



1. Project Data

Project ID P163345	Project Name Supporting EUHC in Argentina	
Country Argentina	Practice Area(Lead) Health, Nutrition & Population	
L/C/TF Number(s) IBRD-88530,IBRD-92220	Closing Date (Original) 31-Dec-2022	Total Project Cost (USD) 550,000,000.00
Bank Approval Date 18-May-2018	Closing Date (Actual) 30-Apr-2025	
	IBRD/IDA (USD)	Grants (USD)
Original Commitment	550,000,000.00	0.00
Revised Commitment	550,000,000.00	0.00
Actual	549,934,800.00	0.00

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2. Project Objectives and Components

a. Objectives

According to the Financing Agreement (FA Schedule 1, p. 5), and the Project Appraisal Document (PAD, p. 17), the Project Development Objective (PDO) was to: (i) increase effective and equitable coverage of key health services provided to the eligible population; and (ii) increase the institutional capacity of the National Ministry of Health (Ministerio de Salud de la Nación - MSN) and the Provincial Ministry of Health (Ministerio Provincial de Salud - MSP) to implement mechanisms for an integrated delivery system”.



For the purpose of this ICRR, the PDO can be unpacked as follows:

Objective 1. Increase effective and equitable coverage of key health services provided to the eligible population; and

Objective 2. Increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system.

During implementation, associated outcome targets for two of the three objectives were revised downward when the disbursement weight was 27 percent. The original outcome target for the first objective was not attained, but was achieved after the revision, and under a predominant disbursement weight of 73 percent. Both of the original and revised targets for the second objective were exceeded. The unchanged outcome target for the third objective was also exceeded. As the overall efficacy ratings were similar, both before and after the revision, this ICR Review does not apply a split rating which is moot in this case, with no practical value added to deriving the project’s overall outcome rating.

b. Were the project objectives/key associated outcome targets revised during implementation?

No

c. Will a split evaluation be undertaken?

No

d. Components

The Supporting Effective Universal Health Coverage in Argentina project included three components:

Component 1: Support the Strengthening of Effective Public Health Coverage (Original financing US\$192.47 million, equivalent to 64.2 percent of the original loan proceeds; Actual cost at closing US\$ 494.64 million, equivalent to 89.9 percent of the actual loan proceeds) was designed to provide capitation payments to provinces for the provision of: (i) selected General Health Interventions (GHIs); and (ii) selected interventions for High Complexity Diseases (HCDs). The provinces were selected based on specific conditions of entry/continuation (see Table 1).

Table 1. Conditions of Entry and Continuation

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 Universal Health Coverage Strategy.	
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Source: PAD, p. 45

It included two sub-components:

Subcomponent 1.1: Making Capitation Payments for the Provision of Selected GHSs (Original financing US\$171.4 million; Actual cost at closing US\$563.0 million). This sub-component funded capitation payments for eligible populations in participating provinces, combining a basic and equity component to determine the total amount per person with effective coverage. Payments were disbursed in two stages—first upon coverage verification (50 percent) and then based on tracer targets—and were directed to health providers for service delivery, empanelment strategies, and quality-of-care incentives (ICR, pp. 5-6).

Subcomponent 1.2: Making Capitation Payments for the Provision of Selected HCD Interventions (Original financing US\$21.1 million; Actual cost at closing: US\$101.1 million). The Sub-Component financed capitation payments to a newly established National Fund for High-Complexity Diseases (NFHCD), covering congenital heart diseases, congenital malformations, and selected cardiovascular procedures. Replacing the Solidarity Reinsurance Fund for Catastrophic Diseases (FRSEC), the NFHCD was supposed to function as a public health insurance system, pooling monthly transfers from the MSN to pay authorized providers for eligible services (PAD, p. 21).

Component 2: Strengthening the Institutional Capacity of the MSN and MSPs (Original financing US\$54.7 million, equivalent to 18.2 percent of the original loan proceeds; Actual cost at closing US\$ 36.2 million, equivalent to 6.6 percent of the actual loan proceeds). It included two sub-components:

Sub-Component 2.1: Providing Support to the MSN and MSPs for Increasing their Coordination and Establishing an Integrated Quality-Based Model of Care (Original financing US\$27.3 million). This sub-component sought to strengthen coordination and build an integrated, quality-driven care model across the public health system. It focused on training provincial health workers for effective empanelment, establishing and monitoring facility-level quality indicators, standardizing services and care standards, improving health information systems, supporting providers in cost recovery from social security organizations, fostering inter-program collaboration, and delivering technical assistance through studies, evaluations, and payment mechanism development (ICR, p.6).

Sub-Component 2.2: Improving the Service Delivery Capacity of the MSN and MSPs to Enhance Effective Coverage in the Public Health Subsystem (Original financing US\$27.4 million). This sub-component aimed to strengthen the capacity of the MSN and MSPs to expand effective coverage in the public health system. It did so by providing equipment to address service delivery gaps - particularly at the primary care level and within HCD networks - and by supplying additional equipment, services, and IT resources aligned with provincial needs and their progress in integrating health information systems under sub-component 2.1 (ICR, p. 6).

Component 3: Supporting Management, Monitoring and Evaluation (Original financing US\$52.2 million, equivalent to 17.4 percent of the original loan proceeds; Actual cost at closing US\$ 17.8 million, equivalent to 3.3 percent of actual loan proceeds). This component would provide financing for: (i) technical assistance to build 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); and (ii) project monitoring and evaluation; and (iii) financial and independent technical audits (PAD, p. 23).

Table 2. Project budget per component (original vs actual)

Component	Budget (original)			Actual		
	IBRD	Local	TOTAL	IBRD	Local	TOTAL
Component 1: Support the Strengthening of Effective Public Health Coverage	192,465,246	287,342,990	479,808,236	495,275,300	167,782,289	663,057,589
Component 2: Strengthening the Institutional Capacity of the National and Provincial Ministries of Health	54,698,048	56,261,959	110,960,007	35,208,781	1,437,842	36,646,623
Component 3: Supporting Management, Monitoring and Evaluation	52,086,706	14,446,286	66,532,992	18,075,719	6,849,389	24,925,108
Total	299,250,000	358,051,235	657,301,235	548,559,800	176,069,520	724,629,320
Front-end fee	750,000	0	750,000	1,375,000	0	1,375,000
Total	300,000,000	358,051,235	658,051,235	549,934,800	176,069,520	726,004,320

e. Comments on Project Cost, Financing, Borrower Contribution, and Dates

The project underwent five L2 restructurings:

