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Report No: PAD1397

INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT

PROJECT PAPER

ON A

PROPOSED ADDITIONAL LOAN

IN THE AMOUNT OF US$200 MILLION

TO THE

ARGENTINE REPUBLIC

FOR A

PROVINCIAL PUBLIC HEALTH INSURANCE DEVELOPMENT PROJECT

June 3, 2015

Health Nutrition and Population Global Practice
Latin America and Caribbean

CURRENCY EQUIVALENTS

Exchange Rate Effective June 3, 2015

Currency Unit	=	Argentine Peso
RS$9.00	=	US$1
US$0.11	=	ARS$1

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AF	Additional Financing
CPS	Country Partnership Strategy
DALY	Disability-Adjusted Life Year
EA	Environmental Assessment
EMR	Electronic Medical Records
EPHF	Essential Public Health Functions Project *(Funciones Esenciales de la Salud Pública)*
EMF	Environmental Management Framework
FM	Financial Management
FY	Fiscal Year
GAAP	Governance and Accountability Action Plan
GDP	Gross Domestic Product
GGHE	General Government Health Expenditure
GHI	General Health Interventions
GRS	Grievance Redress Service
IBRD	International Bank for Reconstruction and Development
ICB	International Competitive Bidding
ICD	International Classification of Diseases
IDA	International Development Association
IFR	Interim Financial Report
IMR	Infant Mortality Rate
INDEC	National Institute of Statistics and Census
IPP	Indigenous Peoples Plan
IPPF	Indigenous Peoples Plan Framework
IT	Information Technology
LA	Loan Agreement
MSN	National Ministry of Health *(Ministerio de Salud de la Nación)*
MSP	Provincial Ministry of Health *(Ministerio de Salud Provincial)*
MTR	Mid Term Review
NCB	National Competitive Bidding
NCD	Non-Communicable Diseases
OP/BP	Operational Policy/Bank Procedures
P4P	Pay for Performance
PAMI	Comprehensive Medical Assistance Program *(Programa de Atención Médica Integral)*

PHIP	Provincial Public Health Insurance Development Project
PDI	Project Development Objective indicator
PDO	Project Development Objective
PCU	Project Coordination Unit *(Unidad Coordinadora del Proyecto)*
PHIU	Provincial Health Insurance Unit
RBF	Results-Based Financing
SBD	Standard Bidding Document
SEPA	Procurement Plan Implementation System *(Sistema de Ejecución de Planes de Adquisiciones)*
SHICD	Selected Health Interventions for Catastrophic Diseases
SITAM	National Cancer Screening Information System *(Sistema de Información para el Tamizaje)*
TA	Technical Assistance
THE	Total Health Expenditure
UFI-S	International Financing Unit for Health – National Ministry of Health
UHC	Universal Health Coverage
WB	World Bank
YLD	Years Lost due to Disability
YLL	Years of Life Lost

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

Argentina
Additional Financing – Provincial Public Health Insurance Development Project (P154431)

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ADDITIONAL FINANCING DATA SHEET

Argentina

AF for Provincial Public Health Insurance Development Project (P154431)

LATIN AMERICA AND CARIBBEAN

Health, Nutrition and Population Global Practice

Basic Information – Parent			
Parent Project ID:	P106735	Original EA Category:	C - Not Required
Current Closing Date:	31-Dec-2015		

Basic Information – Additional Financing (AF)			
Project ID:	P154431	Additional Financing Type (from AUS):	Scale Up
Regional Vice President:	Jorge Familiar	Proposed EA Category:	B - Partial Assessment
Country Director:	Jesko S. Hentschel	Expected Effectiveness Date:	01-Oct-2015
Senior Global Practice Director:	Timothy Evans	Expected Closing Date:	30-Sept-2017
Practice Manager/Manager:	Daniel Dulitzky	Report No:	PAD1397
Team Leader(s):	Andrew Sunil Rajkumar, Vanina Camporeale		

Borrower				
Organization Name	Contact	Title	Telephone	Email
National Ministry of Health	Federico Kaski Fullone	Secretary of Promotion and Health Programs	+54 11-43799020	fkaski@msal.gov.ar

Project Financing Data - Parent (Provincial Public Health Insurance Development Project-P106735) (in USD Million)

Key Dates

Project	Ln/Cr/TF	Status	Appro-val Date	Signing Date	Effectiveness Date	Original Closing Date	Revised Closing Date
P106735	IBRD-80620	Effective	28-Apr-2011	06-Aug-2012	17-Oct-2012	31-Dec-2015	31-Dec-2015

Disbursements

Project	Ln/Cr/TF	Status	Currency	Original	Revised	Can-celled	Dis-bursed	Undis-bursed	% Dis-bursed
P106735	IBRD-80620	Effec-tive	USD	400.00	400.00	0.00	218.04	181.96	54.51

Project Financing Data - Additional Financing AF for AR Provincial Public Health Insurance Development Project (P154431)(in USD Million)

[X] Loan [ ] Grant [ ] IDA Grant
[ ] Credit [ ] Guarantee [ ] Other

Total Project Cost:	260.60	Total Bank Financing:	200.00
Financing Gap:	0.00		

Financing Source – Additional Financing (AF)	**Amount**
Borrower	60.60
International Bank for Reconstruction and Development	200.00
Total	260.60

Policy Waivers

Does the project depart from the CAS in content or in other significant respects?	No
Explanation	
Does the project require any policy waiver(s)?	No
Explanation	

Team Composition

Bank Staff

Name	Role	Title	Specialization	Unit
Andrew Sunil Rajkumar	Team Leader	Sr Economist (Health)	Senior Economist	GHNDR
Vanina Camporeale	Team Leader	Senior Operations Officer	Senior Operations Officer	GHNDR
Fabiola Altimari	Counsel	Senior Counsel	Senior Counsel	LEGLE
Alvaro Larrea	Procurement Specialist	Senior Procurement Specialist	Senior Procurement Specialist	GGODR
Victor Manuel Ordonez Conde	Financial Management Specialist	Senior Finance Officer	Senior Finance Officer	WFALN

Luz Meyer	Financial Management Specialist	Financial Management Specialist	Financial Management Specialist	GGODR
Daniela Paula Romero	Team Member	Operations Officer	Operations Officer	GHNDR
David Groisman	Team Member	Consultant	Information Systems Consultant	GHNDR
Isabel Tomadin	Safeguards Specialist	Consultant	Safeguards Consultant	GSURR
Luis Orlando Perez	Team Member	Sr Public Health Spec.	Senior Public Health Specialist	GHNDR
Paula Giovagnoli	Evaluation Specialist	Consultant	Monitoring and Evaluation Consultant	GHNDR
Maria Pia Cravero	Team Member	Junior Counsel	Junior Counsel	LEGLE
Marcelo Roman Morandi	Environmental Specialist	Consultant	Safeguards Consultant	GENDR
Maria Gabriela Moreno Zevallos	Team Member	Program Assistant	Program Assistant	GHNDR
Silvestre Rios Centeno	Team Member	Team Assistant	Team Assistant	LCC7C
Mariela Alvarez	Team Member	Team Assistant	Team Assistant	LCC7C

Extended Team

Name	Title	Location
Juan Sanguinetti	Economist	La Plata, Argentina
Oscar Lopez	IT Health Specialist	Buenos Aires, Argentina

Locations

Country	First Administrative Division	Location	Planned	Actual	Comments
Argentina	Misiones Province	Provincia de Misiones	X		
Argentina	Formosa Province	Provincia de Formosa	X		
Argentina	Buenos Aires City	Ciudad Autonoma de Buenos Aires	X		
Argentina	Entre Rios Province	Provincia de Entre Rios	X		
Argentina	Corrientes Province	Provincia de	X		

		Corrientes			
Argentina	Buenos Aires Province	Provincia de Buenos Aires	X		
Argentina	Tucuman Province	Provincia de Tucuman	X		
Argentina	Tierra del Fuego Province	Provincia de Tierra del Fuego	X		
Argentina	Santiago del Estero Province	Provincia de Santiago del Estero	X		
Argentina	Santa Fe Province	Provincia de Santa Fe	X		
Argentina	Santa Cruz Province	Provincia de Santa Cruz	X		
Argentina	San Luis Province	Provincia de San Luis	X		
Argentina	San Juan Province	Provincia de San Juan	X		
Argentina	Salta Province	Provincia de Salta	X		
Argentina	Rio Negro Province	Provincia de Rio Negro	X		
Argentina	Neuquen Province	Provincia del Neuquen	X		
Argentina	Mendoza Province	Provincia de Mendoza	X		
Argentina	La Rioja Province	Provincia de La Rioja	X		
Argentina	La Pampa Province	Provincia de La Pampa	X		
Argentina	Jujuy Province	Provincia de Jujuy	X		
Argentina	Cordoba Province	Provincia de Cordoba	X		
Argentina	Chubut Province	Provincia del Chubut	X		
Argentina	Chaco Province	Provincia del Chaco	X		
Argentina	Catamarca Province	Provincia de Catamarca	X		

Institutional Data
Parent (Provincial Public Health Insurance Development Project-P106735)

Practice Area (Lead)				
Health, Nutrition & Population				
Cross Cutting Topics				
[ ] Climate Change				
[ ] Fragile, Conflict & Violence				
[x] Gender				
[ ] Jobs				
[ ] Public Private Partnership				
Sectors / Climate Change				
Sector (Maximum 5 and total % must equal 100)				
Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	86		
Public Administration, Law, and Justice	Public administration-Health	14		
Total		100		
Themes				
Theme (Maximum 5 and total % must equal 100)				
Major theme	Theme	%		
Human development	Health system performance	46		
Human development	Child health	18		
Human development	Population and reproductive health	18		
Social dev/gender/inclusion	Gender	18		
Total		100		
AF for Provincial Public Health Insurance Development Project (P154431)				
Practice Area (Lead)				
Health, Nutrition & Population				
Cross Cutting Topics				
[ ] Climate Change				
[ ] Fragile, Conflict & Violence				
[X] Gender				
[ ] Jobs				
[ ] Public Private Partnership				
Sectors / Climate Change				
Sector (Maximum 5 and total % must equal 100)				

Major Sector	Sector	%	Adaptation Co-benefits %	Mitigation Co-benefits %
Health and other social services	Health	90		
Health and other social services	Other social services	10		
Total		100		

Themes

Theme (Maximum 5 and total % must equal 100)

Major theme	Theme	%
Human development	Child health	18
Human development	Health system performance	46
Human development	Injuries and non-communicable diseases	18
Social dev/gender/inclusion	Gender	18
Total		100

I. INTRODUCTION

1. **This Project Paper (PP) seeks the approval of the Executive Directors to provide an additional loan in an amount of US$200 million for the Argentina Provincial Public Health Insurance Development Project** (IBRD-8516-AR). The Argentina Provincial Public Health Insurance Development Project (PHIP) – also called the *Sumar Program*[1] – is financed by a Specific Investment Loan (IBRD-8062-AR) in the amount of US$400 million, approved by the Board of Executive Directors on April 28, 2011. Its current Closing Date is December 31, 2015. The *Sumar Program* aims to provide effective health insurance coverage for the vulnerable population in Argentina, which is not covered by formal (social or private) health insurance providers. As such, about 80 percent of eligible beneficiaries belong to the poorest 40 percent of the population.

2. **The proposed additional loan would finance the continuation and scaling-up of the well-functioning PHIP Project**, specifically the activities supported by the parent Project's three components: (a) Component 1 (Supporting Provincial Public Health Insurances); (b) Component 2 (Institutional and Management Strengthening of the National and Provincial Ministries of Health); and (c) Component 3 (Building Capacity of the National Ministry of Health and Provincial Ministries of Health to Deliver Services).

3. **The bulk of the funds under the proposed additional loan (US$137 million) would be for Component 1, which finances results-based capitation payments to provinces**, covering the provision of a pre-defined package of cost-effective services to eligible beneficiaries. Under the proposed additional loan, the eligible beneficiaries of the Project would also include uninsured men aged under 65[2], in addition to current Project beneficiaries (children, youth and women aged under 65 without formal health insurance). In addition, under Component 1, the proposed additional loan would finance capitation pilots to test different approaches to enhance progress towards effective Universal Health Coverage (UHC) within the context of provincial public health insurance schemes (estimated cost US$2 million). The Project is a key element of the new Argentina Country Partnership Strategy (CPS) (FY15-FY18)[3]: (i): It directly supports one of the nine Results Areas of the CPS (Achieving Universal Health Coverage with a focus on the nine poorest provinces); and (ii) it is poverty-targeted, uses a results-based financing mechanism and is based on rigorous impact evaluation.

4. The proposed additional loan would also provide further financing for activities under Components 2 and 3 totaling US$25.5 million and US$37 million respectively. These would include technical assistance to reinforce the development of integrated information systems, and to enhance integration over time between the *Sumar Program* and other existing insurance schemes, as well as the purchase of hardware and medical equipment to address supply-side gaps related to health services covered under the capitation payments of Component 1.

[1] PHIP means *Programa de Desarrollo de Seguros Públicos Provinciales de Salud*, the Borrower's Provincial Public Health Insurance Development Program, as set forth in the PHIP Ministerial Resolution No. 1195/2012, with the objective of strengthening the coverage and quality of health services to be provided throughout the Borrower's territory. By Ministerial Resolution No. 1460/2012, PHIP is also called the *Sumar Program*.

[2] Throughout this document, the term "men aged under 65" refers to adult men aged between 20 and 64.

[3] Argentina Country Partnership Strategy FY 2015-2018 (Report No. 81361-AR), discussed by the Executive Directors on September 9, 2014.

5. **The Project Development Objective (PDO) would not change**, but there are some modifications to the Results Framework. The Closing Date of both the additional loan and the original loan would be September 30, 2017. Also, there would be a change in the percentage of expenditures to be financed under Category 3 of the Withdrawal of Loan Proceeds table of the original Loan Agreement (IBRD-8062- AR), which finances the capitation payments for general health interventions. Finally, the Operational Policy on Environmental Assessment (OP 4.01) is triggered, resulting in a change in the Environmental Safeguards category from C to B.

II. BACKGROUND AND RATIONALE FOR ADDITIONAL FINANCING

A. Country and Sectoral Context

6. **Since the economic crisis of 2002, Argentina has seen a significant reduction in poverty and inequality.** Total poverty (measured at US$4 a day) declined from 31.0 percent in 2004 to 10.8 percent in 2013. Income inequality, measured by the Gini coefficient, fell from 50.2 in 2004 to 42.5 in 2012. Argentina's poverty rate and Gini coefficient are among the lowest in Latin America and the Caribbean[4]. Nonetheless, differences in poverty rates and access to services persist, particularly across provinces. Poverty rates in the Northern provinces are two to three times higher than the country average. Inequalities in access to quality social services and outcomes remain.

7. **Strong economic growth over the past decade was accompanied by rising macro imbalances.** Key macroeconomic challenges include the existence of inflationary pressures, deficits in the fiscal and current accounts, and limited international reserves. In this regard, the recent increase in reserves is a welcome development. Argentina has relatively modest fiscal and current account deficits, as well as a low ratio of public sector debt to gross domestic product. Nonetheless, given the limited access to international markets, they create pressure on the economy. These imbalances need to be resolved in order to avoid unwanted effects on the medium-term sustainability of the gains in equity and development achieved during the last decade. In this regard, the Government of Argentina (GOA) has recently implemented various public policy interventions aimed at resolving key macroeconomic imbalances. Continued and consolidated efforts are required for achieving the desired results.

8. **The GOA remains committed to promoting growth with equity and inclusion by reducing the gap in basic services.** In an increasingly challenging economic environment, the difficulty is not only sustaining the social policies established in recent years, but also creating space to promote effective social inclusion, with universal access to basic services.

9. **Argentina's health system has historically been split into three distinct regimes, with two of them involving formal (social or private) health insurance and the other – the public sector – providing health services used mostly by the uninsured.** The three regimes are: (i) the contributory social insurance sector that includes the *Obras Sociales* schemes[5] run by trade unions and professional organizations, as well as the Comprehensive Medical Assistance Program (PAMI) for retirees and pensioners that have worked in the formal sector – jointly covering 57 percent of the total population[6]; (ii) the contributory private health insurance sector

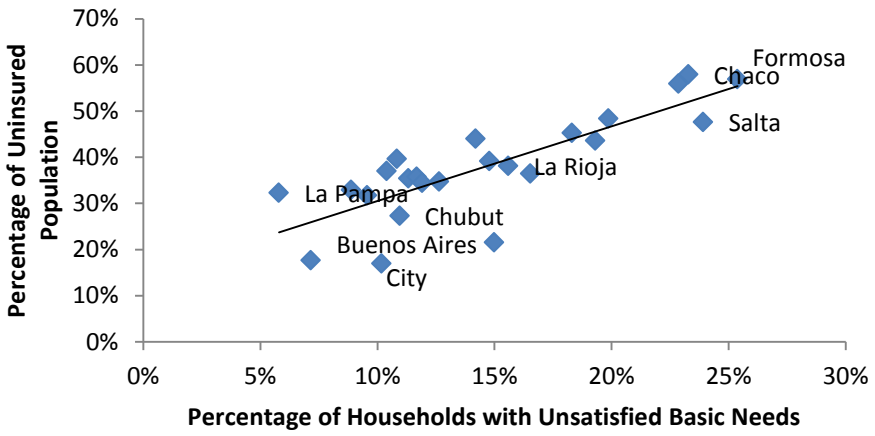
[4] National Institute of Statistics and Censuses (*Instituto Nacional de Estadística y Censos*, INDEC).
[5] There are more than 250 of these in existence, although a small percentage of these dominate market share.
[6] According to 2010 Census data, the total population of Argentina is 40 million people.

covering 5.1 percent of the population; and (iii) the public sector, providing services used mostly[7] by the remaining 37.9 percent of the population that are not covered by any formal health insurance schemes.[8] These three regimes are largely implemented at the provincial level; most of the formal health insurance schemes operate at the provincial level, and almost all of the public-sector health facilities are under the purview of the Provincial or municipal governments.

10. **There is a very clear association between being poor (or otherwise vulnerable) and the probability of being excluded from the formal health insurance schemes.** According to data from the National Survey of Urban Households (2013), the "uninsured rate" (percentage without formal health insurance) for people living in extremely poor areas is 65.5 percent, compared to 25.5 percent for those living outside extremely poor areas. In addition, Figure 1 shows that there is a strong correlation at the provincial level between the percentage of households with unsatisfied basic needs[9] and the percentage that is uninsured. Overall, about 80 percent of the uninsured population under the age of 65[10] are in the lowest two quintiles of the income distribution (see Section D and Table 1 below).

11. **The uninsured[11] (those without formal health insurance) have access to free, non-contributory (tax-financed) health care at health facilities in the public sector.** User fees are prohibited at public facilities, and enrollment or registration is not necessary to access their services.

Figure 1: Unsatisfied Basic Needs and the "Uninsured Rate", by Province, 2010



Data source: 2010 Population Census, INDEC.

[7] Health services produced by facilities in the public sector (public facilities) are available to all, without any user fees charged. Those with formal health insurance sometimes use services offered by public facilities, when coverage by their health insurance scheme is inadequate or would imply high co-payments. But public facilities are used mostly by those without formal health insurance.

[8] These figures are based on data from the 2010 Population Census, INDEC.

[9] This is generally much higher in the poorer provinces of the North.

[10] These are the eligible beneficiaries under the proposed AF as explained below.

[11] Throughout this document, the term "uninsured" refers to those without formal health insurance (i.e. without coverage by an *Obra Social*, by PAMI or by one of the private health insurance schemes).[12] *Plan Nacer* is the predecessor of the *Sumar Program*, and is described in detail in Annex 4.

12. **But services received from health facilities in the public sector – in the absence of programs such as *Plan Nacer*[12] and the *Sumar Program* – often have variable quality[13].** In the absence of payments flowing to public health facilities from insurance or risk-pooling schemes[14], inputs are usually received in-kind and in fixed amounts, and salaries are fixed. Providing more or better services to the uninsured does not lead to more in-kind inputs or cash being received by public health facilities, nor to higher salaries (or cash bonuses) for the health facility personnel. These personnel, furthermore, do not have any autonomy in decision-making regarding the mix of in-kind inputs. These constraints typically have adverse effects on performance and on the quality of services rendered.

13. **Public health service providers have also tended to under-emphasize the provision of preventative services – despite their high cost-effectiveness – to those not enrolled in any insurance or risk-pooling scheme.** In part, this is because these individuals are hard to track and monitor, since they are not enrolled or registered. As an example, the National Risk Factors Survey of 2009 found that the percentage of uninsured women that had breast cancer screening in the previous two years was 37.7 percent, as compared to 58.3 percent for women with formal health insurance. The same survey found that 54.8 percent of the uninsured had received a cholesterol check, compared to 82.4 percent of those with formal health insurance.[15]

14. **In effect, until public risk-pooling mechanisms were established starting in 2004, there was a two-tier health care system, where effective health coverage for the poor and uninsured was limited.** Many of the uninsured are *still* not covered by public risk-pooling mechanisms. In effect, nominally Argentina has Universal Health Coverage (UHC) because health care (at the public facilities) is available to all for free. But in practice, the country has a substantial way to go before being able to achieve effective UHC.

B. Road to Effective Universal Health Coverage, and Role of PHIP Project

15. **In 2004, the Government embarked on a series of reforms on the road to effective UHC, aimed at establishing provincial risk-pooling schemes – provincial public health insurances – for the otherwise uninsured, starting with the flagship *Plan Nacer* program.** *Plan Nacer* was supported by two successive Bank loans as part of an Adjustable Program Loan (APL) series: the Provincial Maternal-Child Health Investment Project Phase I (P071025, US$135.8 million) and Phase II (P095515, US$300 million). These loans were approved in April 2004 and November 2006 respectively, and have now both closed. *Plan Nacer* was one of the first large-scale programs worldwide to use a Results-based Financing (RBF) approach in the health sector. Subsequently, various other RBF programs in the health sector around the world have been modeled after it.

16. **Under *Plan Nacer*, provincial public health insurances were created, covering a basic package of pre-defined cost-effective maternal and child health services.** Eligible

[12] *Plan Nacer* is the predecessor of the *Sumar Program*, and is described in detail in Annex 4.
[13] These deficiencies have been addressed gradually with the implementation of *Plan Nacer* and the *Sumar Program*, through the introduction of risk pooling and results-based mechanisms (see below).
[14] "Risk-pooling schemes" here refers, in particular, to the provincial public health insurances financed under the *Sumar Program*.
[15] These services were not covered, at the time, by *Plan Nacer*, the *Sumar Program* or any other public risk-pooling scheme.

beneficiaries consisted of uninsured pregnant and lactating women (up to 45 days after delivery), as well as uninsured children under six. A rigorous Impact Evaluation (IE) of *Plan Nacer* found that it had a substantial positive impact on key health indicators – of utilization, quality and outcomes. See Box 1.

Box 1: Some Findings from Rigorous Impact Evaluation Studies Done for Plan Nacer

Results from a recent IE study of *Plan Nacer*[16] showed that the program improved health outcomes for vulnerable pregnant women and children living in the poorest regions of the country. The program was found to have increased the use and quality of prenatal care services and the probability of receiving the tetanus vaccine. The study also found that being a *Plan Nacer* beneficiary reduces the probability of a stillbirth by 26 percent and the probability of low birth weight by 7 percent. For a subset of provinces, the results showed that beneficiaries have a 74 percent lower chance of in-hospital neonatal mortality in larger facilities. In addition, the cost of a Disability-Adjusted Life Year (DALY) saved through *Plan Nacer*'s financing of maternal health services was estimated at US$814, which is very low when compared to the GDP per capita of US$6,075 over the relevant period, indicating a high degree of cost-effectiveness.

