Combined Project Information Documents / Integrated Safeguards Datasheet (PID/ISDS)

Appraisal Stage | Date Prepared/Updated: 29-Nov-2017 | Report No: PIDISDSA22950

BASIC INFORMATION

A. Basic Project Data

Country	Project ID	Project Name	Parent Project ID (if any)
Argentina	P163345	Supporting Effective Universal Health Coverage in Argentina	
Region	**Estimated Appraisal Date**	**Estimated Board Date**	**Practice Area (Lead)**
LATIN AMERICA AND CARIBBEAN	30-Nov-2017	27-Feb-2018	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 key health services provided to the eligible population in an equitable manner; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for coordination among selected health financing and service delivery stakeholders.

Components

Strengthening Effective Public Health Coverage
Strengthening the Institutional Capacity of the National and Provincial Ministries of Health
Supporting Management, Monitoring and Evaluation

Financing (in USD Million)

Financing Source	Amount
Borrower	358.05
International Bank for Reconstruction and Development	300.00
Total Project Cost	**658.05**

Environmental Assessment Category

B - Partial Assessment

Decision

The review did authorize the preparation to continue

Other Decision (as needed)

B. Introduction and Context

Country Context

1. **The Government has introduced several economic reforms since taking office in December 2015.** It unified the exchange rate, ended the dispute with holdouts creditors, abandoned the system of discretionary import licenses, resumed the publication of credible official statistics, significantly lowered export taxes, cut the personal income tax by increasing the minimum threshold and reduced energy and transport subsidies. It expanded several social benefits (e.g. child allowances), increased unemployment insurance significantly, and introduced a plan to settle social security lawsuits and to adjust pensions upwards. The recent mid-term election primaries results were seen as a display of support for the current administration. These results are expected to empower the government to stick to its reform agenda, which will likely include a tax and labor reform, among others.

2. **Economic activity is expected to continue its recovery in 2018.** Economic activity contracted 2.2 percent during 2016, taking a toll on labor markets, where up to 0.6 percent of formal private sector jobs were lost[1]. But GDP has expanded for four consecutive quarters (2.7 percent) since the second quarter of 2016, and employment in the formal private sector recovered to its December 2015 level. The economy is expected to grow by 2.7 percent[2] in 2017 and in 2018, for the first time in seven years, on the assumption that the positive impact of 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 lower energy and transport subsidies. But inflation has decelerated rapidly and is expected to be 22 percent in 2017[3], despite increases in energy and transport tariffs. The central government overachieved its primary deficit target in 2016 (4.3 vs. 4.8 percent of GDP) and is expected to do so in 2017 (4.0 vs. 4.2 percent of GDP). The target primary deficit for 2018 (3.2 percent of GDP) will require further fiscal consolidation efforts.

3. **The 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 strong interest from foreign investors and firms. Going forward, Argentina aims to continue building a growth-enabling policy framework to enhance credibility and to 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 and 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,

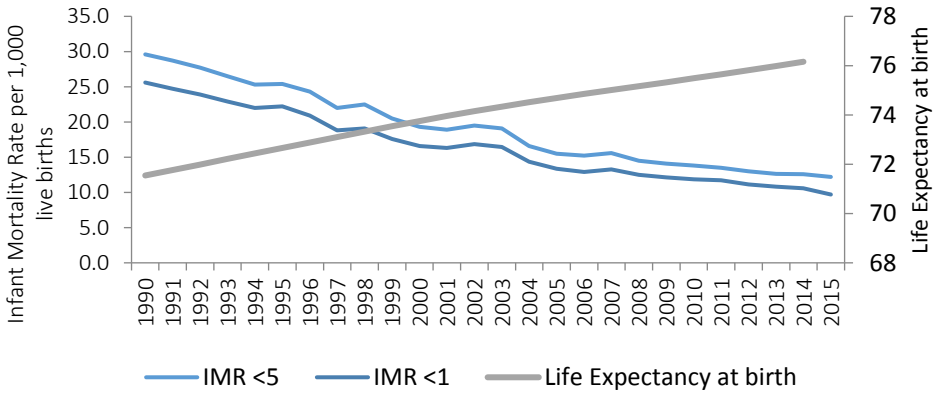
[1] Source: Ministerio de Trabajo, Empleo y Seguridad Social
[2] Source: World Bank Group. 2017. *Global Economic Prospects, January 2017 Weak Investment in Uncertain Times*. Washington, DC: World Bank. doi:10.1596/978-1-4648-1016-9.
[3] Source: *Relevamiento de Expectativas de Mercado* (REM), Banco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

health, and education) and reducing regional disparities.

