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Health Benefits Package Monitoring Maturity Assessment Tool (HBPM MAT)

OPERATIONAL MANUAL AND CASE STUDIES IN ARGENTINA AND CHILE

Adrian Gheorghe, Ursula Giedion, Abha Mehndiratta, Martin Sabignoso, and Rodrigo Munoz

Abstract

This paper builds on and complements the policy paper "*Health Benefits Package Monitoring—a Global Public Good*," which makes the case for the robust monitoring of health benefits packages (HBPs) and introduces a conceptual framework based on eight foundational principles and three pillars—indicators, institutions and health information systems. It introduces a health benefits package monitoring maturity assessment tool (HBPM MAT) comprising 13 statements, with each statement broken down into key attributes defined through concrete and observable characteristics; the pattern of answers is then used to classify HBPM systems into one of three maturity levels—Emerging, Established and Advanced. The paper also demonstrates the application of the tool through two detailed case studies in Argentina (Programa Sumar) and Chile (Guarantias Explicitas de Salud). HBPM MAT is intended as a strategic insight tool that can help countries identify the strengths and weakness in their HBPM systems and take appropriate action to strengthen them and bring the promise of the HBPs closer to reality.

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Health Benefits Package Monitoring Maturity Assessment Tool (HBPM MAT): Operational Manual and Case Studies in Argentina and Chile

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Abbreviations

GES	Explicit Health Guarantees (Garantias Explicitas en Salud)
HBP	Health Benefits Package
HBPM	Health Benefits Package Monitoring
HBPM MAT	Health Benefits Package Monitoring Maturity Assessment Tool
HIS	Health Information System
ICD	International Classification of Diseases
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SNOMED CT	Systematized Nomenclature of Medicine—Clinical Terms
UHC	Universal Health Coverage

1 Introduction

The policy paper "*Health Benefits Package Monitoring—a Global Public Good*", which accompanies this paper, outlines a comprehensive, evidence-based argument for robust monitoring of health benefits packages as critical for making sure they have the intended impact and don't "stay on paper". It defines the monitoring of health benefits packages (HBPM) as:

> measuring and monitoring the implementation of explicitly defined health benefits packages, operating at the intervention level to assess whether specific services in the HBP are being delivered—to all those needing them, at good quality, and without creating financial hardship—and what is enabling or hindering that delivery, such as adequate budgets, rates, and provider payment mechanisms that create the right incentives, or clear communication to all stakeholders about the HBP and the rules of the game.

HBPM monitors HBP goals, and potentially some Universal Health Coverage (UHC) goals as well, by tracking not just results, but also the enablers and barriers that influence them.

Eight foundational principles of HBPM reflect the basic conditions and choices needed to design HBPM systems that are both practical and purposeful (Table 1). These principles outline the essential conditions and policy choices required to make HBPM systems practical and useful. While they are aspirational in nature and unlikely to be fully met in most settings, they provide a guiding vision for strengthening HBPM.

TABLE 1. Foundational principles for HBP monitoring

Principle	Description
Principle 1 Clearly and Explicitly Defined HBP	Monitoring depends on clearly defined HBP goals and on a well-defined and explicit package—what's covered at what quality, for whom, and under what conditions of financial protection—enabling monitoring of actual access.
Principle 2 Clinical Guidance Documents as a Foundation for HBP content and monitoring	Clinical guidelines and care pathways provide the technical foundation for structuring and operationalizing HBPs. Aligning the services included in the HBP with recommendations in evidence-based clinical practice guidelines, enables consistent implementation of appropriate clinical care and create a reference point for systematic monitoring of service coverage and quality across the continuum of care.
Principle 3 Linking Monitoring to the HBP Updating Cycle and related decision space	For HBPM to be effective, it must generate evidence that aligns not just with what is measurable, but with what is actionable within the HBP updating cycle. Monitoring should feed directly into decisions across the design, updating and implementation of HBP.
Principle 4 Focus of Monitoring Domains: HBP Goals and Direct Enablers	Monitoring should concentrate on HBP-specific goals and direct enablers being addressed during the HBP updating cycle. While goals capture the intended outcomes of the package, focusing on direct enablers ensures attention to the operational factors that truly drive its performance. Together, these two domains provide a complementary perspective that links strategic objectives with the conditions required for their achievement.

(Continued)

TABLE 1. (Continued)

Principle	Description
Principle 5 Strategic and feasible indicator selection	Within each priority domain, monitoring should focus on tracer indicators that are most valuable for decision-making related to updating the HBP, avoiding unnecessary measures and ensuring each indicator has a clear policy purpose.
Principle 6 Feasible and Phased Monitoring	Monitoring should start with a scope that is feasible and realistically manageable with existing capacity and scale up progressively as systems mature. This principle of graduality applies across all three pillars of HBPM—indicators, health information systems, and institutional arrangements—ensuring that early efforts remain manageable while creating space for adaptive learning and sustainable scale-up.
Principle 7 HBPM aligned with National HIS Strategy	HBP monitoring should strengthen, not bypass, national data governance and HIS policies, ensuring sustainability and avoiding parallel systems, including standards for data quality, interoperability and progressive digitalization to enable real-time, scalable monitoring.
Principle 8 Institutionalization and Multi-Level Governance of HBPM	Effective HBPM requires robust institutionalization embedded in national frameworks, with clear mandates, sustainable financing, capacity-building, and accountability mechanisms across all levels. A solid institutional backbone—anchored in a clear vision, legal frameworks, and managerial capacity—ensures coherence and long-term sustainability, while integration into multi-level governance arrangements guarantees responsiveness to subnational implementation and feedback.

Source: Giedion U, Mehndiratta A, Gheorghe A and Sabignoso M. *Health Benefit Package Monitoring—a Global Public Good.*

Based on the eight foundational principles above, the HBPM framework consists of three pillars, or domains: HBPM indicators (what to measure), HBPM institutions (who is responsible for measuring) and HBP-related Health Information Systems (how data are produced, managed and used). Together, these domains form the foundation for assessing the monitoring of a HBP.

In this working paper, we extend the HBPM concept by introducing a HBPM maturity assessment tool (HBPM MAT) and demonstrate its practical application. Section 2 introduces the fundamentals of HBPM maturity assessment tool design and application. Section 3 presents the findings of two case study applications of the HBPM MAT in Argentina and Chile. Section 4 concludes with final remarks.

2 Introducing the HBPM maturity assessment tool (HBPM MAT)

2.1 Purpose of the HBPM maturity assessment tool (HBPM MAT)

The HBPM maturity assessment tool (MAT) pursues three core objectives, consistent with the traditional aims of maturity frameworks:

- Provide a structured framework for assessing capacity to monitor a HBP.
- Make HBPM tangible, moving beyond abstract principles and concepts.
- Support countries in identifying gaps and priorities for strengthening their HBP monitoring systems.

2.2 Approach to the HBPM MAT

The HBPM MAT is structured as a set of 13 maturity statements, grouped under 4 domains: HBP prerequisites; HBPM indicators; HBPM institutions; and HBP-related Health Information Systems (HIS)—see Table 2. Each maturity statement is broken down into key attributes, defined through concrete and observable characteristics which are assessed using a **No/(Partially)/Yes** *checklist*. The pattern of answers from the checklist is then used to classify HBPM systems into one of three maturity levels:

1. **Emerging** → most characteristics scored "No".
2. **Established** → a mix of "Yes" and "No", or mostly "Partially".
3. **Advanced** → most characteristics scored "Yes".

TABLE 2. Structure of the HBPM MAT

Maturity Domain	Maturity Statement
Prerequisites	1. Health benefits are defined clearly, in sufficient detail to be operational, verifiable, and enforceable.
	2. A formally endorsed HBPM framework is in place, with clear and measurable monitoring goals that are aligned with HBP objectives and updating cycle.
Indicators	3. HBPM indicators reflect the HBP goals or intended outcomes of the health benefits package as well as the direct enablers that are operational factors driving achievement of these goals.
	4. HBPM indicators are linked to the HBP updating cycle.
	5. Clinical guidance documents are explicitly linked to the definition and periodic update of HBPM indicators to ensure evidence-based monitoring.
	6. HBPM indicators' definitions are formulated in a SMART way, standardized and harmonized with the national health information system.
Institutions	7. Roles and responsibilities for key HBPM functions are covered by legislation and procedures, are clear, complete, consistent, enforceable and sustainable.
	8. HBPM results inform HBP updates.
	9. Managerial, technical, and financial resources are backing HBPM.
	10. HBPM results are communicated to multiple audiences and government levels.
Health information systems	11. HBPM aligned with national HIS norms, using standardized codes and classifications to ensure data comparability, efficiency, and sustainability.
	12. HIS supports a strong data use culture by sharing raw and analysed HBPM data accessible across all levels, and by providing dashboards and feedback loops to drive regular reviews and HBP-related decisions within the HBP updating cycle.
	13. The HIS is primarily funded by domestic financing to ensure sustainability and national ownership, with strong privacy and ethical safeguards that protect data, reinforce trust, and uphold accountability.

Source: The authors.

For example, *Statement 9. Managerial, technical, and financial resources are backing HBPM* aims to capture the extent to which HBPM is supported by adequate and sustainable financial, managerial and technical resources, distributed equitably across national and subnational levels. The maturity level for this statement—Emerging, Established or Advanced—is assessed cumulatively across these considerations (Table 3).

TABLE 3. Example of maturity levels for Statement 9 in the HBPM MAT

Emerging	Established	Advanced
Most of the following apply: Resources are insufficient, unpredictable, and largely dependent on external support. No structured training or technical capacity for HBPM. Resource allocation is ad hoc and unstable.	Most of the following apply: Resources are partially adequate but unstable or concentrated in one level of the system. Ad hoc capacity-building activities exist but are not sustained. Funding is allocated but vulnerable to reallocation or discontinuity.	Most of the following apply: Resources are stable, sufficient, and equitably distributed across all levels. Sustained efforts exist to build and retain technical and managerial capacity. Funding is institutionalized within government budgets, ensuring long-term sustainability.

The detailed meanings, characteristics and levels for maturity statements are in Annex 1.

This approach provides a structured and transparent way of moving from broad maturity statements to measurable assessments. It ensures that judgments are based—to the extent possible—on observable evidence rather than subjective impressions, allows for comparability across countries and over time, and clarifies what progress is needed to move from one maturity level to the next.

2.3 Expected value and challenges in using the HBPM MAT

HBPM MAT can serve multiple purposes:

- **Policy dialogue tool:** Provides a neutral and structured platform for discussion among ministries, subnational actors, and partners. Framing issues in terms of maturity levels can help identify gaps without finger-pointing.
- **Policy design tool:** The Emerging, Established, Advanced levels provide a roadmap for reform, highlighting missing elements and guiding improvement efforts.
- **Policy assessment tool:** When applied periodically, it allows tracking progress, identifying stagnation, and linking improvements to institutional reforms or investments.

Key challenges expected when applying HBPM MAT across multiple countries include:

- Context diversity: A global tool must be flexible enough to fit low, middle, and high-income settings, but detailed enough to be meaningful.
- Risk of self-assessment bias: Countries may overestimate their maturity unless the process is facilitated, evidence-based, and triangulated.
- Interpretation of terms: Concepts like “detailed”, “institutionalization” or “integration” may mean different things across systems, so clear definitions and real-world examples are essential for consistency.

Despite these challenges, we believe HBPM MAT can bring important value:

- Provoking reflection: Even if applied imperfectly, it helps countries ask the right questions: Are health benefits defined in enough detail? Are HBPM roles clear? Are HBPM results used?
- Safe entry point: By framing weaknesses as "Emerging" rather than "failures" the tool allows sensitive issues to be discussed in a constructive way. In this way, the tool presents "Emerging" as a starting point. This reduces the incentive to inflate ratings out of fear of looking weak.
- Strengthening conceptualization: The tool helps identify underdeveloped aspects of HBP management and helps outline a strategic and operational path for improvement, while also highlighting its additional contributions in stimulating strategic thinking on how HBPM can drive improvements in the broader health system monitoring architecture and in the strategic management of health data.
- Encouraging institutionalization: By emphasizing legal anchoring, sustainable financing, and feedback loops as key elements of maturity, the tool supports lasting institutional reforms often overlooked in technical monitoring.

If well applied, the HBPM MAT can act both as a "mirror" and a "compass", reflecting current capacity while guiding reform. Despite its limitations, it can stimulate dialogue, orient policy design and planning, and deepen understanding of what it takes to monitor HBPs effectively.

2.4 How to apply the HBPM MAT

HBPM MAT is designed as an evidence-informed self-assessment tool. In principle, applying the HBPM MAT should be seen much more as a learning exercise rather than an audit. Its main value lies in facilitating structured reflection on how countries organize, use, and institutionalize their HBPM functions.

For HBPM MAT to achieve its intended aims (see **section 2.1**), its ideal application starts with the commitment of the organization(s) responsible for financing, delivering and monitoring the HBP. This institutional ownership ensures learning, legitimacy and policy action, but it also raises the risk of superficial or overly optimistic self-assessment.

To limit this risk and promote credible results, the following approaches are recommended:

- **Evidence-based scoring:** Each maturity level selected should be backed (when available) by laws, decrees, HIS reports, budgets, organizational charts, Where such documents are missing, alternative validation (stakeholder interviews or meeting minutes) can be used.
- **Facilitated workshops:** Apply the MAT in multi-stakeholder workshops (Ministry of Health, Ministry of Finance, subnational authorities, technical agencies) with a neutral facilitator. This reduces bias and promotes shared interpretation of maturity levels.

- **Triangulation:** Cross-check results with other existing assessments where available (for example HIS maturity, UHC indicators). Triangulation strengthens consistency and helps avoid over-rating.
- **Structured guidance and examples:** Provide real-world examples for statements where available, to base judgments in observable reality rather than vague impressions.
- **External validation:** Apply peer review or regional exchange mechanisms to confirm results and promote learning.

In essence, the HBPM MAT should be applied as a collaborative, evidence-based reflection, aimed at learning and improvement rather than simply scoring and/or ranking.

The team conducting the maturity assessment should follow these steps:

1. **Familiarize themselves** with the HBPM conceptual framework and the HBPM MAT by reading this paper and the conceptual framework paper. There may be value in discussing potential unclarities with the tool developers.

2. **Agree on the assessment scope** in terms of:
   - Selecting the HBP whose monitoring maturity can be assessed.
   - Identifying potential restrictions within the chosen HBP. For example, rehabilitation interventions and high-cost drugs may be delivered via vertical programs which are related to but distinct from the "main" HBP, therefore may be left out of the HBPM maturity assessment.
   - Identifying resource constraints for the maturity assessment in terms of staff time, skills, budget, permissions etc.
   - Identifying key evidence sources relevant for HBPM that may offer the best value for the maturity assessment, considering all the above. For example, key informant interviews with senior decision-makers may be expected to provide more valuable information than examining comprehensive legislation; or vice versa, depending on the context and the assessors' experience.

3. **Compile and review evidence.** Organize the information systematically to support scoring for each maturity statement.
4. **Complete the assessment template** (Annex 2) based on the available evidence.
5. **Summarize findings and lessons learned**.

3 Case study applications of the HBPM MAT

This section outlines the findings and learnings of two case studies where the HBPM MAT has been applied, with respect to the Sumar Program in Argentina and the Explicit Health Guarantees in Chile. The case studies had two aims: to characterize how HBPM functions in practice within the pilot countries using both the HBPM conceptual framework and the HBPM MAT; and to refine and improve the HBPM conceptual framework and the HBPM MAT based on pilot countries' realities.

3.1 Sumar Program (Programa Sumar) in Argentina

Context. The Sumar Program began in 2004 as Plan NACER in nine provinces of northern Argentina, creating Provincial Health Insurances to provide explicit coverage to uninsured pregnant women, mothers and children under 6 years of age. In 2012, the Sumar Program was launched to include young and adult population and increase the number of covered health interventions.

In the context of Argentina's federal health system, the Sumar Program transfers additional resources to provinces through a Results-Based Financing (RBF) model to expand the effective coverage of services under an explicit Health Benefit Package.

Under the Program, funds are transferred to provinces and municipalities via capitation payments based on: 1) the enrolment of eligible population who effectively received a preventive service in the last 12 months; and, 2) provincial performance on health output indicators (such as prenatal care, vaccine coverage, healthy child and adolescent visits, adequate care for patients with diabetes and hypertension and cancer prevention). The Program initially focused on key services for pregnant women and children, and has gradually expanded coverage by adding new primary and secondary preventive services. As of 2025, the Program covers more than 700 health services organized in 50 care pathways within its benefit package.

Provinces must use these additional resources for purchasing health services included in the Program's benefit package, provided by public health facilities in the province. Health facilities have autonomy to use the resources received for the improvement of health care, being able to allocate them to hiring personnel, payment of incentives, infrastructure, and medical and non-medical equipment.

The pilot was conducted by two experts with deep familiarity of the Sumar Program design and operations, and is based on official Program documents and publicly available resources such as legislation and official government websites.

Maturity assessment. The application of the HBPM MAT to the Sumar Program provides a structured picture of current monitoring maturity across domains. The main findings of applying the HBPM MAT to the Sumar Program are summarized in Table 4 below, with detailed assessments for each maturity statement in Annex 3. Overall, the assessment found that maturity in the Indicators domain was at an Advanced level, while the Institutional arrangements and supporting Information Systems were predominantly at an Established level-pointing to potential opportunities for further procedural strengthening and consolidation.

TABLE 4. Summary of maturity assessment for the Sumar Program, Argentina

Maturity Statement	Maturity Score
1. The HBP is defined clearly and explicitly.	Established: The HBP is broadly explicit and operational for program management, but gaps remain in national-level specification of exclusions, medicines, referral rules, access guarantees, and citizen-facing transparency and complaints and appeals procedures.
2. A formally endorsed HBPM framework with clear goals is in place, with monitoring goals aligned to the HBP.	Established: A formally approved HBPM framework exists and is used in practice, but public availability is limited and feedback into package updating is not fully institutionalized.
3. HBPM indicators are aligned with the HBP.	Advanced: the monitoring indicators in the HBPM framework are well aligned with the goals and direct enablers of the HBP.
4. HBPM indicators are linked to the HBP updating cycle.	Advanced: the monitoring indicators provide the necessary and sufficient evidence to inform the HBP decision-making cycle.
5. Clinical guidance documents are explicitly linked to HBP monitoring.	Established: Clinical guidelines are formally in place and are strongly integrated into HBP service definitions and monitoring standards; however, processes for their regular update and systematic incorporation into HBPM revisions remain insufficiently standardized and institutionalized.
6. HBPM indicator definitions are SMART, standardized and harmonized with the health information system (HIS).	Advanced: the monitoring indicators meet all three characteristics under this statement.
7. Roles and responsibilities are defined clearly and assigned across all HBPM functions.	Established: the Program's Operational Manual covers roles and responsibilities in detail, though some intergovernmental interfaces could be further clarified.
8. HBPM results are used in the HBP updating cycle.	Established: HBPM results are referenced in documents substantiating program decisions, but there is no clearly defined procedure for this purpose.
9. HBPM is supported with adequate resources.	Established: Dedicated resources remain in place, but as provincial authorities now finance a larger share of implementation functions, tracking allocations consistently across jurisdictions is more difficult.
10. HBPM results are communicated to all key stakeholders.	Established: HBPM dissemination mechanisms are defined and functional, however they focus on national and provincial authorities but engagement with health providers, civil society and the public is more limited.
11. HBPM uses standardized norms and codes aligned with national HIS.	Advanced: the technical standards for collecting and reporting digital data for HBPM are clear, detailed and aligned with broader national HIS requirements.
12. HIS fosters data use by sharing HBPM data, with dashboards and feedback loops driving reviews and HBP-related decisions.	Established: Functional systems for data sharing, dashboards, and feedback mechanisms support HBPM implementation, though greater institutionalization of interoperable access and systematic use of evidence in HBP review processes remains an area for further strengthening.
13. HIS is supported by domestic financing and underpinned by strong privacy and ethical safeguards.	Emerging: domestic financing for HIS operations is established, but long-term sustainability planning is partial, and data privacy and ethical safeguards remain underdeveloped.