Another analytical study carried out by the World Bank with the support of the National and Provincial Governments focused on testing whether increasing financial incentives during a fixed period improved the quality of prenatal care in the short-term, and whether the impact would persist over time.[17] The study was run in 2010 in one of the poorest provinces of the country, and was based on a randomized control trial at the health facility level. The main findings show that the rate of early initiation of prenatal care was 34 percent higher in the treatment group than in the control group while the incentives were being paid, and that this effect persisted at least 12 months after the incentives ended.

17. ***Plan Nacer* was succeeded by the *Sumar Program* – co-financed by the current PHIP Project for which the additional Loan is proposed.** The program design retains the essential features of *Plan Nacer*, but includes new population groups not covered by *Plan Nacer* – children aged 6 to 9 years, youth aged 10 to 19 years and women aged under 65 without formal health insurance. Additional benefit plans[18] of mostly preventative health services have been defined for these new groups.[19]

18. **About 73 percent of the total proceeds of the original loan is for Component 1, which finances results-based capitation payments to the provincial public health insurances.** The funds from the capitation payments are used to provide marginal top-up payments to public health facilities, to incentivize the provision of key services to the uninsured

[16] Gertler P.; Giovagnoli P.; & Martinez S. (2014). "Rewarding Provider Performance to Enable a Healthy Start to Life: Evidence from Argentina's Plan Nacer". World Bank Policy Research Working Paper 6884.

[17] Gertler, P.; Celhay, P.; Giovagnoli, P; Vermeersch, C. (2015). The Long Run Effects of Temporary Incentives on Medical Care Productivity". Mimeo, 2015.

[18] This document uses the term "benefit plan" for the set of services covered by the capitation payments, whereby a fee-for-service mechanism is used to pay health facilities for providing these services to eligible beneficiaries. This is also sometimes referred to in other documents as the "benefit package" or the "package of services".

[19] Health services have been carefully selected with an emphasis on effectiveness in preventing, treating, and curing diseases that impose a significant burden for each population group, taking into account: (i) the cost of the services and the capacity of the public health care system to deliver them; and (ii) the need to encourage the use of services along the entire chain of pre-defined "lines of care" (e.g. comprehensive care services for infants and children, from prenatal care to regular general health check-ups including dental, ophthalmological and Ear, Nose and Throat services to treatment of diarrhea and pneumonia, and congenital heart disease surgery).

(and eligible) population following a set of protocols that assure adequate quality standards. These payments are made via a fee-for-service mechanism. The capitation payments are co-financed by the provinces and the National Government. The size of the capitation payments received at the provincial level is based in part on provincial performance, as measured by fourteen tracer indicators (e.g. indicators of prenatal care and immunization coverage in eligible women and children, following pre-determined quality protocols). Thus, in effect, incentives are provided at two stages – at the provincial level as well as the health provider level – and are based on outputs and results instead of a traditional health system based on inputs and fixed budgets. The achievement of performance indicators by both provinces and health facilities is verified by an external audit firm. See Annex 4 for more details.

19. **In order to make sure that health facilities are adequately prepared to deliver the agreed services under Component 1, Components 2 and 3 of the Project support a series of strategic investments and technical assistance (TA) to strengthen health service delivery capacity on the supply side at lower levels.** The mix of investments and the nature of the TA are carefully chosen, taking into account key gaps at the provincial and health facility levels in service delivery capacity, and based on a thorough assessment taking into account provincial heterogeneity, that is continually updated. The investments focus in particular on strengthening information systems and on selected medical equipment, while the TA focuses on institutional and management strengthening.

20. **Like *Plan Nacer,* the *Sumar Program* is very cost-effective, costing little compared to the provincial health budgets**. Total expenditures under the *Sumar Program* add up to less than 2 percent of provincial health budgets, on average. One of the reasons for the program's high impact and cost-effectiveness is the high degree of flexibility and autonomy in the use of the funds at the health facility level. The financing usually represents the only source of funding where the health service providers have autonomy in the use of the funds.

21. **The *Sumar Program* represents a further step towards effective UHC for everyone in Argentina**, by expanding health insurance coverage to include additional groups of people (uninsured adult women, older children and adolescents) – albeit with significantly smaller health service benefit plans than those covered by most formal health insurance programs.

22. **Attaining effective UHC is also a key strategic goal at the level of the provinces, and support for the *Sumar Program* at the provincial level is high.** The provincial public health insurance schemes supported by the Program are seen as essential to the goal of effective UHC.

23. **The only major population group in Argentina now that is not covered by any type of insurance or risk pooling mechanism consists of adult men aged under 65,** and expanding coverage to include this group would be one of the logical next steps on the road to UHC**.** While the *Sumar Program* is the main vehicle for achieving effective UHC in Argentina, other public schemes involving capitation payments to the provinces – mostly operating independently of the *Sumar Program* – do exist. For example, *Incluir Salud*, managed by the National Ministry of Health, covers a broad range of services (including high-complexity curative services) for around 1,100,000 extremely vulnerable and uninsured people including women with seven or more children; those with severe disabilities; and older people receiving a non-contributory pension. A portion of the program's financing is transferred to the provinces in the form of

capitation payments, with an incipient incentive mechanism at the provincial level but not yet at the provider level, unlike in the case of the *Sumar Program*. Other public schemes involving capitation payments also exist, across all provinces as well as for individual provinces.

24. **As Argentina moves towards effective UHC for everyone, there is also a need for an integrated approach involving the *Sumar Program* and the other schemes with capitation payments –** both public (e.g. *Incluir Salud*) and otherwise (e.g. the *Obras Sociales*) that operate independently of the *Sumar Program*, to avoid fragmentation and inefficiency in the use of existing resources.

C. Implementation Progress of the Parent Project and Results to Date

25. **After a slow start, performance of the *Sumar Program* has substantially improved and the program is now fully on track, with steadily improving performance and with disbursements accelerating.** The program began slowly, especially for the newly included population groups (eligible older children, youth and adult women aged under 65); this was compounded by the delay in effectiveness of the original loan (IBRD-8062-AR), which occurred in October 2012, almost eighteen months after Board approval.[20] More recently**,** performance has substantially improved, with effective coverage and utilization of key services increasing steadily for the newly included groups. Almost two years after effectiveness, the three provinces that had not entered the Program finally joined, in July 2014. As of end May 2015, roughly 55 percent of the loan funds have been disbursed and the disbursement rate is accelerating. It is expected that total disbursements will reach around 80 percent by December 31, 2015.

26. **The Project Development Objective (PDO) and Implementation Progress (IP) ratings are Moderately Satisfactory (MS) and Satisfactory (S), respectively, and annual targets for most PDO indicators have been achieved or surpassed over the first two years of Project implementation.** For example, the proportion of eligible children, youth and women with "effective" coverage rose by five times (from 7 percent to 36 percent) between 2010 and 2014. The proportion of eligible pregnant women who received prenatal care before the 13th week doubled from 15 percent to 30 percent. The proportion of eligible children under 10 years who received complete health check-ups tripled from 15 percent to 45 percent. (See Annex 1 for full details.) The Midterm Review (MTR) of the Project held in November 2014 found that progress overall is encouraging, with a high level of commitment on the part of the central Project Coordination Unit (PCU) as well as the provinces.

27. **There has been variation across provinces in implementation progress and in performance, but more recently even the lagging provinces have been catching up, supported by efforts by the PCU.** A range of provincial-level indicators is monitored regularly by the PCU – on performance (e.g. the provincial tracer indicators), capacity and implementation progress, among others. Where needed, support is provided to provinces in the form of activities financed by Components 2 and 3 (see above), as well as close hands-on support for "Prioritized Health Providers" especially in lagging provinces, among others. This has helped improve

[20] The delay in effectiveness was due to a delay in the approval of the Presidential Decree needed for the signing of the original LA. Given the Project's current visibility and high level of political support, a delay in the signing of the AF LA is not expected.

performance across provinces, leading to the rapid improvement in Project indicators as mentioned above.

28. **Finally, ratings related to fiduciary safeguards continue to be rated as satisfactory.** Not long ago the International Financing Unit for Health (UFI-S) at the National Ministry of Health (MSN), which is MSN's unit responsible for overall administrative and fiduciary matters, successfully concluded the implementation of a Governance and Accountability Action Plan (GAAP), and the first phase of a Performance Improvement Plan in Procurement, which was developed with support from the Bank The successful implementation of the GAAP should be highlighted, along with its impact on the performance of the UFI-S by strengthening of oversight of contract implementation, revision of technical specifications and training for UFI-S staff. Both exercises have improved significantly the way that the overall procurement activities are carried out and have had a significant impact on performance indicators, and on the quality of the bidding documents produced. At the request of UFI-S, a second phase of the Performance Improvement Plan in Procurement is currently under implementation. UFI-S is an experienced unit that has handled procurement and financial management not just for this Project, but also for various other health projects financed by the World Bank, Inter-American Development Bank and other development organizations.

D. Rationale for Additional Financing

29. **The rationale for the proposed AF is to finance the scaling up of activities to enhance the impact of a well-performing project, in support of the goal of moving towards effective Universal Health Coverage** over the next several years. Key elements underpinning this move would include:

- **Inclusion of uninsured adult men aged under 65, as an additional group of eligible beneficiaries:** This is the main remaining population subgroup that currently does not have any form of coverage by insurance or risk-pooling mechanisms. The sub-package of services for adult men would be relatively small, at least initially.

- **Activities to enhance integration in the future between the *Sumar Program* and other insurance schemes.** These schemes would include those within the public sector (such as *Incluir Salud*), as well as the formal health insurance schemes (in particular the *Obras Sociales*).[21]

- **Testing different approaches to enhance progress towards effective UHC:** This would be done through small capitation-based pilots, with the aim of moving over time towards an integrated and efficient structure for delivering effective UHC.

30. **The *Sumar Program* is well known in the country, and ownership is strong at the National and Provincial levels, across the political spectrum. Provincial co-financing levels**

[21] Elements of the integration would include: (i) harmonization between the information systems used by the different schemes; and (ii) coordination between the packages of services covered by the different schemes. The integration would be enhanced through Technical Assistance (TA) and the development of integrated information systems.

for the program have been rising substantially over the last few years (see Table 3 of Annex 2), as has the level of National Government co-financing from domestic sources, and these trends would continue. Furthermore, participating Provinces are financing a steadily increasing share of the staffing of the Provincial Health Insurance Units (PHIUs) which oversee the provincial public health insurance schemes, with the goal of absorbing most or all of these staff over time as civil servants under the Provincial Ministries of Health (see sub-sections on Implementing Arrangements below in Section III).

31. **The Program is fiscally sustainable; even with the inclusion of uninsured adult men aged under 65 as an eligible group, the capitation payments would be small relative to provincial public health spending – an estimated 1.6 percent of the latter in 2015.** The capitation payments act as marginal incentive payments – linked to provincial performance, and geared towards results – that are made on top of financing that is provided via a traditional, rigid, fixed-budget modality.

32. **Bank financing for the Program provides benefits in the form of high-quality technical assistance, the ability to benefit from international experience, and other forms of support** that would not be so readily available if Bank financing were withdrawn. Furthermore, co-financing by the National Government, or by the Bank (IBRD) working with the National Government, allows the National Government to exert influence over the provincial Governments and hold them accountable for results.

33. **The proposed AF would reach an estimated annualized total of 5.4 million beneficiaries in its last year (2017), and would be strongly targeted towards the poor**. According to analysis using data from the National Survey of Urban Households (2013), around 80 percent of the population that is eligible under the proposed AF (all under the age of 65 without formal health insurance) are in the lowest two quintiles of the income distribution. (See Table 1, as well as Annex 4 for full details.)

Table 1: Percentage of Eligible Population in Each Quintile of Income Distribution

Income Quintile	Percentage of Eligible Population in Income Quintile
Q1 (Poorest)	56.2
Q2	23.1
Q3	11.4
Q4	6.8
Q5 (Richest)	2.6

Source: Own calculations using micro-data for the Annual Survey of Urban Households of 2013.

34. **The proposed additional loan meets the eligibility criteria for additional financing under the World Bank Operational Policy for Investment Project Financing, OP10.00**:

- The ISR ratings for implementation progress and Development Objectives will have been MS or higher for more than 12 months at the time of consideration by the Board.
- The data for the PDO indicators imply that progress against set targets is on track.
- There has been compliance with all legal covenants, including audit and financial management reporting requirements.

- The fiduciary and safeguards ratings have been MS or S for the last 12 months.
- The proposed AF activities are consistent with the PDO and strategically aligned with the CPS.

III. PROPOSED CHANGES

Summary of Proposed Changes

This PP proposes: (i) new activities and scaled up activities under the AF, retaining the same three components as under the parent Project; (ii) changes in the Institutional Arrangements related to new activities; (iii) changes in the Results Framework; (iv) a change in the percentage of expenditures to be financed by IBRD under Category 3 of the original Loan; (v) setting a Closing Date of September 30, 2017 for both the original loan as well as the additional loan; and (vi) a change in the Environmental Safeguards category from C to B as a result of triggering the Operational Policy on Environmental Assessment (OP 4.01), reflecting findings from an Environmental Assessment conducted in March 2015.

Change in Implementing Agency	Yes [ ] No [X]
Change in Project's Development Objectives	Yes [ ] No [X]
Change in Results Framework	Yes [X] No [ ]
Change in Safeguard Policies Triggered	Yes [X] No [ ]
Change of EA category	Yes [X] No [ ]
Other Changes to Safeguards	Yes [ ] No [X]
Change in Legal Covenants	Yes [X] No [ ]
Change in Loan Closing Date(s)	Yes [X] No [ ]
Cancellations Proposed	Yes [ ] No [X]
Change in Disbursement Arrangements	Yes [X] No [ ]
Reallocation between Disbursement Categories	Yes [ ] No [X]
Change in Disbursement Estimates	Yes [X] No [ ]
Change to Components and Cost	Yes [X] No [ ]
Change in Institutional Arrangements	Yes [X] No [ ]
Change in Financial Management	Yes [ ] No [X]
Change in Procurement	Yes [X] No [ ]
Change in Implementation Schedule	Yes [X] No [ ]
Other Change(s)	Yes [ ] No [X]

Development Objective/Results

Project's Development Objectives

Original PDO:

The PDOs are to: (a) increase utilization and quality of key health services for the uninsured target population; and (b) improve institutional management by strengthening the incentives for results in Participating Provinces and among Authorized Providers.

The PDO remains unchanged.

Change in Results Framework

Explanation:

The following changes would be made to the PDO indicators (PDIs):

(i) A new PDI – "proportion of eligible men with effective coverage" – would be introduced as PDI 7 to reflect the inclusion of uninsured men aged under 65 into the provincial public health insurances. PDI 1 would be rephrased as "proportion of eligible children, youth and women with effective coverage".

(ii) PDI 5 now measures the "proportion of eligible women between 25 and 64 years of age with least one cervical cancer screening every two years". The way in which PDI 5 is measured would be modified – and its name slightly changed to "proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms" – to reflect modifications in the norms for cervical cancer screening that are being now introduced in some provinces (as discussed in detail in Section A of Annex 1).

(iii) The targets for the following indicators would be revised to better reflect expected progress (as discussed in detail in Section C of Annex 1): (a) PDI 1 ("proportion of the eligible children, youth and women with effective coverage"); (b) PDI 2 ("proportion of eligible pregnant women receiving prenatal check-ups before the 13th week"); (c) PDI 4 ("proportion of eligible youth between 10 and 19 years of age receiving complete health check-ups according to protocol"); and (d) PDI 5 ("proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms"). This is based on one of the main conclusions of the Mid Term Review (MTR) of the parent Project conducted in November 2014 – that when conducting the parent Project appraisal, the time period needed to see substantial improvements in performance had been underestimated, especially for youth and adult women (both newly eligible population groups under the parent Project).

Also, four new intermediate indicators would be added to track: (a) citizen engagement (2 indicators); (b) progress in program institutionalization; and: (c) the extent to which certain prioritized health facilities serving indigenous people comply with their work plan. Target values would also be revised downwards for Intermediate Results Indicator 2 ("proportion of eligible indigenous population with effective coverage"), to a similar degree as the downward revision of PDI 1 ("proportion of the eligible children, youth and women with effective coverage"). The reasons for this are the same as those underlying the downward revision of PDI 1, combined with additional factors specific to Intermediate Results Indicator 2 – such as cultural factors, and methodological difficulties with measurement (see Annex 1 for full details).

The revised Results Framework for the Project is described in Annex 1.

Compliance

Change in Safeguard Policies Triggered

Explanation (see also Annex 3 on Implementation Arrangements):

Based on the findings of the Environmental Assessment carried out in March 2015, OP/BP 4.01 on Environmental Safeguards has been triggered due to the potential environmental concerns around the handling of health care waste resulting mainly from the expansion of already-included high-complexity health interventions. The *Sumar Program*'s Benefit Plan already includes high-complexity interventions to address high-risk pregnancies, high-complexity neonatal services and congenital heart surgeries for children under 6 years of age. In 2014, the benefit plan was expanded to cover congenital heart surgeries for youth aged under 20 and congenital malformations.

Therefore, the Project would use an Environmental Management Framework (EMF) that focuses on health care waste management nationwide and electronic waste. This EMF was built upon the Second Essential Public Health Functions and Programs (EPHF) II Project (P110599) experience and was found to be appropriate to address any potential environmental issue generated by this Project. The EMF was disclosed both at the MSN and the World Bank Group external web page before Project appraisal. In addition, the Project will use the "Guide to Rational Vaccine Waste Management" developed under the H1N1 Prevention and Management of Influenza Type Illness (P117377) Project. Activities related to the application of the environmental safeguards would be carried out by the EPHF II Environmental Safeguards technical staff in liaison with the Technical Assistance and Training area of the PHIP. Once the EPHF II is closed, the Environmental Unit of the EPHF II will continue working under the Protecting Vulnerable People Against Noncommunicable Diseases Project (P133193) which is planned for Board discussion in June 2015. EPHF II's closing date is June 30th, 2016.

For Social Safeguards, the Indigenous Peoples policy (OP/BP 4.10) was triggered under the parent Project, and an Indigenous Peoples Planning Framework (IPPF) was developed and published in 2010. In order to reflect the scaling up of Project's activities, the IPPF was updated and re-consulted on April 9th, 2015. The IPPF was disclosed on the MSN web page and on the World Bank external web page, before appraisal. Changes to the IPPF are mainly related to the expansion of the eligible population to incorporate uninsured men aged under 65 and the inclusion of selected health interventions for this group within the *Sumar Program*'s benefit plan. The objective of the updated IPPF continues to be to promote indigenous peoples' access to Project benefits and to adapt the services in a culturally appropriate manner. Participating Provinces would prepare Indigenous Peoples' Plans (IPPs); the IPPs developed under the parent Project would have to be updated and re-disclosed (after conducting relevant consultations) to reflect the new eligible population sub-group as well as the new health services covered by the Project. This would be done as part of the update of the Annual Performance Agreements to be signed between each Participating Province and the MSN. Provinces would be able to start new activities after updating and re-consulting the IPP.

Current and Proposed Safeguard Policies Triggered:	**Current(from Current Parent ISDS)**	**Proposed(from Additional Financing ISDS)**
Environmental Assessment (OP) (BP 4.01)	No	Yes

Natural Habitats (OP) (BP 4.04)	No	No
Forests (OP) (BP 4.36)	No	No
Pest Management (OP 4.09)	No	No
Physical Cultural Resources (OP) (BP 4.11)	No	No
Indigenous Peoples (OP) (BP 4.10)	Yes	Yes
Involuntary Resettlement (OP) (BP 4.12)	No	No
Safety of Dams (OP) (BP 4.37)	No	No
Projects on International Waterways (OP) (BP 7.50)	No	No
Projects in Disputed Areas (OP) (BP 7.60)	No	No

Change of EA Category

Original EA Category:	Current EA Category:	Proposed EA Category:
Not Required	Not Required	Partial Assessment

Explanation:

The Project's Environmental Category was upgraded from C to B based on the findings of the Environmental Assessment carried out in March 2015. See Section on Safeguards Compliance above.

Covenants - Additional Financing (AF for AR Provincial Public Health Insurance Development Project - P154431)

Source of Funds	Finance Agreement Reference	Description of Covenants	Date Due	Recurrent	Frequency	Action
IBRD	Section I.A.6 (a) of Schedule 2 to the Loan Agreement	Amendment of respective Umbrella Agreements entered into between the Borrower, through MSN, and each Participating Province, before the carrying out of Project activities for the Participating Province.		☐		New
IBRD	Section I.A.6 (b) of Schedule 2 to the Loan Agreement	Every year, on January 1, signature of the Annual Performance Agreement between		☒	Yearly	New

		the MSN and each Participating Province.				

Conditions

Source Of Fund	Name	Type
IBRD	PHIP Ministerial Resolution's Amendment	Effectiveness

Description of Condition

Amendment of PHIP Ministerial Resolution to include selected general health interventions for men of ages 20 to 64.

Source Of Fund	Name	Type
IBRD	Retroactive Financing	Disbursement

Description of Condition

No withdrawal shall be made for payments made prior to the date of the Legal Agreement, except that withdrawals up to an aggregate amount not to exceed $24,000,000 may be made for payments made prior to this date but on or after April 1, 2015 (but in no case more than twelve months before the Signature Date), for Eligible Expenditures under Category (3) with respect to *Nomenclador Unico–C*.

Source Of Fund	Name	Type
IBRD	Withdrawal Conditions under Categories (3), (4) and (6)	Disbursement

Description of Condition

No withdrawal shall be made for expenditures under Categories (3), (4) and (6) until the Technical Auditor has been contracted under terms of reference acceptable to the Bank.

Source Of Fund	Name	Type
IBRD	Withdrawal Conditions under Categories (3) and (4)	Disbursement

Description of Condition

No withdrawal shall be made for expenditures under Category (3) in respect of Capitation Payments for health services provided under *Nomenclador Unico-AB* and for expenditures under Category (4) before the loan proceeds allocated to Category (3) and (4), of Section IV.A.2 of Schedule 2 to the original Loan, respectively, have been fully disbursed.

Risk

Risk Category	Rating (H, S, M, L)
1. Political and Governance	Moderate
2. Macroeconomic	Moderate
3. Sector Strategies and Policies	Moderate

4. Technical Design of Project or Program	Moderate
5. Institutional Capacity for Implementation and Sustainability	Substantial
6. Fiduciary	Moderate
7. Environment and Social	Moderate
8. Stakeholders	Moderate
9. Other	N/A
OVERALL	Moderate

Finance

Loan Closing Date - Additional Financing (AF for AR Provincial Public Health Insurance Development Project - P154431)

Source of Funds	Proposed Additional Financing Loan Closing Date
Borrower	30-Sept-2017
International Bank for Reconstruction and Development	30-Sept-2017

Loan Closing Date(s) - Parent (Provincial Public Health Insurance Development Project - P106735)

Explanation:

The Closing Date of the proposed additional Loan (IBRD-8516-AR) would be September 30, 2017. The Closing Date of the original Loan (IBRD-8062-AR) would be extended from December 31, 2015 to September 30, 2017.

