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Report No: 24326

IMPLEMENTATION COMPLETION REPORT
(SCPD-4004S; CPL-40040; SCL-4004A)

ON A

LOAN

IN THE AMOUNT OF US$ 25.0 MILLION

TO THE

ARGENTINE REPUBLIC

FOR A HEALTH INSURANCE TECHNICAL ASSISTANCE PROJECT

06/30/2002

Country Management Unit for Argentina, Chile and Uruguay
Human Development Sector Management Unit
Latin America and the Caribbean Regional Office

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CURRENCY EQUIVALENTS

(Exchange Rate Effective As of May 30; 2002)

Currency Unit	=	Argentine Peso (AR$)
AR$3.7	=	US$ 1.00
US$ 1.00	=	AR$3.7

FISCAL YEAR

January 1 through December 31

ABBREVIATIONS AND ACRONYMS

ANSSAL:	Administración Nacional de Seguros de Salud (National Health Insurance Administration)
APE:	Administración de Programas Especiales
CAS:	Country Assistance Strategy
CBA:	City of Buenos Aires
DGI:	Dirección General Impositiva (Federal Tax Collection Agency)
FROS:	Fondo de Reconversion de Obras Sociales (Restructuring Fund for National Health Insurers)
FSR:	Fondo Solidario de Redistribución (Solidarity Redistribution Fund)
IBRD:	International Bank for Reconstruction and Development
ICR:	Implementation Completion Report
INSSJP:	Instituto Nacional de Servicios para Jubilados y Pensionados (National Social Service Institute for Retirees and Pensioners)
MOE:	Ministerio de Economía y Obras y Servicios Públicos (Ministry of Economy and Public Works)
MOH:	Ministry of Health
OSs:	Obras Sociales (Health Insurance Fund)
PAMI:	Instituto Nacional de Servicios para Jubilados y Pensionados
PCU:	Project Coordination Unit
PMO:	Programa Médico Obligatorio (Standard Health Benefits Package)
PRESSAL:	Proyecto de Reforma del Sector Salud (Provincial Health Sector Development Project)
PRESSS:	Programa de Reconversión del Sistema de Seguro Social (Restructuring Program of Health Insurance System)
PROMIN:	Programa de Salud Materno-Infantil y Nutrición (Maternal and Child Health and Nutrition Project)
SSS:	Superintendencia de Servicios de Salud (Health Services Superintendency)
UEC:	Unidad Ejecutiva Central del Proyecto de Desarrollo del Sector Salud en las Provincias
UEP:	Unidad Ejecutora Provincial
UNDP:	United Nations Development Program

Vice President:	David de Ferranti
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ARGENTINA
HEALTH INSURANCE TECHNICAL ASSISTANCE

CONTENTS

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Project ID: P045687	*Project Name:* AR-HEALTH INSURANCE TA
Team Leader: Daniel Cotlear	*TL Unit:* LCSHH
ICR Type: Core ICR	*Report Date: June 27, 2002*

1. Project Data

Name: AR-HEALTH INSURANCE TA

L/C/TF Number: SCPD-4004S; CPL-40040; SCL-4004A

Country/Department: ARGENTINA

Region: Latin America and Caribbean Region

Sector/subsector: HR - Reform and Financing

KEY DATES

			Original	*Revised/Actual*
PCD:	04/17/1995	*Effective:*	07/12/1996	07/12/1996
Appraisal:	06/12/1995	*MTR:*		
Approval:	04/25/1996	*Closing:*	12/31/1999	06/30/2001

Borrower/Implementing Agency: REPUBLIC OF ARGENTINA/MINISTRY OF HEALTH

Other Partners:

STAFF	Current	At Appraisal
Vice President:	David de Ferranti	Shahid Javed Burki
Country Manager:	Myrna Alexander	Gobind T. Nankani
Sector Manager:	Evangeline Xavier	Alain Colliou
Team Leader at ICR:	Daniel Cotlear	Robert Hecht
ICR Primary Author:	Luis Perez; Sati Achath; Ruth E. Levine	

2. Principal Performance Ratings

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HL=Highly Likely, L=Likely, UN=Unlikely, HUN=Highly Unlikely, HU=Highly Unsatisfactory, H=High, SU=Substantial, M=Modest, N=Negligible)

Outcome: S

Sustainability: L

Institutional Development Impact: SU

Bank Performance: S

Borrower Performance: S

	QAG (if available)	ICR
Quality at Entry:	S	
Project at Risk at Any Time:	No	

3. Assessment of Development Objective and Design, and of Quality at Entry

3.1 Original Objective:

The US$25 million Argentina Health Insurance Technical Assistance Project accompanied two adjustment operations (Health Insurance Reform loans 4002-AR and 4003-AR, totaling US$350 million), each of which sought to improve the efficiency and long-term financial solvency of the country's major health insurers (known as *Obras Sociales* - OS).

The loans were designed to support several objectives of the Government: to introduce competition in the health insurance market, while avoiding risk selection; to create a fund that would on-lend to health insurers – many of which ran chronic deficits – conditioned on their implementation of organizational and administrative reforms that would lead to long-term solvency; to reallocate money in the existing insurance redistribution fund to insured individuals on the basis of their income and health risk profile; and to develop an effective regulatory framework for health insurance that would promote competition, while at the same time ensuring transparency and accountability, and protecting consumers' rights. The reform was expected to benefit a total of 18 million people covered by the national social insurance providers.

Historically, both the OS and the National Social Services Institute for Retirees and Pensioners (*Instituto Nacional de Servicios Sociales para Jubilados y Pensionados* -INSSJP, also known as PAMI) had operated as monopolies, with captive, employer-based beneficiary populations. Many of the insurers operated in inefficient and non-transparent ways, chronically running large debts; a large share had such small risk pools that the chances of solvency were small. Through the introduction of competition among the OS, and the improved regulation of the health insurance system, millions of insured Argentines were expected to obtain higher quality of service, resulting in better health outcomes and higher user satisfaction. In addition, the reform included: (a) legalizing competition between Obras and Argentina's private pre-paid health plans (Pre-Pagas) in the market for voluntary health insurance; (b) implementation of a Standard Health Benefits Package (*Programa Medico Obligatorio*, PMO) for insured persons; and (c) the redirection of Redistribution Fund (FSR) resources to OS with the lowest levels of revenue per beneficiary.

These changes were expected to substantially improve the equity of the health insurance system. The reform was also expected to reduce waste and misuse of funds, eliminating the estimated US$150 million in combined operating deficits (5 percent of annual revenues) at the time of appraisal. Further, the health insurance reforms were expected to improve health outcomes for a large segment of the country's formal work force, leading to lower absenteeism and higher productivity.

The technical assistance (TA) loan reviewed in this report was designed to provide the Government with the necessary technical resources to meet the important policy conditions attached to the health insurance reform loans (as well as a later Social Sector Adjustment Loan), and to strengthen the public sector institutions charged with designing, implementing, and monitoring the planned reforms of the social insurance system. The specific objectives of the project were to: (a) design and put in place a set of key reform policies such as competition, standard benefits package, and automatic distribution from the Solidarity Redistribution Fund (*Fondo Solidario de Redistribución*, or FSR); (b) develop the regulatory framework and institutions for the future system; and (c) formulate and implement organization and management changes in the PAMI.