Sectoral and Institutional Context

4. **Argentina's health outcomes have improved significantly during the past decades, especially for maternal and child health indicators and to a more limited extent for noncommunicable diseases (NCDs).** Over the last 5 years, both infant and child mortality rates have decreased and life expectancy increased (see Figure 1). In addition, the country has reduced inequalities in health outcomes and access to services; for example, the gap between the average infant mortality rate of the poorer Northern provinces and other provinces fell from 6.8 per 1,000 live births in 2004 to 2.7 in 2015. Between 2005 and 2013 the percentage of women aged 25-65 years receiving cervical cancer screening rose from 60.6% to 71.6%, and the percentage of adults having a high blood pressure control test rose from 78.7% to 82.4%.[4]

Figure 1. Infant Mortality Rate and Life Expectancy at Birth



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 Study 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[5]). 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. **Despite these efforts, significant challenges remain, including persistent inefficiencies and inequities and relatively poor performance of the public health sector, particularly with NCD-related**

[4] This is according to the national Risk Factor Surveys of 2005 and 2013.
[5] Global Burden of Disease Study by the Institute of Health Metrics and Evaluation (IHME), 2015.

indicators. 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. For example, the maternal mortality ratio in Argentina is 39 per 100,000 live births, as compared to 31 in Romania and 26 in Costa Rica.[6] The age-standardized mortality for cervical cancer is 6.6 in Argentina, compared to 5.9 in Romania and 3.9 in Costa Rica (IHME, 2015). The poor overall outcomes are due, in part, to a lack of efficient risk pooling mechanisms (to pool high-risk groups with low-risk ones), as explained below. In addition, there are multiple examples of inefficiencies and inefficient use of scarce resources at a more "micro" level especially in the public sector. For example, a lack of mechanisms to readily share clinical records between different health providers often results in repeated testing and/or prescriptions of the same medication, or in inadequate advice given due to incomplete information. A lack of integrated mechanisms to track the prescription and delivery of drugs often leads to wastage and to inefficient use of the existing stock of drugs, resulting in rather frequent stockouts of some drugs at public pharmacies.

7. **Individuals exclusively using the public health subsystem (mostly the poor) are less likely to receive NCD-related screenings.** The percentages of i) women aged 25-65 years receiving cervical cancer screening, ii) of women aged 50-70 years receiving a mammography and iii) adults having a high blood pressure control test are significantly lower for those exclusively using the public subsystem vs. the rest of the population (60.4% vs. 71.6%, 48% vs. 65.7%, and 71.2% vs. 82.4%).[7] Yet the average (public) per capita spending for those exclusively using the public subsystem is higher than for members of an *Obra Social* (OS)[8]. With the caveats that (i) the public subsystem cross-subsidizes the OS subsystem to some degree and (ii) public spending figures include financing for public health functions[9] benefiting the entire population, these results show the poor efficiency of public spending.

8. **These inefficiencies and inequities are due in part to the highly-fragmented nature of the Argentine health system which is structurally 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. The public service delivery network is decentralized to the provincial level and sometimes to municipalities, adding to the system's fragmentation. The social security subsystem covers the population with formal sector employment, and consists of about 300 national OSs (*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 schemes. Finally, there is a small voluntary private insurance market.[10]

[6] According to data from the World Development Indicators for 2015. Per-capita GDP in 2015, in Purchasing-Power Parity terms, was US$19,881 in Argentina, compared to US$20,389 for Romania and US$15,028 for Costa Rica.
[7] According to data from the Risk Factors Survey of 2013.
[8] 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*.
[9] Such as regulation, health promotion, disease surveillance, immunization, and others.
[10] Around 38% of the total population relies exclusively on the public subsystem, including almost 60% of the poor and about three-fourths of the extremely poor (according to the Permanent Household Survey of 2016). Most of the others in the population are covered by the social security subsystem (including INSSJP).

9. **The system's inherent fragmentation is due in part to the 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 the national Government plays a limited role in coordinating the actions of the provinces, which are highly autonomous.

10. **Another factor adding to the fragmentation is the existence of different National and provincial programs within the public subsystem that have different management structures.** 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.

11. **The system's fragmentation operates along two different dimensions. 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.[11] 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. Within the public subsystem, the available financing per person varies widely across provinces, and there is no major equalizing transfer mechanism to reduce the inter-provincial inequities in health spending, unlike in many other Federal countries. There is also continuing cross-subsidization by the public subsystem of the OS subsystem, by amounts that are likely substantial although not known with precision. One reason for this is that many public health facilities lack the billing systems and the capacity needed to bill the OSs for health services given to their members. There are also other underlying reasons.

12. **The 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.** 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.

13. **The Government is now embarking on a new Strategy in support of effective Universal Health Coverage (UHC) – a holistic approach where all health programs and initiatives would work together in an integrated manner, focusing on enhancing effective coverage in the public sector** – 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 Presidential Decree in support of the Strategy was issued,

[11] 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.

mentioning the need to address the fragmentation and organizational problems of the health system, and the division between the three subsystems. Among others, the Strategy aims for: (i) everyone without formal health insurance eventually being traceable across the continuum of care; and: (ii) strengthening of electronic systems to enable OSs to be billed when their members use public health facilities.

