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Report No: PAD2521

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$300 MILLION

TO THE

ARGENTINE REPUBLIC

FOR A

SUPPORTING EFFECTIVE UNIVERSAL HEALTH COVERAGE IN ARGENTINA PROJECT

APRIL 27, 2018

Health, Nutrition & Population Global Practice
Latin America and Caribbean Region

CURRENCY EQUIVALENTS

Exchange Rate Effective March 31, 2018

Currency Unit =	Argentine Peso
ARS 20.13500 =	US$1

FISCAL YEAR
January 1 - December 31

Regional Vice President:	Jorge Familiar
Country Director:	Jesko S. Hentschel
Senior Global Practice Director:	Timothy Grant Evans
Practice Manager:	Daniel Dulitzky
Task Team Leaders:	Andrew Sunil Rajkumar, Vanina Camporeale

ABBREVIATIONS AND ACRONYMS

AGN	Argentine Supreme Audit Institution *(Auditoría General de la Nación)*
BNA	Bank of Argentina (*Banco de la Nación Argentina)*
COFESA	Federal Health Council (*Consejo Federal de Salud)*
CPS	Country Partnership Strategy
DA	Designated Account
DALYs	Disability Adjusted Life Years
DEIS	Directorate of Statistics and Health Information
EMF	Environmental Management Framework
EMR	Electronic Medical Records
EPHFP	Essential Public Health Functions and Programs
FM	Financial Management
FMA	Financial Management Assessment
FRSEC	Solidarity Reinsurance Fund for Catastrophic Diseases *(Fondo de Solidaridad de Reaseguro para Enfermedades Catastróficas)*
GDA	General Directorate of Administration
GHI	General Health Intervention
HBP	Health Benefit Plan
HCD	High-Complexity Disease
HPGD	Public Hospitals with Decentralized Management (*Hospitales Públicos de Gestión Descentralizada)*
IDB	Inter-American Development Bank
IDS	Integrated Delivery Systems
IHIS	Integration in Health Information Systems
IHME	Institute of Health Metrics and Evaluation
INDEC	National Institute of Statistics and Censuses *(Instituto Nacional de Estadistica y Censos)*
INSSJP	National Institute of Social Services for Retirees and Pensioners (*Instituto Nacional de Servicios Sociales para los Jubilados y Pensionados)*
IP	Indigenous Peoples
IPF	Investment Project Financing
IPP	Indigenous Peoples Plan
IPPF	Indigenous Peoples' Planning Framework
IUFR	Interim Unaudited Financial Report
IT	Information Technology
M&E	Monitoring and Evaluation
MSN	National Ministry of Health *(Ministerio de Salud de la Nación)*
MSP	Provincial Ministry of Health *(Ministerio de Salud Provincial)*
NCDs	Noncommunicable Diseases
NFHCD	National Fund for High Complexity Diseases
NEA	Northeast of Argentina *(Nordeste argentino)*
NOA	Northwest of Argentina *(Noroeste argentino)*
OM	Operational Manual
OS	Social Security Subsystem *(Obras Sociales)*
OSN	National Social Security Subsystem *(Obras Sociales Nacionales)*

OSP	Provincial Social Security Subsystem *(Obras Sociales Provinciales)*
PCT	Project Coordination Team
PHC	Primary Health Care
PHCPI	Primary Health Care Performance Initiative
PPSD	Project Procurement Strategy for Development
SIDIF	Integrated Financial Information System *(Sistema Integrado de Información Financiera)*
SISA	Integrated Health Information System *(Sistema Integrado de Informacion Sanitaria)*
SORT	Systematic Operations Risk-Rating Tool
SSS	Superintendent of Social Security
TA	Technical Assistance
TGN	National Treasury Office *(Tesorería General de la Nación)*
TOR	Term of Reference
TSA	Treasury Single Account
TVM	Time Value of Money
UAC	Undersecretariat of Administrative Coordination
UEPEX	System for Units Executing External Loans *(Sistema de las Unidades Ejecutoras de Préstamos Externos)*
UFI-S	International Financing Team of the MSN (*Unidad de Financiamiento Internacional de Salud)*
UHC	Universal Health Coverage
WB	World Bank
YLD	Years Lost due to Disability
YLL	Years of Life Lost

BASIC INFORMATION

Is this a regionally tagged project?	Country(ies)	Financing Instrument
No		Investment Project Financing

[ ] Situations of Urgent Need of Assistance or Capacity Constraints

[ ] Financial Intermediaries

[ ] Series of Projects

Approval Date	Closing Date	Environmental Assessment Category
18-May-2018	31-Dec-2022	B - Partial Assessment

Bank/IFC Collaboration
No

Proposed Development Objective(s)

The Development Objective of the proposed Project would be to: (i) increase effective and equitable coverage of key health services provided to the eligible population; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system.

Components

Component Name	Cost (US$, millions)
Support the Strengthening of Effective Public Health Coverage	479.81
Strengthening the Institutional Capacity of the National and Provincial Ministries of Health	110.96
Supporting Management, Monitoring and Evaluation	66.53

Organizations

Borrower :	Argentine Republic
Implementing Agency :	Ministry of Health

PROJECT FINANCING DATA (US$, Millions)

[✓] Counterpart Funding	[✓] IBRD	[ ] IDA Credit	[ ] IDA Grant	[ ] Trust Funds	[ ] Parallel Financing

Total Project Cost:	Total Financing:	Financing Gap:
658.05	658.05	0.00
	Of Which Bank Financing (IBRD/IDA): 300.00	

Financing (in US$, millions)

Financing Source	Amount
Borrower	358.05
IBRD-88530	300.00
Total	**658.05**

Expected Disbursements (in US$, millions)

Fiscal Year	2018	2019	2020	2021	2022	2023
Annual	0.00	71.45	74.92	79.37	54.84	19.42
Cumulative	0.00	71.45	146.37	225.74	280.58	300.00

INSTITUTIONAL DATA

Practice Area (Lead)

Health, Nutrition & Population

Contributing Practice Areas

Climate Change and Disaster Screening

This operation has not been screened for short and long-term climate change and disaster risks

Explanation

Climate co-benefits cannot be assigned because the Project's activities are not included in the list of defined Eligible Mitigation Activities, based on an assessment (see paragraph 41).

Gender Tag

Does the project plan to undertake any of the following?

a. Analysis to identify Project-relevant gaps between males and females, especially in light of country gaps identified through SCD and CPF

Yes

b. Specific action(s) to address the gender gaps identified in (a) and/or to improve women or men's empowerment

Yes

c. Include Indicators in results framework to monitor outcomes from actions identified in (b)

Yes

SYSTEMATIC OPERATIONS RISK-RATING TOOL (SORT)

Risk Category	Rating
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Low
4. Technical Design of Project or Program	Substantial
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Substantial
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	
10. Overall	Substantial

COMPLIANCE

Policy

Does the project depart from the CPF in content or in other significant respects?

[ ] Yes [✓] No

Does the project require any waivers of Bank policies?

[ ] Yes [✓] No

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment OP/BP 4.01	✓	
Natural Habitats OP/BP 4.04		✓
Forests OP/BP 4.36		✓
Pest Management OP 4.09		✓
Physical Cultural Resources OP/BP 4.11		✓
Indigenous Peoples OP/BP 4.10	✓	
Involuntary Resettlement OP/BP 4.12		✓
Safety of Dams OP/BP 4.37		✓
Projects on International Waterways OP/BP 7.50		✓
Projects in Disputed Areas OP/BP 7.60		✓

Legal Covenants

Sections and Description

Schedule 2 Section I.A.6(a) of Loan Agreement: The Borrower, through the National Ministry of Health, shall: (a)before carrying out any Project activities, enter into an agreement (the Umbrella Agreement) with the respective Participating Province, setting forth the technical, financial, administrative, safeguard and fiduciary aspects of the national and provincial participation in the implementation and use of funds under the Project, including, inter alia: (i) the obligation of the Participating Provinces to make available the Padrón de Obra Social Provincial to the National Ministry of Health MSN, all in terms and conditions acceptable to MSN and the Bank; and (ii) the obligation of each Participating Province to provide its respective counterpart funding.

Sections and Description

Schedule 2 Section I.A.6(b) of Loan Agreement: The Borrower, through the National Ministry of Health shall: (b)

every year, starting immediately after the Effective Date for the first year of the Project, and no later than March 31 thereafter, enter into a performance agreement (the Annual Performance Agreement) with each Participating Province, setting forth annual targets for the Trazadoras Matrix and enrollment goals, the payment mechanisms and prices to be paid for each health service to Authorized Providers under Part 1.1. of the Project, work programs and resource requirements for the implementation of the Project, all on terms and conditions acceptable to the Bank.

Sections and Description

Schedule 2 Section I.A.10(a) of Loan Agreement: For the purposes of the certification and validation procedure referred to in 8 and 9 above, the Borrower, through the National Ministry of Health, shall: (i) appoint under terms of reference satisfactory to the Bank and thereafter maintain during the execution of the Project, an independent technical auditing entity with qualifications and terms of contracting satisfactory to the Bank (the Technical Auditor).

Conditions

Type	Description
Disbursement	Schedule 2 Section III.B.1(a) of Loan Agreement: No withdrawal shall be made for payments made prior to the Signature Date, except that withdrawals up to an aggregate amount not to exceed $60,000,000 may be made for payments made prior to this date but on or after March 8, 2018 (but in no case more than one year before the Signature Date), for Eligible Expenditures under Categories (3) and (4).
Disbursement	Schedule 2 Section III.B.1(b) of Loan Agreement: No withdrawal shall be made for expenditures under Category (3) before the loan proceeds allocated to Category (3) of Section IV.A.2 of Schedule 2 to Loan Agreement 8516-AR have been fully disbursed.
Disbursement	Schedule 2 Section III.B.1(c) of Loan Agreement: No withdrawal shall be made for expenditures under Category (4) before the loan proceeds allocated to Category (4) of Section IV.A.2 of Schedule 2 to the Loan Agreement 8516-AR have been fully disbursed.
Disbursement	Schedule 2 Section III.B.1(d) of Loan Agreement: No withdrawal shall be made under Categories (3) and (4), until the Technical Auditor has been contracted under terms of reference acceptable to the Bank.

Type	Description
Disbursement	Schedule 2 Section III.B.1(e) of Loan Agreement: No withdrawal shall be made under Category (4) until the National Fund for High-Complexity Diseases has been duly established in a manner acceptable to the Bank.

PROJECT TEAM

Bank Staff

Name	Role	Specialization	Unit
Andrew Sunil Rajkumar	Team Leader(ADM Responsible)	Health	GHN04
Vanina Camporeale	Team Leader	Health	GHN04
Alvaro Larrea	Procurement Specialist(ADM Responsible)	Procurement	GGOPL
Luz Maria Meyer	Financial Management Specialist	Financial	GGOLF
Daniela Paula Romero	Team Member	Health	GHN04
Fabiola Altimari Montiel	Counsel	Legal	LEGLE
German Nicolas Freire	Social Safeguards Specialist	Social	GSU04
Jennifer Lynne Zelmer	Team Member	Health	GHN04
Jeremy Henri Maurice Veillard	Team Member	Health	GHNGE
Jose C. Janeiro	Team Member	Financial - Disbursement	WFACS
Luis Orlando Perez	Team Member	Health	GHN04
Marcelo Roman Morandi	Environmental Safeguards Specialist	Environmental	GEN04
Maria Gabriela Moreno Zevallos	Team Member	Program Assistant	GHN04
Maria Gracia Lanata Briones	Team Member	Program Assistant	LCC7C
Marvin Ploetz	Team Member	Health	GHN04
Paula Giovagnoli	Team Member	Health	GHN04
Santiago Scialabba	Social Safeguards Specialist	Social	GSU04
Zlatan Sabic	Team Member	Health	GHN03

Extended Team

Name	Title	Organization	Location

ARGENTINA
SUPPORTING EFFECTIVE UNIVERSAL HEALTH COVERAGE IN ARGENTINA

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I. STRATEGIC CONTEXT

A. Country Context

1. **The Government has introduced important economic reforms since taking office in December 2015**. It unified the exchange rate, ended the dispute with holdout creditors, abandoned the system of discretionary import licenses, resumed the publication of credible official statistics, significantly lowered export taxes, cut the personal income tax by increasing the minimum threshold and reduced energy and transport subsidies. It expanded several social benefits (e.g. child allowances), increased unemployment insurance significantly, and introduced a plan to settle social security lawsuits and to adjust pensions upwards. The results of the mid-term elections of October 2017 were seen as a display of support for the Administration and empowered the Government to move forward with its reform agenda, which included tax and pension reforms.

2. **Economic activity is expected to continue its recovery in 2018.** Economic activity contracted 1.8 percent during 2016, taking a toll on labor markets, where up to 0.6 percent of formal private sector jobs were lost.[1] However, GDP has expanded for six consecutive quarters (5 percent) since the second quarter of 2016, and employment in the formal private sector recovered to its December 2015 level. The economy expanded by 2.9 percent[2] in 2017 and is expected to continue to grow in 2018[3], on the assumption that the positive impact of policy changes kicks in and the global economy recovers. Inflation in the city of Buenos Aires was 40 percent in 2016, mostly due to currency depreciation and lower energy and transport subsidies, but has decelerated rapidly to 24.8 percent in 2017.[4] The Government overachieved its primary deficit target in 2016 (4.1 percent vs. 4.8 percent of GDP) and in 2017 (3.8 percent vs. 4.2 percent of GDP). Achieving the primary deficit target for 2018 (3.2 percent of GDP) would require further fiscal consolidation efforts.

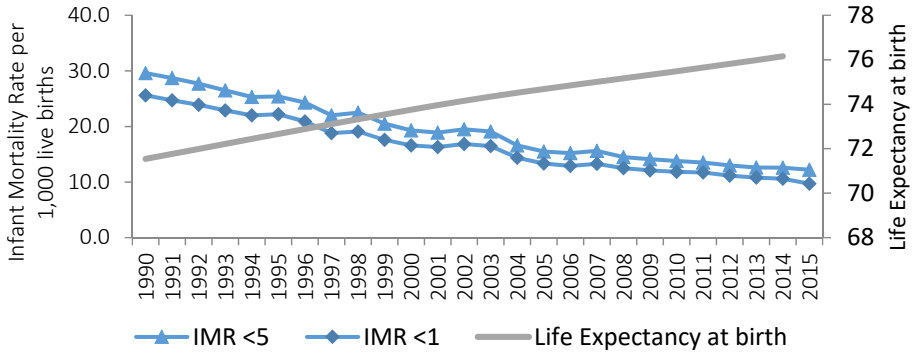
3. **The Government has taken important steps to address the key macroeconomic imbalances with the objective of creating an environment conducive to economic growth and employment creation.** Argentina offers many business opportunities for foreign investors and firms in a weak global environment. Going forward, Argentina aims to continue building a growth-enabling policy framework to enhance credibility and to support broad-based growth and quality employment. In particular, the Government promotes the following policies to reduce inflation and put Argentina on a sustainable growth path: (i) increase public spending efficiency and efficacy and reduce the fiscal deficit to meet targets; (ii) continue fostering the credibility of the Central Bank so that monetary policy can further anchor inflation expectations; (iii) strengthen competitiveness and productivity through an improved business environment and investments in infrastructure and increasing competition in markets and improving the regulatory framework in sectors; (iv) continue strengthening the credibility of official statistics; and (v) continue improving the provision of public goods (including transportation, health, and education) and reducing regional disparities.

[1] Source: *Ministerio de Trabajo, Empleo y Seguridad Social.*
[2] Source: National accounts and Monthly Estimate of Economic Activity, *Instituto Nacional de Estadistica y Censos* (INDEC).
[3] Consensus Forecast, February 2018.
[4] Source: INDEC.

B. Sectoral and Institutional Context

4. **Argentina's health outcomes have improved significantly during the past decades, especially for maternal and child health indicators and to a more limited extent for noncommunicable diseases (NCDs).** Over the last 5 years, both infant and child mortality rates have decreased and life expectancy increased (see Figure 1). In addition, the country has reduced inequalities in health outcomes and access to services; for example, the gap between the average infant mortality rate of the poorer Northern provinces and other provinces fell from 6.8 per 1,000 live births in 2004 to 2.7 in 2015. Between 2005 and 2013 the percentage of women aged 25-65 years receiving cervical cancer screening rose from 60.6% to 71.6%, and the percentage of adults having a high blood pressure control test rose from 78.7% to 82.4%.[5]

Figure 1. Infant Mortality Rate and Life Expectancy at Birth



5. **At the same time, Argentina is facing a rapid demographic and epidemiological transition.** As the population ages and is increasingly exposed to health risk factors, NCDs have become the main causes of death and disability. According to the Global Burden of Disease Study of 2015, the main causes of Disability Adjusted Life Years (DALYs) lost in Argentina were ischemic heart disease, low back and neck pain, lower respiratory infection, cerebrovascular disease, depressive disorders and diabetes, in that order (IHME, 2015[6]). NCDs have become an important focus for health policy in recent years; in 2009, the country formally initiated the implementation of the National Strategy for the Prevention and Control of NCDs, and in 2012 the country enacted one of the first sodium reduction laws in the world.

6. **Despite these efforts, significant challenges remain. Health outcomes in Argentina are generally poor compared to other countries with similar or even lower per-capita incomes, pointing to low overall efficiency of health spending.** Countries such as Malaysia and Romania fare better with maternal mortality and age-standardized mortality rate of cervical cancer, which are good indicators of the effectiveness of the health system (Table 1). Life expectancy at birth in Argentina is comparable to these countries, but does not compare as well to other countries in South America with similar per capita income such as Chile, Uruguay, and Costa Rica. Argentina's outcomes are also worse than the average in countries of the Organization of Economic Cooperation and Development, an organization with which Argentina is seeking full membership.

[5] This is according to the national Risk Factor Surveys of 2005 and 2013.
[6] Global Burden of Disease Study by the Institute of Health Metrics and Evaluation (IHME), 2016.

Table 1: Health Outcomes in Argentina and Comparator Countries in 2015

Indicators	Argentina	Malaysia	Romania	Chile	Costa Rica	Uruguay	OECD average
GDP per capita, PPP *(current international $)*	**19,881**	25,766	20,389	22,129	15,028	20,886	40,589
Mortality rate, infant[7] *(per 1,000 live births)*	**11.5**	6.2	10.1	7.2	8.6	9.1	5.8
Mortality rate, neonatal *(per 1,000 live births)*	**6.5**	4	6.5	5.1	6.3	5.3	3.7
Mortality rate, under-5 *(per 1,000 live births)*	**12.9**	7.2	11.5	8.3	9.9	10.6	6.8
Maternal mortality ratio *(modeled estimate, per 100,000 live births)*	**54**	41	31	23	26	15	14
Life expectancy at birth, total *(years)*	**76**	75	75	81	79	77	80
Population, total *(in millions)*	**43.0**	29.9	19.9	17.8	4.8	3.4	1,282
Population ages 65 and above *(% of total population)*	**10.8**	5.7	16.9	10.7	8.6	14.3	16.2
Age-standardized mortality for cervical cancer	**6.6**	2.9	5.9	5.2	3.9	6.9	3.5

Source: World Bank Development Indicators and Global Burden of Disease Study 2015 for age-standardized rate of mortality for cervical cancer (for the year 2015).

7. **The performance of the country's public health sector is affected by persistent inefficiencies – especially in addressing NCDs.** The poor overall health outcomes in Argentina are partially due to a lack of efficient risk pooling mechanisms (i.e. pooling together high-risk and low-risk groups), as explained below. In addition, there are multiple examples of inefficiencies and inefficient use of scarce resources at a more "micro" level, especially in the public sector. For example, a lack of mechanisms to readily share clinical records between different health providers often results in repeated testing, prescriptions of the same medication, or inadequate medical advice. A lack of integrated mechanisms to track the prescription and delivery of drugs often leads to waste and to inefficient use of the existing stock of drugs, resulting in rather frequent stockouts of some drugs in public pharmacies.

8. **In addition, there are significant inequities across geographical regions.** Health outcomes in Argentina differ substantially across provinces, with the provinces in the Northeast (NEA) and Northwest (NOA) regions having the poorest health outcomes and the lowest rates of effective coverage for key services (Table 2).

[7] According to official data for 2015 from MSN's Directorate of Statistics and Information, the maternal mortality rate was 3.9 per 100,000 live births. The neonatal and infant mortality rates were 6.6 and 9.7 per 1,000 live births, respectively.

Table 2: Percentage of Different Population Subgroups Receiving NCD Screening, by Region (2013[8])

	Total	Gran Buenos Aires and Pampeana	NOA Region	NEA Region	Patagonia Region	Cuyo Region
High blood pressure control test in population 18 years and older	82.4	83.6	76.8	77.9	80.6	84.2
High cholesterol control test in men aged 35 and older and women aged 45 and older	77.5	79.4	69.3	69.7	77.3	77.3
High blood glucose control test in population aged 18 and above	76.8	78.8	69.6	65.7	75.9	80.7
Women aged 50-70 receiving a mammography	65.6	70	47.6	47.2	64	61.9
Women aged 25-65 receiving cervical cancer screening	71.6	74.5	58.2	62.8	72.9	70.2
Population aged 50-75 receiving colon cancer screening	24.5	26.9	13.7	19.2	22.5	20.3

Source: National Risk Factors Survey 2013 - National Ministry of Health.

9. **Individuals exclusively using the public health subsystem (mostly the poor) are less likely to receive NCD-related screenings.** The percentages of: (i) women aged 25-65 years receiving cervical cancer screening; (ii) women aged 50-70 years receiving a mammography; and (iii) adults having a high blood pressure control test are significantly lower for those exclusively using the public subsystem than the rest of the population (60.4% vs. 71.6%, 48% vs. 65.7%, and 71.2% vs. 82.4%).[9] Yet the average (public) per capita spending for those exclusively using the public subsystem is higher than for members of an *Obra Social* (OS)[10]. This comes with the following caveats: (i) the public subsystem cross-subsidizes the OS subsystem to some degree; and (ii) public spending figures include financing for public health functions[11] benefiting the entire population. Still, these results show the relatively low efficiency of public spending.

10. **These inefficiencies and inequities are due in part to the highly fragmented nature of the Argentine health system which is structurally segmented according to labor market status and across geographic areas,** with three distinct subsystems that largely operate independently of each other: public non-contributory, social security, and private. In principle, the public non-contributory subsystem offers services to all Argentinians, but it is mainly used by people with no formal labor employment and thus with no social security or private insurance coverage – predominantly the poor. The public service delivery network is decentralized to the provincial level and sometimes to municipalities, adding to the system's fragmentation. The social security subsystem covers the population with formal sector employment, and consists of about 300 national OSs (*Obras Sociales Nacionales*, OSNs) linked to individual trade unions; 24 provincial OSs (*Obras Sociales Provinciales*, OSPs) insuring provincial and municipal civil servants; an OS

[8] From the National Risk Factors Survey of 2013 – the latest year for which a survey of this kind was conducted.
[9] According to data from the National Risk Factors Survey of 2013.
[10] The data show that average public spending per person exclusively using the public subsystem in 2014 was 6,048 Pesos, as compared to 5,930 Pesos for average spending per *Obra Social Nacional* member in the same year, and average spending of 5,375 Pesos per member of an *Obra Social Provincial*.
[11] Such as regulation, health promotion, disease surveillance, immunization, and others.

that insures pensioners and retirees (*Instituto Nacional de Servicios Sociales para los Jubilados y Pensionados*, INSSJP); and other schemes. Finally, there is a small voluntary private insurance market.[12]

11. **The system's inherent fragmentation is due in part to the federal nature of the country, with a high degree of provincial autonomy and few mechanisms to effectively coordinate the provinces' actions or to reduce inter-provincial inequities in health spending.** In Argentina, the role of the national Government in health is much more limited than in other federal countries. The National Government accounts for just 19 percent of total public health spending and plays a limited role in coordinating the actions of the provinces, which are highly autonomous.

12. **Another factor adding to the fragmentation is the existence of different national and provincial programs within the public subsystem that have different management structures.** This is a common feature of many countries but is especially relevant in the case of Argentina, where – together with the other inherent characteristics mentioned above – the result is an especially high degree of fragmentation.

