementación de la investigación. Preparado para la Unidad de Financiamiento Internacional de Salud (UFI-S). Préstamo BIRF n.º 7225-AR- PNUD ARG/04/023.
- ECLAC (Economic Commission for Latin America and the Caribbean). 2006. *La protección social de cara al futuro: Acceso, financiamiento y solidaridad*. Santiago, Chile, ECLAC. Available at: <http://www.eclac.org/publicaciones/xml/9/24079/lcg2294e.pdf>. Accessed: September 2013.
- Gertler P., S. Martínez and P. Celhay. 2011. *Informe de evaluación de impacto del plan Nacer sobre utilización de servicios y resultados sanitarios. Resultados con datos administrativos de las provincias de Misiones y Tucumán*. Washington, DC, World Bank.
- Giedion U., E. A. Alfonso and Y. Díaz. 2013. The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence. UNICO Studies series 25. World Bank. Available at: <http://siteresources.worldbank.org/healthnutritionandpopulation/images/impactofuhcschemesindevelopingcountries-areviewofexistingevidence.pdf>. Accessed: September 2013.
- Hurtado J. 2007. "Argentina: Síntesis del Sistema de Salud Actual." Available at: <http://coopsalud.blogspot.com.ar/2007/04/argentina-sntesis-del-sistema-de-salud.html>. Accessed: September 2013.
- Mesa Lago C. 2005. *Las reformas de salud en América Latina y el Caribe: Su impacto en los principios de la seguridad social*. Santiago, Chile, ECLAC. Available at: <http://www.cepal.org/cgi-bin/getProd.asp?xml=/publicaciones/xml/8/24058/P24058.xml&xsl=/dds/tpl/p9f.xsl&base=/socinfo/tpl-i/top-bottom.xslt>. Accessed: September 2013.
- Ministerio de Salud (Ministry of Health) and PAHO (Pan American Health Organization). 2007. Indicadores básicos 2006, Argentina.
- _____. 2012. Indicadores básicos 2011, Argentina.
- Ministerio de Salud (Ministry of Health). 2008. "Cambio en el modelo de gestión de trazadoras. Proyecto de Inversión en Salud Materno Infantil Provincial." Serie de documentos técnicos n.º 31. Buenos Aires, Ministerio de Salud.

- _____. 2009a. "Ejercicio de proyección de población elegible para el Proyecto de Inversión en Salud Materno Infantil Provincial. Total país y detalle por fase y jurisdicción. Años 2007-2012." Serie documentos técnicos n.º 34. Buenos Aires, Ministerio de Salud.
- _____. 2009b. "Cálculo de la prima por inclusión de cirugías de cardiopatías congénitas en el nomenclador plan Nacer." Facultad de Ciencias Económicas, Universidad Nacional de La Plata.
- _____. 2010a. "Cálculo del valor incremental de la cápita por inclusión de cirugías de cardiopatías congénitas en el nomenclador plan Nacer." Serie documentos técnicos del plan Nacer n.º 38. Buenos Aires, Ministerio de Salud.
- _____. 2010b. "Ejercicio de proyección de población elegible para el Proyecto de Inversión en Salud Materno Infantil Provincial. Total país y detalle por fase y jurisdicción. Años 2010-2015." Serie documentos técnicos n.º 39. Buenos Aires, Ministerio de Salud.
- _____. 2010c. "Bases conceptuales para la redefinición del nomenclador único del plan Nacer. Una herramienta estratégica en el contexto de la expansión del modelo de aseguramiento de la salud pública en Argentina." Equipo del plan Nacer, Ministerio de Salud de la Nación.
- _____. 2010d. "Salud y educación. Hacia la integración de una agenda iberoamericana para el desarrollo." Documento presentado en la XII Conferencia Iberoamericana de Ministros y Ministras de Salud. Buenos Aires, Ministerio de Salud de la Nación.
- _____. 2010e. Plan Federal de Salud 2010-2016.
- _____. 2012. "Vigilancia de enfermedades no transmisibles." Dirección de Promoción de la Salud y Control de Enfermedades No Transmisibles, Ministerio de Salud. Available at: <http://www.msal.gov.ar/ent/images/stories/vigilancia/pdf/boletin-epideomologia-5.pdf>. Accessed: September 2013.
- _____. 2012a. "Nomenclador. SUMAR es más salud pública." Available at: <http://www.msal.gov.ar/sumar/images/stories/pdf/nomenclador.pdf>. Accessed: September 2013.
- Plan Nacer. 2008. *Manual operativo del proyecto de inversión en salud materno infantil provincial*. Préstamo BIRF 7225-AR y préstamo BIRF 7409-AR. Buenos Aires, Ministerio de Salud.
- _____. 2010a. Análisis de costo efectividad de los incentivos generados por el plan Nacer.
- _____. 2010b. Evaluación de la fase I del plan Nacer. Evolución, desempeño y aprendizajes de un programa de pago por desempeño en salud. Provincias del NEA y NOA de Argentina. 2004-2010. Estudios y estadísticas.
- _____. 2010c. "Bases conceptuales para la redefinición del nomenclador único del plan Nacer. Una herramienta estratégica en el contexto de la expansión del modelo de aseguramiento de la salud pública en Argentina."
- Presidencia de la Nación (Office of the President). 2004. "Bases del Plan Federal de Salud 2004-2007." Buenos Aires, Presidencia de la Nación.