The project's objectives were consistent with the Bank's Country Assistance Strategy (CAS) during a period of fiscal crisis in the mid-1990s. In particular, they corresponded to the Government's interests in restoring and maintaining a fiscal balance through improvements in the efficiency of public expenditures;

and supporting investments in human resources, especially education, nutrition, and health. On the fiscal side, the sector adjustment and TA loans were aimed at eliminating the operating deficits and improving the efficiency of entities providing social health insurance. In doing so, and in making additional changes in the "rules of the game" under which social insurance was organized, it also sought to improve access and quality of health care for Argentines in the formal sector – thus responding to human development concerns.

The Bank was well placed to develop this operation, given its involvement in Argentina's health sector through projects for maternal and child health (PROMIN, 6025-AR) and provincial public hospital management (PRESSAL, 3931-AR). Importantly, the Bank's economic and sector work on health financing (*Argentina: Facing the Challenge of Health Insurance Reform*, Report No. 16402-AR), developed during late-1994 and much of 1995, provided timely and in-depth analytic background when the Government of Argentina faced a fiscal crisis and turned to the Bank for an adjustment operation.

The project took into account the main risk factors to successful implementation of the reform and developed measures to minimize their impact. The first risk factor was the *political risk* that the Government would be unable to overcome opposition to change. To deal with this, the Government adopted a unified position on the reform, which was initially endorsed by the President, the Ministers of Economy and Labor and the Chief of the President's Office. The Government also had a detailed strategy for dealing with those who were opposed to the reforms, including trade union leaders and health provider associations. This included frequent consultations with all stakeholders, and a set of special incentives for joining the reform process early and performing well. To further mitigate this risk, the project financed a campaign to disseminate information on project actions and their benefits to OS members and management, before and during implementation. These measures were partially successful, although as discussed later (under Section 4), success was hampered by stronger than anticipated stakeholder opposition, as well as obstacles to change PAMI.

The second risk factor was the *risk of possible difficulties and delays* in building up and maintaining the institutional capacity of the Ministry of Health (MOH), PAMI and the relevant regulatory agencies to carry out the reform. This risk was addressed by developing a strong core team of Argentine managers, lawyers, and technical specialists at the project design stage. Many complex technical tasks, such as assisting OS in preparing restructuring plans, carrying out financial and creditworthiness analysis of individual OS, and designing a new organizational structure of the PAMI, were subcontracted to private firms. The Program Committee provided technical oversight to ensure that the Coordinating and Executing Unit (UEC), PAMI, and the Government regulatory body were adequately staffed and budgeted. By and large, these measures were successful.

Overall, the TA project, although complex due to the quantity and depth of the subjects and the high number of agents involved, had a demanding level that the Government and the implementation agency could adequately deal with; timely resources available for the conformation of professional teams, supported adequate progress in project implementation. However, as discussed later, the implementation of the institutional strengthening and policy reforms within PAMI was difficult for the Borrower because of various external constraints.

3.2 Revised Objective:
Objectives were not revised.

3.3 Original Components:
The project consisted of six components, all of which were designed to support the country's efforts to meet

the goals of the adjustment loans and their follow-up. The relationship among components, as well as with other concurrent Bank operations, was seen as essential to a global approach. For example, the PRESSAL operation was supporting several studies – such as a study on national health priorities and a national survey (or inventory) of health resources – which were expected to feed directly into the technical work of the TA project.

A. Policy Design and Implementation (US$1 million estimated at appraisal). This component included: (i) designing and enacting a series of important policies through presidential decrees, ministerial resolutions, and institutional changes. These policies included, for example, the refinement of the PMO based on international and domestic experiences with benefit packages, and the implementation of a new mechanism for financing low frequency, high-cost medical procedures (*alta complejidad*); (ii) redesigning and improving the FSR, which had operated in a non-transparent and inequitable manner; (iii) analyzing the cost of the compensatory system using the available enrollment data and estimates of the cost of the PMO; and (iv) analyzing the options for regulating the private, pre-paid health plans and submitting the draft legislation to the Congress for debate and approval.

B. Upgrading of National Beneficiary Enrollment Information System (US$4.5 million estimated at appraisal). This component included upgrading the Register of Beneficiaries Data Base (*Padrón*) maintained by federal tax collection agency (*Dirección General Impositiva*, or DGI) that it could serve as a basis for a competitive insurance market. Activities included: (i) reviewing essential rules and operational requirements; (ii) updating the current DGI register; (iii) designing the register of beneficiaries; and (iv) implementing a new enrollment database, including installation of computer equipment, training and performance monitoring.

C. Regulation and Supervision of Social Health Insurance (US$2.4 million estimated at appraisal). This component consisted of: (i) formulating and enacting a new regulatory code; (ii) carrying out a diagnostic study of National Health Insurance Administration (*Administración Nacional de Seguros de las Salud*, or ANSSAL) to evaluate its performance and related structure, staffing, procedures and resources; and (iii) revamping the regulatory agency to include the appropriate organizational structure, staffing and information systems.

D. Preparation of Restructuring Plans (US$10 million estimated at appraisal). The project provided technical assistance for the drafting of restructuring plans for OS that were eligible to receive loans for "*reconversión*." This was intended to encourage the OS to participate in the Restructuring Fund for the National Health Insurance Funds (*Fondo de Reconversión de las Obras Sociales*, or FROS), which was partially financed by the adjustment operations and partially by government counterpart funds.

E. Institutional Strengthening of INSSJP (US$8.5 million estimated at appraisal). This component financed the following activities: (i) preparing plans for reorganizing and downsizing PAMI; (ii) installing new information systems for personnel and budgeting; (iii) improving contracting; and (iv) strengthening the management of pharmaceuticals purchasing and payment. It also included expanding social communications and consumer relations services, as well as outsourcing two large polyclinics in the city of Rosario (Province of Santa Fe) and the ambulance service operated in the City of Buenos Aires (CBA).

F. Coordinating and Executing Unit (UEC) (US$ 3.5 million estimated at appraisal). The TA project financed the operating expenses for the unit that coordinated the health insurance reform, covering both the adjustment and TA loans.

3.4 Revised Components:

Three significant changes related to the project were made:

First, in July 1999, approximately $4.2 million were reallocated within the Provincial Health Sector Reform (PRESSAL, 3931-AR) project to support several policy design-related technical assistance activities under a program known as PRESSS (*Programa de Reconversión del Seguro de Salud*); these activities (including the development of national health accounts and a provincial health information system), though not formally part of the TA loan, were coordinated with the PROS activities within the MOH and were supervised by the PROS task manager. (Consistent with the source of financing, the results of PRESSS activities are assessed under the PRESSAL ICR.).

