Project Information Document/ Integrated Safeguards Data Sheet (PID/ISDS)

Concept Stage | Date Prepared/Updated: 29-Jun-2017 | Report No: PIDISDSC21921

Public Disclosure Authorized

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Parent Project ID (if any)	Project Name
Argentina	P163345		Supporting Effective Universal Health Coverage in Argentina (P163345)
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	Sep 18, 2017	Dec 07, 2017	Health, Nutrition & Population
Financing Instrument	**Borrower(s)**	**Implementing Agency**	
Investment Project Financing	Ministry of Finance	Ministry of Health	

Proposed Development Objective(s)

The Development Objective of the proposed Project would be to: (i) increase the effective coverage of the health services provided to the population exclusively covered by the public sector; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for coordination among selected health financing and service delivery stakeholders.

Financing (in USD Million)

Financing Source	Amount
Borrower	100.00
International Bank for Reconstruction and Development	300.00
Total Project Cost	**400.00**

Environmental Assessment Category	Concept Review Decision
B-Partial Assessment	Track II-The review did authorize the preparation to continue

B. Introduction and Context

Country Context

1. **After taking office in December 2015, the new Argentine Government moved with significant speed to implement reforms.** The Government has rapidly implemented various macroeconomic reforms and initiated a program of structural reforms. These include *inter alia* (a) the elimination of export taxes on major crops, beef, and most industrial manufacturing products and the reduction by 5 percent of export taxes on soy; (b) unification of the exchange rate, effectively ending most foreign exchange restrictions; (c) moving from a system of discretionary to automatically provided import licenses in line with World Trade Organization procedures; (d) resolution of the dispute with holdout creditors; and (e) measures to enhance public transparency and accountability. In addition, the National Institute for Statistics launched a new inflation index and improved the overall quality of statistics. Electricity tariffs and transport fees were increased to reduce subsidies, while protecting low-income users with a social tariff. Broader efforts to reduce energy subsidies (which account for a large portion of fiscal deficit) are under way.

2. **Economic activity contracted in 2016, but growth is expected in 2017**. Economic activity contracted 2.3 percent during 2016, taking a toll on labor markets, where up to 0.9 percent of formal private sector jobs were lost in the first semester1. However, GDP expanded in the second half of 2016 (0.6 percent), and employment in the formal private sector recovered to its previous peak level (October 2015). The economy is expected to continue to grow in 2017 (+2.7 percent2) on the assumption that the positive impact of recent policy changes kicks in and the global economy recovers. Inflation in the city of Buenos Aires was 40 percent in 2016, mostly due to currency depreciation and the reduction of energy and transport subsidies. However, inflation is expected to decrease to 21 percent in 20173, despite further increases in energy and transport tariffs. The central government primary deficit in 2016 was 4.6 percent of GDP, below the official target (4.8 percent). The target primary deficit for 2017 (4.2 percent), though higher than originally planned, will require further fiscal consolidation efforts.

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

[1] Source: Ministerio de Trabajo, Empleo y Seguridad Social
[2] Source: World Bank Group. 2017. *Global Economic Prospects, January 2017 Weak Investment in Uncertain Times*. Washington, DC: World Bank. doi:10.1596/978-1-4648-1016-9.
[3] Source: *Relevamiento de Expectativas de Mercado* (REM), Banco Central de la República Argentina, April 2017.

Sectoral and Institutional Context

4. **Argentina's health outcomes have improved significantly during the past decades, especially for maternal and child health indicators. Improvements have also taken place in indicators linked to noncommunicable diseases (NCDs), but NCD-related challenges are growing and much more still needs to be done.** Over the last 5 years, both infant and child mortality rates have decreased and life expectancy increased. In addition, the Country has reduced inequalities in health outcomes and access to services.

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

6. **Many of these efforts have been supported by the World Bank Group**. For the past 12 years, the Bank's partnership with Argentina's health sector has been very strong. In support to the sector, the World Bank prepared nine operations during this time totalizing U$S2.2 billion. Three of these projects have supported the expansion of health coverage for those without social security health insurance by financing an explicit benefit plan of health services (package of services) using an innovative results-based scheme: (i) *Plan Nacer* I (US$135 million) and (ii) *Plan Nacer* II (US$300 million), both already closed; and (iii) the *Sumar* Program (US$600 million)[4], currently under implementation. Two other projects – the Essential Public Health Functions and Programs (EPHFP I) project (US$220 million, already closed) and its successor EPHFP II (US$220 million, now under execution) have been contributing to strengthening the Ministry of Health's stewardship regarding public health functions, and orienting public policy to face the challenges of the growing burden of chronic diseases. Continuing with this strong partnership in service delivery and public health, in 2015 the Bank approved a new operation aimed at Protecting Vulnerable People against NCDs (US$350 million)[5]; the PROTEGER Project.