- Rosales W., E. Acevedo and J. Caporale. 2010c. Costeo de intervenciones asociadas a maternidad y neonatología. Producto n.º 5. Universidad Nacional de La Plata.
- UNDP (United Nations Development Program). 2010. *Informe nacional sobre el desarrollo humano. Desarrollo humano en Argentina: trayectos y nuevos desafíos*. Buenos Aires, UNDP.
- Universidad Nacional de La Plata. 2009a. *Cardiopatías congénitas en la Argentina. Oferta (capacidad), demanda, ajuste entre demanda y oferta, y costos*. Convenio proyecto n.º ARG/04/023 del PNUD y la Facultad de Ciencias Económicas. Available at: http://sedici.unlp.edu.ar/bitstream/handle/10915/3832/Documento_completo.pdf?sequence=1. Accessed: September 2013.
- _____. 2009b. Estimación de costos de prestaciones para el tratamiento de la diabetes tipo II en Argentina. Universidad Nacional de La Plata.
- _____. 2010a. Costeo de intervenciones asociadas a maternidad y neonatología. Convenio Programa de Inversión Materno Infantil en las Provincias Argentinas, producto n.º 3. Facultad de Ciencias Económicas.
- _____. 2010b. Definición de una metodología de cálculo para el valor de la cápita del paquete prestacional básico del plan Nacer. Convenio Programa de Inversión en Salud Materno Infantil en las Provincias Argentinas, producto n.º 4. Facultad de Ciencias Económicas.
- WHO (World Health Organization). 2008. *Informe sobre la salud en el mundo 2008. La atención primaria de salud, más necesaria que nunca*. Geneva, WHO.
- _____. 2011. *Informe sobre la salud en el mundo 2010. Financiación de los sistemas de salud: el camino hacia la cobertura universal*. Geneva, WHO.
- World Bank. 2003. "Project Appraisal Document APL 1. Provincial Public Health Insurance Development Project. Human Development Department. Argentina, Paraguay and Uruguay Country Management Unit. Latin America and the Caribbean Region." Washington, DC, World Bank.
- _____. 2006. "Project Appraisal Document APL 2. Provincial Public Health Insurance Development Project. Human Development Department. Argentina, Paraguay and Uruguay Country Management Unit. Latin America and the Caribbean Region." Washington, DC, World Bank.
- _____. 2009. "Argentina: Provincial Maternal and Child Health Insurance. A Results-Based Financing Project at Work." En breve, n.º 150.
- _____. 2012. "Argentina builds on Plan Nacer to evolve into Plan Sumar. Results-Based Financing for health." Available at: <http://www.rbhealth.org/news/item/655/argentina-builds-plan-nacer-evolve-plan-sumar>. Accessed: September 2013.

Chapter 7



Honduras: The Basic Health Package (PBS)

Mauricio Dinarte and Luis Bolaño Prado

Summary

Context. The health system of the Republic of Honduras is segmented into public and private subsectors. The public subsector encompasses 63% of the total population but serves just 50% of those eligible for services. Gaps in access to health services exist among different socioeconomic levels of the population and geographic areas. The greatest inequalities are observed in rural areas of the country, where the public sector has no presence or coordinated network. In 2003, Honduras began implementing a decentralized management model with a health benefit plan (HBP) at its core.

Key elements of the Basic Health Package under the decentralized management model (PBS). The PBS was implemented in Honduras as part of a process of health care decentralization. The plan aims to increase coverage, especially for the country's poorest and most rural inhabitants, and improve the quality of services. The plan contains explicit benefits, mostly consisting of health care services for mothers and children, including prevention and health promotion, which are provided at the primary care level as a complement to labor and delivery care. As part of the plan's implementation, agreements were signed with health service management providers (GPs), which negotiate, receive and administer a per capita amount to guarantee the delivery of services.

Achievements. Coverage was expanded to 891,938 people in 67 municipalities within 14 departments, corresponding to 10.7% of the total population, 16.8% of the poor population and 25.5% of the rural population. In addition to expanding coverage, the PBS has guaranteed the availability of critical inputs for the provision of services. User surveys show high levels of satisfaction (over 85%). Furthermore, studies comparing service delivery through the PBS versus the traditional model found that the level of production at health centers where the PBS has been implemented is higher than at centers operating under the traditional model. It has also been shown that this model is more cost-effective; it achieves the coverage goals of the prioritized programs at a lower average unit cost for general care, while including a greater number of health services.

Challenges. The absence of legal and regulatory backing for the coverage expansion strategy and provision of the PBS gives rise to a lack of institutionalization that may compromise the plan's continuity and sustainability. Added to this is the public's lack of awareness of the PBS; with no communication strategy or entity that safeguards the rights of beneficiaries, it is difficult for people to view the PBS as a right.

Another challenge is poor quality control. Not all health centers meet the licensing

standards defined by policy regulations. Additionally, the decentralized GPs are not yet included in the Ministry of Health’s quality assurance program. The absence of a management information system to monitor compliance with the PBS’s production and quality targets contributes to poor monitoring of GP performance.

Delays in the financing of the GPs, stemming from a lack of planning and proactive management by the Ministry of Health (SESAL) in its dealings with the Ministry of Finance, and the lack of integration of PBS resources into the institutional health budget have led to delayed disbursements to the GPs, which compromises their financial liquidity at the beginning of each year. Highly

unequal bargaining power exists between the Coverage Expansion and Funding Unit (UECF) and the GPs. This is due to the fact that the management staff lacks the necessary technical training; therefore, during the negotiation process, the UECF’s criteria always prevail in the end, increasing the risk that some GPs will agree to contracts with excessively risky terms and conditions.

Another of the package’s weaknesses lies in the vast difference in production costs among the GPs. This difference is mainly attributable to the number of SESAL staff paid by the GPs,¹ the shortage of clinical staff, and the number of health centers managed by the GPs. These factors constitute a threat to the scalability and financial sustainability of the PBS.

Key Elements of Honduras’ Basic Health Package Under the Decentralized Health Management Model (PBS)

Name of HBP	Basic Health Package
Year plan began operations	2003
Central motivation	Establish a decentralized management system with separate service delivery, financing, and regulatory functions in order to expand service coverage to the poorest of the rural population, with a focus on care for mothers and children
Target population	The rural poor, with an emphasis on women and children
Service coverage	Maternal and child health services at the primary care level, with a focus on health promotion and prevention
Financial coverage	No copayments or charges of any kind for services
Population coverage	16.8% of the country’s poor population and 25.5% of the rural poor population (as of December 2012)
Estimated annual cost per capita	US\$25 (2011)
Percentage of public health resources channeled to HBP funding	2.61% of the Ministry of Health’s total expenditure and 1.8% of total public health expenditure (2011)
Provision of non-prioritized services	Within the public network under the traditional model of supply-side subsidies
Principal innovations	<p>Definition of an explicit benefit plan</p> <p>The introduction of health service management providers, which sign agreements with SESAL to guarantee the provision of PBS benefits</p> <p>A pay-for-performance model that combines a capitation payment and fee-for-service payment in the case of births attended by health personnel. There is also a model in which capitation payments are subject to compliance with health targets and indicators</p>

¹ SESAL staff earns higher salaries with greater benefits, thus increasing the cost of the HBP for these health centers.

Introduction

Context, reasons for adoption and the adoption process

Honduras is the poorest, most rural and smallest of the countries studied in this book. It has a very high level of poverty and a per capita gross income that ranks among the lowest in the region, with US\$3,820 in purchasing power parity terms (2011) versus an average of US\$12,330 in the other countries discussed in this book (according to WHO's Global Health Observatory). Figures show that 66.2% of the population lives below the poverty line and 45.3% lives in conditions of extreme poverty (2012). In addition, 76.5% of the poor are located in rural areas (ECLAC, 2012).

