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HNP DISCUSSION PAPER

Results-Based Financing for Health in Argentina:

The Plan Nacer Program

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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Results-Based Financing for Health in Argentina: *The Plan Nacer Program*[1]

Rafael Cortez,[a] Daniela Romero,[b] Vanina Camporeale,[c] and Luis Perez,[d]
with contributions from Phil Musgrove and Cecilia Zanetta [e]

[a] Senior Economist, Health, Nutrition and Population Unit, Latin American and the Caribbean Region (LCSHH), the World Bank, Washington DC
[b] Consultant, LCSHH, the World Bank, Buenos Aires
[c] Operations Officer, LCSHH, the Work Bank, Buenos Aires
[d] Senior Health Specialist, LCSHH, the World Bank, Buenos Aires
[e] Consultants, LCSHH, the World Bank, Washington DC

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Abstract

The Plan Nacer Program was designed by the Argentine Ministry of Health to provide health coverage to uninsured women during their pregnancies and for an additional 45 days after giving birth, as well as to children under the age of six. In doing so, it focuses on the most vulnerable populations, addressing a basic inequity in health care. In addition, the program includes three main distinctive features: an explicit menu of health benefits, disbursements linked to achieving agreed-upon targets of enrollment and health results, and audits conducted by an independent external firm to corroborate service delivery and quality.

The Plan is an innovative way to strengthen health systems. Rather than simply funding more facilities and inputs or adjusting existing insurance mechanisms—neither of which have been successful in dealing with the health problems of the poor, the Argentine Ministry of Health realized that improvements to quality and coverage of

1. The report considered the main results of two commissioned studies prepared by Phil Musgrove (2011) and Cecilia Zanetta (2011), as well as several reports prepared by the national Ministry of Health and technical discussions between the World Bank team and the Project Coordination Unit.

health services for the uninsured would require drastic operational changes. To do so, it decided to introduce performance incentives at all levels and to focus on results.

Although many challenges remain, the program has already improved basic health indicators and restructured the ways in which health facilities deliver services. The program will build on its success by (a) strengthening financial sustainability when the provincial programs expand; (b) improving the links between primary health care centers and hospitals, as well as raising overall health care standards; (c) including a wider range of health services in the program; (d) further developing incentives at the provincial health facilities; (e) improving procedures to monitor health indicators under the national monitoring system; and (f) supporting efforts to improve maternal and child health indicators. These processes will be supported through a new lending operation for a national health program called the Provincial Public Health Insurance Development Program. This program, soon to be implemented, will expand service delivery and coverage developed through the Plan Nacer to include uninsured children and youth under 19 and women 20 to 64 years of age.

Keywords: Health, incentives, enrollment, targets, equity, auditing, monitoring, results.

Correspondence Details: Rafael Cortez, Human Development Department (LCSHD), 1818 H Street, NW, Room I7-700, Washington, DC, 20433; telephone: (202) 458-8707; fax: (202) 522-0050; e-mail: rcortez@worldbank.org; website: http://www.worldbank.org.

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1. INTRODUCTION

1. **As is the reality in most Latin American countries—and many low-and middle-income countries worldwide—Argentina's population of just fewer than 40 million has experienced varied levels of access to health care in recent decades.** A large percentage of the population has been covered by the Obras Sociales (an estimated 21 million at the beginning of 2009), which include various employment-related social insurance schemes that also cover many retirees. However, while the number of enrollees grew in the 1990s, these programs still reached only 53 percent of the population in 2009 because they could not easily be extended to the informal sector. Another 4 million (10 percent) either had private insurance or enough disposable income to pay out of pocket for private health care. The remaining 15 million (almost 38 percent) were not enrolled in any insurance scheme. This group is sometimes described as having no access to basic health care, but is supposedly covered by public sector facilities. As the global experience shows, such public sector financing and delivery models often face problems of low performance and accountability, and governments are thus required to think about innovative mechanisms that change the relationship between purchasers, providers and users.

2. **Since Argentina is a federal country, responsibility for providing care is decentralized and rests mainly with the nation's 23 provinces and the capital city, the Autonomous City of Buenos Aires.** This responsibility is assumed by the provincial health ministries, which provide health care services at no cost to all users—although their main goal is to provide services to the uninsured population. Formal insurance typically covers only public and private employees under a payroll system, not the large population of people who do not belong to an Obra Social or have private insurance or the means to pay the full cost of care.

3. **Publicly funded services in the provinces have operated in the traditional Latin American manner, with investments and operating costs paid from fixed budgets transferred from the provincial health ministries.** These public providers

(for example, health posts, clinics and hospitals) do not bill for services and have little or no autonomy in decisions about how to use their resources. Moreover, the budgets are often too small to cover the care needed by the uninsured; also, the rigid budgeting process means they do not obtain the supplies and inputs they need in the right proportions. Further, since the provincial resources and budgets differ greatly, depending on level of per capita income, care for the uninsured and health indicators vary from province to province. In 2001, for example, the highest provincial infant mortality rate was more than twice as high as the lowest, and the variation in maternal mortality was much greater, more than 10 to 1.

4. **Plan Nacer was created primarily to address these inequities and respond to the effects of Argentina's economic collapse in 2001.** The economic crisis lasted until 2004 and pushed many to or beneath the poverty line, which was 37 percent of the population from 2000–03 and 51.7 percent in 2004. The figures did not drop significantly until 2009. The recession caused many to lose their health insurance, since they had lost the jobs that covered it, and reduced the capacity of the uninsured to pay for health care out of pocket. The negative trend of heath indicators best tells this story. Infant mortality, which had dropped from 25.6/1,000 in 1990 to 16.6/1,000 in 2000, rose slightly during the sharp recession and did not fall again until 2004. By 2009, however, the rate had declined to 12.1/1,000. The recession hit some provinces harder than others, with varying effects on health status: inequality in infant mortality rose from a Gini coefficient among provinces of about 0.1 in the 1990s to a peak of 0.13 in 2002 (a large relative increase). However, the overall number for the provinces masks the much greater differences *within* provinces, which did not return to 1990 levels until 2005.

2. WHAT IS PLAN NACER?

5. **In response to this situation, in 2005, the Argentine Government launched Plan Nacer, a program of maternal and child health insurance designed to reform some features of the health sector.** The program was intended not only to increase access to health care overall, but to reduce inequalities and improve health conditions that had deteriorated during the recession. These concerns led authorities to focus on

pregnant women, newborns, and young children, who were the most vulnerable among the uninsured; such emphasis led to the name *Plan Nacer* (Birth Plan).

6. **The Plan's first phase was limited to nine provinces in the northeast and northwest, which are among the poorest in the country.** The second phase began at the end of 2007, after the following conditions were met: at least 25 percent of the target population in four or more of the original nine provinces had been enrolled; at least 20 percent of the proceeds of a World Bank loan that helped finance the program was disbursed; evidence that auditing of the project was satisfactory; and at least five more provinces were ready to join. Since Phase II started, the remaining fifteen provinces have been included. After Phase I ended in July 2010, the nine Northern provinces were included in the second phase of support for the program nationwide. At present, the Government is ready to expand the health insurance program to cover new groups of beneficiaries and offer new services.

7. **The Plan's most novel feature is its results-based financing, which refers to the way it is financed and the incentives it offers to provincial governments and health care providers.** The Plan provides a unique opportunity to design performance-based interventions that can begin to change the "business as usual" behavior in the health sector. The plan involves (a) funding to improve health facilities' capacity to deliver services; (b) a formal insurance scheme for people who have no access to employment-based coverage and cannot afford private insurance; (c) two legally binding agreements—one between the central and provincial governments and the other between provincial governments and providers; (c) a scheme through which individual health care providers can affiliate with the program; and (d) a new system for keeping records, performing audits, and conducting evaluations to ensure that funds are used as intended and results are documented. Each element will be detailed in the next section.

8. **The Plan does not expand the Obras Sociales or any other preexisting insurance schemes. The Plan seeks to enroll those who were previously uninsured.** As such, it is an insurance program that complements the existing social security scheme

and somewhat resembles Mexico's Seguro Popular, which does not affect coverage by the two large social security plans (the Instituto Mexicano del Seguro Social [IMSS] for workers in the formal sector and the Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado [ISSTE] for public employees). Also, it differs from the insurance expansion under Colombia's Law 100, which allowed many new insurers to enter the market and take advantage of the public subsidy for the previously uninsured population. In addition, it does not impose a uniform national scheme on the provinces, although that option was initially considered. Further, it replaces neither the provinces' existing public health services nor the budgeting and allocation by provincial governments; rather, it adds new features to that system.

9. **The Plan is a radical departure from past insurance schemes, since it targets clients who were previously uninsured and funds health facilities based on their results, which are determined by independent external audits.** It also explicitly intends to improve governance, accountability, and transparency in health care delivery, in addition to improving health conditions.

2.1 Investment in Service Delivery

10. **Until the Plan was launched, provincial governments often found it difficult to meet the existing demand for health services of the uninsured population.** Now, Plan Nacer allows health facilities to reach out and enroll the uninsured population. Some initial investment was needed to add equipment and train staff, so as not to overburden the services. To this end, provincial governments analyzed their facilities' needs and proposed specific investments to the national Ministry of Health, which then negotiated these costs with the World Bank (described in section "Prior Requirements and Start-up Efforts"). Substantial funds were invested to add equipment and train staff before Plan Nacer was implemented or very soon thereafter. However, because these preliminary investments were not guided by the insurance scheme, they are not considered here. Some small-scale investments by providers can be financed by the insurance funds independently of national or provincial government decisions, and these can continue throughout the operation of the Plan. This reinforces the lesson learned that

there is a need for upstream investment in health facilities, even if payment mechanisms change in support of improved resource allocation and incentives.

2.2 MATERNAL AND CHILD HEALTH INSURANCE

11. **Of the nearly 15 million uninsured people for whom the public sector is responsible, 2 million (pregnant women or children up to six years old) were considered eligible.** Although the Plan does not specify that the target population must be low-income individuals, it is directed at the uninsured, who are much more likely to be poor than those in insured households. While their enrollment is voluntary, the Plan offers incentives to health care providers to encourage those who are eligible to join.

12. **Plan Nacer insurance is limited to specific services and defined periods of coverage, and is completely free (clients pay no premiums).** For women, coverage begins with the start of a pregnancy (or when it is confirmed) and extends until 45 days after the birth or the loss of the fetus if that occurs—a maximum, that is, of ten and a half months. Each new pregnancy starts a new period of coverage. As mentioned above, coverage for children extends from infancy to age six, and focuses on delivering health care during the first year of life. Health problems caused by pregnancies and deliveries are not covered if they occur after 45 days; instead, women who need health services for such problems are referred to the provincial reproductive health program. Also, services that the Plan does not cover remain the responsibility of the provincial health service system, whether delivered by the same providers or others.

13. **Given Plan Nacer's success in covering the target population, Argentine authorities are extending coverage to age 18 through an expanded health insurance program starting in 2012.** Thus, a teenage woman could be covered without interruption from her own birth until the birth of one or more of her children. Cancer interventions for all women 20 to 64 years old are covered by the new insurance, as are vulnerable groups with certain chronic diseases in further stages of the program. The long-term goal is to expand coverage to about 9.5 million people, or approximately 70 percent of the uninsured population. By extending the ages at which women and

children are covered, health centers will need to add services for older children and adolescents and for women of childbearing age who are not pregnant.

Table 1. Services Covered by Plan Nacer in Phases I and II by Target Group or Function

Group or Function		Services
Women	Pregnant (low risk)	Consultations for healthy pregnancy Pap test for cervical dysplasia or cancer Tetanus immunization
	Pregnant (high risk)	Consultations for control of pregnancy risks Ambulatory treatment for HIV infection
	Childbirth	Care in childbirth and for the newborn
	Following childbirth or fetal loss	Rubella immunization Consultation on postnatal health
Children	Newborn	Immunization (including BCG and hepatitis B) Care in incubator for up to 48 hours Immediate treatment for vertical transmission of HIV
	Up to age six	Eye examination Consultations on mouth and dental health
Laboratory tests and procedures		Pregnancy test Colposcopy following positive Pap test Taking blood samples Blood tests
Imaging in pregnancy		Sonogram Chest x-ray
Community-level services		Active recruitment of pregnant women in first trimester Complete rounds in rural areas by health agent Socio-epidemiological diagnosis of population at risk Group meetings to promote healthy nutrition Group meetings to promote child development
Transportation		Emergency transport of newborn as needed

Source: Argentina Ministry of Health 2008.

14. **In its operation so far, the benefits of Plan Nacer are primarily personal services directed to individuals (Table 1).** The services broadly defined in the table are further disaggregated into 80 specific interventions. For pregnant women, these include prenatal examinations, screenings for sexually transmitted diseases (STDs), and treatment for dental problems, urinary infections, and mild anemia, among others. For those with high-risk pregnancies, the Plan also covers treatment for severe anemia, hypertension and bleeding, and focuses on HIV infections so as to prevent them from being transmitted to the fetus or infant. Newborns are treated immediately for congenital

infection (syphilis or Chagas disease) and for other severe problems, including metabolic disorders. For those one to six years old, the Plan focuses on visual and dental problems, respiratory and diarrheal infections, and malnutrition. However, treatment of chronic HIV infections or AIDS is outside the Plan's scope, as are all other chronic conditions.

15. **The Plan of benefits covers some community-level services.** These include (a) women's group meetings, which aim to promote good nutrition and child development, and (b) regular health care workers' visits to rural areas to offer follow-up care to beneficiaries who have limited access to facilities. During these visits, workers encourage the uninsured to enroll.

16. **The Government decided to focus on maternal and child health because it determined that the existing services were inadequate.** The Government assumed health care providers would be more motivated to deliver services when given incentives.

17. **If other countries adopt some of Plan Nacer's features, they will need to determine which services to prioritize and will have to ensure that other services will not suffer in volume or quality.** The project has the advantage of a discrete benefits package. It may be limited if the intention is to apply it to a full benefits package as it is difficult to cost out. As of now, Panama, the Dominican Republic, and Guatemala have adopted the Plan's capitation and incentives arrangements through World Bank–financed projects that support national health strategies, including a specific health benefits plan.

2.3 VOLUNTARY LEGAL AGREEMENTS

18. **Plan Nacer is unique in that it includes legal contracts that are voluntarily assumed by the national and provincial governments and affiliated health care providers, which refer specifically to the Plan's insurance scheme and financing.** Health sector efforts have always been governed by agreements between the central

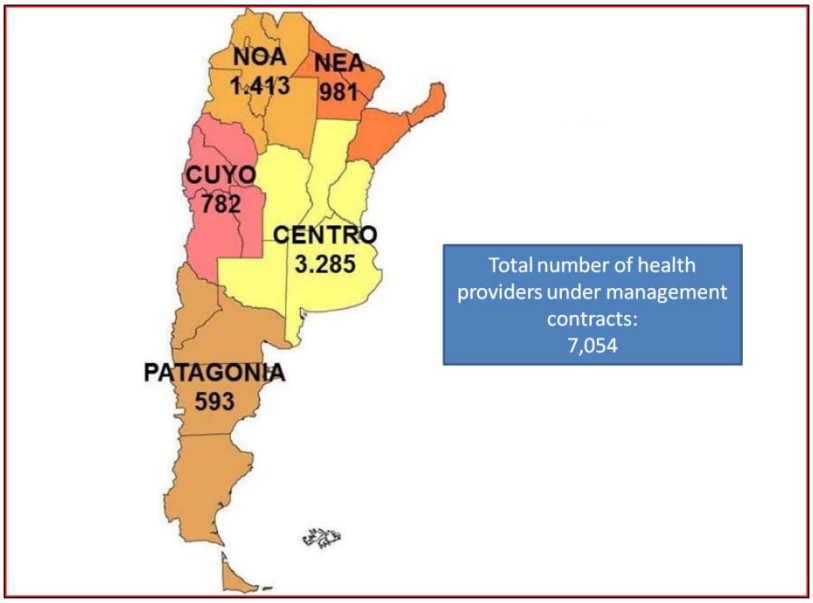
government and the provinces, and various laws and regulations between provincial ministries of health and the public providers they finance and supervise. Some regulations also apply to private providers. Plan Nacer contracts are between the national Ministry of Health and each province, as well as between provincial governments and the affiliated providers who operate in that particular geographic subdivision. The government-to-government agreement is called a *Convenio Marco* or umbrella agreement (Annex 3). It defines the responsibilities of each jurisdiction and provides for funds to be transferred to the provinces based on the number of beneficiaries enrolled and the achievement of specific targets. The national Government determines the types of benefits to be offered and monitors enrollment and compliance with those targets; provincial governments (a) determine the amounts to be paid for the services, and (b) monitor enrollment, health care service delivery, and the appropriateness of the expenditure of funds. This umbrella agreement is implemented through a contract or *Compromiso Anual* that is renegotiated each year.

19. **The Plan was gradually expanded and initially adopted in nine provinces; now, all twenty-three provinces plus the Autonomous City of Buenos Aires have entered the program.** Each province is required to create a separate unit to manage the Plan—the Unidad de Gestión del Seguro Provincial or Provincial Insurance Implementation Unit (UGSP)—and report to the Unidad Ejecutora Central or Central Implementation Unit (UEC), the agency in the national Ministry of Health that was created to oversee the Plan and report to the Bank.

20. **The second type of agreement—the *Compromiso de Gestión* or management contract—defines the providers' responsibilities, which include enrolling beneficiaries, delivering services, billing the province for them, and maintaining clinical and financial records (Annex 4).** This represents a major change in the way public providers operate, as it requires them to be much more involved in attracting patients and obtaining funding. Equally important, the contract specifies how providers can use the incentive payments to meet their targets. A key aspect of the Plan is that it allows providers to determine how the funds they receive should be spent.