7. **The impact of the *Nacer/Sumar* program has been demonstrated through a rigorous Impact Evaluation exercise, as well as excellent performance of Project indicators.** A rigorous Impact Evaluation of Plan Nacer found – among others – that in the poorer Northern provinces, being a *Plan Nacer* beneficiary reduces the probability of a stillbirth by 26 percent and the probability of low birth weight by 7 percent.

[4] *Programa de Desarrollo de Seguros Públicos Provinciales de Salud* (PDSPP), the Borrower's Provincial Development Public Health Insurance Program, as set forth in the PDSPP 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, PDSPP is also called the *Sumar Program*.

[5] Plan Nacer I& II: 071025AR and P095515 -Provincial Maternal-Child Health Investments Project (1st. Phase and 2nd Phase APLs), the SUMAR Program: P106735 Provincial Health Insurance Development Project, and the PROTEGER Project: P133193 Protecting Vulnerable Population Against of Non-Communicable Diseases Project.

Beneficiaries were found to have a 74 percent lower chance of in-hospital neonatal mortality in larger facilities.[6] Project Indicators for the *Sumar* Program showed substantial progress over relatively short periods of time. For example, between 2010 and 2016 under the *Sumar* Program, the proportion of eligible children, youth and women with "effective coverage" [7] rose by five times, while the proportion of the newly added group of eligible men reaches 14 percent in its first year of implementation, surpassing expectations.

8. **Despite these efforts, significant challenges remain, including persistent inefficiencies and inequities and relatively poor performance of the public health sector, particularly with NCD-related indicators**.[8] Health outcomes in Argentina are generally poor compared to other countries with similar or even lower per-capita income, pointing to low overall efficiency of health spending.

9. With the support of the *Nacer/Sumar* Program, birth outcomes have improved among the population without formal health insurance (predominantly the poor); but geographic inequalities still remain as noted earlier. The poorer Northern provinces still have the highest infant and maternal mortality rates and malnutrition rates, and the lowest coverage of key health services, particularly services aimed at preventing and controlling NCDs. Individuals that exclusively use the public health subsystem (predominantly the poor) show relatively poor performance for indicators such as the percentage of women aged 25-65 years receiving cervical cancer screening, the percentage of women aged 50-70 years receiving a mammography and the percentage of adults having a high blood pressure control test. These percentages for those exclusively using the public system are 60.4%, 48% and 71.2% respectively, as compared to 71.6%, 65.68% and 82.4% respectively for the rest of the population.[9] Yet average public spending per person exclusively using the public system is higher than average OS spending per member[10] – an indicator of inefficiency of the former, given the poor outcomes obtained (although a caveat here is that the public subsystem cross-subsidizes the OS subsystem to some degree, as discussed below).

10. **These inefficiencies and inequities are due in part to the highly fragmented nature of the Argentine health system which remains structurally highly segmented according to labor market status and across geographic areas,** with three distinct subsystems that largely operate independently of each other: public non-contributory, social security, and private. In principle, the public non-contributory subsystem offers services to all Argentineans, but it is mainly used by people with no formal labor employment and thus with no social security or private insurance coverage – predominantly the poor.[11] The public service delivery network is decentralized to the provincial level and in some cases – such as in the provinces of Buenos Aires, Santa Fe and Cordoba – to the municipal level, adding to the fragmentation of the system. The social security subsystem covers the population with formal sector employment. This subsystem consists of close to 300 national OSs

[6] 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.
[7] "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.
[8] A more detailed diagnostic on this is provided in the new World Bank Strategy document, currently under preparation, outlining the World Bank's support for the health sector in Argentina.
[9] According to data from the Risk Factors Survey of 2013.
[10] The data show that average public spending per person exclusively using the public subsystem in 2014 was 6,048 Pesos, as compared to 5,930 Pesos for average spending per *Obra Social Nacional* member in the same year, and average spending of 5,375 Pesos per member of an *Obra Social Provincial*.
[11] According to data from the Permanent Household Survey of 2016, almost 60% of the poor and about three-fourths of the extremely poor depend exclusively on the public non-contributory subsystem.