Second, in December 2000, responsibility for implementing all activities related to policy development and insurance regulation were moved to the Superintendent of Health Insurers (*Superintendencia de Servicios de Salud)*, leaving the MOH with only a limited number of activities to implement. This change was made more for internal political reasons than technical ones.

Third, several activities related to PAMI ceased in the second half of the project, after it was recognized by both the Bank and the Government that the intense resistance to change and the institution's negative reputation would overwhelm any reform efforts.

3.5 Quality at Entry:
The project design predates the existence of the Quality Assurance Group, so the project's quality at entry was not formally assessed. However, for the purposes of this report, quality at entry is judged to be **satisfactory**. The technical basis was sound, and the aims were consistent with Government and Bank priorities and strategies. It is particularly noteworthy that a large and comprehensive TA loan was even conceived. The team designing the adjustment operations recognized the need for both broad and deep technical support to help the Government meet the adjustment objectives, and the TA loan provided the resources for that support.

It is useful to note the innovative features of the operations package that accompanied the health insurance reform efforts of the mid-1990s, of which the technical assistance loan is a part. First, the operations were much like the "programmatic lending" that has come into favor more recently: based on a long-term vision, with high quality technical policy development inputs from the Government and from the Bank, a well balanced sequence of Bank instruments (economic and sector work, a sector adjustment loan, a technical assistance loan, and a social sector adjustment loan) were put in place. Second, the Argentina health reform package overcame a common problem of sector adjustment loans: instead of transferring resources solely to the Ministry of Finance – thus failing to provide sectoral ministries with incentives for action and reform – the Argentina health SECALs used the proceeds of the Bank loan (together with Government counterpart) to create a fund managed by the health sector authorities. This fund then made loans (adjustment loans) to reform the OS. The fund was "Government money," however the loans to the OS followed criteria previously agreed with the Bank and received WB supervision and no objection as part of the supervision of Loan 4004. This feature served two main functions: (i) put the incentives squarely in the sector and, by doing so, give greater impulse to the macro-reform, and (ii) allow the same money to be used twice for reforms consistent with the project objectives.

4. Achievement of Objective and Outputs

4.1 Outcome/achievement of objective:
This loan fits within a set of actions and transformations that affected the Argentine health sector over a period of almost 10 years. As such, it is difficult to isolate the effects of this TA loan from the large number of other related factors in the health sector during the 1990s. For this ICR, we assess the

implementation and results of the TA loan both as part of and in isolation from the implementation and results of the companion adjustment loan, which have already been evaluated in an earlier ICR (Report No. 19426). In the earlier ICR, the adjustment loan was evaluated very positively, and the report concluded that the financial condition and quality of the OS (and the sector in general) were significantly improved through the intervention of the project (including the TA loan). More recent information sheds some additional light on those findings. Thus, we review below how well the *combined* adjustment and TA loans achieved their aims, with an emphasis on the role of the TA loan. Then, in Section 4.2, we primarily focus on three questions: Were the planned TA activities realized? Was the quality of the TA provided adequate? What were the eventual results of the TA?

Overall, the adjustment and the TA loans contributed to bring positive changes in the culture of decision making within Argentina's health system, including the incorporation of efficiency analysis, genuine improvements in efficiency, and a new perspective about consumer satisfaction. The TA activities were instrumental in developing the capacity for health financing policy analysis, and the design and promulgation of new laws, decrees, and regulations, thereby helping the Government to meet the conditionalities for the three tranche releases of the adjustment loans. Its performance is judged to be **satisfactory**, on balance. Major outcomes are:

(i) *Opening up competition among OS:* Based on the studies financed under the project, the Government passed laws to open and regulate competition among OS, allowing enrollees to freely choose any OS as their health insurance carrier. Effective January 1997, these new laws represented a fundamental change in the health insurance system in Argentina. Since September 1998, the average of number of transfers per month is about 11,500.

Although some of the pieces were put into place to create a competitive environment (and consequently the higher patient responsiveness this would bring about), the results have not been entirely positive: the rate of transfer is lower than some would initially expect and it appears that adverse selection is occurring. Of the 440,000 transfers completed by February 2000, 65 percent correspond to employees with salaries below $1,000, and 25 percent to employees earning between $1000 and $2000. It appears that the beneficiaries changing among OSs tend to be the ones with higher incomes and consequently higher contributions.

The appearance of "*Gerenciadoras de Salud*" (loosely translated as "health management agencies") was not imagined at the time of initial design of the legal framework. These entities, to whom OSs transfer their portfolio of beneficiaries (in part or completely) to administer risk, used cream-skimming purposes in many cases. Higher income level population segments went to private insurers (*pre-pagas*), taking advantage of the weaknesses of the regulatory framework that permitted their operation. This constituted one the major failures of the reform process, leading to an even greater fragmentation of the system and creating a non-transparent image.

(ii) *Improvement in the Standard Benefits Package (PMO).* The project facilitated improvement in the content of the benefit package and subsequently extended the mandatory provision of the standard package of services to *pre-pagas*. Although the PMO is subject to critique on a number of technical grounds, it is now routinely used as a reference package by the national OS, private insurers, and even the intermediaries. It represents an important starting point for future reforms and has the potential to reorient utilization toward primary care. In 2002, primary health care programs and chronic disease programs were incorporated to the PMO.

Formally, all the OS most offer the Standard Benefit Package, according to decree number 492/95 and resolution MS 247/96, eventhough there are no reliable facts regarding to the current execution of this

norm within the program scope.

(iii) *Development of the Health Services Superintendency.* The *Superintendencia de Servicios de Salud* (SSS), which was created with project support in early 1997 and came into operation in 1998, made progress in the following areas: (a) setting up a new organization and creating a strategic development plan; (b) hiring and training personnel; (c) developing a consumer services unit; (d) establishing a team of inspectors and auditors; and (e) issuing regulations related to consumer choice among the OS, health plans offered by the OS (including the PMO), contracts with providers, outsourcing of administrative and medical services, publicity and communications (including the contracting of promoters), and sanctions and penalties in case of non-compliance.

(iv) *Restructuring of Obras Sociales.* Technical assistance provided by the project for drafting restructuring plans made it possible for the OS to participate in the loan restructuring fund. Only agencies with a minimum of 10,000 beneficiaries could apply for the FROS resources. Thus only 84 OS were eligible at the start of the program out of almost 280 OSs registered with the SSS. The Support Letter (*Carta de Adhesión)* was signed by 90 OSs, 30 of which had loan approved. This represents approximately 43 percent of all OS beneficiaries.

However, many of the OSs that obtained loans under the program are currently in financial jeopardy (and were at risk even before Argentina's recent financial crisis). In October 1, 2001, a SSS-developed monitoring tool – which has 50 variables corresponding to services, legal and economical-financial aspects, was applied to 28 OSs with loans. The results showed that more than 64 percent of the obras were at high risk (18 OSs); approximately 7 percent were at moderate-to-high risk (2 OSs); and about 29 percent were at medium risk (8 OS). These values are worse than the system-wide averages. Across 205 OSs, only about 60 percent are considered to be at high risk.