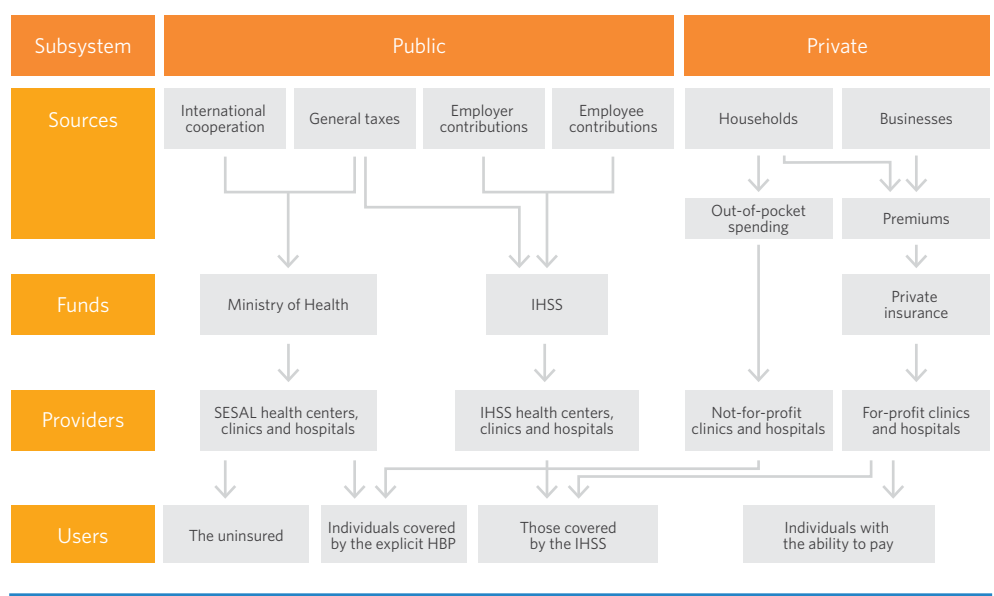
The health system in Honduras is segmented; a social security system for

formal sector workers coexists with a public sector program that attempts to cover the rest of the population (figure 7.1).

The Honduran Social Security Institute (IHSS) has its own health care network, and it covers formal sector workers and their immediate families. The IHSS insures 43.75% of the population employed in the formal sector and 18% of the economically active population, representing 16.8% of the total population, according to 2011 data from the IHSS. Social security spending per capita is approximately US\$193 per year, the lowest figure in the region after Nicaragua, with US\$125.²

SESAL, responsible for sectoral stewardship and regulation, coordination of activities, and guidance of the public and private subsectors, formally provides health care to the entire population,

Figure 7.1. The Honduran health system



Source: Developed by the authors based on Bermúdez-Madriz et al. (2011)

² According to World Bank statistics for 2011. Other countries in the region: Belize, US\$262; Costa Rica, US\$943; El Salvador, US\$251; Guatemala, US\$214; Panama, US\$703; Argentina, US\$892; Chile, US\$1,075; Colombia, US\$432; and Mexico, US\$620.

especially those who are not covered by social security, through its network of public providers. However, it is estimated that only about half of Hondurans access these services (Bermúdez-Madriz et al., 2011). The public sector has very limited resources; public health expenditure per capita (SESAL, IHSS, and the Military Hospital) is only US\$92.05 according to data from 2012,³ one of the lowest spending levels in Central America and the region.

Honduras has made progress in health, such as an increase in life expectancy at birth from 66 to 72 years over the last decade and a reduction in the maternal mortality rate from 108 to 74 per 100,000 live births, according to a 2010 study on maternal mortality by SESAL. Despite these advances, the infant mortality rate is 24 per 1,000 live births, which is higher than the regional average of 19 per 1,000 births (ECLAC, 2012). Institutional deliveries also fall below the regional average (83% versus 86% in the region, according to demographic and health surveys and data from ECLAC). Chronic malnutrition stands at 23%, the second highest figure in the region after Guatemala. This indicator is even more alarming in those areas of the country that have fallen the furthest behind, where the figure can be up to 53% of the population. Similar trends are verified by other maternal and child health indicators (IDB, 2011). These percentages prove that considerable gaps exist between access, supply and demand for health services. On the supply side, it is common to find health centers closed, without sufficient medical personnel or with a lack of supplies and medicines. On the demand side, factors such as the great distances separating certain areas from health centers, low socioeconomic and educational levels, and women's lack of autonomy hinder the utilization of services.

The government of Honduras began to experiment with different models

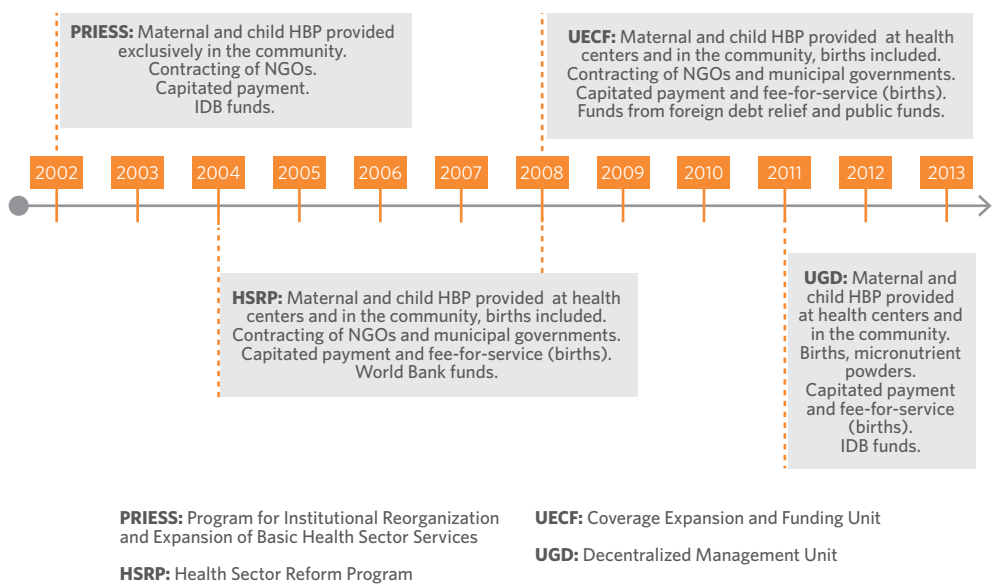
of decentralized management for the delivery of health care services, exploring alternative approaches to providing an HBP to the most underserved population. Figure 7.2 presents a timeline of the main phases of this process and the changes that were introduced with the PBS.