In theory, any provider in a province that can deliver the services included in the Plan may sign a management contract. However, nearly all participating providers are public, as most for-profit private providers treat only patients who have private or Obras Sociales coverage. Private nonprofit providers with other sources of financing may also participate. By November 2011, 7,054 health providers had signed the management contracts; of these, 2,394 were in the nine provinces included in Phase I, and 4,660 were in the fifteen provinces, plus the Autonomous City of Buenos Aires, which joined in Phase II.

Figure 1. Number of Health Providers under Management Contracts



Source: Argentina Ministry of Health 2011.

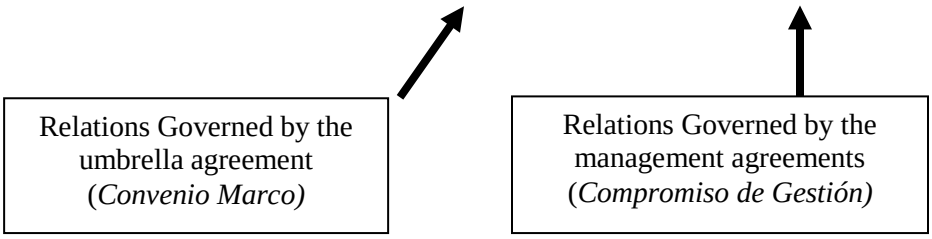
2.4 AUDITING ARRANGEMENTS, ACCOUNTABILITY, AND EVALUATION

21. **Neither the provincial ministries of health nor their public health care providers previously kept the accurate, detailed records required by Plan Nacer.** Since Plan funds are at stake (not available under a traditional budget), both provinces and providers have reason to overstate the number of enrolled beneficiaries and the volume of services delivered. For these reasons, the incentives built into Plan Nacer are complemented by a scheme of regular external and independent audits whose purpose is

to prevent fraud and hold the recipients of funds accountable, as well as to provide the basis for further evaluation and capacity building to manage the insurance program effectively (Annex 5). These arrangements include penalties for any irregularities identified by the external auditors. For example, if an audit reveals that a province has enrolled individuals who are ineligible, then the amount paid is deducted from the next installment, and the province is fined a penalty of 20 percent of capitation transfers. Table 2 summarizes the different actors' responsibilities (those of the national and provincial governments, affiliated providers, external auditors, and eligible beneficiaries).

Table 2. Responsibilities of the Different Actors in Plan Nacer

Function or element	National Government	Provincial government	Affiliated provider
Population Coverage	Validates enrollment as the basis for financing	Confirms enrollment of beneficiaries	Identifies and enrolls eligible beneficiaries
Specific interventions (*nomenclador*)	Determines the content of the benefit package	Determines the FFS prices for services	Delivers services and bills for them
Tracers and targets	Determines the tracers Negotiates the targets with the provinces	Combines data from providers to determine tracer achievements	Reports data on coverage of the tracer services or conditions
Financing	Transfers funds for * Enrollment (60% of the capitation payment) * Achievement of the tracer targets (up to 40% of the *capitation payment*)	Pays providers for the services delivered	Uses the FFS payments for investments, recurrent inputs, and bonuses to staff
Auditing and monitoring	Monitors and audits the data from provinces, via the concurrent external auditors	Monitors and audits the data from providers	Keeps records of enrollment, services delivered, and receipt and uses of funds



Source: Argentina Ministry of Health 2008.

22. **The auditing scheme comprises independent external audits, both financial and technical, and internal oversight.** The Argentine Supreme Audit Institution (Auditoría General de la Nación [AGN]) conducts an annual financial audit. The technical audit is carried out by an independent external firm that verifies the project results in terms of enrollment, improvements in health conditions as determined by the tracers (health indicators), and health care service delivery and quality. The audits are also expected to determine whether and how much of the funds will be transferred to the health care facilities. In addition, the technical auditors review the records to determine if the provinces have complied with the Plan's standards. They then report their findings on a bimonthly basis (which includes errors and deviations from Plan's goals) to the UEC, proposing sanctions and recommending ways to solve identified problems. The UEC, through the Internal Oversight area, then reviews the auditors' findings and proposes the amount of refunds or fines to correct deviations and improve critical situations.

23. **The auditing process has helped identify problems and obstacles in each stage of Plan Nacer's implementation.** In the beginning, the provinces found it difficult to reach agreed-upon beneficiary enrollment targets and to contract health care providers. Also, a significant number of errors were detected that related to consolidating and correcting the list of individuals enrolled in the program (*Padrón* in Spanish). The enrollment problem remained after two years, as did problems related to payments to providers. At present, the main issues are related to achieving the tracers' targets (that is, quality and quantity of services), reducing the lag time for provider payments, and improving the information and management systems.

24. **The checks and balances created by the audits, which verify results, have not only identified errors, but have served as incentives to improve the performance at different levels.** For instance, in the provinces funded in Phase I, the number of errors in beneficiaries' enrollment identified each month dropped from 22 percent in December 2006 to 11 percent in December 2009. For this reason, fines also decreased from Arg$2,700 to Arg$1,700. Moreover, in 2009, the total amount to be refunded (due to

inconsistent or noncertified billing) along with fines for the entire program was nearly 10 percent of the transfers to provinces, and 60 percent of the cost of the annual external audit. While the audit costs are significant, audits ensure that funds are used according to the guidelines, which, in turn, leads to refunds to the program through the application of monetary penalties recommended by the audits. Thus, the independent audit has been extremely valuable not only in implementing Plan Nacer but also in helping to identify bottlenecks and improving the manner in which the program functions.

3. RESULTS-BASED FINANCING AND INCENTIVES

25. **Until Plan Nacer was introduced, the Argentine public health sector followed traditional practices, purchasing inputs for the system.** This differs from private health care providers, which are paid for outputs by private patients, and the Obras Sociales under a fee-for-service (FFS) system or by capitation. Plan Nacer pays providers for outputs, but the payments depend indirectly on certain outcomes, as described below. It is particularly the payment for meeting certain targets that qualifies this as a model of results-based financing.

3.1 RESULTS AS BENEFICIARY ENROLLMENT

26. **Under Plan Nacer, the provinces are given two related incentives.** The first involves their success in enrolling eligible beneficiaries, since they receive a capitation payment for each pregnant woman and child who joins the program. This per capita payment functions somewhat like an insurance premium and has two parts: 60 percent of the amount is paid for the number of individuals that enroll, even before any services are delivered (see below for an explanation of the second incentive related to the other 40 percent). These funds are transferred from the national Ministry of Health to the provinces, where they are used to pay the providers for specific services rendered. Although health care facilities do not receive the capitation payment, they have a major incentive to identify potential beneficiaries, certify that they meet eligibility criteria (uninsured children under six years old and pregnant women) and enroll them, because they will then be reimbursed for the services they provide. The capitation payment supplies the funds to pay for those services. In this way, the Plan operates as an

insurance scheme, and represents a break from the traditional supply-side provision of care to the target population based on a financing of inputs not necessarily motivated by results.

3.2 RESULTS AS SERVICES DELIVERY

27. **Once a woman or child is enrolled, providers have another incentive linked to the services they deliver, since they bill and are paid for those services that are covered by the Plan.** Thus, the more individuals enrolled, the more funds are transferred to the province to pay for services. The list of covered services—called the "benefit package"—is known as the *nomenclador*, and is the same in all provinces (each service corresponds to a general category of care as indicated in Table 1). Payments are standard FFS arrangements whose amounts are determined by the provincial government; thus, fees vary among the provinces because of differences in the cost of providing services (which could include higher or lower overhead costs). However, since the provincial governments continue to pay for most health care costs, including the public health workers salaries, these FFS payments do not cover the full cost of the services covered, just the incremental cost.

28. **This combination—the fixed capitation payment for enrollment that goes to the provinces, and FFS payments to providers, which vary according to the type and amount of care delivered—constitutes a financing scheme that attempts to avoid the negative effects that the capitation or FFS payment alone might generate.** For example, capitation payments sent directly to providers might lead to under delivery of care, while FFS financing alone, without a clear benefits package (for example, who is covered and how much will be paid for specific services) might promote excessive utilization with their accompanying costs.

29. **A key Plan objective is to improve recordkeeping and auditing and providers have an incentive to properly record and bill for services delivered.** If they do not, penalties will be levied and the FFS payments will be reduced. Other penalties may also be levied if a required input or resource was not used in the service delivery—that is, if

the protocol was not followed. By reducing payments, the Plan intends to protect the quality of care and the providers' responsiveness to patients. Thus, they have explicit incentives not only to offer certain services but also to provide health care according to the national Ministry of Health standards.

3.3 RESULTS AS MEETING COVERAGE TARGETS

30. **The remaining 40 percent of the capitation payment is managed quite differently than the 60 percent linked to enrollment. It rewards the percentage of coverage of ten health indicators known as tracers.** A target level of coverage is set for each tracer (Table 3) and the amount of funding received depends on whether provinces meet or exceed the target. If they meet any one target, they are paid 4 percent of the total capitation payment. Thus, a province can receive anything from 0 to 40 percent of the capitation amount by meeting targets, and from 60 to 100 percent of the total value, when the sums paid for enrolling beneficiaries are included.

Table 3. The Ten Tracers *(Trazadoras)* in Plan Nacer

No.	Health objective	Corresponding tracer: number of ____as a share of all the relevant women, newborns, or children
1	Early enrollment of pregnant women	Pregnant women with first prenatal consultation before the 20th week
2	Effectiveness of childbirth care and care for the newborn	Newborns with Apgar score of 6 or better, five minutes after delivery
3	Effectiveness of prenatal care and prevention of prematurity	Women with newborn weighing at least 2,500 grams (2.5 kg)
4	Effectiveness of prenatal care and care in childbirth	Women with VDRL (tests for STDs) and tetanus immunization during pregnancy
5	Attention in cases of maternal or infant death	Cases of maternal death or death of infant under one year of age, fully evaluated as to cause
6	Immunization coverage	Children under the age of 18 months with measles or measles-mumps-rubella (MMR) vaccination
7	Sexual and reproductive health	Women receiving sexual and reproductive health consultation within 45 days after giving birth
8	Care of healthy child to age one	Children under age one with complete record of consultations and height, weight, and head diameter
9	Care of healthy child from age one to age six	Children between one and six in age with complete record of consultations and height and weight
10	Inclusion (coverage) of the indigenous population	Providers who deliver services to indigenous populations, with personnel trained in that group's specific culture and health needs

Source: Argentina Ministry of Health 2008.

Eight of the ten tracers refer to specific services delivered to eligible women, infants, or children. However, tracer no. 5 is quite different: since one of Plan Nacer's objectives is to reduce maternal and child mortality, this tracer refers to the evaluation of cases in which a mother or child dies. Provinces are rewarded for investigating why deaths occur—for example, if they were due to inadequate or low-quality care—in hopes of reducing mortality in the future. Tracer no. 10 is also different, because it applies to a particularly vulnerable group—indigenous populations. These traditionally poor and excluded groups comprise about 3 percent of the total population and are concentrated in rural areas, mainly in the Northern provinces where the Plan was first launched. Since they have different cultural practices and beliefs regarding pregnancy, births, and child care than Argentines of European descent and may not speak Spanish adequately, it is important that some providers be culturally and linguistically equipped to provide care to these groups.

31. **Since the provinces differ in their resources and capacity to deliver the services listed in the Plan, the target levels for the ten tracers are negotiated between the national and provincial governments and vary between the provinces in Plan Nacer Phase I and Phase II.** The provinces naturally want to set targets at a low, achievable level, so funds can be obtained. However, the national Government wants targets set as high as can be reasonably attained, to avoid rewarding low levels that could be achieved even without the 4 percent incentive payments. Still, if the levels are too high, the provinces will obtain less revenue and be unable to pay for services. Thus, the negotiated target levels represent a compromise. Targets can be renegotiated at four-month intervals, which correspond to the frequency of audits and payments.

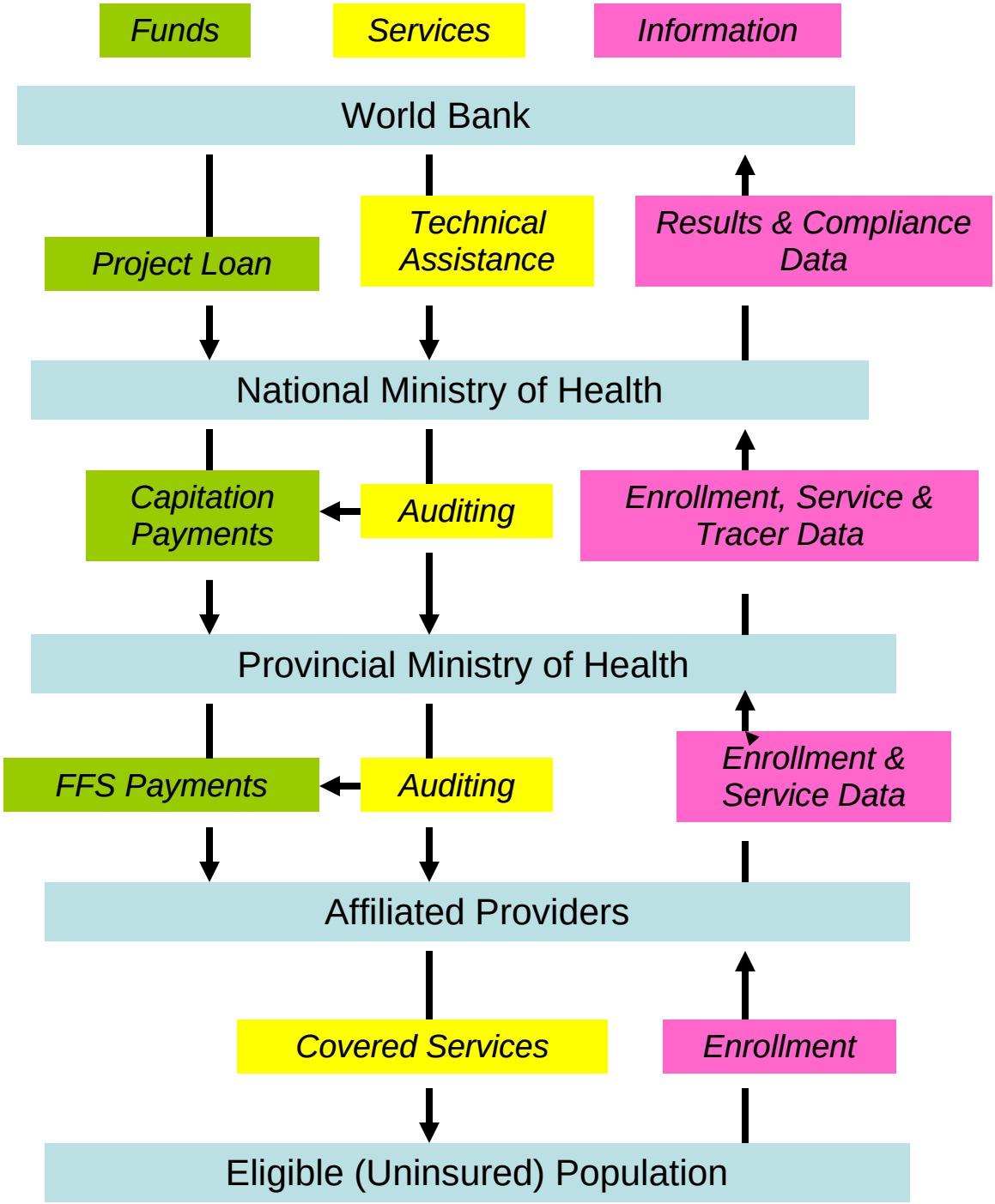
32. **The payments for reaching the targets have been adjusted since the Plan Nacer was introduced.** At the beginning, the payments for reaching the targets were all-or-nothing; that is, provinces only had incentives to reach targets, not to exceed them. But since 2008, payments have been made according to a sliding scale of two or more steps: the full 4 percent is paid only for reaching relatively high targets, while smaller rewards of 1 to 3 percent are paid for lower ones. Compared to the original scheme, the

newer targets motivate providers to aim for higher targets rather than reduce their efforts once targets are reached. Thus, the more targets a province meets, the more revenue the province receives under the Plan and the more funds it has for the FFS payments to providers. Since the payments depend on the total volume of services, this type of arrangement encourages providers to increase their efforts to deliver better care, even after a target is met. Some provinces have also authorized payments to staff at health facilities from providers' revenues collected from the fee-for-service.

3.4 FLOWS OF FUNDS, SERVICES, AND INFORMATION

33. **Relations among the World Bank, the national and provincial Ministries of Health, affiliated providers, and eligible populations involve the flow of (a) funds; (b) services (including technical assistance, auditing and evaluation, along with health care); and (c) information.** Figure 2 depicts these flows, with funds and services going downwards to providers and beneficiaries, and laterally, with audits. Information flows upwards, starting with the registration of beneficiaries. Providers send information about enrollment and delivery of services to provincial ministries. Once information is audited and approved, the ministries calculate the providers' FFS payments. Thus, a loop is created, where information flowing in one direction sets in motion two flows in the reverse direction. A similar loop exists between the provincial and national ministries. The data from providers about the services they delivered determines the extent to which the tracer targets were achieved. That data, together with information on enrollment numbers, determines the amount of the national ministry's capitation payments to the provinces. These loops operate on a four-month cycle.

Figure 2. Flows of Funds, Services, and Information in Plan Nacer



While Figure 2 presents the flows and relations that characterize the results-based financing, it does not include the national and provincial funding for the Plan—as described below; that is, Plan Nacer funds cover only part of the insurance premium, the rest is obtained from domestic sources. The two components of capitation—60 percent for enrollment and up to 40 percent for meeting tracer targets—are not separated in the Figure and the financial penalties (for errors or fraud that appear in the records) are subsumed in the flow of FFS payments. "Auditing" in the column labeled "Services" is shorthand for the technical assistance and supervision provided by the two ministerial levels. Similarly, Figure 2 presents only the information flows that directly affect funding and services. The providers also report how they use the FFS payments. The audit reviews the use of those funds at each level and verifies or corrects the reported use of the loan proceeds and the capitation payments.