13. **The system's fragmentation operates along two different dimensions. One of these is the fragmentation of resource pools and lack of redistributive mechanisms across them.** This is not just inequitable but also contrary to principles of efficient risk pooling and insurance.[13] Yet there are few politically feasible ways at present to pool funds from the public and OS subsystems, or to establish redistributive mechanisms between the two. Within the public subsystem, the available financing per person varies widely across provinces, and there is no major equalizing transfer mechanism to reduce the inter-provincial inequities in health spending, unlike in many other federal countries. There is also continuing cross-subsidization of the OS subsystem by the public subsystem, by amounts that are likely substantial although not known with precision. One reason for this is that many public health facilities lack the billing systems and the capacity needed to bill the OSs for health services delivered to their members. There are also other underlying reasons (see Annex 1 for more details).

14. **The second dimension of fragmentation leading to inefficiencies and inequities is the lack of instruments for coordination across subsystems and within subsystems (for instance across provinces) – including a lack of integrated information systems.** The National Ministry of Health (MSN) nominally oversees all three subsystems, but in practice exerts a degree of control only over the public non-contributory system. Even here, it has limited control over the provincial Ministries of Health (MSPs), including limited mechanisms for enforcing common standards in the definitions of services, clinical guidelines and protocols, models of care and information standards and systems. In the absence of common standards, establishing integrated information systems (i.e. information systems that are interoperable) is impossible. In addition, MSN has limited control, in practice, over the actions of the national and provincial OSs and the INSSJP.

[12] Around 38% of the total population relies exclusively on the public subsystem, including almost 60% of the poor and about three-fourths of the extremely poor (according to the Permanent Household Survey of 2016). Most of the others in the population are covered by the social security subsystem (including INSSJP).

[13] An efficient and equitable health system would feature as few resource pools (risk pools) as possible, so that high-risk groups could be pooled efficiently with low-risk groups. If a large number of pools is unavoidable, effective redistributive mechanisms across resource pools is essential.

15. **The Government is now embarking on a new strategy in support of effective Universal Health Coverage (UHC) – a holistic approach where all health programs and initiatives would work together in an integrated manner, focusing on enhancing effective coverage in the public sector** (i.e. health care coverage of adequate quality for the population exclusively using the public subsystem). In August 2016, a Presidential Decree in support of the Strategy was issued, mentioning the need to address the fragmentation and organizational problems of the health system, and the division between the three subsystems. Among other things, the Strategy aims to: (i) ensure that everyone without formal health insurance will eventually be traceable across the continuum of care; and (ii) strengthen electronic systems to enable OSs to be billed when their members use public health facilities.

16. **The new Strategy would strengthen the public subsystem through a model of care based on principles of integrated delivery systems (IDS), continuity of care, and the assignment of a primary care provider for everyone. For this to happen, instruments for improved coordination – together with other reforms – are essential.** The literature shows that large gains in impact and efficiency can be attained by developing and implementing an appropriate IDS-based model of care, where several providers including a main primary care provider work together in an integrated, coordinated manner to provide care for an individual. Such a system would place strong emphasis on patient traceability and continuity of care, which implies continuity: (i) of information (through the use of shared records); (ii) across the secondary-primary care interface, especially for key clinical care pathways; and (iii) at the individual provider level (patients seeing the same professional during different care episodes, especially at the primary care level, adding value in the form of a therapeutic, trusting relationship).[14] None of this is possible without: (i) defining and measuring utilization of services along the entire continuum of care (i.e. across the secondary-primary care interface), especially for key clinical care pathways; and (ii) a common approach towards protocols, clinical guidelines, standards etc. as well as integrated information systems.

17. **An IDS-based model of care would be especially useful for effectively managing NCDs.** In the public sector, often the only explicitly defined NCD-related services are those in a limited package of mostly primary and preventative services covered by the *Sumar*[15] program. Other services in the public sector – notably curative services – will also need to be defined, and their utilization tracked for each patient (in the same way as for the services under the *Sumar* program), before one can start to trace patient utilization of services along entire key clinical care pathways. Among others, this would require information systems with appropriate capabilities that are sufficiently integrated (i.e. interoperable).

18. **An integrated model of care in the public subsystem would also require the resolution of various other coordination problems, including with: (i) referral networks for diagnosis, treatment and follow-up of complex conditions and diseases; and (ii) drug-tracking**. Establishing referral networks for complex conditions/diseases requires coordination among provinces, which is not easy in a decentralized context with limited coordination structures. As another example of coordination failure, the *CUS-Medicamentos*[16] program (formerly called *Remediar*) tracks the flow of different types of essential drugs

[14] See "Trends in Integrated Care – Reflections on Conceptual Issues" by Gröne, O & Garcia-Barbero, M (2002). World Health Organization, Copenhagen, 2002, EUR/02/5037864.
[15] The ongoing *Sumar* program (financed in part by a World Bank Project – see below) aims to improve access and quality for a package of mostly primary and preventative services, provided to the eligible population, through Results-Based Financing mechanisms at the provincial and health care provider levels. See Box 1 below for more details.
[16] "CUS" refers to *Cobertura Universal de Salud*, or Universal Health Coverage.

to public pharmacies; but there is no link with other programs that could track the prescription and dispensing of drugs, such as the *Sumar* program. Establishing this link with the *Sumar* program would help ensure rational prescribing and use of drugs, and would thus reduce the stockouts of primary care drugs now often seen at public pharmacies. But these types of linkages do not arise naturally between two programs with different management structures.

19. **The model of care would need to have a strong primary (including preventive) health care (PHC) focus, with strategies to actively expand effective coverage at the primary care level and to promote "empanelment" (assignment to a regular primary care provider for provider continuity).** In Argentina, as in many countries, large segments of the population hardly visit health facilities for preventative health services such as screening for cancer, diabetes, heart disease and other NCDs. The result is that these diseases often reach quite advanced stages before detection, resulting in much higher rates of mortality and morbidity – and much higher treatment costs – than if they had been detected and addressed much earlier. An approach focused on PHC would also emphasize preventative actions on the part of the population to reduce the incidence of these diseases in the first place. International experience shows that PHC can be effectively promoted through an "empanelment" strategy, under which – as one example of a viable approach – primary care providers would be encouraged to actively seek new persons from their catchment area for regular preventative care (checkups, screening, etc.) as well as treatment, needed referrals to higher-level providers and regular follow-up care.

20. **Equity would also need to be appropriately addressed.** The model of care would need to be designed and implemented in a manner that takes into account the large differences across provinces in health outcomes, institutional capacity and the ability to raise domestic revenues.

21. **The Government has requested World Bank financing for a Project to support its strategy for increasing effective UHC, building on successful ongoing initiatives such as the *Sumar* program supported by the Bank.** The use of financial incentives in innovative ways – building upon mechanisms already being implemented under the ongoing *Nacer/Sumar* program[17] – would be key under the Project. The Project would act as the cornerstone of an integrated approach that would also involve various other ongoing programs[18], all acting in complementary fashion in support of effective UHC.

C. Higher Level Objectives to which the Project Contributes

22. **This Project is aligned with the World Bank Group's twin goals of alleviating poverty and boosting shared prosperity and with the objectives of the latest Country Partnership Strategy (CPS).** It contributes to the goals defined in the CPS 2015-2018 (Report 81361-AR) discussed by the Board on September 9, 2014 and the Performance and Learning Review of the CPS (PLR) FY15-FY18 (Report 110546-AR). In particular, the proposed Project would contribute to the CPS outcome focusing on the "proportion of eligible people benefiting from effective healthcare" (Results Area 5). In addition, Results-Based Financing (RBF) is mentioned as a key theme in the CPS.

[17] Supported first by the World Bank *Plan Nacer* I (US$135 million) and *Plan Nacer* II (US$300 million) Projects – both already closed – and then the Provincial Public Health Insurance Development Project (P106735 - US$600 million), now under implementation, that supports the *Sumar* program.

[18] Including: (i) the Protecting Vulnerable People against NCDs or "*Proteger*" Project (US$350 million – P133193), supported by the World Bank and now under implementation; and (ii) other national programs such as *Redes* and *CUS-Medicamentos*.

23. The Project is closely aligned with the Sustainable Development Goals (SDGs) which stress the importance of achieving UHC and financial protection, since it contributes to increasing the access and use of health services with a focus on vulnerable families. The Project is also aligned with the new World Bank Strategy in support of the health sector in Argentina[19], which calls for: (i) improved effective coverage of essential services among the poor in the poorest areas together with structural reforms in the provincial public subsystem; (ii) a focus on NCD prevention and control while continuing the support provided for maternal and child care; and (iii) efforts to reduce fragmentation and increase coordination in the country's health system. A core objective of the Project is to reduce important institutional capacity gaps which exist in the country – especially between the national level and better-off provinces on the one hand, and more lagging provinces in the North on the other hand. Employing a number of mechanisms, the Project aims to reduce these institutional gaps and to expand effective health coverage, especially for the vulnerable population in poorer areas.

II. PROJECT DEVELOPMENT OBJECTIVES

A. PDO

24. The Development Objective of the Project is to: (i) increase effective and equitable coverage of key health services provided to the eligible population; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system.

B. Project Beneficiaries

25. The **eligible population** consists of all individuals aged under 65 without formal health insurance (nearly 15 million people); these individuals are exclusively covered by the public subsystem. The Project would be implemented throughout the country, with a focus on the poorest provinces and municipalities.

C. PDO-Level Results Indicators

PDO (i)
Percentage of eligible population with effective health coverage.[20]
Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes.

PDO (ii)
Percentage of eligible population enrolled and assigned to a health facility, for continuous care ("empaneled").

26. These indicators will also be monitored separately for men and women. (See Section VII for more details).

[19] "Argentina: Towards Universal Health Coverage-Challenges and Opportunities". Series of technical reports of the World Bank in Argentina, Paraguay and Uruguay Nº 12, 2017.
[20] Effective health coverage is defined as being enrolled in the program and having utilized one or more essential health services provided according to established quality protocols – from a list of predefined key services listed in the Operational Manual (OM).

III. PROJECT DESCRIPTION

A. Project Components

27. **The Project would build on the successful approach of the ongoing *Sumar* program (supported by a World Bank-financed Project) – which aims to improve access and quality for a package of prioritized health services for the eligible population through RBF mechanisms at the provincial and health care provider levels.** The eligible population for the *Sumar* program is the same as it would be for this Project. Specifically, the *Sumar* program provides financial incentives: (i) to encourage provinces to increase "effective coverage" for priority services (delivered according to established quality protocols)[21] among the eligible population while actively working to improve selected provincial health indicators; and (ii) to incentivize health care providers to increase delivery of services in the prioritized package.

Box 1. How the Project Would Build on the Ongoing *Sumar* program

The Project would build on the successful approach of the ongoing *Sumar* program (supported by a World Bank-financed Project). *Sumar* features a two-stage incentive structure under which: (i) provinces receive capitation payments that are adjusted on the basis of provincial performance for "tracer" indicators, and are paid for those people in the eligible population who have "effective coverage"; and (ii) capitation payments are used to make fee-for-service payments to health service providers for selected services provided following established quality protocols.

The Project would continue to support the goals of the *Sumar* program, with Component 1 financing capitation payments for General Health Interventions (GHIs) and for services related to High-Complexity Diseases – similar to the ongoing Bank-supported Sumar program. However, this Project would support additional goals, as can be seen from its proposed PDO: (i) increase effective **and equitable** coverage of key health services provided to the eligible population; and (ii) **increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system**. The second part of the PDO and the emphasis on "equitable" (and not just "effective") coverage in the first part of the PDO are innovations under this Project that are not currently supported by the *Sumar* program.

To support these additional goals, new activities would be introduced under Component 2 – targeted instruments and goods to enhance coordination and to support an integrated model of care oriented around a regular primary care provider. (See Figure 2, under "Tools/Instruments"). These would be complemented by innovations introduced to the capitation payments supported by Component 1 (see Table A1-2 of Annex 1):

- The provincial "tracer" indicators would include a measure of provincial progress regarding "empanelment" (assignment to a regular primary care provider for provider continuity) – a key Project goal. Depending on initial provincial performance, the Project could also support additional "tracer" indicators directly related to the second part of the PDO. There would be conditions that the provinces would need to fulfil first to enter into, and then to remain in, the program: conditions of "entry" and "continuation", related to actions the provinces should take to advance with the second part of the PDO. For example, progress would be needed with activities related to "empanelment", establishment of common service definitions and standards, integration of health information systems, and coordination across programs. (See Box A1-3 of Annex 1).
- In addition to the fee-for-service payments to health service providers now supported under the *Sumar* program, additional types of bonus payments to providers would be introduced to incentivize key actions

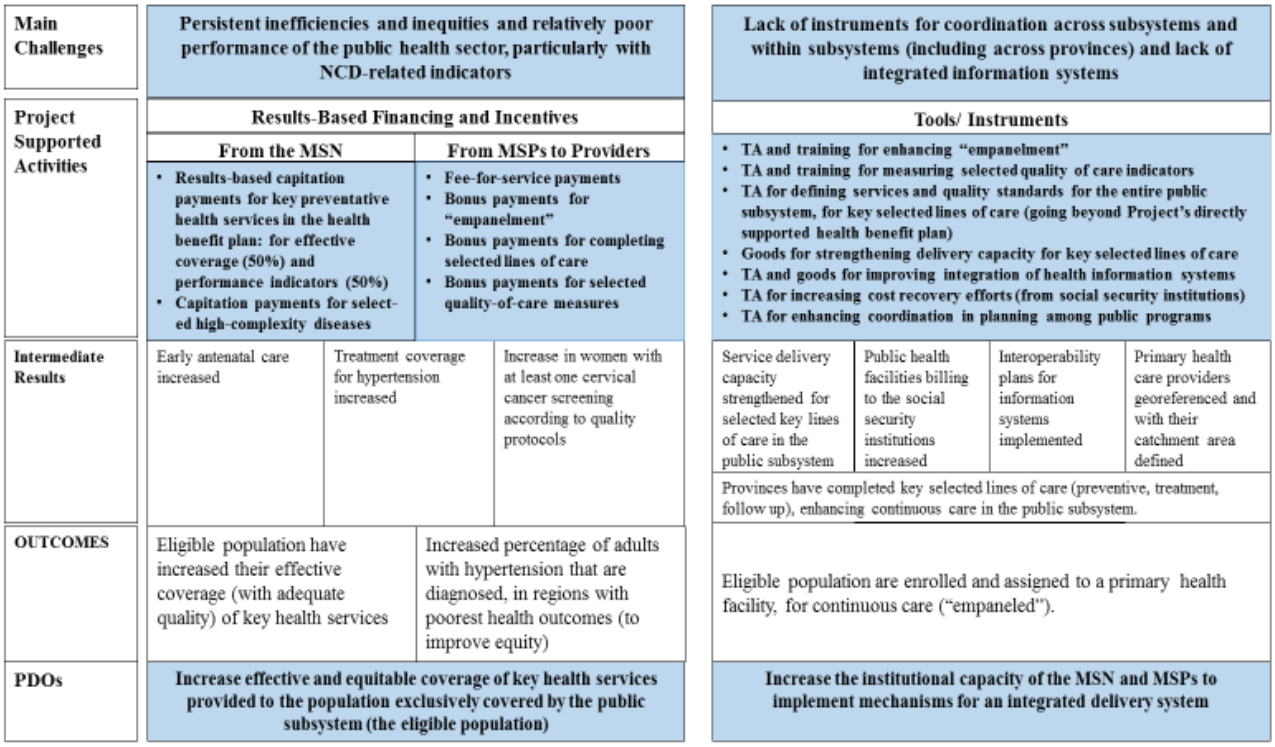
[21] See previous footnote for the definition of "effective coverage", used for the *Sumar* program (and also for this Project).

related to the second part of the PDO, including: (i) payments for "empanelment" activities; (ii) payments for eligible persons completing selected "lines of care"; and (iii) payments for attaining selected quality-of-care targets.

Component 2 would support the key agenda of moving towards integration of health information systems by providing targeted Technical Assistance (TA) and limited financing for personnel and Information Technology (IT) goods/services, to Provinces willing to undertake key actions for this agenda. For these Provinces, there may also be larger amounts of financing available for equipment and connectivity from other National Government sources like the *Proteger* program. (This is in addition to the incentives mentioned above under Component 1).

Finally, to ensure that coverage is "equitable" and not just "effective", the Project would introduce an "equity" component into the capitation payments for GHIs, as described below.

Figure 2: Project Results Chain



28. **The Project would expand on the incentive structure under the *Sumar* program. It would finance additional incentives (Component 1) and targeted instruments and goods (Component 2) to enhance coordination and to support an integrated model of care oriented around a regular primary care provider** (see Box 1)**.** These two components would create synergies to support key Project goals and to thereby enhance effective UHC for the eligible target population, especially for key "lines of care" (related to common cancers such as cervical cancer, to common chronic diseases such as diabetes, and to maternal and child health – see Box A1-1 in Annex 1). The instruments to be supported under Component 2 would include tools to define a benefit plan for the entire public subsystem (especially for the key "lines of care"); to enhance integration in health information systems; to further increase the focus on the quality of care;

to strengthen cost recovery efforts by public health service providers from the OSs; and to enhance coordination in planning across programs (see Figure 2). The Project aims to address coordination and fragmentation issues as highlighted above, while recognizing that although these are major factors leading to inefficiencies in the country's health system, they are not the only ones.

29. **The Project would include three components** as follows:

30. **Component 1: Support the Strengthening of Effective Public Health Coverage (US$479.81 million, US$192.47 million from IBRD).** This Component would finance: (i) capitation payments for the provision of selected General Health Interventions (GHIs) under Sub-Component 1.1; and (ii) capitation payments for the provision of selected interventions for High Complexity Diseases (HCDs) under Sub-Component 1.2. The GHIs and the HCD interventions would be part of the Health Benefit Plan (HBP) that will contribute to improving the quality of services as well as extending coverage. Results will be monitored using supervision protocols and information systems, and will be verified by an independent technical auditor.

31. **The capitation payments would cover a share of the total cost of selected health services provided by service providers**. The selected services would be those in the prioritized HBP defined for the eligible population[22]. To this end, the MSN carried out an actuarial calculation to estimate the incremental cost of this HBP to be financed by the Bank. See Annex 1 for more details.

32. **Sub- Component 1.1. Making Capitation Payments for the Provision of Selected General Health Interventions (US$437.61 million, US$171.37 million from IBRD).** This Sub-Component, accounting for 67 percent of the Project cost, would finance results-based capitation payments for GHIs for all eligible people in participating provinces who are enrolled and with effective health coverage. This builds upon the successful experience of the *Sumar* program in incentivizing not just enrolment but also utilization of key (especially preventative) health services with adequate quality standards. Health services in the HBP covered by the Project were selected based on their cost-effectiveness in preventing, treating, or curing diseases that contribute significantly to the burden of disease of the selected population subgroups.

33. **The capitation payment for each province would be the sum of: (i) a "basic" component; and (ii) an additional "equity" component whose size would depend on equity considerations**. The sum of these would make up the total capitation payment given to the province for each eligible person with effective coverage. The total capitation payments would be transferred in two steps: (i) 50 percent of the financing after effective coverage for the eligible population is verified; and (ii) the remaining share transferred based on the achievement of a set of specific provincial health indicators ("tracers"). The introduction of an "equity" component in the capitation payment for each province is an innovation under the Project and would result in additional funds going to the worse-off provinces. Annexes 1 and 2 describe in detail how the value of the capitation payment for each province – including the "equity" component – is calculated and verified, and the "tracer" indicators are listed in Table A1-1.

[22] Services covered by the HBP were selected based on their effectiveness in addressing diseases that impose a large burden for each selected population group, mainly preventative and primary health care services. The HBP would be periodically reviewed in agreement with the Government and the Bank, as established in the OM.

34. **A share of the capitation payments would be financed from domestic resources, and this share would be rising over the life of the Project**. This is in line with the Government's goal of gradually taking over the financing of the capitation payments. See the "Sustainability" section for more on this.[23]

35. **The funds from the capitation payments for each province would be transferred to health service providers to support the provision of services in the HBP, through "fee-for-service" payments as well as incentives to adopt an effective strategy for "empanelment" and eventually for selected quality-of-care indicators.** Under the Project, strategic purchasing by provinces to incentivize the use of key (especially preventative) services via "fee-for-service" payments would continue[24], building on the successful experience of the *Sumar* program. But other types of provider payment modalities will also be used, including incentive payments to encourage activities related to "empanelment" (see Box A1-4 in Annex 1). Providers would largely have autonomy in the use of these funds. Eventually, bonus payments would also be made to health facilities for attaining targets for selected quality-of-care indicators, to be chosen from the measures tracked under activity (b) of Sub-Component 2.1 – starting with pilots in selected provinces with better information systems. Later, more complex pilots may be introduced (see Annex 1).

36. **Sub- Component 1.2. Making Capitation Payments for the Provision of Selected High-Complexity Disease Interventions (US$42.20 million, US$21.10 million from IBRD):** This Sub-Component would finance capitation payments for the provision of a separate package of HCD-related services to the eligible population, as part of a newly created National Fund for High-Complexity Diseases (NFHCD). The HCDs include congenital heart diseases, congenital malformations and selected cardiovascular procedures. This Fund would be similar in design (with similar implementation arrangements) to the Solidarity Reinsurance Fund for Catastrophic Diseases (FRSEC) under the *Sumar* program. This Fund would replace the FRSEC and would operate as a public health insurance system for services related to HCDs.[25] Each month the MSN will transfer capitation payments to the NFHCD based on the number of beneficiaries enrolled in the Program, to create a risk pool at the national level. (See Annex 1 for further details). The funds will be used to make payments to authorized providers for the provision of services included in the HCD package to the eligible population.

37. **Component 2: Strengthening the Institutional Capacity of the National and Provincial Ministries of Health (US$110.96 million, US$54.70 million from IBRD).** This component would have two Sub-Components, as follows:

[23] The National Government would establish co-financing shares for the provinces' financial contributions to the "basic" capitation payments (for the GHIs). An alternative co-financing mechanism would eventually be introduced for the provinces, designed to incentivize traceability of patients along the entire continuum of care, for key "lines of care". Provinces would be allowed to provide their required co-financing for the capitation payments in the form of public provision of certain curative (treatment/follow-up) services outside the package supported by the Project (mostly preventative services). The OM will set the terms for the domestic co-financing. This would not imply any change in the nature or share (i.e. co-financing percentage) of the contribution by the Project Loan to the capitation payments.

[24] The fee for each service included in the HBP would be defined by each province, allowing flexibility so that the higher capitation payments (per person with effective coverage) received by the worse-off provinces under the "equity" component would translate into higher fees for services provided (and higher payments for "empanelment"-related activities).

[25] Maintaining a national structure for this Fund is appropriate, because: (i) a national structure for the existing FRSEC under the *Sumar* program has proved to be effective; and (ii) national (inter-provincial) networks are needed to address HCDs, since many provinces (with quite small populations) do not have the capacity to maintain intra-provincial networks for HCD interventions.

38. **Sub-Component 2.1. Providing Support to the National and Provincial Ministries of Health for Increasing their Coordination and Establishing an Integrated Quality-Based Model of Care (US$44.83 million, US$27.26 million from IBRD).** This Sub-Component would provide support towards increased coordination and establishment of an integrated quality-based model of care within the public health subsystem through: (a) the enhancement of participating provinces' efforts towards "empanelment" and the carrying out of training to health workers at primary care facilities for the targeting of new eligible patients within the geographical area mapped to each health facility; (b) the development and tracking of effective quality-of-care measures at the health facility level; (c) the definition of services and standards for the entire public health subsystem; (d) the improvement of integration of health information systems; (e) the provision of support for cost recovery by public health service providers from *Obras Sociales* (OS); (f) the enhancement of coordination among different health programs; and (g) the provision of technical assistance (TA) including the carrying out of studies and evaluations, and the development and implementation of mechanisms for payments to health service providers.