(*Obras Sociales Nacionales*, OSNs) linked to individual trade unions; 24 provincial OSs (*Obras Sociales Provinciales*, OSPs) insuring provincial and municipal civil servants; an OS that insures pensioners and retirees (Instituto Nacional de Servicios Sociales para los Jubilados y Pensionados, INSSJP); and other smaller schemes. Finally, there is a relatively small private insurance market providing voluntary insurance. The private sector, however, has a much stronger presence in service provision.[12]

11. **The system's inherent fragmentation is worsened by the highly Federal nature of the country, with a high degree of provincial autonomy and few mechanisms to effectively coordinate the provinces' actions or to reduce inter-provincial inequities in health spending.** In Argentina, the role of the national Government in health is much more limited than in most other Federal countries. The national Government accounts for just 19% of total public health spending – much lower than in most other Federal countries – and there is no major health transfer to the provinces or municipalities.[13] (In many Federal countries, such a transfer is an essential mechanism to reduce inequities across provinces in health spending.) Aside from spending relatively little on health, the national Government plays a limited role in coordinating the actions of the provinces, which are highly autonomous.

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

13. **The system's fragmentation operates along two different dimensions, both contributing to the persistent inefficiencies and inequities. One of these is the fragmentation of resource pools and lack of redistributive mechanisms across them.** This is not just inequitable but is also contrary to principles of efficient risk pooling and insurance.[14] Yet there are few politically feasible ways at present to pool funds from the public and OS subsystems, or to establish redistributive mechanisms between the two[15]. Within the public subsystem, the available financing per person varies widely across provinces, and there is no major equalizing transfer to reduce the inter-provincial inequities in health spending.[16] In addition, there is continuing cross-

[12] Around 38% of the total population relies exclusively on the public subsystem. The share of the population having coverage via the social security subsystem (including INSSJP) is around 62%, while around 5% of the population has coverage via a private insurance scheme.

[13] There are transfers from the national Government to the provincial Governments under specific national programs such as the *Sumar* program and *Incluir Salud*, but these are of relatively small size, e.g. these transfers amount to around 1%-2% of total provincial health spending in the case of the *Sumar* program.

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

[15] Even within the OS subsystem, the existing redistributive mechanisms are weak; the Solidarity Redistribution Fund (FSR) is a mechanism that enables all OSs to have access to a minimum level of resources per beneficiary. But several studies had concluded that although the redistributive impact of the Fund has improved over time, it still remains relatively low. [16] The size of the budget per person exclusively covered by the public sector varies widely from around 25,000 AR Pesos in Salta Province to 275,000 AR Pesos in Santa Cruz province. Health spending per person exclusively covered by the public sector also thus varies widely (from 3,000 AR Pesos in Santiago del Estero Province to 30,000 AR Pesos in Tierra del Fuego Province).

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subsidization by the public subsystem of the OS subsystem, by amounts that are likely substantial although not known with precision. This is because most public health facilities lack the billing systems and the capacity needed to bill the OSs for health services given to their members.

14. **A second dimension by which the fragmentation leads to inefficiencies and inequities is the lack of instruments for coordination across subsystems and within subsystems (including across provinces) – including a lack of integrated information systems.** The national Ministry of Health MSN nominally oversees all three subsystems, but in practice exerts a degree of control only over the public non-contributory system. Even here, it has limited control over the provincial Ministries of Health (MSPs), including limited mechanisms for enforcing common standards in the definitions of services, clinical guidelines and protocols, models of care and information standards and systems. In the absence of common standards, establishing integrated information systems (i.e. information systems that are interoperable) is impossible. In addition, MSN has limited control, in practice, over the actions of the national and provincial OSs and INSSJP. The Superintendent of Health Services oversees the national OSs, but not the provincial OSs nor INSSJP. The coordination body for the provincial OSs is the Council for OSPs, but participation here is voluntary.

15. **Within the public subsystem, what is really needed is an of care based on principles of integrated delivery systems (IDS) and continuity of care, and oriented around a primary care provider identified for each individual. For this to happen, instruments for improved coordination – together with other reforms – are essential.** The literature shows that large gains in impact and efficiency can be attained by developing and implementing an appropriate IDS-based model of care, where several providers including a main primary care provider work together in an integrated, coordinated manner to provide care for an individual. Such a system would place strong emphasis on patient traceability and continuity of care, and this implies: (i) continuity of information (by shared records), (ii) continuity across the secondary-primary care interface, especially for key clinical care pathways; and (iii) provider continuity (seeing the same professional each time especially at the primary care level, with value added if there is a therapeutic, trusting relationship).[17] None of this is possible without: (i) defining and measuring utilization of services along the entire continuum of care (i.e. across the secondary-primary care interface) especially for key clinical care pathways; and without: (ii) a common approach towards protocols, clinical guidelines, standards etc. as well as integrated information systems.