Learnings for policy. The Sumar Program has a history of nearly two decades, having started small and then having expanded in scope and scale purposefully, gradually and over several governments in light of its achievements. From an HBPM perspective, the assessment highlights several key strengths in Sumar's monitoring architecture: a relatively clear and explicit definition of the HBP, strong indicator maturity, and a monitoring framework that goes beyond service outputs to also track key HBP enablers.

Its approach and design have long combined aspects of health financing, capacity development, monitoring and service delivery, resulting in a coherent public health policy instrument. From this perspective, it is unsurprising that its maturity in terms of HBP monitoring capabilities is rather high across most domains of the HBPM MAT, thereby matching its "chronological maturity". The MAT also suggests that many strong monitoring practices are functional, but not yet fully institutionalized through standardized procedures, public-facing mechanisms, or routine governance processes.

Based on the maturity profile in Table 3, the most salient second-generation priorities for strengthening HBPM further relate less to indicator availability, and more to how monitoring evidence is translated into action and accountability. In particular, the assessment highlights: (i) the need to formalize procedural feedback loops through which HBPM results more systematically inform benefit package adjustments and operational decision-making over time; and (ii) the opportunity to enhance citizen-facing transparency and communication mechanisms, so that key information on entitlements, monitoring findings, and program rules becomes more consistently accessible beyond national and provincial authorities.

These priorities are especially relevant in a federal context, where coordinated monitoring can also serve as a platform for sustained capacity-building and convergence across provinces. However, the constant evolution of the program—particularly the gradual handover of responsibilities from the federal to the provincial level—has been key to its sustainability, while also having opened the door for potentially uneven capabilities and implementation, reflected in the Institutional domain of the HBPM MAT.

Overall, this case illustrates the value of the HBPM MAT not only as an assessment instrument, but also as a structured diagnostic and dialogue tool to support continuous improvement of explicit benefits packages in decentralized health systems. By clarifying second-generation priorities, the tool can help countries move from having monitoring systems in place to ensuring they actively drive system learning and performance improvement. Importantly, these improvements in HBPM are also closely linked to broader gains in how the health system functions, allocates resources, and delivers higher-quality care over time.

The Sumar Program is particularly complex as it spans across all levels of health system governance—federal, provincial, municipal and health facilities. The MAT can serve as a practical

platform for intergovernmental dialogue, helping identify where harmonization across jurisdictions may be needed (e.g., in the interpretation and use of monitoring indicators), while preserving space for contextual adaptation and capacity-building in provinces with more limited institutional maturity. In this sense, the tool can help structure performance dialogue across jurisdictions while supporting convergence over time.

3.2 Explicit Health Guarantees (GES) in Chile

Context. Chile's health system is mixed, with 80 percent of the population relying on a single public insurer (FONASA) and a network of public and private providers, and 15 percent relying on seven private insurers (open Isapres) and a network of private providers. The remaining 5 percent of the population relies on closed health systems belonging to security and armed forces, and only 0.2 percent rely on closed health systems belonging to three large companies (closed Isapres).

The pilot covered the GES (Explicit Health Guarantees—in Spanish *Garantias Explicitas en Salud*) package, which defines explicit guarantees in terms of access, financial protection, timeliness and quality, for beneficiaries of FONASA and Isapres that suffer any of the (currently) 87 health problems covered by the plan. Insurers (FONASA and Isapres) are responsible for financing the package and ensuring compliance with the four guarantees.

Compliance with the guarantees is enforced by the Health Superintendence, mostly using three auditing mechanisms: complaints-based auditing (access), HIS-based auditing (financial protection and timeliness) and provider accreditation and auditing (quality). Monitoring of population-level indicators is only used for two specific purposes: measuring coverage targets for preventive interventions (for which access cannot be promoted via complaints) and keeping track of waiting lists in the public sector (where HIS-based auditing has proven partially ineffective).

The pilot was conducted by two experts with deep familiarity of the GES, and is based on official documents, publicly available resources such as legislation and official government websites. Key informant interviews were conducted with the Health Superintendence, a major public hospital, the association of Isapres (private health insurers), one large private health insurance organization and one large private health service provider.

Maturity assessment. Table 5 summarizes the findings of applying the HBPM MAT to the GES as part of the pilot—detailed assessments for each maturity statement are in Annex 4. Overall, the assessment found that domains were at an Established level, with some areas at Advanced levels.

TABLE 5. Summary of maturity assessment for the GES, Chile

Maturity Statement	Maturity Score
1. The HBP is defined clearly and explicitly.	Advanced: HBP definitions are clear, detailed, verifiable and mostly enforceable (except for the timeliness guarantee in the public sector, which has waiting lists for the GES).
2. A formally endorsed HBPM framework with clear goals is in place, with monitoring goals aligned to the HBP.	Advanced: while there is not a GES monitoring framework, (implicitly) the goals are clear and measurable (to comply with the four guarantees), and the Health Superintendence's various auditing and monitoring activities are endorsed.
3. HBPM indicators are aligned with the HBP.	Advanced: the Health Superintendence audits compliance with the four GES guarantees. It does not look at direct enablers (except for the quality guarantee, which the Health Superintendence itself accredits), because these are responsibility of insurers.
4. HBPM indicators are linked to the HBP updating cycle.	Established: any change/addition made to the GES is effectively incorporated into auditing and monitoring, and actual utilization is used for future projections and budget analysis. However, the extent to which decisions about the GES are based on monitoring indicators is still limited.
5. Clinical guidance documents are explicitly linked to HBP monitoring.	Established: clinical guidelines inform GES contents and guarantees. While monitoring is not directly linked to guidelines, monitoring is directly linked to guarantees.
6. HBPM indicator definitions are SMART, standardized and harmonized with the health information system (HIS).	Advanced: GES guarantees are explicit and clear so that compliance with them is unambiguous. Preventive intervention monitoring indicators are also clearly defined.
7. Roles and responsibilities are defined clearly and assigned across all HBPM functions.	Established: Roles and responsibilities are defined clearly, but challenges remain to enforce compliance in the public sector.
8. HBPM results are used in the HBP updating cycle.	Established: the extent to which decisions about the GES are based on monitoring indicators is still limited.
9. HBPM is supported with adequate resources.	Advanced: funding of the Health Superintendence is institutionalized.
10. HBPM results are communicated to all key stakeholders.	Established: GES monitoring data is publicly accessible, but challenges remain to ensure sustained full transparency in the public sector.
11. HBPM uses standardized norms and codes aligned with national HIS.	Advanced: GES uses its own coding and classification system, which is not readily convertible to ICD10 or other international standards. However, all actors use the same coding, making the system internally consistent.
12. HIS fosters data use by sharing HBPM data, with dashboards and feedback loops driving reviews and HBP-related decisions.	Established: in the public sector, we did not find a consistent culture of using monitoring to drive reviews and decisions. Different provinces have different views, and transparency levels vary in time. In the private sector there is full transparency and case by case audits practically ensure full compliance with the guarantees. In spite of this, the extent to which decisions about the GES are based on monitoring indicators is still limited (see maturity statement 8).
13. HIS is supported by domestic financing and underpinned by strong privacy and ethical safeguards.	Advanced: financing is sustainable and privacy and ethical safeguards work.

Learnings for policy. The GES scored well in many features. Having explicit, measurable and monitored health guarantees has clearly been supportive of HBPM, particularly in the Prerequisites and Indicators domain of the HBPM MAT. The Health Superintendence has been effective in monitoring the GES despite lacking an umbrella monitoring framework. Rather, the Health Superintendence has relied on a clear mandate and appropriate resources. It is even possible that a monitoring framework, had it been poorly designed, could have restricted the Superintendence's faculty to respond to unpredicted behavior from insurers, providers and patients, and could have reduced the incentives for innovative solutions.

On the other hand, the HBPM MAT has showed that extent to which monitoring the health guarantees is used in decision-making can improve further. A stronger monitoring framework for the GES should not make the Superintendence's work more rigid but should address the bigger picture: how to make the GES decision-making process more transparent, forcing a reconciliation between new guarantees and the existing gaps in what is currently promised. The differences in monitoring the same HBP between public and private providers also stand out, and may merit the decision-makers' consideration to the extent that they are purposeful and warranted.

4 Conclusion

We have designed the HBPM MAT with the aim to characterize capacity for monitoring HBP implementation as a platform for structured, coherent and relevant policy dialogue and action. The applications in Argentina and Chile have shown that the tool serves its purpose and has the potential to offer valuable and actionable insights for both program-focused and nationwide HBPs.

The tool is in its early stages. Its key intended strengths relate to the comprehensiveness and soundness of conceptualizing HBPM, the data-driven documentary approach to conducting the assessment and the concreteness of the maturity characteristics and levels. What remains unclear at this point is the extent to which the tool can handle complexity and diversity in HBP design and delivery, both in terms of collecting data and in summarizing and interpreting findings. To this end, further applications can bring additional information.

We encourage governments, global and national technical partners and the health priority-setting community to engage critically with the tool, support and document further applications, and integrate its use in the relevant monitoring and evaluation frameworks.

Annex 1. Detailed content of the HBPM MAT

Maturity statement 1: The HBP is defined clearly and explicitly

Maturity Statement: Health benefits are defined *clearly*, in sufficient *detail* to be operational, *verifiable*, and *enforceable*.

Short-hand Statement: HBP is defined clearly and explicitly.

Linked foundational principle: P1&P2

Specific terminology in the maturity statement

Clarity = The HBP is described so that patients, providers, and managers understand what is promised. This involves clarity on:

- **What health benefits are (not) covered** (plain-language description): explicit inclusions/exclusions, organized by major service categories, representative examples, and simple benefit limits (e.g., visit caps, frequency, or maximum quantities) stated in non-technical terms.
- **Who is eligible and under what conditions:** target population groups (age bands, risk groups, disease stages) and eligibility/clinical indications are established.
- **Which providers deliver the services: authorized providers** and the **levels of care** (primary, secondary, tertiary) are listed.
- **With what financial protection:** rules for co-payments, exemptions, out-of-pocket caps, and guarantees of financial protection are specified.
- **Access pathway:** the first point of contact (e.g., family physician, primary care) and simple referral expectations (without technical standards) are defined.

Detail = The HBP is specified in sufficient operational detail. This involves that the HBP specifies:

- **Procedures, medicines, devices, and activities** → ensures the HBP describes in detail all necessary inputs given its scope.
- **Target population groups** → technical descriptions of eligibility groups (age bands, risk factors, disease stages).
- **Facilities and service levels** → which facilities (e.g., primary care centers, district hospitals, tertiary hospitals) must deliver specific services.
- **Clinical guidelines** and care pathways → services included in the HBP align with recommendations in evidence-based clinical practice guidelines.

- **Access guarantees** → maximum waiting times, referral pathways, geographic/service availability standards.
- **Eligibility and referral rules** → detailed criteria for who qualifies, when referrals are needed, and under what conditions services are provided.

Verifiable = The HBP uses standardized terminology and coding systems so that coverage can be measured and compliance checked. This involves the existence of:

- **Standardized terminology** → benefit entitlements are described using uniform language.
- **Coding systems** → application of standardized codes (ICD, ATC, SNOMED, ICHI, etc.) to services, medicines, and procedures.
- **Service coverage catalogs and manuals** → official reference documents that systematically classify entitlements in ways that can be tracked.

Enforceable = The HBP has legal and institutional backing so that entitlements can be claimed, and non-compliance can be sanctioned. This involves clarity on:

- **Eligibility and referral rules** → expressed as binding rights and obligations, not just technical guidance.
- **Policy and budget frameworks** → laws, decrees, or financing instruments that formally authorize and sustain the HBP.
- **Public accessibility** → citizens have access to HBP documents in clear, understandable language (not just technical codes or catalogues).
- **Accountability mechanisms** → complaints procedures, appeals processes, and sanctions that ensure providers and purchasers respect entitlements.

Scope of the maturity statement

- The statement applies to the entire HBP, not to isolated disease programs or vertical initiatives.
- It assesses the clarity, detail, verifiability, and enforceability of the HBP description, but not whether the content of the package is optimal or sufficient (that is assessed elsewhere).
- It focuses on the existence and quality of detailed descriptions, not on their implementation in practice.

Examples of evidence sources to inform assessment

- Legislation, decrees, or official benefit package documents.
- Service coverage catalogs, standardized coding manuals (ICD, ATC, SNOMED, ICHI,[1] etc.).
- Purchaser or insurer provider contracts → sometimes publicly available, outlining covered services, provider obligations, and payment rules.
- Clinical guidelines explicitly linked to the HBP entitlements.
- Policy or budget documents specifying eligibility, providers, or co-payment rules.
- Publicly accessible HBP descriptions provided to citizens.

Assessment and scoring

The assessor will use the checklist below to document the extent (**No/Partially/Yes**) to which the characteristics of each attribute for this maturity statement—**Clarity, Detail, Verifiable,** and **Enforceable**—apply to the HBP, together with the supporting evidence.

When assigning a score **No/Partially/Yes**, the assessor should consider: 1) the **systematic** presence of the characteristic across the HBP; and 2) the availability of verifiable evidence to support it. When uncertain, the lower category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**. For example:

- If technical eligibility criteria are listed for some types of health interventions (e.g., medicines and medical devices) but not for others (e.g., rehabilitation procedures), all other things being equal "Partially" best reflects this characteristic.
- If clinical guidelines and protocols exist, but are not explicitly linked to the HBP entitlements, "No" best reflects this characteristic.

The column "Evidence Support" should summarize the actual evidence examined for each maturity statement. Use the "Example Evidence Sources" provided in the MAT as a guide to identify and cite the most relevant documents, data, or records that justify the maturity level.

1 ICD (International Classification of Diseases): WHO standard for classifying diseases and health conditions for clinical, epidemiological, and statistical purposes. ATC (Anatomical Therapeutic Chemical Classification System): WHO system for classifying medicines by the organ/system they act on and their therapeutic and chemical properties. SNOMED CT (Systematized Nomenclature of Medicine—Clinical Terms): Comprehensive, multilingual clinical terminology standard used in EHRs to code diagnoses, procedures, and clinical findings. ICHI (International Classification of Health Interventions): WHO classification providing a standard framework for coding health interventions (clinical, public health, and preventive).

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Clarity	Plain-language description of what is covered (inclusions, exclusions, service categories, benefit limits) stated in non-technical terms				
	Target population groups and related eligibility or clinical indications				
	Which providers deliver the services: authorized providers and the levels of care (primary, secondary, tertiary) are listed.				
	Financial protection: rules for co-payments, exemptions, out-of pocket caps and guarantees of financial protection are specified				
	Access pathway: the first point of contact (e.g., primary care) and simple referral expectations are defined.				
Detail (Operational)	Procedures, medicines, devices, and activities (included and/or excluded) are specified				
	Target population groups: Technical eligibility criteria (age band, risk factors, disease stages) are provided.				
	Facilities and/or service delivery levels: which facilities (e.g., primary care centers, district hospitals, etc.) must deliver specific services are indicated.				
	Clinical guidelines and care pathways are used to define services included in the HBP.				
	Access guarantees (waiting times, referral pathways, geographic standards) are defined.				
	Eligibility and Referral rules: detailed criteria for who qualifies, when referrals are needed, and under what conditions services are provided				
Verifiable	Standardized terminology: benefits entitlements are described using uniform language aligned with clinical guidelines.				
	Coding systems: standardized codes (ICD, ATC, SNOMED, ICHI, etc.). are applied to services, medicines and procedures.				
	Service coverage catalogs/manuals: official reference documents systematically classify entitlements in ways that can be tracked.				
Enforceable	Eligibility and referral rules: expressed as binding rights/obligations, not only technical guidance				
	Policy and budget frameworks: laws, decrees, or financing instruments formally authorize and sustain entitlements.				
	Public accessibility: citizens have access to HBP documents in clear, understandable language (not just technical codes or catalogues).				
	Accountability mechanisms: complaints procedures, appeals processes, and sanctions ensure providers and purchasers respect entitlements.				

Completing the checklist above allows the assessor to classify the system **emerging, established or advanced**, depending on whether most characteristics score **No, Partially** or **Yes,** respectively.

Emerging	Established	Advanced
Most of the following apply: **Clarity**: Only fragments of what is covered are described; benefits are vague or inconsistent, leaving patients and providers uncertain about entitlements. **Detail:** Minimal operational guidance is available; at most one or two elements (e.g., a list of medicines or conditions) are specified, while referral rules, facilities, and access guarantees are absent. **Verifiable:** No consistent use of standardized terminology, coding, or catalogs; monitoring is not possible. **Enforceable:** Eligibility and coverage rules are missing or not binding; patients cannot reliably claim entitlements.	Most of the following apply: **Clarity:** Benefits are partially described in official documents; patients and providers have some understanding of what is covered, though important gaps remain. **Detail:** Several elements (e.g., medicines, eligibility criteria, authorized providers) are included, but other aspects (such as access guarantees or referral rules) are incomplete or missing. **Verifiable:** Some standardized terminology or coding is applied, but coverage is inconsistent and monitoring remains limited. **Enforceable:** Some entitlements exist on paper, but accountability and redress mechanisms are weak or not fully operational.	Most of the following apply: **Clarity:** Benefits are comprehensively described in plain language; patients, providers, and purchasers all clearly understand entitlements and conditions. **Detail:** Most elements are included—services, medicines, providers, facilities, eligibility/ referral rules, and access guarantees—making the package fully operational. **Verifiable:** Standardized terminology, coding systems, and catalogues are systematically applied, enabling reliable monitoring and reporting. **Enforceable:** Rights and obligations are legally established, backed by policy and budget frameworks; HBP documents are public, and complaints/appeals processes ensure accountability.

Maturity statement 2: A formally endorsed HBPM framework with clear goals is in place, with monitoring goals aligned to the HBP

Maturity statement: A *formally endorsed* HBPM *framework* is in place, with *clear and measurable monitoring goals* that are *aligned* with HBP objectives and updating cycle.

Short-hand maturity statement: A formally endorsed HBPM framework is in place, with monitoring goals aligned to the HBP.

Linked foundational principle: P8.

Specific terminology in the maturity statement

HBPM framework = a formal document (law, decree, policy, strategy, or official guideline) that defines the purpose, scope, and institutional responsibilities of HBPM. A "framework in place" means more than a draft or informal concept: it is an official and operational reference point for HBPM activities.

Formally endorsed = the framework has been officially approved (e.g., through law, decree, ministerial order, or board resolution), embedded in institutional processes (e.g., referenced in plans, budgets, or reports), is systematically used to inform HBP updating, and is publicly available.

Clear and specific monitoring goals = the HBPM has clearly stated aims and goals, which go beyond broad aspirations (e.g., *"strengthen public coverage"*).

Measurable monitoring goals = Measurable goals are formulated in a way that allows them to be operationalized with indicators (without duplicating indicator design in Principles 5–6).

Monitoring goals are aligned with HBP goals and updating cycle = HBPM goals reflect and reinforce the HBP's stated objectives, such as equity of access, efficiency, and financial protection and are reviewed and updated in coordination with the HBP revision process.