The first phase began in 2002 with the Program for Institutional Reorganization and Expansion of Basic Health Sector Services (PRIESS), funded by the Inter-American Development Bank (IDB), whose main objective was to extend coverage to the rural poor. The project included a component focused on coverage expansion of basic health services, which during the 2002-06 period reached approximately 289,000 people in 1,100 poor communities in 14 departments. Its delivery model was based on contracting 13 non-governmental organizations (NGOs) that organized mobile teams composed of a general practitioner, a nurse and two health promoters to provide primary care services in communities, with an emphasis on promoting individual and collective health, preventing harm to health (vaccination, prenatal check-ups, and management of patients with chronic diseases such as diabetes and hypertension) and providing care for women and children for general illness. Services grounded in this model of care were offered every six to eight weeks in all of the communities. The project's coordinating unit assumed responsibility for contracting the NGOs, and the services that these organizations provided were defined by an HBP with 21 areas of intervention: twelve related to health promotion, four to prevention, and the remaining five to care (Jara, 2007). This project began in late 2002 and ended in February 2007.

In 2004, a second phase began with the Health Sector Reform Program (HSRP). Taking advantage of existing health centers that were closed due to lack of staff and equipment, this program sought

³ The authors' estimates based on data from the Ministries of Finance and Health.

Figure 7.2. Timeline of decentralized health management projects



Source: Developed by the authors

to introduce an innovative management model for primary care services by outsourcing the administration of these services. In contrast to the PRIESS model, which mainly operated through mobile teams, HSRP services were chiefly provided at health centers (medical and dental health centers [CESAMOs], rural health centers [CESARs], and maternal and child health clinics [CMI]). The HBP became more explicit as a result of the HSRP.⁴ For example, prenatal check-ups and immunizations, also considered community health promotion activities during the first phase, were described in detail under the HSRP. In addition, this second phase specified what type of health center services must be provided. To provide the PBS, nonprofit, local, public and private entities (civil society or municipal government organizations) were contracted to guarantee services for the covered population in exchange for a per capita amount (except for childbirth,

which was fee-for-service). The United Nations Development Program (UNDP) functioned as the purchasing agency throughout the implementation of this model.

In a third phase, based on the achievements of the PRIESS and HSRP in terms of improved coverage, access and user satisfaction, the institutionalization process for coverage expansion with decentralized management was initiated through the creation of the Coverage Expansion and Funding Unit (UECF), the SESAL agency responsible for contracting the GPs. In 2011, as part of the Program to Strengthen Decentralized Management and Supply of Health Services, the Decentralized Management Unit was created and integrated into the existing model. The unit assumed responsibility for the contracting of GPs when they are externally funded. In addition, benefits were added to the PBS such as the

⁴ Proposed management, care and funding models for the expansion of health coverage to Punta Gorda, Roatán, and Islas de la Bahía. Daniel Bronstein Consulting, Tegucigalpa, May 2003. Primary care model and service portfolio (basic package) to be provided. Gesaworld, Tegucigalpa, July 2004.

distribution of micronutrient powders, nutrition counseling (comprehensive care for children in the community), and zinc for treating diarrhea.

The motivations behind each one of these updates are not clearly documented, but it is presumed that each change was intended to facilitate the management of the PBS. The lack of documentation can be explained by the fact that part of the valuable institutional memory about the motivations and criteria for the updates that were made was lost during the third phase. These three experiences preserved common elements—an explicit HBP, contracting of GPs, and payment based on the population covered—that have brought consistency and continuity to the expansion of coverage for health services in the country.

Objectives, Scope, Coverage and Funding Sources

Objectives

The implementation of a benefit plan aimed at the rural poor was central to several externally funded projects that attempted to improve access to and coverage of health services in rural areas of Honduras. All of these projects sought to establish new programs to provide a minimum package of services to the rural poor. Unlike the other countries analyzed in this book—with the exception of Argentina and its Plan Nacer—the adoption of the HBP in Honduras was not part of a national policy that defines what the government is committed to delivering to the people; instead, it came in response to international cooperation projects seeking to improve access to health services for the most vulnerable.

Currently, local governments are being encouraged to assume the management of primary care services or, alternatively, civil society organizations that have emerged

within those very same municipalities, for example, agricultural production cooperatives, foundations, etc.

Scope

The PBS mainly consists of basic outpatient benefits at the primary care level, which include a mix of preventive and curative interventions, and the plan favors interventions aimed at mothers and children. PBS content is structured around 12 lines of service (table 7.1).⁵

The PBS's technical design team defined a benefit package related to health promotion and prevention and a smaller set of benefits aimed at curative measures, grouped into 12 lines of action. In general, covered services are grouped into syndromes or interventions, for example, febrile syndrome, management of acute diarrhea or acute respiratory infection. Due to weaknesses in the country's health information system, it was not possible to use a coding classification system, such as the 10th Edition of the International Classification of Diseases, to code syndromes included in the PBS.

Population coverage

Since the PBS emerged as an investment project by multilateral cooperation agencies, linked to the strategy of poverty reduction rather than as part of a national policy on social protection in health, coverage targets were aimed at areas where there was a higher proportion of poverty and women of reproductive age. Table 7.2 shows the increase in coverage of the target population over the 2008-13 period. In 2012, the PBS reached 67 of the country's 298 municipalities and covered 891,938 people, equivalent to 10.7% of the total population (the rest of the population receives care through a traditional delivery model with a basket of implicit benefits), 16.8% of the poor population⁶ and 25% of the

⁵ Section 6 of the annex to this chapter details the current HBP.

Table 7.1. Scope of the PBS

Lines of service	Areas of service delivery	Target population group
1. Contraception and safe sex	Health promotion	Adolescents, individuals of reproductive age
	Prevention	Adolescents, women of reproductive age and adults
	Care	Adolescents, women of reproductive age and adults
2. Monitoring of pregnancy and postpartum recovery	Health promotion	Women of reproductive age, pregnant women and postpartum women
	Prevention	Women of reproductive age, pregnant women and postpartum women
	Care	Women of reproductive age, pregnant women and postpartum women
3. Postnatal care	Health promotion	Women of reproductive age, postpartum women
	Prevention	Women of reproductive age and postpartum women, infants up to 10 days
	Care	Newborn infants
4. Comprehensive monitoring of children's health	Health promotion	Adolescents, women of reproductive age
	Prevention	Children up to age 14 Target populations determined by the Ministry of Health
	Care	Children up to age 14 Children, adolescents and adults
5. Adolescent and adult care	Health promotion	Adolescents, adults, community, the elderly Community integrated through participation
	Prevention	Target populations determined by the Ministry of Health Adolescents and adults, particularly vulnerable groups
	Care	Adolescents and adults
6. Screening for cervical and breast cancer	Prevention	Adult women (ages 25 to 64)
7. Oral health	Health promotion	Children ages 4 to 10, adolescents, adults
	Prevention	Children, adolescents and adults
	Care	Children, adolescents and adults
8. Epidemiological surveillance	Prevention	Community
9. Acute and emergency care	Care	Children, adolescents and adults
10. Diagnostic support	Care	Children, adolescents and adults
11. Specific nursing techniques	Care	Children, adolescents and adults
12. Rehabilitation	Chronic disease rehabilitation	Children, adolescents and adults
	Physical rehabilitation	Children, adolescents and adults
	Psychiatric rehabilitation	Children, adolescents and adults

rural population. SESAL plans to expand PBS coverage to a total of 1,533,614 people through decentralized providers by December 2015.