Ln/Cr/TF	Status	Original Closing Date	Current Closing Date	Proposed Closing Date	Previous Closing Date(s)
IBRD-80620	Effective	31-Dec-2015	31-Dec-2015	30-Sept-2017	

Change in Disbursement Arrangements

Disbursements arrangements for the AF would be as follows:

i) Sequencing of Financing for Capitation Payments for GHIs (which would be financed under Category 3 of the Withdrawal of Loan Proceeds table under Section IV.2 of the additional loan: (a) Funds under Category 3 of the AF LA would be immediately available for capitation payments for uninsured under-65 adult men (the newly included group of beneficiaries); and (b) Funds under Category 3 of the AF LA would be available for capitation payments for the beneficiary groups already included under the parent Project (uninsured children, youth and adult women aged under 65) only after funds for this group under the original LA (under Category 3) have been fully disbursed. See also Box 4 of Annex 2.

ii) Sequencing of Financing for Capitation Payments for Selected Health Interventions for Catastrophic diseases (SHICD), which would be financed under Category 4 of the Withdrawal of Loan Proceeds table under Section IV.2 of the additional loan: Funds under Category 4 of the additional loan would be available for capitation payments for SHICDs only after funds for

these capitation payments under the original LA (under Category 4) have been fully disbursed.

iii) IBRD Co-Financing Percentages for Category 3 of the Withdrawal of Loan Proceeds table under Section IV.2 of the additional loan (GHI Capitation Payments), would be:
(a) Until December 31, 2015, IBRD would finance 100 percent of the capitation payments (this would only be for uninsured adult men aged under 65);
(b) Between January 1, 2016 and Dec 31, 2016 , IBRD would finance 70 percent of the capitation payments, while the co-financing percentages for the National and Provincial Governments would be 15 percent each; and
(c) From January 1, 2017 until Project completion, IBRD would finance 65 percent of the capitation payments, while the co-financing percentages for the National and Provincial Governments would be 20 percent and 15 percent respectively.

iv) The IBRD Co-Financing Percentage for Category 5 of the Withdrawal of Loan Proceeds table under Section IV.2 of the additional Loan (Operating Costs) would be 85 percent, instead of 100 percent which is the IBRD co-financing percentage for the corresponding category of the original LA (also Category 5, Operating Costs).

v) Capitation Pilots under Component 1: A new Category (Category 6) is added to the Withdrawal of Loan Proceeds table in Section IV.2 of the additional Loan to finance this.

vi) The proposed ceiling for advances to the designated account will be adjusted according to projections presented in the quarterly IFRs.

vii) Retroactive financing: The Borrower would request retroactive financing for Category 3 of the Withdrawal of Loan Proceeds table under Section IV.2 of the additional Loan, to finance capitation payments for eligible under-65 adult men paid up to one year before the signing date of the Loan Agreement but not before 1 April 2015. Retroactive financing would not exceed US$24 million. This would be for reimbursing the Borrower for capitation payments already made (financed by own domestic resources) by the MSN to the Provincial Ministries of Health (MSPs) for uninsured eligible adult men, once this new eligible group is formally included under the *Sumar Program*. The Borrower's application for reimbursement of expenditures paid before the loan signing date would be accompanied by certification – by Independent Technical Auditors acceptable to the Bank – of the veracity of the figures reported on enrollment and on the number of eligible beneficiaries with effective coverage. In addition, the MSN would need to provide evidence of accomplishment of the following actions: (i) approval of an MSN resolution that incorporates the new population sub-group under the *Sumar Program*; (ii) signed addendum of the Umbrella Agreements for Participating Provinces; (iii) signed Annual Performance Agreements for Participating Provinces, incorporating the GHI for the new group (uninsured adult men) and the IPPs, all on terms agreed with the Bank.

The disbursement percentages for the original Loan would change as follows, as part of an amendment to the original LA (IBRD-8062-AR)**:** (i) The IBRD co-financing percentage under Category 3 of the Withdrawal of Loan Proceeds table in Section IV.2 of the original Loan, would increase from 60 percent to 70 percent; (ii) the percentage financed by the National Government would increase from 10 percent to 15 percent; and: (iii) the percentage financed by the Provincial

Governments would decline from 30 percent to 15 percent. These changes would be applied from July 1, 2015 until funds under Category 3 have been fully disbursed.

Change in Disbursement Estimates (including all sources of Financing)

Explanation:

Expected disbursement estimates below reflect the proposed Additional Financing.

Expected Disbursements (in USD Million) (including all Sources of Financing)

Fiscal Year	2016	2017	2018
Annual	44.8	125.2	30.0
Cumulative	44.8	170.0	200.0

Allocations - Additional Financing (AF for AR Provincial Public Health Insurance Development Project - P154431)

Source of Fund	Currency	Category of Expenditure	Allocation	Disbursement % (Type Total)
			Proposed	Proposed
IBRD	U$S	(1) Goods	37,000,000	85%
		(2) Consultants' services (including technical audits), Non-consultant Services and Training	24,000,000	100%
		(3) Capitation Payments under Part A.1(a) of the Project	127,000,000	Under *Nomenclador Unico*–C: 100% until December 31, 2015; 70% until December 31, 2016; and 65% thereafter
				Under *Nomenclador Unico*–AB, 70% until December 31, 2016; and 65% thereafter
		(4) Capitation Payments under Part A.1(b) of the Project	8,000,000	60% as per Section B.1 (d) below
		(5) Operating Costs	1,500,000	85%
		(6) Pilot Capitation Payments under Part A.2 of the Project	2,000,000	100%
		(7) Front-end Fee	500,000	Amount payable pursuant to Section 2.03 of this Agreement in accordance with

				Section 2.07 (b) of the General Conditions
		(8) Interest Rate Cap or Interest Rate Collar premium	0	Amount due pursuant to Section [2.08(c)] of this Agreement
		TOTAL AMOUNT	200,000,000	

Components

Change to Components and Cost

Explanation:

The proposed AF would continue to finance activities under the three components of the parent Project, introducing some new activities and/or scaled up activities[22], as described below (see Annex 2 for more details):

A. New Activities under Component 1 of Parent Project (Supporting Provincial Public Health Insurances)

i. Capitation payments for adult men (US$52 million), to be financed under Category 3 of AF LA: Adult men aged under 65 without formal health insurance would be included as an additional eligible population sub-group for capitation payments from the National Ministry of Health (MSN) to the Provincial Ministries of Health (MSP) supporting general health interventions (GHIs) with a specific health benefit plan defined for this population sub-group (*Nomenclador Unico-C*).

ii. Capitation Pilots (US$2 million), to be financed under new Category 6 of AF LA: This would support pilot testing of different approaches to achieve effective Universal Health Coverage (UHC). The pilots would continue to be based on the concept of provincial public health insurances with results-based capitation payments testing different modalities for payment mechanisms from Provinces to health service providers.

B. Scaled-Up Activities under Component 1 (Supporting Provincial Public Health Insurances)

i. Capitation payments for GHIs for beneficiary groups already covered under Parent Project – uninsured children, youth and adult women aged under 65 (US$75 million), to be financed under Category 3 of AF LA.

ii. Selected health interventions for catastrophic diseases (SHICD) (US$8 million), to be financed under Category 4 of AF LA.

C. Scaled-Up Activities under Component 2 (Institutional and Management Strengthening of the National and Provincial Ministries of Health)

[22] The wording in the original Loan Agreement describing the activities under Component 2 would be rephrased (in the original Loan itself which would be amended) to follow the description of the scaled-up activities under Component 2 in Section C above (and on the next page), to provide a more accurate description of them.

The AF would finance the some of the activities that were already supported by Component 2 of the parent Project, under Categories 2 and 5 of the AF LA, with an emphasis placed on certain specific sub-activities as follows:

i. Sub-Component 2.1: Improving the institutional capacity of national and provincial Ministries of Health (US$4.4 million): This sub-component would provide additional financing for consultant TA/training services for the MSN and participating MSPs, mainly to support: (a) developing integrated information systems (see Box 1 of Annex 2), instruments, and capacity to manage the PHIP, including administrative and billing data systems and the promotion of electronic medical records, the preparation and execution of annual performance agreements between MSN and MSPs, and between MSPs and Authorized Providers and new contracts and payment systems; (b) carrying out of outreach and service delivery strategies for rural and indigenous peoples (including the promotion of communities' participation, user rights, and culturally appropriate services for the inclusion of indigenous populations) and strengthening the health workforce skills of health staff in rural areas; (c) carrying out of studies on health system financing and related mechanisms, including mechanisms for integrating other public health programs with insurance/capitation schemes into the PHIP, all aimed at facilitating policy-making decisions of MSN and MSPs related with achieving effective Universal Health Coverage (see Box 2 of Annex 2); and (d) improving MSN and MSP's communication strategies for disseminating information about health plans, changing behavior among health sector staff, and promoting social participation (see Box 3 of Annex 2).

ii. Sub-Component 2.2: Supporting management, monitoring and evaluation (US$21.1 million): This sub-component would support management, monitoring and evaluation capacities of the PCU, UFI-S and PHIUs, through the provision of technical assistance (including the financing of operating costs and training), and the carrying out of monitoring and evaluation, and financial and technical audits under the Project.

D. Scaled-Up Activities under Component 3 (Building capacity of the National and Provincial Ministries of Health to deliver services)

This component would provide AF of US$37 million towards strengthening the supply capacity of the MSN and the MSPs through, inter alia: (a) the provision of equipment (medical, transportation, information technology and communications); and (b) maintenance services needed to upgrade and expand MSN and MSPs' information and communication systems (excluding civil works).

Current Component Name	Proposed Component Name	Current Cost (US$ M)	Proposed Total Cost (US$M)	Action
Supporting Provincial Public Health Insurance	Supporting Provincial Public Health Insurance	290.00	427.00	Revised
Institutional and Management	Institutional and Management Strengthening of the National	59.00	84.50	Revised

Strengthening of the National and Provincial Ministries of Health	and Provincial Ministries of Health			
Building capacity of the National Ministry of Health and Provincial Ministries of Health to deliver services	Building capacity of the National Ministry of Health and Provincial Ministries of Health to deliver services	50.00	87.00	Revised
Front-end fee		1.00	1.50	
	Total:	400.00	600.00	

Other Change(s)		
Implementing Agency Name	**Type**	**Action**
National Ministry of Health		

Change in Institutional Arrangements

Explanation (see Annex 3 on Implementation Arrangements for more details):

Institutional Arrangements for the new activities under the proposed AF would be as follows:

(i) The MSN would update the PHIP resolution to incorporate the new population sub-group under the Project – eligible adult men aged under 65.
(ii) Each Participating Province would sign an addendum of the Umbrella Agreement in order to incorporate the new population sub-group.
(iii) Participating Provinces would sign an addendum of the Annual Performance Agreements of 2015, incorporating the GHI for this sub-group and the updated IPPs; updated IPPs would be re-consulted and re-disclosed before any new activity takes place in the Participating Province.
(iv) Capitation pilots under Component 1: For the purpose of implementing these pilots, an amendment to the Annual Performance Agreements would be signed between MSN and the MSP and with the health service provider, incorporating the pilot capitation payment amount, the agreed results to be achieved, the related payments and the verification mechanisms. In addition, the Operations Manual contains details of the pilot design, the requirements to be met by a Province in order to be eligible for these pilots, the selection criteria for providers and how the results are going to be measured and evaluated.

Implementation Arrangements for the newly included population sub-group would be as follows: As under the parent Project, GHI capitation payments would be transferred from the MSN to the MSP in two steps: (a) a share of the financing (60 percent) would be provided after effective coverage is verified, and: (b) the remaining share (40 percent) would be transferred based on provincial performance as measured by achievement regarding several pre-defined tracer indicators, except during an initial startup period (until December 31st, 2015) when the full 40 percent would be transferred regardless of provincial tracer performance[23].

[23] The idea behind this is that initially during the startup period for a new group of beneficiaries, the main focus should be on incentivizing enrollment and obtaining a critical mass of enrollees. The next step (after the startup period) would be to incentivize utilization of key services among the enrollees. This would be done by applying the

Implementation Arrangements[24] for Component 2 would change as follows: Under the AF and starting in March 2016, financing of the PHIU staffing would decline from 70 percent to 60 percent, and then to 55 percent in March 2017. These changes would be reflected under the Umbrella Agreements to be signed by the Participating Provinces. As for the PCU, currently 60 percent of PCU staffing is financed. But starting in March 2016 financing would decline to 50 percent, and then to 45 percent starting in March 2017.

Change in Procurement

Explanation

New Procurement Guidelines: Procurement for the proposed Project would be carried out in accordance with the World Bank's "Guidelines: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 and revised on July 2014; and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 and revised on July 2014, and the provisions stipulated in the Legal Agreement.

Advance Contracting: In addition, it is expected that there would be advance contracting for concurrent audits of the capitation payments for the groups that are not eligible under the parent Project (i.e., uninsured adult men aged under 65), based on contracts with firms currently performing audits for the rest of the eligible groups. Also, individual consultants that are currently being financed with the proceeds of the parent Project will be hired using sole-source selection based on the justification of continuity of previous assignments.

Change in Implementation Schedule

Explanation

Due to delays in implementation caused by the eighteen-month delay in effectiveness of the parent Project, the implementation schedule (indicator targets, expected disbursement schedule etc.) for the parent Project would be moved forward in order to provide sufficient time to achieve the expected results.

IV. APPRAISAL SUMMARY

Economic and Financial Analysis

Explanation:

Based on a modest scenario the proposed AF would potentially save more than 1,700 lives and contribute more than 266,289 productive life-years to the economy over the period of

tracer system, where the size of the capitation payments is adjusted (downwards) according to provincial tracer performance (which is mainly determined by enrollees' utilization levels of key services). A startup period of several months would also allow sufficient time to fully update the electronic tracer system to be used for transfers from the MSN to the MSP, and to conduct sufficient training on the new systems.

[24] The procurement processes to be undertaken under Components 2 and 3 of this proposed AF are based on a thorough assessment done at the provincial level, involving the PHIUs. Thus, the PCU and UFI-S have been working on the technical specifications and other details for the relevant procurement processes, and are ready to launch the processes immediately when the AF is approved.

implementation of the proposed AF. The economic analysis shows that the Project will yield a net present value of benefits, after investment and recurrent costs, of about US$482.9 million and would have an internal rate of return 21.8 percent, with a Benefit-to-Cost Ratio of 2.9. The economic analysis sought to quantify health gains and to translate these into estimates of direct and indirect benefits. Direct benefits are related to the cost savings associated with reduced hospitalizations, consultations and treatments of the population. Indirect benefits are derived from: (i) the positive economic benefits associated with the reduced economic costs of illness and death of working-age adults; and (ii) the impact on quality of life. The value of each death avoided is estimated using the human capital approach. Full details of the analysis are presented in Annex 5. The Annex also explains why intervention by the public sector as proposed under the AF is key for redistributional reasons, and describes the value added of involvement by the Bank (see also Section II-D above).

Technical Analysis

Explanation:

The proposed AF design is based on the country's priorities and consistent with international good practice. The proposed extension of public health insurance coverage to vulnerable adult men aged under 65 is consistent with the country's strategy for advancing towards effective Universal Health Coverage. The benefit plan for this new population subgroup is focused on cost-effective, preventative health interventions selected based on their effectiveness in the early detection, diagnosis and follow-up of diseases that impose the highest burden of disease on the male population in Argentina, i.e. hypertension and cardiovascular diseases, diabetes, overweight and obesity, colorectal cancer and intentional self-harm. Common health problems leading to disability (related to visual basic oral health) were also included. Interventions were selected jointly by the MSN and the Program Coordination Unit (PCU) of the *Sumar Program*, ensuring relevance and sustainability of the program, and following international best practice in selecting interventions that correspond to IDC-10 codes (based on the International Classification of Diseases). In addition, most of the health services related to Noncommunicable Diseases (NCDs) that would be added to the benefit plan for uninsured adult men would also be added to the benefit plan for uninsured adult women, while additional female-specific services such as cervical cancer and breast cancer screening would continue to be covered by the benefit plan for uninsured adult women.

Social Analysis

Explanation (see also Safeguards Compliance Section and Annex 3):

The propsed AF would continue the MSN and MSP efforts to increase the utilization and quality of priority health care services for all uninsured population groups, consistent with the principle of effective UHC for all.

The proposed AF would continue to have a strong emphasis on gender issues, and on monitoring of gender-related indicators (as is the case with the parent Project). Women aged under 65 years will continue to be a key group of beneficiaries under the *Sumar Program*, with a sub-package of critical health services tailored to this group – including preventative services for breast cancer and cancer of the cervix, and for other common pathologies in women. A major portion of the capitation payments would continue to go towards payments for services related to maternal health. Moreover, all NCDs interventions that would be added to the benefit plan for uninsured adult men would also

be added to the benefit plan for uninsured adult women. Finally, out of the seven PDO indicators, two will continue to be specifically for women (PDO Indicators 2 and 5 – see Annex 1).

One vulnerable group is indigenous people, 48 percent of whom live in rural areas; as mentioned under the Safeguards Compliance Section, the Bank's OP/BP 4.10 Indigenous People policy continues to be triggered, and changes to the IPPF are mainly related to the expansion of the eligible population to incorporate eligible men aged under 65 and the inclusion of selected health interventions for this group within the *Sumar* benefit plan. The objective of the updated IPPF continues to be to promote indigenous peoples' access to Project benefits and to adapt the services offered in a culturally appropriate manner.

In addition, Provinces would prepare Indigenous Peoples' Plans (IPPs) that include culturally appropriate mechanisms to reach this group. The IPPs developed under the parent Project would have to be updated and re-disclosed (after conducting relevant consultations) to reflect the new eligible population group as well as the new health services covered by the Project. This would be done as part of the update of the Annual Performance Agreements to be signed between each province and the MSN. Provinces would be able to start a new activity not covered under the parent Project after updating and consulting the IPP. The scope of each IPP would depend on the specific needs in each province and the level of commitment as well as available financing. The PCU's Technical Assistance and Training area would continue to be responsible for monitoring screening, certification and enrollment in indigenous areas, and for launching the IPPs in the provinces. Also, this area would continue supervising the implementation of the IPPs.

The PCU has adequately monitored the preparation and carrying out of the IPPs and their consultation. (Twenty-one indigenous peoples groups have been consulted between 2013 and 2014.) Findings from the *Sumar* Program's MTR show that while almost all provinces have successfully carried out the strategic actions included in their IPPs, results in terms of effective coverage lagged behind the Project's target. This situation is also reflected by the low performance of the Project's Intermediate Result (IR) indicator termed "Proportion of eligible indigenous population with effective coverage" (IR Indicator 2). Although this indicator has improved steadily since the start of the Project, the actual value achieved for this indicator in 2014 is far behind its target value of 20 percent (7 percent compared to 20 percent). This was one of the issues looked into in detail at the MTR which found that the target values were too ambitious in general for PDO Indicator 1 which measures the proportion of the overall eligible population (not just the indigenous population) with effective coverage.

Lessons from implementation: In the case of the eligible indigenous population, there are specific additional factors related to this vulnerable group that hamper the capacity of the *Sumar* Program to adequately reach them. These are both: (a) on the demand side, where cultural barriers hamper indigenous people's willingness to identify themselves as indigenous at the health facility; and (b) on the supply side, with limited incentives for provinces to adequately reach out to this group at present, given the existing incentive structure. In addition, methodological difficulties leading to probable underestimation of this Indicator were also identified.

Based on these findings, the PCU has developed an action plan to address these issues, concentrating its efforts on 54 priority health facilities with high proportions of indigenous people

in their catchment areas (accounting for around 48 percent of the entire population of indigenous people in the country). Among others, these prioritized health facilities will be allowed to have a special benefit plan for indigenous beneficiaries with higher unit fees, to help them in their efforts. Other measures have also been taken, and incentives have been incorporated, to address these points on both the supply and demand side. (See Annex 1 Section B for more details.)

Environmental Analysis

Explanation:

As was already discussed under the Safeguards Compliance Section above, based on the findings of an Environmental Assessment carried out in March 2015, the AF Project has triggered the OP/BP 4.01 Environmental Assessment Policy, and was updated from Category C to Category B.

The Project would use an Environmental Management Framework (EMF) that focuses on health care waste management nationwide and electronic waste. This EMF was built upon the Second Essential Public Health Functions and Programs (EPHF II) Project (P110599) experience and was found to be appropriate to address any potential environmental issue generated by this Project.

The proposed AF would complement EPHF II's efforts to foster and promote health care waste regulations by: (i) using the *Sumar* Program's e-Learning platform to disseminate good practices for the management of health care waste, and: (ii) expanding the number of hospitals that apply the "Guide to Self-Diagnosis on Waste Management of Health Care" to include the referral and treatment hospitals and maternities currently under the *Sumar* Program. In addition, the *Sumar* Program's E- Learning platform would be used to deliver the second introductory course on Vaccination developed by the National Directorate of Vaccine-Preventable Disease (DiNaCEI). This course includes a module on safe disposal of health care waste.

The *Sumar* Program has contributed to waste management efforts through (among others) dissemination of the "Guide to Rational Vaccine Waste Management" to vaccination centers, and the disclosure and dissemination of the first introductory course on Vaccination developed by the ProNaCEI (current DiNaCEI) which included a module on "Safe Disposal". Between 2012 and 2014, 1682 health staff completed this training. In addition, 200 hospitals have conducted an environmental diagnosis for hospital waste and have adopted waste management mechanisms under EPHF II. The team in charge of implementing the EMF has demonstrated good capacity to manage environmental issues.

Risk

Explanation:

The overall risk rating for the Project is Moderate.

High rotation among staff at the PCU and PHIUs could pose a potential risk, given that most activities related with Component 1 are undertaken at the provincial level. This is especially significant at this time because in late 2015, all 23 Provinces and the Autonomous City of Buenos Aires will be having Elections. In addition, there are institutional complexities associated with the newly included population group of uninsured adult men aged under 65, both on the demand side (low use of services) and on the supply side (low capacity to deliver services adapted to this group).

Mitigation measures include: (i) efforts to absorb the PHIU staff over time under the Provincial Ministries of Health (see Annex 3); (ii) inclusion of outreach activities to enhance demand among eligible adult men for utilization of key (especially preventative) health services; and (iii) efforts under Components 2 and 3 to strengthen health service delivery capacity on the supply side, with regard to services for adult men (see Annex 2).

While risks are not significant for public financial management at the country level, a potential moderate financial risk exists given the geographical spread of the proposed expanded activities. Taking into consideration the special features and associated risks of the proposed scaled-up activities, financial management risk mitigation measures would remain the same as for the original loan, namely: (a) capitation payments to the provinces (as well as reported enrollment and achievement of tracer indicators) would continue to be audited bimonthly by an external audit firm acceptable to the Bank; (b) the PCU (Audit and Supervision Area) would continue supervising the provinces' technical and financial implementation of the Project; (c) the provinces' use, control, recording and reporting of the capitation payments would be governed by a Nation-province umbrella agreement that defines roles and responsibilities of all involved parties, and (d) in-depth fiduciary reviews (covering financial management, disbursement, reporting and procurement) would be undertaken by the Bank as necessary.