An important observation is that there was little advancement in the consolidation of small OSs, which continued to be at high risk because of their size. Although managerial and organization performance improved, these improvements did not translate into service improvements. Thus, between August 2000 and March 2001, six OSs under the program filed for bankruptcy laws *"concurso de acreedores"* – a strong sign of financial trouble. (See Annex 8: Summary of the Evaluation Status of Participating OSs in PROS - SSS Syndicature Program).

(v) *Automatic and transparent reallocation of the proceeds of the FSR.* Two major achievements of the project were: i) to increase the transparency in the use of the FSR and ii) to substantially reduce the scope for discretionary transfer of funds. The formula-based, automatic redistribution of funds to the OS gradually increased from zero in September 1995 to 66 percent of the budget of the FSR (corresponding to about $230 million) in 2000, and to 100 percent in 2001. While the changes in the functioning of the FSR are an achievement of the project, it still did not go as far as initially anticipated: The redistribution criteria include beneficiary income level, but do not yet include household size, sex/age distribution, or other risk-related characteristics.

(vi) *Financing High-Complexity Care.* The project supported the creation of the Special Program Agency (*Administración de Programas Especiales*, or APE) to manage the subsidies for long-term and high-complexity care. The program assisted in building institutional capacity of the APE; and the design of eligibility criteria and the establishment of information, monitoring and control systems. Despite these efforts, the eligibility criteria were distorted as a result of intense professional interests and/or lobbying by organized patient groups.

(vii) *Reforming PAMI.* The project contributed in a limited way to building and implementing PAMI's financial and accounting systems and in carrying out analytical and design work for a new system for contracting out services through health maintenance-type organizations. However, PAMI did not carry out the institutional development activities initially contemplated. Finally, many of the recommendations of the studies on its institutional restructuring were deemed irrelevant by the authorities.

4.2 Outputs by components:

A. . Policy Design and Implementation. **Satisfactory**. Under this component, the vast majority of studies originally foreseen were completed, including: "Institutional Strengthening in Analysis of Policies and Regulation of the Health Sector Study," "Solidarity Redistribution Fund Study; Strengthening of the Special Programs Agency Study," and the "Study on Strengthening of the Superintendency for Health Insurance." (See Annex 9, "List of PROS Studies.") In general, the quality of the work was deemed high or very high by supervision missions, and several of the studies directly led to legal and/or regulatory changes. Strong communication efforts in several instances helped to overcome opposition by highlighting key aspects of the studies' implications – for example, the benefits of introducing competition. Overall, however, the project fell short of original expectations in disseminating and obtaining positive results from the preparation of studies.

The early studies, including "Changing Among the OSs Options," "Simulation for the FSR," "Satisfaction Surveys," "Risk Analysis of the OSs," and the PMO studies, were not well disseminated, due to a prevailing belief that the results would be incorrectly interpreted. Preparation of the studies related to the development of a management information system for the provinces, including consensus-building workshops and assessment of the provincial situation, was difficult, in large part because of difficulties obtaining active participation at provincial levels.

The introduction of competition among OSs met with strong opposition; however, although this was mitigated by authorities, and supported by the implementation of a communication strategy to beneficiaries that was initiated by the project. Opposition to the regulation of private health insurers made the approval of a draft law based on one of the project's studies impossible. However, in one notable success, Law 24.754/97 did extend the PMO as a requirement for private health insurers.

B. Upgrading of the National Beneficiary Enrollment Information System. **Satisfactory**. The majority of the technical assistance activities foreseen under this component were conducted and judged to be of adequate quality – eventhough full objectives were not met, and the final impact was more limited than anticipated. The project financed a study on the enrollment database to design and implement a database of beneficiaries. Based on the recommendations of this study, the project financed the upgrading of the enrollment information system and the establishment of a new enrollment database. This database, which has been used by autonomous public hospitals to identify patients enrolled in the OS and facilitate reimbursement, is also used as a census of beneficiaries of the national OS.

The administration of this database has important implications: it provides a tool for monitoring and controlling contributions and the distribution of subsidies. Because of this, the database has been the subject of active discussions among various stakeholders. As a result, there was a lack of commitment to complete the design, update the database and assure proper administrative arrangements. A new decree (1400/01- December), which is required to fulfill the conditions of another Bank operation (SAL-I, 7479-AR), further advances the development and update of the needed database. Thus, while the TA loan financed a large number of inputs related to this product, the final objectives are yet to be consolidated.

C. Regulation and Supervision of Health Insurance Component. **Satisfactory.** The expected technical assistance activities were carried out, and yielded important results – particularly with respect to strengthening regulation. The Regulatory Framework Study facilitated the design of a regulatory framework, including the draft law on the regulation of private insurers and on competition between *pre-pagas* and *OSs de Personal de Dirección* (OS for white-collar employees). The study also covered the modification of the PMO and the analysis of complementary health plans, as well as regulations for competition between *OS de Personal de Dirección* and Professional Associations. In addition, the technical and financial feasibility of establishing a health insurance plan for the self-employed was evaluated.

Strong opposition and lobbying by *pre-pagas* and *OS de Personal de Dirección* were obstacles that could not be overcome. The main stakeholders, which successfully captured higher income enrollees through *Gerenciadores,* opposed the establishment of transparent rules of competition that would have permitted lower income enrollees to access their services.

The study on strengthening of the SSS was conducted with the objective of designing and implementing the regulatory framework. This included an assessment of the organizational set-up and strategic plan, human resources, management and information systems, and communication strategy of the SSS; and the design of consumer protection regulations. As a result of this study, the SSS adopted its strategic plan and issued prudential and consumer regulations in 1998. However, to date, the SSS has not given priority to this area or executed specific systematic actions to develop a meaningful policy to protect beneficiaries.

D. Preparation of Restructuring Plans: **Satisfactory.** (At evaluation time, an estimated value of US$ 10 million). The project provided technical assistance to OS for elaborating restructuring plans which were a prerequisite for obtaining loans from FROS. The objective of this activity was to stimulate the OS in participating in FROS, which was financed through the adjustment operations and government counterpart funds.

As mentioned before, 84 OSs qualified and 30 OSs finally obtained loans. The reform plans were technically evaluated and approved, and were considered to be of good quality. The impact of the restructuring plans was rated as positive at the micro-management level: there was significant modernization at the organizational level, and it seems that managerial processes (including databases and information systems) and health care services did improve. However, there has not been a real evaluation or follow-up analysis of these aspects. The monitoring emphasis has been placed in economic and financing performance aspects linked to the loan disbursements from the FROS to the OS. However, these economic and financial indicators have strongly deteriorated due to the persistent crisis of the OS system, the slow down of economic activity since 2001, the more recent changes introduced in the exchange rate, and the deteriorated purchasing capacity for imported goods needed in medical services. Currently, according to the SSS's monitoring system for OSs, there are no evident distinctions between the OSs that received technical assistance and those that did not.