14. **The new Strategy would strengthen the public subsystem through a model 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).[12] 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.

15. **An IDS-based model of care would be especially useful for effectively managing NCDs.** In the public sector, often the only NCD-related services that have been defined are those in a limited package of mostly primary and preventative 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).

16. **An integrated model of care in the public subsystem would also require resolution of various other coordination problems, including with: (i) referral networks for diagnosis, treatment and follow-up 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 a decentralized context with limited coordination structures. As another example of coordination failure, the *CUS-Medicamentos* program (formerly called *Remediar*) tracks the flow of different types of essential drugs to public pharmacies; but there is no link with other programs that could track the prescription and *dispensing* of drugs, such as the *Sumar* Program. Establishing this link with the *Sumar* program would help ensure rational prescribing and use of drugs, and would thus reduce the stockouts of primary care drugs now often seen at public pharmacies. But these types of linkages do not come naturally between two programs with different management structures.

17. **The model of care would need to have a strong primary (including preventative) health care (PHC) focus, with strategies to actively expand effective coverage at the primary care level and to**

[12] See "Trends in Integrated Care – Reflections on Conceptual Issues" by Gröne, O & Garcia-Barbero, M (2002). World Health Organization, Copenhagen, 2002, EUR/02/5037864

promote "empanelment" (assignment to a regular primary care provider for provider continuity). In Argentina, as in many countries, large segments of the population hardly visit health facilities for preventative health services such as screening for cancer, diabetes, heart disease and other NCDs. The result is that these diseases often reach quite advanced stages before detection, resulting in much higher rates of mortality and morbidity – and much higher treatment costs – than would have been the case if they had been detected and addressed much earlier. An approach focused on PHC would also emphasize preventative actions on the part of the population to reduce the incidence of these diseases in the first place. International experience shows that PHC can be effectively promoted through an "empanelment" strategy, where – as one example of a viable approach – primary care providers would be encouraged to actively seek new persons from their catchment area for regular preventative care (checkups, screening, etc.) as well as treatment, referrals to higher-level providers when needed and then regular follow-up.

18. **Equity would also need to be appropriately addressed.** The model of care would need to be designed and implemented in a manner that takes into account the large differences across provinces in health outcomes, institutional capacity and the ability to raise domestic revenues.

19. **The Government has requested World Bank financing for a new project to support its strategy for increasing effective UHC, building on successful ongoing initiatives such as, in particular, the *Sumar* program supported by the Bank.** The use of financial incentives in innovative ways – building upon mechanisms already being implemented under the ongoing *Nacer/Sumar* program[13] – would be key under the new project. The project would act as the cornerstone of an integrated approach that would also involve various other ongoing programs[14], all acting in complementary fashion in support of effective UHC.

C. Proposed Development Objective(s)

20. 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 an equitable manner; and (ii) increase the institutional capacity of the MSN and MSPs to implement mechanisms for coordination among selected health financing and service delivery stakeholders.

21. The eligible population consists of all aged under 65 without formal health insurance (nearly 15 million people); these individuals are exclusively covered by the public subsystem. The Project would be implemented throughout the country, with a focus on the poorest provinces and municipalities.

Key Results

PDO (i)

[13] Supported first by the World Bank *Plan Nacer* I (US$135 million) and *Plan Nacer* II (US$300 million) Projects – both already closed – and then the *Sumar* Program Project (US$600 million – P106735), now under implementation.

[14] Including: (i) the Protecting Vulnerable People against NCDs or "*Proteger*" Project (US$350 million – P133193), supported by the World Bank and now under implementation; and (ii) other national programs such as *Redes*, *Incluir Salud* and *CUS-Medicamentos*.

Percentage of eligible population with effective health coverage[15]
Percentage of eligible adults with hypertension that are diagnosed, in regions with poorest health outcomes

PDO (ii)
Percentage of participating provinces with reported services for selected key lines of care
Percentage of eligible population enrolled and assigned ("empaneled") to a health facility

D. Project Description

22. **The Project would build on the successful approach of the ongoing *Sumar* Program (currently supported by a World Bank project) – which aims to improve access and quality for a package of prioritized health services for the eligible population through Results-Based Financing (RBF) mechanisms at the provincial and health care provider levels.** The eligible population for the *Sumar* Program is the same as it would be for the new Project; see above. Specifically, the *Sumar* Program provides financial incentives to: (i) encourage provinces to increase "effective coverage" for priority services (delivered according to established quality protocols[16]) among the eligible population, and to actively work to improve selected provincial health indicators; and to: (ii) incentivize health care providers to increase delivery of the services in the prioritized package.