1. In October 2020, a restructuring was approved to respond to the combined impact of the economic crisis and COVID-19. Retroactive to 1 January 2020, the key changes included: (1) **Lowering project targets** and indicators; (2) **Reducing domestic co-financing** for health payments; (3) **Decreasing performance-based payments** to provinces; (4) Expanding eligibility to uninsured adults aged 65+ (about 500,000 people); and (5) **Revising fund flow** arrangements for NFHCD. Additionally, US\$13.4 million was shifted from training and consulting to health payments, as virtual activities reduced supervision costs.
2. In March 2021, an Additional Financing (AF) of US\$250 million and a Level 2 restructuring were approved. The AF had two main purposes: (1) **Addressing a Financing Gap**: Due to worsening economic conditions and reduced government revenues, the government could not meet its expected share of co-financing for health payments. The AF was fully allocated to maintain the domestic co-financing rate at 30 percent from 2021 onward, avoiding a planned increase to 60 percent in 2022. (2) **Covering Cost Overruns**: The funds also helped offset higher-than-expected costs in health payments caused by a surge in eligible beneficiaries - over 2.7 million additional people - due to increased unemployment and loss of job-based health coverage since 2018. Furthermore, the restructuring allowed to extend the loan closing date by 12 months to 31 December 2023.
3. In November 2023, the restructuring resulted in an extension of the loan closing date to 30 April 2024 to address delays in procurement of medical equipment (ICR, p. 9).



4. In April 2024, a project restructuring was approved in response to requests from a new administration that took office in December 2023. The goal was to ensure procurement could be completed and all funds disbursed. Key changes included: (1) **Loan Extension**: The closing date was extended by seven months to 30 November 2024. (2) **Fund Reallocation**: Resources from Loan 8853-AR were shifted from consulting and training to capitation payments. (3) **Full Loan Financing**: Due to worsening economic conditions, the government’s domestic co-financing for health payments was removed, and these costs were fully covered by the loan (ICR, p. 9).
5. In November 2024, the fifth restructuring allowed for the extension of the closing date by an additional five months, from 30 November 2024, to 30 April 2025 (ICR, p. 9).

The project was co-financed by the International Bank for Reconstruction and Development (IBRD) and the Government of Argentina. At closing, the actual cost of the project was 726 million. The total IBRD financing was US\$550 million (IBRD-88530 for US\$300 million and IBRD-92220 for US\$250 million) and the Borrower contribution was US\$176 million. As Table 2 shows, the IBRD amount increased by US\$250 million throughout the life of the project; whereas the Borrower’s contribution decreased by almost US\$293 million from what was originally committed (see Table 3).

Table 3. Project financing by source (original vs actual)

Financing Source	Original	Actual*
World Bank Financing	550,000,000.00	549,934,800.00
IBRD-92220	250,000,000.00	250,000,000.00
IBRD-88530	300,000,000.00	299,934,800.00*
Non-World Bank Financing	468,662,497.75	176,069,519.98
Borrower/Recipient 92220	110,611,263.00	105,777,530.01
Borrower/Recipient 88530	358,051,234.75	70,291,989.97
Total	1,018,662,497.75	726,004,319.98

* Pending disbursement of USD 65,200 to complete the USD 500 million will be processed in the coming days (Source: Project team)

Finally, the project was approved in May 2018 and became effective in December 2018 (ICR, p. ii). The initial project closing date of 31 December 2022 was extended four times for a total of 28 months and the project closed on 30 April 2025 (ICR, pp. 8-9).

3. Relevance of Objectives

Rationale

The project was highly relevant and well-suited to Argentina’s health system challenges, including fragmentation, demographic shifts, rising noncommunicable diseases, and the imperative to integrate new technologies and care models. By prioritizing effective and equitable coverage, the project aimed to reduce persistent inequalities and ensure that vulnerable and marginalized populations receive the care they need - regardless of geographic location, socioeconomic status, or other systemic barriers to access.

The project was aligned with the Government’s strategies and sectoral policies. At appraisal, the project’s PDOs were central to Argentina’s national health policy framework, as articulated in Decrees No.



50/2019 and No. 223/2021, which define equity, access, and quality as core missions of the MSN. Furthermore, the project reinforced by Law No. 27.701/2023, which promoted the integration of the health system within a federal structure to drive systemic improvements in service delivery. The project directly contributed to these national priorities by strengthening institutional capacity and expanding access to essential health services, thereby supporting Argentina’s commitment to inclusive, high-quality healthcare for all (ICR, p. 10).

The project was also fully aligned with World Bank’s strategies throughout its lifetime. The PDOs were fully aligned with the World Bank Group’s Country Partnership Framework for Argentina (FY19–22), as updated by the 2022 Performance and Learning Review. They directly supported Focus Area 2: “Strengthening Service Delivery to Protect the Poor and Vulnerable.” Specifically, PDO 1- expanding equitable access to prioritized health services - advanced Objective 4 (“Improving Access to Basic Service Delivery in Vulnerable Areas”) and Objective 5 (“Improving Human Capital of Vulnerable Populations”), while PDO 2 - enhancing institutional capacity for health system integration - supported Objective 6 (“Improving Governance and Transparency”). The PDOs also reflected the strategic priorities of the World Bank’s Health, Nutrition and Population agenda, including the emphasis on resilient, sustainable health systems and the post-COVID-19 call to reimagine primary health care, as outlined in “Walking the Talk” (ICR, p. 10).

In addition to being fully aligned with national and Bank strategies, the project maintained its relevance through its adaptability to respond to different shocks. The project successfully responded to Argentina’s evolving needs during crisis by restructuring the project in 2020 to address COVID-19 and macroeconomic shocks; aligning health operations to support the emergency response; and approving AF to cover rising demand and budget gaps (ICR, p. 29).

Rating

High

4. Achievement of Objectives (Efficacy)

OBJECTIVE 1

Objective

Increase effective and equitable coverage of key health services provided to the eligible population

Rationale

The Theory of Change (ToC) adopted a two-step approach using Results-Based (RB) financing and targeting provincial governments and health care providers. The ToC held that by providing provincial governments (1) capitation payments to expand the provision of a package of key essential care services (i.e., General Health Services - GHSs) under their health benefit plans; (2) an equity component to promote equitable coverage across provinces; and to health care providers (3)



incentives for delivering these GHSs to the eligible population in line with established quality protocols, effective and equitable coverage of key health services would increase.