16. In Argentina, an explicit package of services – the Mandatory Medical Program (PMO) – has been defined for the national OSs. By contrast, in the public sector the only services that have been defined are those in a limited package of mostly primary and preventative secondary services covered by the *Sumar* program. Other services in the public sector – notably curative services – will also need to be defined, and their utilization tracked for each patient (in the same way as for the services under the *Sumar* program), before one can start to trace patient utilization of services along entire key clinical care pathways. Among others, this would require information systems with appropriate capabilities, and that are sufficiently integrated (i.e. interoperable). In addition, all individuals would need to have a regular primary care provider.

17. **An integrated model of care in the public subsystem would also require resolution of various coordination problems other than those mentioned above, including coordination challenges with: (i)**

[17] There are a number of articles in the literature explaining these concepts, for example: "Trends in Integrated Care – Reflections on Conceptual Issues" by Gröne, O & Garcia-Barbero, M (2002). World Health Organization, Copenhagen, 2002, EUR/02/5037864
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referral networks for diagnosis, treatment and followup of complex conditions and diseases, and with: (ii) drug-tracking. Establishing referral networks for complex conditions/diseases requires coordination among provinces, and this is not easy in the highly decentralized context of Argentina with limited coordination structures. As another example of coordination failure, the *CUS-Medicamentos* program (formerly called *Remediar*) tracks the flow of different types of primary care drugs to public pharmacies; but there is no link with other programs that could track the *dispensing* of drugs, such as the *Sumar* Program. Establishing this link with the *Sumar* program would help ensure rational dispensing and use of drugs, and would thus reduce the stockouts of primary care drugs that are often now seen at public pharmacies. But linkages of this nature do not come naturally between two programs with different management structures.

18. **The Government is now embarking on a new Universal Health Coverage (UHC) strategy – a holistic approach where all health programs and initiatives would work together in an integrated manner, focusing on enhancing effective public sector coverage** – i.e. health care coverage of adequate quality for the population exclusively using the public subsystem (those without formal health insurance). In August 2016, a Decree in support of the move towards UHC was issued by the Presidency. Among others, the Decree mentions the need to address the fragmentation and organizational problems of the health system, and the division between the three subsystems. In his announcement of the new UHC Strategy, President Macri mentioned that: (i) everyone without formal health insurance would eventually be traceable across the continuum of care (a key element of "effective coverage" for the Government); and: (ii) electronic systems would be established to enable OSs to be billed when their members use public health facilities.

19. **The Government has requested World Bank financing for a new project to support the Government's strategy of improving effective coverage in the public subsystem. The project would act as the cornerstone of an integrated approach where other ongoing projects would also play a key complementary role.** This new strategic approach – supported by the new project and other ongoing projects operating synergistically (see below for the specific role of the new project) – would have the following key features:

a. **Focus on establishing instruments for enhanced coordination and for an integrated model of care (as described above), initially within the public subsystem at the national and provincial levels**: Recognizing that nothing can be readily done to correct the first dimension of fragmentation mentioned above – fragmented resource pools and lack of redistributive mechanisms across them – the focus will be on the second dimension of fragmentation, i.e. establishing instruments for coordination, to enhance efficiency and equity.

b. **These instruments will include tools developed under the *Sumar* program (to be extended also to other programs in the public subsystem) as well as other tools for an effective model of care**. Specifically, the goal will be the following:

   - To move towards having all services in the public sector being explicitly defined (made explicit) and traceable, i.e. to define a benefits package for the entire public sector, in the way that a limited benefits package has been defined and tested under the *Nacer/Sumar* program.

   - To move towards common standards in the definitions of services, clinical guidelines and protocols, models of care and information systems. Many of these have already been developed under the *Nacer/Sumar* program. For example, information systems developed under the *Nacer/Sumar* program will be extended to the additional services defined for the public sector, and integrated with other information systems (which would need inter-operability of different information systems).