23. **The proposed Project would expand on the incentive structure under the *Sumar* program. It would finance additional incentives (Component 1) and targeted instruments and goods (Component 2) to enhance coordination and to support an integrated model of care oriented around a regular primary care provider.** These two components would create synergies to support key Project goals and to thereby enhance effective UHC for the eligible target population, especially for key "lines of care" (e.g. diabetes, cervical cancer). The instruments to be supported under Component 2 would include tools to define a benefit plan for the entire public subsystem (especially for the key "lines of care"); to enhance integration in health information systems; to further increase the focus on the quality of care; to strengthen cost recovery efforts by public health service providers from the OSs; and to enhance coordination in planning across programs. (See Figure 2.)

[15] Effective health coverage is defined as "being enrolled in the program and having utilized one or more essential health services provided according to established quality protocols – from a list of predefined key services listed in the Operational Manual (OM).
[16] See previous footnote for the definition of "effective coverage", used for the *Sumar* program (and also for the new Project).

Figure 2. Project Results Chain

<table>
<tr><td>Main Challenges</td><td colspan="4">Persistent inefficiencies and inequities and relatively poor performance of the public health sector, particularly with NCD-related indicators</td><td colspan="4">Lack of instruments for coordination across subsystems and within subsystems (including across provinces) and lack of integrated information systems</td></tr>
<tr><td rowspan="2">Project Supported Activities</td><td colspan="4">Results-Based Financing and Incentives</td><td colspan="4">Tools/ Instruments</td></tr>
<tr><td colspan="2">From the MSN</td><td colspan="2">From MSPs to Providers</td><td colspan="4" rowspan="2">• TA and training for enhancing “empanelment”
• TA and training for measuring selected quality of care indicators
• TA for defining services and quality standards for the entire public subsystem, for key selected lines of care (going beyond Project’s directly supported health benefit plan)
• Goods for strengthening delivery capacity for key selected lines of care
• TA and goods for improving integration of health information systems
• TA for increasing cost recovery efforts (from social security institutions)
• TA for enhancing coordination in planning among public programs</td></tr>
<tr><td colspan="2">• Results-based capitation payments for key preventative health services in the health benefit plan: effective coverage (60%) and performance indicators (40%)
• Capitation payments for selected high-complexity diseases</td><td colspan="2">• Fee-for-service payments
• Bonus payments for “empanelment”
• Bonus payments for completing selected lines of care
• Bonus payments for selected quality-of-care measures</td></tr>
<tr><td>Intermediate Results</td><td>Effective coverage during pregnancy increased</td><td>Effective coverage for children and adolescents increased</td><td>Women with at least one cervical and breast cancer screening according to quality protocols</td><td>Men and women with at least one colorectal cancer screening according to quality protocols</td><td>Service delivery capacity strengthened for selected key lines of care in the public subsystem</td><td>Public hospitals billing to the social security institutions increased</td><td>Interoperability plans for information systems implemented</td><td>Primary health care providers georeferenced and with their catchment area defined</td></tr>
<tr><td>OUTCOMES</td><td colspan="2">Eligible population have increased their effective coverage (with adequate quality) of key health services</td><td colspan="2">Increased equity across provinces in access to health services of adequate quality (for eligible population)</td><td colspan="2">Provinces have completed key selected lines of care (preventive, treatment, follow up), enhancing continuous care in the public subsystem</td><td colspan="2">Eligible population are enrolled and assigned to a primary health facility (“empaneled”), enhancing patient traceability</td></tr>
<tr><td>PDOs</td><td colspan="4">Increase effective coverage of key health services provided to the population exclusively covered by the public subsystem (the eligible population)</td><td colspan="4">Increase the institutional capacity of the MSN and MSPs to implement mechanisms for coordination among selected health financing and service delivery stakeholders</td></tr>
</table>

24. **The Project would include three components** as follows:

25. **Component 1: Support the Strengthening of Effective Public Health Coverage (US$480 million, US$192 million from IBRD).** This Component would finance capitation payments for the provision of a prioritized Health Benefit Plan (HBP) consisting of: (a) General Health Interventions (GHI)s under Sub-Component 1.1; and (b) selected health interventions for High Complexity Diseases (HCDs) under Sub-Component 1.2. The HBP will contribute to improving the quality of services as well as extending coverage. Results will be monitored using supervision protocols and information systems, and will be verified by an independent technical auditor.

26. **The capitation payments would cover a share of the total cost of selected health services provided by service providers**. The selected services would be those in the prioritized HBP defined for the eligible population[17]. To this end, the MSN carried out an actuarial calculation to estimate the incremental cost of this HBP to be financed by the Bank.

[17] Services covered by the HBP were selected based on their effectiveness in addressing diseases that impose a large burden for each selected population group, mainly preventative and primary health care services. The HBP would be periodically reviewed in agreement with the Government and the Bank; as established in the OM.