Amounts and composition of financing

Between 2008 and 2012, PBS spending rose from US\$5.73 million to US\$13.8 million, figures representing 1.55% and 2.61%, respectively, of SESAL resources. Provision of the PBS has consumed a rather marginal proportion of the resources designated to SESAL for public health spending. Furthermore, this percentage has not increased appreciably over time. The reasons behind the lack of increased funding for the PBS are the public sector financial crisis of the last three years and weak institutionalization of the decentralized management model. The PBS is still financed by external resources and is not given sufficient priority for financing with a greater proportion of fiscal resources.

PBS financing comes from Honduran treasury funds (released by external debt relief from the Paris Club and Italy, plus tax revenue) and reimbursable external funds from the World Bank and the IDB. External funds provided the main source of financing in 2013 (table 7.3), with 75% of the total. This dependence on external funds has hindered the expansion of PBS coverage, both in population and financial terms. In addition, some local governments make marginal contributions to cover recurrent costs (basic general services) that are not factored into the PBS budget execution.

The financial sustainability of the PBS is at risk due to funding problems caused by the delay in signing management contracts between the UECF and the GPs. This leads to late payment of the GPs⁷ and compromises both the management capacity of the GPs as well as the continuity of services. Although the

budget allocated to the PBS is relatively small, SESAL fails to secure funds from the Ministry of Finance in a timely manner. Consequently, PBS financing is dependent upon the prevailing political interests, which threatens the program's sustainability.

Determination of Plan Content and Cost

During the initial phase, the central questions to address were which services to include, how to estimate their cost, who would manage the program, and how would services be reimbursed. Initially, the priorities identified by health authorities to reduce maternal and infant mortality were considered along with the installed capacity of the public network's health centers. The longest debate, however, centered on how to introduce private nonprofit organizations into management and service delivery roles without this being perceived as a move toward privatization.

Once the scope of the PBS was defined, mayors, council members, boards and user groups were involved in discussions regarding the form of management and provision of services included in the plan, more so than in the definition of its content.

Priority-setting methods

To identify the services to include in the PBS, throughout 2003 and 2004, there were deliberations, negotiations and a closed technical dialogue, which separately involved teams from the PRIESS and HSRP programs, multilateral organizations and cooperation agencies. SESAL delegated leadership of these discussions to the technical teams of both programs, but no other national health sector institutions were involved

⁶ According to the National Statistics Institute (INE), 60% of the country's total population lives in poverty.

⁷ In-depth interview with Rosa María Cárcamo, UECF coordinator.

Table 7.2. Population coverage, 2008-13

Categories	2008	2009	2010	2011	2012	2013
Beneficiaries	483,782	693,584	737,208	854,576	891,938	1,131,163
Financing, in millions of US\$	5.69	8.84	9.57	10.15	13.8	20.09
Municipalities	38	46	58	62	67	77
Departments	8	13	13	12	14	14
GPs	21	24	24	24	28	37

Source: Developed by the authors, based on data obtained from the UECF, the Decentralized Management Unit, and the Gesalud program's implementation unit

Table 7.3. Population coverage and PBS financing in relation to SESAL spending, 2008-13

Year (1)	Population coverage (2)	PBS financing (in millions of US\$)			SESAL budget (in millions of US\$) (6)	Percentage of SESAL budget allocated to PBS expenditure (7) = (5)/(6)
		External funds* (3)	National funds (4)	Total (5) = (3)+(4)		
2008	483,782	0.02	5.71	5.73	369.98	1.55%
2009	693,584	2.44	6.38	8.82	472.55	1.87%
2010	737,208	9.46	0.10	9.56	480.91	1.99%
2011	854,576	5.23	4.91	10.14	520.09	1.95%
2012	891,938	9.30	4.50	13.80	529.72	2.61%
2013	1,131,163	15.06	5.04	20.09	647.13	3.10%

Source: Developed by the authors based on data obtained from the UECF, the Decentralized Management Unit, and the Gesalud program's implementation unit

*External funds: World Bank in 2008 and IDB in 2012

in the dialogue. In 2012, the current HBP was established by the HSRP with some additional benefits.

To define the content of the PBS, technical teams from both programs first identified the target population and prioritized the rural maternal and child population living in poverty or extreme poverty. Then, to define the content of the benefit plan, this population's health problems were identified and subsequently

analyzed on the basis of morbidity rates among the rural poor, using an analysis of the country's health status and the 2001 National Epidemiology and Family Health Survey. The installed capacity was also evaluated, which had to comply with licensing standards for health facilities. This evaluation process relied on records from licensed facilities as a source of information.

Based on these analyses, a list of interventions,⁸ tests and medications for the promotion, prevention and treatment of health problems was defined. The choice of medications was based on the official basic drug formulary established by SESAL for primary care health centers. To select laboratory tests, technical standards of care defined by SESAL for health centers in the public network were used as a reference. The main steps that defined PBS content are shown in figure 7.3.

Costing

Once the HBP's benefit list was defined, three cost estimates were performed.⁹ The first study estimated the cost of re-opening primary care health centers that were closed due to lack of personnel, equipment and supplies. The second study included the same health services but added care by mobile health teams in communities. The third study was conducted in 2011 to update previous estimates and also to calculate the cost of expanding services to include delivery by cesarean section, voluntary surgical contraception (male and female), distribution of micronutrient powders, and distribution of temporary family-planning methods. The most important estimates from the aforementioned studies are described below.¹⁰

i. Costing methodology (initial estimate, 2004)

The cost of providing services to more than 10,000 people, between 3,000 and 10,000 people, and fewer than 3,000 people (table 7.4) was calculated. It was noted that the cost is inversely proportional to the size of the insured population; unit fixed costs decrease significantly as the volume of the covered population increases.

ii. Costing methodology (second estimate, 2004)

The methodology used was similar to the previous one. The per capita cost was estimated between US\$13.50 and US\$17.50 per year (2004),¹¹ including health promotion, prevention, maternal and child care, and general illness. This value increases to US\$18.50 if basic dental care is included. This cost estimate differs from the previous one due to the fact that it was conducted for residents of different departments within the country.