E. Institutional Strengthening of PAMI. **Unsatisfactory**. Because PAMI resisted full participation in the reform efforts, much of the TA under this component failed to materialize; the technical work that was financed for the benefit of PAMI in general had only a modest impact on the institution. For example, in May 1997, a study was prepared for the formulation of a strategic plan for systems and organizational development of PAMI at the central and local levels. Overall, the recommendations were not implemented because PAMI was developing an alternative arrangement (i.e., contracting out the management of its medical services to large entities) that would have radically changed its organization and systems. A separate study was completed for contracting out the programmed and non-programmed ambulance

services. This study's conclusions were not taken into consideration.

Other studies financed by the project included analyses of the medical care model, new management systems, diagnosis and restructuring of social programs, and refining the monitoring and accounting systems. Some of the recommendations from these studies were included in the design of the contracts with the three provider networks.

The pharmaceutical study analyzed and defined a strategy for pharmaceuticals provision to PAMI ambulatory and oncology patients. It contained recommendations on contract negotiations for pharmaceuticals. Although not all of the study's conclusions were considered, PAMI reduced its spending on pharmaceuticals by $5 million per month by negotiating a contract with the pharmaceutical industry.

Unfortunately, several of those achievements were not maintained. For example, the contracting of service delivery networks at the national level failed because of legal aspects and lack of transparency. In 2000, this project was replaced by another service delivery scheme, based on local network design.

4.3 Net Present Value/Economic rate of return:

Not applicable for the TA loan.

4.4 Financial rate of return:

N/A.

4.5 Institutional development impact:

The project's institutional development impact has been **substantial**. It was instrumental in creating the *Superintendencia* and in developing its institutional capacity. The project also facilitated the introduction of competition among OS, allowing enrollees to select any OS as their health insurer.

The program was instrumental in the reform process for the *Obras* receiving support under a loan. Most of the improvements were seen at the micro level. Major improvements have been observed in the modernization of administration and service delivery: participating OSs have better managerial processes, databases, data processing capacity, and medical care processes.

The PROS TA operation also was an important agent for cultural change within the sector. Technical assistance under the project contributed to the introduction of "freedom of choice," and initiated or strengthened new activities, including actuarial risk analysis assessment, discussions about the PMO, and reinsurance analysis for high-cost/low-frequency diseases.

5. Major Factors Affecting Implementation and Outcome

5.1 Factors outside the control of government or implementing agency:

Considering the adjustment and TA loans as a package, two major factors outside the governments and the implementing agency's control negatively affected the project's implementation. First, organized opposition to the reform slowed several initiatives. Trade unions, traditional private health insurance companies and other interest groups threatened by the changes tried to slow or stop the move toward an open, unified, competitive and more professionally supervised regulatory system. Resisting introduction of competition, OS lobbied for regulations and supervisory practices that would create disincentives for people to transfer between OSs. Thus, studies provided by the TA did not achieve their full impact. On the other hand, this opposition was mitigated to a large degree by the fact that the Argentine public and the Ministries of Economy and Labor, were in favor of full reform.

Second, the financial crisis that swept East Asia in 1996-97 had its spill-over effect on Argentina's financial market, which in turn adversely affected the national economy and the project implementation. Due to economic slowdown and the resulting higher unemployment, payroll contributions decreased and many firms stopped making payments to the OS, affecting their economic situation and reform processes.

5.2 Factors generally subject to government control:

(i) In the earlier government administration, many communication and coordination problems existed between SSS and the Policies and Regulations Unit of the MOH. The SSS was reluctant to accept advice from the latter. Under the new administration, in 2000, as the Policy and Regulations Unit has been absorbed into the SSS, coordination problems have been eliminated.

(ii) Lack of neutrality by the SSS was a major factor affecting project implementation. The institution was often subject to outside pressure from trade unions and other sources, and at times responded to these pressures by not taking necessary regulatory actions.

(iii) The establishment of the national database of insured persons was delayed during implementation due to several factors, many of which were subject to the control of the implementing agency: (a) the databases that were to be consolidated were heterogeneous, which produced technical problems; (b) mechanisms for updating were insufficient, which hampered the database's utility; (c) the tax authority resisted sharing its database of contributors with other social security institutions; and (d) there was lack of cooperation from the National Social Security Administration (*Administración Nacional de Seguridad Social,* or ANSSAL), which was supposed to establish and maintain the database, but had neither the incentives nor a stake in the reform to do so.

(iv) Frequent changes of directors in PAMI during the course of the project created several problems. Plans developed and approved by one director were not necessarily followed by the successor. Thus, most of the studies drafted with project support were never implemented. Similarly, agreements already negotiated by one director were reviewed and sometimes modified by the second. This created uncertainty among providers and delayed final negotiations of contracts.

(v) At the time of appraisal, repayment of loans by the OSs was ensured through automatic deductions by AFIP, the agency responsible for tax collection. Subsequently, the Government changed the bankruptcy law, such that the loans made by FROS to the OSs lost their preferred status. Four of the OSs have made use of this new law. Likewise, the Government also eased the enforcement of regulations issued by SSS regarding OS functioning.

(vi) The Government was passive in dealing with various subjects (e.g. beneficiaries' rights), and was insufficiently active in public communication efforts about these matters, as well as in dissemination of technical studies and evaluations of system performance. An active attitude on this issues could have mitigated the impact of pressures by interest groups, and could have helped to create a better environment for implementing the reform.

(vii) As a result, social and sector leaders believe that the power struggles within the Government blocked greater progress in many of the initial reform objectives.

5.3 Factors generally subject to implementing agency control:

Several important factors within the control of the implementing agencies (MOH and SSS) had negative effects on the project.

(i) Lack of qualified specialists in various fields, such as health finance, medical service audit, administrative law, and health regulation, resulted in weak management in the Policy and Regulations Unit, and uneven output in the initial stage of the project. The Unit suffered from a chronic shortage of qualified specialists in the design and implementation of a regulatory body for social and private health insurance. There was no explicit will to strengthen the technical weaknesses identified before; the implementing agency did not respond with alternatives such as contracting external specialist, training local staff, or selecting qualified staff.

(ii) In the last stage of the project, the monitoring of the performance of OSs under the program was executed by PROS, which reduced objectivity.

(iii) No handbook or bookkeeping was developed, which would have assured – through the execution of audits – the reliability of the quantitative indicators established for the performance of OSs under program.

(iv) There were coordination problems between the sub-components, which often worked in isolation from one another.

(v) The Executing Unit did not foresee any mechanism to prevent the OSs from being subject to creditors meetings, although law N°24522 on bankruptcy initially only excluded banks and insurance companies.

(vi) The Executing Unit did not develop indicators of service delivery associated with the *reconversión*, although service quality improvement was an objective of the policy changes promoted.

(vii) There was no established regimen on contracting of service delivery, which would have established basic elements, such as an open public competition for service providers, and an evaluation of their economic and financial risk profile. This flaw allowed for the concentration of services among intermediaries, which had low quality and solvency.