Box 2. Details on Activities to be Financed Under Sub-Component 2.1 (see also Annex 1)

a) **Activities related to "empanelment"**: Provinces will be provided with tools, training and TA to be able to effectively enhance their efforts towards "empanelment", including via the use of geo-referencing tools. In addition, tools and training will be provided to facilitate and encourage efforts by health workers at primary care facilities to actively seek new eligible patients within the geographical area mapped to each health facility. (See Box A1-4 in Annex 1 for more).
b) **Developing and tracking effective quality-of-care measures at the health facility level**: Appropriate measures (see Annex 1) will be developed for the Argentinian context, starting with pilots in provinces with better information systems. Mechanisms for reporting, verifying and tracking the key quality indicators will also be developed.
c) **Defining services and standards for the entire public subsystem**. This includes: (i) establishing mechanisms for defining and systematizing an explicit package of services for the entire public subsystem, especially for key clinical pathways (i.e. "lines of care", including services and protocols), based on common agreements on required quality standards and delivery conditions; (ii) defining mechanisms for harmonization (with a convergence plan) around common standards, services and service definitions, clinical guidelines and protocols, models of care, referral networks and information standards; and (iii) designing and implementing an explicit prioritization mechanism for including health services in the HBP (to be revised periodically).
d) **Improving integration of Health Information Systems**. This would include: (i) activities to support the establishment and adoption of basic Information System interoperability standards related to the use of reference registries and standard clinical terminology, vocabularies, clinical document structure and interoperability; (ii) cross-cutting activities related to improvement of eHealth Governance, and adoption of appropriate IT and supporting change management to accompany investments supporting digital data entry at the "point-of-care"; and (iii) advanced activities related to connecting health service providers and promoting electronic information transfer along the line of care; supporting standardization and integration of data flows across programs; digital solutions to support "empanelment" efforts; and improving and streamlining procedures for billing.
e) **Supporting cost recovery efforts by public health service providers from *Obras Sociales***. This would include: (i) analysis of key problems and implementation obstacles with the current cost-recovery system; potential improvements in regulation regarding cost-recovery from the OSPs and the INSSJP; and implications of expanding the system to also include primary health care facilities; (ii) training activities for hospital administrative staff in cost recovery efforts and systems; and (iii) technical support for the process of

registration of public hospitals as Public Hospitals with Decentralized Management (HPGDs) which are legally allowed to invoice the OSs.

f) **Enhancing coordination among different health programs:** This would include: (i) the establishment of integrated implementation teams at the provincial and national levels (involving teams implementing different programs), (ii) the development of a detailed plan showing the roles and responsibilities of each program clearly defined in a complementary way within the overall UHC Framework; (iii) joint planning to address various types of coordination challenges now inherent in the system (e.g. for referral networks and drug-tracking – see Annex 1 for more details); and (iv) eventually, a combined technical audit for all programs (including the Project, as well as others like *Proteger* and *Redes*) – that until now have required separate audits for each.

g) **Providing TA**, including the carrying out of studies and evaluations, and the development and implementation of mechanisms for payments to health service providers.

39. **Sub-Component 2.2: Improving the Service Delivery Capacity of the National and Provincial Ministries of Health to Enhance Effective Coverage in the Public Health Subsystem (US$66.13 million, US$27.44 million from IBRD).** This sub-component would support improvements in the capacity of the MSN and MSPs required to enhance effective coverage in the public health subsystem through: (a) the provision of equipment, based on a systematic analysis of service delivery gaps identified per participating province, especially at the primary level for key "lines of care" and for HCD networks; (b) the provision of equipment, services and information technology for the MSN and MSPs, based on a systematic analysis of gaps and the level of provincial involvement in the activities supporting the integration of information systems under activity (d) of Sub-Component 2.1. The Results Framework would include an indicator to track the impact of the equipment delivered on the utilization of services in the key lines of care.

40. **Component 3: Supporting Management, Monitoring and Evaluation (US$66.53 million, US$52.08 million from IBRD).** This component would finance: (i) technical assistance to strengthen the capacity of the National Project Coordination Team (PCT), MSN's International Financing Team (UFI-S), the Undersecretariat of Administrative Coordination (UAC), and the Provincial Project Implementation Units (PIUs)[26]; (ii) Project monitoring and evaluation activities; and (iii) financial and independent technical audits for the Project.

41. **The Project has not been screened for short and long-term climate change and disaster risks.** The Project Concept Note Review for this Project was carried out on June 26, 2017, and the climate change and disaster screening applies to IBRD operations with a Project Concept Note Review on July 1, 2017 or later. However, during Project preparation, the Climate Co-Benefits Assessment team conducted a preliminary assessment and concluded that the Project cannot be assigned climate co-benefits. The reason for this was that the activities supported by the Project are not included in the list of Eligible Mitigation Activities defined in the "Joint MDB Methodology for Tracking Climate Finance". Notwithstanding, the Project supports improvements in primary health care and disease prevention, which can be seen as forms of climate change mitigation (World Health Organization, 2008[27]), as they reduce the need for energy-intensive health care services and hence the climate footprint of the health sector.

[26] The activities of the PCT and PIUs will include outreach and communication activities to help attain the goals of enhanced coordination and integration under the Project.

[27] "Healthy Hospitals Healthy Planet Healthy People: Addressing Climate Change in Health Care Settings." Discussion draft paper published by the World Health Organization (2008).

42. **The Project would have a strong focus on gender**. An analysis was conducted during the Project preparation stage on gender-disaggregated measures of: (i) utilization of key health services (especially related to NCDs screening), and of: (ii) the incidence of common chronic conditions such as hypertension, diabetes, cardiovascular disease and common cancers (and related mortality rates), using available data. Key findings of this analysis include the following: First, utilization of key preventative health services (e.g. related to NCDs screening) tends to be substantially higher among women than men (e.g. 86.6% vs. 77.8% for high blood pressure testing and 82.9% vs. 70.2% for blood glucose testing[28]). This, in turn, helps explain why effective coverage among the Project's eligible female population (32.1%) is much higher than among eligible males (21.3%). Second, there are significant differences between women and men in the burden of disease – i.e. the share of total DALYs lost – due to several key conditions (e.g. 15.1% vs. 17.2%, 2.87% vs. 2.75% and 1.35% vs. 1.61% for cardiovascular disease, diabetes and colorectal cancer respectively).[29] Third, while the burden of disease from cancer overall is similar among women and men, specific cancers impose a particularly high burden on women (e.g. 2.73% and 1.50% for breast and cervical cancer) and others on men (e.g. 1.21% for prostate cancer). And fourth, men have a substantially higher estimated prevalence of hypertension – linked to several dangerous conditions such as heart and kidney disease, and stroke – than women (34.5% versus 29%).[30]

43. Reducing these gender gaps in coverage and outcomes will be key under the Project, and will be reflected in the Project's activities. For example, the efforts towards increased "empanelment" are expected to have a strong positive impact on the utilization of key preventative health services by men, whose utilization levels are currently much lower than among women. In turn, this would increase NCDs screening among men, and would help reduce the gender gap for the burden of disease from conditions like cardiovascular disease and colorectal cancer. Improved continuity of care is expected to have a disproportionately high positive impact on the burden of disease among women from conditions such as diabetes, where the burden of disease is higher among women to begin with. Improved care for pregnant women is an important part of the Project, and this will also help reduce the burden of pregnancy-related diabetes among women. In addition, the Project will place particular emphasis on breast and cervical cancer, which impose a high burden of disease among women, by fostering early diagnosis and integrated health care within the public health system for these conditions. Finally, the Project will include several indicators to be monitored on a gender-disaggregated basis, or that will track utilization among women only (see below).

44. **The Project's emphasis on citizen engagement would be strong and would include**: (i) a grievance redress mechanism, including a toll-free number to provide feedback and register complaints, with stipulated service standards for response times (this is linked to an indicator in the Project's Results Framework); (ii) a strong participatory process for development of the Indigenous Peoples Plans (IPPs).

B. Project Cost and Financing

45. The Project will be financed and implemented over a four-year period. The total Project cost

[28] Among women and men, respectively, aged 18 years and above, for both these indicators.
[29] Figures are from the Global Burden of Disease Study by the Institute of Health Metrics and Evaluation (IHME), 2016.
[30] See "Trends in Prevalence of Hypertension in Argentina in the Last 25 Years: a Systematic Review of Observational Studies", by Diaz A. and Ferrante D., in the *Pan-American Journal of Public Health* 38(6) – December 2015, pages 496-503.

would be US$658.05 million, of which US$300 million would be financed through an IBRD Loan. US$479.81 million of Project funds would be transferred to participating provinces and providers using results-based mechanisms to provide adequate incentives to those involved in key activities supported by the Project, while ensuring agile and effective loan disbursement mechanisms.

Project Components	Project cost	IBRD or IDA Financing	Trust Funds	Counterpart Funding
1- Support the Strengthening of Effective Public Health Coverage	479.81	192.47		287.34
2- Strengthening the Institutional Capacity of the National and Provincial Ministries of Health	110.96	54.70		56.26
3- Supporting Management, Monitoring and Evaluation	66.53	52.08		14.45
Total Costs				
Total Project Costs	657.30	299.25		358.05
Front End Fees	0.75	0.75		0.00
Total Financing Required	658.05	300.00		358.05

C. Lessons Learned and Reflected in the Project Design

46. The Bank's experience with financing health projects in Argentina (see above) indicates that:

a. **RBF schemes, rather than traditional financing of inputs, successfully foster good governance in service delivery and improved health results**. **Agreements signed with provinces help ensure sustainability over time, even with changes in Government administrations.** Performance agreements and financial transfer mechanisms linked to results with effective monitoring have offered clear incentives to provinces and health service providers to accomplish specific health results.

b. **Organizational changes introduced by RBF are demanding, both technically and institutionally.** Implementation of the Project will require substantial TA from the PCT to provincial units and health care providers, as well as intense policy dialogue and technical supervision by the Bank.

c. **Flexible design is important to adjust to institutional capacities of different provinces and changes in the health condition of the eligible population**. A flexible design allowing for changes to be readily made as needed to tracers, tracer goals and services included in the HBP is essential, in this context.

IV. IMPLEMENTATION

A. Institutional and Implementation Arrangements

47. **The Project would build on the successful implementation arrangements under the *Sumar* program. It would be implemented by the MSN through the Project Coordination Team (PCT) (established within the MSN) which currently supports the *Sumar* program.** The PCT would be responsible for working with participating provinces through the Provincial Implementation Units (PIUs) to implement the Project in a timely manner, conforming to agreed-upon quality standards. The Project would finance 45 percent of the PCT staffing. Once the Project is completed, the MSN would assume full financial responsibility for PCT staffing. The PCT would work closely with teams implementing other key Programs such as *Proteger*, *Redes* and *CUS-Medicamentos*, as well as the *National Sexual and Reproductive Health, School Health, Adolescent Health, Tobacco Control* and *Diabetes Control Programs*.

48. **The Undersecretariat of Administrative Coordination (UAC) of the MSN, through a team responsible for international financing (UFI-S), would be in charge of overall administrative and fiduciary matters,** such as financial management (FM) and procurement. The UAC (through this team) would be responsible for: managing procurement processes; monitoring contract administration; processing payments to suppliers and consultants; managing the Project finances, including control of the Designated Account (DA) and flow of funds; accounting and financial reporting; and collecting information for disbursements.

49. **The UAC, through its relevant departments, will be responsible for the management and transfers of the capitation payments,** in coordination with the PCT. The UAC will also coordinate with the PCT to ensure proper monitoring of the external and internal audit processes and to ensure that the penalties and deductions from the audits are applied properly. All remaining fiduciary functions will be carried out by the UAC through its International Financing Team. This is in line with a key objective of the current National Government administration, which is to institutionalize – and eventually fully take over the management of – the capitation payments sub-components, which are at the core of the Project.

50. **Project implementation at the provincial level would be carried out by the MSPs of participating provinces, through the Provincial Implementation Units (PIUs) currently under the *Sumar* program –** working closely with provincial teams implementing other programs, as part of coordinated structures implementing the UHC Strategy at the provincial level. The structure of the PIUs, including the minimum number of staff for each sub-unit within the PIU and their terms of references, is specified in the Operational Manual (OM).

51. **Participation by provinces would be governed by an Umbrella Agreement signed between each province (represented by the Governor and the Minister of Health) and the MSN, to cover the duration of the Project period.** These agreements would cover all legal, technical, financial, administrative, fiduciary and safeguards aspects of provincial participation in the program. The PIUs and the PCT would also sign Annual Performance Agreements, which would include annual targets for the tracer indicators and for enrollment and "empanelment", as well as details on work programs and resource requirements.

B. Results Monitoring and Evaluation

52. Progress toward achieving the PDO will be monitored using the Project's PDO-level Results Indicators which will be tracked using the MSN's Monitoring and Evaluation (M&E) system. Intermediate results indicators will be used to track implementation progress for different activities. Several indicators, including all three PDO indicators, will be monitored on a gender-disaggregated basis. Gender-disaggregated baseline and target values for these indicators are provided for men and women separately in the Operational Manual. In addition, two intermediate indicators measure utilization of specific health services among women only. The full Results Framework is in Section VII.

53. Data needed on beneficiaries, coverage and on provincial "tracer" indicators will initially come from the Roster Management System and the Tracer System currently used by the *Sumar* program. Eventually these data will come from integrated program databases maintained at the provincial level (covering various public-sector programs) and expanded data collected at the health service provider level (e.g. related to "empanelment"), as provinces make progress with integration of information systems under activity (d) of Sub-Component 2.1. Data on various other health and mortality indicators from sources such as the MSN's Directorate of Statistics and Health Information (DEIS) will also be monitored.

C. Sustainability

54. The MSN plans to increase its share of financing of the capitation payments from national budgetary resources during the lifetime of the Project, with the goal of assuming these fully (with limited amounts of co-financing also expected from the provinces) after the Project ends. This is because these capitation payments are an essential part of the Government's flagship UHC Strategy. This plan will be feasible since (also see Annex 4): (i) the National Government has proven in the past that it is ready to fully take over the financing of essential externally funded programs (e.g. *Remediar)* from its own resources, without reducing budget allocations for other programs; and (ii) the full cost of the capitation payments (that the MSN would mostly be responsible for after Project closing, with relatively low co-financing shares by the provinces) would constitute a small share of the MSN's budget, even assuming limited growth in the MSN budget. (In fact, global evidence shows that public health spending typically rises over time as a share of total public spending, and the latter is projected to grow significantly in Argentina in the coming years). Required provincial contributions to the capitation payments are likely to remain very low as a share of total provincial public health spending.

D. Role of Partners

55. The Primary Health Care Performance Initiative (PHCPI) is a partnership of the World Bank, the World Health Organization and the Bill and Melinda Gates Foundation to catalyze global improvement in primary health care through better performance measurement and knowledge sharing. As part of this Project, the PHCPI will be providing and financing TA to the MSN to support the selection and definition of quality of care indicators under the Project and to support the development of a national yet internationally comparable scorecard assessing the performance of the primary health care system. This scorecard will be updated every two years and results will be made available on the PHCPI website.

V. KEY RISKS

A. Overall Risk Rating and Explanation of Key Risks

56. **The overall Project risk is assessed as Substantial, mainly due to the implementation-related risks.** The main risks identified and their mitigating mechanisms are stated below:

57. Risks related to Technical Design and Institutional Capacity for Implementation and Sustainability are rated as Substantial. This is because the Project aims to address some of the inherent weaknesses in coordination in the country's health system, which will require cooperation by various actors at the provincial and national levels (e.g. to adopt common standards), and may be challenging, given: (i) the number of actors involved; (ii) possible changes in some of the key actors and administrations over time; and (iii) the rather high technical requirements for implementation of some of the Project's activities. These risks will be mitigated by efforts to ensure strong implementation structures at the national and provincial level, constant dialogue with the MSN, use of Nation-Province Agreements signed by the Governor for each province, and a robust structure of financial incentives to encourage actors to coordinate in appropriate ways. In addition, the Project would finance technical assistance to strengthen the Government teams responsible for implementation, including on technical and institutional aspects.

58. The Fiduciary risk is rated Substantial, due to: (i) the variety of participating institutions involved in project implementation, which will include the UAC through its UFI-S and its other relevant departments for FM and disbursement functions; (ii) the complexity of the capitation payments scheme, due to the intervention of UFI-S and the relevant departments under the UAC for funds management as well as accounting; (iii) capitation payments that will be geographically spread across the entire country; and (iv) insufficient procurement capacity in the UFI-S, even though they have prior experience with Bank-financed projects..

59. Taking into consideration the special features of the proposed activities, the following mitigation measures will be implemented to cope with the identified fiduciary risks: (i) capitation payments (and reported enrollment and tracer achievement) would be audited by an external audit firm with TORs acceptable to the Bank; (ii) the Audit and Supervision Area within the PCT would continue supervising the provinces' technical and financial implementation; (iii) the provinces' use, control, recording and reporting of the capitation payments would be governed by a Nation-province Umbrella Agreement; (iv) clear definitions of roles, responsibilities and procedures among the MSN areas involved in the capitation transfers and procurement of goods and consultancies would be documented in the OM; (v) strengthening of the UAC would be achieved through capacity building activities; (vi) Interim Unaudited Financial Reports (IUFRs) for disbursement purposes would be reviewed by the Task Team; (vii) UFI-S would be strengthened with experienced procurement professionals; and (viii) a control panel or similar tool would be implemented to ensure close monitoring of each milestone in the procurement process and contract supervision.

VI. APPRAISAL SUMMARY

A. Economic and Financial Analysis

60. An economic analysis (see Annex 4) was conducted for the Project, taking into account two quantifiable economic benefits: (i) improved health outcomes in the form of – among others – reduced cancer and maternal mortality rates as well as reduced NCD-related morbidity rates (in particular related to type-2 diabetes); and (ii) cost savings at the hospital level from reduced avoidable admissions. Other benefits – such as from enhanced coordination and improved information systems, which are expected to have a very strong and positive, catalytic impact on the system – were not incorporated into the analysis, and were thus in effect treated as zero. Despite this, the Net Present Value of the interventions is high (at least US$227 million, in different scenarios) and the estimated internal rate of return ranges between 14.5 and 16.8 percent, depending on the discount factor used.

B. Technical

61. The Project would have a particular focus on enhancing coordination and promoting an integrated model of care for key "lines of care". After consultation with technical experts, it was decided to focus on three sets of "lines of care", based on the burden of disease and common conditions in the country: (i) common adult cancers (breast, cervical cancer and colorectal cancer); (ii) common chronic diseases/conditions (high-risk cardiovascular disease, Type 2 Diabetes in adults and hypertension); and (iii) maternal and child health (low-risk pregnancies, high-risk pregnancies, and care for children up to 48 months of age). Project interventions will be selected accordingly to focus on these priority "lines of care". Additional priority "lines of care" may be introduced later, as needed.

C. Financial Management

62. Most of the FM arrangements for the Project will build on the arrangements in place for the *Sumar* program. The UAC, through its UFI-S, will be responsible for overall FM and disbursements functions comprising: (i) managing the Project's designated account; (ii) transferring funds assuring adequate and timely financing of eligible expenses; (iii) preparing Project accounting records and financial reporting required by the Bank; and (iv) complying with external auditing arrangements. However, the MSN intends to gradually institutionalize the Project, increasing the use of its own line departments with support from the UAC, for managing the Results-Based Capitation Payments scheme for which the Bank's financing will be gradually decreasing.

63. An FM Assessment was carried out to assess the adequacy of financial management arrangements[31] in place at the UFI-S[32] and UAC, both under the MSN. It was determined that FM

[31] The Financial Management Assessment (FMA) was conducted in accordance with OP/BP 10.00 and in line with specific Bank Guidelines Manual for World Bank-Financed Investment Operations; document issued by Operations Policy and Country Services OPCFM on March 1, 2010.

[32] UFI-S was created in 2009 and reports directly to the Minister of Health (Resolutions 98/2000 and 231-E/2017).

arrangements in place are acceptable to the Bank. UFI-S and UAC are both capable of providing reliable and timely financial reporting to adequately support Project implementation.

D. Procurement

64. Procurement will be conducted using the Bank's 'Procurement Regulations for IPF Borrowers', issued in July 2016 (revised in November 2017), for the supply of goods, works, non-consulting and consulting services. The Borrower prepared a Project Procurement Strategy for Development (PPSD) that establishes the procurement arrangements to enable the delivery of value for money in achieving the PDO. Since the fiduciary function will be executed centrally by the UAC, through its UFI-S, a procurement capacity assessment was carried out for the existing structure. The assessment revealed that although the UFI-S has extensive experience implementing Bank's financed projects, the team should be strengthened with experienced staff and internal processes should be reviewed to ensure efficiency in the implementation of the procurement processes. The Action Plan to manage these risks is provided in Annex 2.

E. Social

65. About 2.5 percent of the Argentinian population self-identifies as having indigenous ancestry. Although there is little information on their health status, available information points to important and persisting gaps in access and health outcomes. The Project does not anticipate adverse effects on these or other vulnerable populations. On the contrary, it is likely to improve health care access and monitoring through the activities described in the Indigenous Peoples' Planning Framework (IPPF).

66. The Project will build on and continue benefitting from the MSN's experience with OP 4.10 (Indigenous Peoples) under previous and ongoing operations. An IPPF was prepared and consulted with relevant Indigenous Peoples (IP) representatives on October 26, 2017, and disclosure in-country was done on November 17, 2017 and on the World Bank's (WB) webpage on November 27, 2017. A round of consultations at the subnational level will be carried out during the design of the respective Indigenous Peoples Plans (IPPs). The IPPF will be implemented and monitored by the existing Safeguards Teams under MSN, created in 2007 under the Essential Public Health Functions and Programs (EPHFP) I Project. These teams, which are already staffed, have been strengthened via the implementation of previous projects and maintain effective linkages institutionally with the provincial governments. In addition, the MSN will continue to collaborate with other health programs to develop and strengthen health policies for indigenous peoples, mainstreaming health care practices consistent with their needs and views on health.

F. Environment

67. The findings from the Project's Environmental Assessment led to a Category B rating, and to the triggering of OP / BP 4.01 (Environmental Assessment). The environmental activities of the Project would be implemented by the MSN Safeguards Teams, mentioned above. (The MSN has solid experience working with World Bank Safeguards procedures). Most investments under the Project would take place in already-existing infrastructure, nationwide, and would not involve natural habitats, forests or cultural property. The specific locations of the proposed interventions would be defined during Project implementation. Argentina has comprehensive national legislation in place to guide health care waste management practices.

68. Provinces will designate focal points/teams or environmental health units, and develop action plans for health care waste management. The Safeguards Teams at MSN formulated an Environmental Management Framework (EMF) through a process of consultation and consensus with the environmental health units of the Argentine provinces. The Project's EMF was publicly consulted through two mechanisms: (i) five regional meetings (one in person and four by videoconference) with representatives of hospitals, environmental areas of the provincial health ministries, and relevant NGOs and key actors involved in environmental issues; and (ii) a survey aimed at the key actors identified under the EPHFP II Project and *Sumar* program. Disclosure of the EMF in-country was done on November 17, 2017 and via the World Bank's webpage on November 27, 2017.

G. World Bank Grievance Redress

69. Communities and individuals who believe that they are adversely affected by a WB supported project may submit complaints to existing project-level grievance redress mechanisms or the WB's Grievance Redress Service (GRS). The GRS ensures that complaints received are promptly reviewed in order to address project-related concerns. Project affected communities and individuals may submit their complaint to the WB's independent Inspection Panel which determines whether harm occurred, or could occur, as a result of WB non-compliance with its policies and procedures. Complaints may be submitted at any time after concerns have been brought directly to the World Bank's attention, and Bank Management has been given an opportunity to respond. For information on how to submit complaints to the World Bank's corporate Grievance Redress Service (GRS), please visit http://www.worldbank.org/en/projects-operations/products-and-services/grievance-redress-service.
For information on how to submit complaints to the World Bank Inspection Panel, please visit www.inspectionpanel.org.

VII. RESULTS FRAMEWORK AND MONITORING

Results Framework

COUNTRY : Argentina

Supporting Effective Universal Health Coverage in Argentina

Project Development Objectives

The Development Objective of the proposed Project would be to: (i) increase effective and equitable coverage of key health services provided to the eligible population; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system.