Scope of the maturity statement

- **Covers the existence of an HBPM framework:** whether a structured approach is in place and formally documented.
- **Covers key characteristics of the HBPM framework:** whether monitoring goals are clear, specific, and stated in ways that can later be operationalized with indicators; whether the HBPM framework's goals reinforce the stated objectives of the HBP (e.g., access, quality, efficiency, financial protection); whether the framework has been formally adopted or approved by relevant national authorities.
- **Covers the formal approval or institutional adoption** of the framework.
- **Does not cover** the appropriateness or technical design of HBPM indicators (addressed under Principles 5–6) nor the effectiveness of HBPM activities in practice (data collection, reporting, and use are addressed elsewhere).

Examples of evidence sources to inform assessment

- Written HBPM frameworks or equivalent policy document.
- National health strategies, sectoral policies, or official HBPM framework documents.
- Laws, decrees, or ministerial orders that establish the HBP and the HBPM framework, goals, linkage with HBP goals.
- Policy or strategy documents that state HBP monitoring goals.
- Results frameworks, logical frameworks, or monitoring and evaluation (M&E) plans that translate goals into trackable areas.
- Cross-references to HBPM goals in HBP revision or update documents.
- Official records of approval (e.g., cabinet decisions, ministerial decrees, governing board resolutions).
- Institutional plans, budgets, performance reports documents citing the HBPM framework.
- Publicly accessible versions of the framework (e.g., official websites, government portals).

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement—**the existence of a HBPM framework, its formal endorsement,** and **key characteristics of HBPM goals**—apply, together with the supporting evidence for each characteristic.

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize: 1) the systematic presence of each attribute across the system; and 2) the availability of verifiable evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Existence of HBPM framework	An HBPM framework document exists.				
	The HBPM framework is publicly available.				
Endorsement of HBPM framework	The HBPM framework has been formally approved through legal, policy, or institutional processes (law, decree, ministerial order, board resolution).				
HBPM goals	The HBPM framework has clearly stated monitoring goals.				
	HBPM goals are specific and measurable (not vague aspirations).				
	HBPM goals are aligned with HBP objectives and updating cycle.				

Completing the checklist allows classification of maturity as **Emerging, Established** or **Advanced** depending on whether most characteristics score **No, Partially** or **Yes**, respectively.

Scoring should reflect both the systematic presence of the framework and the strength of its institutional anchoring and goal clarity.

Emerging	Established	Advanced
Most of the following apply: **Framework**: No HBPM framework exists, or what exists is vague, incomplete, informal or not publicly available. **Clear and measurable monitoring goals**: goals expressed only as broad aspirations, lacking clarity or measurability. **Endorsement**. The framework lacks formal approval—it has no legal or institutional authority, is not referenced or used in practice, and is not accessible to the public.	Most of the following apply: **Framework:** An HBPM framework exists and is documented, but its scope or structure is incomplete. **Clear and measurable monitoring goals:** Goals are defined, but not consistently clear or measurable; partial alignment with HBP objectives. **Endorsement:** The framework may have formal approval, but is not systematically used to guide monitoring practice or package updates.	Most of the following apply: **Framework:** An official HBPM framework exists is publicly available and fully operational. **Clear and measurable monitoring goals:** Goals are clearly stated, measurable, and aligned with HBP objectives. **Endorsement:** The framework is legally or institutionally binding, embedded in routine processes, actively used in practice, and publicly accessible.

Maturity statement 3: HBPM indicators are aligned with the HBP

Maturity statement: HBPM indicators reflect the HBP *goals* or intended outcomes of the health benefits package as well as the *direct enablers* that are operational factors driving achievement of these goals.

Short-hand statement: HBPM indicators are aligned with the HBP.

Linked foundational principle: P4

Specific terminology in the maturity statement

Content of the HBP = which health interventions are covered, under what conditions, at what levels of financial protection, delivered by whom and where (see **Clarity** and **Detail** as defined in the 1st maturity statement above).

Goals of the HBP = the explicitly stated policy goals of the HBP, for example improving and protecting population health, reducing poverty, ensuring access to care of sufficient quality.

Direct enablers of the HBP = policy tools and processes that directly support the implementation, delivery, and monitoring of services included in the HBP, such as sufficient budget allocation, user enrolment plan, costs and purchasing mechanisms and health information systems directly related to the HBP.

Scope of the maturity statement

- This statement does not comment on the extent to which the HBP content, goals or enablers have been identified or articulated appropriately, but on the extent to which HBPM indicators refer to them.

Examples of evidence sources to inform assessment

- Publicly accessible HBP or HBPM descriptions (e.g., official websites, publications).
- Legislation, decrees, or official HBP documents.
- Laws, decrees, or ministerial orders that establish the HBP and the HBPM framework, goals, linkage with HBP goals.
- Policy or strategy documents that state HBP monitoring goals.
- Results frameworks, logical frameworks, or monitoring and evaluation (M&E) plans that translate goals into trackable areas.
- Cross-references in HBP revision documents that cite monitoring goals.
- Institutional documents that reference the HBPM framework (plans, budgets, performance reports).

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement—**content, goals** and **direct enablers of the HBP**—are present in the HBPM framework, together with the supporting evidence for each characteristic.

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which the characteristic is present/applies **systematically**; and 2) the extent to which it can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
HBP goals	HBPM indicators reflect HBP goals.				
HBP direct enablers	HBPM indicators reflect HBP direct enablers.				

Completing the checklist above results in assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: **HBP goals:** HBPM indicators do not reflect HBP goals, or only a minority of them. **HBP direct enablers:** HBPM indicators do not reflect HBP direct enablers, or only a minority of them.	Most of the following apply: **HBP goals:** HBPM indicators reflect to an extent some HBP goals, but gaps remain. **HBP direct enablers:** HBPM indicators reflect to an extent some HBP direct enablers, but gaps remain.	Most of the following apply: **HBP goals:** HBPM indicators reflect most or all HBP goals. **HBP direct enablers:** HBPM indicators reflect most or all HBP direct enablers.

Maturity statement 4: HBPM indicators are linked to the HBP updating cycle

Maturity Statement: HBPM indicators are *linked* to the *HBP updating cycle*.

Short-hand Statement: HBPM indicators reflect and inform the HBP updating cycle.

Linked foundational principle: P3

Specific terminology in the maturity statement:

HBP updating cycle = the structured process of updating the HBP. The process is specific to each context; for illustration, a full cycle is expected to cover the following:

- Assess whether the HBP is on track
- Conduct topic prioritization
- Evaluate and appraise proposed services (HTA)
- Review reimbursement rates and payment mechanisms
- Assess fiscal impact and budget envelope
- Deliberate and hold stakeholder consultations
- Develop the HBP implementation plan
- Establish and use the HBP monitoring system

Linked = HBPM indicators provide evidence that directly informs one or more of the decision cycle steps, ensuring that HBPM is actionable for revising, updating, and managing the HBP dynamically.

Scope of maturity statement

- This statement applies to the **extent to which indicators in the HBPM framework cover** the HBP updating cycle.
- It does not judge the technical quality of the indicators (which is covered under SMART/ standardization), but rather their **policy relevance and alignment with decision-making needs**.

Examples of evidence sources to inform assessment

- HBP update guidelines and procedural manuals.
- Indicator lists and monitoring matrices mapped to HBP updating cycle steps.
- Reports from technical committees on HBP revisions.
- National health planning or budgeting documents referencing HBPM evidence.

Assessment and scoring

The assessor will document the extent to which the HBP updating cycle are covered by HBPM indicators and which are not, together with sources of evidence. When scoring Alignment as **No/ Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which HBPM indicators map to the HBP updating cycle applicable in the context; and 2) the extent to which alignment can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Alignment	Extent to which the HBP updating cycle is linked to HBPM indicators				

The maturity level for this statement is based on the number of steps in the HBP updating cycle which are linked to HBPM indicators, per the table below.

Emerging	Established	Advanced
HBPM indicators cover the HBP updating cycle to a limited extent; or a HBP updating cycle is not in place.	HBPM indicators cover the HBP updating cycle to some extent, but gaps remain e.g., steps in the HBP updating cycle are not monitored.	HBPM indicators cover the HBP updating cycle comprehensively.

Maturity statement 5: Clinical guidelines are formally used in HBP monitoring

Maturity Statement: Clinical guidance documents are explicitly linked to HBP monitoring to ensure appropriate, high-quality care.

Short-hand Statement: Clinical guidelines are formally used in HBP monitoring.

Linked foundational principle: P2—Linkage between clinical guidance and HBP benefits/HBPM indicators needs to be institutionalized.

Specific terminology in the maturity statement

Clinical guidance documents = official guidelines, protocols, or technical standards issued or endorsed by the health authority.

Clinical Practice Guidelines = statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options.

Explicitly linked = guidelines are directly referenced in HBPM processes, including **indicator definitions, quality standards, and performance review**.

HBP monitoring = all processes that track the implementation, quality, and results of the HBP.

Scope of maturity statement

- Assesses whether **national clinical guidelines systematically inform HBPM**.
- Does not evaluate the **quality or completeness of the guidelines themselves**, only their integration into monitoring.
- Applies across all levels of care and programs included in the HBP.

Examples of evidence sources to inform assessment

- Official clinical guidelines and protocols.
- HBPM indicator manuals that show linkage to guidelines.
- Regulations or decrees mandating the use of guidelines in monitoring.
- Reports from quality assurance or monitoring committees.

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement—clinical guidelines **exist, are linked consistently to HBPM, are institutionalized** and **updated regularly**—are present in the HBPM framework, together with the supporting evidence for each characteristic.

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which the characteristic is present/applies **systematically**; and 2) the extent to which it can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Feature	Characteristic	No	Partially	Yes	Evidence Support
Existence	Clinical Practice Guidelines formally exist (national protocols, standards).				
Linkage	Clinical Practice Guidelines' recommendations are explicitly referenced in interventions/ services covered by the HBP, and in HBPM indicators, standards, or reports.				
Consistency	The linkage is **systematic across** the continuum of care covered by the HBP, not ad hoc.				
Institutionalization	**Formal mechanisms** (approved policies, laws, regulations, committees) ensure Clinical Practice Guidelines inform monitoring.				
Updating	Clinical Practice Guidelines are **regularly updated and integrated** into HBPM revisions.				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: Clinical Practice Guidelines exist but are **not linked** to HBPM monitoring. No processes ensure their use in defining indicators or quality standards. Monitoring is based on **ad hoc criteria** or data availability.	Most of the following apply: Clinical Practice Guidelines are partially linked to HBPM monitoring. Some indicators or quality checks are derived from guidelines, but the linkage is inconsistent or informal. Processes exist but lack systematic application across all programs.	Most of the following apply: Clinical Practice Guidelines are fully integrated into HBPM monitoring. Formal processes ensure they inform indicator definitions, quality measurement, and performance review. Updates to guidelines are systematically reflected in HBPM indicators, guaranteeing alignment over time.

Maturity statement 6: HBPM indicator definitions are SMART, standardized and harmonized with the health information system (HIS)

Maturity statement: HBPM indicators' definitions are formulated in a *SMART way*, *standardized* and *harmonized* with the national health information system.

Short-hand statement: HBPM indicator definitions are SMART, standardized and harmonized with the health information system (HIS).

Linked foundational principle: P5, P6 and P7.

Specific terminology in the maturity statement:

SMART = indicators are defined so they are:

- Specific = their meaning is unambiguous. For example:
  - "mortality" is ambiguous as an indicator title because it can mean infant, child, or total mortality expressed as an absolute or relative measure, while "infant mortality rate (per 1,000 live births)" is clear;
  - "access to healthcare" is ambiguous as an indicator title because it does not state what dimension of "access" it captures (e.g., availability, timeliness, financial barriers) and what "healthcare" covers, while "proportion of households enlisted with a family physician" is clear.

- Measurable = they can be measured.
- Achievable = they can be measured using data and information systems that are routinely available.
- Relevant = they capture what matters for policy objectives in relation to the HBP and the HBP updating cycle.
- Time-bound = the frequency of measurement is clear.

Standardized indicator definition = indicator for which all of the following are indicated clearly: calculation formula (e.g., numerator and denominator in case of a ratio); meaning of all formula components (e.g., definitions of the numerator and denominator); data sources for all formula components; frequency of calculating or updating the indicator (e.g., annually).

Harmonized indicator definition = the indicator definition, or its components, are defined the same as in national classification systems and collected by the national HIS.

Scope of the maturity statement

- Only HBPM indicators explicitly acknowledged as such can be considered.

Examples of evidence sources to inform assessment

- Laws, decrees, or ministerial orders that establish the HBP and the HBPM framework.
- Manuals or procedural guides for the implementation of the HBPM framework.
- Results frameworks, logical frameworks, or monitoring and evaluation (M&E) plans that translate goals into trackable areas.

Assessment and scoring

The assessor will document the share of HBPM indicators (%) acknowledged as such in the HBPM framework that meet the characteristics in the table below, with sources of evidence.

Attribute	Characteristic	<30%	30–70%	>70%	Evidence Support
SMART	HBPM indicator definitions are formulated in a SMART way.				
Standardization	HBPM indicator definitions are standardized.				
Harmonization	HBPM indicator definitions are aligned with national classification systems.				

The maturity level for this statement is based on the share (%) of HBPM indicators that have the attributes, per the table below.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
SMART: <30% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.
Standardization: <30% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.
Harmonization: <30% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.

Maturity statement 7: Roles and responsibilities are defined clearly and assigned across all HBPM functions

Maturity Statement: Roles and responsibilities for key HBPM functions are covered by *legislation* and *procedures*, are *clear*, *complete*, *consistent*, *enforceable* and *sustainable*.

Short-hand statement: Roles and responsibilities are defined clearly and assigned across all HBPM functions.

Linked foundational principle: P8.

Specific terminology in the maturity statement

Roles and responsibilities = official mandates or assignments set out in **laws, decrees, regulations, organizational charts, or terms of reference**.

Key HBPM functions = stewardship, institutional coordination, data production and quality assurance, financing of HBPM, and the use of findings in decision-making.

Clear = roles and responsibilities are documented explicitly.

Complete = roles and responsibilities cover all the key HBPM functions (stewardship, coordination, data production, financing, use of findings).

Consistent = roles and responsibilities are non-overlapping and complementary across institutions.

Enforceable = responsibilities are binding (i.e., anchored in law) and enforceable (i.e., accountability mechanisms exist and are clear), not only informal practices.

Sustainable = roles are institutionalized beyond individuals or projects, reviewed and updated periodically.

Scope of maturity assessment

- Assesses whether **all HBPM functions have formally assigned institutional responsibilities**.
- Does **not evaluate performance**, only the **existence and clarity of assignments**.
- Applies at **national and subnational levels** where responsibilities are devolved.

Examples of evidence sources to inform assessment

- Laws, decrees, regulations establishing institutional mandates.
- Procedural or operational manuals or guidelines
- Organizational charts and official job descriptions.
- Budgetary frameworks indicating which institutions finance HBPM.
- Meeting minutes or reports showing roles are enacted in practice.

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement—**legal basis**, **procedural scope**, **clarity, completeness, consistency, enforceability** and **sustainability**—are present in the HBPM framework, together with the supporting evidence for each characteristic.

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which the characteristic is present/applies **systematically**; and 2) the extent to which it can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

For example:

- If procedures/manuals exist for some HBPM functions, but not for others, "Partially" would be appropriate for this characteristic (all other things equal).

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Legal Basis	**Existence of binding legal instruments** (laws, decrees, regulations, approved policy documents) that mention HBPM and institutions responsible for it.				
Procedural Scope	**Formal procedures/manuals** exist for indicator selection, data governance, reporting, financing.				
Completeness	Roles and responsibilities are **assigned for all key HBPM functions** (stewardship, coordination, data production, financing, use of findings).				
Clarity	Roles are **explicitly documented** (laws, decrees, regulations, TORs, org charts).				
Consistency	Roles are **non-overlapping and complementary** across institutions and levels.				
Enforceability	Responsibilities are **binding and enforceable**, not only informal practices.				
Sustainability	Roles are **institutionalized beyond individuals or projects**, reviewed and updated periodically.				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
Legal and procedural basis for HBPM is absent, or is minimal with major gaps in terms of roles and responsibilities.	Legal and procedural basis for HBPM is in place, with some gaps and inconsistencies remaining in terms of roles and responsibilities.	Legal and procedural basis for HBPM are in place, are comprehensive and coherent in terms of roles and responsibilities.
Roles and responsibilities are unclear, overlapping, or missing for key HBPM functions.	Most roles are formally defined, but important gaps remain (e.g., stewardship, operational coordination, or data use).	Roles and responsibilities are fully defined, consistent, and comprehensive, covering stewardship, coordination, data production, financing, and use of findings.
No institution has a formal stewardship or coordination mandate.	Mandates may be fragmented or overlapping, leading to inconsistencies.	Mandates are institutionalized in binding documents (laws, decrees, strategies).
Reliance on ad hoc arrangements or donor-driven projects.	Responsibilities are documented but not consistently enforced.	Roles are regularly reviewed and updated to remain relevant and effective.

Maturity statement 8: HBPM results are used in the HBP updating cycle

Maturity Statement: HBPM results inform HBP updates.

Short-hand Statement: HBPM results inform HBP updates.

Linked foundational principle:

Specific terminology in the maturity statement

HBPM results = findings generated by monitoring the HBP (coverage, financial protection, service delivery, equity, etc.).

HBP updating cycle = the structured, periodic process for revising the HBP, which typically includes priority-setting, evidence appraisal, review of reimbursement and payment methods, fiscal and budget assessment, stakeholder deliberation, service inclusion/exclusion, implementation planning, and monitoring.

Use = not only producing monitoring reports, but having evidence systematically referenced and mandated in policy and financing decisions.

Scope of maturity assessment

- Evaluates whether HBPM results are actually influencing HBP updating **policy decisions**, not just being produced as diagnostics.
- Does not evaluate the technical quality of HBPM indicators (covered elsewhere), only their **policy uptake**.

Examples of evidence sources to inform assessment

- Legislation or decrees mandating HBPM reporting as input for HBP revisions.
- Minutes or reports of technical committees showing use of HBPM evidence.
- Policy documents explicitly citing HBPM results (e.g., service adjustments, financing changes).
- Budget allocations or revisions that reference HBPM findings.

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement are present in the HBPM framework, together with the supporting evidence for each characteristic.

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which the characteristic is present/applies **systematically**; and 2) the extent to which it can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

For example:

- If a single committee is mandated to consider HBPM results in its decisions reportedly does so opportunistically rather than systematically, "No" would be appropriate for this characteristic (all other things equal).
- If several committees with distinct purposes are mandated to consider HBPM results in their decisions, and some committees do it systematically while others do not, "Partially" would be appropriate for this characteristic.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Formal Mandate	Laws, decrees, or guidelines require HBPM reporting as input to **multiple steps** of the HBP cycle, such as priority-setting, budget allocation, inclusion/exclusion, monitoring, revision—depending on context.				
Policy Use	HBPM results explicitly cited in **priority-setting and service inclusion/exclusion** decisions.				
Budget Linkage	HBPM findings are referenced in **budget allocation, resource adjustments, or fiscal space assessments**.				
Committee Use	Technical committees and advisory bodies systematically review HBPM results across **decision steps**.				
Documented Impact	Policy, financing, or package revisions are **formally traceable** to HBPM evidence (e.g., laws, decrees, official reports).				
Monitoring Link	HBPM results are used in **implementation monitoring and performance reviews** of the HBP.				
Revision Trigger	HBPM results systematically trigger **periodic HBP revisions** in line with national guidelines.				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: HBPM results are produced but rarely referenced in HBP policy or update decisions. No formal mechanism ensures that findings influence revisions, financing allocations, or service inclusion/exclusion. Monitoring exists mainly as a diagnostic exercise, disconnected from policy cycles.	Most of the following apply: HBPM results are occasionally referenced in some steps of the update cycle (e.g., pilot revisions, adjustments to a subset of services). Partial mechanisms exist: technical committees may review data, but there is no binding requirement linking findings to package revisions or budgetary decisions. Use of results depends heavily on leadership will or external pressure.	Most of the following apply: HBPM results are systematically used to inform multiple steps of the HBP cycle (priority-setting, evidence appraisal, review of reimbursement and payment methods, fiscal and budget assessment, stakeholder deliberation, etc.). Formal mandates exist (laws, decrees, guidelines) requiring HBPM reporting as an input to HBP revisions. Evidence of policy impact is documented (e.g., revisions or financing changes explicitly citing HBPM findings).