Sub-Component 1.1: Capitation Payments for General Health Interventions

27. **Results-based capitation payments for GHI – accounting for 67% of the Project's financing – would be financed by the MSN for all eligible people in participating provinces who are enrolled and with effective health coverage.** This builds upon the successful experience of the *Sumar* program in incentivizing not just enrolment but also utilization of key (especially preventative) health services with adequate quality standards.

28. **The capitation payment for each province would be the sum of: (i) a "basic" component, and: (ii) an additional "equity" component whose size would depend on equity considerations**. The sum of these would make up the total capitation payment given to the province for each eligible person with effective coverage. The "basic" capitation payments would be transferred in two steps: (i) a share of the financing (60%[18]) will be provided after effective coverage for the eligible population is verified, and: (ii) the remaining share (40%) will be transferred based on achievement for a set of specific provincial health indicators ("tracers"). The introduction of an "equity" component in the capitation payment for each province is an innovation under the Project, and would result in additional funds going to the worse-off provinces.

29. **A share of the capitation payments would be financed from domestic resources, and this share would be rising over the life of the Project**. This is in line with the principle – communicated very clearly by the Government – that financing of the capitation payments will be entirely taken over by the Government after the project ends, with the bulk of the financing to come from the National Government.

30. **The funds from the capitation payments for each province would be transferred to health service providers to support the provision of services in the HBP, through "fee-for-service" payments as well as incentives to adopt an effective strategy for "empanelment", and eventually for selected quality-of-care indicators.** Under the Project, strategic purchasing by provinces to incentivize the use of key (especially preventative) services via "fee-for-service" payments would continue, building on the successful experience of the *Sumar* program. But other types of provider payment modalities will also be used, including incentive payments to encourage activities related to "empanelment". Providers would largely have autonomy in the use of these funds. Eventually, bonus payments would also be made to health facilities for attaining targets for selected quality-of-care indicators, to be chosen from the measures tracked under Sub-Component 2.1 activity (b) – starting with pilots in selected provinces with better information systems. Later, more complex pilots may be introduced.

***Sub-Component 1.2: Capitation Payments for High-Complexity Diseases*:**

31. **In addition to the capitation payments for GHIs, the Project will finance capitation payments for the provision of a separate package of HCD-related[19] services to the eligible population, as part of a**

[18] The exact percentage will be discussed and finalized during the appraisal.
[19] The HCDs include congenital heart diseases, congenital malformations, premature births, high-risk deliveries and selected cardiovascular procedures.

newly created National Fund for High Complexity Diseases (NFHCD). This Fund would be similar in design (with similar implementation arrangements to the Solidarity Reinsurance Fund for Catastrophic Diseases (FRSEC) under the *Sumar* program. This Fund would replace the FREC and would operate as a public health insurance system for services related to HCDs. Each month the MSN will transfer capitation payments to the NFHCD based on the number of beneficiaries enrolled in the Program, to create a risk pool at the national level. The funds will be used to make payments to Authorized Providers for the provision of services included in the HCD package to the eligible population.

32. **Component 2: Strengthening the Institutional Capacity of the Nacional and Provincial Ministries of Health (US$ 125 million, US$ 82 million from IBRD).** This component would have two Sub-Components, as follows:

33. **Sub-Component 2.1. Instruments to Support Increased Coordination and an Integrated Model of Care (US$58 million, US$37 million from IBRD).** This Sub- Component would support the provision to the MSN and MSPs of tools and instruments needed for an integrated quality-based model of care within the public subsystem, and for improved coordination within the public subsystem as well as across subsystems. The Project would finance goods, consulting and non-consulting services, TA, training and operating costs to:

a) **Enhance "empanelment"**. Provinces will be provided with tools, training and Technical Assistance (TA) to be able to effectively enhance their efforts towards "empanelment", including via the use of geo-referencing tools. In addition, tools and training will be provided to facilitate and encourage efforts by health workers at primary care facilities to actively seek new eligible patients within the geographical area mapped to each health facility.
b) **Develop and track effective quality-of-care measures at the health facility level**: Appropriate measures will be developed for the Argentinian context, starting with pilots in provinces with better information systems. Mechanisms for reporting, verifying and tracking the key quality indicators will also be developed. TA and other types of support would be provided for designing and implementing provider payment mechanisms based on selected quality-of-care performance indicators, to be financed under Component 1.
c) **Define services and standards for the entire public subsystem**. This includes: (i) establishing mechanisms for defining and systematizing an explicit package of services for the entire public subsystem, especially for key clinical pathways (i.e. "lines of care", including services and protocols), based on common agreement on required quality standards and delivery conditions; (ii) defining 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; and (iii) 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) **Improve integration of Health Information Systems (ISs)**. This would include: (i) essential activities to support the establishment and adoption of basic IS interoperability standards related to the use of reference registries and standard clinical terminology, vocabularies, clinical documents structure and interoperability; (ii) cross-cutting activities related to: improvement of eHealth Governance, and adoption of appropriate IT and supporting Change Management to accompany investments supporting digital data entry at the "point-of-care"; and (iii) advanced activities related to: connecting health service providers and promoting electronic information

transfer along the line of care; supporting standardization and integration of data flows across programs; digital solutions to support "empanelment" efforts; and improving and streamlining procedures for billing at the health facility level.