At appraisal, Argentina faced persistent challenges in achieving effective health coverage despite notable improvements in maternal and child health indicators over past decades. Overall performance remained weaker than that of countries with similar or even lower per capita incomes, reflecting inefficiencies in health spending. Preventive care was particularly limited: individuals relying on the public system were less likely to receive screenings for non-communicable diseases such as cervical cancer, mammograms, and blood pressure checks compared to those covered by social security. This gap highlighted the system's limited capacity to deliver consistent, high-quality services and undermined the effectiveness of health coverage nationwide.

Equitable health coverage was further constrained by deep fragmentation across subsystems and regions. The division into public, social security, and private insurance reinforced inequalities tied to employment status, leaving the unemployed and poor disproportionately reliant on under-resourced services. Geographic disparities were stark, with provinces in the Northeast (NEA) and Northwest (NOA) experiencing the poorest health outcomes and lowest rates of effective coverage. Uneven provincial funding exacerbated these inequities, resulting in significant differences in access and outcomes across the country.

This objective had two associated Outcomes.

PDOI 1 - Percentage of eligible population with effective health coverage.

Outputs and Intermediate Results

The project achieved the following outputs:

- 20 million people enrolled in the program as of December 2024.
- Over 2,400 patients with congenital heart disease, surgically-resolved neonatal malformations, and acute myocardial infarction received care in 2024 alone (ICR, p. 36).
- 10,101 people who underwent surgery for congenital heart defects between 2019 and 2024, eliminating waiting lists for congenital heart defects (Borrower's ICR, p. 51).
- Financial support for US\$496 million in capitation payments was provided during the project's lifetime (i.e., US\$430 million in General Health Interventions and US\$67 million for High-Complexity Diseases) (ICR, p. 36)
- 6.9 million beneficiaries with Basic Effective Coverage (BEC) as of December 2024 (35 percent), while at the beginning of the Project (2019) there were 5.1 million beneficiaries with (BEC) out of an eligible population of 16.5 million (31 percent) (Borrower's ICR, p. 51).

The project achieved one out of the three Interim Results targets it had established under this Outcome (see Table 4). Whereas, IRI 2 was not achieved due to an increase in eligible population (**cervical cancer screening coverage reached 1.1 million women - 28.2 percent, surpassing original and revised targets, but the indicator fell short due to growth in the eligible population**); IRI3 the (increase in coverage of treatment for patients with hypertension) fell short of original and revised targets due to multiple factors. The COVID-19 pandemic disrupted health services, reducing follow-up visits and causing high treatment abandonment. Structural challenges also played a role: difficulties in capturing data because



medication dispensing was often not digitally recorded, limited digital infrastructure in many provinces, and reliance on manual reporting (Project team, email 2 December 2025).

Table 4. Achievement of outputs and interim results under this objective

Indicator	Baseline	Original Target	Revised Target	Achieved	Percentage achieved
IRI 1 - Percentage of eligible pregnant women with early antenatal care	14.7	25	22	35.9	163%
IRI 2 - Percentage of eligible women 25-64 years of age with at least one cervical cancer screening according to defined protocols	19.6	25	24	20.8	87%
IRI 3 - Percentage of eligible population with hypertension under treatment	0	25	15	8.6	57%

Outcome: PDOI 1 - Percentage of eligible population with effective health coverage - Achieved

As Table 5 shows, notwithstanding the increase in eligible population from 15.26 million to 20 million, the project succeeded in meeting its revised target of covering 35 percent of the eligible population. It also increased the number of beneficiaries covered from 4.32 million at baseline to 6.98 million by the end of the project.

Table 5. Achievement of PDO1 1

Baseline year			Original Target		Revised target		Eligible population due to crisis (2024) (h)	Actual coverage 2024 (million) (i)	Level of achievement		Actual coverage/eligible population (2024) (%) (m=i/h)
Eligible population (million) (a)	Actual coverage (million) (b)	Percentage covered (c = b/a)	Expected coverage (million) (d)	Target (%) (e)	Expected coverage (million) (f)	Target percentage covered (%) (g)			Original target (%) (k=i/d)	Revised target (%) (l=i/g)	
15.26	4.32	28%	6.1	40%	5.34	35%	20	6.98	114%	131%	35%

PDOI 2 - Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes.

The project achieved the following outputs:

- Financial support for US\$47 million in equity-related payments during the operation’s lifetime (ICR, p. 36)
- 199,869 people diagnosed with hypertension in the NOA and NEA regions as of December 2024 (44 percent of the eligible population for that year), while in 2019 only 12,672 people had been diagnosed (4 percent of the eligible population for that year). This exceeded the target of 18 percent foreseen for PDO Indicator 2.



In addition, and though the project’s Results Framework did not include any IRIs associated with this Objective, the project achieved the following (ICR, p. 16):

- **Effective coverage:** NEA/NOA provinces strengthened their advantage, with the gap rising from 9.7 percentage points (pp) to 11.1 pp.
- **Early antenatal care:** NEA/NOA provinces moved from 13.7 pp. behind to 14 pp. ahead of other provinces.
- **Cervical cancer screening:** NEA/NOA provinces lost their edge, shifting from a 6.5 pp. advantage to a -3.6 pp. gap.
- **Hypertension screening:** NEA/NOA provinces gained a small lead, moving from equal coverage to 0.9 pp. ahead.

PDOI 2 - Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes – Achieved

As Table 6 shows, the Outcome was exceeded. In 2024, 44 percent of eligible adults with hypertension were diagnosed in NEA and NOA regions—far exceeding original (30 percent) and revised (18 percent) targets—with NEA provinces outperforming the national average (50.3 percent vs. 38.5 percent) and NOA provinces aligning closely (37.6 percent) (ICR, p. 15).

Table 6. Outcome indicator associated with this objective

Indicator	Baseline	Original Target	Revised Target	Achieved	% Achieved
Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes	0	30	18	44	244%

It is important to point out and as the ICR concludes, while it is difficult to determine the extent to which the equity component had a measurable contribution toward more equitable health coverage across provinces, it likely helped by directing extra financial resources to the poorest areas and reducing gaps in per capita health spending. This approach could be tested at the local level, where provincial transfers to health facilities might combine performance-based incentives with an equity element to address challenges linked to rural or remote locations and other factors affecting health outcomes (ICR, p. 22).

Furthermore, while IRI 3 (Percentage of eligible population with hypertension under treatment) reached 57 percent of a total eligible population of 150,756 eligible adults aged 40 or older (ICR, p. 14), PDOI2 (Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes 44 percent of a total eligible population) which might indicate that the equity gap might not have closed as much as expected.