Maturity statement 9: HBPM is supported with adequate resources

Maturity Statement: Managerial, technical, and financial resources are backing HBPM.

Short-hand Statement: HBPM is supported with adequate resources.

Linked foundational principle: P6—Institutions manage adequate resourcing (financial and human resources) to ensure monitoring expansion is feasible and sustainable.

Specific terminology in the maturity statement

Managerial resources = staff with skills in planning, coordination, and oversight of HBPM processes.

Technical resources = trained personnel, tools, and infrastructure (e.g., data analysts, HIS specialists, monitoring tools).

Financial resources = stable funding sources dedicated to HBPM, equitably distributed across levels.

Backing = resources are sufficient, predictable, institutionalized, and sustained over time.

Scope of maturity statement

- Evaluates whether HBPM is supported by **adequate and sustainable resources**.
- Focuses on **availability, stability, and distribution** of resources, not on detailed efficiency of their use.
- Applies across **national and subnational levels**.

Examples of evidence sources to inform assessment

- Official budgets or financial reports referencing HBPM activities.
- Staffing tables, organizational charts, or TORs for HBPM-related units.
- Training programs or capacity-building initiatives for HBPM.
- Donor agreements or sustainability plans for financing HBPM.

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement are present in the HBPM framework, together with the supporting evidence for each characteristic. For this statement, a quantitative indication for each characteristic should be attempted e.g., how much funding is allocated? How many people are working on HBPM and what are their roles? What type of training is being provided to how many people, how frequently, on which topics?

When scoring each characteristic **No/Partially/Yes**, the assessor will prioritize two considerations: 1) the extent to which the characteristic is present/applies **systematically**; and 2) the extent to which it can be supported by evidence. When in doubt, the low-level category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Financial	**Stable, predictable funding** for HBPM activities is allocated in budgets.				
Managerial	**Dedicated staff/units** exist for planning and coordinating HBPM.				
Technical	**Trained personnel and tools** are available for HBPM implementation.				
Distribution	Resources for HBPM are **equitably distributed** across national and subnational levels.				
Sustainability	**Capacity building is institutionalized** (continuous training, retention).				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: Resources are insufficient, unpredictable, and largely dependent on external support. No structured training or technical capacity for HBPM. Resource allocation is ad hoc and unstable.	Most of the following apply: Resources are partially adequate but unstable or concentrated in one level of the system. Ad hoc capacity-building activities exist but are not sustained. Funding is allocated but vulnerable to reallocation or discontinuity.	Most of the following apply: Resources are stable, sufficient, and equitably distributed across all levels. Sustained efforts exist to build and retain technical and managerial capacity. Funding is institutionalized within government budgets, ensuring long-term sustainability.

Maturity statement 10: HBPM results are communicated to all key stakeholders

Maturity Statement: HBPM results are communicated to multiple audiences and government levels.

Short-hand Statement: HBPM results are regularly disseminated to all key stakeholders.

Linked foundational principle: P9—In a multi-level governance framework, HBPM results must be communicated both to multiple audiences and across all relevant government levels. This ensures transparency, enables coordinated action, and strengthens accountability.

Specific terminology in the maturity statement

HBPM results = outputs of monitoring (indicators, reports, dashboards, performance reviews) produced through the HBPM system.

Communicated = shared systematically, through official reports, presentations, websites, or other dissemination channels.

Multiple audiences and government levels = national and subnational policymakers, health providers, civil society, partners, and the general public.

Regularly = not ad hoc, but institutionalized and recurrent.

Scope of maturity statement

- Evaluates whether HBPM results are **disseminated in a structured and targeted way**.
- Does not assess the **technical quality of the results**, only their dissemination practices.
- Applies to **national, subnational, and external audiences** (where relevant).

Examples of evidence sources to inform assessment

- Official HBPM reports, bulletins, or dashboards.
- Websites or platforms where results are published.
- Meeting minutes or dissemination events.
- Media releases or communications to the public.

Assessment and scoring

The assessor will use the checklist below to document the extent to which the attributes for this maturity statement are present in the HBPM framework, together with the supporting evidence for each characteristic.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Completeness	HBPM results are **disseminated in full**, per the HBPM framework.				
Regularity	HBPM results are disseminated **regularly and not ad hoc**.				
Audiences	HBPM results are shared with **multiple audiences** (policymakers, providers, civil society, public).				
Levels	HBPM results reach **both national and subnational levels** of government.				
Accessibility	HBPM results are **accessible in user-friendly formats** (reports, dashboards, summaries).				
Institutionalization	The dissemination of HBPM results is **mandated and standardized** as part of HBPM routines.				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: No structured communication of HBPM results. HBPM results are rarely shared beyond internal technical teams. No public communication or accountability mechanisms.	Most of the following apply: Communication occurs, but irregularly or ad hoc. Only a selection of HBPM indicators is communicated. Audiences are limited (e.g., only national policymakers). Results are sometimes shared with subnational levels or providers, but not systematically.	Most of the following apply: All HBPM results are disseminated regularly and systematically. Targeted communication reaches national and subnational policymakers, providers, civil society, and the public. Formats are accessible and user-friendly (dashboards, reports, summaries). Dissemination is institutionalized in mandates or procedures, ensuring sustainability.

Maturity statement 11: HBPM uses standardized norms and codes aligned with national HIS

Maturity statement: HBPM aligned with *national HIS norms*, using *standardized codes* and *classifications* to ensure data comparability, efficiency, and sustainability.

Short-hand statement: HBPM uses standardized norms and codes aligned with national HIS.

Specific terminology in the maturity statement

Health Information System (HIS): the set of interoperable subsystems, platforms, and data flows that collectively support the production, storage, analysis, and use of health data for decision-making. It may include multiple components—clinical, administrative, HRH, financial, and vital statistics systems—that together contribute to HBPM monitoring.

National HIS norms = endorsed rules, policies, and technical standards that guide how health data is collected, stored, shared, and used across the health system. These norms ensure consistency and comparability of information across programs and levels of care. They include nationally approved: reporting formats, interoperability requirements, governance frameworks, and data quality protocols.

Interoperability Standards and Codes = HBPM applies uniform and machine-readable coding systems and identifiers that enable the consistent representation, exchange, and comparison of health data across platforms and programs. These standards are the foundation for data interoperability within the HIS. Examples include: ICD (International Classification of Diseases) codes for diagnoses; SNOMED CT for clinical terminology; LOINC for laboratory tests; National codes for patient IDs, facilities, insurance claims, drugs, and related health system elements.

Classification Systems = HBPM uses structured frameworks that organize coded data into meaningful categories for aggregation, analysis, and decision-making. These systems rely on standardized codes to enable comparable reporting across services and population groups. Examples include: ICD chapters or groupings for diseases; ATC (Anatomical Therapeutic Chemical) classification for medicines; DRG (Diagnosis-Related Group) systems for service outputs.

Scope of maturity statement

- Covers the existence, accessibility, and consistent use of national HIS norms, standardized codes, and classifications in HBPM.
- Assesses the availability and use of national HIS norms, standardized codes, and classifications for HBPM.
- Evaluates both the existence and implementation relevant documents and policies, and its alignment with broader HIS standards.

Examples of evidence sources to inform assessment

- **Official documents and policies:** National HIS strategies, digital health frameworks, reporting manuals that define standards for data collection, storage, sharing, and reporting.
- **Guidelines and technical specifications:** Governance frameworks, interoperability requirements, data quality protocols, and training materials for staff.
- **Master lists and coding systems:** Standardized codes for diagnoses (ICD), procedures, lab tests (LOINC), drugs (ATC), facilities, providers, patient IDs, and insurance claims.
- **Classification manuals:** National or program-level classification systems (e.g., ICD chapters, DRG groups) used for aggregation and reporting.
- **HIS configurations and outputs:** Software documentation, dashboards, and reports showing actual use of codes and classifications are actually applied.
- **Audits, supervision, and evaluation reports:** Data quality assessments, verification exercises, and internal audits confirming correct application of norms, codes, and classifications in health benefits package monitoring.
- **Stakeholder interviews:** Discussions with HIS and HBPM managers, program officers, and facility staff about adherence to norms and practical application of codes and classifications in health benefits package monitoring.

Assessment and scoring

The assessor documents the extent to which **national HIS norms, standardized codes** and **classification systems**—are present and applied within HBPM, citing evidence for each.

When rating each characteristic (*No/Partially/Yes*), priority should be given to: 1)the systematic presence and consistent use of standards, and; 2) the availability of verifiable documentation. When in doubt, the lower category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
National HIS Norms	Official policies, and technical standards for HBPM exist.				
	Standards define data collection, storage, sharing, and use across the health system.				
	Reporting formats, interoperability requirements, governance frameworks, and data quality protocols are clearly defined.				
	Policies and standards are accessible to all programs and levels of care relevant to HBP implementation				
	National HIS norms are applied consistently in practice.				
Interoperability Standards and Codes	Uniform, machine-readable codes and identifiers exist for health conditions, services, facilities, and populations, ensuring consistent data representation across platforms.				
	Examples include ICD for diagnoses, SNOMED for clinical terms, LOINC for laboratory tests, HL7/ FHIR for data exchange, and national codes for patients, facilities, insurance claims, and drugs.				
	These codes are applied consistently across programs or subsystems supporting HBP implementation.				
	These codes enable interoperability, data comparability and seamless information exchange across the HIS				
Classification systems	Structured classification systems exist for aggregation and analysis of coded health data				
	Classification systems like ICD chapters, ATC for medicines, DRG for service outputs, or program-specific categories are available and used where relevant.				
	Classifications are applied consistently across programs and subsystems relevant to HBP implementation.				
	Classification outputs are systematically used for monitoring, reporting, and policy decisions.				

Completing the checklist above leads to assessing maturity for this statement in one of three levels—emerging, established or advanced—per the table below.

Emerging	Established	Advanced
Most of the following apply: **National HIS norms:** largely absent or incomplete, covering few aspects of data management. Reporting formats, governance, interoperability, and data quality protocols are unclear, and policies are not widely accessible, leading to fragmented implementation. **Interoperability standards and codes:** are limited or absent, inconsistently applied, and rarely machine-readable, reducing comparability across programs. **Classification systems:** limited or inconsistently applied, with minimal use for monitoring or decision-making.	Most of the following apply: **National HIS norms:** exist and cover most areas, but application across HBP related HIS is inconsistent. Standards, reporting formats, and governance frameworks are partially implemented, with policies accessible to some levels. **Interoperability standards and codes** exist for most areas and are partially applied, improving data comparability, though gaps and inconsistent implementation remain. **Classification systems: systems** cover most relevant areas and are partially used, improving data aggregation and analysis, but use in decision-making is inconsistent.	Most of the following apply: **National HIS norms:** fully documented and consistently applied for HBPM and across levels, covering key aspects of data management. Policies, reporting formats, interoperability, governance, and data quality protocols are systematically applied, ensuring efficiency and comparability. **Interoperability standards and codes** (e.g., ICD, SNOMED CT, LOINC, HL7/ FHIR, and national identifiers): extensively applied for HBPM. Codes are machine-readable and support integrated monitoring, reporting, and efficient HIS operations. **Classification systems:** implemented and consistently applied for HBPM, supporting aggregation, analysis, reporting, and evidence-informed decisions.

Maturity statement 12: HIS fosters data use by sharing HBPM data, with dashboards and feedback loops driving reviews and HBP-related decisions

Maturity statement: HIS supports a strong data use culture by *sharing raw and analysed HBPM data* accessible across all levels, and by providing *dashboards and feedback loops* to *drive regular reviews* and HBP-related decisions within the HBP updating cycle.

Short-hand maturity statement: HIS fosters data use by sharing HBPM data, with dashboards and feedback loops driving reviews and decisions.

Specific terminology in the maturity statement

Data sharing across all levels = Raw and analysed HBPM data is accessible through HIS at national, subnational, and facility levels through the HIS, ensuring transparency and usability.

Dashboards and feedback loops = visualization tools and mechanisms (e.g., dashboards, automated reports, alerts) that translate data into actionable insights and promote continuous feedback across levels of the HBP monitoring system.

HIS data for regular reviews and evidence-informed decisions = HIS data are **systematically used** in structured review processes to guide **HBP-related planning, policy, and benefit-package updates**, ensuring that monitoring results directly inform decisions within the HBP policy and update cycle.

Scope of the maturity statement

- **Covers:** The use of HIS-generated data to monitor and review the HBP and to inform periodic policy decisions on its implementation and updating.
- **Assesses:** the availability, accessibility and systematic use of data sharing mechanisms across all levels, dashboards, feedback loops, to support the HBP management and revision process.
- **Evaluates:** existence and quality of mechanisms and use of these tools in evidence-informed HBP decision-making.

Examples of evidence sources to inform assessment

- HIS reports and data extracts showing availability at facility, district, and national levels
- Access logs or user permissions demonstrating who can view data
- Data-sharing protocols or SOPs
- Audit reports to assess data availability
- Interviews with facility, subnational, and national staff regarding access
- Existence of dashboards within the HIS (live or screenshot evidence)
- Documentation of automated or manual feedback reports
- Meeting minutes showing use of dashboards for decision-making
- User manuals or training materials for dashboard and feedback tools
- Staff interviews or surveys assessing awareness and use of feedback mechanisms.
- Records of structured review meetings at facility, district, or national levels
- Meeting agendas and minutes from HBP review sessions showing use of HIS data Performance reports or decision memos showing data-informed actions—Documentation of policies or program changes based on HIS data
- Staff interviews confirming how data feed into HBP reviews and updates.

Assessment and scoring

The assessor documents the extent to which **data sharing across all levels, dashboard and feedback loops** and **effective data use** support HBPM and decision-making, citing evidence.

When scoring each characteristic (*No/Partially/Yes*), the assessor should prioritize:

1. Systematic implementation and use across all levels, and
2. Evidence of actual application in HBP reviews and policy decisions.

When in doubt, the lower category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Data sharing across all levels	Raw and analysed HBPM data is accessible at national, subnational, and facility levels through the HIS.				
	Data-sharing protocols or SOPs exist and are followed.				
	Users at all levels have appropriate access to HIS data.				
Dashboards and feedback loops	Dashboards exist within HIS to visualize HBPM data for decision-making.				
	Feedback mechanisms (reports, alerts, summaries) are provided for action.				
	Staff are trained and use dashboards and feedback mechanisms effectively.				
Data use for HBP-related reviews decisions	HIS data are used systematically in structured HBP review and update processes.				
	Review meetings, performance dashboards, or reports reference HIS data to inform HBP decisions.				
	HIS data informs planning, policy, and operational decisions within the HBP update cycle.				
	Evidence of follow-up actions or policy adjustments based on HIS data is documented.				

Completing the checklist allows classification as **Emerging**, **Established**, or **Advanced**, depending on whether most characteristics score *No*, *Partially*, or *Yes*. Scoring should reflect both the **existence and practical use** of HIS data tools and their systematic use to inform the HBP policy and update cycle.

Emerging	Established	Advanced
Most of the following apply: **Data sharing:** No indication that data are shared, or it is shared sporadically, with access restricted to certain health r programs. **Dashboards and feedback loops:** No indication they are present, or they exist and are used rarely. **Data use:** No indication of HIS data used in evidence-informed decisions, or ad hoc use.	Most of the following apply: **Data sharing:** Data shared at some levels, but not all; access protocols exist but are inconsistently applied. **Dashboards and feedback loops:** Available, but gaps remain in their design and use (e.g., in some health programs but not others; staff are not trained to use all functionalities). **Data use:** Some data are used in decision-making, but gaps remain (e.g., not used systematically; follow-up actions are not documented).	Most of the following apply: **Data sharing:** Data accessible at national, subnational, and facility levels with clear protocols. **Dashboards and feedback loops:** Dashboards and feedback loops are fully functional and widely used to track HBP performance. **Data use:** Structured HBP reviews processes systematically reference HIS data with documented actions policy decisions based on evidence.

Maturity statement 13: HIS is supported by domestic financing and underpinned by strong privacy and ethical safeguards

Maturity statement: The HIS is primarily funded by *domestic financing* to ensure sustainability and national ownership, with *strong privacy and ethical safeguards* that protect data, reinforce trust, and uphold accountability.

Short-hand maturity statement: HIS is supported by domestic financing and underpinned by strong privacy and ethical safeguards.

Specific terminology in the maturity statement

Domestic Financing = Funding for the HIS comes from national or subnational government budgets, rather than relying primarily on external donor support. Domestic financing ensures continuity of system operations beyond donor cycles, alignment with national priorities, and long-term sustainability.

Strong Privacy and Ethical Safeguards =Policies, protocols, and technical measures that protect the confidentiality, integrity, and ethical use of health data. These include access controls, secure storage, data anonymization, consent frameworks, and public transparency mechanisms. Strong safeguards reinforce trust among patients, providers, and policymakers, and ensure that HIS data is used responsibly for accountability and decision-making.

Scope of the maturity statement

- Covers: Whether HIS is financially sustained through domestic resources and whether privacy and ethical protections are in place and effectively implemented.
- Assesses: The extent, reliability, and sustainability of domestic financing, and the existence and enforcement of privacy and ethical safeguards.
- Evaluates: Both the formal frameworks (laws, policies, budgets) and their practical implementation of these financing mechanisms and safeguards across the HIS.

Examples of evidence sources to inform assessment

- **Domestic Financing**
  - National or subnational government budget allocations for HIS operations and maintenance
  - Expenditure reports showing domestic spending on HIS infrastructure and data systems
  - Official financing plans or strategic investment frameworks
  - Legislative or policy documents mandating domestic funding for HIS
  - Audit reports or financial reviews confirming use of domestic funds
  - Interviews with finance and HIS officials on funding sources and sustainability plans

- **Privacy and Ethical Safeguards**
  - National or institutional policies on data privacy, confidentiality, and ethical use
  - SOPs specifying access controls, secure storage, anonymization and data handling
  - Technical documentation of HIS security measures (e.g., anonymization, encryption, authentication
  - Consent forms, patient information sheets, or data-sharing agreements
  - Records of audits, data breach reports, or compliance assessments
  - Public data governance frameworks, transparency reports, or accountability portals or reports
  - Interviews with HIS managers, IT staff, or program officers on how privacy and ethical safeguards are implemented in practice.

Assessment and scoring

The assessor records the extent to which **domestic financing** and **strong privacy and ethical safeguards** are present and applied, supported by evidence. When rating each characteristic (No/Partially/Yes), priority should be given to:

1. The consistency and sustainability of domestic financing, and
2. The scope and enforcement of privacy and ethical safeguards

When in doubt, the lower category should be chosen i.e., **No** rather than **Partially**, and **Partially** rather than **Yes**.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Domestic Financing	The HIS is primarily funded through national or subnational government budgets rather than external donors.				
	Budget allocations for HIS are documented in official budgets or financing plans.				
	Expenditure reports confirm that domestic funds are used for HIS operations and maintenance.				
	Long-term sustainability plans reflect continued domestic financing.				
Privacy and Ethical Safeguards	Policies exist covering confidentiality, ethical use, and data protection.				
	Technical measures such as access controls, secure storage, anonymization, and authentication are implemented.				
	Data-sharing agreements, consent frameworks, or SOPs demonstrate ethical compliance.				
	Evidence of monitoring, audits, or compliance assessments confirms safeguards are applied.				
	Transparency mechanisms are in place (e.g., governance frameworks, public reports) to reinforce accountability and trust.				