iii. Updated cost estimate (third estimate, 2011)

In 2011, another study (Véllez, 2011) based on the PBS's explicit benefit portfolio was performed. This one considered the cost of the PBS, the preventive nutrition strategy,

Figure 7.3. Priority-setting criteria



Source: Developed by the authors

⁸ See the table in section 4 of the annex to this chapter. The HBP's explicit list is a positive list.
⁹ The technical reports from PRIESS and the HSRP are not publicly available. The PBS cost study by the Mesoamerican Health Initiative 2015 is available at <http://www.saludmesoamerica2015.org>.
¹⁰ See details in section 5 of the annex to this chapter.
¹¹ See section 5 of the annex to this chapter.

micronutrients, distribution of family-planning methods, and referrals and hospital-based care for obstetric emergencies and neonatal complications. To that end, a costing methodology was developed that includes health promotion and preventive and curative interventions. This study identified per capita costs for the HBP ranging from US\$19 to US\$30, with an average per capita cost of US\$25. According to the study, the beneficiary population and the provision of infrastructure for each GP (health centers and vehicles) account for the differences in per capita cost.

A comparison of the three studies shows a per capita cost for the PBS ranging from US\$13.50 to US\$30. The difference is mainly explained by the amount of the population taken as the basis for the calculation (providing permanent staff involved a greater annual per capita cost in smaller populations) and the number of services that were included in the PBS.

These studies were never shared with the various stakeholders in the Honduran health sector, and only the third study is publicly available.

Legitimacy of the PBS

One of the biggest obstacles to the implementation and adjustment of the PBS is the lack of legal and technical legitimacy.

Legal legitimacy. Legitimization requires the formal institutionalization of the plan within the health sector. While there are generic legal guidelines for the plan in the Honduran Constitution and the Health Code, the legal framework that formalizes the implementation of the PBS came about through an administrative order. The management agreements that establish the responsibilities of SESAL and the GPs are recorded therein. Consequently, although this instrument is administratively valid, it lacks legal enforceability.

To date, no law, regulation or ministerial resolution has been passed that offers explicit legal backing for the delivery of the PBS by the GPs. There were various proposals to this effect, but none was adopted. One was the “Regulation on the Delegation and Reassignment of the Role of Health Service Provision and Its Management” of 2009. Despite clearly establishing the obligations of the state, the regulation was not a priority for SESAL, and it never took effect. This is partly due to the high turnover of UECF leaders, which limited the unit’s influence and management capacity at SESAL.

Technical legitimacy. The design of the PBS was assigned to outside technical teams that were not part of SESAL but instead were hired specifically for two externally-funded health projects. At the time, the technical team was endorsed by high-ranking authorities within SESAL, but

Table 7.4. PBS cost estimate, 2004

Description	Service Portfolio No. 1 > 10,000 inhabitants			Service Portfolio No. 2 3,000 to 10,000 inhabitants			Service Portfolio No. 3 < 3,000 inhabitants		
	Inhabitants			Inhabitants			Inhabitants		
	Maximum 12,500	Minimum 10,500	Average	Maximum 10,000	Minimum 3,500	Average	Maximum 3,000	Minimum 1,250	Average
Total Lp (lempiras)	482.10	532.70	507.40	331.45	646.40	488.92	291.91	545.02	418.46
Total US\$	26.78	29.59	28.19	18.41	35.91	27.16	16.22	30.28	23.25

Source: Report from consulting firm Gesaworld, Tegucigalpa, Honduras

the PBS design lacked a communication strategy to involve all Honduran health sector stakeholders and to make the plan public knowledge. Civil society, health care workers and the Ministry of Finance had no role in the discussion and negotiations surrounding the PBS.

Additionally, when PBS interventions were selected and prioritized, there was a failure to consider technical studies that would facilitate priority setting, such as the analysis of burden of disease and cost-effectiveness studies for the interventions included in the PBS.

The legal and technical legitimacy of the PBS must be improved. The plan needs regulations that provide legal backing. Lastly, burden of disease and economic evaluation studies should be performed to ensure the sustainability of the PBS.

Implementation

The PBS posed significant challenges for the Honduran health system, the greatest of which involved implementing prioritized services and reaching the entire population. While there was an attempt to link prioritized services to a payment mechanism through a system of capitation payments and pay for performance, several obstacles still stand in the way of implementing prioritized services. These include delayed payment of the GPs, weak mechanisms for performance monitoring of the GPs, and the beneficiary population's lack of knowledge about the plan.

Purchasing of services

Beginning in 2008, the UECF became responsible for purchasing PBS services when public funds are the source of financing. Since 2011, this responsibility is shared with the Decentralized Management Unit when GPs are financed with external funds. As of December

2012, there were 28 GPs present in 67 of the country's 298 municipalities and 14 of its 18 departments.

The contracting process involved negotiating the population to be covered, per capita payment amounts, and outcomes and targets to be met by each GP. Once a consensus was reached, management contracts were prepared.

In the years 2008 to 2011, the GPs were paid, on average, between US\$16 and US\$18 per person, depending on the individual's place of residence. This average capitation payment is adjusted according to the conditions of each GP and negotiated with the UECF. One of the variables used to determine the payment for each GP is the proportion of SESAL employees that make up the GP's institutional health team.¹² SESAL requires the GPs to pay the salaries of the SESAL staff assigned to them, even though management of the PBS is outsourced. This means that the greater the number of SESAL staff members at a GP—whose salaries are higher than those in the private subsector—the greater the benefit load and, therefore, the GP's fixed operating costs. Consequently, in real terms, the capitation payment is higher for GPs with fewer SESAL workers on the payroll. Another adjustment criterion for capitation payments is geographic location and distance from the country's major cities. Neither cost studies nor the estimate of the original capitation rate has been used as a reference for these variations. The criteria used by the UECF also fail to conform to previously defined rules or standards. Generally speaking, these adjustments have been handled by the UECF at its discretion.

In order for capitation rate adjustments to be made in a more technically-sound manner, consistent with standards, in early 2010 the UECF conducted a study to develop a cost estimate guide for primary health services. The study proposed a methodology for estimating

¹² According to Hugo Godoy, former director of the HSRP, during an in-depth interview.

and analyzing the costs of service provision and improving resource management in public institutions. This information was intended to define the rules for determining the GPs' capitation payments according to criteria of distance, target population, geographic location, and economies of scale, among others; however, the technical authorities at SESAL never used it as a reference.