Rating
Substantial



OBJECTIVE 2

Objective

Increase the institutional capacity of the MSN and MSPs to implement mechanisms for an integrated delivery system

Rationale

The ToC held that by (i) georeferencing primary health care providers and defining catchment areas for eligible populations; (ii) tracking effective quality-of-care measures at the health facility level; (iii) defining system-wide services and standards; (iv) further integrating health information systems; (iv) improving cost recovery from OSs (Social Security Subsystem - *Obras Sociales*) ; and (v) supplying medical equipment to strengthen lines of care, the share of the eligible population empaneled would increase, reflecting improved coverage, equity, and continuity of care.

At appraisal, fragmentation within the public health subsystem limited coordination among MSN and MSPs, resulted in uneven quality of care, weak integration of information systems, and insufficient cost recovery. Fragmentation within Argentina's public health subsystem had weakened coordination between the MSN and provincial ministries (MSPs), producing uneven care quality, poor integration of information systems, and limited cost recovery. For example, the capitation payment for Chaco was ARF\$225 compared to ARG\$11 for CABA (*Ciudad Autónoma de Buenos Aires*) in 2024 (ICR, Footnote 26, p. 15). At the micro level, inefficiencies were evident: the absence of mechanisms to share clinical records led to repeated tests and prescriptions, while weak drug-tracking systems caused waste, mismanagement of stock, and frequent shortages in public pharmacies. These issues highlighted the system's inability to use scarce resources effectively (PAD, pp. 15-16).

This fragmentation was compounded by the coexistence of national and provincial programs with separate management structures, resulting in inequities and inefficiencies across two dimensions. First, resource pools were fragmented, with no redistributive mechanisms to balance financing between provinces or across subsystems, leaving significant disparities in per capita health spending. Second, coordination tools were lacking both within and across subsystems, preventing the establishment of interoperable information systems and common standards. The MSN's limited authority over provincial MSPs and other subsystems further entrenched these gaps, perpetuating inequities and inefficiencies throughout the health system (PAD, pp. 15-16).

Outputs and Interim Results

The project achieved the following output:

- Provision of medical equipment to health facilities; however, this output was completed with substantial delays affecting the timely achievement of some IRIs, especially IRI 7.

It also reached the Interim Results targets it had established under this Outcome (see Table 7).

- 3,804 health responsibility areas digitized throughout the country as of December 2024, representing an increase of 2,346 establishments since 2020 (Borrower's ICR, p. 51).
- Twenty provinces disclosed consultation and response mechanisms to the beneficiary population.
- 272 million services provided and billed in the period 2019-2024 (Borrower's ICR, p. 51).



- 1,159 health care providers categorized for the acute myocardial infarction (AMI) care network (Borrower’s ICR, p. 51).
- 2.9 million beneficiary people assigned to a health facility (15 percent of the eligible population, a significant increase from 2020 (1.8 million out of an eligible population of 17.7 million, or 10 percent) (Borrower’s ICR, p. 51).
- 8,971 public health facilities with an agreement with the program; that is, an increase of 971 establishments since 2019 (Borrower’s ICR, p. 51).

Table 7. Achievement of interim results under this objective

Indicator	Baseline	Original Target	Revised Target	Achieved	Percentage achieved (based on original target)	Percentage achieved (based on revised target)
IRI 4. Percentage of participating provinces with reported health services for selected key lines of care increased	0	29	21	91.7	316	437
IRI 5. Percentage of primary health care providers georeferenced and with a catchment area defined	0	80	60	58.2	73	97
IRI 6. Percentage of participating provinces with a Level 4 maturity in the development of their Interoperability Plan for Information Systems	0	50	37.5	95.8	192	255
IRI 7. Percentage of health care facilities that had their service delivery capacity strengthened for key lines of care as a result of the medical equipment provided under the operation	0	40	30.0	37.3	93	124
IRI 8. Percentage of public health facilities billing to the OSs increased	25	30	28	50.3	168	180

Outcome

PDOI 3 - Percentage of eligible population enrolled and assigned to a health facility for continuous care (“empaneled”) - Achieved

The outcome associated with this objective was achieved with the percentage of eligible population empaneled increasing from 0 percent in 2017 to 14.6 percent in 2024, exceeding the original target (equivalent to 122 percent level of achievement with respect to the original target) (ICR, p. 17).

The project helped strengthen the capacity of national and provincial health authorities to deliver an integrated healthcare system. This was demonstrated by higher enrollment of eligible populations in health facilities for continuous care, exceeding project targets. Additional progress was made in line-of-care reporting, defining provider catchment areas, applying health information system standards, and improving cost recovery at the provincial level. Service capacity also grew with the delivery of medical equipment,



though these gains were limited by procurement delays, with some equipment arriving late in the project period. This also likely led to greater disparities between the provincial governments since the better-off ones were able to procure the necessary equipment and the less-resourced ones had to await the procurement of equipment at the national level to be delivered to them (Project team, email 14 December 2025). Finally, while the project achieved its targets which were revised downwards, some of the targets were not particularly ambitious, in particular IRI 8 and PDOI3.

Rating
Substantial

OVERALL EFFICACY

Rationale

The project's overall efficacy is rated **Substantial** based on the aggregated achievements of project objectives and targets discussed above. The project achieved two out of the three IRI and the two PDOIs associated with Objective 1, thus improving both the effectiveness and the equity of health service delivery. It also met the revised five IRIs associated with the Objective 2 as well as the related PDOI contributing to further strengthening the institutional capacity of national and provincial health authorities to implement an integrated healthcare delivery system.

Overall Efficacy Rating

Substantial

5. Efficiency

Efficiency is analyzed based on economic and implementation efficiency.

Economic efficiency:

The project delivered highly positive economic outcomes, as anticipated during Appraisal and AF preparation. An ex-post economic analysis conducted for the ICR, using actual outcome and cost data, confirmed benefits similar to earlier ex-ante evaluations. These benefits included both **direct savings** (reduced hospitalization and treatment costs) and **indirect gains** (avoided productivity losses) (ICR, p. 19).

In addition, **the project is estimated to have prevented 5,105 deaths and 328,249 Disability-Adjusted Life Years (DALYs)**. The corresponding economic benefits yielded an internal Economic Rate of Return (ERR) of 18 percent and a Net Present Value (NPV) of US\$509.8 million (based on a 5 percent annual discount rate over the implementation period). These results are slightly more favorable than the original ex-ante projections which were 16.8 percent and US\$ 364 million, respectively (ICR, p. 42).