Given the complexity that health's sector purchases inherently have, the overall procurement risk rating for the Project has been established as moderate. As mentioned before, UFI-S has concluded successfully the implementation of a Governance and Accountability Action Plan (GAAP), and the first phase of a Performance Improvement Plan in Procurement. Both exercises have improved significantly the way that the overall procurement activities are carried out. The second phase of the Performance Improvement Plan in procurement aims to address gaps identified during the capacity assessment.

V. WORLD BANK GRIEVANCE REDRESS

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

Annex 1. Revised Results Framework and Monitoring

ARGENTINA: Additional Financing (P154431) – Provincial Health Insurance Development Project (P106735)

Table 1. Results Framework

Project Name:	AF for AR Provincial Public Health Insurance Development Project (P154431)			Project Stage: Additional Financing	Status: FINAL
Team Leader(s)	Andrew Sunil Rajkumar	Requesting Unit:	LCC7C	Created by:	Maria Gabriela Moreno Zevallos on 10-Mar-2015
Product Line:	IBRD/IDA	Responsible Unit:	GHNDR	Modified by:	Daniela Paula Romero on 01-Jun-2015
Country:	Argentina	Approval FY:	2016		
Region:	LATIN AMERICA AND CARIBBEAN	Lending Instrument:	Investment Project Financing		
Parent Project ID:	P106735	Parent Project Name:	Provincial Public Health Insurance Development Project (P106735)		

Project Development Objectives

Original Project Development Objective - Parent:

The PDOs are to: (a) increase utilization and quality of key health services for the uninsured target population; and (b) improve institutional management by strengthening the incentives for results in Participating Provinces and among Authorized Providers.

Proposed Project Development Objective - Additional Financing (AF):

Results

Core sector indicators are considered: Yes

Results reporting level: Program Level

Project Development Objective Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	PDO Indicator 1: Proportion of eligible children, youth and women with effective coverage	☐	Percentage	Value	7.00	36.00	50.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			
Revised	PDO Indicator 2: Proportion of eligible pregnant women receiving prenatal check-ups before the 13th week.	☐	Percentage	Value	15.00	30.10	40.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			
Revised	PDO Indicator 3: Proportion of eligible children under 10 years of age receiving complete health check-ups according to protocol.	☐	Percentage	Value	15.00	45.00	60.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			
Revised	PDO Indicator 4: Proportion of eligible youths between 10 and 19 years of age receiving complete health check- ups according to protocol.	☐	Percentage	Value		18.00	25.00
				Date		31-Dec-2014	30-Sep-2017
				Comment	Not available		
Revised	PDO Indicator 5: Proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms.	☐	Percentage	Value	5.00	9.40	20.00
				Date	31-Dec-2010	31-Oct-2014	30-Sep-2017
				Comment			
Revised	PDO Indicator 6: Percentage of provinces which meet the	☐	Percentage	Value	17.00	38.00	58.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017

	targets of their Annual Performance Agreements.			Comment			
New	PDO Indicator 7: Proportion of eligible men with effective coverage	☐	Percentage	Value	0.00		10.00
				Date	31-Mar-2015		30-Sep-2017
				Comment			
Intermediate Results Indicators							
Status	Indicator Name	Core	Unit of Measure		Baseline	Actual(Current)	End Target
Revised	IR Indicator 1: Proportion of prioritized departments (those with IMR above the provincial average) with enrollment rate above the provincial average.	☐	Percentage	Value	10.00	48.00	70.00
				Date	31-Dec-2010	30-Nov-2014	30-Sep-2017
				Comment			
Revised	IR Indicator 2: Proportion of eligible indigenous population with effective coverage.	☐	Percentage	Value	0.00	7.00	30.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			
Revised	IR Indicator 3: Percentage of health facilities billing regularly on line.	☐	Percentage	Value	0.00	55.00	65.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			
Revised	IR Indicator 4: Number of institutional staff trained in the provinces.	☐	Number	Value	0.00	7006.00	14000.00
				Date	31-Dec-2010	31-Aug-2014	30-Sep-2017
				Comment			
Revised	IR Indicator 5: Percentage of provinces with at least 40% of participating health facilities visited by the	☐	Percentage	Value	0.00	63.00	90.00
				Date	31-Dec-2010	31-Dec-2014	30-Sep-2017
				Comment			

	provincial internal auditors.						
Revised	IR Indicator 6: Percentage of hospitals that received equipment and submitted a maintenance plan.	☐	Percentage	Value	0.00		60.00
				Date	31-Dec-2010		30-Sep-2017
				Comment			
New	IR Indicator 7: Participating provinces implementing actions to disseminate the *Sumar Program* grievances redress' mechanisms.	☐	Number	Value	0.00		13.00
				Date			30-Sep-2017
				Comment			
New	IR Indicator 8: Percentage of grievances responded to within the stipulated service standards for response	☐	Percentage	Value			70.00
				Date			30-Sep-2017
				Comment	Not available		
New	IR Indicator 9: Participating Provinces with the Provincial Health Insurance Unit included within the organizational structure of theMSPs	☐	Number	Value	6.00		10.00
				Date	31-Dec-2014		30-Sep-2017
				Comment			
New	IR Indicator 10: Proportion of health facilities with a high proportion of indigenous people in their catchment areas that comply with their work plan.	☐	Percentage	Value	0.00		70.00
				Date	31-Dec-2014		30-Sep-2017
				Comment			

Table 2. Revisions to the Results Framework

PDO		
Current (PAD)	***Proposed Change***	**Comments/ Rationale for Change**
To: (a) increase utilization and quality of key health services for the uninsured target population, and (b) improve institutional management by strengthening the incentives for results in Participating Provinces and among Authorized Providers.	No change	
PDO Indicators		
PDO Indicator 1: Proportion of eligible population with effective coverage	Replace "population" by "children, youth and women" and revise targets.	In the parent Project, the eligible population consists of uninsured children, youth and adult women aged under 65. Under the proposed AF, uninsured adult men aged under 65 would be added as a newly eligible population subgroup. This new group would be tracked under Indicator 7 (see below), separately from the existing group (uninsured children, youth and adult under-65 women) which would be tracked under Indicator 1. On target revision, see below.
PDO Indicator 2: Proportion of eligible pregnant women receiving prenatal check-ups before the 13th week.	Revise targets	See Section C below.
PDO Indicator 3: Proportion of eligible children under 10 years of age receiving complete health check-ups according to protocol.	No change	
PDO Indicator 4: Proportion of eligible youth between 10 and 19 years of age receiving complete health check-ups according to protocol.	Revise targets	See Section C below.

PDO		
Current (PAD)	***Proposed Change***	**Comments/ Rationale for Change**
PDO Indicator 5: Proportion of eligible women between 25 and 64 years of age with least one cervical cancer screening every two years.	Minor revision in definition of indicator, changing it to "proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms". Also, start to monitor an additional related indicator[1]; and revise targets.	This is to reflect a change in the procedures used for cervical cancer screening, as explained below. On target revision, see Section C below.
PDO Indicator 6: Percentage of provinces which meet the targets of their Annual Performance Agreements.	No change	
PDO Indicator 7: Proportion of eligible men with effective coverage	New	See comments above for PDO Indicator 1.
Intermediate Results (IR) Indicators)		
Current (PAD)		
IR Indicator 1: Proportion of prioritized departments (those with IMR above the provincial average) with enrollment rate above the provincial average.	No change	
IR Indicator 2: Proportion of eligible indigenous population with effective coverage.	Revise targets, and start to monitor an additional related indicator.[2]	See Section C below.
IR Indicator 3: Percentage of health facilities billing regularly on line.	No change	
IR Indicator 4: Number of institutional staff trained in the provinces.	No change	
IR Indicator 5: Percentage of provinces with at least 40% of participating health facilities visited by the provincial internal auditors.	No change	

PDO		
Current (PAD)	***Proposed Change***	**Comments/ Rationale for Change**
IR Indicator 6: Percentage of hospitals that received equipment and submitted a maintenance plan.	No change	
IR Indicator 7: Participating provinces implementing actions to disseminate the *Sumar Program's* grievance redress mechanisms.	New	These are Citizen Engagement Indicators that would reflect the program's efforts to obtain and act on feedback from the population.
IR Indicator 8: Percentage of grievances responded to within the stipulated service standards for response times.	New	
IR Indicator 9: Participating Provinces with the Provincial Health Insurance Unit included within the organizational structure of the MSPs.	New	This is to reflect the program's ongoing efforts towards sustainability and institutionalization over time. This indicator is a measure of efforts (already ongoing) to mainstream the program within the Government structure at the provincial level.
IR Indicator 10: Proportion of health facilities with a high proportion of indigenous people in their catchment areas that comply with their work plan.	New	This is to reflect the Program's efforts to increase indigenous people's use of health services, by focusing in particular on selected health facilities where the potential for reaching indigenous people is relatively high, compared to others.

Notes:
1. PDO Indicator 5 measures the proportion of eligible women that have regular cervical cancer screening (following established norms), using data from the billing records of the *Sumar Program* (i.e. screenings that are invoiced under the *Sumar Program*), as explained below. In addition, the Project will also use data from the National Risk Factors Survey to monitor the proportion of eligible women that have regular cervical cancer screening – even if not invoiced under the *Sumar Program* – based on self-reporting. The baseline value for this indicator is 58% according to data from the National Risk Factors Survey of year 2013. The next National Risk Factors Survey, expected in year 2017, will provide an updated value for this indicator.
2. In addition to the "proportion of eligible indigenous population with effective coverage", the Project will also start to monitor the "proportion of *enrolled* indigenous population with effective coverage", to better reflect the Program's efforts to increase health service access for the indigenous people already identified by the Program (see below for more on this). The latest available figure for this indicator is 33.4 percent in December 2014.

Table 3. Current Performance and Targets for Indicators

Description	Baseline	Actual Performance	Original			Revised		
Implementation Year		**Y2[3]**	**Y3**	**Y4**	**Y5**	**Y3**	**Y4**	**Y5**
PDO Indicators								
Current								
PDO Indicator 1: Proportion of eligible children, youth and women with effective coverage	7% (2010)	36%	45%	55%	70%	40%	45%	50%
PDO Indicator 2: Proportion of eligible pregnant women receiving prenatal check-ups before the 13th week.	15% (2010)	30%	38%	45%	52%	32%	36%	40%
PDO Indicator 3: Proportion of eligible children under 10 years of age receiving complete health check-ups according to protocol.	15% (2010)	45%	44%	53%	60%	No change		
PDO Indicator 4: Proportion of eligible youth between 10 and 19 years of age receiving complete health check-ups according to protocol.	n.a.	18%	25%	38%	47%	18%	22%	25%
PDO Indicator 5: Proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms	5% (2010)	9%	30%	40%	53%	12%	16%	20%
PDO Indicator 6: Percentage of provinces which meet the targets of their Annual Performance Agreements.	17% (2010)	38%	38%	50%	58%	No change		
New								
PDO Indicator 7: Proportion of eligible men with effective coverage	0% (2014)	N.A.				5%	7%	10%
Intermediate Results (IR) Indicators								
Current								
IR Indicator 1: Proportion of prioritized departments (those with IMR above the provincial average) with enrollment rate above the provincial average.	10% (2010)	47%	50%	60%	70%			
IR Indicator 2: Proportion of eligible indigenous population with effective coverage.	0% (2010)	7%	30%	40%	50%	10%	20%	30%
IR Indicator 3: Percentage of health facilities billing regularly on line.	0% (2010)	55%	35%	50%	65%	No change		
IR Indicator 4: Number of institutional staff trained in the provinces.	0 (2010)	7006	6000	9000	14000	No change		
IR Indicator 5: Percentage of provinces with at least 40% of participating health facilities visited by the provincial internal auditors.	0% (2010)	63%	70%	80%	90%	No change		

Description	Baseline	Actual Performance	Original			Revised		
IR Indicator 6: Percentage of hospitals that received equipment and submitted a maintenance plan.	0% (2010)	Not applicable	40%	50%	60%	No change		
New								
IR Indicator 7: Participating provinces implementing actions to disseminate the *Sumar Program*'s grievance redress mechanisms.	0	N.A.				6	9	13
IR Indicator 8: Percentage of grievances responded to within the stipulated service standards for response times.	n.a.	N.A.				40%	60%	70%
IR Indicator 9: Participating Provinces with the Provincial Health Insurance Unit included within the organizational structure of the MSPs	6	N.A.				7	8	10
IR Indicator 10: Proportion of health facilities with a high proportion of indigenous people in their catchment areas that comply with their work plan.	0% (2014)	N.A.				50%	60%	70%

Notes:
1. See Note 1 under Table 2.
2. See Note 2 under Table 2.
3. The actual values of all PDO and Intermediate Results Indicators are values as of December 2014, except for the following: Actual values for PDO Indicator 5, IR Indicator 1 and IR Indicator 4 are for October, November and August 2014, respectively. Note that actual values for PDIs 2, 3, and 4 are based on unaudited values of the tracer indicators (for the September-December 2014 "cuatrimestre").
4. As defined in the original PAD (Annex 1), the denominator for IR Indicator 6 should be the total number of hospitals under the Program that received equipment via the Program, while the numerator should be the total number of these hospitals that submitted a maintenance plan. However, the *Sumar Program* has not distributed any medical equipment yet, since the related procurement processes have only recently been finalized (or are about to be finalized in some cases). Hence the denominator is effectively zero, and the Indicator cannot be measured as of now.

1. **Tables 1 to 3 above summarize the changes proposed to the Results Framework:** (A) relatively minor changes to the definitions and method of measurement for one Indicator; (B) addition of new indicators (including one PDO Indicator); (C) revisions in some target values.

A. Change to Definitions and Method of Measurement (for One Indicator)

2. All existing PDO and Intermediate Results Indicators would be retained, but the following relatively minor **change to the definition and method of measurement** would be made for one indicator:

- Change to PDO Indicator 5 from "proportion of eligible women between 25 and 64 years of age with least one cervical cancer screening every two years" to "proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms When PDO Indicator 5 was originally developed, cervical cancer screening was done in all provinces by carrying out a PAP smear every two years, for all women aged 25 to 64 years. But now, some provinces have introduced a different screening procedure for women aged 30 to 64 years: These women should be tested for Human Papillovirus (HPV) every *three* years, and not every two years. A PAP smear would still need to be done if a woman's HPV test shows the presence of HPV.[25] The HPV test would only be for women aged 30 to 64 years. Younger women aged 25 to 30 years would still need to undergo a PAP smear every two years. More provinces will introduce this new screening procedure. Hence PDO Indicator 5 would be redefined as proposed above, to allow for both types of screening procedures.

  Although PDO Indicator 5 will continue to measure the proportion of eligible women that have regular cervical cancer screenings that are invoiced under the *Sumar Program*, survey data will also be used to monitor the proportion of eligible women that have regular cervical cancer screenings – even if they are not invoiced under the *Sumar program* – based on self-reporting. Data from the National Risk Factors Survey will be used to monitor this (see Note 1 under Tables 2 and 3).

B. New Indicators

3. **One new PDO Indicator and four new Intermediate Results (IR) Indicators** would be added to the Results Framework:

- Proportion of eligible men with effective coverage (PDO Indicator 7): This is in recognition of the newly eligible population subgroup that would be included in the *Sumar Program*, with the proposed AF – uninsured adult men aged under 65. PDO Indicator 7 would track the effective coverage in this population group. The target values (see Table 3) have been chosen in a manner that reflects adult men's historical reluctance, in Argentina (as in many countries), to visit health service providers unless this is really needed. Current patterns of utilization of preventative health services by adult men, in

[25] This is considered a superior method of screening (a better preventative approach) since almost all cervical cancer can be linked to certain strains of the HPV virus.

particular, are very low. Changing this pattern of behavior will be challenging, and will take time.

- Participating provinces implementing actions to disseminate the *Sumar Program's* grievance redress mechanisms[26] (IR Indicator 7); and Percentage of grievances responded to[27] within the stipulated service standards for response times (IR Indicator 8): These are Citizen Engagement Indicators. Currently, the Project is implementing different sets of activities to promote Citizen Engagement by raising beneficiaries' awareness and knowledge of the services covered by the Program. In addition, a 0800 hotline (where calls can be made free of charge) has been set up for, as a mechanism for grievance redress. This communication channel was started in 2010, not only to address complaints[28] but also to respond to information requests from the Project's beneficiaries. IR Indicators 7 and 8 are measures of how effective this mechanism is.

- Participating Provinces with the Provincial Health Insurance Unit included within the organizational structure of the MSPs (IR Indicator 9): A key goal of the program is that, over time, it should be institutionalized and mainstreamed into the regular Governmental structure at the Provincial levels. IR Indicator 9 would be a measure of these efforts.

- Proportion of health facilities with a high proportion of indigenous people in their catchment areas that comply with their work plan (IR Indicator 10)[29]: The *Sumar Program* has launched a new strategy to address the problem of low utilization of health services[30] among indigenous people – concentrating its efforts on 54 priority health facilities. The choice of these health facilities was based on the high proportion of indigenous people in their catchment areas (totalling 48 percent of the entire population of indigenous people in the country)[31]. The strategy involves the carrying out of an

[26] Actions to disseminate the *Sumar Program*'s grievance redress mechanisms would include disclosure of the 0800 hotline telephone number on the MSP webpage and at health facilities enrolled in the Sumar Program (where information on this hotline should be clearly displayed).

[27] "Responded to" means that a complaint was addressed by the PCU or the PHIUs, and the beneficiary was informed of the solution. For example, if an eligible person goes to a health facility and did not succeed in being enrolled in the *Sumar Program*, and if he/she registers a complaint using the hotline, the PCU contacts the province to find out the reasons why the health facility is not enrolling eligible people in the Program. Possible solutions are identified, e.g. to address the factors hampering enrollment or providing an alternative mechanism to be enrolled. Then, the PCU (through the 0800 hotline) contacts the person and communicates all this him/her. Another example is when it is reported (via the hotline) that a health provider charged for a service covered by the program. In this case, the PCU contacts the province to open an investigation. The PCU also contacts the beneficiary to let him/her know about the actions taken and offers an alternative solution to receive the health service.

[28] The main types of complaints received until now include difficulties in obtaining enrollment in the *Sumar Program* at a health facility, unwillingness by a health facility to deliver a service covered by the Program (or inability to do so), and attempts by a health facility to charge for a service covered by the program, among others.

[29] This refers to the number of prioritized health facilities that complied with a predefined work plan which includes: (i) a diagnostic to identify barriers that hinder indigenous people from accessing health services, by December 31st, 2015; (ii) design of a plan for improvement based on the findings of the diagnostic, by June 30th, 2016; (iii) implementation of at least 50% of the activities included in the plan for improvement, by December 31st, 2016; and (iv) implementation of at least 70% of the activities in the plan for improvement, by June 30th, 2017.

[30] "Health services" here refers to services offered by health service providers in the formal sector.

[31] This selection was made taking into account data from the 2010 census, the community level registers from National Institute of Indigenous People's Affairs (INAI - *Instituto Nacional de Asuntos Indígenas*), available provincial databases, and the *Sumar Program's* enrollment roster.

action plan that comprises four stages: (i) a diagnostic at the health facility to identify barriers that hinder indigenous people from accessing health services; (ii) the design of a plan for improvement based on the findings of the diagnostic, (iii) implementation of the plan; and (iv) Monitoring and Evaluation of the progress regarding this implementation. Also, prioritized health facilities will be allowed to have a special benefit plan for indigenous beneficiaries with higher unit fees, to help them in their efforts. Full details for this indicator and how to measure it are included in the Project's Operations Manual.

- Monitoring of additional indicators outside of Results Framework, to complement PDO Indicator 5 and Intermediate Results Indicator 2: Additional complementary indicators will be monitored, outside of the Results Framework. See Notes 1 and 2 below Tables 2 and 3 above.

C. Revision of Target Values

4. **Table 3 above shows the current performance and targets for all indicators –** including both the revised as well as original targets where revisions have been made due to delays in the parent Project Effectiveness[32].

5. **The Project's Midterm Review (MTR) held in October 2014 found that the targets set for the parent Project had been too ambitious, particularly where they involved the population groups newly included in the *Sumar Program*** (older children, adolescents and non-pregnant under-65 adult women): These targets had been set on the assumption that the rise in utilization of key services by the newly introduced groups under the *Sumar Program* would occur at roughly the same pace as for the groups covered by *Plan Nacer* (pregnant women and under-five children) when *Plan Nacer* first started. But in fact, service utilization for the newly introduced groups has risen at a much slower pace, perhaps because of the nature of these services. It has proved much more difficult, for example, to attract adolescents to use health facilities than to enhance utilization of maternal and child health services.

6. **In addition, the impact of the "effective coverage" concept – newly introduced when the *Sumar Program* started – proved difficult to predict**. This concept was not applied under *Plan Nacer*, and there are no known precedents in other countries.

7. **As a result of these findings from the MTR, several indicator targets have been adjusted downwards (see Table 3)**. Specific reasons for the extent of the downward revision for individual indicators are as follows:

- PDO Indicator 1 (Proportion of eligible children, youth and women with effective coverage): Although the 2014 target was achieved (35 percent), the MTR found that the targets in subsequent years (especially the end target of 70 percent for Year 5) are at present too ambitious. These targets were set under the assumption that the newly introduced population groups would behave similarly to the groups that had been covered

[32] Consistent with the approach taken in the approved ISRs and in the Project's Midterm Review of October 2014 – Calendar Year (CY) 2013 is treated as the first year of the Project, in practice. Thus, Calendar Years 2015, 2016 and 2017 are treated as Years 3, 4 and 5 respectively of the Project.

by Plan Nacer. However, progress on effective coverage for the new groups two years after the Project launch is lagging well behind progress for other groups. As of December 2014, effective coverage for eligible adolescents and women under 65 was 31 percent and 25 percent respectively, as compared to 61 percent for children aged under 6. Furthermore, as mentioned above, the impact of the newly introduced "effective coverage" concept (and hence the evolution in the number of eligible persons with effective coverage) has been difficult to predict. Although the Government team is working to overcome this situation by intensifying the work at selected health facilities (a "Prioritized Health Facility Strategy"), it is still appropriate to lower the original targets. In particular, the end target (for Year 5) would be reduced from 70 percent to 50 percent.

- PDO Indicator 2 (Proportion of eligible pregnant women receiving prenatal check-ups before the 13th week): Although the value achieved in 2014 for this indicator (30 percent) slightly surpassed the target (28 percent), the MTR and associated analysis found that, here too, the subsequent targets (especially the end target of 52 percent in Year 5) will be difficult to achieve. Recent results from an Impact Evaluation study[33] conducted in Misiones province showed that early prenatal care (before week 13) jumped from 30 percent to 42 percent after a 200 percent increase in the financial incentive associated with this health service.[34] These results were achieved in one of the best performing provinces in terms of the use of incentives, with personal financial incentives to staff linked closely with the achievement of health results. This experience suggests that, given the different contexts found in other provinces, a feasible end target for this indicator should be below the value achieved by Misiones. Thus, annual targets would be reduced for the last three years for this indicator, with the end target (for 2017) being 40 percent.