Project Development Objective Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of eligible population with effective health coverage.		Percentage	26.70	40.00	Annual	Project Roster Management System; Health services database; INDEC and DEIS statistics.	PCT – MSN
Description: Numerator: Eligible population with effective health coverage. Denominator: Total eligible population. This indicator will also be monitored on a gender-disaggregated basis, with baseline and target values provided for men and women separately in the Operational Manual. The baseline value for men for this indicator (21.3%) is lower than that for women (32.1%), because men tend to place much less importance on visiting health providers regularly, even for basic checkups. The Project aims to substantially close the effective coverage gap between men and women.							
Name: Percentage of eligible adults with hypertension		Percentage	0.00	30.00	Annual	Health services database.	PCT– MSN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
that are diagnosed, in regions with poorest health outcomes						The baseline data for the indicator is not yet available and will be determined in the first year of the project.	
Description: Numerator: Number of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes. Denominator: Estimated number of eligible adults with hypertension, in regions with poorest health outcomes. The rationale for selecting this indicator was based on the fact that the poorer Northern and the Northwest regions generally have the poorest health outcomes, including for NCDs. Thus, an NCD coverage indicator was selected to measure interprovincial equity. This indicator will also be monitored on a gender-disaggregated basis, with baseline and target values provided for men and women separately in the Operational Manual.							
Name: Percentage of eligible population enrolled and assigned to a health facility, for continuous care ("empaneled").		Percentage	0.00	12.00	Annual	Project Roster Management System.	PCT – MSN
Description: Numerator: Eligible population enrolled in the Program and assigned to a specific health facility, for continuous care (empaneled) according to the provincial definition of empanelment as agreed with the MSN. Denominator: Total eligible population. Empanelment refers to the assignment of the eligible population to a regular primary health care provider for provider continuity. This strategy implies that the primary health care provider should seek, identify and formally register these people as "patients" and ensure comprehensive and continuous care. This indicator will also be monitored on a gender-disaggregated basis, with baseline and target values provided for men and women separately in the Operational Manual.							

Intermediate Results Indicators

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Name: Percentage of eligible pregnant women with early antenatal care.		Percentage	14.70	25.00	Annual	Project Roster Management System; Health services database; INDEC and DEIS statistics.	PCT – MSN
Description: Numerator: Number of eligible pregnant women receiving at least one antenatal care service before the 13th week of pregancy. Denominator: Number of eligible pregnant women.							
Name: Percentage of eligible women 25 - 64 years of age with at least one cervical cancer screening according to defined protocols.		Percentage	19.60	25.00	Annual	Project Roster Management System; Health services database; INDEC and DEIS statistics.	PCT – MSN
Description: Numerator: Eligible women aged 25-64 years with PAP or Human Papillovirus (HPV) sample and / or PAP or HPV test result following defined protocols. Denominator: All eligible women aged 25 - 64 years.							
Name: Percentage of eligible population with hypertension under treatment.		Percentage	0.00	25.00	Annual	Project Roster Management System; Health services database; INDEC and DEIS statistics. The baseline data for the	PCT- MSN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
						indicator is not yet available and will be determined in the first year of the project.	
Description: Numerator: Number of people in eligible population with hypertension receiving drug treatment for this condition. Denominator: Number of people in eligible population with hypertension. This indicator will also be monitored on a gender-disaggregated basis, with baseline and target values provided for men and women separately in the Operational Manual.							
Name: Percentage of participating provinces with reported health services for selected key lines of care.		Percentage	0.00	29.00		Health services database.	PCT - MSN
Description: Numerator: Number of participating provinces with reported key health services for selected key lines of care. Denominator: Total number of participating provinces. Selected key lines of care include: Cervical cancer; Type 2 Diabetes and Prenatal care for low-risk pregnancy							
Name: Percentage of primary health care providers georreferenced and with a catchment area defined.		Percentage	0.00	80.00	Annual	MSN administrative data sources	PCT – MSN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Numerator: Number of primary health care providers participating in the Program georeferenced and with a catchment area defined. Denominator: Total number of primary health care providers participating in the Program							
Name: Percentage of participating provinces implementing the agreed Interoperability Plan for Information Systems.		Percentage	0.00	50.00	Annual	PCT supervision report.	PCT – MSN
Description: Numerator: Number of participating provinces adhering to the agreed Interoperability Plan for Health Information Systems, with presentation of provincial Action Plans and agreed targets. Denominator: Total number of participating provinces.							
Name: Percentage of participating provinces successfully meeting their annual IPP goals.		Percentage	61.00	83.00	Annual	PCT supervision report.	PCT – MSN
Description: Numerator: Number of participating provinces with IPPs meeting at least 60% of the annual IPP goals. Denominator: Total number of participating provinces that trigger OP 4.10.							
Name: Percentage of participating provinces implementing actions to disseminate information on the Project's grievance redress mechanism.		Percentage	54.00	83.00	Annual	PCT supervision report.	PCT – MSN

Indicator Name	Core	Unit of Measure	Baseline	End Target	Frequency	Data Source/Methodology	Responsibility for Data Collection
Description: Numerator: Number of participating provinces that: (i) disclose online information on the Project's grievance redress mechanism, and (ii) display visual material on this at 40% or more of contracted health facilities. . Denominator: Total number of participating provinces.							
Name: Percentage of participating public health facilities billing to the social security institutions.		Percentage	25.00	30.00	Annual	PCT supervision report.	PCT – MSN
Description: Numerator: Number of public health facilities participating in the Program that are billing to OSs for use by OS members of services provided. Denominator: Total number of public health facilities participating in the Program.							
Name: Percentage of health facilities with service delivery capacity strengthened for key lines of care, through medical equipment provision.		Percentage	0.00	40.00	Annual	MSN administrative data sources.	PCT – MSN
Description: The percentage of all health facilities under the program that: (i) have received medical equipment for key "lines of care" under Sub-Component 2.2 and: (ii) have seen an increase of at least 10% in the number of relevant services that are billed under the program. "Relevant services" refers to health services in the "lines of care" for which medical equipment was provided.							

Target Values

Project Development Objective Indicators

Indicator Name	Baseline	End Target
Percentage of eligible population with effective health coverage.	26.70	40.00
Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes	0.00	30.00
Percentage of eligible population enrolled and assigned to a health facility, for continuous care (“empaneled”).	0.00	12.00

Intermediate Results Indicators

Indicator Name	Baseline	End Target
Percentage of eligible pregnant women with early antenatal care.	14.70	25.00
Percentage of eligible women 25 - 64 years of age with at least one cervical cancer screening according to defined protocols.	19.60	25.00
Percentage of eligible population with hypertension under treatment.	0.00	25.00
Percentage of participating provinces with reported health services for selected key lines of care.	0.00	29.00
Percentage of primary health care providers georreferenced and with a catchment area defined.	0.00	80.00

Indicator Name	Baseline	End Target
Percentage of participating provinces implementing the agreed Interoperability Plan for Information Systems.	0.00	50.00
Percentage of participating provinces successfully meeting their annual IPP goals.	61.00	83.00
Percentage of participating provinces implementing actions to disseminate information on the Project's grievance redress mechanism.	54.00	83.00
Percentage of participating public health facilities billing to the social security institutions.	25.00	30.00
Percentage of health facilities with service delivery capacity strengthened for key lines of care, through medical equipment provision.	0.00	40.00

ANNEX 1: DETAILED PROJECT DESCRIPTION

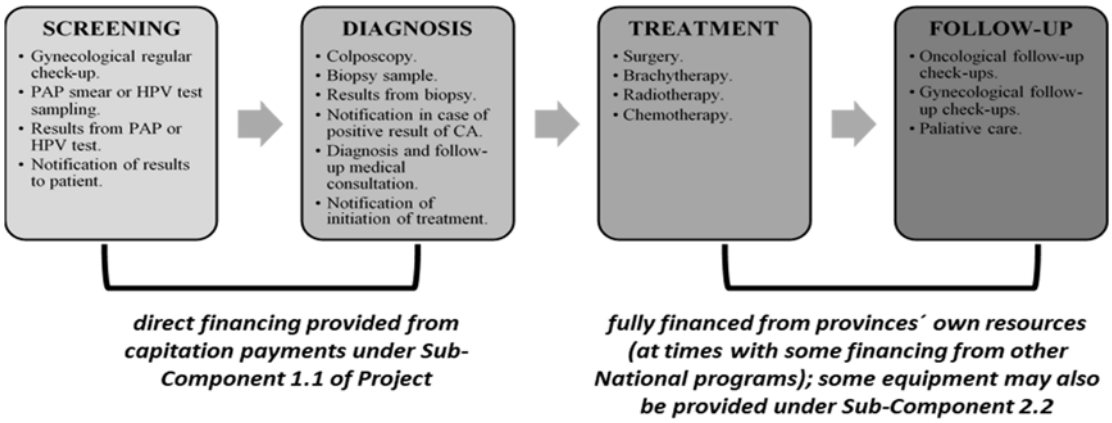
COUNTRY : Argentina
Supporting Effective Universal Health Coverage in Argentina

1. **The Project would aim to enhance effective UHC among the eligible population**, especially for key "lines of care" that are closely related with key drivers of the burden of disease (e.g. diabetes, cervical cancer – see Box A1-1).

Box A1-1: Key "Lines of Care" for the Prioritized Package of General Health Interventions

A line of care can be described as a set of health services that are continuous, comprehensive and integrated, covering health interventions for promotion, prevention, treatment and follow-up/monitoring for a disease/condition. An example of a line of care is given below for cervical cancer.

Line of Care for Cervical Cancer:



The Project would provide financing for certain services – those in the prioritized HBP, mostly preventative (including diagnostic) services – in key lines of care, from the capitation payments under Component 1. (This is illustrated for the cervical cancer line of care above). Other services in the key lines of care – mostly curative and follow-up services – would continue to be fully financed from provinces' own resources (at times with some financing from other National programs), and some equipment may also be provided for these under Sub-Component 2.2. Even though financing would not be provided for the curative services under the key lines of care (except possibly via some equipment purchase), the Project is designed to incentivize actors to work to enhance implementation for all services throughout the entire line of care – through enhanced patient traceability and continuity of care (including continuity of information).

After technical discussions, nine key lines of care were identified for the Project, grouped into three sets:
i) Lines of care related to common adult cancers: breast cancer; cervical cancer; and colorectal cancer.
ii) Lines of care related to common chronic diseases/conditions: being at high risk of cardiovascular disease; Type 2 Diabetes in adults; and hypertension.
iii) Lines of care related to maternal and child health: care for low-risk pregnancies; care for high-risk pregnancies; and care for children up to 48 months of age.

2. **Component 1: Support the Strengthening of Effective Public Health Coverage (US$479.81 million, US$192.47 million from IBRD).** This Component would finance capitation payments for the provision of a prioritized Health Benefit Plan (HBP)[33] consisting of: (i) selected GHIs; and (ii) selected health interventions for HCDs. The HBP will contribute to improving the quality of services as well as extending coverage. Results will be monitored using supervision protocols and information systems, and will be verified by an independent technical auditor.

3. **The capitation payments would cover a share of the total cost of selected health services provided by service providers**. The selected services would be those in the prioritized HBP defined for the eligible population. To this end, the MSN carried out an actuarial calculation in order to estimate the incremental cost of this HBP to be financed by the Bank. (See Box A1-2 for more details on this).

4. **Sub- Component 1.1. Making Capitation Payments for the Provision of Selected General Health Interventions (US$437.61 million, US$171.37 million from IBRD).** This Sub-Component, accounting for 67% of the Project's financing, would finance results-based capitation payments for selected GHIs for all eligible people in participating provinces who are enrolled and with effective coverage. An eligible person would need to have utilized one or more essential health services – from a list of predefined services listed in the Operational Manual (OM), with the service provided according to predefined care protocols – to be considered to have "effective coverage".

5. **Health services covered by the Project were selected based on their cost-effectiveness in preventing, treating, or curing diseases that contribute significantly to the burden of disease of the selected population subgroups.** MSN and the Bank will review the list of selected general health interventions included in the HBP for each population subgroup every year. The review will take into account the rate of utilization of each intervention, and evidence of its effectiveness in solving specific health problems. This builds upon the successful experience of the *Sumar* program in incentivizing not just enrolment but also utilization of key (especially preventative) health services with adequate quality standards.

6. **The capitation payment for each province would be the sum of: (i) a "basic" component; and (ii) an additional "equity" component whose size would depend on equity considerations. The capitation payment (including both the "basic" and "equity" component) would be adjusted for provincial performance regarding selected health indicators ("tracers").** The capitation payment (after the adjustment based on provincial "tracer" performance) would be transferred to every province for each eligible person with effective coverage in the province. The introduction of an "equity" component in the capitation payment for each province is an innovation under the Project, and would result in additional funds going to the worse-off provinces. The size of the "equity" component for each province is calculated as an inverse function of the province's life expectancy at birth, which is a proxy for the province's health outcomes. Based on projections of trends in effective coverage and in "tracer" performance in each province, a maximum amount of funds has been allocated to each province for the "equity" component of the capitation payments. Once the province reaches this maximum amount, no additional funds will be transferred to the province for equity reasons. The methodology for the "equity"

[33] Services covered by the HBP were selected based on their effectiveness in addressing diseases that impose a large burden for each selected population group, mainly preventative and primary health care services. The HCDs include congenital heart diseases, some congenital malformations and selected cardiovascular procedures.

component calculation is described in Box A1 – 2 and in the Operational Manual, and any changes would need to be approved by the Bank. This methodology and the maximum amount per province would be reviewed at the Project's mid-term stage.

Box A1-2: "Basic" and "Equity" Capitation Payment Components for General Health Interventions Under the Project

The capitation payment would function as an insurance premium, as in the case of the *Sumar* program. It would be calculated for the prioritized package of general health services selected based on their cost effectiveness in preventing, treating, or curing diseases that contribute significantly to the burden of disease of the selected population subgroups. The methodology used to determine the capitation payment for each province is as follows:

First, it is necessary to calculate the full actuarial cost for the per capita insurance premium, based on the difference (per person, on average) between: (i) the full cost of service delivery for the prioritized package of health services, assuming all the requisite quality-related protocols are fully adhered to, and (ii) the current level of public spending for these services. Let this value be defined as **C** for now.

The maximum value of the capitation payment for each province i – call this $\mathbf{P_{Max,i}}$ – would consist of the sum of a "basic" component and an "equity" component. Define these as **B** and $\mathbf{E_i}$ respectively. The "basic" component B would be the same for all provinces, while the "equity" component $\mathbf{E_i}$ would differ across provinces, as explained below.

The "equity" component of the capitation payment – $\mathbf{E_i}$ for province i – would be calculated as a function of each province's life expectancy at birth, which is a proxy for the province's health outcomes. Define $\mathbf{L_i}$ as the life expectancy at birth of province i. Define $\mathbf{L_L}$ as the life expectancy at birth of the province with the lowest life expectancy, and define $\mathbf{L_H}$ as the life expectancy at birth of the province with the highest life expectancy. The next step is to calculate $\mathbf{r_i}$ for each province i, using the formula $\mathbf{r_i} = (\mathbf{L_H}–\mathbf{L_i}) / (\mathbf{L_H}–\mathbf{L_L})$. The value of $\mathbf{r_i}$ is then between 0 and 1 by construction, and $\mathbf{r_i}$ is a measure of the relative position of each province in terms of life expectancy at birth, when compared to the performance (using this measure) of the best-performing province and that of the worst-performing province. The value of $\mathbf{E_i}$ for province i is then given by the formula $\mathbf{E_i} = \mathbf{r_i}*\mathbf{s}*\mathbf{B}$, where **s** = 25%. Thus, in no case will **Ei** be higher than 25% of the "basic" component of the capitation payment (i.e. **Ei** cannot exceed **0.25*B**).

The values **C**, **B** and $\mathbf{E_i}$ (for each province in the latter case) will need to be reviewed and updated periodically. These values are stated in the Operational Manual, and any changes to them will need to be approved by the Bank.

In practice, the maximum value $\mathbf{P_{Max,i}}$ of the capitation payment for any province ($\mathbf{B}+\mathbf{E_i}$) would only be attained if the province were to attain a "perfect score" – i.e. to reach the maximum targets – for all "tracer" indicators. The "tracer" indicators are a set of indicators of provincial performance that have been carefully selected in line with the Project's goals (see Table A1-2). Of the maximum value of $\mathbf{P_{Max,i}}$, a province would automatically attain a predetermined percentage share 50% – i.e. it would attain 50% x $\mathbf{P_{Max,i}}$ – per eligible person enrolled and with effective coverage, regardless of performance. The remaining share (50% of $\mathbf{P_{Max,i}}$) would be adjusted downwards according to provincial performance regarding the tracer indicators. This methodology for adjusting downwards the size of the capitation payment based on performance regarding provincial "tracer indicators" is similar to the methodology used under the *Sumar* program.

The parameters used to determine the size of the "basic" and "equity" components are such that the sum of the "basic" and "equity" components ($\mathbf{B}+\mathbf{E_i}$ or $\mathbf{P_{Max,i}}$) will always be less than the full actuarial cost of the insurance premium **C**, even if a province were to attain the maximum targets for all tracer indicators (i.e. $\mathbf{B} + \mathbf{E_i} < \mathbf{C}$ for all provinces). This is in keeping with the principle under the *Sumar* program (and its predecessor *Plan Nacer*) that the capitation payments made to the provinces should not exceed the additional cost that the provinces would need to incur to provide a prioritized package of services following all requisite quality-related protocols.

7. The capitation payment for each province (including the "basic" and "equity" components) would consist of a portion that would not depend on performance, as well as a variable portion whose size would depend on performance regarding a set of indicators of provincial performance called "tracer" indicators. The variable portion would consist of 50% of the maximum value of the capitation payment (including the "basic" and "equity" components – see Box A1-2). The capitation payments would be transferred to provinces as follows: (i) a share of the financing (50%) would be provided after the "effective coverage" for the eligible population is verified, and (ii) the remaining share (50%) would be transferred based on achievement for a set of provincial indicators (tracers).

8. There would initially be 10 tracer indicators, including an indicator of provincial performance regarding "empanelment" (see Table A1-1). The tracer indicators are reflected in the Operational Manual, and any changes would need to be approved by the Bank.

Table A1-1: Tracer Indicators

Tracers associated with preventive health services for pregnant women, children 0-9 years of age and adolescents 10-19 years of age
Percentage of all eligible pregnant women receiving complete prenatal check-ups according to protocol.
Percentage of all eligible children 0 - 9 years of age with complete health check-ups according to protocol.
Percentage of eligible children 2 - 9 years of age with diagnosis of overweight or obesity, according to national standards.
Percentage of eligible adolescents 10 - 19 years of age with complete health check-ups according to protocol.
Tracers associated with disease management and treatment for population 20 – 64 years of age
Percentage of eligible population 45 - 64 years of age with type 2 diabetes with complete health check-ups according to protocol.
Percentage of eligible population 50 - 64 years of age with fecal occult blood test administered.
Percentage of eligible women 25 - 64 years of age with initiation of treatment for High-grade lesions (HSIL) or invasive cervical carcinoma, during the last 12 months.
Percentage eligible women 30 - 64 years of age with initiation of treatment for breast cancer, during the last 12 months.
Percentage of eligible population 40 – 64 years of age with hypertension diagnosed.
Tracers associated with management of target population
Percentage of primary health care providers georreferenced and with a catchment area defined.

9. **A share of the capitation payments would be financed from domestic resources, and this share would be rising over the life of the Project**. It is planned that the Government's share of financing the capitation payments will steadily increase in the next years with the goal of fully assuming such payments through 2021.

10. **The National government would establish co-financing shares for the provinces' financial contributions to the "basic" capitation payments (for the GHIs). An alternative mechanism would eventually be introduced by the National government for the provinces, designed to incentivize traceability of patients along the entire continuum of care, for key "lines of care".** Provinces would be allowed to provide their co-financing for the capitation payments in the form of public provision of certain curative (treatment/follow-up) services outside the package supported by the Project (mostly preventative services). The services would need to be: (i) defined according to commonly established standards and protocols; and (ii) measured and reported appropriately. This could not be readily achieved without robust provincial information systems that are interoperable within each "line of care" – hence allowing patient traceability along the continuum of care – and with other systems nationwide. The OM sets the terms for the domestic co-financing.[34]

11. **The funds from the capitation payments would be transferred to health service providers to support the provision of services in the HBP, through "fee-for-service" payments as well as incentives to adopt an effective strategy for "empanelment".** Under the Project, the use of strategic purchasing by provinces to incentivize the use of key (especially preventative) services via "fee-for-service" payments would continue, building on the successful experience of this under the *Sumar* program. But other types of provider payment modalities will also be used, including incentive payments to encourage activities related to "empanelment" (see Box A1-4 below). Providers would have autonomy in the use of these funds (subject to some guidelines/procedures). Eventually, bonus payments would also be made to health facilities for attaining targets for selected quality-of-care measures, which would be selected from the measures to be tracked under Sub- Component 2.1 activity (b) (see below) – starting with pilots in selected provinces with more robust information systems. Eventually, more complex pilots may be introduced, e.g. incentives provided to groups of providers furnishing services at different points in a "line of care".[35]

12. **To incentivize provinces to take key steps towards enhanced coordination and an integrated model of care – essential for this Project and the Government's UHC Strategy – there will be conditions for continued participation, in addition to conditions of entry into the program.** An initial set of conditions has been established, that provinces need to comply with to enter the program and been communicated to them during preparation. In addition, provinces will need to progressively take additional steps ("conditions of continuation") to remain in the program. The conditions of entry and of continuation are described in the OM and may be modified in agreement with the Bank. (See Box A1-3, for some of the key conditions of entry and continuation). TA will be provided to provinces as needed to help them to meet the conditions of entry and of continuation.

[34] This would not imply any change in the nature or share (i.e. co-financing percentage) of the contribution by the Project Loan to the capitation payments.

[35] Efforts to encourage independent providers to work together and function as a group – providing coordinated care to users – have been at the core of the approach followed by managed-care organizations such as Kaiser Permanente. Some countries have also followed or tested similar approaches, incorporating payments to groups of providers. For example, in the Netherlands, a bundled-payment approach to integrated chronic care is applied nationwide for diabetes, Chronic Obstructive Pulmonary Disease, and cardiovascular risk management – with a single payment made to a care group (per person) to cover a full range of chronic disease services for a fixed period.

Box A1-3: Conditions of Entry and Continuation

The following are key conditions of entry and continuation that would be included under this Project:

Conditions of Entry	Conditions of Continuation
Undertaking key initial actions regarding establishment of common standards and service definitions, and to enable progress later with interoperability of information systems.	Complying with additional actions needed for common standards and service definitions, and for the agenda of interoperability of information systems.
Presenting a viable operational Plan for "empanelment" of the eligible population.	Undertaking actions needed for implementation of the Plan for "empanelment".
Setting up provincial umbrella structures ("*Mesas*") where the implementation teams for the different projects/programs would work jointly under one coordinator from the provincial MSP.	Undertaking actions to show progress on the part of these joint implementation structures (regarding joint planning, coordination among the different programs, etc.).
Issuing of a Directive (or similar) indicating support for the UHC Strategy.	

In addition to the above, there would be other conditions of entry and continuation that are considered important for: (i) the success of the new UHC Strategy; (ii) the efforts to increase the extent to which public health facilities bill the *Obras Sociales* (*OS*s) for provision of services to OS members; and (iii) effective implementation of the Project (e.g. timeliness of payments to health providers, continued compliance with co-financing requirements).

13. **Sub-Component 1.2. Making Capitation Payments for the Provision of Selected High-Complexity Disease Interventions (US$42.20 million, US$21.10 million from IBRD):** This Sub-Component would finance capitation payments for the provision of a separate package of selected HCD-related[36] services to the eligible population, as part of a newly created National Fund for High Complexity Diseases (NFHCD).

14. **The MSN has decided to create the NFHCD that will follow similar implementation arrangements as the Solidarity Reinsurance Fund for Catastrophic Diseases (FRSEC) in place under the *Sumar* program.** Under the *Sumar* program, the scope of the FRSEC – which had initially addressed congenital heart disease diagnosis/treatment for children under *Plan Nacer* – was modified to also finance other catastrophic health interventions for the Project's beneficiaries. Building on the successful experience of the FRSEC, the NFHCD Program will provide financing for the provision of selected interventions for HCDs, to the eligible population. Unlike in the case of the GHIs, this would be a National Fund, with the MSN (with co-financing from the Project Loan) fully financing capitation payments – with no provincial co-financing requirement – for each beneficiary enrolled. The idea is to have a risk pool at the national level under the NFHCD, similar to the FRSEC which aimed to strengthen the public Federal network for high complexity care.