- To establish and implement tools for "empanelment" (having a regular primary care provider for each individual) – efforts that have already started using tools developed under the *Sumar* program.

c. **Enhanced collaboration between different programs will be fostered via integrated teams established at the level of each province, headed by the Coordinator of Programs at the provincial Ministry of Health** (MSP) and comprising members of the provincial implementing teams from each relevant program (e.g. *Sumar*, *Proteger*, *Redes*, etc.)

d. **Mechanisms for public health facilities to bill the OSs for utilization of health services by OS members will be key**. This is essential to address the cross-subsidization by the public subsystem of the OS subsystem, which worsens inherent inequities due to fragmentation of resource pools. But this would require instruments for enhanced coordination across subsystems (e.g. via common definitions of services, and agreements on prices and auditing processes).

e. **Structures to enhance coordination between the national and provincial Governments will be explored,** following successful international examples where this has been done elsewhere in very decentralized, Federal countries like Germany, Mexico and Canada. In particular, the intergovernmental coordination structures in Canada – which promote common standards and interoperable information systems, among others – are useful, illustrative examples.

f. **Use of incentives to encourage the above:** The *Nacer/Sumar* program pioneered the use of financial incentives to stimulate performance regarding key health indicators, and other projects such as FESP and Proteger have also used incentives at the provincial level. As part of the Government approach to move towards effective public coverage, the use of financial incentives in innovative ways – drawing from the example of other countries – will be key.

Relationship to CPF

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

21. **The proposed new project is aligned with the new World Bank Strategy currently under preparation by the HNP Global Practice in support of the health sector in Argentina**. This Strategy calls for further focusing Bank support on the poor and on the poorest areas of the country, by contributing to improving access and quality of basic services for the poor, and completing the structural changes in the public health subsystem that were launched under the Bank's program in the last decade. The Strategy also proposes to build capabilities to reduce the functional fragmentation of the health sector nationwide and to enhance mechanisms for cost-recovery from OSs for utilization of health services by OS members at public health facilities. The proposed Project is aligned with the Health Nutrition and Population goals of achieving Universal Health Coverage and financial protection as it contributes to increasing the access and use of health services

with a focus on vulnerable families.

C. Proposed Development Objective(s)

The Development Objective of the proposed Project would be to: (i) increase the effective coverage of the health services provided to the population exclusively covered by the public sector in the prioritized areas; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for coordination among selected health financing and service delivery stakeholders.

Key Results (From PCN)

Linked with first part of PDO and with Component 1:

PDI 1.1: Proportion of eligible children, youth, women and men with effective coverage[18]

PDI 1.2: Equity in cervical cancer screening (gap between percentage of eligible women without formal health insurance aged 25-65 years receiving cervical cancer screening and the National Average for the same)

Linked with second part of PDO and with Component 2:

PDO 2.1: Percentage of provinces measuring and reporting all services in key clinical care pathways (i.e. key integrated lines of care) for the eligible population *[this implies making the health services explicit and traceable according to the approved standards and protocols]*

PDO 2.2: Percentage of the eligible population with a defined primary care provider

D. Concept Description

22. **The proposed project would assist the Government in improving effective public health coverage among the population exclusively covered by the public subsystem, while working synergistically with other ongoing projects/programs[19] to reduce systemic inefficiencies and inequities – all as part of an integrated approach moving towards effective UHC.[20]** The proposed Project would be financed through an Investment Project Financing (IPF) loan of US$300 million over a four- year period. The Project would be implemented in the 23 provinces and the Autonomous City of Buenos Aires, with a focus on the poorest provinces and municipalities.

[18] An individual in the eligible population is defined as having "effective coverage" if he/she has received a key health service that was delivered and registered according to defined protocols, within a given period of time (from a list of key health services defined for each age group).
[19] *PROTEGER*, *CUS-Medicamentos*, *Redes*, *Incluir Salud*, etc.
[20] The eligible population includes children under 10, youths 10-19 and adults exclusively covered by the public sector, reaching nearly 15 million people.

23. The proposed Project would **support a two-pronged approach: (i) supporting efforts to enhance effective public health coverage; and (ii) fostering conditions for the improvement of coordination and for the establishment of an integrated model of care in the public subsystem.** Under (i), the Project would support improvements in access and quality of prioritized health services delivered by public health care facilities through the provincial ministries of health. As in the case of the *Sumar* program, there would be incentives for improved performance through Results-Based Financing mechanisms between the National and Provincial level and between Provinces and Health Care facilities. But these incentives would be broader than those now applied under the *Sumar* program, as described below. Under (ii), the project would go well beyond the current *Sumar* program, supporting instruments and structures (including incentive mechanisms) for enhanced coordination within the public subsystem and across subsystems, and for the establishment of an integrated model of care within the public subsystem.