Implementation efficiency:

Implementation efficiency is analyzed based on coverage, timeliness, technical capacity and cost and presents a mixed picture with some elements contributing to greater efficiency whereas others decreasing both the project's efficiency and effectiveness.

High coverage of the poor population. The project effectively targeted the poorest groups by focusing on those reliant on the public health system without contributory insurance, providing a safety net for over 2.2 million unemployed during crisis, and prioritizing provinces with the lowest life expectancy and GDP per capita (NEA and NOA) (ICR, p. 21).

Extension of closing date beyond two years. The project became effective within seven months of approval (ICR, p. iii). Its closing date was extended by more than two years with the last extension requiring approval at the Regional Vice President level since it exceeded the maximum two-year cumulative limit for extensions to be approved at the Country Director level (ICR, p. 29).

Delays were due to (1) external factors (COVID-19 and macroeconomic conditions) which disrupted both supply and demand of health services and constrained implementation; and **(2) government-related constraints also impacted the project's efficiency and effectiveness.** Tight budgetary limits were imposed at different times during the project which delayed significantly the purchase of IT and medical equipment. At times, they also slowed the transfer of capitation payments to provinces. The delayed transfers diminished purchasing power, reducing funds that previously enabled health facilities to invest in medical equipment, making incentives far less attractive and increasing political tensions between national and provincial governments (ICR, p. 24).

The project's efficiency was partly due to exceptional technical capacity. The project benefitted from a remarkably strong installed technical capacity. Technically strong implementation units with intimate knowledge of the program at both the national and provincial levels were a key factor supporting implementation amidst a highly challenging environment (ICR, p. 24).

The project's operating costs were low and constituted 0.1 percent of total project costs (see Table 8).

Table 8. Project costs per category

Category	Original budget	% share of total original budget	Actual budget	Actual vs Original budget	% share of total actual budget
1. Goods	66,130,000	10.0%	26,306,541	39.8%	3.6%
2. Consulting services, non- consulting services and Training	102,172,999	15.5%	34,845,424	34%	4.8%
3. Capitation payments under Subcomponent 1.1	437,608,236	66.5%	562,999,640	128.7%	77.5%
4. Capitation payments under Subcomponent 1.2	42,200,000	6.4%	100,057,949	237.1%	13.8%



5. Operating costs	9,190,000	1.4%	419,766	4.6%	0.1%
6. Front-end-Fee	750,000	0.1%	1,375,000	183.3%	0.2%
Total	658,051,235	100.0%	726,004,320	110.3%	100.0%

Efficiency Rating

Substantial

a. If available, enter the Economic Rate of Return (ERR) and/or Financial Rate of Return (FRR) at appraisal and the re-estimated value at evaluation:

	Rate Available?	Point value (%)	*Coverage/Scope (%)
Appraisal	✓	16.80	100.00 <input type="checkbox"/> Not Applicable
ICR Estimate	✓	18.00	100.00 <input type="checkbox"/> Not Applicable

* Refers to percent of total project cost for which ERR/FRR was calculated.

6. Outcome

The project's Outcome is rated Satisfactory. Its design was highly relevant to the context and remained so at project close. Notwithstanding the challenging context and the increase in the eligible population, the project achieved satisfactorily its three PDOs and six out of its eight IRIs. Furthermore, it demonstrated substantial economic and implementation efficiency, albeit with delays in procurement and transfer of capitation payments which affected also its effectiveness and resulted in extending the project's end date by more than two years.

a. **Outcome Rating**
Satisfactory

7. Risk to Development Outcome

The risk to development outcome is analyzed across the following dimensions: policy, institutional, organizational, financial, and human resources capacity.

At the policy level, the Nacer/SUMAR model has successfully aligned provincial health priorities with national objectives through results-based incentives. Its credibility and integration into Argentina's health system -strengthened by the 2023 Program for Effective Universal Health Coverage - secure long-term policy sustainability by embedding financing within national frameworks. Crucially, this marks a decisive step toward the model's full institutionalization, shifting from project-based financing to a stable, budget-based approach (ICR, p. 29).



Institutionally, the project has contributed to improvements at the national and provincial level which contribute to long-term sustainability. Nationally, it has enabled the Ministry of Health to exercise its stewardship role more effectively, coordinating policies across Argentina's diverse and autonomous provinces. Provincially, it has ensured a transparent flow of financial resources, provided technical assistance for essential management tools, and strengthened coordination among public health care facilities—together driving better health service delivery and outcomes (ICR, p. 29).

Financial sustainability is supported by increased cost recovery from social security organizations, efficient resource use, and co-financing mechanisms that boost provincial ownership. Continued investment in digital health and uninterrupted fund flows remain critical to institutionalizing financing within Argentina's broader public health system. However, the unresolved and politically sensitive merging of OS funding mechanisms into public health financing creates uncertainty. In the short term, insufficient progress in cost recovery from OSs risks weakening financial sustainability and undermining trust in the system (ICR, p. 30).

At the organizational, the project has played a key role in strengthening the health system both at the provincial as well as facility level which will contribute to its the long-term sustainability. At the provincial level, the project introduced several key improvements to strengthen primary care and disease management: (1) **Institutional and technical capacity:** Financial incentives helped provinces and health facilities expand their ability to monitor, prevent, control, and treat prioritized diseases. (2) **Digital health integration:** Provinces were supported in implementing the MSN's National Digital Health Strategy (2018–2024), which set guidelines for interoperable health information systems at the primary care level. (3) **Standardized clinical data management:** Health facilities organized patient data using interoperability standards to simplify and harmonize information flows. (4) **Patient-centered care pathways:** 22 of 24 provinces established a line of care for Type 2 Diabetes, integrating services across primary and specialized care. (5) **Continuity of care:** These lines of care reduced fragmentation, ensured timely and coordinated services, and improved outcomes through early diagnosis, consistent follow-up, and effective chronic disease management. Equally, at the facility level, the project succeeded in improving different organizational aspects: (1) **Defined service areas:** Nearly half of the 6,539 participating facilities established clear areas of responsibility for their populations. (2) **Population management:** 14.6 percent of the service population was nominalized, enrolled, and geo-referenced, linking care provision directly to communities and territories. (3) **Expanded access and accountability:** This territorial approach strengthened routine prevention, control, and treatment services, especially for vulnerable groups, while enhancing accountability at the facility level (ICR, p. 21).