e) **Support cost recovery efforts by public health service providers from *Obras Sociales* (OSs)**. This would include: (i) analysis of key problems and implementation obstacles with the current cost-recovery system; potential improvements in regulation regarding cost-recovery from the OSPs and the INSSJP; and implications of expanding the system to also include primary health care facilities; (ii) training activities for hospital administrative staff in cost recovery efforts and systems; and (iii) technical support for the process of registration of public hospitals as Public Hospitals with Decentralized Management (HPGDs) which are legally allowed to invoice the OSs.

f) **Enhance coordination in planning and activities among different programs**. This would include: (i) establishment of integrated implementation teams at the provincial level as well as the National level (involving teams implementing different programs), (ii) the development of a detailed plan showing the roles and responsibilities of each Program clearly defined in complementary fashion within the overall UHC Framework; (iii) joint planning to address various types of coordination challenges now inherent in the system (e.g. for referral networks and drug-tracking); and: (iv) eventually, a combined technical audit for all programs (including the proposed new Project, as well as others like *Proteger* and *Redes*) – that until now have required separate audits for each.

g) **Other forms of support for reaching effective UHC.** This would include support for: (i) studies on health system financing and organization to help MSN and the MSPs design public policies to enhance UHC, including mechanisms to integrate the different health subsystems; (ii) support for evaluation activities, including for Impact and Process Evaluations; (iii) developing and implementing mechanisms for payments to health service providers, including for the GHIs and CHD services under the Project; (iv) other forms of TA for efforts towards effective UHC.

34. **Sub-Component 2.2: Improving Service Delivery Capacity at the National and Provincial Ministries of Health (US$66 million, US$45 million from IBRD).** This sub-component would support improvements in the supply capacity of the MSPs and MSN required to enhance effective coverage in the public subsystem. It would finance: (a) the provision of equipment (medical, transportation, information technology and communications) based on a systematic analysis of service delivery gaps identified by province, especially at the primary level for the key "lines of care" and for HCD networks; (b) equipment and services, and information technology, for the MSN and MSPs, based on a systematic analysis of gaps and the level of provincial involvement in the activities supporting the integration of information systems under Sub-Component 2.1 activity (d). The Results Framework would include an indicator to track the impact of the equipment delivered on utilization of services in the key lines of care.

35. **Component 3: Supporting Management, Monitoring and Evaluation (US$53 million, US$25 million from IBRD**). This component would finance: (i) 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); (ii) monitoring and evaluation; and (iii) financial and independent technical audits under the Project.

E. Implementation

Institutional and Implementation Arrangements

36. **The Project would build on the successful implementation arrangements under the *Sumar* Program. It would be implemented by the MSN through the Project Coordination Unit (PCU) (established within the MSN) which currently supports *the Sumar Program*.** The PCU would be responsible for working with participating provinces through the Provincial Implementation Units PIUs to implement the Project in a timely manner, conforming to agreed-upon quality standards**.** The Project would finance 45 percent of the PCU staffing. Once the Project is completed; the MSN would assume full financial responsibility for PCU staffing. The PCU would work closely with the National Directorate of Jurisdictional Public Coverage (NDJPC) and other key Directorates at MSN, as well as the teams implementing other key Programs such as *Proteger*, *Redes, CUS-Medicamentos and Incluir Salud.* The NDJPC will, among others, provide overall support to the various MSN programs to ensure adequate articulation and implementation of the Government's UHC strategy, and will help ensure an integrated and coherent approach when working with the provinces.

37. **As in the case of the *Sumar* program, the International Financing Unit of the MSN (UFI-S) would be responsible for overall administrative and fiduciary matters** such as financial management (FM) and procurement. UFI-S is the MSN's central fiduciary agency that manages external financial resources and provides support to all executing units involved in Project implementation. The UFI-S would be responsible for: managing procurement processes; monitoring contract administration; processing payments to suppliers and consultants; managing the project finances, including control of the Designated Account (DA) and flow of funds; accounting and financial reporting; and collecting information for disbursements.

38. **The MSN Undersecretary of Administrative Coordination (UAC) will be responsible for transferring the capitation payments to the provinces and for essential aspects of the selection process for the associated independent technical auditor** (e.g. technical aspects, establishing an independent evaluation committee for proposals submitted), in coordination with the UFI-S and the PCU. The UAC will also coordinate with the PCU to ensure proper monitoring of the external and internal audit processes and to ensure that the penalties and deductions from the audits are applied properly. All remaining fiduciary functions will be carried out by the UFIs. This is in line with one of the key objectives of the current National Government administration, which is to institutionalize – and eventually fully take over the management of – the capitation payments sub-component, which is at the core of the new Project.