5.4 Costs and financing:

The total cost of the project was about US$24.2 million, compared with the MOP estimate of US$30 million. The Bank financed US$23.6 million, and the Government contributed about US$0.6 million equivalent in local costs.

6. Sustainability

6.1 Rationale for sustainability rating.

Likely. The current social and economic situation in Argentina makes any assessment of sustainability a gamble. However, it is reasonable to say that the sustainability of the project is likely, if macro and micro economic conditions improve. The health reform was introduced and consolidated through several Presidential decrees, regulations issued by the SSS, and approved by the PAMI's Board of Directors. These legal and regulatory instruments suggest that the health insurance reforms will be sustained. In addition, the new rights and expectations of the beneficiaries and the OS are irreversible – or at least difficult to reverse.

The Government administration of 2000-2001, although under tremendous pressure due to the current fiscal and political crisis, is committed to supporting the sector both financially and on important policy reforms. The current administration appears to be committed to maintaining the conceptual approach, although the country now suffers from uncertainties in the health sector, as in all other sectors. That said,

the reforms continue to be highly politicized, and thus sustainability cannot be assured.

6.2 Transition arrangement to regular operations:
The *Restructuring* Committee established under the project will continue to work with OSs after project closing. The Policy and Regulations Unit that has been absorbed into SSS will continue to manage the enrollment database. The SSS will maintain the performance monitoring of OSs under the tracking-down criteria provided by the TA. The FSR will continue to disburse its funds automatically, but without granting discretional subsidies to OSs. No transitional arrangements are envisioned for PAMI-related activities.

7. Bank and Borrower Performance

Bank
7.1 Lending:
The Bank's performance in the identification of the project was **satisfactory.** The Bank was proactive in responding to the Government's request for financial and technical support for the overhaul of its health insurance system, and at the time of project identification had in hand a fresh analysis of the situation and reform opportunities. The project was innovative and its objectives were consistent with the Government's development strategy and the Bank's assistance strategy. Project preparation was well organized. The Bank, which had a harmonious team with a good skill mix, brought state-of-the-art expertise into project design. During project appraisal, the Bank team took into account the technical complexity of the project and assessed the project's risks and benefits. The Bank had a consistently good working relationship with the Borrower during preparation and appraisal.

7.2 Supervision:
The Bank's performance during the implementation of the project was **satisfactory**. Over the five years of project implementation, there were 11 supervision missions, with an average of two missions per year. The Bank's client relationship was productive. Supervision teams included Bank's health economists, financial economists, as well as specialists in health insurance, health regulations and social security.

The Bank staff took a firm and dynamic role in the supervision of the project implementation, and brought in outside experts as needed. They were effective in establishing partnerships with a wide range of stakeholders, which facilitated the sustainability of major policy reforms. The aide-memoires were regularly prepared and transmitted, alerting the Government to problems with project execution and suggested remedies in a timely manner, in conformity with Bank procedures.

It must be said, however, that a number of the difficulties in implementation – such as the ones mentioned in Section 5.3 – do not appear to have been detected and/or solved through interventions by the supervision teams or Bank management.

7.3 Overall Bank performance:
Overall, the Bank performance was **satisfactory.**

Borrower
7.4 Preparation:
The Borrower's performance in the preparation of the project was **highly satisfactory**. During the preparation stage, the Borrower displayed commitment to the objectives of the project. The Ministries of Health and Economy nominated qualified staff and consultants to work on preparation of the various policy and program components. The Government team, and in particular the group from the Ministry of Economy, actively participated in the development of the policy conditionality for the loan. Throughout the

project preparation, the government officials and staff of the implementing agency worked closely with the Bank's project team on a continual basis, with full cooperation and enthusiasm.

7.5 Government implementation performance:
The Government's performance was **satisfactory**. During implementation, the Government consistently maintained its commitment to improving the health insurance system. Despite strong pressures from various quarters, the Government ensured the maintenance of the agreed core program and commitments established in the Letter of Development Policy. The Government had established a productive project implementation unit, and the day-to-day implementation of the project was reasonably smooth, with the exceptions already mentioned.

7.6 Implementing Agency:
Performance of the MOH was **marginally satisfactory.** It sought support outside the health sector and maintained inter-sectoral collaboration through the project implementation period. The change in government administration in late 1999 did not greatly affect project implementation, as the outgoing project team in the MOH ensured continuity by extending full support to the in-coming team. The executing unit was well organized and effective in dealing with procurement, disbursement, progress reports, and in maintaining proper records of the project. The quality of the work of the OS Restructuring Unit was satisfactory in approving new plans and monitoring OS in the process of restructuring, except in the ways mentioned in Section 5.3.

7.7 Overall Borrower performance:
The overall performance of the Borrower was **satisfactory.**

8. Lessons Learned

1. The technical assistance loan was an essential companion to the adjustment operations. The technical work financed under this project provided the core underpinnings for all of the results that can be attributed to the adjustment operation, including the legal, regulatory and institutional changes. In addition, given that the adjustment operation required thorough analyses of the financial and institutional conditions of the health insurers receiving loans for conversion, the resources under the TA loan were indispensable.

2. Strong sector work helps timely and good quality project preparation. The sector work on health financing, which eventually provided the analytic foundation for the combined adjustment and technical assistance operations, was conducted before a health insurance operation was in the Bank's pipeline. It happened that the results of the sector work were available just when the country was affected by a fiscal crisis, and thus an opportunity opened for adjustment lending based on the prior analyses. The value of having up-to-date sector knowledge, even in the absence of a direct lending objective, was clear in this case.

3. Intense supervision is crucial for smooth project implementation, especially in the face of political turbulence. Because the task team was provided with sufficient budget for close supervision, the Bank was able to keep track of the impact of the political developments on the project and adapt the project design to changing circumstances, while at the same time ensuring that the core conditions were being met.

4. It is necessary to make a strong effort to improve the understanding of the client's unique situation, and to be more keenly aware of political will (as it is sometimes expressed indirectly). In this particular case, OSs had little commitment for conversion, and after 1999, neither did the SSS. This was expressed in the design and operation in several ways: for instance, in the existence of non-reimbursable funds to OSs from the FSR, which directly competed with the FROS; and in the laxity of the controls on OSs, which entered the FROS when the subsidies mechanism was interrupted.

5. Reform processes need high levels of support from the civil society. In this case, the reforms required changes at the state level, as well as at the federal level; had long implementation periods (outlasting a single government administration); and implied deep cultural changes. To be fully viable and less vulnerable to political volatility, the reform process would have benefited greatly from an on-going and meaningful consultation not only with the government and the implementation agency, but also (and especially) with civil society and stakeholders. This would have helped to ensure that the reform was socially accepted, and that it would be viable even in the absence of the individuals responsible for its design.

6. Social communication is an essential element of policy reform. Full access to TA reports from the begining, and active dissemination of this information in a systematic way among health sector stakeholders, could have been instrumental to the reform process. This could have minimized the obstacles created by interest groups threatened by the reform.