The Project would have three components:

24. **Component 1: Support the strengthening of Effective Public Health Coverage (US$XXX million).** This component would have two Sub-Components, as follows:

25. **Sub-Component 1.1: Results-Based Capitation Payments for General Health Interventions and Catastrophic Diseases (US$XXX million).** This Sub-Component would finance results-based capitation payments for the provision of: (a) a general health intervention; and (b) selected health interventions for catastrophic diseases. Under part (a) these capitation payments would be transferred by the National Ministry of Health (MSN) to participating provinces to cover a share of the cost of health services included in a prioritized Health Benefit Plan (HBP) for the eligible population. These payments would vary among provinces depending on the level of poverty and other key factors such as equity in health outcomes, access to health services and institutional capacity for health service delivery. In addition, these payments would be adjusted based on the level of achievement of selected health indicators and the level of effective coverage. These results would be tracked through results indicators called tracer indicators and verified by an independent third-party entity. In turn, they would be exclusively used by the Provinces to strategically purchase health services included in the Health Benefit Plan from participating public health care facilities. Payments mechanisms would likely include a mix of capitation payments for the population in the public health care facility catchment area, fee-for-service, pay-for-performance and possibly DRG-based[21] payment methods. Providers would have autonomy in the use of these funds (subject to some guidelines/procedures).

26. Under part (b) (see previous paragraph), the Component would support the development of a National Health Insurance for selected catastrophic diseases. It would finance capitation payments from the National Ministry of Health to a national risk pool, which would be used to pay for health services related to selected catastrophic diseases for the eligible population. MSN would classify health care facilities based on the level of complexity of care that each is capable of giving (for each type of catastrophic disease), and his certification would be a prerequisite for the billing of health services included in the Health Benefit Plan to the National Health Insurance. In effect, referral networks for more complex conditions/diseases would be established, using

[21] DGR stands for "Diagnosis-Related Group".

national coordination structures and incentives to overcome the inherent interprovincial coordination problems that often hamper the establishment of these types of networks.

27. **Sub-Component 1.2 Improving Service Delivery Capacity at the National and Provincial Ministries of Health (Loan: US$XXXX million).** The objective of this sub-component is to support improvements in the supply capacity of the provincial and national Ministries of Health required to enhance effective coverage in the public subsystem. The sub-component would finance: (a) the provision of equipment (medical, transportation, information technology and communications) based on a systematic analysis of service delivery gaps identified, especially at the primary level; and (b) maintenance services needed to upgrade and expand MSN's and the MSPs' information and communication systems (excluding civil works).

28. **Component 2: Strengthening the Institutional and Service Delivery Capacity of the National and Provincial Ministries of Health for an Integrated Model of Care (US$XXXX million).** This component would support the provision to the national and provincial health ministries of the tools and instruments needed for an an integrated model of care within the public subsystem, and for improved coordination within the public subsystem as well as across subsystems.

29. **Sub-Component 2.1: Supporting the Development and Implementation of Instruments for Improved Coordination and for an Integrated Model of Care.** This sub-component would finance the following efforts and tools for improved coordination within the public subsystem and across subsystems and for an integrated model of care, as well as others to be discussed and developed during preparation:

a) mechanisms for defining and systematizing an explicit package of services for the entire public subsystem, and for defining key clinical pathways (including services and protocols), based on common agreement on required quality standards and delivery conditions;
b) related to the previous point, mechanisms for harmonization (with a convergence plan) around common standards, services and service definitions, clinical guidelines and protocols, models of care, referral networks and information standards (for which successful examples can be drawn upon from other Federal countries such as Canada);[22]
c) designing and implementing an explicit prioritization mechanism for including health services in the health benefits package under Component 1 – this is key for allocative efficiency – and also their monitoring and update;
d) implementation of a Health Information System Interoperability Plan with the objective of ensuring that the information generated by the different national and provincial health information systems is harmonized and can be easily exploited for analytical and decision making purposes (including the adoption of interoperability standards at the national and provincial levels and support for a national interoperability team in charge of supervising the implementation of the Interoperability Plan);
e) promotion of Medical Electronic Records and a path towards a "one patient one record" system;
f) mechanisms for assigning patients to health facilities, with geo-referencing of patients;

[22] Canada has 11 "Pan-Canadian Organizations" charged with promoting coordination and collaboration among national and provincial actors on key health themes such as information standards, procedures, protocols, etc. They are intergovernmental bodies, typically with members from both the national and provincial Governments.

g) improved mechanisms to identify and register people as beneficiaries under Component 1 and other public sector programs
h) structures to enhance coordination between the National and Provincial Ministries of Health, and to strengthen the National Ministry of Health's capacity for coordinating the different actors in the system;
i) improved mechanisms for public health facilities to readily bill OSs for utilization of their services by OS members (including mechanisms for developing common service definitions across the public and social security subsystems)
j) strengthening coordination structures at the provincial level, e.g. by establishing provincial teams headed by a Coordinator from the Provincial Ministry of Health and including members from different project implementation units (PIUs) at the provincial level;
k) carrying out of studies on health system financing and organization to help MSN and the MSPs design public policies to enhance universal health coverage, including mechanisms to integrate the different health system subsectors.