Completion of the checklist allows classification as Emerging, Established or Advanced—depending on whether most characteristics score No, Partially, or Yes. Scoring should consider both the financial sustainability of HIS and the strength of data protection mechanisms.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
Domestic financing: No domestic financing provisions for HBPM. Domestic financing is minimal or ad hoc. No long-term financial sustainability plan.	**Domestic financing:** Some domestic financing provisions for HIS, with gaps remaining (e.g., domestic financing covers some but not all HIS functions; there are no long-term sustainability plans).	**Domestic financing:** Stable and comprehensive domestic financing covers all core HIS operations, ensuring sustainability and ownership.
Privacy and ethical safeguards: No indication of privacy and ethical safeguards applicable. Privacy policies, consent frameworks, or access controls are absent or rarely enforced.	**Privacy and ethical safeguards:** Policies and safeguards exist but are inconsistently applied, limited evidence of audits being conducted or enforcement mechanisms in place.	**Privacy and ethical safeguards:** Comprehensive privacy and ethical policies, technical safeguards, and consent frameworks are in place, regularly audited and consistently enforced.

Annex 2. Assessment template

To be completed by the assessment team.

Scope of the assessment: [*describe briefly the setting (country, demographics, health system fundamentals etc.) and the HBP assessed, including its content and institutional arrangements for financing and delivery; note any HBP exclusions for the scope of the assessment*].

- **Maturity assessment:** For each statement, list (1) evidence examined, (2) evidence not yet examined, (3) completed checklist, (4) maturity level (Emerging/Established/Advanced) and (5) assessor's rationale.
- **Summary table:** Compile results by maturity statement, including the score and key evidence.

Description of the assessment: [*summarize the activities undertaken for the assessment– e.g., desk review, key informant interviews with Ministry of Health and Sub-national governments.—and the timeframe*]

Maturity assessment:

For **each statement**, the following will be documented:

Evidence examined [*list*]:
Evidence not yet examined [*list and describe reasons*]:
Completed checklist [*paste checklist from this operational manual, score characteristics with **No/Partially/Yes** and complete **Evidence support***]

Maturity assessment for this statement [***Emerging/Established/Advanced*** *with brief description of the assessor's judgement on the attributes and characteristics based on the available evidence; include uncertainties in assessing maturity, if they exist.*]
Potential Actions [*briefly capture improvement ideas or areas where policy intervention might be useful*]
Suggestions for improving this maturity statement [*e.g., concept validity, definitions, examples of evidence sources*]

Summarize the findings by completing the table below. For each maturity statement, indicate the assessed maturity level (Emerging/Established/Advanced), summarize key supporting evidence, and note any suggestions for improving the statement itself or its clarity

Maturity Statement	Maturity Level	Evidence Support	OPTIONAL—Potential Actions/External Support	Suggestions for Improving the Maturity Statement

Overall, consider answering the following questions:

Which particular strengths of the HBPM system does the tool reveal?
Which HBPM areas for improvement should be prioritized and why?
Are there unexpected findings which warrant closer scrutiny?

Annex 3. Details on the HBPM maturity assessment of the Sumar Program, Argentina

Maturity Statement 1: Health benefits are defined *clearly*, in sufficient *detail* to be operational, *verifiable*, and *enforceable*.

Emerging	Established	Advanced
Most of the following apply: **Clarity:** Only fragments of what is covered are described; benefits are vague or inconsistent, leaving patients and providers uncertain about entitlements. **Detail:** Minimal operational guidance is available; at most one or two elements (e.g., a list of medicines or conditions) are specified, while referral rules, facilities, and access guarantees are absent. **Verifiable:** No consistent use of standardized terminology, coding, or catalogs; monitoring is not possible. **Enforceable:** Eligibility and coverage rules are missing or not binding; patients cannot reliably claim entitlements.	Most of the following apply: **Clarity:** Benefits are partially described in official documents; patients and providers have some understanding of what is covered, though important gaps remain. **Detail:** Several elements (e.g., medicines, eligibility criteria, authorized providers) are included, but other aspects (such as access guarantees or referral rules) are incomplete or missing. **Verifiable:** Some standardized terminology or coding is applied, but coverage is inconsistent and monitoring remains limited. **Enforceable:** Some entitlements exist on paper, but accountability and redress mechanisms are weak or not fully operational.	Most of the following apply: **Clarity:** Benefits are comprehensively described in plain language; patients, providers, and purchasers all clearly understand entitlements and conditions. **Detail:** Most elements are included—services, medicines, providers, facilities, eligibility/referral rules, and access guarantees—making the package fully operational. **Verifiable:** Standardized terminology, coding systems, and catalogues are systematically applied, enabling reliable monitoring and reporting. **Enforceable:** Rights and obligations are legally established, backed by policy and budget frameworks; HBP documents are public, and complaints/appeals processes ensure accountability.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Clarity	Plain-language description of what is covered (inclusions, exclusions, service categories, benefit limits) stated in non-technical terms.			X	Descriptive document of the HBP of the Sumar Program. Communication tools exist to facilitate its understanding by providers and patients.	The HBP explicitly details the guaranteed services in simple language. The document does not provide an exhaustive list of exclusions and benefit limits. The HBP is clear for health authorities and facilities, as well as for the population.	Established
	Target population groups and related eligibility or clinical indications.			X		The HBP identifies the services by population group, by line of care, and according to the quality attributes established by the clinical guidelines.	
	Which providers deliver the services: authorized providers and the levels of care (primary, secondary, tertiary) are listed.		X			For high-complexity services financed by the National Health Equity Fund, it is the National Ministry of Health that defines and authorizes the providers. Regarding services financed directly by the provinces, it is the subnational jurisdictions that authorize providers according to the level of complexity, categorization, and service delivery capacity at the time of signing the agreements between the parties. From the user's perspective, access to information about the providers delivering the benefit package varies depending on the strategy defined by each subnational jurisdiction (institutional websites, patient portals, etc.). The national government does not have official publications detailing the providers that guarantee access to the HBP.	
	Financial protection: rules for co-payments, exemptions, out-of pocket caps and guarantees of financial protection are specified.			X	Umbrella Agreement signed between the Nation and the provinces. Management Commitments between the provinces and the providers.	The Umbrella Agreement of the Sumar Program, signed by the National Minister of Health and the Governor of each province, establishes the gratuity of the services guaranteed by the HBP for the population with exclusive public coverage. The management agreements signed between the provinces and the providers explicitly include the guarantee of free access to these services.	
	Access pathway: the first point of contact (e.g., primary care) and simple referral expectations are defined.		X		Provincial Ministries of Health websites, patient portals, and other digital media.	The definition of the first point of contact is a responsibility of subnational governments, with different mechanisms implemented depending on the jurisdiction, in some cases explicitly and publicly accessible (websites of the Ministries of Health, official social media channels, etc.).	

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Detail (Operational)	Procedures, medicines, devices, and activities (included and/or excluded) are specified.		X		Descriptive document of the HBP of the Sumar Program. Communication tools exist to facilitate its understanding by providers and patients.	The HBP does not explicitly guarantee the medicines and devices associated with the lines of care and included services. As an exception, medicines are explicitly listed within the high-complexity care modules financed by the National Health Equity Fund. It is worth noting that medicines are covered and available free of charge for the population with exclusive public coverage through other national health policies (such as the Remediar Program the Incluir Salud Program, among others).	Established
	Target population groups: Technical eligibility criteria (age band, risk factors, disease stages) are provided.			X		The target population is explicitly identified in the descriptive document of the Sumar Program's HBP, which also groups the services by line of care.	
	Facilities and/or service delivery levels: which facilities (e.g., primary care centers, district hospitals, etc.) must deliver specific services are indicated.			X	Sumar Program Operational Manual and Management Agreements between provinces and providers.	Management Agreements between provinces and providers. The definition of service delivery levels is determined by each province based on the categorization and service delivery capacity of providers. At the time of signing the agreements, the set of HBP services that each provider is authorized to deliver and invoice is identified.	
	Clinical guidelines and care pathways are used to define services included in the HBP.			X	Regulatory framework of the Sumar Program	The development of the Sumar Program's HBP was a participatory process involving national and provincial health authorities responsible for substantive programs. Through this process, the prioritized services to be guaranteed were defined, following technical criteria and the specifications of the associated quality guidelines. The HBP also identifies the mandatory minimum data elements to be reported, in accordance with the national quality-of-care guidelines. Care pathways are of recent development and have been applied in several prioritized lines of care, such as diabetes, cancers, congenital heart disease, acute myocardial infarction, among others.	
	Access guarantees (waiting times, referral pathways, geographic standards) are defined.	X			Regulatory framework of the Sumar Program	Access guarantees are not explicitly documented in national regulations. The exception is the package of high-complexity services financed by the National Health Equity Fund.	
	Eligibility and Referral rules: detailed criteria for who qualifies, when referrals are needed, and under what conditions services are provided.	X			Regulatory framework of the Sumar Program	Referral rules are not explicitly defined at the national level by the Sumar Program. The exception is the high-complexity modules financed by the National Health Equity Fund.	

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Verifiable	Standardized terminology: benefits entitlements are described using uniform language aligned with clinical guidelines.			X	Descriptive document of the HBP of the Sumar Program. Communication tools exist to facilitate its understanding by providers and patients.	The services included in the HBP are defined according to the guidelines of the national quality-of-care standards currently in force.	Established
	Coding systems: standardized codes (ICD, ATC, SNOMED, ICHI, etc.). are applied to services, medicines and procedures.		X		Regulatory framework of the Sumar Program	The HBP has a coding methodology specifically designed by the Sumar Program for the purpose of billing its services. There are provincial initiatives that have advanced in mapping equivalencies with the SNOMED clinical terminology and with the ICD-10 coding system, although these are not available to all subnational governments.	
	Service coverage catalogs/ manuals: official reference documents systematically classify entitlements in ways that can be tracked.		X		Provincial Ministries of Health websites, patient portals, and other digital media	The HBP is not currently published on the National Ministry of Health's website or on other digital platforms accessible to users. Instead, users access information through specific and diverse initiatives led by subnational governments.	
Enforceable	Eligibility and referral rules: expressed as binding rights/ obligations, not only technical guidance.	X			Regulatory framework of the Sumar Program	Referral rules are not explicitly defined or published.	Emerging
	Policy and budget frameworks: laws, decrees, or financing instruments formally authorize and sustain entitlements.			X	Loan agreement signed with the World Bank. Specific budget allocations from the Ministries of Health (national and provincial).	The financing of the Sumar Program is guaranteed through a loan agreement with the World Bank and annual budget allocations from the National Ministry of Health. In addition, provincial Ministries of Health co-finance the program with their own resources. The benefit package for the care of congenital conditions is also supported by a national law that guarantees its financing (Law 27,713).	
	Public accessibility: citizens have access to HBP documents in clear, understandable language (not just technical codes or catalogues).	X			Websites, patient portals, and other digital media of the Ministries of Health (national and provincial).	The HBP is not currently published on the National Ministry of Health's website or on other digital platforms. In some cases, users access it through specific initiatives led by subnational governments.	
	Accountability mechanisms: complaints procedures, appeals processes, and sanctions ensure providers and purchasers respect entitlements.	X			Regulatory framework of the Sumar Program, and websites, patient portals, and other digital media of the Ministries of Health (national and provincial).	Compliance with provider obligations is verified by an independent external audit, which issues bi-monthly reports and, when applicable, requests the application of deductions and penalties in accordance with the sanction regime established in the agreements between the national government and the providers. Users, for their part, do not have explicitly defined mechanisms or procedures to file a complaint in cases of provider non-compliance.	

Maturity statement 2: A *formally endorsed* HBPM *framework* is in place, with *clear and measurable monitoring goals* that are *aligned* with HBP objectives and updating cycle.

Emerging	Established	Advanced
Most of the following apply: **Framework:** No HBPM framework exists, or what exists is vague, incomplete, informal or not publicly available. **Clear and measurable monitoring goals:** goals expressed only as broad aspirations, lacking clarity or measurability. **Endorsement**. The framework lacks formal approval—it has no legal or institutional authority, is not referenced or used in practice, and is not accessible to the public.	Most of the following apply: **Framework:** An HBPM framework exists and is documented, but its scope or structure is incomplete. **Clear and measurable monitoring goals:** Goals are defined, but not consistently clear or measurable; partial alignment with HBP objectives. **Endorsement:** The framework may have formal approval, but is not systematically used to guide monitoring practice or package updates.	Most of the following apply: **Framework:** An official HBPM framework exists is publicly available and fully operational. **Clear and measurable monitoring goals:** Goals are clearly stated, measurable, and aligned with HBP objectives. **Endorsement:** The framework is legally or institutionally binding, embedded in routine processes, actively used in practice, and publicly accessible.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Existence of HBPM framework	An HBPM framework document exists.		X		Operational Manual of the Sumar Program	The Operational Manual of the Sumar Program (a document that forms an integral part of the agreement signed between the national government and the subnational jurisdictions) explicitly establishes the mechanisms for monitoring the HBP. Within the transfer scheme between the central level and the provinces, they submit on a monthly basis the digital database of services billed by contracted providers (known as the SIRGE report) and the registry of eligible individuals enrolled in the program, which identifies whether they have received a preventive service in the last 12 months (a monthly measurement indicator). Additionally, every four months, they submit to the national level the digital database of services for the monitoring of 10 health indicators known as "tracers."	Established
	The HBPM framework is publicly available.	X			Websites, patient portals, and other digital media of the Ministries of Health (national and provincial).	The monitoring framework is partially accessible to both the national government and the subnational governments, but for the general public only basic information is available, such as data on enrolees, compliance with the 10 performance indicators, and the associated transfers.	
Endorsement of HBPM framework	The HBPM framework has been formally approved through legal, policy, or institutional processes (law, decree, ministerial order, board resolution).		X		Operational Manual of the Sumar Program and decree approving the World Bank loan.	The Operational Manual (OM) of the Sumar Program is approved through a decree issued by the national government, within the framework of the loan agreement signed between the Nation and the international financing agency (World Bank), through which the program is funded.	Established
HBPM goals	The HBPM framework has clearly stated monitoring goals.		X		Operational Manual of the Sumar Program	The Operational Manual and technical documents explicitly describe the prioritized health objectives associated with the HBP within the monitoring framework, referring to the HBP goals and their enablers.	Established
	HBPM goals are specific and measurable (not vague aspirations).		X		Operational Manual of the Sumar Program	The defined objectives are specifically detailed and measurable, and are explicitly included in the Operational Manual, which also establishes the reporting system, verification mechanisms, and the associated audit scheme.	
	HBPM goals are aligned with HBP objectives and updating cycle.		X		Operational Manual of the Sumar Program	The monitoring framework objectives established in the Operational Manual are with the objectives of the HBP. However, the exercise of linking the HBPM findings does not always connect with the Ministry of Health's HBP management processes.	

Maturity statement 3: HBPM indicators reflect the HBP *goals* or intended outcomes of the health benefits package as well as the *direct enablers* that are operational factors driving achievement of these goals.

Emerging	Established	Advanced
Most of the following apply: **HBP goals:** HBPM indicators do not reflect HBP goals, or only a minority of them. **HBP direct enablers:** HBPM indicators do not reflect HBP direct enablers, or only a minority of them.	Most of the following apply: **HBP goals:** HBPM indicators reflect to an extent some HBP goals, but gaps remain. **HBP direct enablers:** HBPM indicators reflect to an extent some HBP direct enablers, but gaps remain.	Most of the following apply: **HBP goals:** HBPM indicators reflect most or all HBP goals. **HBP direct enablers:** HBPM indicators reflect most or all HBP direct enablers.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
HBP goals	HBPM indicators reflect HBP goals.			X	Operational Manual of the Sumar Program	The monitoring indicators defined in the Sumar Program's Operational Manual accurately reflect the objectives of the HBP.	Advanced
HBP direct enablers	HBPM indicators reflect HBP direct enablers.			X	Operational Manual of the Sumar Program	The direct enablers are established in the program's Operational Manual (user enrolment process, service purchasing mechanisms, associated information systems, reporting procedures between levels of government, etc.).	Advanced

Maturity Statement 4: HBPM indicators are *linked* to the *HBP updating cycle*.

Emerging	Established	Advanced
HBPM indicators cover the HBP updating cycle to a limited extent; or a HBP updating cycle is not in place.	HBPM indicators cover the HBP updating cycle to some extent, but gaps remain e.g., steps in the HBP updating cycle are not monitored.	HBPM indicators cover the HBP updating cycle comprehensively.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Alignment	Extent to which the HBP updating cycle is linked to HBPM indicators			X	Operational Manual of the Sumar Program	The monitoring indicators provide the necessary and sufficient evidence to inform the HBP decision-making cycle. Their regular and systematic measurement (enabled through the transfer mechanisms between the national and provincial levels) ensures the availability of updated and robust information on the delivery of services included in the benefit package.	Advanced

Maturity statement 5: HBPM indicators' definitions are formulated in a *SMART way*, *standardized* and *harmonized* with the national health information system.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
SMART: <30% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.
Standardization: <30% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.
Harmonization: <30% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.

Maturity level: advanced.

Attribute	Characteristic	<30%	30–70%	>70%	Evidence Support	Evaluator's Comments	Maturity Level
SMART	HBPM indicator definitions are formulated in a SMART way.			X	Operational Manual of the Sumar Program	The indicators are fully operationalizable and aligned with the Sumar Program's coverage priorities.	Advanced
Standardization	HBPM indicator definitions are standardized.			X	Operational Manual of the Sumar Program	Their regular and systematic measurement (enabled through the transfer mechanisms between the national and provincial levels) ensures the availability of updated and robust information on the delivery of services included in the benefit package.	Advanced
Harmonization	HBPM indicator definitions are aligned with national classification systems.			X	Operational Manual of the Sumar Program	The indicators are aligned with the nomenclature, quality definitions, and classification used by the MoH programs.	Advanced

Maturity Statement 6: Roles and responsibilities for key HBPM functions are covered by *legislation* and *procedures*, are *clear*, *complete*, *consistent*, *enforceable* and *sustainable*.