7. Key objectives of the project – such as improvement in service delivery quality – can only be realized through a careful assessment and monitoring process. Lack of attention to the issue of service delivery contracting (e.g., the creation of an open competition for service providers, and a systematic evaluation of their economic and financial risk profiles) allowed the concentration of service delivery by intermediaries that had low quality and solvency. This led to a situation in which the OSs did not merge or consolidate; instead, health managers entered the scene, assimilating the service delivery risk to a small number of beneficiaries. This became one of the major failures of the reform process, leading to greater fragmentation and less transparency.

9. Partner Comments

(a) Borrower/implementing agency:
Though we have no major comments for a project that closed June 30, 2001, that is various months before this administration took office (January, 2002), we have read it carefully and have taken note of its useful conclusions.

We would like to focus briefly on Point 6. Sustainability and, in particular, paragraph 6.1, which indicates that the current administration of the National Government of Argentina "appears committed to maintaining the conceptual direction" of the proposed reforms implemented in the project.

We confirm our full accordance with and commitment to the reforms mentioned, as shown by the following actions, outlined below for your attention:

1. Beneficiary Database.

   On April 4, 2002, a joint resolution between ANSES and the SSS was sanctioned (ANSES 274/2002/SSS 144/2002). This resolution mandates the construction of the beneficiary database for the National Health Insurance System (SNSS), and mentions that "the mechanisms that lead to a gradual and progressive implementation of requests foreseen in the Decree 1400/01, must be developed preserving the spirit and objective of this norm." We should emphasize that the process of elaborating the updated beneficiary database is currently fully underway.

2. Automatic subsidy per beneficiary and not per contributor.

Having the beneficiary database ready, we will proceed to subsidize lower income affiliates per beneficiary and not per contributor (or employee), thereby addressing the risk related to the number of beneficiaries per insured family. To this effect, the Health Emergency Decree (DNU) 486/2002 has changed the financing system of the Solidarity Redistribution Fund (FSR), increasing its resources and, as a result, improving the overall equity of the SNSS. The new form of financing mandates contributions to the FRS as follows: in the case of "*obras sociales sindicales*", 10% for monthly incomes up to $1,000 and 15% for greater remunerations; in the case of "*obras sociales de personal de dirección*", 15% for monthly incomes up to $1,000, and 20% for higher remunerations.

We would like to recall that the 2002 Budget Law 25.565 increased the contributions of employers to the SNSS from 5% to 6%. This also increases the resources of the FSR.

Both guidelines are in effect starting March 1, 2002; hence, the FSR is already experiencing an increase in resources.

Within the SSS and the PROS, we are running simulations of the FSR's flows, considering different alternatives of subsidies, and giving special attention to the contributions from workers who earn less than the defined minimum income base (3 MOPRES).

3. Eliminating financial subsidies.

Through the Resolution APE 77/02 we have abolished APE Resolutions 577/98 and 1040/98, and eliminated financial subsidies (to "*obras sociales*") due to operational deficit; such subsidies were characterized in the past by being highly discretionary. With this measure, we are increasing the available resources for financing high cost / low incidence events covered through APE.

Comment: the points 1, 2 and 3 above are outlined in the Decree 1400/01, **which has not been revoked**. The crisis outlined in said Decree is being reformulated to meet the special health emergency situation that is currently occurring in the sector.

4. Regulation of private insurers.

A regulatory instrument is being explored to avoid the need for approving a new law, given the bad experience with the draft law approved by the Senate several years ago, and which has lost parliamentary status. This could be done by a presidential DNU or further regulations derived from Law 24.754 (which extends the obligations of the PMO to private insurers). The regulatory system to be obtained through this means will not be as detailed as a law could be, but it will give enough space for the SSS to create a list of entities and effectively supervise the provision of the PMO, as well as other fundamental aspects of contracts between private insurers and their affiliates, thus hopefully preserving the portability of benefits, which is a determining factor in a health insurance contract.

5. Low frequency and high cost.

In the scope of the APE, and based on the technical developments reached during the current year in the PROS, a new system for coverage of said loans is being implemented. The objective is the design of a nation-wide insurance system for covering high cost/low frequency events, called the "

Seguro Nacional para Patologías Especiales".

6. Reforming the PMO.

The Decree 486/02 reformed the previous PMO into a mandatory health benefits package for the crisis ("*Programa Médico Obligatorio de Emergencia*" . This reformulation was formalized in the Resolution 201/02 of the Ministry of Health. The fundamental objective was to adjust the benefits menu to the available resources in the system, aimed at obtaininig the necessary long term balance between available resources and demand. The expected result is an increase of the services really provided, by means of a strict control of the benefits program, which in the past has been surpassed by too many benefits included in the basic package.

7. Strengthening the SSS.

The management teams of the SSS and the PROS are committed to developing the regulatory framework that will guarantee the SSS's capacity to properly intervene in the SNSS.

8. Monitoring the PROS

A new monitoring system is being implemented for the "*obras sociales*" that participated under PROS, with rigorous control in recuperating the loans and effectively accomplishing the monitoring indicators.

In this condensed synthesis, we have outlined the actions undertaken during our administration, which without a doubt follow the main directions set forth by the project of reference. We will gladly clarify or explain any point that is necessary.

(b) Cofinanciers:
N/A.

(c) Other partners (NGOs/private sector):
N/A.

10. Additional Information

ICR Team
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Annex 1. Key Performance Indicators/Log Frame Matrix

Annex 1.1 Key Performance Indicators: Outcome/Impact

Outcome Indicators	Projected in SAR/PAD End of Project	Actual/Latest Estimate
1. Start of effective competition among Obras Sociales	Yes, without date of beginning.	Yes.- Decree N° 09-93 - Sep/Oct 97///Decree N° 504- may 98
2. Approval of law to regulate pre-paid private insurance	Not mentioned at SAR	No
3. Implementation of new regulatory body for health insurance	Yes, without date of beginning	Yes.- SSS- (Superintendencia Sistema de Salud) Decree N° 1615/96 (Dic 96) –creation-; Decree N° 405/98 (April) –structure at entry- Decree N° 1576/98 –(Feb 99)
4. Number of high quality Obras Sociales restructuring plans approved	SAR does not mention numbers, but does mention date beginning of : May 96.	30 OS (19 OS since 1997; 8 since 1998, 1 since 1999 and 2 since 2000).
5. New department for high complexity health care financing functioning in MOH	Not mentioned at SAR.	Yes.- APE (Administración Prestaciones Especiales), Decree N° 651/97 (June); Decree N° 53/98 (Jan.)