30. In addition, modalities will be explored for building in incentives for supporting the establishment of instruments for coordination and for an integrated model of care. For example:

- Adherence to predefined standards for the definition of services and for information systems – looking here at services in the public subsystem as a whole, going beyond those paid for under the *Sumar* program – could be among the preconditions needed for entry into the program on the part of each province, and for remaining in the program.
- The provinces may be allowed to consider the provision by public health facilities of sufficient quantities of key services outside the regular (i.e. paid) *Sumar* benefits package (subject to adherence to predetermined protocols) as in-kind contributions that would fulfil the provincial co-financing requirement for the capitation payments under Component 1. This would incentivize the development of instruments (including information systems) to measure utilization of these services, following service definitions and protocols established by the national Government.
- Tracking of drug prescriptions for services included in the HBP could be prerequisites for payments for those services (under Component 1). This information could be linked to information on drug deliveries at public pharmacies, thereby incentivizing rational drug prescription and use.
- Payments to health providers under Component 1 could be structured in a manner that incentivizes empanelment, i.e. defining a regular primary care provider for each individual.

31. **Sub-Component 2.2: Provincial Integration Pilots (US$XXX million). This sub-component would support pilots in around two selected provinces to test particular approaches towards enhanced integration at the provincial level**. The sub-component would finance the further development, pilot testing and refinement of tools for integration and for an integrated model of care. This would include tools to enhance integration within the public subsystem and between the public and social security subsystems (in particular mechanisms for public health facilities to bill OSs for health services provided to OS members). Robust evaluation mechanisms would be established to monitor the pilots and to draw appropriate lessons for possible expansion of these pilot approaches to other provinces.

32. **Component 3: Supporting Management, Monitoring and Evaluation (US$XXX million**). This component would finance the strengthening of the National Project Implementation Unit (PIU), the International Financing Unit of the MSN (UFI-S) and the Provincial PIUs, through the provision of technical assistance (including the financing of Operating Costs), monitoring and evaluation and financial and independent technical audits under the Project.

SAFEGUARDS

A. Project location and salient physical characteristics relevant to the safeguard analysis (if known)

The Project would be implemented nationwide. Based on the information available at this stage, the Project would not involve natural habitats, forests or cultural property. Most of the Project investments are planned to take place in existing infrastructure. The specific location of the proposed intervention would be defined during the project implementation and it is expected to be wide.

B. Borrower's Institutional Capacity for Safeguard Policies

The Project would be implemented by the National Ministry of Health (MSN), which has a strong experience working with World Bank Safeguards. In the case of OP 4.01 and 4.10, this Project would build on and continue benefitting from Argentina's broad experience in the management of these polices under previous and current operations (i.e. Essential Pubic Health Project (EPHP) I and II (P090993 and P110599), Provincial Maternal-Child Health Investment Project I and II (P071025 and P095515), Provincial Health Insurance Development Project and AF (P106735 and P154431) and Protecting Vulnerable People against Noncommunicable Diseases Project (P133193).

Under these projects Environmental Management Frameworks and Environmental Action Plans were developed and are currently under implementation. In addition, Argentina has comprehensive national legislation in place to guide health care waste management practices. Project environmental and social management would rely on the existing Safeguards Unit which has been created in 2012 for the EPHF II Project. This unit is already staffed, and has been strengthened with the implementation of the previous projects, and has institutional articulation with the provincial governments. During project preparation, the Bank team will review the ongoing experience with the active projects and consider the institutional needs to engage in a new operation with a broad number of provinces.

In the case of the OP 4.10, the MSN prepared IPPFs and the provincial governments prepared and implement IPPs for all provinces where indigenous peoples live. These processes have been found to be up to standard in previous Bank evaluations. The Project would follow the same approach.

The MSN would continue supporting provincial governments through technical assistance and training to prepare and implement the IPPs, including prior consultations. In addition, it would also monitor and evaluate the implementation of the activities agreed upon in these documents. In addition, the MSN will continue 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, full medical check-ups, field screening of indigenous people at high risk to confirm diagnoses and treatment adherence, and workshops covering intercultural health adaptations in health care delivery.