39. **Project implementation at the provincial level would be carried out by the MSPs of participating provinces, through the Provincial Implementation Units (PIUs) currently under the *Sumar Program* –** working closely with provincial teams implementing other programs, as part of coordinated structures implementing the UHC Strategy at the provincial level. The structure of the PIUs, including the minimum number of staff for each sub-unit within the PIU and their terms of references, would be in the OM.

40. **Participation by provinces would be governed by an Umbrella Agreement signed between each province (represented by the Governor and the Minister of Health) and the MSN, to cover the duration of the Project period.** These agreements would cover all legal, technical, financial, administrative, fiduciary and safeguards aspects of provincial participation in the program. The PIUs and the PCU would

also sign Annual Performance Agreements – which would include annual targets for the tracer indicators and for enrollment and “empanelment”; and details on work programs and resource requirements.

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F. Project location and Salient physical characteristics relevant to the safeguard analysis (if known)

The Project will be implemented nationwide. Based on the information available at this stage, the Project will 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 will be defined during project implementation and it is expected to be wide. The implementation will be in those provinces that will sign the Umbrella Agreement on Participation.

G. Environmental and Social Safeguards Specialists on the Team

Santiago Scialabba, Social Safeguards Specialist
Marcelo Roman Morandi, Environmental Safeguards Specialist
German Nicolas Freire, Social Safeguards Specialist

SAFEGUARD 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 cancer, and the application of high-complexity interventions within the benefits of the universal health coverage plan (ii) the disposal of old IT equipment, caused by the provision of new equipment (medical, emergency, transport, computer systems and communications) in the ministries of national and provincial health as well as primary health care centers. Therefore, the Project’s Environmental Category is B.
Natural Habitats OP/BP 4.04	No	The Project's investments are planned to take place within existing hospitals, health centers, labs and as primary health care centers. The project will not finance any new infrastructure or other physical works that would involve the conversion or

		degradation of natural habitats nor does it involve the improved management of natural habitats.
Forests OP/BP 4.36	No	The Project will not affect the health or management of forests nor will affect any forest dependent communities.
Pest Management OP 4.09	No	Project will not finance the procurement of pesticides nor will it support activities which lead to the increased use of pesticides or other hazardous chemicals.
Physical Cultural Resources OP/BP 4.11	No	No new buildings will be built. No modifications will be made to existing buildings of historical or cultural importance.
Indigenous Peoples OP/BP 4.10	Yes	About 2.5 percent of the Argentinian population self-identifies as having indigenous ancestry. Although there is little information on their health status in the country (ethnic variables are not available in official statistical records), specialized studies and IP organizations point at important and persisting gaps in access and health outcomes. The Project will build on and continue benefitting from the Ministry's experience with OP 4.10, under previous and ongoing operations. An IPPF was prepared and consulted with relevant IP representatives, and a round of consultations at subnational level will be carried during the design of the respective IPP. The main objective of the IPPF was to unify the criteria used for the inclusion of IP throughout the portfolio of the MSN associated to the Bank, so as to maximize positive impacts and improve results, by looking, for example, into areas of complementarity and overlap, strengthening both national and sub-national capacities to implement and monitor IP policies, mainstreaming statistical capacity to capture IP status in public health records, etc. The project does not anticipate adverse effects on indigenous peoples or other vulnerable populations. On the contrary, it is likely to improve health care access and monitoring through the activities described in the IPPF.
Involuntary Resettlement OP/BP 4.12	No	The proposed Project will 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.

KEY SAFEGUARD POLICY ISSUES AND THEIR MANAGEMENT

A. Summary of Key Safeguard Issues

1. Describe any safeguard issues and impacts associated with the proposed project. Identify and describe any potential large scale, significant and/or irreversible impacts:
The Project does not anticipate large scale, significant and/or irreversible social or environmental impacts. An IPPF was prepared to foster the capacity of the MSN and its provincial counterparts to reach indigenous peoples.

2. Describe any potential indirect and/or long term impacts due to anticipated future activities in the project area:
Increased generation of WEEE for equipment replacement.
Higher amount of Health-care waste (HCW), through increased cancer diagnostic screening.

3. Describe any project alternatives (if relevant) considered to help avoid or minimize adverse impacts.
Not necessary to analyze alternative options.

4. Describe measures taken by the borrower to address safeguard policy issues. Provide an assessment of borrower capacity to plan and implement the measures described.
The Project will be implemented by the MSN, which has a strong experience working with World Bank Safeguards. In the case of OP 4.01 and 4.10, this Project will 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 will rely on the existing Safeguards Unit within the UFIs, which was created in 2012 for the EPHF II Project. This unit is already staffed and has been strengthened with the implementation of the previous projects, it also has institutional articulation with the provincial governments. During project preparation, the Bank team reviewed past experiences in active projects and assessed the institutional needs to engage in a new operation with a broad number of provinces.