15. **The capitation payment will cover a share of the cost of providing the selected health interventions for high complexity diseases.** To this end, the MSN has carried out an actuarial calculation to estimate the incremental cost of the selected health services to be financed, similar to the one carried out for the GHIs (see Box A1-2). The estimation took into consideration: (i) the estimated eligible population; (ii) the incidence and prevalence of the pathologies included; (iii) utilization rates; (iv) quality guidelines; and (v) unit costs.

[36] The HCDs include congenital heart diseases, some congenital malformations, and selected cardiovascular procedures.

16. The health service package will contribute to improving the quality of services as well as extending coverage. Results will be monitored using supervision protocols and information systems, and will be verified by an independent technical auditor. The MSN, in agreement with the Bank, may revise the selected HCD services to include new interventions, which would need to be justified based on a prioritization exercise and financial sustainability analysis.

17. Each month the MSN will transfer the capitation payments to the NFHCD based on the number of beneficiaries enrolled. The NFHCD funds will be used to finance selected HCD interventions included in the HBP, delivered to the eligible population by Authorized Providers. Payments to Authorized Providers will be made through a fee-for-service mechanism with payments adjusted based on achievement of quality and utilization goals. These payments will serve as financial incentives to health facility managers who will have autonomy to decide how to use the funds. The OM describes the relevant procedures in detail. The selected HCD interventions included will be provided according to Authorized Provider Agreements and contractual or quasi-contractual agreements, as appropriate. Only public providers would generally be included, to foster the strengthening of the public health care network for the relevant pathologies. Private providers would be contracted only in exceptional cases.

18. **Component 2: Strengthening the Institutional Capacity of the National and Provincial Ministries of Health (US$125 million, US$82 million from IBRD).** This component would have two Sub-Components:

19. **Sub-Component 2.1. Providing Support to the National and Provincial Ministries of Health for Increasing their Coordination and Establishing an Integrated Model of Care (US$44.83 million, US$27.26 million from IBRD**). This Sub-Component would support the provision of the instruments needed for an integrated quality-based model of care in the public subsystem, and for improved coordination in the health system. Table A1-2 shows the complementarity between the instruments financed under Sub-Component 2.1 and the incentives financed under Sub-Component 1.1.

Table A1-2: Complementarity Between Activities of Sub-Component 2.1 and Incentives Built into Sub-Component 1.1

Activities to be Financed Under Sub-Component 2.1 ***(via goods, services, training, operating costs, TA)***	**Accompanying Incentives Built into the Capitation Payments Scheme Financed Under Sub-Component 1.1**[1]
(a) Enhancing "Empanelment"	- One of the provincial "tracer" indicators would be progress regarding "empanelment". - Adequate progress regarding "empanelment" is among the conditions of "entry" and "continuation" for provincial participation (see Box A1-3). - Financial incentives would be paid to health service providers to incentivize "empanelment" activities (see Box A1-4 below).
(b) Developing/ Tracking Effective Quality-of-Care Measures at Health Facility Level	- Payments will be made to health facilities for selected quality-of-care measures (in addition to the payments related to "empanelment" mentioned above – to be introduced eventually).
(c) Defining Services and Standards for the Entire	- Adoption of certain common standards and service definitions would be among the conditions of "entry" and "continuation" for provincial participation.

Activities to be Financed Under Sub-Component 2.1 ***(via goods, services, training, operating costs, TA)***	**Accompanying Incentives Built into the Capitation Payments Scheme Financed Under Sub-Component 1.1**[1]
Public Subsystem	
(d) Improving Integration of Health Information Systems	- Pre-defined steps that are key for this agenda would be among the conditions of "entry" and "continuation" for provincial participation. - Provinces willing to take steps for key actions under this agenda would receive: (i) targeted, specialized TA from the National Government and limited amounts of financing for personnel and IT goods/services under this Project, as well as (ii) possibly larger amounts of financing for equipment and connectivity from other National Government sources like the *Proteger* program.
(e) Supporting Cost Recovery from *Obras Sociales* (OSs)	- Agreed actions in support of cost recovery from the *OS*s would be among the conditions of "entry" and "continuation" for provincial participation.
(f) Enhancing Coordination in Planning and Activities *Among* Different Programs	- Pre-defined steps that are key for this agenda (e.g. establishment of integrated implementation teams in each province, covering all key programs, at the provincial level) would be among the conditions of "entry" and "continuation" for provincial participation.

Table Notes: The incentives listed in the right-hand column are linked to the transfers for capitation payments under Sub-Component 1.1, except for TA, equipment, services etc. for information systems. The latter would be financed under Component 2 and possibly from other National Government sources like the *Proteger* program.

20. The activities financed under Sub-Component 2.1 can be divided into 7 activity streams (a) to (g):

a) Enhancing "Empanelment"

21. **Stream (a) of Sub-Component 2.1 will support activities to expand "empanelment" in the public subsystem, building on ongoing efforts in-country and drawing on successful experiences elsewhere**. (See Box A1-4 for more details). As part of the preparation process, the MSN undertook a detailed diagnostic of the situation regarding "empanelment" in all provinces; in fact, many are already undertaking efforts towards "empanelment", to varying degrees. Under the Project, provinces will be provided with tools, training and TA to: (i) support efforts towards "empanelment", including via the use of tools for geo-referencing; and: (ii) facilitate and encourage efforts by health workers at primary care facilities to actively seek new eligible patients within the geographical area mapped to each health facility. These would be encouraged to visit health facilities or would benefit from community outreach sessions, home visits and similar means of reaching patients who do not visit health facilities. The design of the activities under this Sub-Component will draw on experiences of countries that have established successful models focused on "empanelment", such as Brazil and Costa Rica.

Box A1-4: Enhancing "Empanelment" Under the Project Stream (a) of Sub-Component 2.1

The Project will directly incentivize health facilities for being responsible for the population living in their catchment area. That is, the health facility should seek, identify and formally register these people as "patients" and ensure comprehensive and continuous care. Linking each health facility to a given population is fundamental for developing a solid model of care with a strong primary and preventative care focus. It is particularly effective for reaching those in the population that do not regularly seek care at health facilities – the riskiest subgroup.

There is a set of requirements a province would need to fulfill before being able to successfully implement this new scheme: (i) The province would need to identify the health facilities to be responsible for implementing the "empanelment" approach. These would usually be primary care providers, but the type of facilities chosen would vary from province to province, depending on how each province organizes its network. (ii) The province would then provide to the nation, through the Federal Registry of Health Establishments system, the list of facilities selected and their precise geo-coordinates. (iii) For each facility in the list, the province would also define a catchment area – that is, the geographical area for which the facility would be responsible. The catchment area can be defined using different criteria, e.g. geographic boundaries, distance to a health facility, transportation network, or others. Each province should inform the National Government which criteria it would apply. The catchment areas should be defined so that they jointly cover the whole province without any overlaps. (Overlapping would be acceptable only when two or more facilities are working as a group – offering different, complementary, preventive services). (v) For each facility, the province would identify, assess and report prioritized areas within each catchment area.

The whole process from (i) to (v) would be included in the Agreement to be signed with the provinces (see Annex 2). The process should be reviewed annually and updated as needed. Progress regarding "empanelment" would be one of the provincial "tracer" indicators (see Table A1-2). Support for improved information systems to facilitate the "empanelment" activities would be provided under stream (d) of Sub-Component 2.1. And adequate progress on "empanelment" would be among the key conditions for each province to first enter, and then remain in, the program (and to continue receiving transfers from the National Government) – see Box A1-3.
During the implementation of the scheme itself, the province would provide financial incentives to providers to implement "empanelment", i.e. to undertake extra efforts to be responsible for the population in their catchment area. The following is the scheme to be applied initially (first on a pilot basis), but modifications may be made over time and there may be some differences across provinces:

- For each eligible person in the catchment area of a health care provider that has not yet been "empaneled" (i.e. assigned to the health facility), a one-time payment would be made if the provider registers the person, *and* if the person receives a priority health service (from a pre-identified list of key services) within a specified time period after registration.
- For each service in the prioritized package of general health services (HBP), utilization by an eligible person that has been "empaneled" to the health facility will have a unit fee (under the "fee-for-service" scheme) that is higher than the fee paid for utilization by a person that has not been "empaneled". (For example, utilization of this service by a person not living in the health facility's catchment area would have a lower unit fee than utilization by a person living in the catchment area and already "empaneled").
- An additional fee would be paid for each "empaneled" person that completes a set of timely interventions within a key integrated "line of care". (This is a reward for providing comprehensive and continuous care).

Under the proposed scheme, each person would still be allowed to choose to visit any health facility – retaining the open-access feature of the current public health system. A health facility providing services to a person that cannot be assigned to it – living within a different catchment area – would still be paid a unit fee for each service in the HBP that is provided to this person. But the fee would be significantly higher in the case of utilization by an assigned ("empaneled") person – hence incentivizing "empanelment".

b) Developing and Tracking Effective Quality-Of-Care Measures at the Health Facility Level

22. **This activity stream would support activities to develop, closely track and report measures of quality at the health facility level**. A close focus on defining, measuring and tracking quality over time can often result, in turn, in substantial increases in quality in the provision of care. TA and other types of support would also be provided for designing and implementing provider payment mechanisms based on selected quality-of-care performance indicators, to be financed under Component 1 (see above).

23. The quality-of-care indicators to be tracked and reported would build upon quality measures already being tracked under the *Sumar* program; possible measures could include, for example, the proportion of the target population receiving complete health check-ups that follow clinical protocols and that have included a detailed description of the findings in the patient's medical records. A number of options for quality indicators would become available – and could be measured – once existing systems are able to capture data on the population in the catchment area of each health facility (as part of the "empanelment" efforts). As information systems become more developed in some part of the country, pilots could be implemented for tracking measures related to first contact access, care integration, care coordination, comprehensiveness of services; person-centeredness and patient safety. Bonus payments would eventually be made to health facilities based on selected quality-of-care indicators, financed from the capitation payments supported by Component 1 (see above), and starting on a pilot basis.

c) Defining Services and Service Quality Standards for the Entire Public Subsystem

24. **To move towards patient traceability along the entire continuum of care in the public sector – an essential element of an integrated model of care – an explicit package of services would first need to be defined and systematized for the entire public sector, starting with the key "lines of care".** This should be based on common agreement on the required quality standards and protocols, and delivery conditions, for the defined services. This activity stream will support these activities. It will also support mechanisms for harmonization (with a convergence plan) around common standards, services and service definitions, clinical guidelines and protocols, models of care, referral networks and information standards.

25. **This activity stream will also support ongoing activities to modify the prioritized package of services (prioritized HBP) as needed, particularly to promote utilization of key services in line with implementing an integrated model of care with a primary care focus.** An initial HBP has been defined for the Project, based on a prioritization exercise; this covers the services that will be financed from the capitation payments under Component 1. Prioritization activities will be undertaken on an ongoing basis as needed, under this stream of activities, to suit changing conditions and new information obtained on the ground – especially information obtained from a National Technology Assessment Agency which will be established by the Government.

d) Improving Integration of Health Information Systems

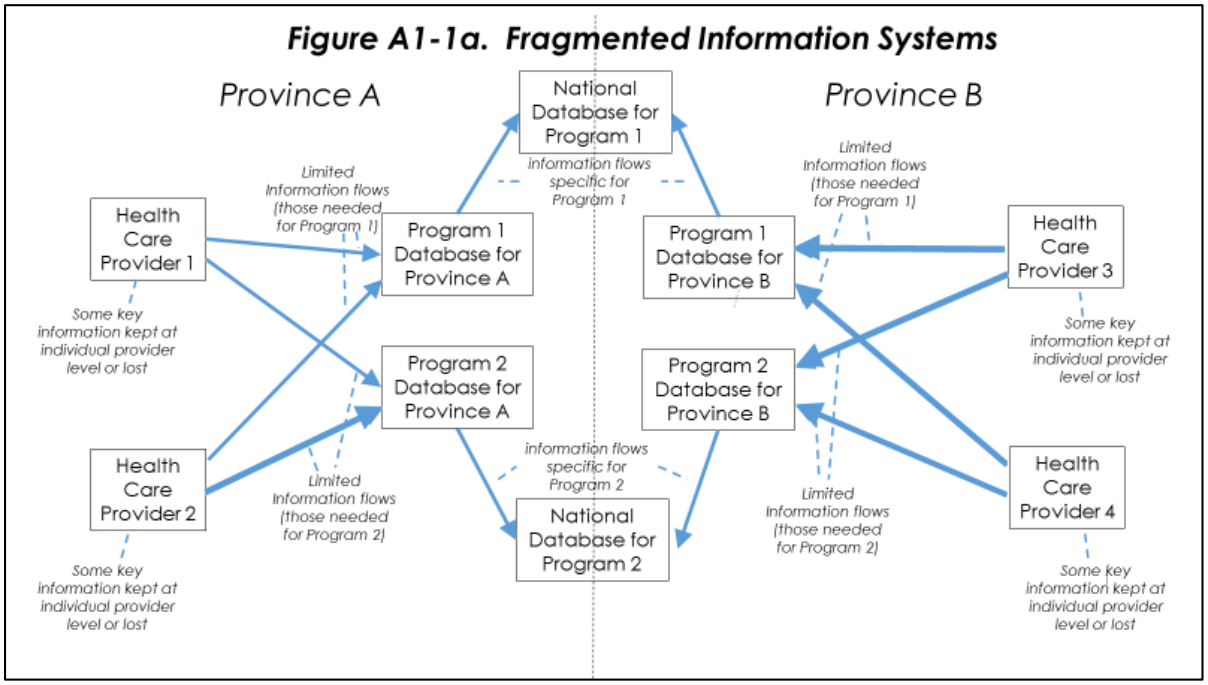
26. **This stream of activities will address one of the major reasons for the lack of coordination in Argentina's health system: the existence of several different health information systems that operate in parallel to each other, with little integration between them – even within the public subsystem**. This is due in large part to the inherent fragmentation of the country's health system. But there are also other

factors underlying the problem, including a lack of Electronic Medical Records (EMR) systems at many health facilities (see Box A1-6). Figure A1-1a depicts the current situation regarding information systems in many provinces. (There are some others that have made significant advances).

27. **Some of the Project's key goals – including achieving continuity of information across health care providers (via shared records) – clearly cannot be attained without taking active steps to increase Integration in Health Information Systems (IHIS)**. A successful approach for doing this would work along several fronts to reduce inefficiency in the system – by reducing duplicate testing, ensuring that the results of consultations are shared across providers and facilitating follow-up care, for example. In addition, linking different databases at the provincial or National level would enable data analytics and informed decision-making, making full use of the available data in a way that is not possible now.

28. **Stream (d) of Sub-Component 2.1 will finance a set of limited, specific and strategic interventions to establish an environment for a systemic and coordinated move over time – likely over many years – towards information systems deployment and utilization at the point of care, and better integration of health information systems in Argentina**. The ultimate goal would be to move as close to possible to a situation of fully integrated information flows like that depicted in Figure A1-1b. But it would take a multi-year process with large (and not cheap) investments to get there, with many complexities to address along the way. This process is already under way, resulting in a variety of systems being implemented for different purposes (from clinical EMR systems to national vertical databases and registries). The project will not aim at integration of these systems through "single solutions for all" but rather through integration of diverse systems by using common standards and structures. The goal is not to make everyone use the same tool, but rather to use the tool they prefer, but following a standards framework that will allow integration of data flows and reduce duplications and overlaps.

29. **The interventions supported would require close cooperation between the National Government and the provinces, as well as significant additional financing from the provinces' own resources, especially for investments in support of equipment and connectivity for individual health providers**. The latter are critical for moving towards integration of health information systems. But these investments would not be cheap; they would account for the bulk of the financing needed to move close to the final goal depicted in Figure A1-1b. A limited amount of financing for these investments would come from Sub-Component 2.2 of this Project, and possibly from other National programs such as "*Proteger*". But the bulk of the needed financing would have to come from the provinces themselves, over time.



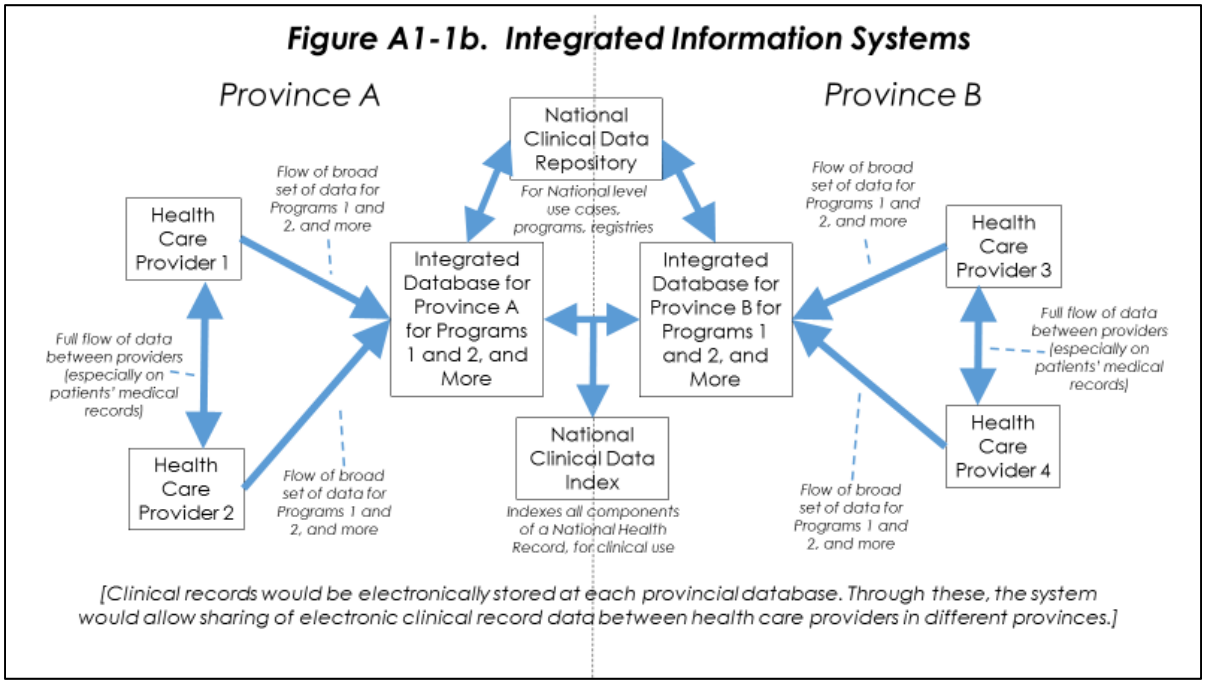
Note: One of the programs depicted could be the *Sumar* program, for which information flows are as described above in many provinces.

30. **Stream (d) would support ten activities in support of Integration of Health Information Systems (IHIS) as follows, with five of them being particularly essential** (see Table A1-3 for more details)**:**

(a) Activities to support the establishment and adoption of basic IS interoperability standards (four basic IHIS activities): These common standards – including common registries, codes, clinical terminology and clinical documents structure (see Table A1-3) – would ideally need to be adopted by all actors at the National and provincial levels. Legislation, procedures and technical systems at the National and provincial levels would need to be modified accordingly.

(b) Supporting eHealth governance (cross-cutting IHIS activity): The Project would support the creation of enabling governance infrastructure for health information systems, sustainable mechanisms and institutionalized responsibilities for coordinated, effective and efficient eHealth implementation at both the National and provincial levels.

31. **It will be especially important to make substantial advances under the Project with these five essential activities in all provinces. These will feature prominently in the Project's "conditions of continuation"**. These are conditions that the Provinces would need to comply with to be able to remain in the Program, and to continue receiving transfers from the National Government for capitation payments under the Project (see Box A1-3). The establishment of basic interoperability standards and eHealth governance structures are core requirements for the Project's goals of enhancing coordination within the public subsystem and across subsystems. And they can proceed without the need for substantial investments in equipment and connectivity.



32. **Building on these five essential IHIS activities, stream (d) would support five other additional activities that would need to be implemented in a more gradual manner, accompanied in many cases by investments in hardware and software at the "point of care"** – i.e. equipment and connectivity, and associated software, at the health facility level (largely to be financed separately from the provinces' own resources). These activities would be:

(c) Adoption of appropriate information technology (IT) and supporting Change Management activities to accompany investments in hardware (and associated software) at the "point-of-care" (cross-cutting IHIS activity): The latter refers to investments in equipment (e.g. computers) and software in support of digitalized data entry, especially EMR (i.e. entry of patients' clinical data by health workers, e.g. doctors and nurses). See Table A1-3 for more details on this activity.

(d) Advanced IHIS activities (four) to support more complete capture of required information as well as more complete, integrated information flows between different entities (health service providers, provincial databases and others). See Table A1-3 for full details.

33. **For the four advanced IHIS activities, there would be an especially strong focus on rapid implementation in two pilot provinces[37].** This would inform subsequent implementation efforts for these more complex activities in other provinces.[38]

Table A1-3. Activities Supporting Integration of Health Information Systems (IHIS) – Stream (d)

(1) Use of Reference Registries (basic activity for IHIS stream): The lack of authentic lists of key healthcare system entities (such as patients, health facilities and health professionals) – and the use of different lists (and codes) by different information systems – is one of the major obstacles to integration of health information systems. The MSN would design and implement infrastructure to support the development of key reference registries to be used by all actors (including at the provincial level, and for the public non-contributory, social security as well as private subsystems). It would introduce legal and institutional procedures for their maintenance. Provinces would need to adopt (and require use of) the reference registries through their own legislation, procedures and technical systems.

(2) Standard clinical terminology and standard vocabularies (basic IHIS activity): The MSN would define a list of standard clinical terminologies (definitions and codes for clinical findings, diagnoses, procedures etc.) and would resolve the necessary licensing requirements. The MSN would make the selected terminologies available to all users in the country, with frequent updates, and necessary local adaptations. The MSN would create guidelines and training material to support the adoption of the standard terminologies, including references to relevant open source and commercial tools. A plan would be developed to gradually modify existing provincial clinical registries, repositories and MSN Business Intelligence tools to incorporate the standard clinical terminologies.

(3) Standard clinical documents structure (basic IHIS activity) (i.e. standard structure for recording patients' medical records): The federal nature of Argentina, with significant decentralization of health care provision, presents the challenge of having clinical information being generated at a large number of different sources, using different structures/formats – making it difficult to transfer clinical information between providers. The MSN would review and update national regulations and policies for medical documentation and minimum datasets for clinical documentation and public health reporting. An implementation guide to facilitate the adoption by all of a standard clinical documents structure would be developed. The MSN would provide support to provinces to adopt the updated national regulations and policies and to promote the use of the standard clinical documents structure. Internal tooling and registries would be modified to comply with the proposed standards.

(4) Interoperability standards (basic IHIS activity): The MSN would define a set of syntactic interoperability standards (i.e. modalities for information communication between different information systems). It would develop a National Interoperability Bus – a central structure for information exchange – applying the selected standards, hence providing a national infrastructure for health records indexes, reference registries and patient identification. Provinces would need to adopt these interoperability standards in their own provincial health information system(s), and to use the National Interoperability Bus to transfer relevant information.

[37] Mendoza Province and one more to be decided.

[38] The Project would aim for substantial advances in implementation for the five essential IHIS activities in all provinces. For the cross-cutting activity to support IT and change management to accompany "point-of-care" investments (especially in EMR systems), support would be available for all provinces that proceed with significant investments in EMR systems. But this is expected to proceed quite slowly for most provinces, given the cost and complexity of this undertaking. For the two pilot activities, significant support for "point-of-care" investments would be provided under Sub-Component 2.2, and possibly from other funding sources likes the *Proteger* program, but the provinces would still need to finance much of this from their own domestic resources.

(5) EHealth governance (cross-cutting IHIS activity): The Project would support the creation of enabling governance infrastructure for health information systems, sustainable mechanisms and institutionalized responsibilities for coordinated and effective eHealth implementation at the National and provincial levels.