At the human resources level, the project's sustainability depends on retaining specialized personnel and strengthening community health workers to ensure continuity of care. Program Implementation Units (PIUs), established in all 24 jurisdictions, have built strong capacities in planning, monitoring, and evaluation, generating quality health information for decision-making. However, the continuity of these technical teams is at risk, as some provinces are dissolving PIUs and absorbing them into health ministries, threatening the sustainability of results and the preservation of institutional expertise (ICR, p. 24). In addition, weak connections between facilities and service populations risk undermining continuity of care and efficient use of capacity. Without reinvigorating family and community health workers and restoring the original panelment approach, service delivery may remain fragmented (ICR, p. 30).



8. Assessment of Bank Performance

a. Quality-at-Entry

The project's design relied on lessons learnt from previous operations, was flexible, and addressed government priorities.

The project's design incorporated lessons from both Bank-funded and other donors' projects (PAD, p. 16). The project was grounded in the technical and implementation foundation established by four earlier Bank-financed projects supporting the Nacer/SUMAR model. This model reflected a deep understanding of Argentina's health system and its decentralized institutional framework. Furthermore, the design was also informed by the Remediator program financed originally by the Inter-American Development Bank (IDB) in support of essential medicines (PAD, p. 80).

Furthermore, the project used previous experience to expand the use of results-based financial incentives and promote equitable access to healthcare services. It leveraged two decades of M&E capacity developed through earlier projects to implement RB financing mechanisms aligned with national health priorities.

The project's design was both flexible and innovative. The flexibility enabled the project to be agile and respond to the COVID-19 pandemic and to **adapt to the diverse capacities and contexts of provincial health systems.** The innovation regarded the introduction of an "equity component" in the capita payment system, ensuring that additional funds reached the most disadvantaged provinces. The operation also piloted new practices, such as strengthened cost-recovery mechanisms at the provincial level and the provision of medical equipment to expand service capacity.

The Task Team included members with direct experience in the preceding Nacer/SUMAR operations. This continuity ensured that lessons learned - such as simplifying operational definitions - were integrated into the new operation. It also facilitated trust, institutional memory, and smoother coordination with provincial counterparts.

The project's overall risk was rated Substantial with the most substantial risks related to implementation issues (technical design, institutional capacity and fiduciary) (PAD, p. 28). The project's risks were well identified and mitigated to the extent possible (ICR, p. 20), such as employing technical assistance (TA) to strengthen institutional capacity; using Third-Party Monitoring to address fiduciary risks; defining clearly the roles, responsibilities and procedures of all actors (PAD, p. 28).

Quality-at-Entry Rating

Highly Satisfactory

b. Quality of supervision

The World Bank's strong engagement, stable leadership, technical expertise, and flexibility were critical to sustaining effective implementation of the SUMAR Program across multiple administrations and during the COVID-19 crisis.



Cloe and continuous supervision: The World Bank team remained highly engaged throughout the project lifecycle, ensuring effective implementation. Regular supervision missions, candid Aide Memoires, and timely ISRs provided strong oversight, while open communication with the Borrower enabled early identification and resolution of implementation bottlenecks (ICR, p. 28).

Continuity of leadership and presence in country office: Stability of the Task Team reinforced continuity and effectiveness. One TTL accompanied the project from preparation to closing, offering strategic direction. The presence of the TTL and sector/operational specialists in the country office facilitated continuous oversight (ICR, p. 28).

Technical support and expertise: Extensive technical support was provided, financed through loan proceeds and additional Bank resources. This support was essential given the SUMAR Program's reliance on advanced information technology. Financial Management (FM) support from the Bank was timely and responsive (ICR, p. 27), and continuous procurement support was ensured through weekly monitoring, risk assessments, and contract-specific guidance (ICR, p. 28).

Flexibility in response to evolving needs: The project was restructured in 2020 to address the impacts of COVID-19 and macroeconomic challenges. Health operations were aligned to support Argentina's emergency response, and the team responded swiftly to requests for AF to cover financing gaps caused by rising beneficiaries and budget constraints. Adjustments to the Operations Manual sustained implementation momentum. Flexibility was further demonstrated through four extensions of the closing date and reduced domestic co-financing requirements for capitation payments. Between March 2020 and March 2022, hospitalization coverage was ensured for people with suspected or confirmed COVID-19 who lacked formal health coverage (ICR, p. 49).

In conclusion, the project was successfully implemented despite changes in government administrations and the health crisis of the COVID-19 pandemic. Politically and institutionally, the operation's lifecycle (2018–2025) spanned three different government administrations. Presidential elections in 2019 and 2023 brought changes in national leadership, while the national health portfolio was managed under five different ministerial authorities (ICR, p. 47).

Quality of Supervision Rating

Highly Satisfactory

Overall Bank Performance Rating

Highly Satisfactory

9. M&E Design, Implementation, & Utilization

a. M&E Design

The M&E design had several strengths including:

- **Project Results Chain.** The project was designed prior to the issuance of the in 2019, it did not include a well-developed ToC as was mandated by the World Bank's guidelines (May 2018).



Nevertheless, the PAD included a Project Results Chain describing the inputs, outputs to outcomes and objectives (PAD, p. 19).

- **Use of existing M&E system.** The project leveraged both the MSN's existing information systems and tools developed under previous Bank-financed projects (ICR, p. 25).
- **Well-defined SMART indicators.** The project had a clearly defined PDO measured through three PDOIs, eight IRIs as well as ten tracer indicators. These indicators consolidated data from the extensive M&E systems developed in each province, used to track progress toward the tracer indicator targets outlined in their Annual Work Programs (ICR, p. 25).
- **The use of independent verification; clear rules and transparent implementation mechanisms.** The M&E design included a well-defined operational framework anchored in annual performance agreements between the NMOH and provincial governments. These agreements outlined mutually agreed tracer targets and established the basis for financial transfers. Provinces were responsible for regularly reporting enrollment and service delivery data, which were subject to rigorous verification by both the PCU and an independent external auditor. This robust oversight process strengthened accountability, minimized disputes, and reinforced the credibility and legitimacy of the RBF (Project team, email 5 December 2025).

A weakness of the Results Framework was the uneven use of sex-disaggregated indicators and the lack of absolute numbers reached (targets were only percentages which does not provide a clear idea of that the project achieved). Given that eligibility for the SUMAR Program fluctuates with external factors, in particular, unemployment – M&E design could have included both number of beneficiaries reached as well as percentages. This would ensure that an increase/decrease in eligible beneficiaries – due to higher unemployment, or conversely, improved labor market conditions – would be captured and would not artificially boost/lower performance metrics.