- PDO Indicator 4 (Proportion of eligible youth between 10 and 19 years of age receiving complete health check-ups according to protocol): As mentioned above, utilization of the *Sumar Program* services by the newly introduced population groups (including uninsured adolescents) has risen more slowly than expected. It is now understood that the trajectory of utilization for these groups is probably going to show much more gradual rises than what was observed for young children and mothers in the first phase of Plan Nacer. Although the value achieved in 2014 for this indicator (18 percent) surpassed the target (14 percent), the MTR and associated analysis found that, here too, the subsequent targets (especially the end target of 47 percent in Year 5) will be difficult to achieve.

  According to a provincial diagnostic on PDI 4, three main factors are constraining the performance of this indicator: (i) some of the necessary institutional requirements at the provincial level were not fully in place; (ii) low propensity of adolescents to visit/attend a health facility to receive health checkups; and (iii) the poor quality of related medical records. Although corrective measures are already being implemented, it is clear that the

[33] Pablo Celhay, Paul Gertler, Paula Giovagnoli and Christel Vermeersch. 2015. "The Long Run Effects of Temporary Incentives on Medical Care Productivity." World Bank, Washington, DC.

[34] The intervention was carried out in 2010 and randomly allocated a three-fold increase in the fee paid to health facilities for each initial prenatal care visit that occurred before week 13 of the pregnancy.

originally planned targets will not be attained and need to be changed to more realistic ones (as shown in Table 3).

- PDO Indicator 5 (Proportion of eligible women between 25 and 64 years of age with regular cervical cancer screening following established norms): As in the case of PDO Indicator 4, this indicator is linked to service utilization by one of the population groups newly introduced into the *Sumar Program* – uninsured non-pregnant adult women aged under 65. And similarly, it is now understood that utilization for under-65 adult women is also probably going to rise much more slowly than what was observed in the initial stages of Plan Nacer, for young children and mothers. Although this indicator has recently shown significant improvements,[35] the actual value achieved of this indicator as of October 2014 (9 percent) is lagging well behind its target value of 20 percent.

8. The lagging performance of this indicator is due to a combination of factors, mainly: (i) difficulties in many provinces in addressing a lack of cultural awareness regarding the need for cancer screening, with a need to reinforce social advocacy efforts on this issue; (ii) the poor quality of related medical records; and: (iii) changes in the information system platform used to register screening, with the introduction of a new national web platform (SITAM[36]), aiming to centralize the information but competing with traditional systems for registering screenings at the provincial level.

9. The latter point is especially important: Because of the changes mentioned with the information system platform, the values for this Indicator are now being measured purely using data from *Sumar Program* billing records – which capture a relatively small portion of all screenings because the invoicing rate for screenings is still low (as is the case for many services used by the population groups newly introduced into the *Sumar Program*). This exclusive reliance on the *Sumar Program* billing records as the data source for this Indicator will continue to be the case until SITAM is fully mainstreamed at the National as well as Provincial levels – but that will likely take a long time. The situation is further compounded by the introduction now in several provinces of a new method for screening, based on the HPV test instead of on PAP smears (see above), which will require adaptations to the information systems.

10. For these reasons, the targets for this Indicator need to be revised substantially downwards, as can be seen from Table 3.

- Intermediate Results Indicator 2 (Proportion of eligible indigenous population with effective coverage): Although this indicator has improved steadily since the start of the Project,[37] the actual value achieved of this indicator in 2014 is far behind its target value of 20%. The MTR found that there are several factors that explain this, mainly: (a) cultural barriers that hamper indigenous people's willingness to identify themselves as indigenous at the health facility; (b) limited incentives for provinces to adequately reach

[35] The value achieved of this indicator was 3% in 2013 compared to 9.4% in 2014.
[36] SITAM is the National Cancer Screening Information System (Sistema de Información para el Tamizaje).
[37] Starting from a baseline of 0% for this indicator, the actual values achieved (with targets in parentheses) were: 4% (target of 5%) in 2013 and 7% (target of 20%) in 2014.

out to this group, given the existing incentive structure; and (c) there are methodological difficulties leading to probable underestimation of this Indicator. With respect to point (a) the difficulty is that indigenous people often have a collective (group) approach towards the use of health services, and do not seem to respond well to the concept of individual or family insurance coverage requiring individual registration. This is compounded by a lack of incentives to identify themselves as indigenous at the health facility, and a fear of being discriminated against by the health facility staff. Regarding point (b), the Sumar Program's Project Coordination Unit (PCU) works with the provinces, through the implementation of the Indigenous People Plans (IPPs), to provide (and encourage the use of) tools that help increase access to health services, especially for this vulnerable group. However, the impact of these activities varies across provinces, and depends very much on the institutional capacity and political will within each province.

11. On point (c), the methodological difficulties are mainly due to the different approaches used to measure the numerator and the denominator, when calculating the value of this Indicator. The denominator is based on self-reported data from the 2010 Census – specifically, based on answers to the following question: "Is anyone in this household indigenous or a descendant of indigenous people?" However, the numerator is based on *Sumar Program* data, where a person is considered indigenous if he/she declares that he/she is indigenous (without any reference being made to whether he/she is a descendent of indigenous people). It is quite likely that a significant number of individuals captured in the denominator may not be captured in the numerator, even if they have effective coverage under the Program. Thus, the measured values for this Indicator are likely to be substantial underestimates of the true values, but it is not clear exactly how much the extent of the underestimation is. The problem is compounded by the use of a sample-based approach in the census to estimate the number of indigenous people.[38]

12. In the context of these challenges, the *Sumar Program* has launched a new strategy to address the problem, focusing its efforts on 54 priority health facilities with large numbers of indigenous people in their catchment areas – see Section B above for more details. (In addition, the PCU will review the methodology used to calculate values for this Indicator, but data constraints make it difficult to find a much better method.) As a result, performance of this indicator is expected to improve substantially. Even so, the current targets are estimated to be too high, and would be lowered. The end target would be lowered from 50 percent to 30 percent – i.e. by 20 percent. This is in line with the proposed lowering of the end target for PDO Indicator 1 (measuring effective coverage of the overall eligible population and not just indigenous people – excluding the newly included group of adult men) by 20 percent from 70 percent to 50 percent.

13. In addition, the PCU would start to monitor a variant of Intermediate Results Indicator 2 as a complement to this Indicator: the proportion of enrolled (not eligible) indigenous population with effective coverage (see Note 2 under Tables 2 and 3). This would better reflect the Program's efforts to increase health service access for the indigenous people already identified and enrolled by the Program.

[38] The selection of samples was guided by the limited and scarce information provided by the National Institute of Indigenous People's Affairs (INAI - *Instituto Nacional de Asuntos Indígenas*) which maintains registers of indigenous people at the community level.

Annex 2. Proposed Changes to the Provincial Health Insurance Development Project

ARGENTINA: Additional Financing (P154431) – Provincial Health Insurance Development Project (P106735)

1. This Annex describes: (i) the nature of the proposed additional Loan of $200 million; and (ii) how the original Loan would be restructured.

I. PROPOSED ADDITIONAL FINANCING

2. **The proposed additional Loan of US$200 million (IBRD-8516-AR) would finance the scaling-up of the activities supported by the parent Project's three components**: (a) Component 1 (Supporting Provincial Public Health Insurances); (b) Component 2 (Institutional and Management Strengthening of the National and Provincial Ministries of Health); and (c) Component 3 (Building Capacity of the National Ministry of Health and Provincial Ministries of Health to Deliver Services). See Table 1 below.

Table 1: Total Project Financing by Component

Component	Total Cost US$	IBRD Financing US$	IBRD Financing as % of Total Cost (%)
Component 1: Supporting Provincial Public Health Insurance	184,222,959	137,000,000	74%
Component 2: Institutional and Management Strengthening of the National and Provincial Ministries of Health	32,354,813	25,500,000	79%
Component 3: Building capacity of the National and Provincial Ministries of Health to deliver services	43,529,412	37,000,000	85%
Front End Fee	500,000	500,000	100%
TOTAL	**260,607,184**	**200,000,000**	**77%**

3. **Component 1: Supporting Provincial Public Health Insurance (Additional Financing of $137 million).** The AF would continue to finance the same activities as was the case under the parent Project and the original Loan (IBRD-8062-AR) with the below changes:

i. Adult men aged under 65 without formal health insurance would be included as an additional eligible population sub-group for capitation payments from the National Ministry of Health (MSN) to the Provincial Ministries of Health (MSP) supporting general health interventions (GHIs) with a specific health benefit plan defined for this population sub-group (**US$52 million**). This is in line with the principle of achieving effective Universal Health Coverage (UHC) over time, and supporting the scaling up

the *Sumar Program*. Capitation payments for this new population sub-group would be financed exclusively through the proposed additional Loan, in Phase 1 starting immediately after the Loan becomes effective.

ii. GHIs for uninsured adult men aged under 65 years would consist of 4 prioritized "lines of care" covering 13 health interventions. These "lines of care" were selected due to their relevance to reduce the highest burden of disease on the male population in Argentina, i.e. hypertension and cardiovascular diseases, diabetes, overweight and obesity, colorectal cancer and intentional self-harm. In addition, common health problems leading to disability (related to visual health and basic oral health) were included. GHIs for this new group would be focused in scope and number, at least initially, given implementation complexities on the supply side for this particular subgroup. Services covered under each "line of care" would include only cost-effective practices for promotion, prevention and care. The "lines of care" were selected jointly by the MSN and the Program Coordination Unit (PCU) of the *Sumar Program*, ensuring relevance and sustainability of the program, and approved by the Bank. The Bank and the MSN may review the list of selected health interventions ("*Nomenclador*") for each eligible population sub-group on a yearly basis.

Table 2. General health interventions (GHIs) prioritized for men aged under 65

Lines of Care	***Health Interventions and Codes***[39]
I. Regular monitoring and control of health status	1. General medical examination (Z00)
	2. Preventive actions (vaccination and counselling: diet Z71.3; alcohol Z71.4; drug abuse Z71.5, tobacco Z71.6)
	3. Detection for disorders of refraction and accommodation (H52) and for cataract and other disorders of lens in diseases (H28)
	4. Detection and treatment of the oral cavity disease: dental cavities (K02), pulp and periapical tissues diseases (K04), gingivitis and periodontal diseases (K05)
II. Detection of prevalent chronic non-communicable risk and diseases	*5. NCDs' risk evaluation in lifestyle-related issues:* - Tobacco (Z72.0); - Lack of physical exercise (Z72.3) and - Inappropriate diet and eating habit (Z72.4)

[39] From ICD-10. The International Classification of Diseases (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups. It is used to monitor the incidence and prevalence of diseases and other health problems, proving a picture of the general health situation of countries and populations. ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. ICD is currently under revision, and ICD-11 is expected to be released in 2017.

Lines of Care	*Health Interventions and Codes*[39]
	- *NCDs detection*: - Hypertensive diseases (I10-I15), - Ischemic heart diseases (I20-I25; I51), - Diabetes (E10- E11), - Overweight and obesity (E66)
	6. Specific risk level determination in vulnerable population for NCDs
	7. Follow up of NCDs' patient
III. Screening and diagnostic for prevalent oncologic illness	8. Colorectal cancer (II C18;19;20); screening in risk groups
	9. Diagnosis of colorectal cancer
	10. Notification of treatment commencement for colorectal cancer
	11. Notification of treatment performed for colorectal cancer (pre-neoplastic lesion)
IV. Prevalent mental health illness	12. Diagnosis and follow-up of substance consumption and / or abuse (F10-F19)
	13. Emergency care and ambulatory follow-up of intentional self- harm (X60- 84)

iii. The AF would provide further financing for the incentive structure already introduced under the parent Project. The province would receive a capitation payment for each enrolled eligible man with verified effective coverage[40]. The capitation payment would function as an insurance premium with an estimated initial value of AR$ 22[41] for eligible men aged under 65, as proposed by the MSN and approved by the Bank. As in the case of the parent Project, the actuarial cost for the per capita insurance premium (the capitation payment) was calculated, based on the difference between: (i) the full cost of service delivery for each unit provided of the relevant service/intervention, assuming all the requisite quality-related protocols are fully adhered to, and: (ii) the current level of public spending for each unit of the service. The MSN and the Bank may review the per capita cost annually. However, the MSN may ask the Bank to review the capitation payment at any time according to procedures established in the Operations Manual, providing technical and institutional evidence to support the change requested.

iv. A small amount under Component 1 (**US$2 million**) would be set aside for small pilots testing different approaches to achieve effective Universal Health Coverage (UHC), and this would be financed under a separate and new category under the AF LA. These pilots would finance capitation payments to selected provinces, and these

[40] "Effective coverage" means that a beneficiary has received at least one priority health intervention financed by the *Sumar Program* – based on a pre-defined list of priority interventions defined in the Operations Manual – within the previous 12 months.

[41] Equivalent to approximately US$2.5, taking into account a nominal exchange rate in April 2015 of (AR$8.8/US$).

funds would in turn be transferred to selected health service providers based on the achievement of specific health indicators related to the PDO. Thus, these pilots would continue to be based on the concept of provincial public health insurances with results-based capitation payments testing different modalities for payment mechanisms from Provinces to Providers. (See Annex III for more details).

v. Capitation payments (**US$75 million** in total) to finance GHIs for beneficiaries covered by the parent Project (under Category 3 of the LA for the original loan IBRD-8062-AR) – uninsured children, youth and women aged under 65 – would be eligible to be financed by the additional loan after funds for the relevant category under the original loan (Category 3) have been fully disbursed.[42] To reflect the inclusion of all population sub-groups, the capitation payment amount would be reassessed and re-estimated jointly with the MSN as established in the Operations Manual. To the extent possible, all groups would be treated as part of a single risk pool. In addition, health services related to Noncommunicable Diseases (NCDs) that are added to the benefit plan for uninsured adult men would also be added to the benefit plan for uninsured adult women, while additional female-specific services such as cervical cancer and breast cancer screening would continue to be covered by the benefit plan for uninsured adult women.

vi. In addition, selected health interventions for catastrophic diseases (SHICD) – currently financed under Category 4 of the original LA (IBRD-8062-AR) – would start to be financed by the AF after funds for the relevant category under the original loan (Category 4) have been fully disbursed (**US$8 million** in total). Capitation payments for SHICD had been included under the *Plan Nacer* Project (under APLII – Loan IBRD-7409-AR) in order to address treatable diseases related to the infant mortality rate (IMR). The SHICD has its own capitation value and health benefit plan, that includes diagnosis, treatment and surgery for catastrophic diseases (e.g. congenital heart disease), and others. To continue the process of reducing the IMR steadily, the additional loan would continue financing the SHICD capitation payments (and the SHICD health benefit plan), with the same implementation arrangements as in the parent Project.

vii. As in the case of the parent Project, the design would continue to include an integrated incentive framework for the provinces to ensure the achievement of the expected results. An appropriate mix of incentives would continue to be provided to provinces and provincial health providers through: (i) capitation payments adjusted based on performance regarding health tracer indicators (under Component 1); (ii) provision of technical assistance to boost managerial capabilities (Component 2 below); (iii) strong support for information systems and electronic medical records implementation (Component 3 below); (iv) delivery of selected medical equipment

[42] It is estimated that funds under Category 3 of the original (parent Project) Loan – which finance capitation payments for the current eligible population (children and adolescents aged under 20 years as well as adult women aged under 65 years without formal health insurance) would be exhausted (although not necessarily fully documented) around May 31, 2016.

(Component 3 below); and (v) autonomy in the use of funds for health centers and hospitals.

4. **Component 2. Institutional and Management Strengthening of the National and Provincial Ministries of Health (Additional Financing of US$25.5 million).** This component would continue to finance some of the activities that were under the parent Project, through the same two Subcomponents. The wording used in the original Loan Agreement (IBRD-8062-AR) describing the activities under Component 2 would be rephrased in the original LA (which would be amended) to follow the description of the scaled-up activities below, to provide a more accurate description of them.

5. **Sub-component 2.1: Improving the institutional capacity of national and provincial Ministries of Health (US$4.4 million):** This sub-component would provide additional financing for consultant TA/training services for the MSN and participating MSPs, mainly to support: (a) developing integrated information systems (see Box 1), instruments, and capacity to manage the PHIP, including administrative and billing data systems and the promotion of electronic medical records, the preparation and execution of annual performance agreements between MSN and MSPs, and between MSPs and Authorized Providers and new contracts and payment systems; (b) carrying out of outreach and service delivery strategies for rural and indigenous peoples (including the promotion of communities' participation, user rights, and culturally appropriate services for the inclusion of indigenous populations) and strengthening the health workforce skills of health staff in rural areas; (c) carrying out of studies on health system financing and related mechanisms, including mechanisms for integrating other public health programs with insurance/capitation schemes into the PHIP, all aimed at facilitating policy-making decisions of MSN and MSPs related with achieving effective Universal Health Coverage (see Box 2); and (d) improving MSN and MSP's communication strategies for disseminating information about health plans, changing behavior among health sector staff, and promoting social participation (see Box 3).

Box 1. Lines of Support for Information Systems Strengthening at the Provincial Level

1. **Support for strengthening the billing system of health centers (US$500,000)**
   The goal here is to facilitate and promote the billing of services in health care centers; the system would have to work both for the *Sumar Program* as well as for other programs. The support will be carried out through pilots that will test the use of the tool and will evaluate the improvement in billing.[43]

2. **Expansion of use of Electronic Medical Records (EMR) (US$1,500,000)**
   The goal here is to generate sufficient background material and evidence to evaluate the advantages and disadvantages (and cost) of implementing the widespread use of EMR at the national level. First some successful experiences in several jurisdictions will be identified, and then they will be implemented in some health centers.

[43] The recommended eligibility criteria for selecting the jurisdictions where the *Sumar Program* will finance information technology (IT) is that they are able to ensure conditions for its correct implementation. The tool will have to be available to any province or municipality that wishes to adopt it for administrative purposes and for improved health care information management in the health facilities within its jurisdiction.

Afterwards, these pilots can be extended to other jurisdictions. Studies will also be financed to explore several options and to assess critical issues regarding EMR implementation.

Activities to be financed: (i) adapting of software, (ii) technical support for system implementation, (iii) training, (iv) technical assistance and follow-up, (v) review of experiences in other countries, and: (vi) a study that will cover several issues related to EMR implementation (including digital signature, evidence on the advantages and disadvantages of using EMR, and confidentiality/security of generated and accessed information).

3. Pilot of computer-assisted audits (USD$ 200,000)

A pilot will be financed to carry out some computer-assisted verification exercises (audits), which at present are done as part of the independent technical audit mentioned above (also called the External Concurrent Audit). Support will be provided for the adaptation of existing systems, and training and follow-up tests will be run in parallel, in order to verify findings obtained by the External Concurrent Audit and by the computer-assisted audits.

Activities to be financed: (i) contracts supporting appropriate software development leading to availability of suitable software products; and (ii) consultancies for implementation support and for providing technical inputs for the development of relevant information tools.

Additional funds would be allocated under Component 3 for purchasing of hardware needed for the activities to be supported under Component 2.

Box 2: Move Towards Effective UHC – Integration Between the Sumar Program and Other Existing Insurance and Capitation Schemes

The proposed AF would provide **$2 million** for technical assistance (TA) under Component 2 to enhance integration over time between the *Sumar Program* and other existing insurance/capitation schemes such as *Incluir Salud* and the *Obras Sociales*. This would be consistent with moving towards an integrated and cost-effective structure for attaining effective UHC in the longer run. The TA would cover the following types of activities, among others:

- Customization of the *Sumar Program*'s information platforms and software to include services covered under the benefit plans of other insurance/capitation schemes
- Harmonization of the benefits plans of the *Sumar Program* and other insurance/capitation schemes
- Costing studies to help determine appropriate capitation values
- Support for activities to enhance the quality of data on enrollees and on the population in the catchment areas of health facilities (and on vital data of these individuals/families)
- A study to confirm whether the Sumar Program's incentive structure can be

applied to other insurance/capitation schemes
- Progressive integration of reporting systems
- Strengthening of purchasing mechanisms

Box 3. Moving Towards Effective UHC – Linking the Sumar Program Beneficiaries With Primary Health Centers, and Promoting Beneficiaries' Rights

A key objective of the *Sumar Program* is to register as many people as possible from the eligible population, and then to take steps to enhance the utilization and quality of key health services among them – i.e. to enhance their effective coverage. This is a key element of the Program's approach for moving towards effective UHC.

The Program will now reinforce this strategy as follows: It will make efforts to ensure that each registered beneficiary is linked explicitly to a primary health center. Primary health centers will thus, effectively, take charge of providing close monitoring and ongoing care, and close follow-up, for the *Sumar Program* beneficiaries under their care. The new reinforced strategy would enhance the possibility of acting proactively on individual health conditions which would be carefully identified beforehand. It will also facilitate the provision of key preventative health services to the eligible population.

In addition, the new reinforced strategy would facilitate the promotion of knowledge of individual rights among beneficiaries under their care, regarding their access to health services. Primary health centers would play a key role in enhancing the knowledge of beneficiaries about their program enrollment status, and about the benefits included in the Program Benefits Plan.

The new reinforced strategy would be tested as part of the UHC pilots to be financed under Component 1. One of the aspects to be monitored and tested could be the extent to which key parameters and timelines affecting the quality of service are adhered to, such as: (i) timely testing of PAP smear samples and timely notification of the results of the test; and (ii) ability to obtain an appointment in a reasonable amount of time, among others.

6. **Sub-Component 2.2: Supporting management, monitoring and evaluation (US$21.1 million).** This sub-component would support management, monitoring and evaluation capacities of the PCU, UFI-S and PHIUs, through the provision of technical assistance[44] (including the financing of operating costs and training), and the carrying out of monitoring and evaluation[45], and financial and technical audits under the Project.

7. **Component 3: Building capacity of the National and Provincial Ministries of Health to deliver services (Additional Financing of US$37 million)**: This component would provide AF towards strengthening the supply capacity of the MSN and the MSPs through, inter alia: (a) the provision of equipment (medical, transportation, information technology and

[44] Including the salaries of PCU, Provincial Health Insurance Unit (PHIU) and UFI-S contractual staff, and relevant consulting services.
[45] Including impact evaluations and Project evaluations.

communications); and (b) maintenance services needed to upgrade and expand MSN and MSPs' information and communication systems (excluding civil works).

8. Goods financed under this component (as described in the above paragraph) would complete the Information Technology and medical equipment needs for improved Program execution, including the needs related to the newly eligible population group (uninsured under-65 adult men). The PCU assessed the equipment needs to be financed under the additional loan. As under the parent Project, the MSPs will assume the responsibility for financing the maintenance needs for the equipment procured by the Project. The Procurement Plan, approved by the Bank, includes details on the goods to be financed.

Box 4. Correspondence between categories financed under the original LA (8062-AR) and those under the additional Loan (AF LA)

- **Category 1 of AF LA (US$37 million), financing goods under Component 3 of the Project**: Funds under this Category would be used for the purchase of goods as indicated in the Project Procurement Plan approved by the Bank, and subject to reporting via quarterly IFRs. (This Category would continue to finance the same types of activities as Category 1 of the original LA).

- **Category 2 of AF LA (US$24 million), financing consultant services, non-consultant services and training under Component 2:** Funds under this Category would be used for consultant and non-consultant services, as well as training, as indicated in the Project Procurement Plan and Annual Operating Plan approved by the Bank, and subject to reporting via quarterly IFRs. (This Category would continue to finance the same types of activities as Category 2 of the original LA).