(6) Adoption of appropriate information technology and supporting Change Management to accompany investments supporting digital data entry at the "point-of-care" (especially EMR investments) (cross-cutting IHIS activity): These types of investments – in support of equipment (e.g. computers) and software – would largely need to be financed from the provinces' own resources. These investments would be supported by this activity, in a number of ways. The MSN would create documents and a toolkit related to Change Management in Health Information Technology adoption. This is in recognition of the importance of trained Human Resources to lead Change Management, so that health workers will actually use the new digitalized systems to input the full set of patient data (which they typically do not start to do without a proper change management process). The MSN would also indicate the minimum requirements for infrastructure (hardware, software and connectivity) to be financed, and would communicate details on functional requirements for the EMR systems as well as other requirements (e.g. for user experience) that are consistent with the overall IHIS agenda. The Project would also support a limited number of provinces/municipalities with decisions on homegrown development, adaptation or service contracting for EMR software or other "point-of-care" software such as telemedicine applications, mobile apps for population outreach or home care, etc.

(7) Connecting health service providers and promoting electronic information transfer along the line of care (advanced IHIS activity). Continuity of patient care depends on the ability to connect patients and clinicians with others in the line of care, and for patients' medical records to be transferred electronically between health care providers. This activity will support the development of implementation standards-based tools and capacity to enable connectivity between service providers, in priority areas identified through collaborative consultations and assessments. These areas may include e-referrals (electronic information transfer between health service providers); e-consultation (for primary care providers to obtain answers from specialists for key questions, via secure messaging and/or telehealth); e-prescribing and electronic pharmacy management solutions (digital solutions for the drug management process); e-ordering of tests/results reporting (for laboratory and other tests); and e-scheduling (coordinated scheduling of clinical services).

(8) Supporting standardization and integration of data flows across programs. The Project will support the streamlining and integration of administrative and public health data flows across programs. (In the context of Figures A1-1a and A1-1b, it would lead to the integration of the different provincial program databases). It will build on the data flows already occurring under the *Sumar* program, as well as the effort to develop basic interoperability standards (see above). It would introduce new methodology, systems, tools and capacity to support robust data warehouse-based analytics (including visual tools) – using the integrated databases – to inform decision-making at the point of care, building on efforts to date (e.g. SISA).

(9) Digital solutions to support "empanelment" efforts: The Project will create digital processes/tools to enable the use of standardized geo-referenced attachment models to be implemented at the health service provider level, to support the Project's efforts towards "empanelment" and to improve overall population care efforts.

(10) Improving and streamlining procedures for billing at the health facility level (advanced IHIS activity): Currently, due to a lack of appropriate automated solutions, administrative personnel often spend large amounts of time entering health-facility-level data necessary for billing for each individual program (e.g. the *Sumar* program, other National programs, different OSs) – with information being entered separately for each of them. There is potential to substantially improve this process, especially with the progressive introduction of EMR

systems (with support from activity (6)), and with the establishment of basic interoperability standards supported by activities (1) to (4). This activity would support this, so that the digital entry by a health worker (e.g. doctor, nurse) of patient data during each patient visit would automatically lead to the appropriate billing information being communicated to the relevant provincial entity for each program (including the present Project), without need for further data entry. Improvement/streamlining of the billing process could still occur to some extent if a health facility is still using paper-based clinical records or limited digital data-entry systems. With ongoing "empanelment" efforts and new provider payment systems introduced (see Box A1-4), the optimized billing information would eventually also incorporate data needed for the new types of provider payments (e.g. data on population in the catchment area of each health facility) – and this would be helped by activity (9).

34. **During implementation, each activity would be referred to as an "adoption package" – since it would consist of a package of services, software, training, actions and other types of support that would be customized for each province**, and would require adoption on the part of the province. Each "adoption package" would have its own province-specific implementation plan, with standardized activities, indicators and budgets for the National Government as well as for the province.

e) Supporting Cost Recovery Efforts by Public Health Service Providers from *Obras Sociales* (OSs):

35. **This activity stream will support efforts to reduce the extent of cross-subsidization by the public subsystem of the OS subsystem, by supporting efforts to encourage billing by public health service providers of OSs (for provision of services to OS members)**. Public health service providers are estimated currently to provide services to almost 30% of those enrolled in OSs and other insurance schemes. A large portion of the services provided to these individuals is not billed for by the public service providers. (The exact amount of this cross-subsidy by the public health system is not known).

36. In the current system, only a particular type of public health facility is allowed to bill health services to the OSNs: the Public Hospitals with Decentralized Management (*Hospitales Públicos de Gestión Descentralizada* – HPGD). There are 1,814 HPGDs, located in 22 provinces, representing approximately 18% of the total number of public health facilities. Each HPGD can enter into bilateral agreements with each OS, setting prices for the health services provided to the beneficiaries. But, the national OSs (OSNs) tend to delay payments and thus financial resources do not flow in a timely manner to the public hospitals.

37. In this context, the role of the Superintendent of Social Security (SSS) is crucial, as the national agency in charge of overseeing the obligations of the OSNs with respect to payments to the HPGDs. In the absence of payment by the OSN, the HPGD is entitled to claim the payment from the SSS, through an automatic debit. The HPGDs with no signed agreement with OSNs are allowed to claim payments directly from this Automatic Debit System; however, they have to do so at prices set by the MSN.

38. The process of billing and payment faces many obstacles due to lack of administrative capacity at public hospitals, deficiencies in existing information systems, absence of computer equipment, and complex bureaucratic procedures (including for registration of a public hospital as a HPGD) – and lack of familiarity by many public hospital employees with norms and procedures for cost recovery from the OSs.

39. **This activity stream would support analytical, TA and training activities, with the objective of expanding the number of hospitals registered as HPGDs and to increase the volume of billing to social security organizations by public hospitals registered as HPGDs.** Specifically, the stream would finance:

(i) Analysis of the current cost-recovery system, identifying key problems and implementation obstacles; potential improvements in regulation regarding cost-recovery from the OSPs and INSSJP; and implications of expanding the system to also include primary health care facilities;
(ii) Training activities for HPGD administrative staff in cost recovery efforts and systems;
(iii) Technical support for the process of registration of public hospitals as HPGDs.

f) Enhancing Coordination in Planning and Activities Among Different Programs:

40. **There will be a strong focus on joint planning and harmonization between different programs at the National as well as provincial levels, with the Project acting as a sort of "integrator" project.** The Project would work in complementary fashion to other programs such as *Proteger*, *Redes*[39] and *CUS-Medicamentos*, as well as the *National Sexual and Reproductive Health, School Health, Adolescent Health, Tobacco Control* and *Diabetes Control Programs.* All will work together – each with clearly defined roles – to implement the country's UHC Strategy. Steps to be taken to ensure a coordinated approach include:

(i) Establishment of integrated implementation teams at the provincial levels (within each province), and also at the National level. These would involve the implementation teams of the different projects working closely together under one structure.
(ii) A detailed plan showing the roles and responsibilities of each program clearly defined in complementary fashion within the overall UHC Framework.
(iii) Joint planning to address various types of coordination challenges now inherent in the system. For example, joint planning would help establish referral networks especially for more complex conditions/diseases, addressing inherent interprovincial and inter-programmatic coordination problems that often hamper the establishment of these types of networks. Tracking of drug prescriptions for services included in the HBP could be prerequisites for payments for those services (under Component 1). This information could be linked to information on drug deliveries at public pharmacies, thereby incentivizing rational drug prescription and use.
(iv) Eventually, a combined technical audit for all programs that until now have required separate audits for each individual program – e.g. *Proteger*, *Redes* and others (and the Project).

g) Other Forms of Support for Reaching Effective UHC

41. **This activity stream would finance TA and analytical work in support of reaching effective UHC**, including studies on health system financing and organization to help MSN and the MSPs design public policies to enhance UHC – including mechanisms to integrate the different health subsystems. Activities to support evaluation work (including Impact and Process Evaluations) would also be supported.

[39] REDES Project (*Programa Multifase de Atención Primaria de la Salud para el Manejo de Enfermedades Crónicas No Transmisibles, Segunda Operación*). Financed by the Inter-American Development Bank (BID 3772/OC-AR).

42. **This stream would also support the design and implementation of provider payment mechanisms (new ones and modifications of existing mechanisms)** for purchasing services under the Project, as well as for other programs (especially related to high-complexity conditions and disabilities). TA would be supported for: (i) customization of the existing information platforms and software under the *Sumar* program to include services covered under the benefit plans of other insurance/capitation schemes; (ii) harmonization of the benefits plans of the *Sumar* program and other capitation schemes; (iii) costing studies to help determine appropriate capitation values; (iv) analysis to confirm whether the *Sumar* program's incentive structure can be applied to other insurance/capitation schemes; and (v) progressive integration of reporting systems to strengthen purchasing mechanisms.

43. **Sub-Component 2.2. Improving the Service Delivery Capacity of the National and Provincial Ministries of Health to Enhance Effective Coverage in the Public Health Subsystem (US$66.13 million, IBRD financing US$27.44 million).** This sub-component aims to support improvements in the supply capacity of the MSPs and MSN to enhance effective coverage in the public subsystem. It would finance: (a) provision of equipment (medical, transportation, information technology and communications) based on a systematic analysis of service delivery gaps identified by province, especially at the primary level for the key "lines of care" and for HCD networks; and (b) maintenance services needed to upgrade and expand the MSN's and the MSPs' information and communication systems (excluding civil works). A scorecard would be used to determine the service delivery gaps for each province, for the key lines of care, and would draw on information from an ongoing survey of health facilities nationwide[40] as well as the *Sistema Integrado de Informacion Sanitaria* (SISA) information system, among others.

44. In the case of information systems, the Project would finance the provision of communications equipment and services, and information technology, needed by the MSN based on a systematic analysis of gaps and the level of provincial involvement in the activities supporting the integration of information systems under stream (d) of Sub-Component 2.1. This will include: (i) support for central systems at a national eGovernment center; and (ii) improvement of the systems platform within MSN itself, including investments into an MSN data center, communication systems, and related services, as well as support for an effective digital health infrastructure to support the activities of stream (d). A limited allocation of these items would also be provided for provincial Ministries of Health (MSPs).[41]

45. **Component 3: Supporting Management, Monitoring and Evaluation (US$66.53 million, US$52.08 million from IBRD).** This component would finance: (i) provision of technical assistance to strengthen the capacity of the National Project Coordination Team (PCT), MSN's International Financing Team (UFI-S), the Undersecretariat of Administrative Coordination (UAC), and the Provincial Project Implementation Units (PIUs); (ii) carrying out of Project monitoring and evaluation activities; and (iii) carrying out of the financial and independent technical audits for the Project.

[40] The *Estudio de Capacidad Prestacional.*

[41] The bulk of the financing needed for these items to achieve full integration of information systems and for full rollout of Electronic Medical Records would need to come from the provinces' own domestic resources. (See description below of activities under stream (d) of Sub-Component 2.1).

ANNEX 2: IMPLEMENTATION ARRANGEMENTS

COUNTRY : Argentina
Supporting Effective Universal Health Coverage in Argentina

Project Institutional and Implementation Arrangements

1. **The Project would be implemented by the MSN through the Project Coordination Team (PCT) (established within the MSN) which currently supports *the Sumar* program.** The PCT institutionally depends on the Secretariat of Health Coverage and Resources. The PCT will be responsible for working with participating provinces through the Provincial Implementation Units (PIUs) to implement the Project in a timely manner, conforming to agreed-upon quality standards. It will also provide technical advice to, and consider recommendations by, the Federal Health Council (COFESA) related to the Project. The PCT would work closely with the teams implementing other key Programs such as *Proteger*, *Redes* and *CUS-Medicamentos,* as well as the *National Sexual and Reproductive Health, School Health, Adolescent Health, Tobacco Control* and *Diabetes Control Programs.*

2. **The PCT would continue to be staffed by a coordinator (appointed by the Minister of Health and subject to approval by the Bank), and a multidisciplinary team recruited according to specific terms of reference which are part of the Operational Manual.** The PCT under the *Sumar* program consists of three sub-units ("areas") that provide logistical and strategic support to coordinate the Project's management and six operational departments. Their experience in project implementation has continued to be strengthened throughout the duration of the ongoing *Sumar* program. The Project would finance 45 percent of the PCT staffing. Once the Project is completed, the MSN will assume full financial responsibility for PCT staffing.

3. **The Undersecretariat of Administrative Coordination (UAC), through its International Financing Team (UFI-S) and other relevant departments, would be responsible for overall administrative and fiduciary matters such as financial management and procurement.**[42] UFI-S is the MSN's central fiduciary agency that manages external financial resources and provides support to all executing teams involved in Project implementation. The UFI-S was created by MSN Resolution 98/2000 and reports directly to the MSN. It has its own Operational Manual (approved by the Bank) which describes procedures for separating functions among the different stages of the Project. The UFI-S Operational Manual is part of the overall Project's Operational Manual. The UFI-S has conducted financial management and procurement functions over the last 16 years for Bank-financed projects. The UAC, through its UFI-S, will be responsible for the following: managing the procurement processes; monitoring contract administration; processing payments to suppliers and consultants; managing the project finances, including control of the Designated Account (DA) and flow of funds; accounting and financial reporting; and collecting the information needed for disbursements.

[42] This is in line with Decree No. 945 (17 Nov. 2017) which states, in Article 1, that public entities such as the National Ministry of Health that manage programs with external financing (as well as programs involving public-private partnerships) need to centralize key functions related to the execution of these programs under their respective Undersecretariats of Administrative Coordination (or equivalent). These key functions include fiduciary functions (including procurement, contracting and audits), and actions related to safeguards.

4. **The UAC, through its relevant departments, would be responsible for the management and transfers of the capitation payments**, in coordination with the PCT. The UAC would also coordinate with the PCT to ensure proper monitoring of the external and internal audits and to ensure that the penalties and deductions from the audits are applied properly. This is in line with one of the key objectives of the current National Government administration, which is to institutionalize – and eventually fully take over the management of – the capitation payments sub-components, which are at the core of the Project and account for the bulk of its financing.

5. **Project implementation at the provincial level would be carried out by the MSPs of participating provinces, through the Provincial Implementation Units (PIUs) currently supporting *the Sumar* program.** The PIUs are expected to continue as the provincial health sector purchasing agencies/departments when the Project is completed, as stipulated in the Operational Manual. Their main responsibilities would include: (i) identifying beneficiaries and mobilizing their participation; (ii) identifying, authorizing, and contracting health service providers for the beneficiaries under their jurisdictions; (iii) overseeing the technical quality of services; (iv) liaising with the PCT to obtain Project technical, financial, and administrative support; and (v) carrying out actions that guarantee compliance with safeguards objectives at the provincial level. Each PIU has a Coordinator and an organizational structure whose complexity depends on the number of beneficiaries under its jurisdiction. The conditions the PIUs must meet to determine their structures, as well as the minimum number of staff defined for each sub-unit of the PIU organizational structure and their terms of references, are listed in the Operational Manual.

6. **Participation by the provinces would be governed by an Umbrella Agreement signed between each province (represented by the Governor and the Minister of Health) and the MSN, to cover the duration of the Project period.** The PIUs and the PCT would sign Annual Performance Agreements. The Umbrella Agreements would be agreed to by the Bank. (See Box A2-1).

Box A2-1. Institutional Agreements

- **Umbrella Agreements** are the agreements signed between the MSN and participating provincial Governors, covering all legal, technical, financial, administrative, fiduciary and safeguards aspects of provincial participation in the program, including: (i) the provincial program goals; (ii) establishment of entities and their responsibilities; (iii) operational guidelines; (iv) financing requirements; (v) financial and auditing relationships between the MSN, the province, the MSP, and the Bank; (vi) conditions with respect to eligibility; (vii) provincial performance indicators; (viii) results-based payment mechanisms and provider payment mechanisms; (ix) Bank safeguard policies; and (x) the terms of the OM.
- **Annual Performance Agreements** are the agreements signed between the MSN and participating provinces, including annual targets for the provincial tracer indicators, enrollment and "empanelment" targets, other health and performance goals, and details on work programs and resource requirements.
- **Authorized Provider Agreements** and contractual or quasi-contractual agreements, as appropriate, are the agreements signed between MSPs and authorized health care providers covering the package of health services to be provided and their pricing; quality standards and control measures; payment mechanisms; expected results; reporting and document support requirements; and modalities for supervision and inspection by the independent technical auditors and the PCT/PIU supervision and monitoring units.

7. **The key institutional arrangements for the results-based capitation payments for GHIs will be:**

a. For each beneficiary enrolled and with "effective coverage", the capitation payments (including both the "basic" and "equity" component) will be transferred in two steps as follows:

(i) A share of 50% will be transferred immediately after each province sends the monthly register of enrollees with effective coverage to the PCT, which then certifies its validity (cross-checking with current enrollee databases from the OSs). This register would be a "quasi-bill".
(ii) The remaining share (50%) will be transferred every four months based on performance for provincial tracer indicators (which will be the same and with the same targets for all provinces). If a province fully achieves all tracer targets at their maximum values, it will receive the entire 50% of the capitation payment, and otherwise its share of this payment will be adjusted downwards accordingly. The length of the initial four-month period may be adjusted if needed; this would need to be approved as part of the OM.

b. Given the complexity of the system, a grace period of eight months (starting from the first month for which capitation payments are made) may be offered under the Project to allow time to fully implement the new tracer system. (Full details on how this will operate would be in the OM).
c. Disbursements of loan proceeds for the capitation payments for the GHIs will be made against the certified "quasi-bill" and certified tracer report submitted by each province. The UAC, in coordination with the PCT, will certify and verify them through a bimonthly independent technical audit. Both the "quasi-bill" submitted by the province (based on enrollment with effective coverage) and the provincial report on the tracer targets achieved will be audited.
d. An independent external technical audit, conducted by an independent firm contracted by the MSN and with TORs acceptable to the Bank, would verify (and correct as needed): (i) eligibility of all beneficiaries for which capitation payments were made; and (ii) tracer performance.

8. **As part of the institutional arrangements, the Provinces would have to fulfill certain conditions to enter into, and then to remain in, the program – as described above in Annex 1.** These "conditions of entry" and "conditions of continuation" would be described in the Annual Performance Agreements and in the OM, and may be modified in agreement with the Bank.

9. **The key institutional arrangements for the capitation payments for HCDs would be:**

a. The beneficiaries of the National Fund for High Complexity Diseases (NFHCD) will consist of all in the eligible population that have been enrolled under the Project (including those without "effective coverage"). After the certification process described under point (a)(i) of the previous paragraph, the PCT will consolidate the monthly register of enrollees sent by each province into a unique national beneficiary register for the NFHCD. This will constitute a "quasi-bill".
b. For each beneficiary enrolled, a capitation payment will be transferred to the NFHCD every month. This Fund will be managed by the UAC.
c. Disbursements of loan proceeds for the capitation payments for the HCD interventions will be made against the certified "quasi-bill" consolidated by the PCT, which will be audited via an independent technical audit on a bimonthly basis.

10. **Retroactive financing for capitation payments.** The MSN may request retroactive financing to finance capitation payments for the eligible population enrolled with effective coverage paid up to one year before the signing date of the Loan Agreement. Retroactive financing would not exceed US$60 million. The Borrower's application for reimbursement of expenditures paid before the loan signing date would be accompanied by certification – by Independent Technical Auditors acceptable to the Bank – of the veracity of the figures reported on enrollment, on the number of eligible beneficiaries with effective coverage, and on the performance of the tracer's matrix. In addition, the MSN would need to provide evidence of accomplishment of the following actions: (i) signed Umbrella Agreements for Participating Provinces; and (ii) signed Annual Performance Agreements for Participating Provinces.

Implementation for Activities Supporting Integration of Health Information Systems (IHIS)

11. **During implementation, each of the ten activities under this stream would be referred to as an "adoption package" –** a package of services, software, hardware, training, technical assistance, actions and other types of support customized for each province, and would require adoption by the province. Each "adoption package" would have its own province-specific implementation plan, with standardized activities, indicators and budgets for the National Government and the province.

12. **Before implementation, there would be a thorough assessment of each province's readiness for IHIS activities – financed from funding outside the Project[43] – followed by the development of an implementation plan for IHIS activities in the province**. The readiness assessment would be based on an in-depth examination of existing systems, capabilities, resources and priorities for each province. The implementation plan would be developed jointly by each province and the National Government team, taking into account available resources and provincial priorities.

13. **Each of the activities (with its associated "adoption package") would have a national leader** that defines the implementation plan for the national components. This person would consult closely with the provinces throughout the process of developing the activities and actions on the part of the provinces, and to coordinate the steps needed for provincial adoption of the package. Each adoption package would have a national component that would start being "unwrapped" at the start of the Project, creating the necessary interoperability infrastructure, standards, toolkits and documentation. These activities would be performed at the national level and the results would be available for all provinces.

14. **At the start, provinces would need to express their willingness to participate in the eHealth implementation program with support from the National Level, and their adequate participation would be linked to the conditions of entry and continuation of the project.** During the first year of the Project, agreement would need to be reached regarding provincial activities and actions, and steps to be taken for provincial adoption of the packages – all using inputs from the readiness assessment mentioned above. The Project would manage available resources and provincial preferences to create a schedule of activities and goals over time (with separate goals and indicators for the national and provincial levels).

[43] Specifically, from the national *Proteger* program, via a proposed allocation of around US$5 million.

15. **The bulk of the financing for the provincial activities in the adoption packages is expected to come from provinces' domestic resources**, but to promote interoperability and shared learning, each package would have a specified allocation of funding for a subset of eligible activities at the provincial level. These activities are intended to be planned and executed in collaboration with the core national team.

16. **The National Ministry of Health MSH would establish a new Electronic Medical Records and Interoperability Team**, **which would lead this work at the national level. This team would also be in charge of producing a Strategic Plan for Federal Health Information Systems.** At the national level, the IHIS work would be undertaken with close collaboration with: (i) various entities within the MSN, including the teams leading various Programs (including SISA) and UAC; and (ii) the SSS and INSSJP. There will be an especially strong initial focus on implementation in two pilot provinces. There will be a core national team responsible for technical coordination of all activities, fundamental analytical work and quality control of the work of other consultants employed.

Financial Management and Disbursements

17. **Staffing**. The FM professionals at UFI-S have relevant experience in implementing previous Bank financed projects[44]. In addition, a former UFI-S FM Coordinator with extensive experience in WB-financed activities has been appointed as Director of the *Dirección de Programación y Control Presupuestario* of the UAC since April 2017. There is adequate segregation of duties within the UAC to maintain an adequate level of control. Capacity building activities would be delivered to support the UAC in managing Sub-Component 1.1 and 1.2. activities.

18. **Budgeting arrangements.** The national integrated budget and accounting system (SIDIF) will be applied. A separate line item in MSN's annual budget will be created and maintained throughout the entire project implementation period so that budget resources from different sources and Project expenditures can be tracked. SIDIF is a reliable tool to support the Project's budget accounting requirements.

19. **Accounting and financial reporting**. UAC through its UFI-S will be responsible for Project accounting and will produce annual financial statements. Project accounts will be maintained in the UEPEX[45] system, which is an in-house information tool developed by the Federal government. UFI-S will be responsible for: (i) recording Project transactions on a cash basis using a chart of accounts that reflects disbursement categories, program components and sources of funding; and (ii) producing the requisite annual financial statements of the whole Project following International Accounting Standards. UFI-S will also prepare semiannual forecasts of Project expenditures to request advances that are supported by quarterly Interim Unaudited Financial Reports (IUFRs) to be delivered to the Bank 45 days after each reporting period. Unlike previous operations with the MSN, the FM functions of the capitation payments

[44] Health Vigilance Program and Disease Control VIGIA (P055482); the Provincial Maternal-Child Health Investment Project - *Plan Nacer* I (P071025); the Provincial Maternal-Child Health Investment Project - *Plan Nacer* II (P095515); the Essential Public Health Functions projects – EPHFP I & II (P090993 & P110599); the Emergency Project for the Prevention and Management of Influenza-Type Illness and Strengthening of Argentina's Epidemiological System (P117377); the AR Provincial Public Health Insurance Project – *Sumar* (P106735); and the Protecting Vulnerable People Against Noncommunicable Diseases Project (P133193).
[45] UEPEX: Argentina budget execution and recording software for multi-lateral financed operations.

component/scheme will be carried out by UAC including the following: (i) management of an operative bank account in local currency that will receive advances from the DA controlled by UFI-S; (ii) making and recording capitation payments in local currency in UEPEX; and (iii) budget formulation and execution. A consolidated chart of accounts will be prepared to consolidate project accounting records and financial reporting for the entire Project. The UAC will record capitation payments in UEPEX that will then be consolidated by UFI-S as part of the IUFR as well as the annual financial statements. The Operational Manual clearly defines roles, responsibilities and robust mechanisms to allow coordination of arrangements (for UFI-S and other relevant departments under the UAC) required for Project implementation. The following financial reports will be presented by UFI-S to the Bank:

Table A2-1: Reports Schedule

Report	Due date
Quarterly IUFRs reflecting the sources and uses of funds for each quarter and cumulative uses by category, including starting and ending cash balances.	Within 45 days after the end of each quarter.
Annual audit report on project financial statements.	Within six months after the end of each calendar year of loan disbursements (or other period agreed with the Bank).
Special opinions on Statements of Expenditures and Designated Account.	