3.5 PROVINCIAL FISCAL EQUILIBRIUM

34. **Payments for the three different results—two to provinces and one to providers—has the potential to create a financial imbalance for the provinces.** For instance, the provinces obtain their revenues under Plan Nacer based on enrollment and tracer target achievement, but their expenditures (payments to health facilities) for the *nomenclador* (the benefit package) are based on the number of each type of service that is provided. These expenditures are not directly linked to either enrollment or target achievements; rather, they depend on how many enrolled beneficiaries receive health care services as well as on the frequency of services, including those that are not connected to the tracers.

In fact, provincial ministries' and providers' expectations about the Plan's incentives are not necessarily alike: providers will naturally expect (nearly) all the provincial revenues to be transferred as FFS payments, while provincial health ministries will be concerned that providers' expenses should not exceed what they receive from the capitation payments, including the rewards for meeting targets. Thus, provincial ministries have a strong incentive to set their FFS rates in line with what providers can deliver in meeting the targets, as well as to help providers achieve them.

35. **Plan Nacer's results-based financing requires an intricate balance between incentives and financial flows.** This arrangement is consistent with one of the Plan's major objectives: to use a marginal financing arrangement to improve the effectiveness of the much larger pool of resources that continue to be spent under traditional provincial budgets. To this end, both the provinces and providers must actively recruit beneficiaries, follow protocols for their care, expand service coverage, and audit their work to assure financial efficiency and medical quality.

3.6 PROVIDERS' DISCRETIONARY USE OF FUNDS

36. **Financing for results is innovative for Argentina because it introduced a rewards scheme for provinces meeting the tracer targets and for providers delivering services under FFS payments.** The Plan also gives providers considerable autonomy in determining how the FFS funds are used. According to its guidelines, at least 50 percent of payments to a provider must be used to deliver the services listed in the *nomenclador*; these funds cannot be used for salaries, which the provinces continue to finance. However, providers can choose to spend the funds on investments, for example, to purchase medical supplies or small equipment, or for maintenance and inputs.

37. **Staff decisions on how to use the funds empower the staff at the health facility level.** Evidence suggests decisions made through a staff consensus helps to empower staff. This type of decision-making can also help a provider to correct imbalances in resource use that result from the rigid guidelines imposed by provinces (for the funds they transfer to the facilities) about budget outlays. Under the Plan, the management from the health facilities can spend up to 50 percent of their revenues obtained from the FFS for bonuses or incentive payments for the staff. Specifics about the amount of the bonuses and how they should be allocated among staff can be decided in various ways: for example, health professionals can be rewarded individually or the reward can be applied to improve the capacity of the health facilities to deliver better or more services. If funds are properly accounted for and guidelines are respected as to the

amounts that may be used for staff bonuses and other expenses, neither the provincial nor the national authorities need to be involved in the decisions. This greatly empowers the providers, which is one of the Plan's goals.

3.7 USER SATISFACTION AND QUALITY OF SERVICES

38. **An important goal of the Plan is to empower patients, through the following:** (a) the Plan defines their rights; (b) they obtain information through communication campaigns; and (c) opinions about the Plan and its services are solicited through periodic surveys. Since the Plan was introduced in 2005, there have been five such surveys carried out between May 2006 and March 2009 (monitoring user satisfaction and quality of health care services provided by Plan Nacer). This includes the analysis of five dimensions of quality: enrollment, knowledge of the benefits plan, first-level attention and hospitalization assessment, nurse and doctor assessment, and utilization of the system of complaints. The surveys included a representative sample of 3,600 cases in the nine Northern provinces (400 cases in each province: 100 women and 300 children).

39. **On average, 84.3 percent of respondents had a positive perception of the Plan Nacer, ranging from 56 percent in Salta to 98 percent in Chaco.** In the case of all but two provinces (that is, Salta and Formosa), there has been a positive trend in terms of beneficiaries' perceptions of the program (Table 4). Other important findings from the satisfaction surveys include the following:

- 15 percent of beneficiaries received printed information on the health care services that are guaranteed under the Plan Nacer.
- Half of respondents report being familiar with the health care services covered under the Plan Nacer.
- On average, 40 percent of respondents received domiciliary visits from health care agents for recruitment or follow-up.
- 60 percent of respondents have had all the control visits included under the program.

- 60 percent of users have received medical information and advice on child development and proper child care. Of those, only half received information about home accidents. This is one of the main causes of death among children.
- In 2009, 88 percent and 90 percent of users agreed that first-level attention and hospital-attention services, respectively, were satisfactory—representing an increase from 80 percent and 82 percent in 2005.
- Six percent of users filed complaints on the services through the complaint system, and 23 percent of them confirmed that their complaints were responded to satisfactorily by the health facility

Table 4. Percentage of Respondents with Positive Perception of the Plan Nacer

Provinces	Round				
	1	2	3	4	5
Salta	76.1	78.6	70.3	60.7	56.2
Catamarca	65.9	78.4	90.5	93.8	92.3
Santiago	49.3	79.8	76.1	90.1	85.3
Jujuy	73.7	74.3	82.1	90.5	83.8
Tucumán	75.3	78.9	88.7	87.6	82.5
Corrientes	89.5	89.0	91.0	93.4	92.8
Chaco	84.0	73.4	84.1	61.9	98.2
Formosa	92.3	83.0	78.2	73.4	77.0
Misiones	83.1	85.2	90.3	82.2	90.8
Total	**76.6**	**80.1**	**83.5**	**81.5**	**84.3**

Source: Plan Nacer's Impact Evaluation 2009.

4. WHAT DOES PLAN NACER COST?

40. **The Plan offers extra resources for specific services (although provincial governments may adjust the amount of their budgets) as long as they do not reduce the totals.** In any case, the amount of funds obtained through Plan Nacer is small when compared to the provinces' health budgets. In 2009, for example, the Plan provided just under US$12 million to the Northern provinces, or only 1 percent of the total health spending of roughly US$1 billion in those provinces. Spending under Phase I was also small when compared to other health expenditures: in 2008, the Plan accounted for US$39.3 million, compared to just under US$4 billion in publicly financed health

services, and nearly US$2 billion through the Obras Sociales and other insurance schemes for the retired.

41. **The total cost of Phase I was estimated at just under US$290 million.** A World Bank loan, approved in October 2003, financed US$136 million of this total, with the remaining US$154 million financed by the national and provincial governments. For Phase II, the Bank loan provided US$300 million toward the total cost of US$919 million. For their part, the provinces were expected to invest US$10.4 million of their resources in Phase I and US$36.6 million in Phase II. The provincial share in total financing is higher in the second phase because the provinces that joined the program were generally richer. An expanded health insurance project drawing on Plan Nacer's institutional arrangements is being launched in 2012, with a Bank contribution of about US$400 million. After this new operation ends, all financing is to come from domestic sources, with the provinces gradually assuming all costs.

42. **Most of Plan Nacer's costs are related to the capitation payments that finance the beneficiaries' services.** These were 12 pesos a month (US$4 per person in 2004) in Phase I, and 15 pesos a month (US$5 per person in 2006) when Phase II started. In Phase I, the Bank loan financed US$90.4 million of the capitation transfers (Component 1 of the project), which constituted the bulk of the US$112 million devoted to the first component, to implement the insurance program. This was the only cost shared between the Bank and the national government; other components were financed entirely by the Bank. These included US$6.4 million to strengthen national and provincial ministries of health; US$4.2 million for communications and community outreach (to promote enrollment); US$3.9 million to monitor, evaluate, and audit the program; and US$1.3 million to administer the project.

43. **It should be stressed that these figures refer to the incremental cost of the insurance program, not the total cost of health care services provided by the provincial health ministries.** The provinces continue to budget for and cover the costs of the required inputs, including the salaries of publicly employed providers. These

providers can earn more under the Plan, but only in the form of bonuses, and then only up to a maximum of 50 percent of the revenues received for providing and billing health services. More can also be spent on other inputs, from the revenues that are not used for bonuses, but these will be expenses that providers judge useful to improve the quality of care or to offset supply imbalances or shortages of inputs covered by the provincial budgets.

4.1 PRIOR REQUIREMENTS AND START-UP EFFORTS

44. **Implementing Plan Nacer required four kinds of start-up efforts.** The first, already mentioned, was an investment in physical capacity to improve facilities and prepare them for the expected increase in demand for care. These expenditures were limited to equipment, including computers for the record-keeping and reporting required under the Plan. The second involved training for providers who assumed new responsibilities for recruiting beneficiaries, keeping track of the services provided to them, and deciding how to use and report on the new, non-budgetary resources that the Plan offered. These investments focused on administrative tasks, since it was assumed that providers were already medically competent and that deficiencies could be corrected through preexisting mechanisms. Only one of the tracers—no. 5, which rewards a review of maternal and child deaths so that medical errors or lapses can be detected and corrected—explicitly refers to the quality of care. The third necessary step was to create units at both the national (UEC) and provincial (UGSP) levels to oversee and manage the Plan. While such units are standard elements of many Bank-financed projects, in this case they are expected to outlive the Bank's participation in the Plan and form permanent structures to administer the insurance scheme once it becomes an entirely Argentine funded program. Increases in consumable inputs were not considered investments and were covered by provincial budgets.

A fourth requirement is to obtain adequate demographic and vital registry statistics to estimate the eligible population and determine how well the Plan succeeds in covering them. However, because this data cannot be gathered with the same precision as can the numbers of enrollment and services provided, the tracers reward coverage of the

enrolled, not the entire eligible population.

Since the Plan's launch, there has been opposition from within the provincial Ministries of Health, presumably with respect to the third change, which involved the establishment of supervisory units. Tensions between existing staff and the new offices and staff whose task is to administer the project are not unusual. This often occurs when a new approach is implemented because people resist change and especially resent a more stringent level of oversight. In contrast, investments in physical capacity generate little or no opposition unless they disrupt the way people go about their work. However, this initial friction appears to have been "bought off" by the influx of new resources that come with the Plan, and perhaps also by the fact that the loan financed the full cost of the noninsurance components of the program, rather than that being paid out of provincial budgets.

4.2 RESULTS FROM PHASE I

45. **A full account of Plan Nacer's achievements will be part of the impact evaluation to be completed in September 2012.** However, the information now available reviews three results: enrollment of beneficiaries, delivery of services and achievement of the tracer targets, and changes in infant mortality rates.

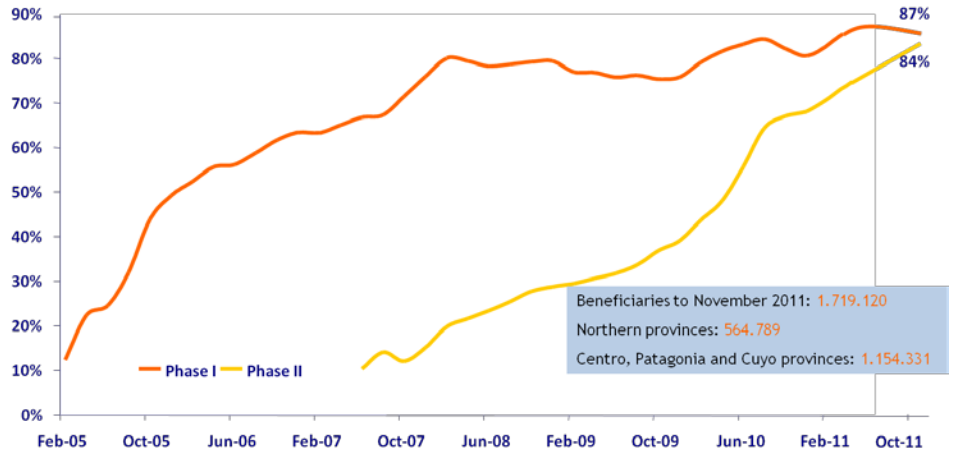
Enrollment

46. **A total of 4.1 million beneficiaries have participated in Plan Nacer since it began.** Enrollment in the Northern provinces was estimated to be about 20 percent of all eligible women and children in April 2005, and 50 percent by the end of that year. From then until August 2007, enrollment grew steadily but more slowly, to approximately 65 percent. At the start of 2008, the number jumped to 80 percent, after which expansion effectively ceased and even dropped slightly, to 76 percent by the end of 2009. It is unclear what caused the growth curve to flatten, but one explanation is that the remaining eligible population is much harder to reach—this may include the more rural or indigenous residents—and that the Plan did not devote enough resources to the communications and outreach component. However, in the first months of 2010,

enrollment started to grow again, reaching 82 percent, due to the implementation of the Universal Family Allowance Policy, which made enrollment in Plan Nacer a requirement to access this benefit. This policy targeted poor families with children, providing US$50 a month per child to the family. By Phase I closure in July 2010, enrollment reached 84.2 percent of the eligible population in the Northern provinces. Total enrollment, including the provinces that joined in Phase II, reached nearly 1.72 million in November 2011, representing 84.6 percent of the eligible population: almost 266,000 in the northeast, 299,000 in the northwest, 160,000 in the Cuyo region (the three provinces in the center-west), 914,000 in the five provinces plus Buenos Aires, which make up the center region (the most populous area), and 80,000 in the four southern provinces of Patagonia. Coverage as a share of the estimated eligible or target population represents 83.5 percent in the center and 74.2 percent and 85.9 percent in Patagonia and Cuyo, respectively. Newborns enrolled in 2005 would still be counted as beneficiaries one year later, unless their mothers removed them from the program.

Turnover is more rapid among pregnant women and new mothers. Women who were enrolled early in the insurance plan would not appear on the beneficiary rolls in later years unless they became pregnant again.

Figure 3. Enrollment of Target Population Percentage of Estimated Eligible Population



Source: Argentina Ministry of Health 2011.

Health Care Service Delivery and Targets

47. **The enrollment of so many beneficiaries over a period of just a few years shows that many more services have been delivered to the target population because of the Plan.** However, it is also true that many of the women who enrolled would probably have given birth in public facilities. While they might have had fewer prenatal consultations and postnatal services, current levels of coverage cannot simply be attributed to the insurance. For example, 4 million interventions covered by Plan Nacer's insurance scheme were delivered in the second semester of 2009, of which 48.5 percent were services to children under age six and 36.9 percent were to women. Large differences in coverage occur among provinces; for example, from January to October 2008, the share of births that were covered by Plan Nacer was as low as 39 percent in Jujuy Province and as high as 86 percent in Corrientes Province. However, the data do not compare these numbers to service delivery before the Plan or to an uninsured control group. It is encouraging that these differences have no systematic relation to the prices paid to providers, which vary from one province to another—since results-based financing that was overly sensitive to prices would discriminate against poorer provinces.

48. **Substantial attention has focused on how well the tracer targets (which include financial rewards) have been achieved. These targets have become a more strategically important goal than the coverage targets.** Some improvement in coverage was to be expected even without the Plan Nacer implementation, since the services are mostly financed by the provincial ministry's budgets and because the Plan includes financial rewards for meeting enrollment targets.

Not surprisingly, coverage increased sharply from 2005 to 2008 and differs considerably in the Northern region from one tracer or service to another. In the period from May to August 2005, only 4 percent of women received their first prenatal consultation before the 20th week of their pregnancies (tracer no. 1)—partly because many had been pregnant for more than 20 weeks when they enrolled. However, from

May to August 2009, the share rose to 48.4 percent. Coverage also started low for tracer no. 2—the share of newborns with an Apgar score of 6 or more five minutes after delivery—but by mid-2009, it had reached 87.5 percent.

Some services have clearly been easier to expand than others, which justifies setting targets at different levels. For example, the target was set at only 20 percent for tracer no. 8, which involved producing complete records of consultations and anthropometry for children up to age one, but was set at 70 percent or more for tracers 2, 3, and 4, which refer to the effectiveness of prenatal and childbirth care. The much shorter interval of coverage for women than for children probably makes achievement easier; also, beneficiaries probably see pregnancy and childbirth as more urgent services than well-baby checkups. The result of this variation in targets and the incentives for provinces to meet or exceed them is that outcomes in October 2009 for the nine Northern provinces were always within 15 percentage points of the goal set for December of that year. In general, the higher a target, the more likely it was to be reached. Overall, six targets were exceeded and four were not; the share of successes varied among provinces. Thus, the variations make it difficult to draw hard conclusions about how well the provinces are delivering the services under the Plan. For this reason, the national Health Ministry is considering using the target-setting process to motivate improved coverage and better outcomes especially where achievement is currently low.

Empowerment of Users

49. **The program informs and empowers beneficiaries by linking their satisfaction to the service providers' incentives.** If beneficiaries do not use the services, providers are not paid. Beneficiaries are educated about the program through public awareness campaigns (through radio, newspapers, and television), informational cards sent through the mail, and pamphlets at health facilities. Each presents user rights and services provided, user satisfaction surveys, educational courses on how to monitor children's health, and efforts by health agents (promoters) working with affiliated health providers. Plan Nacer services are explicitly characterized as rights. This creates a dimension of social accountability to complement the formal accountability provisions

(audits).

Infant Mortality

50. **Argentina's declines in infant mortality occurred for many different reasons, including the country's recovery from the economic collapse of 2001–03; thus, improvements cannot be attributed solely to the insurance program nor can any financial incentives be related explicitly to final impacts on health outcomes.** Nonetheless, a comparison between the nine provinces included in Phase I (in the northeast and northwest) and the country as a whole suggests that the Plan contributed to improvements in the poorest provinces, with a narrowing of the gap between infant mortality in those regions and the rest of the country. As Table 5 shows, from 2004–09, overall infant mortality declined somewhat faster in the Northern provinces than in the country as a whole.