Social:
In the case of the OP 4.10, the MSN has prepared IPPFs and the provincial governments prepared and implement IPPs for all provinces where indigenous peoples live. These processes were found to be up to standard with Bank policies, so this projects will follow the same approach.

The MSN will continue supporting provincial governments through technical assistance and training to prepare and implement the IPPs, including prior consultations. In addition, it will monitor and evaluate the implementation of the activities agreed upon with the provinces. 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.

Environmental:
By Ministerial Resolution 136/2016, the UFI-S applies the Environmental Safeguard, with the MSN team. The technical team has already applied the environmental safeguard of the Essential Public Health Functions (EPHF) I and II (P090993) (P110599); of the Prevention & Management of Influenza H1N1 (P117377); Support to the Integral Strategy for the Prevention and Control of Non-communicable Diseases Project (P133193); and the AF for AR Provincial Public Health Insurance Development Project (SUMAR), (P106735). In those projects: recommendations were formulated and adopted in MSN laboratories, Environmental Work Management Plans were formulated for construction of health facilities, a system of diagnosis of the management of HCW was established in 32 hospitals throughout the country, Waste Management Plans of Health Establishments were formulated. The Argentine Guide for the rational management of waste from campaigns and immunization centers and the Signage Guide for HCW Management was designed, the evaluation of the progress in the internal management of HCW was carried out, a tool was designed to include Criteria of Valuation for Sustainable Public Procurement, an Introductory Virtual Course of Integral Management of HCW was formulated, the provincial capacities for the Integral Management of HCW were strengthened, and the provinces were assisted in the creation of 13 (thirteen) Environmental Health Units. Therefore, the MSN has acquired considerable experience in complying with environmental safeguards, fulfilling its objectives without difficulty.

5. Identify the key stakeholders and describe the mechanisms for consultation and disclosure on safeguard policies, with an emphasis on potentially affected people.
Social:
Consultations with indigenous peoples' representatives at national level were conducted on October 26, 2017, and a series of provincial level consultations will be carried out before project implementation. IPP's will be prepared following Bank standard consultation processes with provincial IP organizations and representatives. The consultation mechanism has been built in a way that allows for continuous monitoring and feedback, and the MSN will keep the Bank team informed on the advances of these exchanges periodically.

Environmental:
The Environmental Management Framework of the Project was put into public consultation through two mechanisms: a) five regional meetings (one in person and four by videoconference) with representatives of hospitals; environmental areas of the provincial health ministries; Relevant NGOs and key actors involved in environmental issues; b) a survey aimed at the key actors identified in the EPHF II and SUMAR program databases.

B. Disclosure Requirements

Environmental Assessment/Audit/Management Plan/Other

Date of receipt by the Bank	Date of submission for disclosure	For category A projects, date of distributing the Executive Summary of the EA to the Executive Directors
12-Oct-2017	17-Oct-2017	

"In country" Disclosure

Argentina
17-Nov-2017

Comments
http://www.ufisalud.gov.ar/

Indigenous Peoples Development Plan/Framework

Date of receipt by the Bank	Date of submission for disclosure
19-Oct-2017	08-Nov-2017

"In country" Disclosure

Argentina
17-Nov-2017

Comments
http://www.ufisalud.gov.ar/

C. Compliance Monitoring Indicators at the Corporate Level (to be filled in when the ISDS is finalized by the project decision meeting)

OP/BP/GP 4.01 - Environment Assessment

Does the project require a stand-alone EA (including EMP) report?
No

OP/BP 4.10 - Indigenous Peoples

Has a separate Indigenous Peoples Plan/Planning Framework (as appropriate) been prepared in consultation with affected Indigenous Peoples?
Yes
If yes, then did the Regional unit responsible for safeguards or Practice Manager review the plan?

Yes

If the whole project is designed to benefit IP, has the design been reviewed and approved by the Regional Social Development Unit or Practice Manager?

NA

The World Bank Policy on Disclosure of Information

Have relevant safeguard policies documents been sent to the World Bank for disclosure?

Yes

Have relevant documents been disclosed in-country in a public place in a form and language that are understandable and accessible to project-affected groups and local NGOs?

Yes

All Safeguard Policies

Have satisfactory calendar, budget and clear institutional responsibilities been prepared for the implementation of measures related to safeguard policies?

Yes

Have costs related to safeguard policy measures been included in the project cost?

Yes

Does the Monitoring and Evaluation system of the project include the monitoring of safeguard impacts and measures related to safeguard policies?

Yes

Have satisfactory implementation arrangements been agreed with the borrower and the same been adequately reflected in the project legal documents?

Yes

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