In addition, the Results Framework provided baseline information for three out of the eight IRIs.

Finally, a corporate indicator “People receiving quality health, nutrition, and population services (Number of people) was added to the RF at the end of the project. However, since the project was requested not to double-count it and another operation would monitor this indicator, the project decided to leave the information out. This may create some confusion by the reader as to why there is an indicator in the RF with no data available.

b. M&E Implementation

The project's M&E system was central to effective implementation, ensuring timely data, strong oversight, and strengthened national health information systems.

Effective M&E for implementation: Timely data collection supported the identification of bottlenecks and the introduction of corrective measures. Initial delays in facility-level reporting for newly added services (e.g., hypertension treatment) were eventually resolved.

Strong control environment for RB incentives: The successful implementation of results-based financial incentives relied on robust oversight. Bi-monthly independent technical audits verified progress on tracer indicators, provided hands-on training, and standardized evaluation criteria across provinces.



Strengthening national M&E systems: The operation advanced the development of MSN’s digital information systems and integrated key management tools at provincial and facility levels. This included digitalization and georeferencing of service areas, nominal registration of populations, and electronic systems for core functions such as appointment scheduling, medical records, referrals, and prescription management.

Downward revision of IRIs to reflect the increase in number of eligible population: In order to ensure the meeting of its targets and to compensate for the large increase of the eligible population due to the macroeconomic shocks, the project revised downwards all of its IRI targets (see Table 9).

Table 9. Baseline, original and revised IRI targets

Indicator	Baseline	Original Target	Revised Target
IRI 1 - Percentage of eligible pregnant women with early antenatal care	14.7	25	22
IRI 2 - Percentage of eligible women 25-64 years of age with at least one cervical cancer screening according to defined protocols	19.6	25	24
IRI 3 - Percentage of eligible population with hypertension under treatment	0	25	15
IRI 4. Percentage of participating provinces with reported health services for selected key lines of care increased	0	29	21
IRI 5. Percentage of primary health care providers georeferenced and with a catchment area defined	0	80	60
IRI 6. Percentage of participating provinces with a Level 4 maturity in the development of their Interoperability Plan for Information Systems	0	50	37.5
IRI 7. Percentage of health care facilities that had their service delivery capacity strengthened for key lines of care as a result of the medical equipment provided under the operation	0	40	30
IRI 8. Percentage of public health facilities billing to the OSs increased	25	30	28

Interoperability and system integration: By supporting the adoption of basic interoperability standards, the operation helped standardize information flows, reducing fragmentation within and across provincial health information systems.

c. M&E Utilization

Monitoring and Evaluation (M&E) data played a pivotal role in strengthening project outcomes; guiding resource allocation; and improving efficiency. Specifically,

- Nominalized data from the Program’s Comprehensive Management Report System (SIRGE) and Sumar registries validated eligibility for national social protection programs (*Asignación Universal*)



por Hijo - AUH, Asignación Universal por Embarazo - AUE, Progresar), ensuring better targeting and coordination between health and social policies.

- Systematic measurement and reporting of performance indicators (*trazadoras*) from provincial Ministries of Health to the national level fostered a culture of data-driven management, guiding strategic adjustments and resource allocation.

Applied analysis of specific indicators, such as breast cancer, directly informed program strategies, leading to actions aimed at reducing delays in treatment access (Project team, email 2 December 2025).

M&E Quality Rating

High

10. Other Issues

a. Safeguards

The project's overall safeguards rating was recorded as Satisfactory in the Operations Portal.

The project's social risk was consistently rated moderate, primarily due to the widespread presence of Indigenous Peoples (IPs) across 23 of 24 jurisdictions. While the initiative improved healthcare access for vulnerable groups without causing direct harm, social safeguards focused on preventing exclusion, especially for IPs. An Indigenous Peoples Planning Framework (IPPF) was developed and implemented to ensure culturally appropriate service delivery. Subnational governments led IP Plan execution with varying capacity, requiring ongoing support from MSN's safeguards team. A Vulnerable Groups Plan was also introduced during the AF phase to address the needs of Afro-descendants, Roma, persons with disabilities, migrants, older adults, and the LGTBI+ community—though the latter was excluded by the current administration (ICR, p. 26).

OP 4.10 implementation was rated satisfactory throughout. Most provinces delivered annual IPPs from 2020–2024, expanding coverage for IPs. During COVID-19, MSN adapted outreach strategies and coordinated with agencies to maintain intercultural service delivery. Citizen engagement was strengthened through improved grievance mechanisms at both provincial and national levels (ICR, p. 26).

Environmental risk remained low throughout the project, with consistently satisfactory performance and strengthened waste management systems. The operation triggered OP 4.01 (Environmental Assessment) and achieved notable progress in environmental management. Key achievements included clear assignment of responsibilities at the jurisdictional level, regular training and improved materials, and the rollout of a systematic evaluation process for healthcare waste. The project also introduced self-assessment tools, virtual trainings, and a professional network that engaged over 2,200 participants. An integrative report by jurisdiction further supported dialogue and monitoring. These efforts collectively enhanced capacity, accountability, and sustainability in healthcare waste management (ICR, p. 27).



b. Fiduciary Compliance

In terms of financial management, the project team maintained constructive engagement with the Bank throughout implementation and at closing, with timely and responsive support. Moderate shortcomings - mainly delays in submitting Interim Financial Reports (IFRs) and audited statements - were addressed through corrective actions. FM performance ranged from *Satisfactory* to *Moderately Satisfactory*, ending with a *Satisfactory* rating (ICR, p. 27).

Disbursements were processed via quarterly IFRs, all deemed acceptable. Loan IBRD 9222-AR was fully disbursed and documented, while Loan IBRD 8853-AR disbursed 99.9 percent of its amount, with an outstanding US\$23.2 million which was resolved during the grace period ending on 30 October 2025 (Project team, email 2 December 2025).

Financial audits, conducted by Argentina's Supreme Audit Institution (AGN), were generally acceptable despite delays, with no accountability issues or ineligible expenditures. The 2024 audit report remains pending due to vacancies in AGN's General Auditors Board, which must endorse reports. Fieldwork is complete, and provisional reports have been requested to provide updated data and flag potential issues. Additionally, independent technical audits by external firms validated the RB scheme (capitation payments), with reports reviewed alongside IFR submissions.