Pay for performance. The UECF negotiates with each GP to reach an agreement on pay for performance, according to goals based on the following principles:

1. Population to be covered. Unlike other countries with HBPs where the population to be covered is selected from lists of beneficiaries (e.g., Argentina with its Plan Nacer, which is described in this book), in Honduras, the beneficiary population is determined by a poverty map and the population living within the catchment area of the health centers managed by the GP.¹³ Part of the payment is calculated on the basis of potential beneficiaries rather than the actual enrolled population, since this exact figure is unknown and there is no information system that tracks the care received by each beneficiary.
2. Production targets. These are defined on the basis of an initial characterization of some morbidity indices in the catchment area. With this information, and in coordination with the departmental health region, the GP's production targets are determined. For example, the target for deliveries attended at the GP's maternal and child health clinic, or referred to a hospital in the case of complications, was set at 85%.

Institutional deliveries are reimbursed on a fee-for-service basis, meaning that the greater the number of deliveries, the greater the reimbursement. This encourages the active recruitment of

pregnant women to give birth at health facilities.

Adequacy of resources

In general, there is consistency between the installed capacity (technology, medical supplies and infrastructure) and the services included in the PBS. This results from the fact that during the implementation of the PBS and subsequent coverage expansion, it was recognized that the supply of services would be insufficient without the necessary equipment and medical supplies. Great efforts were made to acquire the minimum equipment needed to ensure delivery of the PBS. In many cases, the GPs' health centers have better basic equipment than SESAL's centralized service provider clinics, which explains the high levels of satisfaction (over 85%) recorded in the GPs' annual evaluations.

There are no studies providing evidence that payments to the GPs adequately cover PBS services. However, GPs with maternal and child health clinics located in remote areas contend that the capitation payment meant to cover the costs of labor and delivery is insufficient. Given that these clinics must maintain permanent medical staff to attend infrequent deliveries, their fixed costs are proportionately greater in these areas. In addition, GPs have difficulty staffing doctors, specialists and nurses in some regions of the country. As in many countries, rural areas prove undesirable to most professionals. According to the GPs, this makes hiring employees more expensive.

Quality control, monitoring and supervision

Honduras, like other countries in the region, makes the contracting of providers conditional upon a licensing process and a monitoring system for prioritized services.

¹³ According to Yolany Batres, Deputy Minister of Service Networks at SESAL, during an in-depth interview.

The GPs' health facilities must first go through a licensing process led by SESAL. If a GP does not meet standards, SESAL grants it a temporary license and a grace period to come into compliance. Then, the GP formulates an investment plan and a schedule of actions supervised by the departmental health region, which reports to the UECF and the General Office of Health Regulation on the GP's compliance.

The monitoring of services included in the PBS and the GPs' production and quality targets is the responsibility of the departmental health regions. The quality of services provided by the GPs' health centers is evaluated according to the indicators established in the agreement between the UECF and the GPs. Medical records are particularly scrutinized, a task performed by professional nurses hired by the GPs for that purpose. Medical records are also used for quality monitoring conducted on a quarterly basis by the SESAL health region and for the UECF's annual evaluation. Additionally, SESAL conducts an annual user satisfaction survey that forms part of its yearly evaluation of the GPs. Despite this, there is no formal program that monitors the quality of the GPs' services. Although there are tools for the monitoring, supervision and evaluation of goals, regulation is weak due to insufficient personnel and the lack of both coordination and a single governing body. Improvements in these three aspects would help standardize monitoring processes, thus avoiding arbitrary performance ratings for the GPs.

One priority put before SESAL is to identify the relationship between the services received by the PBS beneficiary population and the resources invested. While the plan's design defined the normative aspects necessary to ensure the quality of services, regulatory components that would allow for the effective operation of the program were not established. This has resulted in the need to create a quality assurance program for the GPs, which, for example, standardizes clinical management tools (e.g., the

patient's chart) and the management of users (e.g., the patient referral form).

Outcomes

No impact assessment has been performed for the PBS. Based on the information analyzed and key informant interviews, it may be inferred that this flaw comes from the original design of the coverage expansion strategy developed by PRIESS and the HSRP. Indicators, targets and outcomes were defined for each individual project, which made it difficult to create a baseline for measuring performance and impact at the national level.

Five years after the implementation of the strategy to expand the HBP in Honduras, improvements to service coverage and access in specific communities are observed through evaluations conducted by the UECF on the GPs' performance. However, the impact on key health indicators cannot be quantified given the lack of indicators at the national level. Nonetheless, the results of some studies on the implementation of the PBS are presented below.

Studies

The main studies available include a cost-effectiveness analysis of the HBP versus the traditional model of health care service delivery (Measure Evaluation and Prodim, 2008), an evaluation of the decentralized management model of primary health care (Véllez, 2010), and the work of García Prado and Lao Peña (2010).

These studies compare the results from health centers operating under the HBP (alternative model) to other public institutions governed by the traditional model of the supply-side subsidy. They also report on performance in terms of service production, coverage, cost-effectiveness and quality. According to these studies, HBP health centers show higher levels of production in prioritized

programs and in total services provided. In addition, the PBS has covered more people than the traditional model. The results are similar for prioritized programs focused on prenatal care, labor and delivery care, growth and development monitoring in children, and postpartum care. Also, the HBP model is more cost-effective, with a lower average unit cost for general care.

Performance is similar in terms of the use of care protocols and wait times. However, the PBS made a significant difference in deliveries attended by skilled health personnel, reaching a rate of 100%, which suggests a higher quality of care. In terms of access, no significant differences are observed since both models serve similar populations (those that are traditionally excluded).

In late 2010, the PBS covered 9.16% of the total population. However, there are no studies on the utilization of medical services or the health status of covered individuals. According to a previous study that compared eight health centers under the decentralized and centralized models (Measure Evaluation and Prodim, 2008), the PBS covered 24.4% of the population versus 18.16% under the traditional model.

García Prado and Lao Peña (2010) record higher rates of productivity in HBP health centers, with an average of one health promoter for every 2,000 inhabitants, while in traditional centers, there is one health promoter per 10,000 inhabitants. This study also found that the information at PBS health centers is more complete than at traditional centers, where the information is centralized at SESAL, making follow-ups more difficult.

Conclusions

While there have been positive outcomes in terms of access to and quality of health services, the implementation of the PBS faces challenges that stand in the way of better results.

One of these challenges is that within SESAL, the UECF is still perceived as a parallel agency in competition with other ministerial entities. This is evident in the lack of coordination with agencies with which the UECF should naturally collaborate. There is also a need for coordination with SESAL's technical regulatory units focused on population risks and networks, which are responsible for operating the service network and developing and enforcing standards of care and coordination.