Table 5. Infant Mortality in the North and all of Argentina, 2004–09 (Deaths/1,000 Live Births)

	Total deaths	Neonatal	Post-neonatal
2004			
North	18.7*	12.8	5.6
Argentina	14.4	9.7	4.6
Absolute gap	4.3	3.1	1.0
Percentage gap (%)	*29.9*	*32.0*	*21.7*
2009			
North	14.4	9.3	5.1
Argentina	12.1	7.9	4.2
Absolute gap	2.3	1.4	0.9
Percentage gap (%)	*19.0*	*17.7*	*21.4*
Reduction, 2004–09			
North, absolute gap	4.3	3.5	0.5
North, percentage (%) gap	*23.0*	*27.3*	*8.9*
Argentina, absolute gap	2.3	1.8	0.4
Argentina, percentage (%) gap	*16.0*	*18.6*	*8.7*
Reduction in gap			
Absolute	2.0	1.7	0.1
Percentage (%)	*46.5*	*54.8*	*10.0*

Source: Argentina Directorate of Statistics and Health Information 2009.
*The neonatal and post-neonatal deaths sum to 18.4, not 18.7, so one of these numbers is in error by more than a rounding amount.

Since the north is included in the national figures, the relative gain is actually understated. Deaths declined even more sharply in the Phase I provinces than in the rest of the country. This reduces the gap both absolutely and in percentage terms. As noted above, narrowing this gap contributed to reducing the Gini coefficient of infant mortality among provinces. Neonatal deaths accounted for roughly two-thirds of the total in both years and for nearly 85 percent of the reduction in the gap. As the national figure fell, even a small absolute difference became a larger percentage gap. Post-neonatal deaths, already low in 2004, were harder to reduce. The national figure actually fell by 0.4 per 1,000 while it declined by 0.5 per 1,000 in the Northern provinces. Maternal deaths are generally still more difficult to reduce, and have not been analyzed in the same way. Tracer no. 5 is therefore particularly noteworthy; the more that can be learned about why such deaths occur, the more certain types of services can be offered to improve and save lives.

Impact Evaluation

51. **The Plan Nacer Program provides health services to mothers and children who lack health insurance; it is structured as an innovative performance payment and strategic purchasing scheme whose main objectives are to** (a) improve the quality of health services, and (b) help reach the Millennium Development Goals, which are to reduce maternal morbidity and mortality rates. Although the World Bank and the Argentine Ministry of Health had intended to conduct an impact evaluation of the Plan in all provinces, they encountered difficulties initially in data collection and in the preparation of the baseline. An important lesson learned by the Bank is to allocate additional resources for technical assistance, which accompanies the process of design and basic quality control during the analysis of the impact evaluation.

52. **A preliminary evaluation, using administrative data from the Misiones and Tucumán Provinces,[2] was conducted to estimate the Plan's impact on the use of**

2. Sebastián Martinez et al. 2010.

health services and of health outcomes. The study found that, among the control group, the program increased the probability of a first prenatal care visit before week 13 of pregnancy by 8.5 percent and before week 20 of pregnancy by 18 percent. Program beneficiaries increased the number of prenatal checkups by 0.5 visits, or 17 percent. Pregnant women also benefited from an improvement in the quality of care, measured by increases in the likelihood of vaccinations and ultrasounds. The improvement in the quantity and quality of services translated into healthier births, including an increase in average birth weight of 69.5 grams (a 2 percent increase over the control group), a decrease of 26 percent in the likelihood of children born with very low birth weight (under 1500 grams), and a drop in neonatal mortality of 1.9 percent. Finally, for children under five years, the program raised the likelihood of well-baby checkups, required by the program. These results indicate positive outcomes during the program's first years of operation, and also suggest a promising model of incentives to be considered for other priority areas of the Argentine health care system.

5. LESSONS LEARNED

5.1 LESSONS LEARNED FOR NEW RESULTS-BASED FINANCING HEALTH OPERATIONS

53. **Valuable lessons can be extracted from the Plan Nacer Program, which can be useful when designing future health-sector operations in Argentina and elsewhere.** The lessons learned during both Phase I and II are reflected in the design of the new Provincial Public Health Insurance Development Project, which will be implemented soon. The main lessons are as follows:

54. **Context matters.** Undoubtedly, the economic and social conditions in the aftermath of the 2001–02 crisis provided a unique window of opportunity to reform health care delivery and financing and respond to the crisis. Sharp increases in infant mortality rates, particularly in the Northern provinces, were not only an indicator of grave social conditions, but also a political stigma. Thus, the additional financial support provided through the project was particularly attractive at a time when provincial financial resources were insufficient to respond to health challenges. Strong national-level leadership and a sound project design simultaneously provided momentum to

profoundly change the delivery of primary health care services and financing at the provincial level in response to the health challenges exacerbated by the crisis. The rapidly improving macroeconomic conditions and political stability that prevailed throughout the life of the project also contributed to its smooth implementation.

55. **Government ownership and leadership are fundamental for project success**. The design of Plan Nacer benefited from strong ownership of the national Ministry of Health. In particular, the Argentine Minister of Health's close involvement in the design process and his efforts to champion the project at the provincial level were critical to its success. Support for the project waned under his successor, particularly during 2008, but it was gradually restored and remained strong throughout thereafter. Ownership and support within provincial health ministries varied across provinces. Not surprisingly, the project had the greatest impact in provinces where the overall strategy was closely related to the vision of provincial health authorities and, thus, the project was a tool to carry out the province's own health policy agenda. The project's vision is to develop provincial public health insurance that incorporates incentives and results-based financing and supports the provision of an explicit package of health services, to implement the nominalization of users in a data system in alignment with the Ministry of Health federal policies. It may be argued that the project model creates a separated risk pool and a separate benefit package and that this model, therefore, only further fractures the risk pool. However, the project aims to increase the effectiveness of provincial public health insurance in terms of quality and health targets. The plan makes explicit the provision of health services, introducing incentives and payments for performance mechanisms based on the existing provincial and federal institutional arrangements. As a result, the Ministry of Health considers the Plan Nacer an effective instrument to promote changes in the behavior of health providers and the provincial Ministries of Health management toward results.

56. **Adaptable Program Lending (APL) can be a powerful learning tool**. The choice of an APL as the lending instrument allowed the project design to be tested in the Northern provinces. Additionally, the incorporation of the preliminary lessons into

practices and norms served to guide (a) the delivery of services, (b) the financing regime, and (c) institution building in the APL-II, which expanded the program to the remaining provinces.

57. **The correct combination of lending instruments is crucial to consolidate complex reform processes**. Plan Nacer's success was partly due to the parallel and well-coordinated implementation of a health sector adjustment loan, the Provincial Maternal–Child Health Sector Adjustment Loan (PMCHSAL). While the APL operation provided the technical assistance needed to advance the Ministry of Health's reform efforts at the provincial level, PMCHSAL's stronger financial incentives (that is, US$750 million) provided the momentum to overcome resistance at both the national and provincial levels.

58. **Under a federal system, provincial participation is pivotal for health service delivery**. The project's design effectively captured the critical role of provincial governments in providing health care to the poor under Argentina's federal system. Thus, the project explicitly identified mechanisms to strengthen the role of provincial governments while at the same time respecting their autonomy. Given their strategic importance, the lack of adequate technical and institutional capacity in some provinces posed a significant challenge at early stages of implementation.

59. **Direct targeting increases the project's reach among the intended population although pro-poor challenges remain.** The project's design and implementation strategy included clear targeting criteria, both in terms of participating provinces and in terms of eligible populations. By focusing on Argentina's Northern provinces, the Plan maximized the project's poverty impact, since these are the poorest areas in the country, and, targeting uninsured women and children ensured that the most vulnerable groups within this population would be reached. In this context, the project implementation did not require the use of complex targeting tools.

60. **However, targeting the poorest among the poor is still a challenge**. While health coverage is a universal right, the poorest population is unable to utilize basic health services due to demand and supply factors that exist in the poorest and most remote areas. Vulnerable groups are underserved as they are not aware of the health benefits they are entitled to and that are available to them. Therefore, the Maternal-Child Health Investment Project (MCHIP) sought to guarantee access to an explicit package of basic health care through a program that focuses on uninsured households. The members of these households are likely to be poor, unemployed, or working in the informal sector. The MCHIP targets mothers and children, who are the most vulnerable groups. The MCHIP envisioned a communication strategy to reach the target population and foster health service demand. However, this communication strategy was only partially executed as the communication campaigns were taken up entirely by the Government Communication Unit, without participation of the Ministry of Health. Thus, the program was not able to adequately reach eligible populations, especially indigenous ones. Despite government efforts to reach excluded groups, indigenous people targeted by the program represented only 1.2 percent of the total enrollment, while this group makes up around 2 to 3.5 percent of the total population. The next lending operation supported by the World Bank will include a set of indicators to track the indigenous population's enrollment as well as reductions in intra-jurisdictional inequity in the access to health care services. In addition, it will support a broad range of actions and activities to ensure that screening, enrollment, and services are provided in ways that meet the special health needs of these groups. For instance, the ethnicity and primary language of users will be included in the enrollment forms to aid data disaggregation, monitoring, provision of health services, and access to services by targeted beneficiaries.

61. **Smart sequencing maximizes the chances of project success.** The project structure reflected a carefully sequenced design that would gradually expand at various levels over the medium term. Geographically, it began with the poorest provinces, which have higher concentrations of poverty and poor health indicators, and expanded to the rest of the country. With regard to services, it began by supporting a basic health care package aimed at reducing infant mortality caused by "soft" factors, and later expanded

to include more complex pathologies aimed at reducing "hard" causes of infant mortality, such as cardio-related ones. As for beneficiaries, the Plan's target populations were uninsured pregnant women and children. The target population will be expanded to include adolescents under the Provincial Health Insurance Development Project, which is now being prepared.

62. **Expanding access to infant and maternal health care is crucial for both efficiency and equity objectives.** The high rate of return on the Plan's investments points to its economic efficiency with regard to infant and maternal health care. In addition, the reductions achieved in morbidity and mortality are crucial to enhancing equity over the medium and long terms, as these address the root causes of ex ante and ex post inequality (that is, inequality of opportunity and income, respectively).

63. **A sound results-oriented system of incentives is vital to successful project implementation and, more importantly, to behavior modification.** The project's strong results-oriented system of incentives was essential to its success. Disbursements to provincial governments were tied to their performance with respect to achieving the outputs and intermediary outcome goals (for example, the proportion of eligible pregnant women receiving early prenatal care and of eligible newborns receiving high scores in the post delivery neonatal evaluation). In turn, disbursements to health care providers were based on the service fees for specific outputs (for example, routine checkups, vaccinations, and normal and cesarean delivery procedures) to eligible recipients, and on the way in which they were reported. The implementation experience indicates that Bank financing should be closely linked to results, outputs (actual delivery of services), and, if possible, outcomes (improved final or intermediary health indicators). Also, given the dynamic nature of payment mechanisms, it is important that the results-oriented framework be flexible.

5.2. PROJECT-SPECIFIC LESSONS

64. **There are trade-offs between expediency and institutional arrangements.** Separate project executing units were established at the national and provincial levels

with full responsibility for implementation: the UEC and UGSPs, respectively. While these arrangements ensured a more expedient process, they also could have isolated Plan Nacer from the national and provincial health ministries. Although this seems to have been true during the early stages, the UEC at the national level is now fully integrated with those areas of the Ministry of Health where overlap exists, such as the Maternal and Infancy Directorate. Further, the Plan has become an important tool for these Ministry of Health areas to promote national policies at the provincial level. The degree to which UGSPs have been incorporated within provincial bureaucracies depends on whether provincial health authorities see the Plan as a national program or as an instrument through which to conduct their own health policies. Clearly, the program is more likely to be effective and sustainable in provinces that see it as integrated with their own policies.

65. **Monitoring and evaluation (M&E) instruments cannot be incidental, particularly with projects that have output-based disbursements.** As disbursements to provincial governments were directly linked to achieving specific outcomes in relation to the ten tracers, it was critical to develop a thorough M&E process to effectively review their effect from the start. Thus, introducing an additional independent audit to verify the reported achievements at both the provincial and health care provider levels helped the program succeed. Also, impact studies were developed at the design stage, which helped document valuable lessons.

66. **Reforms introduced by Plan Nacer are demanding, both technically and institutionally.** Implementation has required substantial technical assistance from the UEC to both provincial units and health care providers. It would, however, have been desirable for UGSPs to play a more active role in providing technical assistance to health care providers within each province. The UEC was also crucial in disseminating information about the Plan throughout the country. Finally, the project required intense policy dialogue and technical supervision by the Bank throughout implementation.

67. **The Plan offered great potential for economies of scale and cross-fertilization.** The Plan provides the opportunity to develop management tools at the national level that can be applied in the provinces to support the program's implementation, thus capitalizing on potential economies of scale and easing the institutional burden on provinces that use them. Likewise, projects such as this, where implementation is occurring simultaneously in many provinces, can serve as incubators, fostering innovative solutions for common problems. The ultimate impact, however, will depend on government recognition of the value of the innovations, their potential for replication, and their dissemination among participants.

68. **Ensuring the protection of individual privacy and sensitive information is still a challenge.** One of the Plan's main contributions has been to develop a beneficiary database with health and socioeconomic information. As the Plan continues, it will be crucial to develop a sound institutional framework for these databases, minimizing the risk of illegitimate use of the information.

6. CONCLUSIONS

69. **Beyond contributing to health outcomes and coverage, Plan Nacer has positively altered the relationship between citizens and the state, and between provinces and the national government**. By moving from a traditional health care system based on inputs and fixed budgets to one geared around outputs and results, the Plan gave beneficiaries more influence with respect to service providers, enhanced transparency, increased the accountability of all actors in the system, and improved public performance and productivity. The program also created incentives that encourage each level of the health care system to take steps to improve coverage, quality, and results. Legally binding management agreements between the national Ministry of Health and the provincial governments, and between provincial governments and health care providers define various parties' respective roles and responsibilities and hold them accountable. Likewise, besides offering financial incentives, the Plan incorporated innovative auditing approaches: internal audits verify that the work was performed, while independent external auditors provide detailed reports to the national

Ministry of Health every two months. The feedback from the audits and management reports then helps correct any mismanagement, reduces bottlenecks, and improves the way the program functions.

70. **The program has helped empower beneficiaries by informing them and encouraging their participation through public awareness campaigns, mailings, and interactions with staff at the health facilities**. Beneficiaries learn about the specific services that are available, their rights, and how to monitor children's health—from the staff as well as through radio, newspapers, and television. At the same time, staff has reached poor beneficiaries in isolated areas with mobile teams from affiliated health providers. Plan Nacer services are explicitly characterized as rights; thus, they have helped create (among users and the general public) a sense of social accountability that complements the formal accountability obtained through the audits.

71. **Plan Nacer's new mechanisms have locked in many important institutional changes and extended them beyond the scope of the program to other parts of the health sector.** For example, the availability of detailed and reliable clinical and program data has been important for M&E purposes. Effective participation and active communication between national and provincial governments have made policy-making and program implementation more efficient when compared to traditional programs, which only finance purchases of inputs without focusing on results or enhancing accountability and transparency. Insurance-based billing and reimbursements not only extended services to the poor, but also enhanced governance and financial independence of health care providers compared to others outside the program. Further, providers can manage the resources transferred through the FFS from the provincial ministries and choose how best to use those resources. Finally, the results-based financing led by the national Ministry of Health has improved its stewardship and governance of provincial governments in health care delivery. All these changes were funded by just over US$50 million in annual investments from World Bank loans from 2004 to 2010. The Government will continue developing the provincial health insurance program with a new US$400 million loan approved by the Board of the World Bank in 2011.

72. **The program has demonstrated that inequities in access to and use of health care can be reduced, accountability of public services can be improved, and social financing can be more effective through programs with defined services, output-based funding, and a focus on target populations.** Argentina has already applied this approach to the public health sector program, and the model, with Bank support, has been adapted for health or other social services by the Dominican Republic, Guatemala, and Panama. Argentina has also discussed its experience with Egypt, South Africa, Turkey, and Ukraine, among other countries.

7. THE WAY FORWARD

73. **The World Bank continues to support Argentina in its efforts to achieve the Millennium Development Goals and its own national health goals**. It is now supporting efforts to update and improve the basic health package and to expand Plan Nacer to cover other population groups and services, especially youth 6 to 19 years old and adult women. The Bank has also been providing technical assistance to improve the Ministry of Health's leadership and management capacity.

74. **The program has promoted major institutional improvements including the development of information systems, accountability, and transparency, as well as a focus on results.** Since the Plan's services influence maternal and child health, the program has also likely contributed to improved health outcomes. A rigorous impact evaluation is still underway, but a recent analysis of data from Misiones and Tucumán Provinces found that the program increased the probability of a first prenatal care visit before the 13th week of pregnancy as well as the number of prenatal checkups (when compared to a control group). Pregnant women have benefited from the improved quality of care, infants have higher average birth weights, and neonatal mortality has been reduced. The program also improved the likelihood of compliance with well-baby checkups required by the Ministry. All these results are preliminary evidence that the Plan has had a large effect on child development in the provinces that were analyzed.

75. **In the future, the program will build on its success by** (a) strengthening financial sustainability when the provincial programs expand; (b) improving the links between primary health care centers and hospitals, as well as raising overall health care standards; (c) including a wider range of health services in the program; (d) developing greater incentives at the provincial health facilities; (e) improving procedures to monitor health indicators under the national monitoring system; and (f) supporting efforts to improve maternal and child health indicators. These processes will be supported through a new lending operation in support of a national health program called the Provincial Public Health Insurance Development Program. Just as lessons learned during Plan Nacer's Phase I and II were reflected in the design of the new operation, lessons will provide support to overcome Plan Nacer's main challenges, especially those related to achieving tracer targets (that is, quality and quantity of services), improving information and management systems, and increasing the use of information generated by the program for policy-making purposes.