Procurement capacity improved towards the end of the project despite early institutional challenges and extensive delays. While reorganizations, budgetary limits, lengthy processes, and delays in payments to foreign providers slowed progress, leadership improvements and NPCT oversight gradually enhanced performance. Planning targeted competitive markets, with national procurements conducted through COMPR.AR under Bank safeguards and international procurements using Bank templates, supported by continuous Bank monitoring. Service capacity improved through medical equipment delivery, though gains were constrained by late arrivals in the last year of project implementation. By project close, 39 procurement processes were completed – 78 percent national, 15 percent international, and 7 percent direct contracting—with performance ratings upgraded to *Moderately Satisfactory*. The operation built on the Nacer/SUMAR foundation, applying lessons learned, expanding RB incentives, and leveraging two decades of M&E capacity to align provincial health systems with national priorities (ICR, pp. 27–28).

c. Unintended impacts (Positive or Negative)

The project had some positive unintended impacts, including:

Lower excess mortality rate from COVID-19 than the regional average. While this outcome is due to several factors, the project by swiftly aligning to address the pandemic succeeded (1) in expanding eligible expenditures to cover COVID-19 prevention and care; and (2) in establishing a Provincial Sanitary Emergency Fund to reinforce provincial health services, contributed to Argentina's excess mortality rate from COVID-19 was 0.85 per 1,000 people - less than half the Latin American average (1.79) (ICR, p. 22).

Use of project data (population, benefits, and performance) to inform health and social protection policy decisions at both national and jurisdictional levels. For instance, nominalized data from Sumar has been used to verify eligibility for key social programs such as the Universal Child Allowance (AUH), the Universal Pregnancy Allowance (AUE), and Progresar (ICR, p. 53).



Project data generated by SUMAR has informed health and social protection policy decisions at national and jurisdictional levels, while also producing significant positive externalities.

Nominalized data was used to verify eligibility for key social programs such as the Universal Child Allowance (AUH), the Universal Pregnancy Allowance (AUE), and Progresar. In addition, the system created a comprehensive Nominalized Registry of Health Coverage (PUCO) for the entire population and generated valuable data on obesity, nutrition, vaccination coverage, and the incidence of non-communicable diseases - providing evidence that strengthens both policy design and program implementation (ICR, pp. 25, 53).

d. Other

The operation prioritized gender equity across design and implementation. Women under 65 were a key target group, benefiting from tailored services such as preventive care for breast and cervical cancers and maternal health. Two IRIs focused specifically on women, while three PDOIs were tracked on a gender-disaggregated basis to monitor gaps in preventive service use. By 2024, women accounted for 56 - 62 percent of service users across provinces, compared to 38 - 44 percent for men - reflecting both the project’s emphasis on reproductive and maternal health and cultural factors driving women’s greater use of preventive services (ICR, p. 21). However, the project did not attempt to bridge this gender gap and to address the cultural factors that drive more women than men to use health services.

11. Ratings

Ratings	ICR	IEG	Reason for Disagreements/Comment
Outcome	Satisfactory	Satisfactory	
Bank Performance	Highly Satisfactory	Highly Satisfactory	
Quality of M&E	High	High	
Quality of ICR	---	Substantial	

12. Lessons

The ICRR confirms the series of lessons and recommendations emerging from the project’s experience (ICR, pp. 30-32). The ICRR summarizes the most relevant lessons below:

Effective results-based financing depends on strong monitoring and verification systems to ensure credibility and impact. Robust M&E is key to tracking performance, maintaining accountability, and aligning service delivery with quality standards. External verification builds trust and reinforces the integrity of the incentive structure.

Timely and predictable fund transfers are vital to sustaining health system incentives and performance. Delays in capitation payments from the national government to provinces eroded purchasing power and weakened the incentive structure, limiting stewardship and creating fiscal



imbalances. Similarly, late fee-for-service transfers from provinces to health facilities undermined frontline motivation and reporting. While longstanding trust has helped maintain engagement, it cannot be relied upon indefinitely. Including legal covenants in the Loan Agreement—such as periodic capitation adjustments and enforceable transfer timelines—could help mitigate these risks.

Sustaining preventive and essential health care during health emergencies promotes the fulfillment of long-term outcomes. Argentina’s lower excess mortality during COVID-19 reflected strong crisis response but came at the cost of sharply reduced preventative services. This highlights the need for strategies that ensure continuity of essential care even during emergencies.

Addressing country-specific risks can facilitate implementation and enhance system resilience. Beyond the global challenges of COVID-19, Argentina faced added pressures from macroeconomic instability and political transitions, which complicated implementation across the Bank’s portfolio. Strategic agreements with national authorities can help mitigate these risks and protect key processes like fund transfers. The sustained performance of the Nacer/SUMAR model amid these conditions reflects its institutional strength and relevance.

Blending performance incentives with equity-based allocations can promote fairer health resource distribution. Topping up results-based financing with additional funds tied to equity indicators—such as low life expectancy—can help reduce disparities and expand coverage in underserved areas. Though equity impacts are hard to quantify, directing more resources to provinces with poorer outcomes supports a more balanced system and could be replicated at the facility level, especially in rural settings.

Institutionalizing externally supported programs requires protecting core systems, expertise, and investments. Without strong ICT infrastructure, skilled personnel, and reliable funding, technology-dependent programs risk losing effectiveness and equity. To mitigate these risks, governments could prioritize key procurements or establish hybrid entities to manage ICT and staffing during the transition.

13. Assessment Recommended?

No

14. Comments on Quality of ICR

The ICR reproduced the project’s Results Chain as presented in the PAD (p. 19) without further developing it into a Theory of Chain indicating the pathways to achieve the desired change. It also did not identify key critical assumptions (e.g., timeliness of capitation payments, stable macroeconomic conditions etc.) necessary to meet the project’s desired outcomes.

The ICR provides a wealth of data and information, in particular output level information and number of beneficiaries reached which are not captured in the project’s results framework. This allows a better understanding of the scale of achievements not only in terms of the targets (percentages) set in the RF.



The ICR is consistent with Bank guidelines and is relatively concise. The use of the split rating rendered it longer and more complicated than was strictly necessary.

The Lessons Learned are derived from the project's experience and underpinned by evidence. A lesson regarding the trade-off between using government systems which would ensure ownership and sustainability versus using Bank procurement which would allow for greater ring-fencing during periods of external shocks and avoid extensive delays could have also been useful.

The rating of the quality of the ICR is substantial.

a. Quality of ICR Rating
Substantial