Another challenge is that while, in principle, the management agreement establishes rights and obligations between the UECF or the Decentralized Management Unit and the GPs, in reality, their margin for negotiation is narrow. The UECF establishes most of the agreement's conditions at its discretion. This could compromise the GPs' performance if they were to accept risky terms and conditions, such as a per capita value unadjusted for production costs or inflated goals for some programs, such as vaccination programs, which often overestimate the population. This problem is attributable to the fact that the UECF and Decentralized Management Unit's population estimate is based on a projection from the 2001 census, without considering temporary and permanent migratory flows in the rural area where PBS delivery is concentrated.

To address these weaknesses, the GPs' bargaining power must be strengthened and the capitation rate must be risk-adjusted to reduce unilateral decisions by the UECF and to facilitate expansion of this model to other parts of the country.

Overcoming these obstacles requires actions that strengthen the system's stakeholders, especially those who perform monitoring and control functions. Some of the necessary actions are to i) involve lawyers and politicians in the process of defining a legal framework that institutionalizes the PBS; ii) raise awareness among the country's political authorities in order to expand the plan to the rest of the

municipalities with extreme poverty; iii) inform the covered population of its rights and create an entity that will safeguard them; iv) strengthen management capabilities to reduce unilateral decision-making in the areas of contracting, cost estimation, payment method, quality control, management control, etc.; v) institutionalize a quality control system in SESAL to monitor the services delivered by the GPs, and strengthen its regulatory capacity in order to respond to the gaps observed in implementation; vi) improve information systems to support monitoring and follow-up mechanisms; vii) create a high-

level technical structure within SESAL independent of the purchasing unit, with broad political support, that defines the technical criteria for adjustment of the PBS; viii) promote the development of negotiation skills, technical knowledge of the contracting process, and leadership among GP technicians to encourage more horizontal relations during the negotiation and signing of agreements, without advantages for one party that involve excessive risks for the other; and ix) establish a management control system to ensure the adjustments required by the PBS.

References

- Bortman M. 2010. Final draft of the project completion report for the Health Sector Reform Project. Tegucigalpa, World Bank.
- Bronstein M. 2003. “Propuesta de los modelos de gestión, atención y financiamiento para la extensión de cobertura de los servicios de salud a Punta Gorda Roatán, Islas de la Bahía.” Tegucigalpa.
- Dinarte M. 2009. “Manual de nomas y procedimientos para la contratación de servicios de salud.” Presentación preparada para la inducción al equipo técnico de la UECF. Tegucigalpa, Secretaría de Salud.
- _____. 2011. “Estudio de gasto público en salud en Honduras, en el marco de la iniciativa Salud Mesoamérica 2015.” Tegucigalpa, Presidencia de la República.
- ECLAC (Economic Commission for Latin America). 2012. *Anuario estadístico de América Latina y el Caribe 2012*. Santiago, Chile, ECLAC.
- Fabio D. 2004. “Diseño y desarrollo de estrategias y mecanismos para la contratación, monitoreo y evaluación de proveedores de servicios de salud.” Tegucigalpa, Secretaría de Salud.
- García Prado A. and C. Lao Peña. 2010. “Contracting and providing basic health Care services in Honduras: A comparison of Traditional and Alternative Service Delivery Models.” World Bank.
- Gesaworld. 2004. “Diagnóstico y apertura de los centros de salud con nuevos modelos de gestión y atención.” Tegucigalpa, Secretaría de Estado en el Despacho de Salud.
- _____. 2004. “Modelo de atención primaria y cartera de servicios (paquete básico) a brindar.” Tegucigalpa.
- Instituto Nacional de Estadística y Secretaría de Salud (National Statistics Institute and Secretary of Health). 2006. Encuesta de Demografía y Salud 2005-06.
- _____. 2012. Encuesta de Demografía y Salud 2011-12.
- Inter-American Development Bank. 2011. Ex ante evaluation. Mesoamerican Health Initiative 2015.
- Jara J. 2007. “Informe de evaluación de la prestación de servicios de parte de las ONGs para el Periodo 2003 - 2004.” Tegucigalpa, Consejo Consultivo de ERP.
- Measure Evaluation and Prodim. 2008. “Análisis de costo efectividad entre el modelo alternativo y modelo tradicional en la provisión de servicios de salud en atención primaria en Honduras.” Tegucigalpa, Secretaría de Salud.
- Rojas S. 2004. “Diseño e implementación de un nuevo modelo de gestión para la extensión de cobertura de servicios de salud en la comunidad El Guante.” Tegucigalpa, Secretaría de Salud.

Secretaría de Salud (Secretary of Health). 2001. Encuesta Nacional de Epidemiología y Salud Familiar 2001.

____. 2002. Análisis de situación de salud 2002.

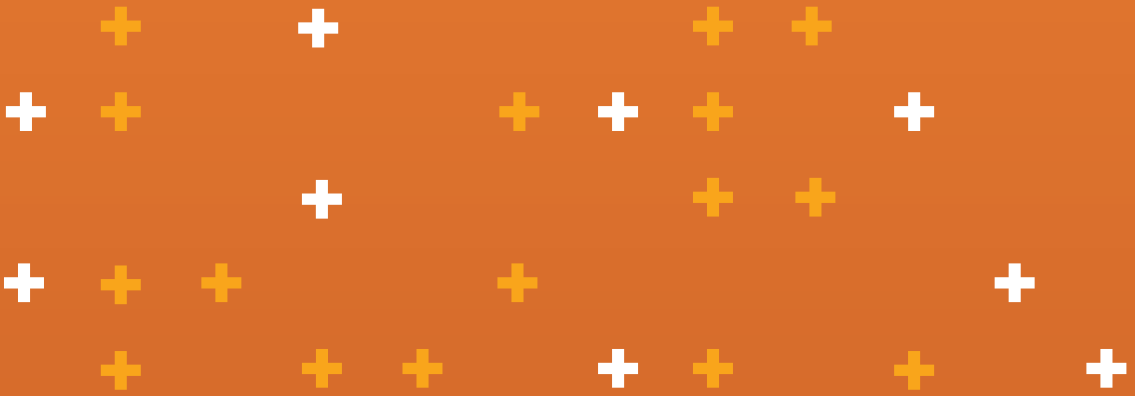
____. 2003. Análisis de situación de salud 2003.

____. 2010. Plan Nacional de Salud 2010-2014.

Véllez M. 2010. "Evaluación del modelo de gestión descentralizada de atención primaria de salud en Honduras." Tegucigalpa, IDB.

____. 2011. "Estimación de costos del conjunto de intervenciones de Salud Mesoamérica 2015." Tegucigalpa, IDB.





ISBN: 978-1-59782-177-3



9 781597 821773