Emerging	Established	Advanced
Most of the following apply: Legal and procedural basis for HBPM is absent, or is minimal with major gaps in terms of roles and responsibilities. Roles and responsibilities are unclear, overlapping, or missing for key HBPM functions. No institution has a formal stewardship or coordination mandate. Reliance on ad hoc arrangements or donor-driven projects.	Most of the following apply: Legal and procedural basis for HBPM is in place, with some gaps and inconsistencies remaining in terms of roles and responsibilities. Most roles are formally defined, but important gaps remain (e.g., stewardship, operational coordination, or data use). Mandates may be fragmented or overlapping, leading to inconsistencies. Responsibilities are documented but not consistently enforced.	Most of the following apply: Legal and procedural basis for HBPM are in place, are comprehensive and coherent in terms of roles and responsibilities. Roles and responsibilities are fully defined, consistent, and comprehensive, covering stewardship, coordination, data production, financing, and use of findings. Mandates are institutionalized in binding documents (laws, decrees, strategies). Roles are regularly reviewed and updated to remain relevant and effective.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Legal Basis	**Existence of binding legal instruments** (laws, decrees, regulations, approved policy documents) that mention HBPM and institutions responsible for it.		X		Operational Manual of the Sumar Program	The Operational Manual (OM) of the Sumar Program, as an integral part of the Umbrella Agreement signed between the national and provincial governments, establishes the program's HBP monitoring framework. It sets out the organizational structures (national and provincial) of the management units responsible for its implementation, identifies the respective areas involved in HBP monitoring, and describes the roles, functions, and responsibilities of these units and of the different levels of government. The description of HBP monitoring activities could be further strengthened by including a dedicated chapter outlining the specific tasks carried out by all actors involved—across the national MoH, provincial health authorities (beyond the Sumar Program Management Units), and health facilities.	Established
Procedural Scope	**Formal procedures/manuals** exist for indicator selection, data governance, reporting, financing.		X		Operational Manual of the Sumar Program	The Operational Manual (OM) provides adequate detail on the procedures for recording and reporting service delivery data that feed the HBP monitoring framework, specifying formats and deadlines. It also outlines the financing arrangements for the human resources that make up the program's management units. The transfer of full responsibility for financing these Management Units to the provinces may have weakened the areas responsible for HBP monitoring, leading to loss and turnover of qualified staff.	Established
Completeness	Roles and responsibilities are **assigned for all key HBPM functions** (stewardship, coordination, data production, financing, use of findings).		X		Operational Manual of the Sumar Program	The Operational Manual (OM) provides adequate detail on the procedures for recording and reporting the service delivery data that feed the HBP monitoring framework, specifying formats and deadlines. It also outlines the financing arrangements for the human resources that make up the program's management units.	Established

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Clarity	Roles are **explicitly documented** (laws, decrees, regulations, TORs, org charts).		X		Operational Manual of the Sumar Program	The Operational Manual (OM) explicitly describes the roles of the responsible areas.	Established
Consistency	Roles are **non-overlapping and complementary** across institutions and levels.		X		Operational Manual of the Sumar Program	The roles are harmonized and complementary, as defined in the OM; however, the interactions between the Sumar Program Unit and other areas of the national and provincial MoH—as well as with providers—should be more explicitly detailed.	Established
Enforceability	Responsibilities are **binding and enforceable**, not only informal practices.		X		Operational Manual of the Sumar Program	The responsibilities are binding based on what is established in the Umbrella Agreement and the program's OM.	Established
Sustainability	Roles are **institutionalized beyond individuals or projects**, reviewed and updated periodically.		X		Operational Manual of the Sumar Program	The areas responsible for monitoring are institutionalized and form part of the organizational structures of the Ministries of Health (national and provincial), although they may have been weakened due to staff turnover and the flexibilization of Terms of Reference following the transfer of responsibility for financing Sumar Program teams to the provinces.	Established

Maturity Statement 7: Clinical guidance documents are explicitly linked to HBP monitoring to ensure appropriate, high-quality care.

Emerging	Established	Advanced
Most of the following apply: Clinical Practice Guidelines exist but are **not linked** to HBPM monitoring. No processes ensure their use in defining indicators or quality standards. Monitoring is based on **ad hoc criteria** or data availability.	Most of the following apply: Clinical Practice Guidelines are partially linked to HBPM monitoring. Some indicators or quality checks are derived from guidelines, but the linkage is inconsistent or informal. Processes exist but lack systematic application across all programs.	Most of the following apply: Clinical Practice Guidelines are fully integrated into HBPM monitoring. Formal processes ensure they inform indicator definitions, quality measurement, and performance review. Updates to guidelines are systematically reflected in HBPM indicators, guaranteeing alignment over time.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Existence	Clinical Practice Guidelines formally exist (national protocols, standards).		X		Resolutions of the National Ministry of Health	Clinical practice guidelines are approved through resolutions issued by the National Ministry of Health. Some lines of care and services included in the HBP still lack approved and published quality guidelines. There is a need to consolidate a standardized methodology for developing clinical guidelines, such as the GRADE approach.	Established
Linkage	Clinical Practice Guidelines' recommendations are explicitly referenced in interventions/services covered by the HBP, and in HBPM indicators, standards, or reports.			X	Descriptive document of the Sumar Program's Health Benefit Package (HBP)	The HBP defines the quality attributes for all health services established in the clinical practice guidelines. The linkage is direct and comprehensive. The quality dimensions of the covered services are part of the HBPM.	Advanced
Consistency	The linkage is **systematic across** the continuum of care covered by the HBP, not ad hoc.			X	Descriptive document of the Sumar Program's Health Benefit Package (HBP)		Advanced
Institutionalization	**Formal mechanisms** (approved policies, laws, regulations, committees) ensure Clinical Practice Guidelines inform monitoring.			X	Operational Manual of the Sumar Program	The Operational Manual (OM) explicitly establishes the mandatory reporting of the minimum data required for each service in order to verify compliance with the quality attributes defined by the clinical guidelines.	Advanced
Updating	Clinical Practice Guidelines are **regularly updated and integrated** into HBPM revisions.		X		Analysis of the Ministry of Health resolutions that approve clinical practice guidelines	The updating of clinical practice guidelines is carried out at the initiative of the substantive area responsible for each specific health program. There is no regular or institutionalized process for reviewing quality guidelines led by the National Ministry of Health. In general, updates to clinical practice guidelines are incorporated relatively promptly; however, this activity is not formally standardized or procedurally defined.	Established

Maturity Statement 8: HBPM results inform HBP updates.

Emerging	Established	Advanced
Most of the following apply: HBPM results are produced but rarely referenced in HBP policy or update decisions. No formal mechanism ensures that findings influence revisions, financing allocations, or service inclusion/exclusion. Monitoring exists mainly as a diagnostic exercise, disconnected from policy cycles.	Most of the following apply: HBPM results are occasionally referenced in some steps of the update cycle (e.g., pilot revisions, adjustments to a subset of services). Partial mechanisms exist: technical committees may review data, but there is no binding requirement linking findings to package revisions or budgetary decisions. Use of results depends heavily on leadership will or external pressure.	Most of the following apply: HBPM results are systematically used to inform multiple steps of the HBP cycle (priority-setting, evidence appraisal, review of reimbursement and payment methods, fiscal and budget assessment, stakeholder deliberation, etc.). Formal mandates exist (laws, decrees, guidelines) requiring HBPM reporting as an input to HBP revisions. Evidence of policy impact is documented (e.g., revisions or financing changes explicitly citing HBPM findings).

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Formal Mandate	Laws, decrees, or guidelines require HBPM reporting as input to **multiple steps** of the HBP cycle, such as priority-setting, budget allocation, inclusion/exclusion, monitoring, revision—depending on context.		X		Operational Manual of the Sumar Program Regular reports from the Capitated Transfers Unit, the Financial Supervision and Audit Unit, the Service Coverage Supervision and Audit Unit, the Strategic Planning Unit, and others.	The program's national management unit has departments responsible for the HBP review process, which draw on the results of the monitoring framework. Although the review process is carried out on an ongoing basis, the program's regulatory framework does not explicitly and systematically establish the methodology or timeframe for triggering managing the HBP cycle.	Established
Policy Use	HBPM results explicitly cited in **priority-setting and service inclusion/exclusion** decisions.		X		Operational Manual of the Sumar Program	The reports produced by these departments explicitly reference the results of the HBP monitoring framework.	Established
Budget Linkage	HBPM findings are referenced in **budget allocation, resource adjustments, or fiscal space assessments.**		X		Operational Manual of the Sumar Program Regular reports from the Capitated Transfers Unit, the Financial Supervision and Audit Unit, the Service Coverage Supervision and Audit Unit, the Strategic Planning Unit, and others.	The results of the monitoring framework are considered annually for the program's financial planning.	Established
Committee Use	Technical committees and advisory bodies systematically review HBPM results across **decision steps.**		X		Financial Planning Reports of the Sumar Program	The monitoring results inform the decision-making criteria of the program's management unit, but there is no clearly defined procedure in place for this purpose.	Established
Documented Impact	Policy, financing, or package revisions are **formally traceable** to HBPM evidence (e.g., laws, decrees, official reports).	X			Operational Manual of the Sumar Program Regular reports from the Capitated Transfers Unit, the Financial Supervision and Audit Unit, the Service Coverage Supervision and Audit Unit, the Strategic Planning Unit, and others.	The reviews are developed based on the results of the HBP monitoring framework but they are not easily traceable, as there is no defined process or specific documentation that describes it.	Emerging
Monitoring Link	HBPM results are used in **implementation monitoring and performance reviews** of the HBP.		X			The information generated through HBP monitoring guides the program's design and implementation decisions;	Established
Revision Trigger	HBPM results systematically trigger **periodic HBP revisions** in line with national guidelines.		X			The HBPM results inform internal discussions and can trigger periodic reviews of the HBP; however, this activity is not sufficiently formalized and, as a result, is not carried out systematically or with the required technical rigor. This process could be more comprehensive, detailed, robust, and clearly prioritized. Although the review process is carried out on an ongoing basis, the program's regulatory framework does not explicitly and systematically establish the methodology or timeframe for triggering the review.	Established

Maturity Statement 9: Managerial, technical, and financial resources are backing HBPM.

Emerging	Established	Advanced
Most of the following apply: Resources are insufficient, unpredictable, and largely dependent on external support. No structured training or technical capacity for HBPM. Resource allocation is ad hoc and unstable.	Most of the following apply: Resources are partially adequate but unstable or concentrated in one level of the system. Ad hoc capacity-building activities exist but are not sustained. Funding is allocated but vulnerable to reallocation or discontinuity.	Most of the following apply: Resources are stable, sufficient, and equitably distributed across all levels. Sustained efforts exist to build and retain technical and managerial capacity. Funding is institutionalized within government budgets, ensuring long-term sustainability.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Financial	**Stable, predictable funding** for HBPM activities is allocated in budgets.		X		Loan agreement signed with the World Bank. Specific budget allocations from the Ministries of Health (national and provincial).	The annual budgets (national and provincial) include specific allocations for financing the program's management units responsible for monitoring. At the national level, this is additionally supported by the financial backing of the current loan agreement with the World Bank. However, the transfer of responsibility for financing the Sumar Program's Management Units to the provinces may have weakened this initial achievement of the Program.	Established
Managerial	**Dedicated staff/units** exist for planning and coordinating HBPM.		X		Operational Manual of the Sumar Program	The organizational charts defined in the Operational Manual (OM) identify the departments responsible for monitoring the HBP. The document also specifies the required training and specific experience for personnel occupying these positions. However, at the provincial level, the implementation of monitoring activities may have been weakened due to the transfer of responsibility for financing the Sumar Program teams to the provinces.	Established
Technical	**Trained personnel and tools** are available for HBPM implementation.		X		Operational Manual of the Sumar Program	The Operational Manual (OM) defines the human resources (and professional profiles) that make up the departments responsible for HBP monitoring. This is fulfilled at the national level, although the competencies of these professionals may have become more heterogeneous in recent years, as institutional responsibilities and capacities have diversified across jurisdictions, with limited evidence of sustained national-level support to ensure consistent capacity over time.	Established
Distribution	Resources for HBPM are **equitably distributed** across national and subnational levels.		X		Operational Manual of the Sumar Program	The national level has specific resources for HBPM activities. However, the National MoH has stopped providing financial support to the provinces for HBPM; current support is technical rather than financial.	Established
Sustainability	**Capacity building is institutionalized** (continuous training, retention).		X		Operational Manual of the Sumar Program	The program's regulatory framework does not explicitly include a capacity-development plan. The institutionalization of the management units (through specific regulations that created them and the co-financing provided by the provinces) and their integration into the organizational structures of the Ministries of Health have contributed to stability within the technical teams. Nevertheless, competency development is not systematized, and various factors have affected the ability to retain or attract qualified personnel for these tasks—particularly salary levels.	Established

Maturity Statement 10: HBPM results are communicated to multiple audiences and government levels.

Emerging	Established	Advanced
Most of the following apply: No structured communication of HBPM results. HBPM results are rarely shared beyond internal technical teams. No public communication or accountability mechanisms.	Most of the following apply: Communication occurs, but irregularly or ad hoc. Only a selection of HBPM indicators is communicated. Audiences are limited (e.g., only national policymakers). Results are sometimes shared with subnational levels or providers, but not systematically.	Most of the following apply: All HBPM results are disseminated regularly and systematically. Targeted communication reaches national and subnational policymakers, providers, civil society, and the public. Formats are accessible and user-friendly (dashboards, reports, summaries). Dissemination is institutionalized in mandates or procedures, ensuring sustainability.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Completeness	HBPM results are **disseminated in full**, per the HBPM framework.		X		Operational Manual of the Sumar Program	The Operational Manual (OM) establishes the mechanisms through which HBP monitoring results are systematically shared (e.g., measurement of basic effective coverage indicators and tracers). However, there is room for improvement to make these mechanisms more comprehensive, up-to-date, tailored to different target audiences, and more frequent. A key area that requires significant strengthening is communication and dissemination among health providers.	Established
Regularity	HBPM results are disseminated **regularly and not ad hoc**.		X		Operational Manual of the Sumar Program	The OM defines the formats and deadlines for the measurements and reports associated with monitoring.	Established

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Audiences	HBPM results are shared with **multiple audiences** (policymakers, providers, civil society, public).		X		Operational Manual of the Sumar Program	The OM specifies the communication channels for disseminating results, directed specifically to health authorities, the technical teams responsible for program management, and the health teams of contracted providers. However, the systematic and explicit communication of results to civil society and the general public is not envisaged.	Established
Levels	HBPM results reach **both national and subnational levels** of government.		X		Operational Manual of the Sumar Program	Both levels of government systematically access the HBP monitoring results.	Established
Accessibility	HBPM results are **accessible in user-friendly formats** (reports, dashboards, summaries).		X		Operational Manual of the Sumar Program	It is a task that can continue to evolve and be further developed, but it is already institutionalized.	Established
Institutionalization	The dissemination of HBPM results is **mandated and standardized** as part of HBPM routines.	X			Operational Manual of the Sumar Program	In line with the OM, both levels of government systematically access the HBP monitoring results, which are accessible due to the procedures, formats, and deadlines established in the OM. However, the dissemination of results to civil society and the general public is not explicitly foreseen.	Emerging

Maturity statement 11: HBPM aligned with *national HIS norms,* using *standardized codes* and *classifications* to ensure data comparability, efficiency, and sustainability.

Emerging	Established	Advanced
Most of the following apply: **National HIS norms:** largely absent or incomplete, covering few aspects of data management. Reporting formats, governance, interoperability, and data quality protocols are unclear, and policies are not widely accessible, leading to fragmented implementation. **Interoperability standards and codes:** are limited or absent, inconsistently applied, and rarely machine-readable, reducing comparability across programs. **Classification systems:** limited or inconsistently applied, with minimal use for monitoring or decision-making.	Most of the following apply: **National HIS norms:** exist and cover most areas, but application across HBP related HIS is inconsistent. Standards, reporting formats, and governance frameworks are partially implemented, with policies accessible to some levels. **Interoperability standards and codes** exist for most areas and are partially applied, improving data comparability, though gaps and inconsistent implementation remain. **Classification systems: systems** cover most relevant areas and are partially used, improving data aggregation and analysis, but use in decision-making is inconsistent.	Most of the following apply: **National HIS norms:** fully documented and consistently applied for HBPM and across levels, covering key aspects of data management. Policies, reporting formats, interoperability, governance, and data quality protocols are systematically applied, ensuring efficiency and comparability. **Interoperability standards and codes** (e.g., ICD, SNOMED CT, LOINC, HL7/FHIR, and national identifiers): extensively applied for HBPM. Codes are machine-readable and support integrated monitoring, reporting, and efficient HIS operations. **Classification systems:** implemented and consistently applied for HBPM, supporting aggregation, analysis, reporting, and evidence-informed decisions.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
National HIS Norms	Official policies, and technical standards for HBPM exist.			X	Operational Manual of the Sumar Program	The Operational Manual (OM) establishes the technical standards for the process of collecting and reporting digital data for HBP monitoring, as well as the information systems that must be used.	Advanced
	Standards define data collection, storage, sharing, and use across the health system.			X	Operational Manual of the Sumar Program	The standards are common to all subnational jurisdictions participating in the program.	Advanced
	Reporting formats, interoperability requirements, governance frameworks, and data quality protocols are clearly defined.			X	Operational Manual of the Sumar Program	The OM defines the format of the reports (sworn statements), the data structure, and the valid information sources for monitoring.	Advanced
	Policies and standards are accessible to all programs and levels of care relevant to HBP implementation.			X	Operational Manual of the Sumar Program	The policies and standards are accessible to both the national government and the provincial governments.	Advanced
	National HIS norms are applied consistently in practice.			X	Umbrella Agreement between the national and provincial governments, and the Operational Manual of the Sumar Program	Compliance with national SIS standards is mandatory and constitutes a requirement for the continuation of intergovernmental transfers.	Advanced

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Interoperability Standards and Codes	Uniform, machine-readable codes and identifiers exist for health conditions, services, facilities, and populations, ensuring consistent data representation across platforms.			X	Billing System of the Sumar Program	The Sumar Program's service billing system enables the nominal identification of the person who received the service, the provider delivering it, the quality attributes associated with the service, and the date on which it was provided.	Advanced
	Examples include ICD for diagnoses, SNOMED for clinical terms, LOINC for laboratory tests, HL7/FHIR for data exchange, and national codes for patients, facilities, insurance claims, and drugs.	X			Descriptive document of the Sumar Program's Health Benefit Package (HBP)	As previously mentioned, the Sumar Program's HBP includes an ad hoc coding system designed for billing purposes.	Emerging
	These codes are applied consistently across programs or subsystems supporting HBP implementation.			X	Billing System of the Sumar Program	The HBP coding system is parameterized within the billing tool used by all contracted providers.	Advanced
	These codes enable interoperability, data comparability and seamless information exchange across the HIS.		X		Billing System of the Sumar Program	The codes for each service are visible within the billing system. As this is a program-specific coding system, its interoperability and comparability require the development of equivalency mapping.	Established

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Classification systems	Structured classification systems exist for aggregation and analysis of coded health data.			X	Descriptive document of the Sumar Program's Health Benefit Package (HBP)	The HBP coding system is structured by line of care, facilitating analysis and comparison.	Advanced
	Classification systems like ICD chapters, ATC for medicines, DRG for service outputs, or program-specific categories are available and used where relevant.		X		Billing System of the Sumar Program	The development of equivalencies with other classification systems is driven by specific provincial initiatives; however, these equivalencies are not available or published at the national level.	Established
	Classifications are applied consistently across programs and subsystems relevant to HBP implementation.			X	Operational Manual of the Sumar Program and Descriptive document of the Sumar Program's Health Benefit Package (HBP)	The HBP coding system is used uniformly across all health programs.	Advanced
	Classification outputs are systematically used for monitoring, reporting, and policy decisions.			X	Descriptive document of the Sumar Program's Health Benefit Package (HBP)	The coding system facilitates HBP monitoring through its structure based on prioritized lines of care, supporting the generation of the specific reports produced by the program's management units.	Advanced

Maturity statement 12: HIS supports a strong data use culture by *sharing raw and analysed HBPM data* accessible across all levels, and by providing *dashboards and feedback loops* to *drive regular reviews* and HBP-related decisions within the benefit-package monitoring and update cycle.