ANNEX 1: ADDITIONAL INFORMATION ON PLAN NACER

Table 6. Total Transfers from National Government to Phase I and II Provinces

(To November 2011; in Arg$)

PROVINCE	Monthly Transfers in November 2011	Total Transfers in November 2011	Accrued Monthly Transfers to November 2011	Accrued Supplementary Transfers to November 2011	Accrued Total Transfers to November 2011
Catamarca	$ 133.529,90	$ 133.529,90	$ 7.857.380	$ 2.488.976	$ 10.346.355
Corrientes	$ 467.534,34	$ 467.534,34	$ 31.880.135	$ 16.311.927	$ 48.192.062
Jujuy	$ 307.027,14	$ 307.027,14	$ 17.338.920	$ 8.707.870	$ 26.046.791
Salta	$ 498.483,86	$ 498.483,86	$ 28.121.236	$ 10.568.909	$ 38.690.145
Santiago del Estero	$ 508.203,78	$ 508.203,78	$ 35.960.788	$ 14.342.554	$ 50.303.343
Tucumán	$ 688.531,62	$ 688.531,62	$ 50.868.614	$ 30.869.864	$ 81.738.478
Chaco	$ 571.535,58	$ 571.535,58	$ 38.624.776	$ 20.197.805	$ 58.822.581
Formosa	$ 287.920,50	$ 287.920,50	$ 18.665.853	$ 8.709.023	$ 27.374.876
Misiones	$ 569.807,70	$ 569.807,70	$ 39.335.473	$ 20.064.732	$ 59.400.205
Sub Total APL I	$ 4.032.574,42	$ 4.032.574,42	$ 268.653.175	$ 132.261.660	$ 400.914.835
CABA	$ 239.068,62	$ 239.068,62	$ 2.739.011	$ 596.739	$ 3.335.750
Buenos Aires	$ 4.335.217,60	$ 4.335.217,60	$ 114.528.981	$ 29.290.378	$ 143.819.359
Córdoba	$ 956.467,26	$ 956.467,26	$ 41.564.617	$ 12.412.553	$ 53.977.170
Entre Ríos	$ 414.805,44	$ 414.805,44	$ 17.242.889	$ 4.573.760	$ 21.816.649
La Rioja	$ 132.982,50	$ 132.982,50	$ 6.284.803	$ 2.380.379	$ 8.665.182
Mendoza	$ 589.642,62	$ 589.642,62	$ 21.360.755	$ 7.472.530	$ 28.833.285
San Juan	$ 288.789,20	$ 288.789,20	$ 9.560.159	$ 3.196.921	$ 12.757.080
San Luís	$ 132.197,10	$ 132.197,10	$ 5.491.108	$ 2.074.724	$ 7.565.832
Santa Fé	$ 581.564,90	$ 581.564,90	$ 11.600.748	$ 2.310.940	$ 13.911.688
Chubut	$ 103.265,82	$ 103.265,82	$ 5.175.670	$ 2.076.503	$ 7.252.173
La Pampa	$ 93.534,00	$ 93.534,00	$ 4.118.007	$ 1.544.199	$ 5.662.206
Neuquén	$ 150.753,96	$ 150.753,96	$ 3.956.490	$ 1.006.727	$ 4.963.217
Río Negro	$ 160.457,22	$ 160.457,22	$ 6.094.685	$ 2.217.927	$ 8.312.611
Santa Cruz	$ 39.484,20	$ 39.484,20	$ 574.573	$ 92.968	$ 667.541
Tierra del Fuego	$ 23.661,96	$ 23.661,96	$ 1.211.538	$ 442.287	$ 1.653.825
Sub Total APL II	$ 8.241.892,40	$ 8.241.892,40	$ 251.504.033	$ 71.689.536	$ 323.193.569
Total	$ 12.274.466,82	$ 12.274.466,82	$ 520.157.208	$ 203.951.196	$ 724.108.404

Source: Argentina Ministry of Health 2011.

Table 7. Tracers Coverage Rate

(From May to August 2011)

NOA		Tracer 1	Tracer 2	Tracer 3	Tracer 4	Tracer 5	Tracer 6	Tracer 7	Tracer 8	Tracer 9	Tracer 10	Number of Tracers achieved (*)	Total % of Tracer rewards (*)	Supplementary Transfer (*)
CATAMARCA	Cases	515	883	835	758	16	955	896	594	7.434	366	8	28,24%	$ 243.721
	Coverage %	55%	100%	95%	81%	112%	108%	102%	22%	40%	101%			
	Reward %	2,18%	4,00%	3,56%	2,50%	4,00%	4,00%	4,00%	0,00%	0,00%	4,00%			
	Denominator	980	980	980	980	15	980	980	2.940	20.828	362			
JUJUY	Cases	1.666	2.105	2.017	1.933	35	1.468	2.086	625	21.432	269	9	30,50%	$ 625.552
	Coverage %	76%	102%	98%	89%	108%	71%	101%	10%	68%	100%			
	Reward %	2,91%	4,00%	3,81%	2,88%	4,00%	2,50%	4,00%	0,00%	2,40%	4,00%			
	Denominator	2.293	2.293	2.293	2.293	34	2.293	2.293	6.878	34.778	269			
SALTA	Cases	3.326	3.610	3.456	2.747	78	2.908	3.047	5.117	14.522	183	7	22,62%	$ 713.502
	Coverage %	80%	91%	87%	66%	124%	73%	77%	43%	24%	101%			
	Reward %	3,03%	3,26%	2,96%	0,00%	4,00%	2,59%	2,78%	0,00%	0,00%	4,00%			
	Denominator	4.402	4.402	4.402	4.402	66	4.402	4.402	13.207	65.888	181			
SANTIAGO DEL ESTERO	Cases	1.943	3.176	3.106	2.966	41	2.056	3.012	2.957	32.968	312	8	24,63%	$ 847.250
	Coverage %	54%	93%	91%	82%	100%	60%	88%	29%	57%	101%			
	Reward %	2,13%	3,39%	3,22%	2,53%	4,00%	2,11%	3,25%	0,00%	0,00%	4,00%			
	Denominator	3.806	3.806	3.806	3.806	43	3.806	3.806	11.417	64.160	310			
TUCUMÁN	Cases	2.945	4.434	4.170	3.691	59	3.665	4.137	12.949	62.895	326	10	36,31%	$ 1.712.896
	Coverage %	73%	117%	110%	92%	104%	97%	109%	114%	73%	101%			
	Reward %	2,81%	4,00%	4,00%	3,12%	4,00%	3,77%	4,00%	4,00%	2,61%	4,00%			
	Denominator	4.219	4.219	4.219	4.219	60	4.219	4.219	12.656	96.106	323			

*Last nonaudited figures.

NEA		Tracer 1	Tracer 2	Tracer 3	Tracer 4	Tracer 5	Tracer 6	Tracer 7	Tracer 8	Tracer 9	Tracer 10	Number of Tracers achieved (*)	Total % of Tracer rewards (*)	Supplementary Transfer (*)
CORRIENTES	Cases	2.386	3.136	2.932	3.109	61	2.287	3.165	2.624	37.193	284	9	33,22%	$ 1.047.790
	Coverage %	84%	117%	109%	109%	121%	85%	118%	33%	81%	100%			
	Reward %	3,24%	4,00%	4,00%	4,00%	4,00%	3,00%	4,00%	0,00%	2,98%	4,00%			
	Denominator	2.989	2.989	2.989	2.989	53	2.989	2.989	8.967	51.325	284			
CHACO	Cases	2.859	4.216	4.045	3.827	40	3.402	4.227	7.218	40.503	145	9	31,70%	$ 1.239.442
	Coverage %	77%	121%	116%	104%	58%	97%	121%	69%	56%	101%			
	Reward %	2,95%	4,00%	4,00%	4,00%	2,26%	3,82%	4,00%	2,67%	0,00%	4,00%			
	Denominator	3.884	3.884	3.884	3.884	73	3.884	3.884	11.651	80.652	143			
FORMOSA	Cases	1.397	2.042	1.912	1.880	52	1.599	2.065	3.918	6.264	229	9	27,62%	$ 538.667
	Coverage %	60%	93%	87%	81%	109%	73%	94%	59%	19%	99%			
	Reward %	2,35%	3,40%	2,95%	2,47%	4,00%	2,56%	3,62%	2,33%	0,00%	3,94%			
	Denominator	2.444	2.444	2.444	2.444	50	2.444	2.444	7.333	37.488	231			
MISIONES	Cases	3.201	3.873	3.635	3.842	59	2.700	3.909	7.592	45.255	391	10	36,56%	$ 1.378.231
	Coverage %	95%	122%	114%	114%	119%	85%	123%	79%	75%	123%			
	Reward %	3,77%	4,00%	4,00%	4,00%	4,00%	2,99%	4,00%	3,07%	2,73%	4,00%			
	Denominator	3.537	3.537	3.537	3.537	52	3.537	3.537	10.611	66.833	318			

*Last nonaudited figures.

CENTRO		Tracer 1	Tracer 2	Tracer 3	Tracer 4	Tracer 5	Tracer 6	Tracer 7	Tracer 8	Tracer 9	Tracer 10	Number of Tracers achieved (*)	Total % of Tracer rewards (*)	Supplementary Transfer (*)
CABA	Cases	1.645	3.712	3.516	2.944	0	5	3.750	0	0	55	6	21,67%	244314
	Coverage %	48%	114%	108%	86%	0%	0%	115%	0%	0%	100%			
	Reward %	2,38%	4,00%	4,00%	3,29%	0,00%	0,00%	4,00%	0,00%	0,00%	4,00%			
	Denominator	3.612	3.612	3.612	3.612	28	3.612	3.612	10.836	56.302	55			
BUENOS AIRES	Cases	24.760	31.216	29.324	29.851	426	2.299	30.925	15.455	21.063	1.996	7	25,95%	$ 7.002.347,92
	Coverage %	74%	98%	92%	89%	100%	7%	97%	16%	5%	101%			
	Reward %	3,00%	3,93%	3,68%	3,45%	4,00%	0,00%	3,89%	0,00%	0,00%	4,00%			
	Denominator	35.299	35.299	35.299	35.299	447	35.299	35.299	105.896	505.104	1.978			
CÓRDOBA	Cases	4.371	4.544	4.291	2.915	73	1.491	3.783	4.682	44.915	806	8	24,21%	$ 1.521.851,28
	Coverage %	73%	80%	75%	48%	97%	26%	66%	27%	49%	130%			
	Reward %	2,97%	3,15%	2,98%	2,10%	3,89%	0,00%	2,78%	0,00%	2,34%	4,00%			
	Denominator	6.340	6.340	6.340	6.340	79	6.340	6.340	19.019	101.135	621			
ENTRE RÍOS	Cases	1.104	2.477	2.333	2.098	19	1.144	2.449	2.103	2.534	254	8	25,72%	$ 716.566,40
	Coverage %	42%	100%	94%	80%	53%	46%	99%	28%	7%	100%			
	Reward %	2,24%	4,00%	3,76%	3,02%	2,48%	2,28%	3,96%	0,00%	0,00%	3,98%			
	Denominator	2.750	2.750	2.750	2.750	38	2.750	2.750	8.251	43.074	255			
SANTA FÉ	Cases	2.553	2.646	2.506	1.649	151	0	2.622	272	95	731	6	16,55%	$ 595.935,88
	Coverage %	38%	42%	40%	25%	194%	0%	42%	1%	0%	101%			
	Reward %	2,15%	2,06%	2,12%	0,00%	4,00%	0,00%	2,22%	0,00%	0,00%	4,00%			
	Denominator	6.982	6.982	6.982	6.982	82	6.982	6.982	20.945	93.786	723			

*Last nonaudited figures.

CUYO		Tracer 1	Tracer 2	Tracer 3	Tracer 4	Tracer 5	Tracer 6	Tracer 7	Tracer 8	Tracer 9	Tracer 10	Number of Tracers achieved (*)	Total % of Tracer rewards (*)	Supplementary Transfer (*)
LA RIOJA	Cases	514	763	751	463	12	268	810	156	5.011	245	8	27,34%	$ 229.964,31
	Coverage %	67%	106%	104%	61%	105%	37%	112%	7%	35%	100%			
	Reward %	2,84%	4,00%	4,00%	2,45%	4,00%	2,05%	4,00%	0,00%	0,00%	4,00%			
	Denominator	802	802	802	802	12	802	802	2.407	16.108	245			
MENDOZA	Cases	1.922	4.037	3.790	4.022	72	606	3.939	3.848	4.268	371	7	24,04%	$ 934.384,29
	Coverage %	41%	91%	85%	86%	140%	14%	89%	29%	6%	105%			
	Reward %	2,21%	3,62%	3,39%	3,29%	4,00%	0,00%	3,53%	0,00%	0,00%	4,00%			
	Denominator	4.934	4.934	4.934	4.934	54	4.934	4.934	14.802	74.417	355			
SAN JUAN	Cases	906	1.999	1.953	1.969	39	1.401	1.753	493	5.435	172	8	27,46%	$ 525.665,00
	Coverage %	41%	96%	94%	90%	124%	67%	84%	8%	19%	100%			
	Reward %	2,22%	3,84%	3,75%	3,49%	4,00%	2,81%	3,35%	0,00%	0,00%	4,00%			
	Denominator	2.308	2.308	2.308	2.308	33	2.308	2.308	6.924	32.552	172			
SAN LUÍS	Cases	501	631	610	531	4	381	600	948	5.416	115	10	25,30%	$ 227.000,76
	Coverage %	54%	72%	70%	58%	32%	44%	69%	36%	40%	88%			
	Reward %	2,53%	2,90%	2,85%	2,36%	2,01%	2,22%	2,83%	2,03%	2,12%	3,45%			
	Denominator	970	970	970	970	13	970	970	2.909	15.003	130			

*Last nonaudited figures.

PATAGONIA		Tracer 1	Tracer 2	Tracer 3	Tracer 4	Tracer 5	Tracer 6	Tracer 7	Tracer 8	Tracer 9	Tracer 10	Number of Tracers achieved (*)	Total % of Tracer rewards (*)	Supplementary Transfer (*)
CHUBUT	Cases	702	829	789	678	9	691	665	1.271	6.343	105	10	30,48%	$ 214.547,78
	Coverage %	72%	90%	85%	69%	86%	75%	72%	46%	48%	99%			
	Reward %	2,95%	3,57%	3,39%	2,70%	3,44%	2,99%	2,91%	2,26%	2,31%	3,96%			
	Denominator	1028	1028	1028	1028	11	1028	1028	3084	14687	106			
LA PAMPA	Cases	408	642	615	605	6	502	658	785	4292	73	10	30,52%	$ 191.712,42
	Coverage %	56%	93%	89%	83%	53%	73%	96%	38%	43%	100%			
	Reward %	2,57%	3,72%	3,56%	3,16%	2,48%	2,95%	3,82%	2,07%	2,19%	4,00%			
	Denominator	765	765	765	765	12	765	765	2296	11078	73			
NEUQUÉN	Cases	1012	994	968	848	8	690	962	1020	1556	200	8	23,01%	$ 223.510,24
	Coverage %	69%	71%	69%	57%	70%	49%	69%	24%	8%	100%			
	Reward %	2,87%	2,86%	2,83%	2,36%	2,89%	2,36%	2,84%	0,00%	0,00%	4,00%			
	Denominator	1554	1554	1554	1554	12	1554	1554	4663	22043	200			
RÍO NEGRO	Cases	803	1031	1002	705	7	346	760	90	762	204	7	18,98%	$ 193.584,06
	Coverage %	56%	76%	73%	49%	41%	25%	56%	2%	4%	92%			
	Reward %	2,56%	2,99%	2,94%	2,11%	2,21%	0,00%	2,54%	0,00%	0,00%	3,63%			
	Denominator	1517	1517	1517	1517	18	1517	1517	4551	21671	221			
SANTA CRUZ	Cases	70	231	216	233	0	16	226	209	0	41	5	13,50%	$ 31.350,85
	Coverage %	16%	55%	51%	52%	0%	4%	54%	16%	0%	100%			
	Reward %	0,00%	2,41%	2,39%	2,21%	0,00%	0,00%	2,49%	0,00%	0,00%	4,00%			
	Denominator	469	469	469	469	5	469	469	1408	5743	41			
TIERRA DEL FUEGO	Cases	118	131	124	129	0	16	115	92	761	17	6	17,51%	$ 29.673,83
	Coverage %	60%	70%	66%	65%	0%	9%	61%	16%	30%	100%			
	Reward %	2,66%	2,83%	2,76%	2,58%	0,00%	0,00%	2,68%	0,00%	0,00%	4,00%			
	Denominator	208	208	208	208	2	208	208	624	2781	17			

Source: Argentina Ministry of Health 2011.
*Last nonaudited figures.

ANNEX 2: PLAN NACER PRESENTATIONS

Explanation of program with interviews (in Spanish with English subtitles)

http://www.youtube.com/worldbank#p/a/u/2/GAyF-jtnz_4

Explaining the Plan Nacer project

http://www.youtube.com/watch?v=UvB7Kcjq1NY&translated=1

http://www.youtube.com/watch?v=0JerZom6efY&translated=1

A short advertisement encouraging use of the system (using iconic Argentine football imagery)

http://www.youtube.com/watch?v=oriLLjBgwww&feature=related

Provincial health ministry messages

http://www.youtube.com/watch?v=bmVPEs8SJXA&feature=related

http://www.youtube.com/watch?v=_sF81FsYuX8&feature=related

ANNEX 3: UMBRELLA AGREEMENT FOR PARTICIPATION IN THE PROVINCIAL MATERNAL AND CHILD HEALTH INSURANCE PROJECT (*CONVENIO MARCO*) BETWEEN THE NATIONAL AND A PROVINCIAL GOVERNMENT

BACKGROUND

Decree No. 2724 of December 31, 2002, adopted by a General Agreement of the Cabinet of Ministers (published in the *Official Gazette* of Jan 9, 2003), established the Maternal and Child Health Insurance to provide comprehensive and universal medical, assistance, and social benefits. The Maternal and Child Health Insurance is under the scope of the national Ministry of Health, which coordinates all actions and programs in order to optimize the use of resources and improve the coverage and the quality of care in the context of the Primary Health Care strategy. section 3 of Decree no. 2724 provides that the insurance shall be implemented gradually, and invites the provinces to take part in the initiative based on the criteria and schedule to be determined by the Ministry of Health.