- **Category 3 of AF LA (US$127 million), financing capitation payments for GHIs under Component 1**: This Category would finance capitation payments for General Health Interventions (GHIs), as does Category 3 of the original LA, except that under the AF LA, uninsured adult men aged under 65 would be added as a new eligible population sub-group. The funds under Category 3 of the AF LA would be used as follows under two different phases:

    - **Under the initial phase (Phase 1) which would start immediately after LA signature,** funds would be used only for GHI capitation payments for uninsured under-65 adult men. Phase 1 would include retroactive financing for GHI capitation payments for eligible adult men.

    - **Under Phase 2,** the funds under Category 3 of the AF LA would be used for GHI capitation payments for the entire expanded eligible population – uninsured adult men as well as uninsured children, adolescents and adult under-65 women. Phase 2 will commence after funds under Category 3 of the original LA are fully disbursed.

- **Category 4 of AF LA (US$8 million), financing capitation payments for Selected**

Health Interventions for Catastrophic Diseases (SHICD) under Component 1: Funds under this Category would only be used after funds under Category 4 of the original LA (which finances the same activities) are fully disbursed.

- **Category 5 of AF LA (US$1.5 million), financing operating costs under Component 2:** Funds under this category would be used for financing operating cost as indicated in the Annual Operating Plan for the Project approved by the Bank, and subject to reporting via quarterly IFRs. (This Category would continue to finance the same types of activities as Category 5 of the original LA).

- **Category 6 of AF LA (US$2 million), financing effective UHC pilots under Component 1:** This is an entirely new category which would provide a small amount of financing for new pilot activities, all based on the concept of provincial public health insurances and capitation payments. The funds under this category would be available immediately the LA becomes effective.

II. PROPOSED PARENT PROJECT RESTRUCTURING

9. **Extension of the Project Closing Date.** The Project closing date would be September 30, 2017 for both the additional Loan as well as the original Loan. The current Project closing date as specified in the original Loan Agreement is December 31, 2015. Therefore, the Project closing date would be extended from December 31, 2015 to September 30, 2017.

10. **Change to the percentage of expenditures to be financed by IBRD under Category 3 of the original Loan.** The co-financing scheme under Category 3 of the original Loan (IBRD-8062-AR) would be modified as follows: (i) The IBRD financing percentage for Category 3 in the Withdrawal of Loan Proceeds table in Section IV.2 of the original Loan would increase from 60 percent to 70 percent; (ii) the percentage financed by the National Government would increase from 10 percent to 15 percent; and: (iii) the percentage financed by the Provincial Governments would decline from 30 percent to 15 percent. These changes would be applied from July 1, 2015 until funds under Category 3 have been fully disbursed, and this would be mentioned in the amended original LA.

11. **The proposed rise in the IBRD co-financing percentage is necessary given the unexpected rise in total expected provincial contribution amounts in 2015, relative to what was originally budgeted.** Under the original Loan (IBRD-8062-AR), IBRD currently finances a fixed and declining percentage of the capitation payments for general health interventions (Category 3), with the rest financed mostly by the provincial governments themselves (and a portion by the national government). IBRD has been co-financing the capitation payments for GHI under Category 3 of the original Loan on a declining basis. Specifically, the IBRD financing percentage for this Category started at 100 percent in Calendar Year (CY) 2012, and then fell to 85 percent in CY 2013, then to 65 percent in CY 2014, and finally to 60 percent in CY 2015. A significant rise over time in the level of provincial contributions was always expected, and planned for.

12. Yet, in 2014 the total amount of provincial co-financing (in US dollar terms) almost doubled when compared to 2013 (see Table 3), in part due to the impact of the increase in the share of the capitation payments funded by the provinces, but mainly due to progress in Project implementation[46] and the adjustment of the capita value[47]. Financial projections for 2015 show that the total amount of provincial co-financing (in US dollar terms) would increase further by another 178 percent (almost tripling in US dollar terms – see Table 3) under the current scheme of co-financing percentages. This sharp increase goes well beyond what the provinces budgeted for this year, for *Sumar Program* capitation payments. The increase implies the need for a substantial re-allocation from other budget lines which is procedurally difficult to do at this point, putting at risk the capacity of the Provinces to comply with co-financing percentages specified in the original Loan Agreement.

Table 3. Total Level of Provincial Co-financing of the Capitation Payments for GHIs
(*US $ million)*

2013	2014	2015 (Estimates)	2015 Revised (Estimates)
7.8	15.25	42.36	30.13

13. With the revised scheme of co-financing percentages (where the co-financing percentage for the Provincial Governments would fall from 30 percent to 15 percent from July 1, 2015 onwards), the total amount of provincial co-financing is projected to be US $30.13 million rather than US $42.36 million in 2015, implying a rise of about 98 percent between 2014 and 2015 (see last column of Table 3). This is still large, but much more manageable than a rise of 178 percent which is projected to occur if there was no change in the provincial co-financing percentages. Furthermore, with the revised co-financing percentages, the rise in total provincial co-financing (in dollar terms) between 2014 and 2015 (by 98 percent) would be similar to the rise between 2013 and 2014 in dollar terms (96 percent).

III. SUMMARY OF MAIN PROPOSED CHANGES TO THE ORIGINAL PROJECT

14. Table 4 below presents the main proposed changes to be made to the original Project, both under the proposed additional Loan (IBRD-8516-AR) and the restructuring of the original Loan (IBRD 8062-AR).

[46] The number of beneficiaries with effective coverage increase by 50percent, from 2,290,018 in 2013 to 3,452,846 in 2014. There was also a large improvement in tracer indicator performance. One way of measuring the latter is to look at the size of the results-based portion of the maximum capita amount that is received by a province for each eligible beneficiary with effective coverage. This results-based portion can vary from 0 percent (lowest possible tracer performance) to 40 percent (highest possible tracer performance) of the maximum capita amount. Between 2013 and 2014, the average value (across all provinces) of the results-based portion of the maximum capita amount rose from 11.6 percent to 17 percent (unaudited figures).

[47] The capita value was adjusted from ARS $12 in 2013 to ARS $34 in July 2014.

Table 4: Summary of Proposed Changes versus parent Project and LA (Components and Loan Allocations)

A. Component	B. Description of Activities Financed Under the original Loan (IBRD-8062-AR)	C. Proposed Activities Under the AF, Compared to the Parent Project	D. Original Loan Allocations and How Reflected in Original Loan Agreement (IBRD-8062-AR)	E. Proposed Changes Under Restructuring of original Loan (IBRD-8062-AR)	F. New AF Loan Allocations (IBRD-8516-AR)
1 (Supporting Provincial Public Health Insurances)	Capitation payments for PHIP services for the provision of: (a) general health interventions (GHI) under Category 3; and (b) selected health interventions for catastrophic diseases (SHICD) under Category 4. The eligible population comprises children and adolescents aged under 20 and adult women aged 20-64 years without formal health insurance. The health services plan contributes to improving the quality of services as well as extending coverage on a per capita basis. Results are monitored using supervision protocols and information systems, and are verified by an independent technical auditor.	Category 3 of the AF LA will finance the same activities as Category 3 of the original Loan, but adult men aged under 65 without formal health insurance will be added as an additional eligible population sub-group, with its own specific Health Benefit Plan. This new sub-group will be financed by the AF LA from the beginning in an initial phase (including retroactive financing). Eligible groups under the original Loan will also be financed by the AF LA (in addition to the eligible adult men) in a second phase starting after funds from the original Loan under the relevant Category (3) have been fully disbursed. Category 4 of the AF LA will finance the same activities as Category 4 of original Loan, starting after funds under Category 4 from the original Loan have been fully disbursed. A new Category 6 will be introduced, which will finance effective Universal Health Coverage (UHC) pilots	Total allocation is **US$290 mn**: Category 3: **US$275 mn** for GHI, and: Category 4: **US$15 mn** for SHICD IBRD co-financing percentages are: (a) decreasing over time from 100% to 60% for Category 3, and: (b) 60% throughout for Category 4.	No changes in activities, implementing arrangements or allocations for this component. Co-financing percentage to change for Category 3 from 100% to 70% (but not for Category 4).	Total allocation is **US$137 mn**: (a) Category 3: **US$127 mn** for GHI, and (b) Category 4: **US$8 mn** for SHICD (c) New Category 6**:** **US$ 2mn** for UHC pilots IBRD co-financing percentages are: (a) decreasing over time from 100% to 65% for Category 3; (b) 60% throughout for Category 4; and: (c) 100% for Category 6. No changes in activities, implementing arrangements

A. Component	B. Description of Activities Financed Under the original Loan (IBRD-8062-AR)	C. Proposed Activities Under the AF, Compared to the Parent Project	D. Original Loan Allocations and How Reflected in Original Loan Agreement (IBRD-8062-AR)	E. Proposed Changes Under Restructuring of original Loan (IBRD-8062-AR)	F. New AF Loan Allocations (IBRD-8516-AR)
2 (Institutional and Management Strengthening of the National and Provincial Ministries of Health (MSN and MSPs))	Provision to the MSN and MSPs of tools and information they need to improve governance and their organizational/ stewardship capacity. Will comprise the following subcomponents: (a) Sub-Component 2.1 (Improving the management capacity of national and provincial ministries of health), and: (b) Sub-Component 2.2 (Supporting management, monitoring and evaluation).	Same eligible activities as in Component 2 of parent Project. Will include $2.2 mn for supporting information systems development at the provincial level (see Box 1), and $2 mn for carrying out relevant studies that would inform policies for the achievement of effective UHC (see Box 2), by financing activities already eligible under the original Loan. .	Total allocation is **US$59 mn**, all corresponding to: (a) Category 2 of the original LA, financing consultant services, non-consultant services and training (total **US$53 mn**), and: (b) Category 5 of the original LA, financing operating costs (**US$6 mn**). IBRD co-financing percentage is 100% for both categories.	No changes in activities, implementing arrangements or allocations for this component (nor for Categories 2 and 5 of the original LA).	Total allocation is **US$25.5 mn**, all corresponding to: (a) Category 2: **US$24** mn financing consultant services, non-consultant services and training, and: (b) Category 5: **US$1.5 mn** financing operating costs IBRD co-financing percentage is 100% for Category 2, and 85% for Category 5. No changes in activities, implementing arrangements.
3 (Building Capacity of the MSN and MSPs to Deliver Services)	Strengthening of the supply capacity of the MSN and the MSPs through: (a) the provision of equipment (medical, transportation, IT and communications); and (b) maintenance services needed to upgrade and expand MSN and MSPs' information and communication systems	Same eligible activities as in Component 3 of parent Project. Financing goods already eligible under the original Loan. IBRD co-financing percentage to remain at 85%.	Total allocation is **US$50 mn**, all corresponding to Category 1 of the original LA, which only finances goods. IBRD co-financing percentage is 85%.	No changes in activities, implementing arrangements or allocations for this component, nor for Category 1 of the original LA.	Total allocation is **US$37 mn**, all corresponding to Category 1 which only finances goods. IBRD co-financing percentage is 85%.
Front End Fee			US$1 mn	No change	US$0.5 mn
Closing Date	December 31, 2015	September 30, 2017		September 30, 2017	
Environmental Assessment (EA) (OP/BP 4.01)	EA Category C	EA Category B		EA Category B	
Indigenous	Triggered; IPPF and IPPs	Triggered; updated IPPF and IPPs		No changes	

A. Component	B. Description of Activities Financed Under the original Loan (IBRD-8062-AR)	C. Proposed Activities Under the AF, Compared to the Parent Project	D. Original Loan Allocations and How Reflected in Original Loan Agreement (IBRD-8062-AR)	E. Proposed Changes Under Restructuring of original Loan (IBRD-8062-AR)	F. New AF Loan Allocations (IBRD-8516-AR)
Peoples (OP/ BP 4.10)	consulted and disclosed	including new group of eligible men, consulted and disclosed.			

Annex 3: Revised Institutional and Implementation Arrangements under the Additional Financing

ARGENTINA: Additional Financing (P154431) – Provincial Health Insurance Development Project (P106735)

A. Overall Implementation Arrangements

1. **The institutional arrangements for the Additional Financing (under the additional Loan IBRD-8516-AR) would remain the same as for the parent Project, in line with the parent Project design**, except for minor adjustments. The Project would continue being implemented by the MSN through the Project Coordinator Unit (PCU), established within the MSN. The PCU would continue being responsible for working with participating provinces through the PHIUs to implement the Project in a timely manner, conforming to agreed-upon quality standards. It would also provide technical advice and consider recommendations by COFESA related to the PHIP.

2. **The PCU would continue to be staffed by a Coordinator (appointed by the Minister of Health and subject to approval by the Bank), and a multidisciplinary team** that provides logistic and strategic support to coordinate the Project's management and six operational areas within the PCU. Their experience in project implementation has continued to be strengthened throughout the duration of the ongoing *Sumar Program*. Currently, the Project finances 60 percent of the staff at the PCU, but this would drop to 50 percent by March 2016 and 45 percent by March 2017.

3. **The International Financing Unit of the MSN (UFI-S) would continue being responsible for overall administrative and fiduciary matters** such as financial management and procurement. UFI-S is the MSN's central fiduciary agency that manages external financial resources and provides support to all MSN units involved in Project implementation. The UFI-S has its own Operations Manual (approved by the World Bank), which is part of the Project's Operations Manual. The UFI-S has conducted financial management and procurement functions over the last 14 years for Bank-financed projects.

4. **Project implementation at the provincial level would continue being carried out by the MSPs of participating provinces, through the Provincial Health Insurance Units (PHIUs)**, which were created as part of the intended structural reforms for provincial health financing**.** The PHIUs are expected to continue as the provincial health sector purchasing agencies/departments when the Project is completed, as stipulated in the Operations Manual. Their main responsibilities include: (a) identifying beneficiaries and mobilizing their participation; (b) identifying, authorizing, and contracting health service providers for the beneficiaries under their jurisdictions; (c) controlling the technical quality of services; and (d) liaising with the PCU to obtain Project technical, financial, and administrative support. Currently, the parent Project finances 70 percent of PHIU staffing. Under the additional loan and starting in March 2016, financing will decline to 60 percent, and then to 55 percent in March 2017.

5. **Institutional Arrangements for the Project would be adjusted as follows, all in terms agreed by the Bank**: (i) The MSN would update the PHIP resolution to incorporate the new population sub-group under the Project – eligible men aged under 65; (ii) Each Participating Province would sign an addendum of the Umbrella Agreement in order to incorporate the new population sub-group; and (iii) Participating Provinces would sign an addendum of the 2015 Annual Performance Agreements, incorporating the GHI for this sub- group and the updated IPPs; updated IPPs would be re-consulted and re-disclosed before any new activity takes place in the Participating Province.

6. **Implementation arrangements under Component 1 would remain the same as in the parent Project.** Capitation payments would be transferred from the MSN to the MSP in two steps: (a) a share of the financing (60 percent) would be provided every month after effective coverage is verified by the PCU, and: (b) the remaining share (40 percent) would be transferred every four months, based on provincial performance as measured by achievement of tracer indicators, except during an initial startup period (until December 31st, 2015) when the full 40 percent would be transferred regardless of provincial tracer performance[48]. This initial startup period would only apply for adult men aged under 65 (the newly eligible beneficiaries), which are the only population group that would receive financing under Component 1 of the AF in 2015. An independent technical audit, conducted by a firm contracted by the PCU and with TORs acceptable to the Bank, would verify the eligibility of all beneficiaries for which capitation payments were made. In addition, tracer performance assessed for each province, and used to determine the size of the results-based portion of the payments made to the province, would ultimately be based on the findings of this audit firm.

7. **The set of tracer indicators for GHIs for the Project would be adjusted to reflect the inclusion of the new group of eligible men aged under 65, with two additional tracer indicators added to reflect health priorities for this new group.** These would be used starting January 1st , 2016 for all groups (see Table 1). The final list of tracer indicators would be defined in the Operations Manual (via an update of the existing Manual) before December 30th, 2015. In addition, the MSN may ask the Bank to review the tracer indicators periodically, and to approve requests for changes in these indicators, according to procedures established in the Operations Manual.

Table 1: Additional Proposed Tracer Indicators

Number	Tracer	Description
XV	Colorectal cancer prevention	Numerator: Number of eligible adult population, ages 50-64 who received at least one colorectal cancer screening in the last 24 months.

[48] The idea behind this is that initially during the startup period for a new group of beneficiaries, the main focus should be on incentivizing enrollment and obtaining a critical mass of enrollees. The next step (after the startup period) would be to incentivize utilization of key services among the enrollees. This would be done by applying the tracer system, where the size of the capitation payments is adjusted (downwards) according to provincial tracer performance (which is mainly determined by enrollees' utilization levels of key services). A startup period of several months would also allow sufficient time to fully update the electronic tracer system to be used for transfers from the MSN to the MSP, and to conduct sufficient training on the new systems.

Number	Tracer	Description
		Denominator: Number of eligible adult population, ages 50-64.
XVI	Early Detection of prevalent NCDs	Numerator: Number of eligible adult population ages 30-64 receiving NCD screening. Denominator: Number of eligible adult population ages 30-64

8. **Effective Universal Health Coverage (UHC) Pilots: The AF provides the opportunity to test a series of design changes intended to strengthen the relationship between provider performance incentives and health outcomes, exploring different approaches to achieving effective UHC over time.** In particular, a part of the additional Loan, funds would be used to design and to test new payment mechanisms from Provinces to Providers through capitation pilots in a subgroup of selected health service providers in specific provinces.[49] The experiments would produce important insights for the implementation of new payment mechanisms to improve health outcomes of those most in need. In addition, the implementation of new mechanisms in different provinces facing different policy environments and institutions would also allow a comparison across regions and would guide future health policy decisions, including a scaling up of the experiments if proven effective.

9. **For the purpose of implementing the pilots, a small amount under Component 1 (US$2 million) would be set aside and it would be financed under a separate category under the additional Loan (Category 6)**. These pilots would continue to be based on the concept of provincial public health insurances with results-based capitation payments from MSN to MSPs, and would follow the implementation arrangements already in place for this Component. These pilots would finance payments from the PCU to the participating PHIU and from the participating PHIU to the selected health service providers based on the achievement of specific health indicators related to the PDO, after verification. In this case, the PCU would disburse 100 percent of the Pilot Capitation Payment amount periodically to the participating PHIU after verification of the selected providers' aggregate performance. To this end, an amendment to the Annual Performance Agreement would be signed between MSN and the MSP and with the health service provider, incorporating the pilot capitation payment amount, the agreed results to be achieved, the related payments and the verification mechanisms. In addition, the Operations Manual contains details of the pilot design, the requirements to be met by a Province in order to be eligible for these pilots, the selection criteria for providers and how the results are going to be measured and evaluated.

B. Financial Management and Disbursement

10. **Financial management (FM) and disbursement arrangements for the additional Loan will follow the arrangements already in place for the original Loan** with the International Financing Unit for Health (UFI-S) of the Ministry of Health responsible for the

[49] As an example, provider payment mechanisms other than the current modality of fee-for-service would be tested.

financial management and disbursement functions of the Project. FM arrangements in place at UFI-S continue to comply with Bank requirements as shown by independent technical audits, annual financial audit reports, and Bank FM supervision. The last FM supervision mission carried out in November 2014 determined that project FM performance continues to be satisfactory. There are no overdue audit reports for the ongoing projects under implementation by the Ministry of Health.

11. **Retroactive financing.** It is expected that the Borrower would request retroactive financing for Category 3 of the additional LA, to finance capitation payments for uninsured under-65 adult men paid up to one year before the date of the Loan Agreement signing but not before April 1st 2015; retroactive financing should not exceed US$24 million[50]. The Borrower's application for reimbursement of expenditures paid before the loan signing date would be accompanied by certification – by Independent Technical Auditors acceptable to the Bank – of the veracity of the figures reported on enrollment and on the number of eligible beneficiaries with effective coverage. In addition, the MSN would need to provide evidence of accomplishment of the following actions: (i) approval of an MSN resolution that incorporates the new population sub-group under the *Sumar Program*; (ii) signed addendum of the Umbrella Agreements for Participating Provinces; (iii) signed Annual Performance Agreements for Participating Provinces, incorporating the GHI for the new group (uninsured adult men) and the IPPs, all on terms agreed with the Bank.

C. Procurement

i. General

12. **Procurement for the proposed Project would be carried out in accordance with the World Bank's "Guidelines**: Procurement of Goods, Works, and Non-Consulting Services under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 and revised on July 2014; and "Guidelines: Selection and Employment of Consultants under IBRD Loans and IDA Credits & Grants by World Bank Borrowers" dated January 2011 and revised on July 2014, and the provisions stipulated in the Legal Agreement. The general description of various items under different expenditure categories are described below. For each contract to be financed by the Loan, the different procurement methods or consultant selection methods, the need for prequalification, estimated costs, prior review requirements, and time frame was agreed between the Borrower and the Bank in the Procurement Plan. The Procurement Plan will be updated at least annually or as required to reflect the actual Project implementation needs and improvements in institutional capacity.

13. **Procurement activities under this Project are aligned with the CPS cross-portfolio approach to governance[51] and with the CPS governance indicator related to supporting**

[50] This was calculated based on the following assumptions/premises: (i) all 24 Participating Provinces sign the Umbrella Agreement Addendum in April 2015, (ii) 48% of eligible uninsured under-65 men are enrolled in the Program (1.9 million men) between April 2015 and September 2015 as verified by the external audit (iii) the capitation amount for the new group of men is AR$22, and (iv) AF Loan signing takes place in October 2015.
[51] See paragraph 85 of the Argentina Country Partnership Strategy FY 2015-2018 (Report No. 81361-AR).

open procurement: First, all invitations to bid, bidding documents, minutes of bid openings, requests for expressions of interest and the pertinent summary of the evaluation reports of bids and proposals of all Goods, Non-Consultant Services and Consultants' Services procured by the Borrower, through MSN, will be published in the web page of the Borrower's Office of National Procurement (*Oficina Nacional de Contrataciones*). Second, the Procurement Plan, including execution data, will be managed through SEPA (Bank's Procurement Plan Execution System), for which there is public access once the plan is approved by the Bank.

14. **Procurement of Works**: It is not expected that there will be contracting of any civil works under this Project.

15. **Procurement of Goods**: Goods to be procured under this Project would include IT and medical equipment, ambulances and health related goods (i.e., medicines). Procurement of goods will be done using the Bank's SBD for all ICB processes; procurement of goods under NCB and Shopping procedures shall be done using SBDs agreed with, or satisfactory to, the Bank. Such SBDs are included as annexes in the Project's Operations Manual.

16. **Procurement of Non-Consulting Services:** Non-Consulting Services for the Project would include logistics for capacity-building events, printing of training materials, media campaigns, and related services for institutional strengthening components. Procurement of non-consulting services will be done using SBDs and simplified formats agreed with or satisfactory to the Bank for ICB, NCB and shopping procedures, respectively. Said SBDs and simplified formats are part of the Project's Operations Manual.

17. **Selection of Consultants:** Selection and employment of consultant firms and individual consultants will be needed to provide technical assistance, develop integrated information systems, improve communication strategy, perform audit reviews, improve epidemiological information, financial monitoring, and evaluation, and human resource management systems, streamline regulatory and planning capacity within public health program units and strengthen the health workforce skills. Short lists of consultants for services estimated to cost less than US$1,000,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. Regardless of the method used or the estimated cost of the contracts, selection and contracting of consultant firms will be done using the Bank's Standard Request for Proposals (SRfP). Selection and contracting of Individual Consultants will be done using a simplified request for curriculum vitae (CVs) and a contract model agreed with, or acceptable, to the Bank; processes for the competitive selection of Individual Consultants shall be made public. Such documents are part of the Project's Operations Manual.