Emerging	Established	Advanced
Most of the following apply: **Data sharing:** No indication that data are shared, or it is shared sporadically, with access restricted to certain health programs. **Dashboards and feedback loops:** No indication they are present, or they exist and are used rarely. **Data use:** No indication of HIS data used in evidence-informed decisions, or ad hoc use.	Most of the following apply: **Data sharing:** Data shared at some levels, but not all; access protocols exist but are inconsistently applied. **Dashboards and feedback loops:** Available, but gaps remain in their design and use (e.g., in some health programs but not others; staff are not trained to use all functionalities). **Data use:** Some data are used in decision-making, but gaps remain (e.g., not used systematically; follow-up actions are not documented).	Most of the following apply: **Data sharing:** Data accessible at national, subnational, and facility levels with clear protocols. **Dashboards and feedback loops:** Dashboards and feedback loops are fully functional and widely used to track HBP performance. **Data use:** Structured HBP reviews processes systematically reference HIS data with documented actions policy decisions based on evidence.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Data sharing across all levels	Raw and analyzed HBPM data is accessible at national, subnational, and facility levels through the HIS.		X		Billing System of the Sumar Program, and reporting system between the national and provincial levels (Beneficiary Registry, Tracer Indicators, and SIRGE database)	Subnational governments and providers can access HBP service production data through the Sumar Program's billing system. The national government accesses this information through a monthly report of billed services submitted by the participating subnational governments, known as SIRGE. However, access is not yet fully uniform or seamlessly integrated across all levels in real time, and some data flows remain mediated through jurisdictional reporting arrangements.	Established
	Data-sharing protocols or SOPs exist and are followed.		X		Operational Manual of the Sumar Program	The process for reporting billed service data from subnational governments to the national level is defined in the OM, which specifies the required format, deadlines for submission, and sanctions applicable in case of non-compliance. However, protocols mainly support upward reporting, and more interoperable data-sharing across levels could further strengthen institutionalization.	Established
	Users at all levels have appropriate access to HIS data.		X		Operational Manual of the Sumar Program	Access to data by both national and subnational governments is established in the OM, ensuring its usability. Facility-level access and analytical use may vary across jurisdictions, pointing to opportunities for further standardization and capacity-building.	Established

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Dashboards and feedback loops	Dashboards exist within HIS to visualize HBPM data for decision-making.		X		Billing System of the Sumar Program, and reporting system between the national and provincial levels (Beneficiary Registry, Tracer Indicators, and SIRGE database)	The program's information systems (billing, enrollment, and tracer systems) allow for the analysis of production levels and performance against prioritized health indicators. However, the use of these tools could be further strengthened through more systematic institutionalization and expanded functionality tailored to different decision-making levels.	Established
	Feedback mechanisms (reports, alerts, summaries) are provided for action.		X		Reports from the Capitated Transfers Unit, the Supervision and Audit Unit, the Service Coverage Unit, etc.	There are specific managerial units within the program's management structure that generate regular reports providing targeted analyses to guide the action plan (e.g., capitation, strategic planning, service coverage, and supervision and audit areas). Nonetheless, there remains scope to formalize reporting routines by frequency, level of detail, and audience, particularly to enhance feedback and usability for frontline health facilities and provincial teams.	Established
	Staff are trained and use dashboards and feedback mechanisms effectively.		X		Operational Manual of the Sumar Program	The Sumar Program management units include managerial and technical teams assigned to these functions and trained in the use of information generated through feedback mechanisms. At the same time, documentation of systematic training approaches and the continuous development of new tools to broaden data use across all implementation levels remains limited, suggesting opportunities for further capacity-building.	Established

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Data use for HBP-related reviews decisions	HIS data are used systematically in structured HBP review and update processes.		X		Operational Manual of the Sumar Program	The program has established processes for analyzing and reviewing the HBP, with designated managerial units responsible for these functions. However, further formalization of routine review cycles and clearer procedural linkages to package updates could strengthen systematic use over time.	Established
	Review meetings, performance dashboards, or reports reference HIS data to inform HBP decisions.		X		Reports from the Capitated Transfers Unit, the Supervision and Audit Unit, the Service Coverage Unit, etc.	The set of reports generated by the program's various managerial units draws specifically on data provided by the information systems used. Opportunities remain to ensure that these analytical products are consistently embedded in structured decision-making forums across all jurisdictions.	Established
	HIS data informs planning, policy, and operational decisions within the HBP update cycle.		X		Operational Manual of the Sumar Program	The digital data generated by the program's information systems guide the process of reviewing and updating the HBP, with designated managerial units responsible for this function. Nonetheless, the extent to which data-driven recommendations translate into routine and standardized package adjustment processes could be further strengthened.	Established
	Evidence of follow-up actions or policy adjustments based on HIS data is documented.		X		Operational Manual of the Sumar Program	The actions defined through this process are documented in technical reports produced by the program's managerial units. Greater consistency in documenting follow-up actions and linking them explicitly to benefit package revisions would further reinforce institutional learning and accountability.	Established

Maturity statement 13: The HIS is primarily funded by *domestic financing* to ensure sustainability and national ownership, with *strong privacy and ethical safeguards* that protect data, reinforce trust, and uphold accountability.

Emerging	Established	Advanced
Most of the following apply: **Domestic financing:** No domestic financing provisions for HBPM. Domestic financing is minimal or ad hoc. No long-term financial sustainability plan. **Privacy and ethical safeguards:** No indication of privacy and ethical safeguards applicable. Privacy policies, consent frameworks, or access controls are absent or rarely enforced.	Most of the following apply: **Domestic financing:** Some domestic financing provisions for HIS, with gaps remaining (e.g., domestic financing covers some but not all HIS functions; there are no long-term sustainability plans). **Privacy and ethical safeguards:** Policies and safeguards exist but are inconsistently applied, limited evidence of audits being conducted or enforcement mechanisms in place.	Most of the following apply: **Domestic financing:** Stable and comprehensive domestic financing covers all core HIS operations, ensuring sustainability and ownership. **Privacy and ethical safeguards:** Comprehensive privacy and ethical policies, technical safeguards, and consent frameworks are in place, regularly audited and consistently enforced.

Maturity level: emerging.

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Domestic Financing	The HIS is primarily funded through national or subnational government budgets rather than external donors.		X		Budget allocations of the National Ministry of Health and the World Bank loan agreement	The program's information systems are financed by the national government.	Established
	Budget allocations for HIS are documented in official budgets or financing plans.		X		Budget allocations of the National Ministry of Health and the World Bank loan agreement	Financing for the program's information systems is guaranteed through specific budget allocations and the World Bank loan agreement currently in force.	Established
	Expenditure reports confirm that domestic funds are used for HIS operations and maintenance.		X		Budget allocations of the National Ministry of Health	Annual budget allocations enable verification of funding for the maintenance of the HIS, including the hiring of specialized human resources assigned to this function.	Established
	Long-term sustainability plans reflect continued domestic financing.	X			World Bank loan agreement	The existence of a World Bank loan agreement ensures the sustainability of financing over time.	Emerging

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support	Evaluator's Comments	Maturity Level
Privacy and Ethical Safeguards	Policies exist covering confidentiality, ethical use, and data protection.	X			Regulatory framework of the Sumar Program (Technical document)	Because health data are considered personal and sensitive, the national personal data protection law applies. Nonetheless, the program does not have specific policies for the handling of sensitive data explicitly defined within its regulatory framework.	Emerging
	Technical measures such as access controls, secure storage, anonymization, and authentication are implemented.	X			Regulatory framework of the Sumar Program (Technical document)	There is a set of good practices in place for accessing and processing program data, applied by the technical staff responsible for this function within the program's management units. However, these good practices are not explicitly documented in the program's normative framework.	Emerging
	Data-sharing agreements, consent frameworks, or SOPs demonstrate ethical compliance.	X			Regulatory framework of the Sumar Program (Technical document)	Good practices for data exchange are applied in practice but are not explicitly defined in the program's regulatory instruments.	Emerging
	Evidence of monitoring, audits, or compliance assessments confirms safeguards are applied.	X			Regulatory framework of the Sumar Program (Technical document)	Regular audits or reviews to verify compliance with good practices in the handling of sensitive data are not implemented.	Emerging
	Transparency mechanisms are in place (e.g., governance frameworks, public reports) to reinforce accountability and trust.	X			Regulatory framework of the Sumar Program (Technical document)	The program does not have regular or systematic mechanisms in place to reinforce accountability.	Emerging

Annex 4. Details on the HBPM maturity assessment of the GES, Chile

Maturity Statement 1: Health benefits are defined *clearly*, in sufficient *detail* to be operational, *verifiable*, and *enforceable*.

Emerging	Established	Advanced
Most of the following apply: **Clarity:** Only fragments of what is covered are described; benefits are vague or inconsistent, leaving patients and providers uncertain about entitlements. **Detail:** Minimal operational guidance is available; at most one or two elements (e.g., a list of medicines or conditions) are specified, while referral rules, facilities, and access guarantees are absent. **Verifiable:** No consistent use of standardized terminology, coding, or catalogs; monitoring is not possible. **Enforceable:** Eligibility and coverage rules are missing or not binding; patients cannot reliably claim entitlements.	Most of the following apply: **Clarity:** Benefits are partially described in official documents; patients and providers have some understanding of what is covered, though important gaps remain. **Detail:** Several elements (e.g., medicines, eligibility criteria, authorized providers) are included, but other aspects (such as access guarantees or referral rules) are incomplete or missing. **Verifiable:** Some standardized terminology or coding is applied, but coverage is inconsistent and monitoring remains limited. **Enforceable:** Some entitlements exist on paper, but accountability and redress mechanisms are weak or not fully operational.	Most of the following apply: **Clarity:** Benefits are comprehensively described in plain language; patients, providers, and purchasers all clearly understand entitlements and conditions. **Detail:** Most elements are included—services, medicines, providers, facilities, eligibility/referral rules, and access guarantees—making the package fully operational. **Verifiable:** Standardized terminology, coding systems, and catalogues are systematically applied, enabling reliable monitoring and reporting. **Enforceable:** Rights and obligations are legally established, backed by policy and budget frameworks; HBP documents are public, and complaints/appeals processes ensure accountability.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Clarity	Plain-language description of what is covered (inclusions, exclusions, service categories, benefit limits) stated in non-technical terms			x	27, 28
	Target population groups and related eligibility or clinical indications			x	27, 28
	Which providers deliver the services: authorized providers and the levels of care (primary, secondary, tertiary) are listed.			x	27, 28
	Financial protection: rules for co-payments, exemptions, out-of pocket caps and guarantees of financial protection are specified			x	27, 28
	Access pathway: the first point of contact (e.g., primary care) and simple referral expectations are defined.			x	27, 28
Detail (Operational)	Procedures, medicines, devices, and activities (included and/or excluded) are specified			x	28
	Target population groups: Technical eligibility criteria (age band, risk factors, disease stages) are provided.			x	28
	Facilities and/or service delivery levels: which facilities (e.g., primary care centers, district hospitals, etc.) must deliver specific services are indicated.			x	28
	Clinical guidelines and care pathways are used to define services included in the HBP.			x	10
	Access guarantees (waiting times, referral pathways, geographic standards) are defined.			x	29
	Eligibility and Referral rules: detailed criteria for who qualifies, when referrals are needed, and under what conditions services are provided			x	8, 28

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Verifiable	Standardized terminology: benefits entitlements are described using uniform language aligned with clinical guidelines.			x	28
	Coding systems: standardized codes (ICD, ATC, SNOMED, ICHI, etc.). are applied to services, medicines and procedures.		x		4, 23 GES uses its own coding system to identify interventions. For the basket resources consumed, there is a combination: resources that are tariffed, such as consultations, bed-days, exams and procedures, FONASA tariff codes are used. For resources that are not tariffed, such as drugs and supplies, or certain types of consultations and procedures, GES uses its own coding system.
	Service coverage catalogs/manuals: official reference documents systematically classify entitlements in ways that can be tracked.		x		4, 23
Enforceable	Eligibility and referral rules: expressed as binding rights/obligations, not only technical guidance			x	8
	Policy and budget frameworks: laws, decrees, or financing instruments formally authorize and sustain entitlements.			x	8, 28
	Public accessibility: citizens have access to HBP documents in clear, understandable language (not just technical codes or catalogues).			x	27
	Accountability mechanisms: complaints procedures, appeals processes, and sanctions ensure providers and purchasers respect entitlements.		f	i	5, 6, 30, 2 En Isapres (private), accountability mechanisms have worked, and guarantees are complied with practically 100 percent. In FONASA (public), there is incompliance with some guarantees, particularly timeliness (waiting list), for which the accountability mechanism cannot be enforced.

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 2: A *formally endorsed* HBPM *framework* is in place, with *clear and measurable monitoring goals* that are *aligned* with HBP objectives and updating cycle.

Emerging	Established	Advanced
Most of the following apply: **Framework:** No HBPM framework exists, or what exists is vague, incomplete, informal or not publicly available. **Clear and measurable monitoring goals:** goals expressed only as broad aspirations, lacking clarity or measurability. **Endorsement:** The framework lacks formal approval—it has no legal or institutional authority, is not referenced or used in practice, and is not accessible to the public.	Most of the following apply: **Framework:** An HBPM framework exists and is documented, but its scope or structure is incomplete. **Clear and measurable monitoring goals:** Goals are defined, but not consistently clear or measurable; partial alignment with HBP objectives. **Endorsement:** The framework may have formal approval, but is not systematically used to guide monitoring practice or package updates.	Most of the following apply: **Framework:** An official HBPM framework exists is publicly available and fully operational. **Clear and measurable monitoring goals:** Goals are clearly stated, measurable, and aligned with HBP objectives. **Endorsement:** The framework is legally or institutionally binding, embedded in routine processes, actively used in practice, and publicly accessible.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Existence of HBPM framework	An HBPM framework document exists.		x		5, 6, 8: Art.19 There is not an HBPM framework per se. The Health Superintendence is the legal auditing and monitoring body of the GES, and carries out several auditing and monitoring activities, which are documented individually, but not as part of a framework.
	The HBPM framework is publicly available.			x	9 While there is not one HBPM framework, all auditing and monitoring rules publicly available.
Endorsement of HBPM framework	The HBPM framework has been formally approved through legal, policy, or institutional processes (law, decree, ministerial order, board resolution).			x	5, 6, 8: Art.19 While there is not an HBPM framework, all auditing and monitoring rules set forth by the Health Superintendence are official.
HBPM goals	The HBPM framework has clearly stated monitoring goals.			x	While there is not an HBPM framework, the HBP goals are very explicit (the four guarantees), and compliance with these guarantees is expected to be enforced at a 100 percent. In the GES everything is explicit, except monitoring.
	HBPM goals are specific and measurable (not vague aspirations).			x	28, 29 The four guarantees are very explicit, and (implicitly) a 100 percent compliance is expected.
	HBPM goals are aligned with HBP objectives and updating cycle.			x	8: Art.19, 4 The law (8: Art.19) says that GES data should be used in the triannual cost verification studies (4)

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 3: HBPM indicators reflect the HBP *goals* or intended outcomes of the health benefits package as well as the *direct enablers* that are operational factors driving achievement of these goals.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
HBP goals: HBPM indicators do not reflect HBP goals, or only a minority of them.	**HBP goals:** HBPM indicators reflect to an extent some HBP goals, but gaps remain.	**HBP goals:** HBPM indicators reflect most or all HBP goals.
HBP direct enablers: HBPM indicators do not reflect HBP direct enablers, or only a minority of them.	**HBP direct enablers:** HBPM indicators reflect to an extent some HBP direct enablers, but gaps remain.	**HBP direct enablers:** HBPM indicators reflect most or all HBP direct enablers.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
HBP goals	HBPM indicators reflect HBP goals.			x	The Health Superintendence audits compliance with the four GES guarantees.
HBP direct enablers	HBPM indicators reflect HBP direct enablers.		x		The Health Superintendence does not look at specific GES enablers, except for the quality guarantee which is directly enabled by the Health Superintendence accreditation process. Enablers of other GES guarantees are the responsibility of insurers, and are not directly measured by the Health Superintendence, at least not specifically for GES.

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity Statement 4: HBPM indicators are *linked* to the *HBP updating cycle.*

Emerging	Established	Advanced
HBPM indicators cover the HBP updating cycle to a limited extent; or a HBP updating cycle is not in place.	HBPM indicators cover the HBP updating cycle to some extent, but gaps remain e.g., steps in the HBP updating cycle are not monitored.	HBPM indicators cover the HBP updating cycle comprehensively.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Alignment	Extent to which the HBP updating cycle is linked to HBPM indicators		x		GES decision-making is guided by the "Consejo consultivo GES" (31), supported by triannual cost studies (4), which use GES utilization data for their projections. Also, any new problems added to the GES are immediately incorporated into Health Superintendence audits. On the other hand, the triannual cost studies do not use GES cost data (normative assumptions about these are still in place). Also, besides using GES utilization for projections and ensuring a sufficient budget for new health problems, the extent to which decisions about the GES are based on monitoring indicators is limited. For example, the most recent update to the GES added 3 new health problems, while waiting list persist for older problems.

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 5: HBPM indicators' definitions are formulated in a *SMART way*, *standardized* and *harmonized* with the national health information system.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
SMART: <30% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.	**SMART:** 30–70% of HBPM indicator definitions are SMART.
Standardization: <30% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.	**Standardization:** 30–70% of HBPM indicator definitions are standardized.
Harmonization: <30% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.	**Harmonization:** 30–70% of HBPM indicator definitions are harmonized with national classification systems.

Maturity level: advanced.

Attribute	Characteristic	<30%	30–70%	>70%	Evidence Support
SMART	HBPM indicator definitions are formulated in a SMART way.			x	GES guarantees are explicitly and clearly defined as part of the GES design (28, 29). Preventive intervention monitoring indicators are also clearly defined (11, 12).
Standardization	HBPM indicator definitions are standardized.			x	
Harmonization	HBPM indicator definitions are aligned with national classification systems.			x	GES indicators are separate from other HIS. The four GES guarantees (access, timeliness, financial protection and quality) are clearly defined, and different than other health indicators (mortality and birth rate definitions, etc.).

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity Statement 6: Roles and responsibilities for key HBPM functions are covered by *legislation* and *procedures*, are *clear*, *complete*, *consistent*, *enforceable* and *sustainable*.

Emerging	Established	Advanced
Most of the following apply:	Most of the following apply:	Most of the following apply:
Legal and procedural basis for HBPM is absent, or is minimal with major gaps in terms of roles and responsibilities.	Legal and procedural basis for HBPM is in place, with some gaps and inconsistencies remaining in terms of roles and responsibilities.	Legal and procedural basis for HBPM are in place, are comprehensive and coherent in terms of roles and responsibilities.
Roles and responsibilities are unclear, overlapping, or missing for key HBPM functions.	Most roles are formally defined, but important gaps remain (e.g., stewardship, operational coordination, or data use).	Roles and responsibilities are fully defined, consistent, and comprehensive, covering stewardship, coordination, data production, financing, and use of findings.
No institution has a formal stewardship or coordination mandate.	Mandates may be fragmented or overlapping, leading to inconsistencies.	Mandates are institutionalized in binding documents (laws, decrees, strategies).
Reliance on ad hoc arrangements or donor-driven projects.	Responsibilities are documented but not consistently enforced.	Roles are regularly reviewed and updated to remain relevant and effective.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Legal Basis	**Existence of binding legal instruments** (laws, decrees, regulations, approved policy documents) that mention HBPM and institutions responsible for it.			x	5, 6. 8: Art.19 While "monitoring" is not mentioned in the law, an "auditing" role is clearly placed upon the Health Superintendence, and sharing information is placed upon insurers.
Procedural Scope	**Formal procedures/manuals** exist for indicator selection, data governance, reporting, financing.			x	9: search for keyword "maestro", 11, 12. The Health Superintendence has developed the procedures.
Completeness	Roles and responsibilities are **assigned for all key HBPM functions** (stewardship, coordination, data production, financing, use of findings).			x	
Clarity	Roles are **explicitly documented** (laws, decrees, regulations, TORs, org charts).	x			Roles for "monitoring" are not clearly specified. GES has a more open policy on who's role it is to "audit" and enforce compliance with the four guarantees.
Consistency	Roles are **non-overlapping and complementary** across institutions and levels.		f	i	In Isapres, Yes In Fonasa, binding by law Yes, but not fully enforceable in practice
Enforceability	Responsibilities are **binding and enforceable**, not only informal practices.		f	i	Idem
Sustainability	Roles are **institutionalized beyond individuals or projects,** reviewed and updated periodically.		f	i	In Isapres, Yes In Fonasa, partly institutionalized, and partly dependent on Fonasa's current director

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity Statement 7: Clinical guidance documents are explicitly linked to HBP monitoring to ensure appropriate, high-quality care.