According to section 4 of the referred Decree, the Maternal and Child Health Insurance shall be financed with the following resources: (1) budget allocations to be determined in the national budget for fiscal year 2003, (2) contributions to be assigned made by the project-participating provinces, (3) funds from credits of international financial institutions to be granted or reallocated for that purpose, (4) grants, contributions, or any other resources supplied to that end.

The recitals of Decree No. 435 of February 28, 2003, (published in the *Official Gazette* of March 3, 2003) expressed the need to increase the credits assigned to the Ministry of Health in order to initiate the implementation of the Maternal and Child Universal Health Insurance established under Decree No. 2724/02, adopted by a general agreement of the Cabinet of Ministers.

On March 22, 2003, the national minister of health, the health ministers of the provinces, and the Autonomous City of Buenos Aires signed the Federal Health Agreement (*Acuerdo Federal de Salud*) in the historical House of the San Nicolás de los Arroyos Constitutional Agreement, declaring their firm will to assign priority, among the public policies in their own jurisdictions and for the coming years, to the “Performance of joint

actions undertaken between the NATION, the Provinces, and the Government of the Autonomous City of Buenos Aires, intended to reduce country's child mortality rate by 25 percent and the maternal mortality rate by 15 percent on the 2002 indicators, over the next five years," and to the "Implementation of a Maternity and Child National Insurance program focusing on comprehensive health care for pregnant women and children under six years of age, as a means to accomplish the goal of the foregoing paragraph," (see clause 2: Maternal and Child Health).

Based on this background, on August 15, 2003, the national minister of health issued Resolution no. 198, whose first section provides for the establishment, under the scope of the Secretariat of Health Programs, of a Program for the Creation of Provincial Maternal and Child Health Insurance Plans (Programa para la Creación de Seguros de Maternidad e Infancia Provinciales) in the context of the Maternal and Child Health Insurance, to assist the provinces and the Autonomous City of Buenos Aires in the establishment of local maternal and child health insurance plans through financial and technical support in the development, implementation, and execution of such programs.

Section 5 of Resolution no. 198 approved the guidelines of the Program for the Creation of Provincial Maternal and Child Health Insurance Programs, which is attached as annex I to the resolution and made an integral part thereof. The referred guidelines include a list of health care services, which are defined as Basic Health Care Services (Conjunto Prestacional Básico, CPB), to which the actions of the Project Central Implementation Unit (Unidad Ejecutora Central, UEC*)* created pursuant to section 2 of the resolution must conform.

Pursuant to section 4 of Decree No. 1140/04, the names Programa para la Creación de Seguros de maternidad e Infancia Provinciales (Program for the Creation of Provincial Maternal and Child Health Insurance Plans) and Programa Nacional para la Creación de Seguros de Maternidad e Infancia Provinciales (National Program for the Creation of Provincial Maternal and Child Health Insurance Plans), as used in Resolutions MSN no. 198/03 and no. 656/03, are hereby replaced by the name Provincial Maternal and Child Health Investment Project (Proyecto de Inversion en Salud Materno Infantil Provincial—PISMIP).

On (date), the Board of Directors of the IBRD approved, at the request of the Argentine government, a loan agreement, which was approved by Decree no. (…/..) of (date) (published in the *Official Gazette* of ../../..); the purpose of the loan agreement is to finance Phase II of the project, and it has been executed on (../../../). The IBRD declared the loan effective on (../../..).

Furthermore, on (date) the province has expressed its interest in taking part in the project through a letter of intent applying for inclusion in the project.

This agreement governs the participation of the province (.....) and its relationship with the nation with respect to this project.

FIRST / DEFINITIONS

For the purpose of this Agreement, the terms listed below shall have the following meaning:

Concept	Definition
Bank//IBRD	International Bank for Reconstruction and Development
Registered eligible beneficiary	A registered eligible beneficiary is any individual who, as a member of the eligible population, falls within the PISMIP's specifically defined coverage and who has, on his own initiative or by means of third-party representatives, fulfilled the corresponding SMIP administrative registration process.
CAPS	Primary Health Care Center (Centro de Atención Primaria de la Salud)
COFESA	Federal Health Council (Consejo Federal de Salud)
Annual commitment	Annual agreement between the UEC and a province on the action plans and targets with respect to the tracers, which is effective for one fiscal year or a shorter period if it is the first annual commitment.
Applicable technical conditions	Official technical and quality standards issued by the MSN in connection with the approval of health service providers under the health care service categories, technical regulations, quality standards, and administrative procedures of the project.
Explicit coverage	An individual is considered to have explicit coverage whenever such individual or in case of minors, their father, mother, or guardian is included in the list of active beneficiaries of the National Provincial Health Care Organizations (Obras Sociales Nacionales) or the Provincial Health Care Organizations (Obras Sociales Provinciales); of the PROFE or substitute program; mutual associations; and, in general, of any health care service financing entity registered in official, regular records.
Umbrella	An agreement signed between the nation and an eligible province

Concept	Definition
agreement	whereby the former becomes a participant of the PISMIP. The agreement sets forth the rights and duties of the parties.
SMIP account	A bank checking account denominated in Argentine pesos and managed by the UGSP to which the funds from capitation transfers are transferred and from which all the expenses for the eligible health services are paid.
SMIP-POGE account	A bank checking account denominated in Argentine pesos and managed by the UGSP where the amounts received as reimbursements for other eligible expenses are deposited.
Expenses for eligible services	Any expenses paid from the SMIP account payable for items included in the medical fee schedule.
Per capita base amount	The per capita amount, which is used as the basis to calculate the capitation transfer for SMIP services. The amount equals the initial value plus/minus any adjustments to be defined in the future by the nation and agreed to by the Bank.
MSN	National Ministry of Health
MSP	Provincial Ministry of Health or equivalent agency
NATION	The Argentine national government
NEA	Northeastern Argentine region, consisting of the following provinces: Chaco, Misiones, Formosa, and Corrientes
NOA	Northwestern Argentine region, consisting of the following provinces: Jujuy, Salta, Tucumán, Catamarca, and Santiago del Estero
Medical fee schedule	The list of health care practices and services included as appendix C to the umbrella agreement and where all the services eligible for the SMIP are defined.
OSN	National Health Care Organization
OSP	Provincial Health Care Organization
Other eligible expenses	Expenses paid out of the SMIP-POGE account for the procurement of consulting and communications services acceptable to the project.
Grace period	A period of up to 6 months after the effective date of the loan, as established therein.
Federal health plan (Plan Federal de Salud)	A joint project (nation–provinces) of health policies to be implemented during the 2004–07 period.
PISMIP or Plan Nacer	Provincial Maternal and Child Health Investment Project. Decree no. 1140/04.
Eligible population	Pregnant women up to the end of pregnancy for any reason, and up to 45 days thereafter, and children under 6 years of age, without explicit coverage and with domicile in the participating province.
Authorized service providers	Public and private service providers duly authorized under the applicable technical conditions; such authorized providers are the only health care providers that may bill for services rendered, as included in the medical fee schedule, to the UGSP after execution of a

Concept	Definition
	performance commitment with such UGSP.
Loan	Loan no. (……)—AR granted by the IBRD to the Argentine nation to finance Phase II of the project.
Program	Provincial Maternal and Child Health Insurance Program, component 1 of the project.
Participating province	Any province that executed the umbrella agreement, provided it remains effective. Only participating provinces may have access to the benefits of the project.
APL-eligible province	Provinces belonging to the NOA and NEA regions.
APL2-eligible province	All Argentine provinces and the Autonomous City of Buenos Aires, except the provinces from the NOA and NEA regions.
Provinces	All Argentine provinces and the Autonomous City of Buenos Aires.
PUCO	Single consolidated operational roster (Padrón Único Consolidado Operativo), prepared by the UEC on the basis of the official available explicit coverage rosters.
Operational rules	Set of rules and specific procedures of mandatory compliance for the nation and the PISMIP-participating provinces. The rules are an integral part of the umbrella agreement.
SMIP	Provincial Maternal and Child Health Insurance (Seguro de Salud Materno Infantil Provincial).
Capitation transfer	The capitation transfer for SMIP services. This transfer consists of a monthly transfer and a supplementary transfer payable on a half-yearly or a four-monthly basis, as determined by the UEC.
Supplementary transfer	An amount equal to 40% of the summation of the monthly base transfers for the last four months, multiplied by a coefficient representing the degree of compliance with the previously established variable control targets (tracers).
Monthly transfer	An amount equal to 60% of the monthly base transfer, except during the grace period, when the province shall receive 100% of the monthly base transfer.
Monthly base transfer	The result of multiplying a per capita base amount by the number of registered and validated eligible beneficiaries.
Tracers	Indicators showing the degree of compliance with the PISMIP objectives.
UEC	PISMIP's Central Implementation Unit (Unidad Ejecutora Central) as established under Resolution MSN no. 198/03
UFI-S	International Financing Health Unit
UGSP	Provincial Insurance Implementation Unit (Unidad de Gestión del Seguro Provincial).
Initial value	The initial value of the per capita base amount, set at Arg$15 per month.

SECOND / PARTIES

The Ministry of Health of the Argentine Republic (hereinafter "the nation"), represented herein by the Minister of Health, Dr. (…), with domicile at Avenida 9 de Julio no. 1925 of the City of Buenos Aires, on the one part, and the government of the province of (...) (hereinafter, "the province"), represented in these presents by (...), in his/her capacity as (…), with domicile at (…) of the city of (…), on the other part, respectively, have agreed upon the following terms and conditions:

THIRD / GENERAL REPRESENTATIONS

3.1. The parties warrant that they intend to achieve the general targets of the Plan Nacer aimed at reducing mother and child mortality in the province, enhancing access to health care services and the formal health care coverage of the population, and establishing new schemes for the management, financing and allocation of health care resources.

3.2. The relationship between the parties under the Plan Nacer shall be governed by this umbrella agreement, which contains all the general provisions to which the contracting parties must conform, in addition to the Plan Nacer operational rules. Furthermore, the parties hereby agree to execute, throughout the life of this agreement, the annual commitments, which are to define, among other aspects the common expectations and accountabilities with respect to the policies for the registration of the eligible population, the accomplishment of goals and targets, and any actions designed for the achievement of such goals. These rules shall be construed and interpreted according to the following prevalence order:

- Umbrella agreement
- Operational rules
- Annual commitment

The above instruments shall not be in conflict with Loan Agreement no. (…-AR) and any other applicable Bank regulations or the project's Operations Manual, which is the guideline for project execution. Insofar as the funds used by the nation in implementing this project are financed through the IBRD Loan Agreement, the rules of the Bank shall prevail upon the parties.

FOURTH / DUTIES OF THE PROVINCE

4.1. The province hereby adheres to the Plan Nacer pursuant to the rules, procedures, and regulations established in this agreement and in the operational rules approved by the nation, as amended from time to time in order to adapt them to the needs of the provinces as a whole, provided such amendments are previously agreed upon with the Bank.

4.2. The province hereby undertakes to comply with the regulations and procedures established in the operational rules attached hereto as appendix B, which, in case of doubt or inconsistency, shall be interpreted by the UEC in accordance with its Operations Manual, namely, the PISMIP Execution Guide (Guía de Ejecución). Notwithstanding the foregoing, the province hereby undertakes to comply with the following obligations:

a) Institutional duties
   i) To establish the Provincial Maternal and Child Health Insurance in accordance with the types set forth under the Plan Nacer; thus, it shall enact any provisions required for that purpose;
   ii) To establish and maintain the Plan Nacer Provincial Insurance Implementation Unit in proper operational conditions; the initial structure of the unit is defined in appendix A of this agreement. The unit shall have sufficient authority to conduct and administer the SMIP, to carry out any proceedings as may be required before the Central Implementation Unit (UEC) and to provide any resources necessary for its operation;
   iii) To advocate, before the Provincial Legislative Branch, for the maintenance of the percentage of provincial expenditure in health, excluding any additional resources received from the Plan Nacer, on the basis of the average for the last three years and during the effective term of this agreement. Furthermore, the province shall take steps to assign any resources as may be necessary to maintain the SMIP Plan at the provincial level.

b) Financial management
   i) To send, on a monthly basis, the updated and refined list of registered eligible beneficiaries and any accountability actions required under the operational

rules; these documents will enable the calculation of the fund transfers to be made by the nation;

ii) To open and maintain two SMIP accounts to be exclusively used under the Plan Nacer rules, and to serve written notice on the nation to communicate such opening, including the name of the banking institution, the authorized signatories and the account type and number. SMIP accounts shall enable maintenance of the outstanding balance at the end of each fiscal year for use in the following years;

iii) To use the funds received from the nation exclusively for the specific purposes established under the Plan Nacer.

c) Registration

i) To register only the population that meets the requirements to be considered eligible population under the rules of the Plan Nacer;

ii) To provide any SMIP eligible beneficiaries with an identification card, in compliance with the essential contents determined by the UEC, to which approval it shall be subject;

iii) To reach, at the end of the life of this agreement, a registration rate of at least 80 percent of the eligible population in the province;

iv) Health care services shall be absolutely free of charge for all the eligible beneficiaries registered in the program; no charges of any kind shall be collected by the province or its contractor providers, whether public or private, for such health care services, either directly or through third parties.

d) Service procurement procedure

i) To subscribe management commitments exclusively with duly authorized service providers, according to transparency and free competition criteria;

ii) To implement provider retaining and payment mechanisms, including payments for services under the Plan Nacer medical fee schedule, so that they are consistent with the accomplishment of the project's goals; only services may be procured (either paid by modules or on the basis of individual services), but under no circumstance shall procurement be for the factors of production (for example, inputs, personnel);

iii) To procure, through the UGSP and from the registered service providers—either public or private—any health care services required to ensure that the registered eligible beneficiaries receive the services listed in the *nomenclador* attached as appendix C of this agreement.

e) Procurement

i) Where the province decides to purchase services and/or hire consultants, it shall apply the rules, which are acceptable to the Plan Nacer and which are described in the operational rules.

f) Registration and reporting duties

i) To submit to the UEC the updated Provincial Health Care Organizations list on a monthly basis;

ii) To submit to the UEC the information required under the operational rules on a monthly basis; in particular, the information regarding the updated list of registered eligible beneficiaries and the statements of account for any transfers received;

iii) To prepare and maintain the list of registered eligible beneficiaries duly updated;

iv) To create and maintain an updated database of authorized health care service providers.

g) Planning duties

i) To submit each year an annual work program to the nation, which shall include any actions planned for the development of the SMIP during the following year, the proposed values for the medical fees schedule, the targets to be achieved with respect to the tracers, the expected registration rate, an investment plan including equipment, a technical assistance plan, a training plan and a social communication plan; all of these shall be subject to the budget constraints as previously notified by the nation and the SMIP plan to deliver services to indigenous populations. This work program will be discussed with the UEC and the results of any agreements made shall be established in an annual commitment, to be signed by the UGSP and the UEC;

a model of such commitment is included in appendix D of this umbrella agreement.

h) Cooperation with the nation

i) Facilitate SMIP oversight, audit, monitoring and evaluation tasks in the context of MSN regulations and the applicable technical conditions, to be undertaken by the representatives to be appointed by the nation;

ii) Facilitate the tasks, allocate physical space and equipment to the staff appointed by the nation so that, in the performance of their duties at the UGSP, they can cooperate with the authorities in the annual planning process, in the preparation of management reports, and in the performance of SMIP advisory and general audit tasks;

iii) Use the basic information technology solution provided by the nation.

i) Communication and citizen participation

i) Conduct a broad publicity and communication campaign on the Plan Nacer, targeted at the eligible population and specifically at indigenous populations;

ii) Implement participatory mechanisms for the population, through which the efficiency and effectiveness of the SMIP (...) may be assessed, in addition to evaluating the level of satisfaction of the registered eligible beneficiaries.

j) Counterpart funds

i) The province hereby undertakes to make the counterpart funds available for execution of the program, understanding as such the existing installed capacity and human resources during execution of the SMIP. Additionally, the province undertakes to provide any funds necessary to maintain the program's continuity after the financing from the nation ceases.

k) SMIP continuity

i) Submit to the UEC a plan to guarantee SMIP continuity in the province at least six months prior to the expiration date of this agreement.

FIFTH / DUTIES OF THE NATION

5.1. The nation hereby accepts the participation of the province, and assumes the responsibilities derived from compliance with the goals of the Plan Nacer.

5.2. The nation hereby undertakes as follows:

a) Transfer an amount calculated on the basis of the list of registered eligible beneficiaries, in a decreasing manner, to partially fund the procurement of health care services included in the *nomenclador* procured by the UGSP for the SMIP's registered eligible beneficiaries. This capitated transfer shall be transferred to the SMIP account following the rules established in this agreement's financial rules and the guidelines and methods set forth in the operational rules of this umbrella agreement.
b) Support the institutional development of the MSP in its governing role, by:
    i) Partially financing or providing for the required investments in equipment, training, consultancy, communication, and audit tasks aimed at the creation and implementation of the SMIP and its UGSP; all such initiatives shall conform to the guidelines, methods, and restrictions contained in the operational rules and shall be subject to any budgetary constrains as notified annually by the UEC to the province as a prior step to the annual planning process;
    ii) Provide the province with a basic information technology solution for SMIP administration and management.

SIXTH / FINANCIAL RULES

6.1. The nation shall transfer resources for specific purposes to the province pursuant to the mechanisms established in this agreement and in the operational rules, under the following concepts:

a) Capitated transfers for SMIP services;
b) Transfers to fund technical assistance, equipment, consulting, training, and communication expenses.