C. Environmental and Social Safeguards Specialists on the Team

Santiago Scialabba, Marcelo Roman Morandi, German Nicolas Freire

D. Policies that might apply

Safeguard Policies	Triggered?	Explanation (Optional)
Environmental Assessment OP/BP 4.01	Yes	The Project has triggered the 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 preventive screening of colon, and the application of high-complexity interventions within the Project's benefit plan, of people without explicit health coverage, and (ii) the disposal of old IT equipment, caused by the provision of equipment (medical, emergency, transport, computer systems and communications) in the ministries of national and provincial health as well as health centers. Therefore, the Project's Environmental Category is B. An Environmental and Social Management Framework (ESMF) would be prepared. Building upon previous projects in the health sector, consultations of the ESMF would take place via two mechanisms: a) five regional meetings (via Videoconference) with representatives from hospitals and environmental areas of the Provincial Ministries. In addition, relevant NGO and key actors involved in environmental issues could participate. b) a quick survey applied to key stakeholders already identified in EPHP II and Sumar program databases.
Natural Habitats OP/BP 4.04	No	Interventions supported by the proposed Project would be undertaken in existing structures, without any adverse environmental impacts to natural habitats.
Forests OP/BP 4.36	No	Interventions supported by the proposed Project would be undertaken in existing structures, without any adverse environmental impacts to forested areas.

Pest Management OP 4.09	No	The proposed Project would not finance the procurement of pesticides nor would it support activities which lead to the increased use of pesticides or hazardous chemicals.
Physical Cultural Resources OP/BP 4.11	No	No modifications would be made to existing buildings of Resources OP/BP 4.11 historical or cultural importance.
Indigenous Peoples OP/BP 4.10	Yes	This is a Project that is expected to cover all regions of the country, and indigenous peoples are present in Argentina (about 2.5 percent of the population). In this context, the OP/BP 4.10 on indigenous peoples would be triggered because indigenous communities in the provinces that might participate in the Project met the OP4.10 criteria. The proposed Project is expected to have a positive impact for vulnerable population throughout the country since it would contribute to enhance their access to quality health services, thus promoting equity in the access to these kind services without causing adverse social impacts. No negative indirect or long term impacts are expected from the activities under the Project. Mechanisms were developed under previous and current projects to disseminate information to stakeholders and beneficiaries as a preventive measure and to avoid any potential conflict. The same approach will be used for this operation. Complaints and suggestions would follow the channels created at the provincial health ministries. An Indigenous People's Planning Framework (IPPF) would be prepared, disclosed and consulted with the representatives of indigenous peoples to promote indigenous peoples' access to Project benefits and adapt the services in a culturally appropriate manner. In this sense, the project will continue fostering screening, enrollment, and provision of health care services in ways that meet the special needs of IP. The IPPF would require each Province to prepare an Indigenous Peoples' Plan (IPP) that should include culturally appropriate mechanisms to reach these groups. The unified IPPs developed under the previous and current projects would have to be updated, re-consulted and re-disclosed to reflect the changes

		incorporated in this 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. According to data coming from the 2010 national census and information provided by the National Registry of Indigenous Communities (ReTeCi), there are indigenous communities in 23 provinces (i.e. all subnational jurisdictions except the Autonomous City of Buenos Aires). In this sense, all may require to prepare an IPP in case they decide to participate in the Program. IPPs should comprise: (i) a diagnosis of the status of IP in relation to the Project's PDO; (ii) the development of strategic actions, including training, dissemination and outreach activities mainly on intercultural health service delivery; (iii) targets to be achieved by health facilities in terms of effective coverage, and delivery of selected health interventions for this group (initial screening to identify at risk indigenous people, and in-field medical checkups); and (vi) a budget for IPP implementation.
Involuntary Resettlement OP/BP 4.12	No	The proposed Project would not support any activity requiring involuntary taking of lands resulting in relocation or loss of shelter, nor the involuntary restriction of access to legally designated parks and protected areas resulting in adverse impacts on the livelihoods of the displaced persons.
Safety of Dams OP/BP 4.37	No	The proposed Project would not support the construction or rehabilitation of dams.
Projects on International Waterways OP/BP 7.50	No	The proposed Project would not finance activities involving the use or potential pollution of international waterways.
Projects in Disputed Areas OP/BP 7.60	No	The proposed Project would not be implemented in disputed areas.

E. Safeguard Preparation Plan

Tentative target date for preparing the Appraisal Stage PID/ISDS

Sep 14, 2017

Time frame for launching and completing the safeguard-related studies that may be needed. The specific studies and their timing should be specified in the Appraisal Stage PID/ISDS

The Borrower is expected to complete the preparation of all the safeguards instruments, including their respected consultation by September 10, 2017. The Appraisal stage PID/ISDS would be tentatively prepared by September 14, 2017.

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