18. **It is expected that the Project would have advanced contracting of concurrent audits** of the capitation payments for the group that is not eligible under the parent Project (i.e., adult men aged under 65), based on contracts with firms currently performing audits for the rest of the eligible groups. Also, individual consultants that are currently being financed with the proceeds of the parent Project will be sole-source selected under the justification of continuity of previous assignments.

19. **Operational Costs:** Operating costs refer to reasonable recurrent expenditures that would not have been incurred by the implementing agency in the absence of the Project. They may include but are not limited to operation and maintenance of office equipment purchased under the Project, as well as nondurable/consumable office materials, as needed for the implementation of the Project. All these activities would be procured using the implementation agencies' administrative procedures, which were reviewed and found acceptable to the Bank.

ii. Implementation Arrangements

20. **A Procurement Assessment on the capacity to implement procurement activities for the Project was carried out in Health's International Financing Unit (UFI-S) within the MSN** based on the fact that the AF would continue applying the same implementing arrangements of the original Loan Agreement (IBRD-8062-AR). UFI-S has extensive previous experience using Bank's procurement and consultant guidelines, procedures and standard documents. The UFI-S Procurement Area is properly staffed with more than 40 specialized professionals who are divided into three units (i.e., planning and contact management, procurement processes' management and human resources) and is coordinated by a well-seasoned professional with over 10 years of specific experience in Procurement under the World Bank's policies and procedures.

21. **UFI-S is properly equipped, and has in place in-house systems to monitor the whole procurement cycle;** furthermore, they have been using SEPA (the Bank's Procurement Plan Execution System) since its inception, and have a well-functioning filing and record-keeping system. UFI-S has developed and progressively improved an Operations Manual which includes the Bank's SBDs already adapted for the Health's Sector, as well as all the necessary SBDs, evaluation formats, etc. Such Operations Manual as well as all the Documents included as annexes would be fine-tuned for its use in this operation.

22. **UFI-S has concluded successfully the implementation of a Governance and Accountability Action Plan (GAAP),** and the first phase of a Performance Improvement Plan in Procurement, which was jointly developed with the Bank. Both exercises have improved significantly the way that the overall procurement activities are carried out and have had a significant impact on performance indicators (e.g., bidding processes' time), and on the quality of the produced documents. At the request of UFI-S, a second phase of the Performance Improvement Plan in Procurement is currently under implementation, which includes, among many other activities, a joint capacity building program aimed to further specialize UFI-S staff in complicated procurement processes.

iii. Procurement Plan

23. **UFIS has developed a detailed Procurement Plan for the first 18 months for the implementation of the Project**. Said Plan provides the basis for the use of different procurement methods, and for the Bank's review process. This Plan was agreed between the Borrower and the World Bank. As soon as the Project is effective, the Procurement Plan will be available via the SEPA portal. The Plan will also be available in the Project's database and on

the Bank's external website. The Procurement Plan will be updated in agreement with the Project Team annually, or as required to reflect the actual Project implementation needs and improvements in institutional capacity.

iv. Frequency of Procurement Supervision

24. In addition to the prior review supervision to be carried out by the Bank, annual supervision missions will visit the field to carry out post-review of procurement actions. One out of every ten contracts should be post-reviewed when applicable.

v. Details of the Procurement Arrangements Involving International Competition

25. Thresholds for the use of the different procurement methods and recommended thresholds for Bank prior review are given in the Table 3.

Table 3: Thresholds for Procurement Methods and for Recommended Bank Review

Estimated Value Contract Threshold	Procurement Method	Bank Prior Review
Goods and Non-Consulting Services:		
>=US$500,000	ICB	All
<US$500,000 and >= US$100,000	NCB	First
<US$100,000	Shopping	First
Any estimated Cost	Direct Contracting	All
Consulting Firms:		
Any Estimated Cost	SSS[52]	All
>=US$300,000	QCBS, QBS, FBS, LCS, CQS	All
<US$300,000	QCBS, QBS, FBS, LCS, CQS	First for each selection method
Individual Consultants:		
Any Estimated Cost	SSS	All
>=US$100,000	IC	All
<US$100,000	IC	First

ICB = International Competitive Bidding. NCB = National Competitive Bidding.
SS = Sole Source. QCBS = Quality- and Cost-Based Selection
QCS = Quality-Based Selection FBS = Selection under Fixed Budget
LCS = Least-Cost Selection CQS = Selection Based on the Consultant's Qualifications
IC = Individual Consultant.

[52] Sole Source selection of Consultants, regardless of the contract amount, shall comply with all the provisions stated in paragraphs 3.8 to 3.11 of the Consultant Guidelines and, therefore, shall be subject to Bank's prior review.

26. **The Procurement Plan defines the contracts that are subject to Bank prior review based on the recommended thresholds given in Table 3**. Such recommended thresholds could be revised at every update of the Procurement Plan.

27. **Short lists composed entirely of national consultants:** Short lists of consultants for services estimated to cost less than US$1,000,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

28. **Special Procurement Conditions:** The following shall apply to procurement under the Project:

- Procurement of Goods, Non-Consultant Services and Consultants' Services (in respect of firms) shall be carried out using: (i) (A) standard bidding documents; and (B) standard requests for quotations/proposals (as the case may be), all acceptable to the Bank, which shall all include, *inter alia*, a settlement of dispute provision and the pertinent provisions of the Anti-Corruption Guidelines; (ii) model bid evaluation forms, and model quotations/proposals evaluation forms (as the case may be); and (iii) model contract forms, all acceptable to the Bank;
- A two-envelope bidding procedure shall not be allowed in the procurement of Goods and Non-Consultant Services;
- After the public opening of bids for Goods and Non-Consultant Services, information relating to the examination, clarification and evaluation of bids and recommendations concerning awards, shall not be disclosed to bidders or other persons not officially concerned with this process until the publication of contract award. In addition, bidders and/or other persons not officially concerned with said process shall not be allowed to review or make copies of other bidders' bids;
- After the public opening of Consultants' proposals, information related to the examination, clarification and evaluation of proposals and recommendations concerning awards, shall not be disclosed to consultants or other persons not officially concerned with this process until the publication of contract award (except as provided in paragraphs 2.23 and 2.30 of the Consultants Guidelines). In addition, consultants and/or other persons not officially concerned with said process shall not be allowed to review or make copies of other consultants' proposals;
- Foreign bidders or foreign consultants shall not, as a condition for submitting bids or proposals and/or for contract award: (i) be required to be registered in Argentina (except as provided in the standard bidding documents referred to in the first bullet point above); (ii) be required to have a representative in Argentina; and (iii) be required to be associated or subcontract with Argentine suppliers, contractors or consultants;
- The invitations to bid, bidding documents, minutes of bid openings, requests for expressions of interest and the pertinent summary of the evaluation reports of bids and proposals of all Goods, Non-Consultant Services and Consultants' Services procured by the Borrower, through MSN, shall be published in the web page of the Borrower's Office of National Procurement (*Oficina Nacional de Contrataciones*), and in a manner acceptable to the Bank. The bidding period shall be counted from the date of publication of the invitation to bid or the date of the availability of the bidding documents, whichever is later, to the date of bid opening;

- Provisions set forth in paragraphs 2.49, 2.50, 2.52, 2.53, 2.54 and 2.59 of the Procurement Guidelines shall also be applicable to contracts for Goods and Non-Consultant Services to be procured under National Competitive Bidding procedures;
- References to bidders in one or more specialized magazines shall not be used by the Borrower, through MSN, in determining if the bidder in respect of goods whose bid has been determined to be the lowest evaluated bid has the capability and resources to effectively carry out the contract as offered in the bid, as referred to in the provision set forth in paragraph 2.58 of the Procurement Guidelines. The provision set forth in paragraph 2.58 of the Procurement Guidelines (including the limitation set forth herein) shall also be applicable to contracts for goods to be procured under National Competitive Bidding procedures;
- Witness prices shall not be used as a parameter for bid evaluation, bid rejection or contract award;
- The Borrower, through MSN, shall: (i) supply the SEPA with the information contained in the initial Procurement Plan within 30 days after the Project has been approved by the Bank; and (ii) update the Procurement Plan at least every three months, or as required by the Bank, to reflect the actual Project implementation needs and progress and shall supply the SEPA with the information contained in the updated Procurement Plan immediately thereafter;
- The provisions of paragraphs 2.55 and 2.56 of the Procurement Guidelines providing for domestic preference in the evaluation of bids shall apply to goods manufactured in the territory of the Borrower in respect of contracts for goods to be procured under International Competitive Bidding procedures;
- Compliance by bidders with the norms issued by ISO with respect to any given good procured under the Project shall not be used as parameter for contract award;
- Consultants shall not be required to submit bid or performance securities;
- Contracts of Goods and Non-Consultant Services shall not be awarded to the "most convenient" bid, but rather to the bidder whose bid has been determined: (i) to be substantially responsive; and (ii) to offer the lowest evaluated bid, provided that said bidder has demonstrated to the Borrower, through MSN, to be qualified to perform the contract satisfactorily; and
- The types of contracts described in Section IV of the Consultant Guidelines shall be the only types of contracts to be used by the Borrower, through MSN, in connection with the contracting of consultants' services provided by a firm and to be financed with the proceeds of the Loan.

D. Environmental and Social Safeguards

29. **The Project has triggered OP/BP 4.01 on Environmental Assessment.** Based on the findings of an Environmental Assessment carried out in March 2015, the Project has triggered OP/BP 4.01 on Environmental Assessment due to the potential environmental concerns around: (i) the handling of health care waste resulting mainly from the inclusion of new high-complexity interventions within the Program's benefit plan, as well as the expansion of already-included

high-complexity health interventions for youth under 20[53]; and (ii) the disposal of old IT equipment. Therefore, the Project's Environmental Category was upgraded from C to B.

30. **Therefore, the Project would use an Environmental Management Framework (EMF) that focuses on health care waste management nationwide and electronic waste.** This EMF was built upon the Second Essential Public Health Functions and Programs (EPHF) II Project (P110599) experience and was found to be appropriate to address any potential environmental issue generated by this Project. The EMF was disclosed both at the MSN and the World Bank Group external web page before Project appraisal. In addition, the Project will also use the "Guide to Rational Vaccine Waste Management" developed under the H1N1 Prevention and Management of Influenza Type Illness (P117377) Project. Activities related to the application of the EMF would be carried out by the EPHF II Environmental Safeguards technical staff in liaison with the Technical Assistance and Training area of the PHIP. Once the EPHF II is closed, the Environmental Unit of the EPHF II will continue working under the Protecting Vulnerable People Against Noncommunicable Diseases Project (P133193) which is expected to be approved by the Board of Executive Directors in June 9th, 2015. EPHF II closing date is June 30th, 2016**.**

31. **For social safeguards, the OP/BP 4.10 on Indigenous Peoples policy was triggered under the parent Project,** and an Indigenous Peoples Planning Framework (IPPF) was developed and published in 2010. In order to reflect the scaling up of Project's activities, the IPPF was updated and re-consulted on April 9th, 2015. A draft of the updated IPPF was delivered to the representatives of indigenous peoples from the provinces that trigger the safeguard one week prior to the consultation. Disclosure of the IPPF on the MSN and the World Bank external web page took place before appraisal. Changes to the IPPF are mainly related to the expansion of the eligible population to incorporate uninsured men aged under 65 and the inclusion of selected health interventions for this group within the *Sumar Program's* benefit plan. The objective of the updated IPPF continues to be to promote indigenous peoples' access to Project benefits and to adapt the services in a culturally appropriate manner.

32. **Implementation arrangements for the Indigenous Peoples safeguards would remain the same as under the original Loan.** The protocol for implementing the IPPF in each community focuses on four areas: (a) Conducting social assessments and initial consultations to present the Project to the communities. The initial screening of beneficiaries includes a needs assessment through free consultations on the socio-economic and cultural characteristics affecting the community's health and on its epidemiological profile and main health care concerns; (b) enrolling beneficiaries, which includes screening indigenous beneficiaries (done by members of their community) and training health teams to complete the parts of the enrollment form that refer to ethnic variables; (c) disseminating information and creating a communications scheme, which includes producing materials in the indigenous languages and devising ways to hold consultations and address grievances at the national and provincial levels;

[53] The *Sumar Program's Benefit Plan includes* high-complexity interventions to address high-risk pregnancies, high-complexity neonatal services and congenital heart surgeries for children under 6 years of age. In 2014, the benefit plan was expanded to cover congenital heart surgeries for youth aged under 20 and congenital malformations.

and (d) training health teams on issues related to inter-cultural health practices and health education.

33. **The IPPF requires that each Province prepares an Indigenous Peoples' Plan (IPP) that includes culturally appropriate mechanisms to reach this group.** IPPs developed under the parent Project would have to be updated, re-consulted and re-disclosed to reflect the new eligible population group as well as the new health services covered by the Project. This would be done as part of the update of the Annual Performance Agreements to be signed between each province and the MSN. Provinces would be able to start a new activity not covered under the parent project after updating and consulting the IPP. The scope of each IPP depends on specific needs in each province and the level of commitment and available financing. The PCU's Technical Assistance and Training area would continue to be responsible for monitoring the screening, certification, and enrollment in indigenous areas, and for launching the IPPs in the provinces. Also, this area would continue supervising the implementation of the IPPs, along with the following activities: promoting and collaborating with other health programs to develop and strengthen health policies for indigenous peoples and health teams, including health care practices consistent with the needs of indigenous peoples (e.g. visits of health agents to rural and indigenous areas), full medical check-ups, field screening of indigenous people at high risk to confirm diagnosis and treatment, and workshops covering therapeutic and traditional practices among indigenous peoples.

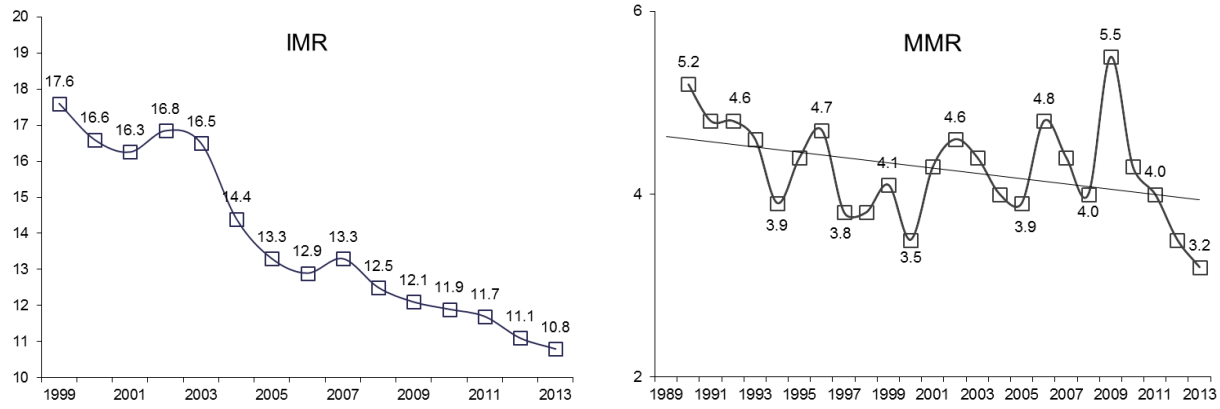
Annex 4: The Health Sector in Argentina, and Background on Plan Nacer and the *Sumar Program*

ARGENTINA: Additional Financing (P154431) – Provincial Health Insurance Development Project (P106735)

A. Health Indicators in Argentina

1. **During the past decade, Argentina has made substantial improvements in health care coverage and health outcomes.** The infant mortality rate (IMR) decreased from 14.4 per 1,000 live births in 2004 to 10.8 in 2013; and the maternal mortality ratio (MMR) is now on a declining trend, reaching 32 per 100,000 live births in 2013[54] (Figure 1). Table 1 provides a comparison of key indicators for Argentina and upper middle-income countries on average.

Figure 1. Infant Mortality Rate and Maternal Mortality Ratio



Source: Statistic and Information System. Health Division. Dirección de Estadísticas e Información de Salud (DEIS)

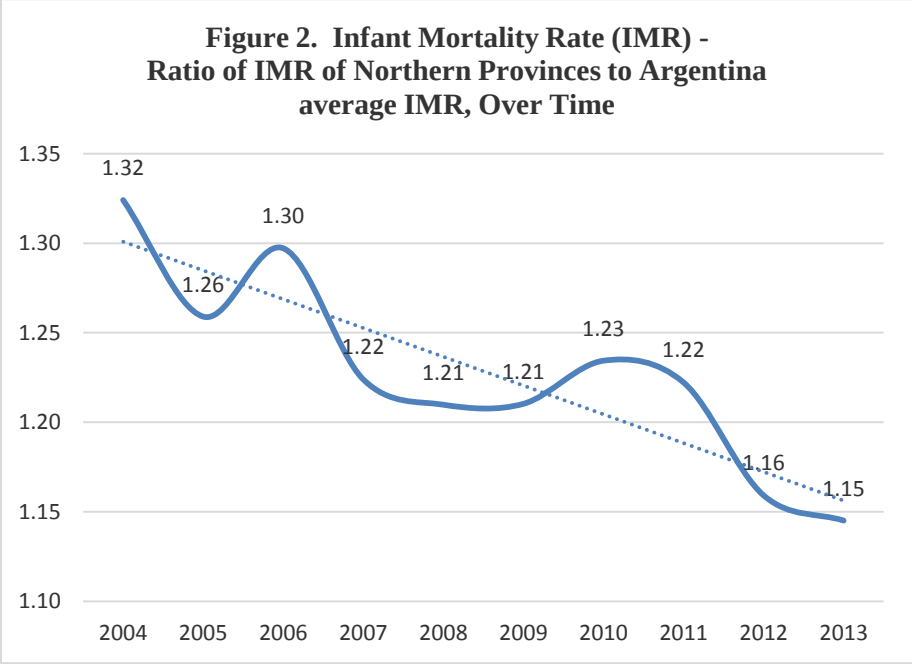
2. **There are significant inequalities across provinces and socioeconomic groups, but there are signs that programs such as Plan Nacer have helped to reduce these inequalities for indicators such as infant mortality and maternal mortality.** For example, Figure 2 shows that the gap between the IMR of the poorer Northern provinces of the country and the average national IMR reduced significantly over time. The Northern provinces were included in Plan Nacer starting in 2004, while the other provinces were included later in a second Phase, starting in 2007.

[54] Data from the National Ministry of Health (DEIS).

Table 1. International Comparisons, Health Indicators (for 2012/2013)

	Argentina	Upper Middle Income Country Average	% Difference
GDP per capita (current US$)	14,715	7,324	-50.2%
Prenatal service coverage	98.1	95.28	2.9%
Skilled birth coverage	98.2	96.2	2.0%
Improved sanitation	97.2	84.9	12.7%
TB success	56	79.8	-42.5%
Infant Mortality Rate	10.8	17.1	-58.3%
<5 Mortality Rate	13.3	21.4	-60.9%
Maternal Mortality Ratio	32	60.94	-90.4%
Life expectancy	76.2	72.6	4.7%
THE % of GDP	7.3	6.6	9.6%
GGHE as % of THE	67.7	63.3	6.5%
Physician Density	3.9	1.7	56.4%
Hospital Bed Density	4.7	3.4	27.7%

Source: World Bank, DataBank. Health, Nutrition and Population Statistics.

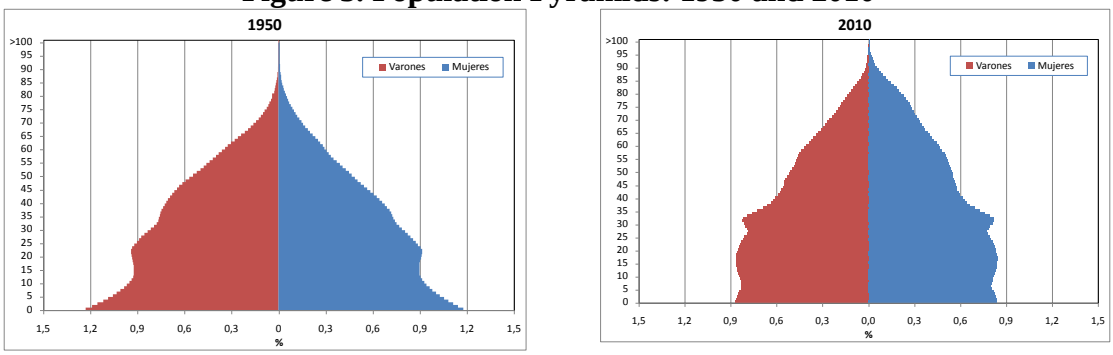


Source: Statistic and Information System. Health Division. Dirección de Estadísticas e Información de Salud (DEIS)

3. **Yet there are persistent inequalities with other key indicators, in particular those linked to preventative health.** For example, the National Risk Factors Survey of 2009 found that the percentage of women in households earning less than 1750 Pesos a month that had breast cancer screening in the previous two years was 40.5 percent, as compared to 72.3 percent for women in households earning more than 4000 Pesos a month. Only 36.2 percent of women in Formosa Province in the North had undergone breast cancer screening, as compared to 72 percent in Tierra de Fuego Province.

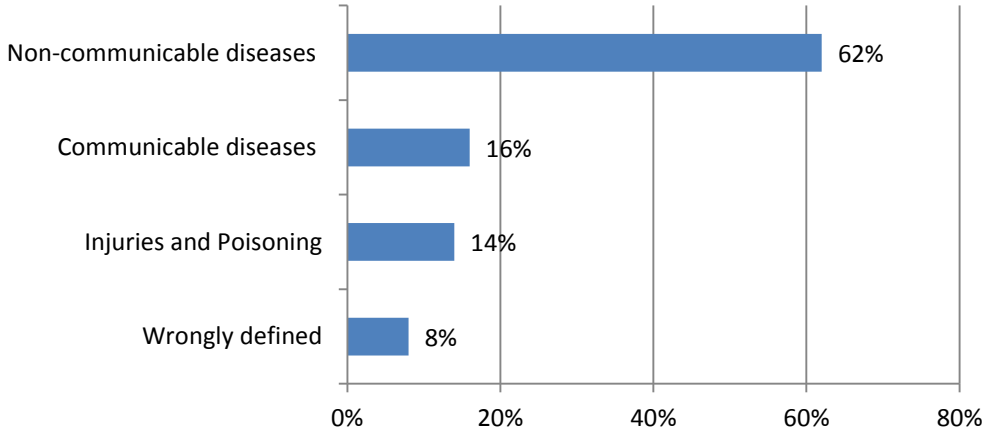
4. **The country is at an advanced phase of its demographic and epidemiological transitions (see Figure 3), and its aging population suffers increasingly from chronic conditions and injuries (CCIs), and less from infectious diseases**. Noncommunicable diseases (NCDs) accounted for 81 percent of all deaths in Argentina in 2009. And, as Figure 4 shows, about 62 percent of the years of potential lives lost in the country are due to NCDs.

Figure 3. Population Pyramids: 1950 and 2010



Source: Gragnolati, M. et.al. Demographic Change and the Welfare System in Argentina. Forthcoming.

Figure 4. Percentage of Years of Potential Lives Lost, by Cause of Death (2009)



Source: Data from Borruel, M., I. Mas, and G. Borruel (2010).