6.2 Amount of capitated transfers

6.2.1. Assessment

For the purpose of determining the transfers to the province, the UEC shall monthly assess the monthly base transfer, which results from multiplying the per capita base amount by the number of registered eligible beneficiaries.

The per capita base amount, which is the same for all the participating provinces, has been set at the initial value of Arg$15 per month for each registered eligible beneficiary. The MSN shall review the initial value every year with the Bank, and it will be decided whether it is necessary to modify such amount.

The UEC shall monthly transfer to the province an amount equal to 60 percent of the monthly base transfer, called “monthly transfer.”

Additionally, every four months the nation shall wire to the province a supplementary transfer, which shall be equal to 40 percent of the summation of monthly base transfers for the last four months, multiplied by a coefficient representing the compliance with the previously established variable control targets (tracers).

The evaluation of the tracers’ performance shall indicate, as possible outcomes, compliance or noncompliance with the target; thus, in calculating the supplementary transfer every four months, the following steps shall be followed:

$TC_c = 0.04 * TB_c * NTC$, where:

TC_c = Supplementary transfer corresponding to the four-month period prior to the assessment date

TB_c = Summation of the monthly base transfers determined for the province for each month in the four-month period prior to the assessment date

NTC = Number of tracers accomplished at the time of the assessment for the relevant period

Notwithstanding the foregoing, all monthly base transfers for the grace period shall be remitted to the province at 100 percent; in this case, the supplementary transfer shall not be considered. The grace period is hereby established in this case at (…) calendar days as from the execution of this agreement.

Capitated transfers shall be calculated at 100 percent of the per capita base amount during the first three years as from the date when the province is included in the Plan Nacer. In the fourth year, the transfers shall be calculated at 70 percent of the referred per capita base amount, and in the fifth year they shall be calculated at 40 percent of said amount. In the sixth year, the transfers for the Plan Nacer to the province shall cease. The province shall thereafter sustain the SMIP with its own funds.

6.2.2. Tracers

Tracers are indicators, which enable the monitoring of the project's execution and the development of the Provincial Insurance Programs; they have been defined as follows:

	Health issue addressed	Description of the Tracer in the PROVINCE
I	Early capture of pregnant women	Number of eligible pregnant women (5) with the first prenatal checkup before the 20th week of gestation / Number of eligible pregnant women
II	Effectiveness of birth care and neonatal care	Number of newborns (RN) from eligible mothers with an Apgar score higher than 6 at 5 minutes after delivery / Total number of births from eligible mothers
III	Effectiveness of prenatal care and premature birth prevention	Number of newborns from eligible mothers with a weight at birth over 2,500g / Number of newborns from eligible mothers
IV	Effectiveness of prenatal care and birth attention	Number of births from eligible mothers with VDRL during pregnancy and tetanus vaccine before birth / Total number of births from eligible mothers.
V	Evaluation of the care procedure in	Number of Evaluation of the care procedure in deaths of eligible mothers and children under 1 year of age / Number of deaths of eligible pregnant women and eligible children under

	Health issue addressed	Description of the Tracer in the PROVINCE
	mother and child deaths	one year of age, as applicable.
VI	Immunization coverage	Number of eligible children under 18 months of age with immunization against measles or with the MMR vaccine / Number of eligible children under 18 months.
VII	Sexual and reproductive care	Number of eligible puerperal women who received counseling on sexual and reproductive health within 45 days after childbirth / Number of eligible puerperal women.
VIII	Follow-up of healthy children up to age 1 year	Number of eligible children under 1 year of age with a completed schedule of checkups and weight, height and cephalic perimeter percentiles / Number of eligible children under 1 year
IX	Follow-up of healthy children from 1 to 6 years	Number of eligible children between 1 and 6 years of age with a completed schedule of checkups and weight and height percentiles/ Number of eligible children between 1 and 6 years of age
X	Inclusion of indigenous population	Number of health care service providers servicing eligible indigenous population with trained personnel specialized in health care for such population / Number of service providers servicing eligible indigenous population

The province shall report on the evolution of the tracers to the UEC on a monthly basis**.** The UEC may audit and verify such figures. Furthermore, the concurrent external audit may also verify such values.

The targets established for the tracers, as well as the evaluation methods shall be established in the annual commitments, and their evolution shall be measured every four months, pursuant to the provisions of the operational rules.

If the province has not achieved the agreed rate of compliance in at least four established targets during three consecutive four-month periods, the nation may terminate the umbrella agreement.

6.2.3. Deductions on the capitated transfers and penalties

At the time of settling the capitated transfers, the nation shall deduct or withhold the relevant amounts if the UEC determines, either on its own or through the concurrent external auditors or financial auditor, at its sole discretion, that errors have been incurred, irrespective of whether they have been fraudulent in nature or not.

The table below presents the contemplated cases, the method used to determine the amounts, penalties, and the opportunity for deduction.

Case	Determination of deduction	Penalty	Opportunity
(a) Cases of disbursements from the SMIP account to pay for noneligible expenses.	The deduction shall be equal to the amount unduly disbursed from the SMIP account.	The UEC shall deduct an additional 20% of the amount of the deduction so determined.	Any deductions and penalties shall be deducted from the monthly transfer following detection of the error.
(b) Cases where the UEC, the concurrent auditors, or the financial auditors, at their sole discretion, find errors attributable to the province in the rosters it reported, such as: duplication of registered eligible beneficiaries, registered individuals who do not fall under the eligible population or any other situation, whether fraudulent or not, deriving in a higher transfer calculation than the appropriate number.	The UEC shall deduct, from the invoice to be submitted by the province, an amount equal to that, which results from multiplying the number of erroneously registered individuals by 60% of the per capita base amount. If the deduction belongs to the grace period of supplementary transfers, 100% of the per capita base amount shall be considered in the calculation.	The UEC shall deduct an additional 20% of the per capita base amount for each individual erroneously registered by the province as a penalty.	Any deductions and penalties shall be deducted at the time of settling the transfer where the errors are detected.
(c) Cases where monthly transfers have been made based on the	The deduction shall be equal to the amount erroneously	The UEC shall deduct an additional 20%	Any deductions and penalties shall be deducted from

rosters reported by the province with errors attributable to it, and which have been detected by the UEC or by the concurrent or financial auditors after the transfer.	transferred both in each of the monthly transfers and in any supplementary transfers made from the time the error was incurred until it was detected.	of the per capita base amount for each individual erroneously listed by the province, multiplied by the number of months erroneously transferred as a penalty.	the transfer following the date the error was detected, whether it is a supplementary or a monthly transfer.
(d) Cases where supplementary transfers were made on the basis of erroneous tracer achievement information reported by the province, attributable to it.	The deduction shall be equal to the amount erroneously transferred as detected by the UEC.	The UEC shall deduct an additional 20% of the amount of the deduction so determined.	Any deductions and penalties shall be deducted from the transfer following the date when the error was detected, whether it is a supplementary or a monthly transfer.
(e) Cases of serious noncompliance or other nonserious but repeated events of noncompliance, as detected by the UEC, the concurrent and/or financial auditors, which, in the judgment of the UEC, jeopardize the achievement of the project's goals.	n.a.	The UEC may impose penalties such as warnings, fines of up to 20% of the transfers; suspension of the right to accrue capitated transfers.	The penalties shall be enforced after detection of the event or events of noncompliance giving rise to the sanction. In the event of fines, they shall be deducted from the transfer following the date when the event of noncompliance so penalized was detected.
(f) Cases where the UEC, the concurrent and	n.a.	The fine shall be equal to	The fine shall be applied upon

the financial auditors find that the participating province fails to comply with the maximum term of 50 days for payment to the service providers hired.		0.15% for each day of delinquency, calculated on the late-paid or unpaid amounts.	making the fund transfer following the date when the situation of noncompliance was detected.
(g) Cases where the UEC, the concurrent and the financial auditors find that a contract service provider uses more than 50% of the funds received to pay personnel incentives.	The deduction shall be equivalent to any excess above the 50% limit.	n.a.	The deduction shall be applied upon making the fund transfer following the date when the situation of noncompliance was detected.

Note: n.a. = not applicable.

Regardless of the cases listed above, the UEC shall include, in the settlement of the transfers, any deductions that may be applicable due to errors of any kind, which may have been found and are duly demonstrable, at the time such errors are detected.

6.2.4. Method of payment

Capitated transfers, and any eventual deductions, shall be wired by the nation to the SMIP account within 30 days after the UEC's receipt of the documents required in the operational rules. The province shall receive the capitated transfers in the conditions established in the project and as from the effective date adhesion to the project and while its participation in the project remains effective.

6.2.5. Use of capitated transfers

The province shall be responsible, through the UGSP, of allocating all the funds transferred to it for the purposes and under the restrictions established herein and in the operational rules.

In particular, in the case of capitated transfers, all funds received by the province may be used exclusively to pay for eligible services to the authorized service providers and contractors (whether they be public or private) and to guarantee that the registered eligible beneficiaries receive all the health care services included in the medical fee

schedule, pursuant to the applicable technical conditions; moreover, they shall be subject to the following clauses:

- These funds may only be transferred for billed eligible services, issued by hired service providers who assume responsibility for the services rendered.
- Any service provider billing their services to the UGSP shall be under the contractual duty to comply, to the extent that is appropriate, with the *nomenclador* and the applicable technical conditions. The province is responsible for the quality of the services provided.
- Eligible services are those included in the *nomenclador* as approved by the nation for the project, which is the same for all the participating provinces. The UGSPs shall be free to choose the method to be followed in contracting with service providers, provided they always use mechanisms ensuring transparency and free competition; however, the following limitations shall apply:
  - (i) Any model management commitments signed by the UGSP with the authorized service providers, as well as any subsequent amendment thereto shall have the no objection of the UEC and the Bank.
  - (ii) In no event shall the purchase of factors of production (for example, personnel, supplies) be allowed, but only that of medical services (either by modules or on an individual service basis) as included in the PISMIP single *nomenclador* and according to the values agreed upon in the applicable annual commitment.
  - (iii) The prices paid for each of the eligible services shall be the same for all the service providers hired.
- The UGSP shall ensure that the provider receives the funds within the term established under the operational rules.
- In the event contracted public service providers have no legal capacity to receive and execute PISMIP funds on their own initiative, they can delegate such powers on third parties, provided they are acceptable to the World Bank, under circumstances in which the service provider is fully assured of the decision-making capacity on the use of the funds and the control over the

expenses, without interferences of any kind whatsoever. The use of funds may under no circumstances be delegated in the UGSP of the relevant province. In this case, any third party administrator of funds shall execute a fund management agreement with the provider and the UGSP; the model of such agreement shall have the no objection of the UEC and the Bank.

6.2.6. *Nomenclador (benefit package)*

The *nomenclador* is the same for all participating provinces, and it contains a detail of all health care services, which can give rise to payments from the SMIP account. The *nomenclador* shall be governed by the Rules and Guidelines for Maternal and Child Health Care (Normativas y Guías para la atención de la salud materno-infantil) developed by the national Ministry of Health, through the National Directorate of Maternal and Child Health.

The prices contained in the provincial *nomenclador* shall be defined by each province, after a prior technical discussion and reporting to the UEC and the Bank. Such prices shall become effective as from the date of the Bank's no objection.

6.3. Payments for contracted technical assistance, equipment, training, and communication services

For the establishment of the relevant plans, the province shall determine the requirements of the following components: technical assistance, equipment, training, information systems, and computers and communications. To that end, the province shall evaluate its needs with respect to the project; in order to access the corresponding financing, the procedures established in the operational rules shall be followed.

The payment for these services shall only correspond to expenses for the project's eligible concepts as previously agreed upon with the province under the applicable annual commitment.

SEVENTH / INDEMNITY

The parties hereby agree that the province shall bear liability for any damages arising from medical and/or paramedical practices or from noncompliance or defective compliance with any of the obligations derived from this agreement. The province shall indemnify and hold the nation harmless for any amount payable to a registered eligible beneficiary, its heirs and assignees, or any third parties, and arising from contract or tort liability incurred as a result of noncompliance or defective compliance with any of the services committed under this agreement.

The province hereby agrees to bear full responsibility for any consequences derived from the hiring of personnel, malpractice insurance, agreements with service providers, and any other activities related to the execution of the SMIP.

EIGHTH / CONDITION PRECEDENT

The nation shall under no circumstance make a transfer to finance the SMIP unless the province has previously complied with the conditions precedent established in paragraphs a.i, a.ii and b.ii of section 4.2 hereof.

NINTH / OPERATIONAL RULES FOR THE PARTICIPANT PROVINCES

The province hereby accepts in its entirety the operational rules governing the execution of the Plan Nacer; and the nation reserves the right to introduce changes therein. To become effective, such changes shall be agreed upon with the Bank and duly notified in writing to the province.

TENTH / DISPUTE RESOLUTION

The parties hereby agree that, in the event of conflict or discrepancies, they shall resort to every possible instance to reach an amicable solution. In that respect, they agree to appoint the COFESA (Federal Health Council) to act in such cases as an amiable compositor.

ELEVENTH / EFFECTIVE TERM

This agreement shall remain in full force and effect until (date), and a new agreement may be negotiated thereafter to the satisfaction of the parties.

For the purpose of the transfers, this agreement shall become effective upon the province's evidencing compliance with the obligations set forth in paragraphs a.i, a.ii, and b.ii of clause 4.2. No transfer shall be made and no amounts shall be accrued in favor of the province for any concept as long as the above conditions have not been met.

The province shall maintain its status as a project participating province; while the umbrella agreement and the annual commitment remain in effect, which will be the case if the following are true:

i) The project remains effective.

ii) The annual commitment remains effective or no more than three months have lapsed from the expiration date with a new commitment not having been executed.

iii) The operations of the SMIP Provincial Insurance Implementation Unit (Unidad de Gestión del Seguro Provincial, UGSP), whose key functional characteristics are described in appendix A of this umbrella agreement, remain in force.

iv) This umbrella agreement has not been denounced by the UEC on the grounds of serious noncompliance by the province, including:

- A delay of more than 60 days in accounting for the use of the funds from the SMIP account.
- Noncompliance by the province with at least 4 of the 10 targets established during three consecutive four-month periods.

Each of the parties are hereby authorized to terminate this agreement at any time, provided they notify in writing such intention to the other party at least 30 days in advance.

TWELFTH / CONFORMITY

The contracting parties hereby represent that they agree to the foregoing terms and conditions, and undertake to strict compliance therewith. In witness thereof, their legal representatives sign two copies of the same legal tenor.

This agreement is signed on this day of month of year.

By the nation

By the province

ANNEX 4: TEXT OF AN AGREEMENT (*COMPROMISO DE GESTIÓN*) BETWEEN A PROVINCIAL GOVERNMENT AND AN AFFILIATED PROVIDER ORGANIZATION

ADDENDUM

The Ministry of Human Development in the Province of Formosa, through the Provincial Insurance Implementation Unit (Unidad de Gestión del Seguro Provincial UGSP**)** on the one hand, represented by the coordinator, (…), domiciled at (…), hereinafter referred to as the UGSP and the (…) hospital/health center on the other hand, represented by Mr./Dr.(…), with following address: (…), town of (…), hereinafter referred to as the "provider," met to discuss contract no. **(…/..)** signed by the parties on (…), 2010. The parties agreed to approve this addendum, pursuant to the provisions of the following clause:

Article 1: Replace article 9, Penalties for Breaches, with this one, in force as of January 1, 2010:

(i) Breaches

The UGSP is authorized to impose penalties if the provider breaches the obligations assumed under this management agreement. The breaches mentioned below, in particular, shall be liable to the penalties set forth in point (ii) of this article:

1. Failure to observe the no charge principle by collecting additional funds and/or coinsurance and/or any other consideration for services provided to beneficiaries of the Provincial Maternal and Child Health Insurance —SMIP (article 4.a.ii).
2. Failure to display the poster or notice providing information on free services in a prominent place in the institution (article 4.a.ii).
3. Rejection of an enrolled beneficiary and/or, if applicable, failing to act as a referring institution (article 4.a.iii).
4. Failure to use the forms produced and provided by the UGSP (article 4.d.ii and 4.d.iii).

5. Failure to fulfill, in whole or in part, the obligation to ensure free access for professional auditors, by providing them with the documentation requested (article 4.g.i).
6. Failure to submit to the UGSP, on a weekly basis, the mandatory data and documentation on the persons enrolled (article 4.h.i).
7. Inaccurate presentation of the corresponding invoice [*cuasi-factura*] (article 4.f.i).
8. Failure to use the funds transferred in keeping with the rules set forth in this agreement (article 7).
9. Failure to post the detailed report on investments made using the funds collected under the Plan in a place where the public can see it (article 4.h.iii).
10. Failure to record services billed and validated correctly on medical files.

(ii) Penalties

The penalties to be imposed for the aforementioned breaches are the following:

1. Warning. This penalty shall be imposed in the following instances:
    a. Breaches mentioned in point 4, on no more than two occasions.
    b. Breaches mentioned in points 2 and 9, within a maximum period of three months.
    c. The breach mentioned in point 7, on one occasion.
2. Payment and fine.

    (i) A fine of 10 percent of the last authentic invoice approved shall be imposed in the following cases:

    a. The breach cited in points 3 and 6, on one occasion.
    b. Repetition of the breaches cited in points 2 and 9.

    The sums for the fines imposed will be automatically deducted from the billing for the month during which the penalty is imposed.

    (ii) The payment of 100 percent of the value of services not duly recorded, in accordance with the provisions of point 10.
3. Suspension of the management agreement. This penalty shall be imposed in the following instances:
    a. The breach cited in points 1 and 8.

b. The breach cited in point 7, in a maximum period of three months, without there being any justification whatsoever for this situation, with the penalties of warning and collection having been previously imposed.

