PROJECT INFORMATION DOCUMENT (PID)
ADDITIONAL FINANCING

Report No.: PIDA25344

Project Name	AF for AR Provincial Public Health Insurance Development Project (P154431)
Parent Project Name	Provincial Public Health Insurance Development Project (P106735)
Region	LATIN AMERICA AND CARIBBEAN
Country	Argentina
Sector(s)	Health (90%), Public administration- Health (10%)
Theme(s)	Health system performance (46%), Child health (18%), Injuries and non-communicable diseases (18%), Gender (18%)
Lending Instrument	Investment Project Financing
Project ID	P154431
Parent Project ID	P106735
Borrower(s)	National Ministry of Health
Implementing Agency	National Ministry of Health
Environmental Category	B-Partial Assessment
Date PID Prepared/Updated	11-May-2015
Date PID Approved/Disclosed	12-May-2015
Estimated Date of Appraisal Completion	13-May-2015
Estimated Date of Board Approval	07-Jul-2015
Appraisal Review Decision (from Decision Note)	

I. Project Context

Country Context

Since its economic crisis of 2002, Argentina has been reducing poverty and sharing the gains of rising prosperity. The middle class grew by 68 percent between 2004 and 2012, reaching 53.7 percent of the population. Total poverty (measured at US$4-a-day) declined from 31.0 percent in 2004 to 10.8 percent in 2013, while extreme poverty (measured at US$2.50-a-day) fell from 17.0 percent to 4.7 percent. But income inequality, measured by the Gini coefficient, remains high reaching 42.5 in 2012; while the proportion of the population with unsatisfied basic needs reached 12.5 percent in 2010. Despite the reduction in poverty and inequality, substantial differences in poverty rates and access to services persist, particularly across provinces.

Sectoral and institutional Context

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 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.

There is a very clear correlation 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 these extremely poor areas. There are also substantial geographical disparities, with the uninsured rate much higher in the poorer provinces (mostly in the North) than in the richer ones (mostly in the South).

The uninsured (those without formal health insurance) still 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 enrolment or registration is not necessary to access their services.

Services received from health facilities in the public sector – except where there are risk-pooling mechanisms involving enrolment for the uninsured such as Plan Nacer or the Sumar Program – often have a number of deficiencies, such as variable quality. In the absence of payments flowing to public health facilities from insurance or risk-pooling schemes, inputs are usually received in-kind and in fixed amounts, and salaries are fixed. And, 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.

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.

In effect, until public risk-pooling mechanisms were established starting in 2004, there was a two-tier health care system, where the poor and uninsured were excluded from effective health coverage. 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.

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 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.

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

Plan Nacer was succeeded by the Sumar Program – financed by the current PHIP Project for which the AF is proposed. The project 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 of mostly preventative health services have been defined for these new groups.

About 73 percent of the total PHIP loan proceeds is for Component 1, which finances results-based capitation payments to the provincial public health insurances. These payments are co-financed by the provinces and the National Government, whose contributions have been rising over time. 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 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). The financing received by the provinces via this mechanism is used to make payments to the health facilities on a fee-for-service basis, and payment for each service is conditional on adherence to pre-defined quality protocols. The achievement of performance indicators by both provinces and health facilities is verified by an external audit firm.

Components 2 and 3 of the Project finance key inputs – such as technical assistance (TA), support for information systems and selected medical equipment. The mix of these inputs is carefully chosen, taking into account key gaps at the provincial and health facility levels in the delivery of services covered under the capitation payments of Component 1 – hence aiming to enhance the impact of these capitation payments. TA focuses on institutional and management strengthening.

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 about 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.

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.

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 expensive and high-complexity curative services) for around 1,100,000 extremely vulnerable and uninsured people including women with seven or more children; the population 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.
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.
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 more or less independently of the Sumar Program, to avoid fragmentation and inefficiency in the use of existing resources.

II. Proposed Development Objectives

A. Current Project Development Objectives – 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.

III. Project Description

Component Name

Component 1: Supporting Provincial Public Health Insurance

Comments (optional)

Component Name

Component 2. Institutional and Management Strengthening of the National and Provincial Ministries of Health

Comments (optional)

Component Name

Component 3: Building capacity of the National and Provincial Ministries of Health to deliver services

Comments (optional)

IV. Financing *(in USD Million)*

Total Project Cost:	260.61	Total Bank Financing:	200.00
Financing Gap:	0.00		

For Loans/Credits/Others	**Amount**
Borrower	60.61
International Bank for Reconstruction and Development	200.00
Total	260.61

V. Implementation

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, 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, a Pilot Agreement would be signed between the MSP and the health service provider incorporating the agreed results to be achieved, the related payments and the verification mechanisms. In addition, the Operations Manual would contain full 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 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.

Implementation Arrangements 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.

VI. Safeguard Policies (including public consultation)

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

Comments (optional)
The Project has triggered OP/BP 4.01 on Environmental Assessment 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 to new sub-groups of beneficiaries. Therefore, the Project's Environmental Category was upgraded from C to B.
For social safeguards, the OP/BP 4.10 on Indigenous Peoples policy was triggered under the original 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.

VII. Contact point

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