B. The Health System and Health Financing in Argentina

5. **The structure of the health system in Argentina is organized around three distinct financing regimes, with two of them involving health insurance and the other – the "pure public sector" – providing services used mostly by the uninsured.** The three regimes are: (i) the contributory social insurance sector which includes the *Obras Sociales* schemes run by trade unions and professional organizations, as well as the Comprehensive Medical Assistance Program (PAMI) for retirees and pensioners that have worked in the formal sector – jointly covering 57 percent of the total population; (ii) the contributory private health insurance sector covering 5.1 percent of the population; and: (iii) the public sector, providing services used mostly by the remaining 37.9 percent of the population that are not covered by any formal health insurance schemes.

6. **There is a high degree of fragmentation in the system.** There are more than 250 *Obras Sociales* schemes in existence, although a small percentage of these dominate market share. And there are close to 200 private insurers nationwide, both non-profit and for-profit – although, again, market share is dominated by just a few (for-profit) insurers.

7. **The government health system has been decentralized to the provinces since 1993.** Most health care responsibilities are assigned to the provincial level, while the coordination role rests with the national government, which is responsible for setting and enforcing quality standards and public health monitoring and data management.

Table 2. Health Financing in Argentina

	2003	2005	2007	2009	2011	2013
GDP per capita (current US$)	n.a	5,768	8,384	9,457	13,694	14,715
Total Health Spending (THE) as % of GDP	6.8	6.8	6.5	7.6	6.3	7.3
General government expenditure on health (GGHE) as % of THE	51.7	53.5	58.2	66	66.3	67.7
Out of pocket spending (OOPS) as % of THE	31.1	29.9	25.7	20.1	21.3	21.1
Private insurance (PI) spending as % of THE	13.7	13.2	12.8	11.1	9.3	8.4

Source: WHO, Global Health Expenditure Database, Argentina

8. **Some key characteristics of the health financing system in Argentina include: (i) relatively high expenditure on health, as share of GDP, and: (ii) the lion's share of the expenditure being undertaken at the provincial and municipal levels**. Key points to note include:

- Argentina has consistently spent a relatively high percentage of GDP (close to 7 percent or more) on health (Total Health Spending or THE) – see Table 2.

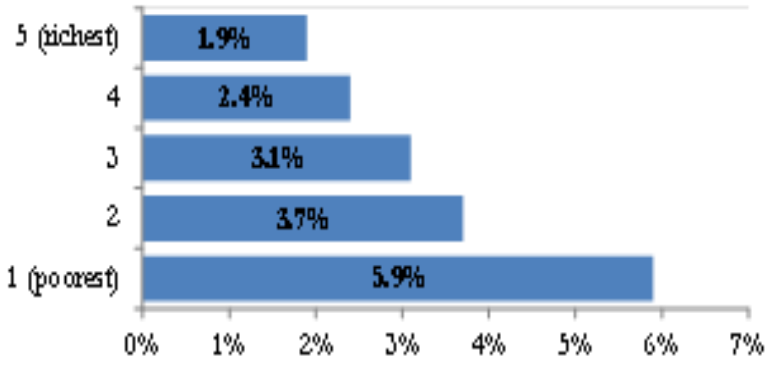
- General government health expenditure (GGHE) includes public as well as *Obras Sociales* and PAMI health spending. GGHE as a share of THE has shown an increasing

trend over time, while private insurance spending remains a smaller but important portion of health spending. Public health expenditure (PHE) represents 42 percent of GGHE.

- 81 percent of PHE consists of direct expenditures by the provinces and municipalities. Only 19 percent of GGHE is spent by the National Ministry of Health.

- Out of pocket spending (OOPS) in Argentina remains lower than in many other Latin American countries as a portion of THE (21.1 percent in 2013). However, it is regressive as it is higher among households in the poorest quintiles (see Figure 5). As expected, the probability of falling into poverty because of catastrophic health expenditure is higher among poorer households[55].

Figure 5. Out-Of-Pocket Spending as % of Income by Income Quintile, 2010



Source: Ministry of Health, Encuesta de Utilización y Gasto en Servicios de Salud, 2010

C. Description of Plan Nacer and the Sumar Program

9. ***Plan Nacer*, the predecessor of the *Sumar Program*, was financed by two successive loans as part of an APL series**: the Provincial Maternal-Child Health Investment Project Phase I (APLI -P071025, US$135.8 million) and Phase II (APLII - P095515, $300 million), approved in April 2004 and November 2006 respectively. Initially, during Phase I, only the nine provinces in the poorest part of the country – the Northeast and Northwest regions – were covered. But during the second APL2 phase which started in 2006, the program was rolled out in all 24 provinces. In April 2011, the Board approved the current financing for the PHIP (for the *Sumar Program*) via a Specific Investment Loan (SIL) of US$400 million.

10. **In 2004, the Government embarked on a series of reforms on the road to effective UHC, starting with the flagship *Plan Nacer* program.** These reforms aimed at establishing risk-pooling schemes at the provincial level for the uninsured in response to Argentina's deep economic crisis of 1999-2002, which resulted in a significant rise in the percentage of the population not covered by formal health insurance from 38 percent in 1997 to 44 percent in

[55] Maceira, D. and Reynoso, A. (2012) "Catastrophic and Impoverishing Health Expenditure in Argentina, 1997-2005", at Knaul, F.; Wong, R.; Arreola-Ornelas, H., "Financing Health in Latin America. Household Spending and Impoverishment", Volume 1. Ed. Global Equity Initiative, Harvard University.

2002. Those without formal health insurance had to use the public healthcare system, where there were significant shortfalls in quality and sometimes in service availability. This system, which provides health services for free at public health facilities, was financed fully from public funds in a traditional manner based on financing of inputs, without any link between health facility revenues and the quality of care provided.

11. **The *Plan Nacer* program was designed to supplement the existing public financing system with an innovative Pay for Performance (P4P) model that incentivized the provision of quality priority maternal and infant health services**. Eligible *Plan Nacer* beneficiaries consisted of all uninsured[56] pregnant and lactating women (up to 45 days after delivery) as well as uninsured children aged under six were eligible. No copayments or prepayments were (or are) required, in line with the principle of mandatory free health care in the public system in Argentina.

12. **The pay-for-performance model implemented under Plan Nacer worked through a two-step system that is aligned with the decentralized nature of the country's health care system:**

- **First**, the National Government transferred a subsidy to the provinces based on a monthly capitation amount for each Plan Nacer beneficiary. The provinces received 60 percent of the maximum capitation amount for every individual enrolled in the program; however, payment of the remaining 40 percent is contingent on achievement of health targets for the eligible population. Health targets are measured using specific indicators called tracers (measured at the provincial level). The tracers are derived from best practice clinical protocols and relate mostly to key preventative services.
- **Second,** health service providers within the provinces receive *Plan Nacer* funds from their respective province based on the delivery to beneficiaries and billing of services included in the Plan's benefit plan (called the *Nomenclador*), and in accordance with a fee-for-service mechanism. The national government determines the content of the benefit plan, which is unique across provinces. The provincial governments define the fees for each service in the benefit plan within their province.
- The entire process is audited by an independent auditing firm, and penalties are applied if irregularities are discovered**.**

13. **Before the existence of *Plan Nacer*, public health service providers had no autonomy in the use of resources received from the provincial Ministries of Health**. The flexibility introduced under *Plan Nacer* allowed a better allocation of scarce resources, resulting in a positive impact on health outcomes of beneficiaries, according to a recent rigorous Impact Evaluation (see Section II of main body of the document). A comprehensive qualitative study carried out by *Universidad ISalud* in 2011 provides evidence that the perception of the program by health facility personnel is positive.[57] In particular, the personnel perceived that *Plan Nacer* helped to deliver better quality of care by improving the daily organization of the work and their priorities, the basic infrastructure of the facility (e.g. heating/air conditioning) and the

[56] "Uninsured" in this document means not having formal health insurance.
[57] See « *Estudio de Financiamiento y Uso de Recursos de Efectores del Plan Nacer en las Provincias de la Fase I* », Chapter 3.

availability of on-time medical inputs needed for providing regular checkups to patients. Negative perceptions are also mentioned, such as the increase in administrative work since the start of implementation of the Program.

14. **Health service providers can use *Plan Nacer* funds in a flexible manner as long as no more than fifty percent of funds received are used for bonuses to pay health professionals.** Each province decides and regulates the percentage of funds allocated to salary bonuses for health professionals. However, health professional salary bonuses cannot be allocated to workers exhibiting high degrees of absenteeism.

15. **While the *Sumar Program* retains the essential features of Plan Nacer P4P model, it does incorporate two major changes:**

- **Inclusion of new population groups – older children, youth aged below 20 and women aged under 65 without formal health insurance (See Table 3 below) – with additional sub-packages (added to the *Nomenclador*) of mostly preventative services for these new groups**: The services for these newly introduced groups have been carefully selected, as was the case for the services selected for the original *Plan Nacer* benefit plan. The consolidated package of all services is now a lot larger under the *Sumar Program* (400 services) than Plan Nacer (80 services), due to the newly introduced groups. Although the health services covered by the *Sumar Program* are mostly preventative, certain services addressing catastrophic diseases are also covered.

Table 3: The *Sumar Program*'s Beneficiaries

Population Groups by Age	Eligible Population	Current Enrolled Population with Effective Coverage[58]	Enrolled Population with Effective Coverage at End of Project (Based on End Targets)
Children aged under 6	1.8	1.2	0.9
Children aged between 6 and 9	1.1	0.4	0.6
Youths aged between 10 and 19	2.9	0.9	1.5
Adult women aged under 65	4.1	0.9	2.1
Adult men aged under 65 (proposed under this AF)	4.3	0.0	0.4
Total	**14.3**	**3.5**	**5.4**

Produced using data from the *Sumar Program*'s Management Report of December 2014.

- **Capitation payments from the National Government to the Provinces are now transferred only if enrolled beneficiaries have received *"effective coverage",*** i.e. if they have used at least one of a pre-defined group of the most essential services – included in the program's benefit plan – within the previous 12 months. Like in the case of *Plan Nacer*, the monetary resources received by the provinces via this mechanism are then used to make payments to the health service providers on a fee-for-service basis.

[58] Current values as of December 2014.

The achievement of performance indicators by both provinces and health service providers (including adherence to quality protocols) is verified by an external audit firm.

Table 4: The *Sumar Program* Tracer Indicators

No.	Tracers
1	Timely inclusion of pregnant women in prenatal care services (before the 13th week).
2	Prenatal follow-up care.
3	Effectiveness of comprehensive neonatal care.
4	Well-baby care (one year old or younger)
5	Equity in health results within province with respect to Well-baby care (one year old or younger)
6	Congenital Heart Disease (CHD) Detection capacity
7	Well-child care (between 1 and 9 years old)
8	Immunization coverage for children aged 2
9	Immunization coverage for children aged 7
10	Well-adolescent care (between 10 and 19 years old)
11	Promoting sexual and reproductive health care and right
12	Cervical cancer prevention
13	Breast cancer care
14	Medical auditing of maternal and infant mortality.

16. **Like Plan Nacer, the *Sumar Program* is very cost-effective, costing little compared to the provincial health budgets**. Total expenditures under the *Sumar Program* amount to less than 2 percent of provincial health budgets, on average. Projected capitation payments for the existing groups and the new group (adult men), for 2015, represent around 1.2 and 0.4 percent of the annual provincial public health spending respectively, on average (See Table 5 below). One of the reasons for the program's high impact and cost-effectiveness is the high degree of flexibility and autonomy in the use of the funds at the health facility level. The financing usually represents the only source of funding where the health service providers have autonomy in the use of the funds.

Table 5: Annual Capitation Payment Impact on Provincial Public Health Spending
(US$, millions)

Item	Amount	Percentage
Total Provincial Public Health Expenditure	9,023	
Total Projected Capitation Payments: (*)	139	1.6%
for Children, Youths and Women aged under 65	106	1.2%
for Men aged under 65	33	0.4%

Produced using data from WHO, Global Health Expenditure Database (Argentina) and MSN's projections
(*) This figure represents the expected Capitation Payments in 2015

17. **The design of the *Sumar Program* was supported by**: (i) knowledge regarding best practices to enhance adequate utilization of preventative health services among all population groups; (ii) experience with noncontributory health insurance systems in other countries; (iii) experience with reforms in public health systems such as provider payment reforms as well as provider contracting and "purchaser-provider split" schemes – all adapted to Argentina's political and regulatory context; and iv) lessons learned from implementing the *Plan Nacer* APL series.

D. Poverty Targeting in the Sumar Program

18. An analysis was conducted to determine whether in fact the *Sumar* Program is reaching mostly the poor, using the latest data available from the Annual Survey of Urban Households, from 2013. The total urban population aged less than 65 was divided into two groups: those eligible for the *Sumar* Program (i.e. uninsured), and those not eligible. The following table shows what proportion of each of these groups belongs to each of the five quintiles of the income distribution.

Table 6: Eligible and Non-Eligible Population, and Income Distribution

Income Quintiles		Non-Eligible	Eligible	Total
Q1 Poorest	Row	33.4	66.6	100
	Column	*16.3*	*56.2*	*30.9*
Q2	Row	64.3	35.7	100
	Column	*24.0*	*23.1*	*23.7*
Q3	Row	75.8	24.2	100
	Column	*20.5*	*11.4*	*17.2*
Q4	Row	84.4	15.6	100
	Column	*21.2*	*6.8*	*16.0*
Q5 Richest	Row	92.3	7.7	100
	Column	*17.9*	*2.6*	*12.3*
Total	Row	63.4	36.6	100
	Column	*100*	*100*	*100*

Source: Own calculations using micro-data for the Annual Survey of Urban Households of 2013.

19. The table shows that 66.6 percent of those in the poorest quintile qualify for the *Sumar* Program (i.e. are eligible), while only 7.7 percent of those in the richest quintile qualify for the program (Rows). At the same time, among all who qualify for the program, 56.2 percent and 23.1 percent are in the lowest and second lowest quintiles respectively (Columns). Thus, around 80 percent of the eligible population are in the two poorest quintiles. This indicates that the *Sumar* Program is well targeted towards the poor.

Annex 5: Economic and Financial Analysis

ARGENTINA: Additional Financing (P154431) – Provincial Health Insurance Development Project (P106735)

1. **Introduction.** This Annex presents a review of the results of economic and financial analysis conducted for the proposed Additional Financing (AF) of US$200 million for the Argentina Provincial Public Health Insurance Development Project (PHIP), taking into account the incorporation of a new population group (uninsured men aged under 65). This new operation will also make it possible to continue financing a set of mainly preventive health care services with a high impact on the burden of disease among uninsured children over six years of age, youth, and women between 20 and 64 years of age (in addition to the uninsured adult men aged under 65).

2. Over the lifespan of the Project, to be extended until September 30, 2017, more than 1,700 lives are expected to be saved and a large number of disabilities are expected to be avoided. There would be savings of approximately 266,289 Disability-Adjusted Life Year (DALYs) during the Project implementation period alone. The total number of DALYs gained over time (going beyond the Project implementation period) is expected to easily exceed this figure, as projects aimed at changing the burden of disease require a longer evaluation period, taking into account the time needed for this kind of health strategy to show full impact. Furthermore, due to the preventive nature of the health interventions prioritized in this Project, it will only be possible to assess the final health impact when the cohorts involved reach the age at which many of the risk factors that this set of interventions seeks to reverse exert their impact.

3. The economic benefits of the Project are associated with the health system's cost savings resulting from the reduction in the number of hospitalizations (direct benefits), as well as with the enhanced economic productivity due to the years of life gained as a consequence of avoiding premature deaths and disabilities (indirect benefits). It is estimated that more than 110,000 hospital admissions will be avoided in the public health sector over the Project implementation period as a result of a reduction in the number of hospitalizations based on a very conservative scenario — less than 8 percent by the end of the Project. In this scenario, the Project would deliver cost savings in the health system of about US$179.4 million at a 4 percent annual discount rate. On the other hand, the present value of productivity benefits — with productivity measured on the basis of Argentina's average annual income per capita — would amount to US$552 million. As shown in Table 1, considering only the Project implementation period, the Net Present Value (NPV) would total US$482.9 million. The Internal Rate of Return (IRR) would be 21.8 percent, and the cost-benefit ratio would be 2.9.

Table 1 Financing (**AF**) – **Summary of Estimated Costs** and **Benefits**

Net Present Value or NPV (US$ million)	482.9
Internal Rate of Return or IRR (%)	21.8
Benefit-Cost Ratio	2.9

Note: NPV benefits are equal to the direct and indirect benefits minus total Project costs (in US$ millions) at a 4 percent annual discount rate.
The benefit-cost ratio is equal to total benefits divided by total costs.

4. The economic impact of the Project depends on the number of beneficiaries who actually receive the health care services to be covered by the Provincial Public Health Insurance systems, and on the health impacts of the interventions prioritized for the population groups selected for this Project.

5. **Assumptions.** The costs and benefits of the Project were estimated taking into account the following basic assumptions:

a) Estimates of progressive beneficiary enrollment and of the evolution of other key variables (e.g. effective coverage) were based on a financial projections model parameterized for the purposes of this exercise.
b) The AF would provide financing for capitation payments only for eligible adult men in an initial Phase. It would finance capitation payments for the other eligible population groups in a second Phase, once the funds for this group under the parent Project are exhausted (estimated to occur around May 2016). These factors were taken into account in the economic analysis.
c) The impact of the Project on health was estimated on the basis of the reductions in the burden of disease among the target population associated with the set of health care services covered by the Provincial Public Health Insurance Development Project. The calculations for the reduction in the burden of disease were based on the concept of Disability-Adjusted Life Year (DALYs), consisting of the sum of Years of Life Lost (YLLs) due to premature mortality in the population and the Years Lost due to Disability (YLDs).
d) The disease burden was estimated on the basis of mortality data for 2008, by sex and age, according to the main causes of disease selected, as published by the Health Statistics and Information Directorate, under the National Ministry of Health.
e) The indirect benefit of the prioritized health interventions was based on the assumption that they have an impact on no more than 20 of the main causes of disease with an effectiveness of no more than 10 percent of reduction in YLLs due to premature mortality, with some exceptions such as maternal and perinatal causes, which were allowed a greater effectiveness (between 20 to 25 percent).
f) A second type of benefit – a direct benefit – was linked to estimated reductions in the number of the target population's hospital admissions due to the impact of the priority interventions. The reduction in the number of hospital admissions results in significant cost savings for the hospital system. The exercise carried out assumed a reduction of up to 8 percent in total hospital admissions for the target population.

g) Daily hospitalization costs were estimated at US$250, and the benefits in time saved and transport of patients and family members were not taken into consideration.
h) In order to calculate the productivity gain, the economic benefit for each year of life lost was assumed to be equal to the national annual average income per capita (approximately US$14,715 per year).

6. **Summary of costs and benefits:** The analysis takes into account the total financial costs of the Project and an estimation of its direct and indirect economic benefits. The components associated with investment, technical assistance and Project administration are included in the costs. The total cost of the Project at current rates is US$260 million.

7. The direct economic benefits were calculated on the basis of savings in hospital expenses derived from the decrease in the number of hospitalizations among the target population due to causes associated with the health interventions prioritized by the Project. In a conservative scenario, a reduction in the number of hospital admissions of 100,000 was estimated. This figure represents a decline in the number of hospital admissions among the target population of less than 8 percent only at the end of the Project's implementation period. The present value of the savings to the public health system discounted at a rate of 4 percent amounts to US$179.4 million during the Project implementation period. This analysis does not include the transportation and eating-out costs associated with the care of an ill relative.

8. The indirect economic benefits were calculated according to the productivity gains resulting from improved health conditions of the target population measured in terms of DALYs gained due to the Project, which result from adding the YLLs due to premature mortality and the YLDs. Table 2 shows annual estimations of the health impact of the Project, taking into account the entire target population. The health impact is affected by the level of enrollment achieved in each Project implementation year.

Table 2: Health Impact Estimates

	2015	2016	2017
Eligible Population (in millions)	4.3	14.6	14.6
Enrolled Population with effective coverage (in millions)	0.2	5.2	5.4
YLLs due to premature deaths avoided	1,645	47,993	37,309
YLDs avoided	2,654	99,481	77,207
DALYs gained	4,299	147,444	114,516

Source: Prepared by the authors

9. Assuming an economic value of US$14,715 for each year of life gained, during the period of implementation of the proposed the Project, the direct and indirect economic benefits discounted at a rate of 4 percent would amount to US$731.3 million. As a result, the Net Present Value of the Project would be US$482.9 million. The Internal Rate of Return would be of 21.8 percent and the Benefit-to-Cost Ratio would be 2.9.

Table 3: Summary of Estimated Costs and Benefits
In thousand US$, discounted at 4%

Year	Present Value of Total Project Costs	Present Value of Benefits	Net Present Value
2015	33.4	32.1	-1.3
2016	130.1	383.9	253.8
2017	84.9	315.3	230.4
Subtotal	**248.4**	**731.3**	**482.9**
		IRR	**21.8%**
		Benefit/Cost Ratio	**2.9**

Source: Prepared by the authors

10. Note that the calculations of the benefits do not incorporate the YLDs avoided, because an economic value was not place on these. Hence, the figures presented significantly underestimate the benefits from the Program and its IRR.

11. Finally, Table 4 presents the results of sensitivity analysis that was conducted. In the sensitivity analysis, two alternative scenarios were considered, a High-Case and Low-Case Scenario. In these alternative scenarios, different assumptions are made regarding the impact of the program on the burden of disease (as reported in the Table). In addition, the Low-Case Scenario assumes a discount rate of 10% rather than 4%. In the three scenarios, it was found that the Internal Rate of Return ranged from 19.5 percent to 34.3 percent. The Net Present Value ranged from US$81.2 million to US$482.9 million, while the Benefit-to-Cost Ratio ranged from 1.3 to 4.0.

Table 4: Sensitivity Analysis

	Baseline Scenario	High-Case Scenario	Low-Case Scenario
Discount rate	4%	4%	10%
Reductions in the burden of disease (in %)	10	15	8
NPV (in million)	482.9	734.1	81.2
IRR (in %)	21.8	34.3	19.5
B/C	2.9	4.0	1.3

Source: Prepared by the authors

12. **Rationale for Public Sector Provision and Bank's Value Added**: According to World Bank guidance on conducting financial and economic analysis, the main rationales warranting intervention by the public sector include the correction of market failures, the incorporation of

externalities or spillovers, redistributional, and social and political concerns. In this case, while a number of arguments could be made for why public action is important, the most important one is the need for intervention for redistributional reasons.

13. As shown in Annex 4 (Section D), the eligible beneficiaries in this case would consist mostly of people in the lower income quintiles. Without public sector intervention in the provision of health care to this vulnerable group of people – a redistributive intervention – these people would not have access to adequate health care. The proposed AF would provide additional resources towards this end, helping to ensure optimal use of public funds to maximize the redistributive impact of these funds in the health sector.

14. Finally, the role of the World Bank is key. Among other things, the involvement of the Bank enables the provision of high-quality technical assistance, engagement in policy dialogue, the ability to benefit from international experience, and other forms of support that would not be so readily available if Bank financing were withdrawn. The Bank has been, and continues to be, a key partner assisting the country on its path to effective UHC, which is a critical goal for the country as well as the Bank.