20. **Treasury.** The UAC through its UFI-S will be responsible for treasury operations other than the capitation payments which will be managed by the *Dirección General de Administración* of UAC (General Directorate of Administration – GDA) following government streamlined payment procedures. Roles and responsibilities are clearly defined in the OM to allow smooth project implementation. Bank financing of the capitation payments under Sub-Component 1.1 will be made on a declining basis throughout project implementation, and will be replaced by Government financing. Based on this, the MSN has expressed to the Bank its intention to start using the Treasury Single Account (TSA), managed by the National Treasury Office (TGN), in the MSN once project implementation progresses. In any case, if there is a specific request from the MSN, the proposed arrangement for using the TSA for capitation payments would be assessed to determine if it is acceptable to the Bank.

21. **Internal controls and auditing.** The internal control environment is part of Argentina's legal and institutional framework. The UFI-S and UAC's operational processes and procedures provide for an adequate internal control framework and proper segregation of duties. In addition, the Audit and Supervision Area of the PCT plays a key role in monitoring provinces' technical and financial implementation of the Project. Also, the operation will be subject to the internal control standards issued by the General Syndicate of the Nation, the Federal government's internal audit agency, which also supervises and coordinates actions of the Internal Audit Teams in all agencies, including MSN. FM supervision will include the review of internal audit reports related to the Project.

22. **External Audit Arrangements:** (i) Annual financial audit. The Project's annual financial statement will be audited under Terms of Reference (TORs) prepared in accordance with Bank guidelines and performed by an independent auditor following standards acceptable to the Bank. It is expected that the

financial audit will be conducted by the Argentine Supreme Audit Institution, *Auditoría General de la Nación* (AGN). (ii) Capitation payments verification. An independent technical audit firm with TORs acceptable to the Bank will be hired to assess the management of the results-based capitation payments. The contracting of the independent technical auditor will be a condition of disbursements for the capitation payments. The auditor will assess the validation of the "billings" based on the enrollment databases and the service (tracers) sent by each province; it will also assess the management of capitation payments and compliance by each province with the umbrella agreement and loan agreement clauses. Technical audit reports will be submitted every two months and will be required to document the eligible capitation payments to the Bank. With the objective of gradually increasing the use of the country own external control institutions, the intervention of participating provinces' Supreme Audit Institutions or *Tribunales de Cuentas* has been discussed with the MSN and will be assessed as project implementation progresses.

23. **Flow of Funds and Disbursements Arrangements.** The following disbursement methods may be used under the loan: (i) Advance; (ii) Reimbursement; and (iii) Direct Payment. Loan proceeds will be disbursed through quarterly IUFR-based Disbursements. Advances will be disbursed into a separate designated account (DA) in dollars to be opened in the "*Banco de la Nación Argentina*" (BNA), which would be used to deposit advances for the Project and controlled by the UFI-S. The ceiling for advances to the DA would be the forecast for 2 quarters to be provided in the quarterly IUFRs. For Categories #3 and #4, the advances to the DA requested in the Interim Unaudited Financial Reports (IUFRs) will be based on (inter alia) estimates of the numbers of eligible persons that are enrolled (and with effective coverage for Categories #3). Documentation for these categories will be based on, inter alia, the actual (and independently verified) numbers of eligible persons that are enrolled (and with effective coverage for Categories #3). Payments of project eligible expenditures will follow 3 different process depending on the type of eligible expenditure, namely: (i) payments under expenditure categories #1, #2 and #5; (ii) capitation payments made by UAC to the provinces under Sub-Component 1.1 (categories #3); and (iii) capitation payments made by UAC to the National Fund for High Complexity Diseases (NFHCD) under Sub-Component 1.2 (category #4). As eligible expenditures arise, funds will be converted to the local currency and deposited in an account managed by the UFI-S that will cover the Project payments to suppliers and consultants while transfers for capitation payments will be managed by UAC through another operative account. UAC will then transfer funds to the participating provinces under the Capitation Payments for selected General Health Interventions including the "Basic" and the "Equity" component (expenditure category #3). Said funds will be deposited by each province in a bank account separate from the provincial consolidated fund, that will be used by each province to make payments to the Project's service providers only. In addition, the project will finance Capitation Payments for selected High-Complexity Disease interventions under Sub-Component 1.2 (expenditure category #4) that will be transferred by UAC to the NFHCD. The creation of the NFHCD will be a condition of disbursements for loan category #4. The Project flow of funds coordination arrangements will be clearly stated in the OM. Once progress implementation progresses under Sub-Component 1.1, TSA use for capitation payments could be proposed by MSN and assessed by the Bank. Loan proceeds would be disbursed against the following expenditure categories:

Table A2-2: Disbursements per Expenditure Category

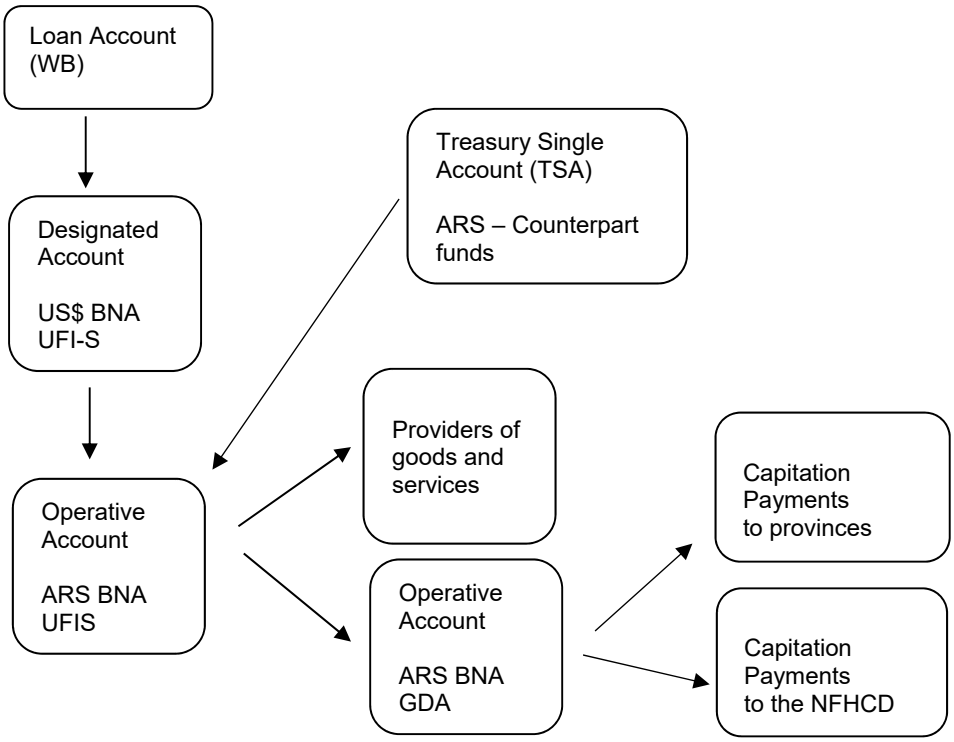
Expenditure Category	Amount in USD	Bank's Financing Percentage
(1) Goods	27.437.200	100%
(2) Consultants' services, non-consultant services and training	74.891.096	100%
(3) Capitation payments under Sub-Component 1.1. of the Project (*)	171,365,246	85% until December 31, 2019; 40% until December 31, 2020; and 25% thereafter
(4) Capitation payments under Sub-Component 1.2 of the Project	21.100.000	50%
(5) Operating costs	4.456.458	100%
(6) Front-end Fee	750.000	Amount payable in accordance with Section 2.07 (b) of the General Conditions
TOTAL AMOUNT[46]	300.000.000	

(*) The total amount for category 3 includes US$18.593.758 related with equity capitation payments. There will be fixed amounts allocated to each participating province to be disbursed under this "equity" component of the capitation payment. Those amounts per province are included in the Operational Manual.

24. The following chart reflects the Project's flow of funds:

[46] All expenditure supporting documentation will be available for review by the external auditors and Bank staff at all times during Project implementation, until at least the later of: (i) one year after the Bank has received the audited Financial Statements covering the period during which the last withdrawal from the Loan Account was made; and (ii) two years after the Closing Date. The Borrower and the Project Implementing Entity shall enable the Bank's representatives to examine such records.

Figure A2-1: Flow of Funds



25. **Disbursement Conditions.** The following conditions will apply for this Project: (i) the contracting of the independent Technical Auditor following terms of reference acceptable to the Bank will be a condition of disbursements for capitation payments under Categories (3) and (4) of Schedule 2, Section III of the Loan Agreement; (ii) retroactive financing may be requested for eligible payments made by the Borrower on or after March 8, 2018, but in no case more than one year before the Signature Date of the Loan Agreement, for an aggregate amount not to exceed US$60 million (20% of the loan amount); and (iii) the establishment of the National Fund for High Complexity Diseases (NFHCD) in a manner acceptable to the Bank will be a condition for capitation payments under Sub-Component 1.2 (Category 4).

Procurement

26. Procurement will be conducted according to the World Bank's Procurement Regulations for IPF Borrowers, issued in July 2016 (revised in November 2017), for the supply of goods, works, non-consulting services and consulting services. The World Bank's Standard Procurement Documents will govern the procurement of World Bank-financed Open International Competitive Procurement. For procurement involving National Open Competitive Procurement, the Borrower will use Standard Procurement Documents acceptable to the Bank already in place for ongoing operations that are included in the Operational Manual.

27. A procurement capacity assessment of UFI-S was carried out on the current structure. Based on this analysis, as well as prior and post review supervision for ongoing operations being implemented by the UFI-S, the preliminary assessment concludes that even though UFI-S has experience in Bank's-financed

projects, the procurement capacity should be strengthened with experienced professionals. It is also recommended to review internal processes ensure efficiency and quality in the implementation of procurement activities.

28. UFI-S has, with close support from the Bank, developed a Project Procurement Strategy for Development (PPSD), identifying the procurement arrangements designed to ensure the delivery of value for money while efficiently achieving the PDOs. The PPSD is focused on the high value and/or high-risk contracts included under all components, except for Component 1 which will not have any procurement. At this stage, it is expected that Sub-Component 2.2 will finance goods to support computer systems interoperability, medical equipment and vehicles. Most of the activities under Sub-Component 2.1 will be targeted to institutional strengthening activities that would include consultancy services for the prioritization of health services and other studies. Finally, Component 3 would include the procurement of minor goods and external audit services. Based on the results of the PPSD, the procurement arrangements for these and the rest of the activities expected to be carried out during the first 18 months are detailed in the Procurement Plan.

29. Based on the capacity assessment carried out for UFI-S, it is recommended to: (i) strengthen UFI-S with experienced procurement professionals; (ii) review internal quality control of the documentation related to procurement; (iii) implement a control panel or similar tool in order to insure close monitoring of each milestone in the procurement process and contract supervision; and (iv) conduct annual supervision missions in the field to carry out the post review of procurement actions.

Environmental and Social

30. The Project will be implemented by the National Ministry of Health, which has solid experience working with World Bank Safeguards procedures. Most investments are planned to take place in already-existing infrastructure, nationwide, and would not involve natural habitats, forests or cultural property. The specific locations of the proposed interventions would be defined during Project implementation and will be in the provinces that will sign the Umbrella Agreements (see above). Argentina has comprehensive national legislation in place to guide health care waste management practices. The environmental and social management activities of the Project would be implemented by technical experts from the MSN Safeguards Teams that were created in 2007 for the EPHFP I Project. These teams, which are already staffed, have been strengthened via the implementation of the previous projects and maintain effective linkages institutionally with the provincial governments.

31. Provinces will designate focal points/teams or environmental health units, and develop action plans for environmental management. The environmental issues relate to: (i) medical waste management from medical care resulting mainly from cancer prevention activities and the application of highly complex interventions as part of the Project plan; and (ii) the elimination of old computer equipment, caused by the provision of new equipment (medical, emergency, transport, computer systems and communications) in the national and provincial Ministries of Health, as well as in primary health care centers. The findings of the Project's Environmental Assessment led to a Category B rating, and to the triggering of OP / BP 4.01 (Environmental Assessment).

32. The MSN formulated an Environmental Management Framework (EMF) through a process of consultation and consensus with the environmental health units of the Argentine provinces. The EMF of the Project was publicly consulted through two mechanisms: (i) five regional meetings (one in person and four by videoconference) with representatives of hospitals, environmental areas of the provincial health ministries, and relevant NGOs and key actors involved in environmental issues; and (ii) a survey aimed at the key actors identified under the EPHFP II Project and *Sumar* program.

33. Regarding social safeguards, about 2.5 percent of the Argentinian population self-identifies as having indigenous ancestry. Although there is little information on their health status (ethnic variables are not available in official statistical records), specialized studies and IP organizations point to important and persisting gaps in access and health outcomes. The Project does not anticipate adverse effects on these or other vulnerable populations. On the contrary, it is likely to improve health care access and monitoring through the activities described in the Indigenous Peoples' Planning Framework (IPPF).

34. The Project will build on and continue benefitting from the MSN's experience with OP / BP 4.10 (Indigenous Peoples) under previous and ongoing operations. An IPPF was prepared and consulted with relevant Indigenous Peoples (IP) representatives from the Council of Indigenous Participation and a round of consultations at the subnational level will be carried out during the design of the respective Indigenous Peoples Plans (IPPs). The main objective of the IPPF was to unify the criteria used for OP 4.10 implementation throughout the portfolio of the MSN associated with the Bank, so as to maximize its positive impacts and improve outcomes by looking, for example, into areas of complementarity and overlap, strengthening both national and sub-national capacities to implement and monitor IP policies, and mainstreaming statistical capacity to capture IP in public health records, among others.

35. The IPPF and the EMF will be implemented and monitored by the existing Safeguards Teams under MSN, created in 2007 under the EPHFP I Project (mentioned above) with assistance and participation of the PIUs. In addition, the MSN will continue to promote and collaborate with other health programs to develop and strengthen health policies for indigenous peoples, mainstreaming health care practices consistent with their needs and views on health.

36. The IPPF was prepared and consulted with relevant Indigenous Peoples (IP) representatives on October 26, 2017, and disclosure in-country was done on November 17, 2017 and on the World Bank's (WB) webpage on November 27, 2017. Disclosure of the EMF in-country was done on November 17, 2017 and via the World Bank's webpage on November 27, 2017.

Monitoring and Evaluation

37. In order to monitor progress toward achieving the PDO, the Program Results Framework will use the PDO-level Results Indicators which will be tracked using the M&E system of the MSN. The Project will track indicators of effective coverage and improvements in the health conditions of the eligible populations. Intermediate results will be tracked to determine if the Project components are being carried out. The full Results Framework is included in Section VII of this document.

38. Information sources and instruments will include: (i) the Roster Management System (*Sistema de Gestión de Padrones*); (ii) Provincial Health Service Billing Systems; (iii) Health Service Consumption Registries and Medical Records; (iv) the Tracer System; (v) the bi-monthly independent technical audit; (vi) bi–annual Project management reports; (vii) midterm and final assessments; and (viii) various studies and analytical work including impact and process evaluation analyses.

39. The Project will also support the strengthening of health information systems under Sub-Component 2.1 and Sub-Component 2.2, increasing the capacity of the MSN and the MSPs to monitor the performance of the public health sector, Project execution and the health status of the population. Eventually the data needed for Project monitoring and for tracking Project performance will come from integrated program databases maintained at the provincial level (covering several or all public-sector programs), as well as expanded data collected at the health service provider level (e.g. related to "empanelment"), as provinces make progress with integration of information systems under activity stream (d) of Sub-Component 2.1.

40. The PCT will be the primary entity responsible for tracking the progress related to Project activities, outcomes and results, providing general supervision of the provinces and ensuring the timely gathering, analysis, and dissemination of information. The PIUs will register beneficiaries and coverage through the Roster Management System and will collect data on health indicator performance through the Tracer System, whose data will be compared against effective coverage and tracer goals as listed in the Annual Performance Agreements signed between the MSN (Nation) and the MSPs (provinces). The PCT will consolidate this information to monitor Project coverage. It will also collect data on health conditions to see if they have improved, primarily from annual reports on mortality rates and causes of death produced by the Directorate of Statistics and Health Information (DEIS).

41. Most health facilities that will be authorized as service providers have medical records systems. The MSN has developed electronic enrollment and billing systems for health care providers to generate basic data on beneficiary numbers and services delivered that flows directly to the MSPs (service providers may use these systems or others with the same functionalities to be accepted in the Project). MSPs currently compile such data for sector management purposes; however, added assistance will be provided to provinces and service providers to upgrade/expand their information/communications systems, with a focus on increasing the interoperability of current systems to support the Project's functions and M&E. The Project will increase MSN's capacity to track performance at the provider level through "empanelment" and measuring health results linked to the prioritized lines of care.

42. The independent (external) and internal audits will contribute useful information to assess the Project's results. An independent Technical Auditor acceptable to the Bank will be contracted under TORs agreed with the Bank to conduct bi-monthly technical audits. These will: (i) verify results such as access to health coverage and improvements in health conditions, service delivery and quality; these items will be assessed by auditing the information the provinces submit on enrollment, tracers achieved, and services provided by health care facilities; and (ii) verify the compliance of each province and the national level with Project guidelines as established in the Loan Agreement and Operational Manual. The audits will report errors and deviations from the Project goals/guidelines to the PCT every two months. The independent Technical Auditor will also propose sanctions and recommend ways to solve the problems. The PCT will conduct remedial and mitigation activities in a reasonable time as established in the OM.

43. The financial audit and supervision area of the PCT supervises the provinces' technical and financial activities and approves the debits and fines recommended by the independent Technical Auditor. Action plans will be prepared and implemented to correct any deviations and improve critical fiduciary challenges. The UAC would apply the debits and fines recommended by the independent Technical Auditor, and approved by the financial audit and supervision area of the PCT.

44. Impact and Process Evaluations and associated analyses will be key activities under the Project and would remain central to the M&E activities under the program, and for informing activities in support of the move to effective UHC. Under the previous *Plan Nacer* and *Sumar* programs, a series of impact evaluations were launched to measure the effects of the pay-for-performance (P4P) model on the use and quality of health care services as well as to test alternative design features in order to increase program effectiveness. Among others, the evaluation strategy will aim at generating new evidence that can inform the design and implementation of expanded health care services and determine the most effective ways to improve health service use and quality for those exclusively covered by the public sector. As the Project develops over the first two years, the MSN technical team and the Bank will conduct provider- or individual-level pilots to test key design features and incentive schemes in select provinces. The pilots will use experimental methods to generate rigorous evidence that is representative at the provincial, provider, and/or individual level depending on the nature of each study.

45. The evaluation work will also assess indicators and trends in sustainability and institutionalization. This work will take into account different dimensions of institutionalization, including in financing, management, integration across programs and information systems.

Role of Partners

46. The Primary Health Care Performance Initiative (PHCPI) is a partnership of the World Bank, the World Health Organization and the Bill and Melinda Gates Foundation to catalyze global improvement in primary health care through better performance measurement and knowledge sharing. As part of this Project, the PHCPI will be providing (and financing) TA to the MSN to support the selection and definition of quality of care indicators under the Project and to support the development of a national yet internationally comparable scorecard assessing the performance of the primary health care system and to help improve the measurement of the quality of primary health care services delivered under the Project. Results will be made publicly available on the website of the Initiative.

ANNEX 3: IMPLEMENTATION SUPPORT PLAN

COUNTRY : Argentina
Supporting Effective Universal Health Coverage in Argentina

Strategy and Approach for Implementation Support

1. The strategy for implementation support is based on the nature of the Project and its risk profile as well as lessons learned from other Bank-financed health projects in Argentina including the ongoing Provincial Public Health Insurance Development Project (P106735) that supports the *Sumar* program. The implementation support plan focuses primarily on providing support to the MSN and MSPs for the implementation of the risk mitigation measures mentioned in Section V above.

2. **Operational support**: Implementation support will include reviewing annual action plans and annual performance agreements with provinces, designing and supervising monitoring and evaluation systems, tracking progress of the Project's indicators, monitoring progress on the implementation of Project components, ensuring conformity with the OM, reviewing results-based mechanisms to transfer funds to provinces, and monitoring Project execution according to annual action plans and interim unaudited financial reports (IUFRs). A senior operations officer and a senior health specialist, together with an operations officer (all based in the country office), and a senior health economist, will provide day-to-day support in all operational aspects, as well as coordination with the Borrower and among Bank team members.

3. **Technical**: The Project will procure medical equipment. Thus, the Project's supervision will need the support of a medical equipment specialist who would provide support reviewing the technical specifications. Additional support will be needed from an IT specialist for various activities related to Information Systems and IT, as well as implementation of the interoperability strategy.

4. **Procurement**: Implementation support will include: (a) training of staff in the UAC and in the international financing team of MSN (UFI-S) as well as detailed guidance on the Bank's Procurement Guidelines as needed; (b) reviewing procurement documents and providing timely feedback to UFI-S; (c) monitoring procurement progress against a detailed Procurement Plan; and (d) undertaking procurement post reviews. A procurement specialist, based in the country office, will provide timely support.

5. **Financial management**: Supervision support will be needed to review the Project's financial management system, including but not limited to, accounting, reporting, and internal controls, as well as compliance with financial covenants. Implementation support will be needed for review of interim unaudited financial reports, annual financial audit, and the independent technical audit (as relevant). The financial audit will provide independent opinion on the use of funds and will complement the work of the independent Technical Auditor. A financial management specialist based in the country office will provide timely support. Financial management on-site supervision will be carried out semiannually during first year of implementation, and once a year thereafter if supervision results are satisfactory.

6. **Environmental and Social Safeguards**: Implementation support will include supervision of actions agreed in the Environmental Management Plan and the review, provision of no objections to and monitoring of the implementation of annual IPPs, together with related intermediate indicators in the Project's Results Framework. The Bank will also provide guidance and recommendations to the MSN as required. Inputs from an environmental and social specialist will be required as well as field visits.

7. **Evaluation activities and analytical support.** The Project will include various impact and process evaluation activities, as well as various studies and analytical work activities. Support for these activities will thus be required from an expert in these types of activities, based in the country office.

8. **A number of the Bank team members,** including operational, financial management, and procurement, environmental, and social consultants will be based in the country office to ensure timely, efficient, and effective implementation support to the Borrower. Formal supervision and field visits will be carried out semiannually. Detailed inputs from the Bank team are outlined in the table below.

Implementation Support Plan and Resource Requirements

Time	Focus	Skills Needed	Resource Estimate	Partner Role
First twelve months	Support the MSN to adjust the M&E framework in line with the Project incentive structure	Operations, Technical, IT, M&E Fiduciary, social and environmental	Supervision budget based on norm	--
12-48 months	Keep project implementation on track	Operations, Technical, IT, M&E Fiduciary, social and environmental	Supervision budget based on norm	--
Closing	Capacity building toward sustainability	Operations, Technical, IT, M&E Fiduciary, social and environmental	Supervision budget based on norm	--

Skills Mix Required

Skills Needed	Number of Staff Weeks	Number of Trips	Comments
CO-TTL			Based in CO
CO-TTL			Based in HQ
Sector Specialist			Based in CO
Health Economist			Based in HQ
Procurement specialist			Based in CO
FM specialist			Based in CO

Social specialist	Based in CO
Environmental specialist	Based in CO
Operations	Based in CO
Technical specialist	Based in CO
Consultants	Based in CO/HQ

ANNEX 4: ECONOMIC ANALYSIS

COUNTRY : Argentina
Supporting Effective Universal Health Coverage in Argentina

A. Economic Analysis of the Project

The Development Impact of the Project

1. The Project aims at increasing the number of people in the general population covered by a package of basic interventions. In addition, it seeks to increase the proportion of the eligible population enrolled and assigned to a primary health care facility and to finance a set of mainly preventive health care services with a high impact on the burden of disease. Apart from the broader impact on the health care system (i.e. by moving it closer to effective UHC and strengthening primary health care), the Project will yield two concretely quantifiable economic benefits: (i) improved health outcomes in the form of – among others – reduced cancer and maternal mortality rates as well as reduced NCD-related morbidity rates (in particular related to type-2 diabetes)[47]; and (ii) cost savings at the hospital level from reduced avoidable admissions. The occurrence of avoidable admissions can be considered as a measure of poor primary health care. In the presence of strong primary health care, patients receive the necessary care for many conditions in an ambulatory setting such that they do not need to be admitted to a hospital in the first place.