Emerging	Established	Advanced
Most of the following apply: Clinical Practice Guidelines exist but are **not linked** to HBPM monitoring. No processes ensure their use in defining indicators or quality standards. Monitoring is based on **ad hoc criteria** or data availability.	Most of the following apply: Clinical Practice Guidelines are partially linked to HBPM monitoring. Some indicators or quality checks are derived from guidelines, but the linkage is inconsistent or informal. Processes exist but lack systematic application across all programs.	Most of the following apply: Clinical Practice Guidelines are fully integrated into HBPM monitoring. Formal processes ensure they inform indicator definitions, quality measurement, and performance review. Updates to guidelines are systematically reflected in HBPM indicators, guaranteeing alignment over time.

Maturity level: established.

Feature	Characteristic	No	Partially	Yes	Evidence Support
Existence	Clinical Practice Guidelines formally exist (national protocols, standards).			x	10
Linkage	Clinical Practice Guidelines' recommendations are explicitly referenced in interventions/ services covered by the HBP, and in HBPM indicators, standards, or reports.		x		Only in the services covered by the GES, but not as part of monitoring
Consistency	The linkage is systematic across the continuum of care covered by the HBP, not ad hoc.			x	10
Institutionalization	**Formal mechanisms** (approved policies, laws, regulations, committees) ensure Clinical Practice Guidelines inform monitoring.	x			
Updating	Clinical Practice Guidelines are **regularly updated and integrated** into HBPM revisions.	x			

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity Statement 8: HBPM results inform HBP updates.

Emerging	Established	Advanced
Most of the following apply: HBPM results are produced but rarely referenced in HBP policy or update decisions. No formal mechanism ensures that findings influence revisions, financing allocations, or service inclusion/exclusion. Monitoring exists mainly as a diagnostic exercise, disconnected from policy cycles.	Most of the following apply: HBPM results are occasionally referenced in some steps of the update cycle (e.g., pilot revisions, adjustments to a subset of services). Partial mechanisms exist: technical committees may review data, but there is no binding requirement linking findings to package revisions or budgetary decisions. Use of results depends heavily on leadership will or external pressure.	Most of the following apply: HBPM results are systematically used to inform multiple steps of the HBP cycle (priority-setting, evidence appraisal, review of reimbursement and payment methods, fiscal and budget assessment, stakeholder deliberation, etc.). Formal mandates exist (laws, decrees, guidelines) requiring HBPM reporting as an input to HBP revisions. Evidence of policy impact is documented (e.g., revisions or financing changes explicitly citing HBPM findings).

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Formal Mandate	Laws, decrees, or guidelines require HBPM reporting as input to **multiple steps** of the HBP cycle, such as priority-setting, budget allocation, inclusion/exclusion, monitoring, revision—depending on context.			x	8: Art.19
Policy Use	HBPM results explicitly cited in **priority setting and service inclusion/exclusion** decisions.		x		4
Budget Linkage	HBPM findings are referenced in **budget allocation, resource adjustments, or fiscal space assessments.**		x		4
Committee Use	Technical committees and advisory bodies systematically review HBPM results across **decision steps.**		x		4
Documented Impact	Policy, financing, or package revisions are **formally traceable** to HBPM evidence (e.g., laws, decrees, official reports).	x			
Monitoring Link	HBPM results are used in **implementation monitoring and performance reviews** of the HBP.	x			
Revision Trigger	HBPM results systematically trigger **periodic HBP revisions** in line with national guidelines.	x			

Maturity Statement 9: Managerial, technical, and financial resources are backing HBPM.

Emerging	Established	Advanced
Most of the following apply: Resources are insufficient, unpredictable, and largely dependent on external support. No structured training or technical capacity for HBPM. Resource allocation is ad hoc and unstable.	Most of the following apply: Resources are partially adequate but unstable or concentrated in one level of the system. Ad hoc capacity-building activities exist but are not sustained. Funding is allocated but vulnerable to reallocation or discontinuity.	Most of the following apply: Resources are stable, sufficient, and equitably distributed across all levels. Sustained efforts exist to build and retain technical and managerial capacity. Funding is institutionalized within government budgets, ensuring long-term sustainability.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Financial	**Stable, predictable funding** for HBPM activities is allocated in budgets.			x	
Managerial	**Dedicated staff/units** exist for planning and coordinating HBPM.			x	
Technical	**Trained personnel and tools** are available for HBPM implementation.			x	
Distribution	Resources for HBPM are **equitably distributed** across national and subnational levels.		f	i	Big public/private divide in monitoring capacities. Also varies within the public sector (not all provinces use dashboard) (13, 14)
Sustainability	**Capacity building is institutionalized** (continuous training, retention).			x	

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity Statement 10: HBPM results are communicated to multiple audiences and government levels.

Emerging	Established	Advanced
Most of the following apply: No structured communication of HBPM results. HBPM results are rarely shared beyond internal technical teams. No public communication or accountability mechanisms.	Most of the following apply: Communication occurs, but irregularly or ad hoc. Only a selection of HBPM indicators is communicated. Audiences are limited (e.g., only national policymakers). Results are sometimes shared with subnational levels or providers, but not systematically.	Most of the following apply: All HBPM results are disseminated regularly and systematically. Targeted communication reaches national and subnational policymakers, providers, civil society, and the public. Formats are accessible and user-friendly (dashboards, reports, summaries). Dissemination is institutionalized in mandates or procedures, ensuring sustainability.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Completeness	HBPM results are **disseminated in full**, per the HBPM framework.		f	i	In Isapres, Yes In Fonasa, partly and dependent on Fonasa's current director
Regularity	HBPM results are disseminated **regularly and not ad hoc**.		f	i	Idem
Audiences	HBPM results are shared with **multiple audiences** (policymakers, providers, civil society, public).		f	i	They are publicly available on the Health Superintendence's website, and other sources also report partial data (13, 14, 24, 25, 26)
Levels	HBPM results reach **both national and subnational levels** of government.		f	i	
Accessibility	HBPM results are **accessible in user-friendly formats** (reports, dashboards, summaries).		f	i	
Institutionalization	The dissemination of HBPM results is **mandated and standardized** as part of HBPM routines.		f	i	The law (8: Art.19) indicates so, but challenges remain to enforce compliance in the public sector

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 11: HBPM aligned with *national HIS norms*, using *standardized codes* and *classifications* to ensure data comparability, efficiency, and sustainability.

Emerging	Established	Advanced
Most of the following apply: **National HIS norms:** largely absent or incomplete, covering few aspects of data management. Reporting formats, governance, interoperability, and data quality protocols are unclear, and policies are not widely accessible, leading to fragmented implementation. **Interoperability standards and codes:** are limited or absent, inconsistently applied, and rarely machine-readable, reducing comparability across programs. **Classification systems:** limited or inconsistently applied, with minimal use for monitoring or decision-making.	Most of the following apply: **National HIS norms:** exist and cover most areas, but application across HBP related HIS is inconsistent. Standards, reporting formats, and governance frameworks are partially implemented, with policies accessible to some levels. **Interoperability standards and codes** exist for most areas and are partially applied, improving data comparability, though gaps and inconsistent implementation remain. **Classification systems: systems** cover most relevant areas and are partially used, improving data aggregation and analysis, but use in decision-making is inconsistent.	Most of the following apply: **National HIS norms:** fully documented and consistently applied for HBPM and across levels, covering key aspects of data management. Policies, reporting formats, interoperability, governance, and data quality protocols are systematically applied, ensuring efficiency and comparability. **Interoperability standards and codes** (e.g., ICD, SNOMED CT, LOINC, HL7/ FHIR, and national identifiers): extensively applied for HBPM. Codes are machine-readable and support integrated monitoring, reporting, and efficient HIS operations. **Classification systems:** implemented and consistently applied for HBPM, supporting aggregation, analysis, reporting, and evidence-informed decisions.

Maturity level: advanced.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
National HIS Norms	Official policies, and technical standards for HBPM exist.			x	For private sector (9: search for keyword "maestro"), for public sector (32)
	Standards define data collection, storage, sharing, and use across the health system.			x	
	Reporting formats, interoperability requirements, governance frameworks, and data quality protocols are clearly defined.			x	
	Policies and standards are accessible to all programs and levels of care relevant to HBP implementation			x	
	National HIS norms are applied consistently in practice.			x	
Interoperability Standards and Codes	Uniform, machine-readable codes and identifiers exist for health conditions, services, facilities, and populations, ensuring consistent data representation across platforms.			x	
	Examples include ICD for diagnoses, SNOMED for clinical terms, LOINC for laboratory tests, HL7/FHIR for data exchange, and national codes for patients, facilities, insurance claims, and drugs.		x		GES uses its own coding system
	These codes are applied consistently across programs or subsystems supporting HBP implementation.			x	
	These codes enable interoperability, data comparability and seamless information exchange across the HIS			x	

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Classification systems	Structured classification systems exist for aggregation and analysis of coded health data			x	
	Classification systems like ICD chapters, ATC for medicines, DRG for service outputs, or program-specific categories are available and used where relevant.			x	
	Classifications are applied consistently across programs and subsystems relevant to HBP implementation.		x		Classifications are used as needed by each program/ subsystem
	Classification outputs are systematically used for monitoring, reporting, and policy decisions.		x		

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 12: HIS supports a strong data use culture by *sharing raw and analysed HBPM data* accessible across all levels, and by providing *dashboards and feedback loops* to *drive regular reviews* and HBP-related decisions within the benefit-package monitoring and update cycle.

Emerging	Established	Advanced
Most of the following apply: **Data sharing:** No indication that data are shared, or it is shared sporadically, with access restricted to certain health programs. **Dashboards and feedback loops:** No indication they are present, or they exist and are used rarely. **Data use:** No indication of HIS data used in evidence-informed decisions, or ad hoc use.	Most of the following apply: **Data sharing:** Data shared at some levels, but not all; access protocols exist but are inconsistently applied. **Dashboards and feedback loops:** Available, but gaps remain in their design and use (e.g., in some health programs but not others; staff are not trained to use all functionalities). **Data use:** Some data are used in decision-making, but gaps remain (e.g., not used systematically; follow-up actions are not documented).	Most of the following apply: **Data sharing:** Data accessible at national, subnational, and facility levels with clear protocols. **Dashboards and feedback loops:** Dashboards and feedback loops are fully functional and widely used to track HBP performance. **Data use:** Structured HBP reviews processes systematically reference HIS data with documented actions policy decisions based on evidence.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence support
Data sharing across all levels	Raw and analysed HBPM data is accessible at national, subnational, and facility levels through the HIS.		f	i	Raw patient data is openly accessible for the private sector (23). It is restricted in the public sector.
	Data-sharing protocols or SOPs exist and are followed.			x	
	Users at all levels have appropriate access to HIS data.		f	i	Raw patient data is openly accessible for the private sector (23). In the public sector it varies, for example, some provinces have made dashboards available (13, 14)

(Continued)

Attribute	Characteristic	No	Partially	Yes	Evidence support
Dashboards and feedback loops	Dashboards exist within HIS to visualize HBPM data for decision-making.		x		
	Feedback mechanisms (reports, alerts, summaries) are provided for action.	f		i	The Health Superintendence has internal alerts for auditing purposes, based on reported microdata from Isapres. Not in Fonasa
	Staff are trained and use dashboards and feedback mechanisms effectively.			x	
Data use for HBP-related reviews decisions	HIS data are used systematically in structured HBP review and update processes.		x		For all the reasons indicated previously
	Review meetings, performance dashboards, or reports reference HIS data to inform HBP decisions.			x	HIS data is used, but GES decisions depend on more than that
	HIS data informs planning, policy, and operational decisions within the HBP update cycle.			x	HIS data does inform the GES update cycle, but decisions depend on more than that
	Evidence of follow-up actions or policy adjustments based on HIS data is documented.	x			

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

Maturity statement 13: The HIS is primarily funded by *domestic financing* to ensure sustainability and national ownership, with *strong privacy and ethical safeguards* that protect data, reinforce trust, and uphold accountability.

Emerging	Established	Advanced
Most of the following apply: **Domestic financing:** No domestic financing provisions for HBPM. Domestic financing is minimal or ad hoc. No long-term financial sustainability plan. **Privacy and ethical safeguards:** No indication of privacy and ethical safeguards applicable. Privacy policies, consent frameworks, or access controls are absent or rarely enforced.	Most of the following apply: **Domestic financing:** Some domestic financing provisions for HIS, with gaps remaining (e.g., domestic financing covers some but not all HIS functions; there are no long-term sustainability plans). **Privacy and ethical safeguards:** Policies and safeguards exist but are inconsistently applied, limited evidence of audits being conducted or enforcement mechanisms in place.	Most of the following apply: **Domestic financing:** Stable and comprehensive domestic financing covers all core HIS operations, ensuring sustainability and ownership. **Privacy and ethical safeguards:** Comprehensive privacy and ethical policies, technical safeguards, and consent frameworks are in place, regularly audited and consistently enforced.

Maturity level: established.

Attribute	Characteristic	No	Partially	Yes	Evidence Support
Domestic Financing	The HIS is primarily funded through national or subnational government budgets rather than external donors.			x	In FONASA, the SIGGES is financed with government budgets complemented with mandatory contributions from beneficiaries. In the private sector, Isapre HIS are funded with beneficiary premiums.
	Budget allocations for HIS are documented in official budgets or financing plans.	x			In FONASA, there is not a specific budget line for the SIGGES. It is mixed with other health information systems. In Isapres, this information is not publicly available
	Expenditure reports confirm that domestic funds are used for HIS operations and maintenance.	x			
	Long-term sustainability plans reflect continued domestic financing.			x	
Privacy and Ethical Safeguards	Policies exist covering confidentiality, ethical use, and data protection.			x	33, 23 (citizen ID data is encrypted), 32
	Technical measures such as access controls, secure storage, anonymization, and authentication are implemented.			x	
	Data-sharing agreements, consent frameworks, or SOPs demonstrate ethical compliance.			x	9: search for "sensible", 32
	Evidence of monitoring, audits, or compliance assessments confirms safeguards are applied			x	Have not found evidence of data breach
	Transparency mechanisms are in place (e.g., governance frameworks, public reports) to reinforce accountability and trust.			x	34

Abbreviations: f – FONASA; I – Isapres; x – both FONASA and Isapres.

List of sources

#	Contents	Weblink
1	Estadísticas de acreditación de prestadores	https://www.superdesalud.gob.cl/app/uploads/2025/11/boletin-n3-2025-acreditacion-enero-septiembre-2025.pdf
2	Estadísticas de reclamos contra prestadores	https://www.superdesalud.gob.cl/app/uploads/2024/01/articles-26441_recurso_4.pdf
3	Balance de gestión Fonasa	https://www.dipres.gob.cl/597/articles-340034_doc_pdf.pdf
4	Estudios de verificación de costos (EVC) GES	https://desal.minsal.cl/regimen-ges/
5	SdS Facultad fiscalización GES	https://www.superdesalud.gob.cl/tax-acerca-de-la-superintendencia/atribuciones-de-la-institucion-segun-dfl-n1-minsal-6117/
6	SdS Facultad fiscalización GES	https://www.superdesalud.gob.cl/superintendencia/auge-ges/#:~:text=La%20Superintendencia%20de%20Salud%20tiene%20la%20facultad,y%20la%20entrega%20de%20los%20medicamentos%20garantizados.
7	Resultados de fiscalización Isapres	https://www.superdesalud.gob.cl/tax-fiscalizacion/resultados-de-la-fiscalizacion-3031/sanciones-aplicadas-5185/sanciones-a-isapres-6248/sanciones-a-isapres-2025/
8	Ley 19.966	https://www.bcn.cl/leychile/navegar?idNorma=229834
9	Circulares Isapres	https://www.superdesalud.gob.cl/tax-instrucciones-dictadas-por-la-superintendencia/para-aseguradoras-4097/circulares-2991/
10	Guías clínicas GES	https://diprece.minsal.cl/le-informamos/auge/acceso-guias-clinicas/guias-clinicas-auge/
11	Metas de cobertura de medicina preventiva	https://www.superdesalud.gob.cl/app/uploads/2025/03/circular-if-n496-2025-1.pdf
12	Manual de cálculo de cumplimiento de metas de cobertura de medicina preventiva	https://www.superdesalud.gob.cl/app/uploads/2025/02/res-exenta-if-n1990-2025-emp-manual-2025.pdf
13	Dashboard servicio de salud tarapaca	https://www.saludtarapaca.gob.cl/estadisticas/ges-estadisticas/
14	Dashboard servicio de salud metropolitana oriente	https://app.powerbi.com/view?r=eyJrIjoiMWFhNzdhYTQtNTJmZi00YjY2LTkxZWQtYjE4YWFhMTExYjNkIiwidCI6IjM2MjkyM2FhLTM3ZTktNGJiYi1hZjg2LTFmODg0NDhkM2UwZSIsImMiOjR9
15	Estadísticas de utilización GES	https://www.superdesalud.gob.cl/biblioteca-digital/estadistica-trimestral-de-casos-ges-auge-de-fonasa-y-sistema-isapre-a-junio-2024/
16	Datos abiertos DEIS	https://deis.minsal.cl/#estadisticas
17	Manuales de acreditación	https://www.superdesalud.gob.cl/tax-observatorio-de-calidad-en-salud/manuales-de-acreditacion-7989/
18	Fiscalización en calidad	https://www.superdesalud.gob.cl/tax-observatorio-de-calidad-en-salud/fiscalizacion-en-calidad-7993
19	Compendio de normas administrativas en materia de Información	https://www.superdesalud.gob.cl/normativa/compendio-informacion/
20	Compendio de normas administrativas en materia de Beneficios	https://www.superdesalud.gob.cl/normativa/compendio-beneficios/

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21	Compendio de normas administrativas en materia de Beneficios	https://www.superdesalud.gob.cl/app/uploads/2022/03/compendio-beneficios-version-actualizada-24-10-24.pdf
22	Ejemplo de formulario de notificación GES	https://www.superdesalud.gob.cl/app/uploads/2024/10/formulario-ges-if-v4.pdf
23	Datos abiertos de Isapres	https://www.superdesalud.gob.cl/tax-biblioteca-digital/datos-abiertos-de-isapres-6988/
24	Visor listas de espera	https://www.listaesperasalud.cl/
25	Informe listas de espera comisión Cámara de Diputados	https://www.listaesperasalud.cl/informes/CEI2025.pdf
26	Informes del MINSAL sobre listas de espera	https://www.listaesperasalud.cl/informes/
27	Información sobre el GES para el público general	https://www.superdesalud.gob.cl/tax-temas-de-orientacion/garantias-explicitas-en-salud-ges-1962/
28	Información técnica sobre la garantías GES	https://auge.minsal.cl/
29	Información técnica sobre la garantías GES	https://auge.minsal.cl/storage/e1Ng5cQh3v1Ge4ckFfJrXAzOrIUkUvQlk1zSWnYM.pdf
30	Ley 20.584	https://www.bcn.cl/leychile/navegar?idNorma=1039348
31	Consejo consultivo GES	https://www.minsal.cl/consejo-consultivo-ges/
32	Manual de procedimientos SIGGES	https://www.saludquillota.cl/biblioteca/gestion_tecnica/admision/Todo%20sobre%20GES/manual%20de%20procediminetos%20redes30.pdf
33	Política de Privacidad Superintendencia de Salud	https://www.superdesalud.gob.cl/superintendencia/politica-de-privacidad/
34	Ley de derechos y deberes	https://www.superdesalud.gob.cl/tax-materias-prestadores/ley-de-derechos-y-deberes-4185/