The imposition of four of the aforementioned fines.

4. Withholdings

Notwithstanding the aforementioned penalties, the UGSP is authorized to make withholdings on monthly transfers, until the breach has been rectified.

In witness whereof, two copies of equal tenor were signed in the City of ( ), on the day, of the month of year.

ANNEX 5: TERMS OF REFERENCE FOR CONCURRENT AUDITING OF ENROLLMENT, ACHIEVEMENT OF TRACERS, AND TRANSFERS AND USES OF FUNDS

Program name: Provincial Maternal and Child Health Investment Project

Loan no.: IBRD 7225-AR

Implementing agency: national Ministry of Health

The Argentine government, through the national Ministry of Health, has decided to implement the Provincial Maternal and Child Health Investment Project, for which it has requested the financial assistance of the World Bank, which has granted Loan IBRD 7225-AR.

Through this program, the eligible provinces will receive capita-based transfers (as a function of the number of active beneficiaries enrolled and the compliance with health targets—*trazadoras*) and other benefits such as equipment, technical assistance, and training.

The policy of the national Ministry of Health (Ministerio de Salud de la Nación, MSN) for this type of programs is to monitor results (using the appropriate management tools) and fiscal integrity; all within a framework of transparency and clarity of procedures.

The Provincial Maternal and Child Health Investment Project has recognized the need to address the responsibility regarding the good management of the resources and the management outcomes on the part of the provincial health insurance implementation units.

For that reason, the current loan agreement provides for the requirement of engaging a concurrent and independent external audit. This is an important element in the process of monitoring and supervision of the program's implementation, in order to ensure that the resources of the operation will be managed and used in accordance with the terms and

and conditions agreed in the respective financing agreement and making it possible to assess the evolution of the targets and objectives defined for the program.

The concurrent external audit will be conducted in accordance with the terms of reference established below and with the general external audit guidelines of the IBRD described in the guidelines and Terms of Reference for Audits of Projects with World Bank financing in the Latin America and Caribbean Region and the International Audit Standards published by the International Federation of Accountants (IFAC).[3]

These terms of reference provide the basic information required by the auditor to sufficiently understand the work to be done, in order to be able to prepare a services proposal and to plan and perform the audit.

Although the program will be subject to an additional financial audit, according to the standard terms of reference of the financing agency, the concurrent audit should also focus on aspects related to verifying the existence of procedures for the payment and invoicing mechanisms of the Provincial Health Insurance Implementation Units.

1. Purpose

The purpose of the project is to contribute to increased coverage and to foster accessibility to health services by pregnant women, puerperal women up to 45 days post-partum, including 45 days after the interruption of the same, and of boys and girls under age six who lack explicit coverage (eligible population). To that end, the creation of maternal and child provincial health insurances is planned. It is thus expected to strengthen the capacity of the public providers in the assisted provinces and to promote social participation.

The project will be financed by means of an Adaptable Program Lending (APL) loan to cover the investment needs described.

3. In the case of Supreme Audit Institutions, the standards issued by the International Organization of Supreme Audit Institutions (INTOSAI) will be applicable. However, in case the Supreme Audit Institution has not yet adopted said standards, the international audit standards issued by IFAC shall be observed.

This financing shall have a term of up to 10 years to be developed in two phases. Each one of these phases will be financed by a specific loan and shall last up to five years.

These terms of reference refer exclusively the first phase financed by the project.
In the first phase of the project or APL-1, financing shall be provided at the national level and in the participating provinces (the nine provinces of the Argentine Northwest (NOA) and Argentine Northeast [NEA]). These nine provinces have been selected as eligible because they belong to the regions in which the combination of child and maternal mortality indicators and the poverty map is more unfavorable.

The project will be executed by a new unit created within the national Ministry of Health (Ministerio de Salud de la Nación, MSN), denominated Central Implementation Unit (Unidad Ejecutora Central, UEC). The provinces will join the program as participating provinces. To that end they shall sign a participation letter, create a Provincial Insurance Implementation Unit (Unidad de Gestión del Seguro Provincial, UGSP) and sign a umbrella agreement with the MSN; this agreement will contemplate the structural aspects and operational details of the program. The participating provinces will be responsible for the implementation of the Provincial Maternal and Child Health Insurance (Seguro de Salud Materno Infantil Provincial, SMIP) in their territories and the MSN through the UEC, will be responsible for the general coordination, supervision, and contribution to the partial funding of the project. The project's operating manual, including its annexes, governs the operational details of the project and its institutional arrangements.

Among others, the project has the objective of providing coverage to the eligible population, by providing access to a set of health services and provisions that comply with the technical conditions in force. To implement the SMIP, the provinces shall comply with the following:

(i) Registration of eligible beneficiaries: The province shall conduct a campaign to foster the registration of beneficiaries. The beneficiaries shall complete a

registration form, to be conveyed to the UGSP, which will centralize all the data.

(ii) Development and validation of rosters: The UGSPs will develop the rosters of the beneficiaries that are registered and will validate them by cross checking against the rosters of the national and provincial union-based health insurance organizations (Obras Sociales), removing from the roster any beneficiaries that have another coverage, if any. It will also periodically remove from the roster those beneficiaries, which do not comply with the defined eligible population criteria. The corrected roster shall constitute the basis to (a) prepare the invoicing to the UEC and (b) back up the services invoiced by the providers to the UGSP.

(iii) Capita-based transfers from the MSN to the UGSPs: the transfers shall be calculated on a monthly basis based on the beneficiaries enrolled in each province appearing in the roster, multiplied times the agreed per capita amount that will be uniform for all the participating provinces. It shall consist of the following: (a) the monthly basic transfers (60 percent of the amount corresponding to the basic per capita amount, times the number of beneficiaries registered in the roster) and (b) the complementary transfers (remaining 40 percent of the amount linked to performance, with tracer targets [*trazadoras*]), which will be remitted every four months.

(iv) Payment to health care providers: the provincial authorities will enter into contracts with health care providers that meet the technical regulations in force. Among others, these should contemplate (a) payments for services (production factors may not be liquidated), (b) the invoices for services shall comply with the technical standards in force and respect the established prices, and both criteria are contained in the single PISMIP *n*omenclature.

Further details of the transfers and arrangements are defined in the project's operations manual, available to the consultants for the preparation of their proposals for this concurrent audit.

The UEC will periodically conduct monitoring, oversight, and evaluation processes. It will focus primarily on the process of enrollment of beneficiaries, roster development and validation, service coverage, and financial transfers.

2. Objectives of the external concurrent audit

The general objective of the required external audit is verifying that the data related to the eligible population and the delivery of services constitute a reliable basis for the transfer of resources from the nation to the province and, consequently, serve as support for the financial audit to be engaged separately. The specific objectives of the concurrent external audit are the following:

- Issue a professional opinion on the integrity, validity, and consistency with the program objectives of the roster of beneficiaries of the Maternal and Child Insurance used by each province for the settlement and payment of services.
- Issue a professional opinion on the integrity, validity, and consistency with the program objectives of the invoices in support of expenses presented by the provinces to the UEC of the national Ministry of Health, including the invoices based on the beneficiaries registered (60 percent of the total) and the invoicing based on the indicators (tracer targets) (40 percent).
- Issue a professional opinion on whether the payments made by the UGSPs to the providers comply with the program's standards; for example, if they are only made to licensed providers, correspond exclusively to practices comprised in the program as indicated in the nomenclature, if said practices have been effectively performed or if they have been invoiced exclusively based on the price contemplated in the nomenclature.
- Issue an opinion on the compliance with the conditions established by the program in the loan agreement and in the umbrella agreements between the provinces and the nation, in the contracts entered into between the Provincial Insurance Implementation Units (UGSP) and the providers.

The specific activities to be periodically conducted by the independent auditor and that the auditor should assess and report upon are the following:

(i) Verifying that the respective province delivers to the UEC the roster of the provincial union-based health insurance organizations (Obras Sociales Provinciales, OSP) acceptable to the UEC.

(ii) Verifying the consistency of the data in the list of people enrolled in the SMIP roster for each participating province, after having cross checked it against the rosters of the national (Obras Sociales Nacionales, OSN) and provincial (OSP) union-based health organizations.

(iii) Verifying the existence of contracts between the UGSPs and the providers, and their adequacy in terms of the program guidelines.

(iv) Verifying that the arrangements for payment by the UGSP to the providers are based on the payment for services and in no case based on production factors (salaries, human resources contracts, investments in equipment, or infrastructure, drugs, or others.)

(v) Verifying the consistency of the invoices sent by the provinces to the UEC to justify the payment of the basic monthly transfer (60 percent of the capita).

(vi) Verifying the consistency of the invoices sent by the provinces to the UEC regarding compliance with the targets (*trazadoras*) (up to 40 percent of the capita).

(vii) Verifying the accuracy, timeliness, and compliance with the program requirements on the part of the UEC regarding the capita transfers to the provinces.

(viii) Maintaining a close relationship with the financial audit to be probably undertaken by the Argentine National Auditor's Office (AGN).

(ix) Issuing periodically (at least at four-month intervals) conclusions and recommendations to improve the processes involved in points i to ix.

3. References

As an essential part of the planning process, the auditor should have available and become knowledgeable of the basic document related to the operation:

(i) Loan contract

(ii) Project's operating manual, including annexes

(iii) Umbrella agreement between the MSN and the province

(iv) Guidelines and procedures for the procurement of goods and consulting services of the UFI-S

(v) Guidelines and procedures for the procurement of goods and consulting services of the IBRD

(vi) Reformulation of documents, if any

4. Scope of the audit

To comply with the objectives of the audit, the audit procedures should have the following minimum scopes in each participating province:

(i) Verifying that the respective province is submitting to the UEC the roster of OSP acceptable to the UEC:

- Verifying the date of submission.
- Verifying that the information is on magnetic media and accompanied by a note of the maximum competent responsible authority, certifying the validity of its contents.
- Verifying that the fields have the required format.

(ii) Verify the consistency of the data of the list of individuals registered in the SMIP roster for each participating province, after its' cross checking against the rosters of the OSNs and OSPs.

- Verifying that the IT cross checking of rosters has taken place: OSP/OSN/SMIP roster.
- Verifying the process of development of the SMIP roster.
- Contracts covering the systems information with the documentary base through a random sampling of households at the provincial level to verify registration. The

sample is not expected to be representative of the province.

- Verifying the automatic and not-automatic roster clean-up process.

(iii) Verifying that the contracts between the UGSPs and the providers are consistent with the program's guidelines:

- Verification of the existence of contracts with the licensed providers.
- Verification that the contracts are consistent with the practices and prices of the single PISMIP nomenclature.
- Verification that the text of the contracts is consistent with the program's guidelines and the rules established by the UEC.

(iv) Verifying that the payment arrangements of the UGSP to the providers are consistent with the program guidelines:

- Verification that the payment arrangements agreed in the contracts is the only mechanism of financial transfer by the UGSP to pay for the services in the nomenclature.
- Verification that the payments for the accounts submitted by the providers responds to the effective application of the nomenclature.

(v) Verifying the consistency of the invoices sent by the provinces to the UEC justifying the payment of the basic monthly transfer (60 percent of the capita):

- Certification of the number of individuals enrolled in the SMIP roster versus the number of beneficiaries invoiced to the UEC.

(vi) Verifying the consistency of the invoices sent by the provinces to the UEC regarding compliance with the tracer targets (*trazadoras*) (up to 40 percent of the "capita"):

- Verification of the targets data capture process.
- Fieldwork through random sampling in the province to determine that the data contained in the individual medical records is consistent with the information of the tracer targets.

(vii) Verifying the accuracy, timeliness, and compliance with the program conditions by the UEC, regarding the transfer of capitation to the provinces.

- Verification of compliance with the manner and timeliness of payments
- Verification of the debit processes conducted by the UEC.

5. Reports of the concurrent external audit

Upon completion of the audit, the auditors will provide a report, containing the specific findings and conclusions for the period audited, as may be required. Such report shall be addressed to the Central Implementation Unit (UEC) of the national Ministry of Health (MSN). For the purpose of the reports, the firm to be contracted shall have to practice a regular review.

The regular review comprises the performance of the tasks and activities indicated in 4 – Audit Scope—of these terms of reference and the submittal of the audit reports corresponding to the time period extending from the date of start of services by the consulting firm up to the end of the contract.

Point 10 of these terms of reference—Requirements for the Submittal of Reports—describes the requirements to be met by the auditor reports.

The proposed methodology to be applied in the required audit will be relevant in the evaluation and negotiation of the service proposal.

Likewise, the audit firm undertakes to make available to the IBRD and allow for review by the IBRD staff the working papers, documentary evidence, and other documents related to the audit work under these terms of reference.

6. Qualifications of the concurrent audit

The audit firm will assign the required and qualified staff to the work in order to deliver the reports on the required dates. In particular, the group should demonstrate experience in the oversight and/or audit of programs financed by multilateral credit agencies or oversight and/or audit of public health programs, including qualified profiles in information systems, evaluation of health care services, and financial audit.

Additionally, in case the participation of specialized staff and from other professions such as engineering, law, or accounting is required, the firm shall bear the costs and the results of the work shall be the exclusive responsibility of the audit firm, in the understanding that for that reason, in its professional opinion it shall not make explicit

references to the work of the specialist or be based on said work. In that sense, we wish to clarify that a reference to the work of the specialist could be misconstrued as a qualification of the auditor's opinion or a division of responsibilities, something to be avoided.

7. Inspection and acceptance of the audit work and reports

The UEC of the national Ministry of Health (MSN) as implementation agency is responsible for reviewing, analyzing, and accepting each external concurrent audit of the program, and may designate a person or a legal entity to conduct this work. A representative of the financing agency may contact the auditors directly to require any additional information regarding the audit or status of the program.

8. Relations and responsibilities

The client for this concurrent audit is the UEC of the national Ministry of Health (MSN). The World Bank is a stakeholder. A duly authorized representative of the UEC will supervise the work performed by the auditors to ensure compliance with the terms of reference. Before signing the contract for the external concurrent audit, the World Bank's "no objection" to these terms of reference and the audit firm selected for the work will be required.

A representative of the Bank may take part in the meetings at the start and end of the audit in order to provide or request additional information or indicate areas to be emphasized. Said participation in no way releases the auditor from compliance with the obligations included in these terms of reference.

The UEC and the UGSP in each province to be audited are responsible for preparing all the required information and ensuring that all the documents and records required for the concurrent audit are available and that the necessary actions have been taken for the auditors to be able to submit the report as scheduled.

The UEC is responsible for sending to the Bank at least one copy of a report for each audited (participating) province in the year besides the report for each province on the

first two months. The auditors shall adequately maintain and file the working documents for a period of three years after the end of the audit. During such period, the auditors shall provide in a prompt and timely manner any working documents requested by the UEC or by the World Bank.

9. Duration of the contract

The contract shall be drafted for one year, with the possibility of being extended to two years, in case of extension of the closing date of Loan IBRD 7225-AR and a satisfactory performance of the contracted firm.

For the purposes of this provision, satisfactory performance will be considered:

1. The delivery of all the audit reports established within the terms established in point 10 of these terms of reference.
2. The submittal of the audit reports in accordance with the formats and the contents indicated in point 10 of these terms of reference.
3. The working methodology and plan executed during the contract performance have been developed in accordance with the proposal awarded, without deviations that have affected compliance with the objectives and scope of the services contracted, as established in the points.
4. The firm has addressed the contingencies emerging during the performance of the contract, by adjusting the work plan and methodology without affecting compliance with the objectives and scope of the services contracted, and adequately maintaining the quality, content, and timeliness of submission of the audit reports.

10. Requirements for the submittal of reports

The reports corresponding to each of the periods comprised in the regular review period shall be submitted no later than two months after the closing of each audited period. Audit reports shall cover two month periods.

Audit reports will be submitted in the Spanish language, duly signed, and in three copies. Each of them should contain at least the following:

- One page with the title, a table of contents, a cover letter addressed to the UEC, and a summary including (a) project background, period covered, project objectives, and a clear identification of all the entities mentioned in the report; (b) the objectives and scope of the concurrent audit and a clear explanation of the procedures applied and any limitation in the scope of work; (c) brief summary of the findings of the audit; and (d) results regarding the management of the findings of previous audits.

- The auditor's report containing the auditor's opinion on the specific objectives mentioned in paragraph 1, Objectives of the External Concurrent Audit. The analysis of this report should allow the UEC and the World Bank, at joint evaluation meetings, to plan corrective actions for the implementation of the program, as may be required. In case the audit firm detects documentation that could indicate that an incorrect application or diversion of funds has taken place in an intentional or nonintentional way, it shall report it directly and in a detailed manner in its audit reports so that the backing documents and amounts involved may be readily identified in order to make the corresponding adjustments.

11. Conflict of interests

From the start of the contract and up to a period of no less than three months after the end of the contract, the audit firm (including its partners, managers, or people responsible for the work in relation to the UEC on an individual basis) will not hold another type of contract for advising, consulting, or accounting with the national Ministry of Health.

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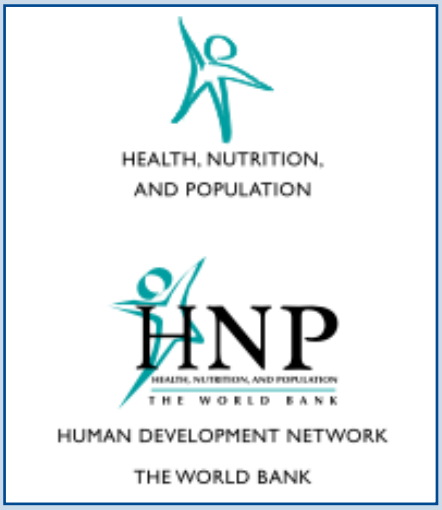

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1818 H Street, NW
Washington, DC USA 20433
Telephone: 202 473 1000
Facsimile: 202 477 6391
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