2. Prominent areas of intervention within the basic service package include cervical cancer, type 2 diabetes, and prenatal care. Around 2,000 women die from causes directly related to cervical cancer each year (the National Cancer Institute, 2014). Especially in the country's northern regions where the cancer incidence is particularly high, the low coverage of cervical cancer screening needs to be increased. Therefore, cervical cancer care remains a national health care priority, with a particular focus on screening and early detection. An estimated 6% of the total population and more than 7% of all adults have type 2 diabetes in Argentina. Also, the number of undiagnosed diabetes cases is high due to the inconspicuous onset of the disease. Hence, health care services for and early diagnosis of adults with type 2 diabetes need to be strengthened. Even though more than 99% of total deliveries occur in a health institution and are attended by trained personnel, around 10% of pregnant women receive no prenatal care before delivery. Moreover, only 25% of pregnant women have their first check-up before the 20th week of gestation. Thus, the quality and timeliness of prenatal care need to be further promoted.

Costs and Benefits Considered in the Analysis

3. For the purpose of the cost-benefit analysis at hand, the following benefits are being considered: (i) cost savings from a reduction in the number of hospitalizations (direct benefits); and (ii) enhanced economic productivity of Project beneficiaries due to the years of healthy life gained as a consequence of prevented premature deaths and disabilities (indirect benefits). The analysis does not set out to quantify

[47] The interventions targeted at reducing cancer mortality through increased screening rates will also reduce cancer-related morbidity, just as improved quality of care in NCD treatment in general will not only reduce NCD-related morbidity but also lower mortality. For the ease of exposition here, increased cancer screening will be considered as a means of reducing mortality, while Project activities focused at improving the quality of care for NCDs will be reflected as measures to primarily decrease morbidity.

the considerable benefits from investments in improved information systems and enhanced care integration (accounting for about 20 percent of the total Project cost) due to the lack of an established estimation methodology. Also, due to the long-term nature of the activities financed by the Project, the cost-benefit analysis framework (only considering benefits from changes in the health care system occurring within 10 years of Project effectiveness) greatly underestimates the actual Project benefits.

4. *Specification and assumptions of the cost-benefit analysis*

a) Beneficiary population: The main beneficiaries are children under 10, adolescents aged 10 to 19 years and adults aged 20 to 64 years that exclusively receive their services from the public provincial service delivery system. While the eligible population for Project interventions is much bigger, the economic impact of the Project depends on the number of beneficiaries who: (i) are in principle eligible to receive health care services from the prioritized intervention package, and (ii) will actually use any services (i.e. effective coverage) during the benefit accrual period.
b) The health impacts of the Project were estimated based on reductions in the burden of disease among the target population for the set of health care services covered under the basic service package. The calculations for the reduction in the burden of disease were based on the concept of Disability-Adjusted Life Years[48] (DALYs).
c) The indirect benefits from the prioritized health interventions were derived based on the assumption that Years of Life Lost (YLLs)[48] due to premature mortality will be reduced by 10 percent as a result of the Project, with the exception of maternal and perinatal causes, for which greater reductions in YLL (20 percent) are being assumed.
d) The direct benefits in the form of reductions in the number of hospital admissions among the target population benefitting from the priority interventions result in significant cost savings for the health care system. The analysis assumes a reduction of up to 8 percent in total hospital admissions for the target population and estimates daily hospitalization costs to be about US$250[49].
e) Productivity and human capital gains from prevented YLLs are assumed to equal the national annual average income per capita (approximately US$15,000) for each avoided YLL.
f) The Project costs occur during calendar years 2018 to 2022 (corresponding to Bank fiscal years 2019 to 2023): Due to the delay with which benefits start materializing, benefits accruing until 2028 are considered in the analysis. While Project benefits are expected to persist much longer, the short reference period of 10 years for accruing benefits is considered for the analysis due to the increasing uncertainty about the counterfactual scenario in the absence of the Project. Benefits from reduced mortality will start accruing in the first Project year (i.e. in the course of 2019), and cost savings will start accruing towards the end of the second Project year.
g) Basic discount rate: In order to make the costs and benefits occurring at very different points in time during (and after) the Project comparable, they need to be discounted taking into account both inflation and the time value of money (TVM). The TVM reflects the fact that money available today can be invested to yield a positive return and is therefore more valuable than the same amount of money received in the future. Nevertheless, the choice of the TVM discount

[48] The concept of DALYs allows quantifying the Burden of Disease from mortality and morbidity. DALYs can be thought of as one lost year of "healthy" life. DALYs are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with health conditions or its consequences.
[49] Additional Financing – Provincial Public Health Insurance Development Project (P154431), Economic and Financial Analysis.

rate (especially in longer-term and public investment contexts) is to some extent subjective. A higher rate implies a higher relative valuation of the Project costs, given that benefits accruing in the long term are discounted more heavily, whereas a lower rate implies a lower relative valuation of the costs. Therefore, costs and benefits are discounted at 5% to account for the TVM.[50] A higher discount rate of 10% is also applied to verify the sensitivity[51] of the results to this assumption. A sensitivity analysis with respect to inflation is not conducted, given that expected benefits are measured in real terms (e.g. real cost savings & monetized benefits from prevented premature deaths).

h) Expected disbursements of investments: When discounting the financial costs of the Project, it is assumed that the funds provided by the Bank are disbursed according to the planned disbursement schedule (see Project Financing Data). Likewise, the analysis assumes that the co-financing from the Argentine Government will follow the estimated disbursement schedule.

i) Temporality of benefit streams: Estimated direct benefits (i.e. savings from a reduction in the number of avoidable hospital admissions due to improved disease prevention in ambulatory care settings) are only accounted for during the time of the Project interventions (i.e. until 2022). However, indirect benefits from prioritized health interventions (i.e. human capital gains from averted mortality and morbidity) are considered beyond the end of the Project implementation period – in fact until 2028 – so for ten years from the time of Project effectiveness. The indirect benefits estimated to accrue beyond the Project implementation period are from prioritized health interventions for adolescent, maternal and child health related conditions. (In these cases, Project beneficiaries will not need to receive the same health interventions again after the end of the Project). Such indirect benefits will accrue without the need for additional investments after the end of the Project. This approach is conservative, since such indirect benefits are expected, in fact, to accrue over the lifetime of Project beneficiaries, which on average is expected to be longer than just 10 years. This conservative approach is adopted since the counterfactual (what would happen in the absence of the Project) becomes more and more difficult to predict, the longer the considered time horizon.

Summary of costs and benefits

5. The analysis accounts for the total financial costs of the Project – including components associated with investment, technical assistance and Project administration – of US$660 million.

6. Savings in hospital care (direct benefits) due to fewer hospitalizations among the target population were – in a conservative scenario – estimated to come from the reduction in the number of

[50] Countries following guidelines for economic evaluations in health care use different discount rates, but they are mostly between 3% and 5%. This is true within Argentina as well. In fact, the most comprehensive review of such evaluations found that 5% is the most commonly used discount rate (e.g. see "The Practice of Discounting in Economic Evaluations of Health Care Interventions" by Smith D.H. and Gravelle H. in the *International Journal of Technological Assessment in Health Care* 2001, 17: pgs. 236–43). Given that benefits from health care reforms (that take a long-term approach of changing the system) accrue later than the costs needed to invest, a higher discount rate leads to a more conservative estimation of the benefits. Hence, the team chose to use 5% as the baseline discount rate, being the highest discount rate commonly used. The analysis includes another, even more conservative scenario, using 10% as the discount rate. The presented Net Present Value estimates are hence at the lower bound of estimates produced using typical rates of discount.

[51] The estimated benefits are sensitive to a higher TVM, since it decreases the present value of the more distant benefits from gains in human capital. The related reforms are long-term oriented, and it takes some time until benefits materialize.

hospital admissions of 200,000 from 2018 to 2028. This figure represents a decline in the number of hospital admissions among the target population of less than 5 percent over the assumed benefit accrual period. The present value of the savings to the public health system discounted at a rate of 5 percent amounts to US$247.58 million. Indirect economic benefits from productivity gains due to improved health conditions of the target population were measured using DALYs gained. Table A4-1 provides estimates of the annual health impact of the Project.

Table A4-1: Health Impact Estimates

	2018	2019	2020	2021	2022	2023-2028	TOTAL
YLLs[48] due to premature deaths	955	12,776	26,010	13,427	28,564	104,013	185,745
YLDs[48] avoided	2,589	26,012	14,112	28,153	17,124	211,008	298,998
DALYs[48] gained	3,544	38,788	40,122	41,580	45,688	315,021	484,743

Source: Own calculations.

7. Assuming an economic value of US$15,000 for each year of life gained, the direct and indirect economic benefits would amount to US$951.4 million using a 5 percent discount rate. The Net Present Value of the Project would be US$364 million and the Internal Rate of Return would be 16.8 percent. Given that the analysis does not quantify the considerable benefits from improved information systems and enhanced care integration and uses a benefit accrual period of 10 years, it greatly underestimates the actual benefits from Project implementation.

8. Over the Project evaluation period, more than 5,000 deaths and many disabilities are expected to be avoided, leading to a reduction of the Burden of Disease in Argentina of approximately 480,000 DALYs (just from 2018 to 2028). The total number of DALYs gained beyond the benefit accrual period is expected to be considerably higher, as interventions focused on enhancing the prevention of NCDs are a long-term endeavor. The Project's full impact on health outcomes will only materialize once targeted cohorts of children and adolescents reach an adult age at which most of the risk factors addressed by Project interventions start affecting health outcomes.

Table A4-2: Summary of Estimated Costs and Benefits in Million US$ - 5% TVM

Year	Present Value of Project Costs	Present Value of Benefits	Net Present Value
2018	22.7	0	-22.7
2019	149.8	28.7	-121.1
2020	154.5	74.1	-80.4
2021	148.8	96.2	-52.6
2022	111.5	120.9	9.4
2023-2028	0	631.5	631.5
Subtotal	**587.3**	**951.4**	**364.1**

Source: Own calculations.

9. Table A4-3 presents the results of a sensitivity analysis looking at two alternative scenarios, one corresponding to a high discount rate scenario (10% instead of 5 %) and another one assuming low effectiveness of the supported interventions (reduction of the Burden of Disease of 7.5% instead of 10%). In the three different scenarios, the Internal Rate of Return ranged from 14.5% to 16.8%. The Net Present Value ranged from US$227 million to US$364 million and the Benefit-to-Cost Ratio from 1.42 to 1.62.

Table A4-3: Sensitivity Analysis

	Baseline Scenario	High Discount Rate	Low Reduction of Burden of Disease
Discount rate	5	10	5
Reductions in the burden of disease	10	10	7.5
Net Present Value (in millions of US$)	364	227	279
Internal Rate of Return (in %)	16.8	16.8	14.5
Benefits/Costs Ratio	1.62	1.42	1.51

Source: Own calculations

10. **Rationale for Public Sector Provision**: The main rationale warranting intervention by the public sector include the correction of market failures, the incorporation of externalities or spillovers, redistributional, social and political concerns. In the case of the proposed Project, a number of arguments could be made for public sector provision, the most important one being the need for redistributional measures. Eligible Project beneficiaries consist mostly of people in the lower income quintiles. Without public sector intervention in the provision of health care, these people would have no access to adequate health care. The proposed Project would support a redistribution of public funds in the health sector to ensure a more equal access to health care. Another reason for public sector provision is that the Project promotes health care prevention which has the positive externality of reducing health care costs and the burden of disease further down the line.

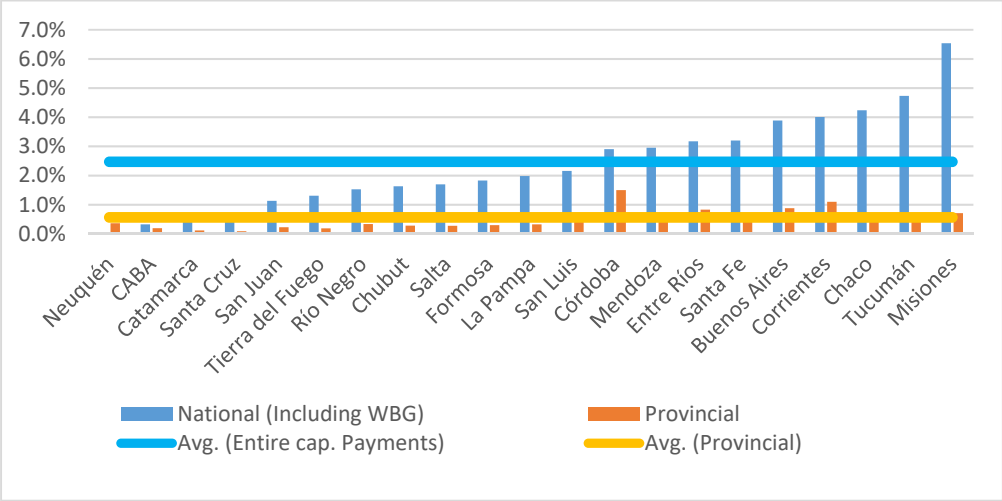
B. Sustainability Assessment[52]

11. The activities to be financed by the Project, and crucially capitation payments for the prioritized package of services, will be sustainable as: (i) the MSN has proven in the past that it is ready to fully take on externally funded programs from its budget after the external funding period ends; (ii) the provincial contribution to capitation payments represents a small share of provincial health budgets (and for this Project, the MSN has committed to taking on most of the financing for the capitation payments from its own budget, once the Loan period ends); and (iii) the full cost of the capitation payments (that would be mostly financed by the MSN from its own resources after Project closing) would constitute a small share of the MSN's budget, even if the MSN budget was not to increase. (In practice, with economic growth and expected increases in the total National budget, the MSN budget is expected to increase significantly).

[52] Data cited in this section are based on historical MSN and provincial budgets. GDP and exchange rate data are from the IMF World Economic, Outlook 2017.

12. As in the case of the Project, in the past under *Plan Nacer* and now under the *Sumar* program, the provinces have provided co-financing for capitation payments. Figure A4-1 shows that the average financing share for *Nacer/Sumar* capitation payments borne by provinces was equivalent to less than one percent of provinces' health budgets net of salaries (for the period of 2012-2014). The contributions amounted to more than one percent only for Cordoba and Corrientes provinces. The combined financing share of provinces and the MSN (including financing from IBRD loans), however, corresponded to about 3% of provincial health care budgets net of salaries, on average. In the case of some provinces, this combined financing share represented considerably more than 3% of the provincial health care budgets (net of salaries), e.g. it was almost 7% for the province of Misiones.

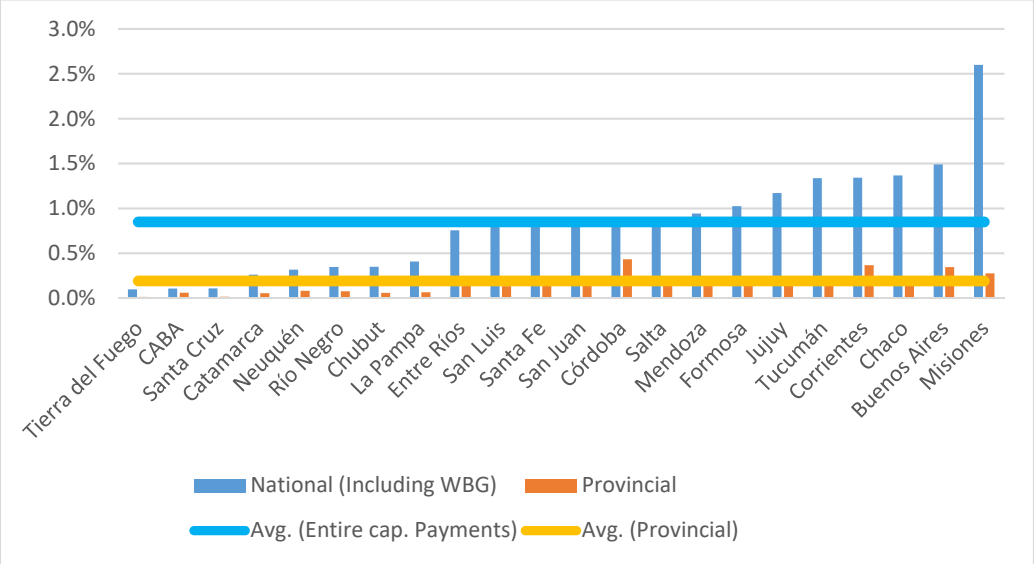
Figure A4-1: Capitation Payments for *Nacer/Sumar* as Percentage of Provincial Budgets Net of Salaries (2012-2014 Average)



Source: Own calculations based on MSN and provincial health budget data.

13. Figure A4-2 shows similar calculations as in Figure A4-1, but with the costs for the capitation payments depicted as a percentage of the entire provincial health care budgets including salaries. Even the combined financing from the MSN and provinces for the capitation payments (i.e. the full cost of the capitation payments) was on average less than one percent of provincial health budgets including salaries. For some provinces, the combined financing contributions of the MSN and the provinces accounted for less than 0.5% of the provincial health budget (including salaries), whereas for others they were substantially more (e.g. about 2.5% in the case of Misiones). While Figures A4-1 and A4-2 illustrate that on average the financing burden from the *Nacer/Sumar* programs for provinces has been manageable, it is clear that the variation in this financing burden across provinces has been considerable. As a consequence, sustained financial support for the prioritized package of services from the MSN is needed in order to avoid overburdening the provinces.

Figure A4-2: Capitation Payments for *Nacer/Sumar* as a Percentage of Provincial Budgets Inclusive of Salaries (2012-2014 Average)



Source: Own calculations based on MSN and provincial health budget data.

14. Despite the very decentralized nature of the health system in Argentina, the MSN does finance some programs that support service provision as well as the purchase and distribution of medicines to citizens that would otherwise lack access. Apart from the *Nacer/Sumar* programs implemented through Bank-financed projects, the *Remediar* program financed originally by the Inter-American Development Bank (IDB) in support of essential medicines has been an example of such a program that is critical, and managed by the MSN. Figure A4-3 shows the evolution of financing for the program by financing source. Once the financing for this program from the IDB stopped, the program's name was changed from *Remediar* to *CUS-Medicamentos*, and financing for the program was fully taken over by the National Government from its own sources. Financing from the IDB for this program ended recently (almost entirely by 2015, and then entirely in 2016), and the MSN more than tripled its contribution from domestic resources to the program.

15. At the same time, the increased funding of *Remediar/CUS-Medicamentos* by the National Government from domestic sources did not come at the expense of domestic financing for other MSN programs (Table A4-4). The Government increased its domestic financing for the program substantially in 2015 and maintained the same level of financing in 2016 without cutting domestic financing allocations for its other programs.

Figure A4-3: Remediar/CUS-Medicamentos in Constant Arg. Pesos (2016)

Source: Own calculations based on MSN budget data.

Table A4-4: MSN (Government) Financing Net of Salaries by Budget Program Type – Constant Arg. Pesos (2016)

Budget Program	2014	2015
Nacer/Sumar	131,631,726	257,423,712
Remediar/CUS-Medicamentos	187,868,081	646,255,850
All other MSN programs net of salaries	15,704,597,355	17,928,897,297

Source: Own calculations based on MSN budget data.

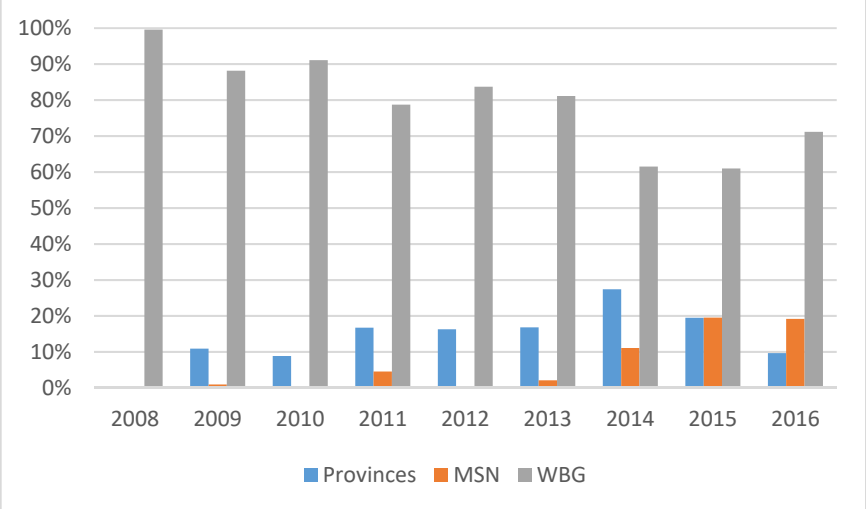
16. Likewise, for the Bank-funded *Nacer/Sumar* programs, the MSN has increased its financing share over time (see Figure A4-4). Within three years (from 2013 to 2016), the MSN increased its contribution to *Nacer/Sumar* capitation payments from about 2% to 20% of the overall financing envelope. Both the experience of the *Remediar/CUS-Medicamentos* as well as the *Nacer/Sumar* programs suggest that the MSN is committed to ensuring the sustained financing of priority programs that initially were financed using external funding. This evidence is key for the assessment that the Project is not only economically sound, but will also be financially sustained by the MSN, once Bank financing stops in 2023.

17. The other key consideration for assessing the sustainability of the Project activities (and the capitation payments for the prioritized package of health care services) is whether the MSN will have sufficient space in its budget to take over the share previously financed by the Bank after Project closing. Table A4-5 provides projections of the estimated financing needs for capitation payments (both for the GHIs and HCDs) in absolute terms (in USD) and as a percentage of the MSN budget (as of 2016).

18. Crucially, the analysis assumes a very conservative scenario under which the MSN budget will remain unchanged from its 2016 level. Given estimated real GDP growth rates for Argentina (IMF World Economic Outlook, October 2017), as well as projections for national public spending, this would imply that the MSN budget would actually *decrease* as a share of the total national budget and as a share of

GDP. The evidence from countries around the world, however, is that public health expenditure in fact grows faster than GDP. Table A4-5 shows that the estimated financing contributions to capitation payments from the MSN would: (i) amount to less than 4% of the annual MSN budget during the years of Project implementation; and (ii) only be around 4.5% of the annual MSN budget after financing support for capitation payments from the Bank comes to an end after Project closure in December 2022. Given the very conservative nature of these estimates and the fact that the capitation payments constitute an essential part of the Government's flagship UHC Strategy, there appears to be little doubt regarding the sustainability of the capitation payments even after project closure.

Figure A4-4: Financing for *Nacer/Sumar* Capitation Payments by Financing Source



Source: Own calculations based on MSN and provincial health budget data.

Table A4-5: MSN Contributions to Finance Capitation Payments as a Percentage of the MSN Budget

Year	Total Financing Needs*** - Capitation Payments & Auditing Costs - Constant Million USD (2016)	Planned MSN Financing Contribution to Capitation Payments - Constant Million USD (2016)	MSN Financing Contribution to Capitation Payments as a Percentage of the 2016 MSN Budget
2018	26.64	1.77	0.08%
2019	94.49	6.90	0.31%
2020	102.73	52.63	2.38%
2021	106.90	72.75	3.30%
2022	85.19	77.62	3.52%
2023^^^ (after Project closing)	100.00	100.00	4.53%

Source: Own calculations based on MSN budget data and the International Monetary Fund World Economic Outlook, October 2017 (for the exchange rate).
*** Excludes co-financing from provinces which are assumed to finance 12% of capitation payments during the Project implementation period and beyond.
^^^ For 2023, the approximate value of capitation payments and related audits is stated.