Annex 1.2 Key Performance Indicators: Outputs

Output Indicators	Projected in SAR/PAD	Actual /Latest Estimate
1. Start of effective competition among Obras Sociales	Yes	Yes.-1998
2. Approval of law to regulate pre-paid private insurance	No	No
3. Implementation of new regulatory body for health insurance	Yes	Yes, SSS (Superintendencia Sistema de Salud).- 1996
4. New department for high complexity health care financing functioning in MOH	No	Yes, APE (Administración Prestaciones Especiales).-1998

Annex 2. Project Costs and Financing

Project Costs by Components (in US$ million equivalent)

Project Component	Appraisal Estimate	Actual/Latest Estimate	Percentage of Appraisal
Policy Design and Implementation	1.0	1.192.716,72	113,8
Development of Enrollment Information System	4.5	3.861.634,78	85,8
Regulation of Social Health Insurance	2.4	2.950.337,30	122,9
Preparation of Restructuring Plans	10.0	10.197.525,94	101,97
Institutional Strengthening of Inssjp	8.3	1.893.797,29	22,8
Project Coordination Units	3.6	4.108.287,36	105,2
Total	29.8	24.204.299,39	79,3

ANNEX 2B.

Project Costs by procurement Arrangements (in US$ million equivalent)

Expenditure Categories	Procurement Method Appraisal Estimate	Procurement Method Actual/ Latest Estimate			
	ICB	NCB	Other	NBF	Total
1. Works	----------	-----	----	----	----
2. Goods	5.600.000 (800.000)			400.521,60	996.430,11
3. Services	23.600.000 (23.600.000)			596.667,14	23.502.428,01
4. Misc. (Administration)	600.000 (600.000)			31.630,47	624.954,50
Total	29.800.000			1.028.819,21	25.123.812,62

ANNEX 2C.

Project Financing by Components (in US$ million equivalent)

Component	Appraisal Estimate			Actual/Latest Estimate			Percentage of Appraisal		
	Bank	Govt.	CoF	Bank	Govt.	CoF	Bank	Govt.	CoF
Policy Design and Implementation	840	160	1000	1183	9	1192	140.8	5.0	113.8
Development of Enrollment Information System	3775	725	4500	3441	420	3861	91.1	57.9	85.8
Regulation of Social Health insurance	2013	387	2400	2950		2950	146.5		122.9
Preparation of Restructuring Plans	8390	1610	10000	10197		10197	121.5		101.97
Institutional Strengthening of Inssjp	6962	1338	8300	1893		1893	27.1		22.8
Project Coordination Units	3020	580	3600	3977	131	4108	131.7	22.5	105.2
Total	25000	4800	29800	23641	560	24201	94.5	11.6	81.2

Annex 3. Economic Costs and Benefits

N/A.

Annex 4. Bank Inputs

(a) Missions:

Stage of Project Cycle	No. of Persons and Specialty (e.g. 2 Economists, 1 FMS, etc.)		Performance Rating	
Month/Year	Count	Specialty	Implementation Progress	Development Objective
Identification/Preparation				
April/95	*4*	1 Health Economist, 2 Health Specialists, Financial Economist		
Appraisal/Negotiation				
June/95	*5*	1 Health Economist, 2 Health Specialists, 1 Financial Economist, 1 Social Security Specialist		
Supervision				
June/96	*3*	2 Health Economist, 1 Financial Economist	HS	HS
October/96	*4*	1 Health Economist, 1 Health Specialists, 1 Social Security Specialist, 1 Implementation Officer	S	S
December/96	*5*	2 Health Economists, 1 Health Specialist, 1 Financial Economist, 1 Social Security Specialist	S	HS
May/97	*4*	1 Health Economist, 1 Lawyer, 2 Health Specialists	S	HS
November/97	*6*	2 Health Economists, 1 Health Specialist, 1 Financial Economist, 1 Social Security Specialist, 1 Implementation Officer	S	HS
March/98	*5*	2 Health Economists, 1 Financial Economist, 1 Social Security Specialist, 1 Implementation Officer	S	HS
July/98	*5*	1 Health Economist, 2 Health Specialists, 1 Regulatory Specialist, 1 Implementation Officer	HS	HS
October/98	*4*	1 Health Economist, 1 Health Specialist, 1 Social Security Specialist, 1 Implementation Officer	S	S
July/99	*4*	1 Health Economist, 1 Financial Economist, 1 Lawyer, 1 Implementation Officer	S	S
March/00	*4*	2 Health Economists, 1 Health Specialist, 1 Financial Economist	S	S
December/00	*2*	1 Health Economist, 1 Health	S	S

June/01		Specialist 1 Health Economist	S	S
ICR June/01		According to the last PSR of June 2001, an ICR Mission was planned for October	S	S

(b) Staff:

Stage of Project Cycle	Actual/Latest Estimate	
	No. Staff weeks	US$ ('000)
Identification/Preparation	4.2	15.6
Appraisal/Negotiation	15.2	129.5
Supervision	107.33	267.2
ICR	11.00	35.2
Total	137.73	447.5

Annex 5. Ratings for Achievement of Objectives/Outputs of Components

(H=High, SU=Substantial, M=Modest, N=Negligible, NA=Not Applicable)

	Rating
☐ *Macro policies*	○ *H* ○ *SU* ○ *M* ○ *N* ◒ *NA*
☐ *Sector Policies*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Physical*	○ *H* ○ *SU* ○ *M* ◒ *N* ○ *NA*
☐ *Financial*	○ *H* ● *SU* ○ *M* ○ *N* ○ *NA*
☐ *Institutional Development*	○ *H* ◒ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Environmental*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
Social	
☐ *Poverty Reduction*	○ *H* ○ *SU* ○ *M* ◒ *N* ○ *NA*
☐ *Gender*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ◒ *NA*
☐ *Private sector development*	○ *H* ○ *SU* ● *M* ○ *N* ○ *NA*
☐ *Public sector management*	○ *H* ◒ *SU* ○ *M* ○ *N* ○ *NA*
☐ *Other (Please specify)*	○ *H* ○ *SU* ○ *M* ○ *N* ● *NA*

Annex 6. Ratings of Bank and Borrower Performance

(HS=Highly Satisfactory, S=Satisfactory, U=Unsatisfactory, HU=Highly Unsatisfactory)

6.1 Bank performance	*Rating*
☒ *Lending*	○ *HS* ● *S* ○ *U* ○ *HU*
☒ *Supervision*	○ *HS* ● *S* ○ *U* ○ *HU*
☒ *Overall*	○ *HS* ● *S* ○ *U* ○ *HU*

6.2 Borrower performance	*Rating*
☒ *Preparation*	● *HS* ○ *S* ○ *U* ○ *HU*
☒ *Government implementation performance*	○ *HS* ● *S* ○ *U* ○ *HU*
☒ *Implementation agency performance*	○ *HS* ● *S* ○ *U* ○ *HU*
☒ *Overall*	○ *HS* ● *S* ○ *U* ○ *HU*

Annex 7. List of Supporting Documents

Type of Document	Subject	Date
Text	AR- Health Insurance Reform program – WB Mission AIDE MEMOIRE	06/01/95
E-mail Note	Arg – Health Insurance Reform Operation - Pre-Appraisal Mission, Back-to-Office Report	05/05/95
E-mail Note	Arg – Social Sector Support Program - Back-to-Office Report	04/10/95
E-mail Note	Arg – Health Insurance Reform Loans - Mission June 30- July 5 - AR 4003/4	06/01/96
E-mail Note	Our Trip to Argentina - ARG - Loan 4004 AR	12/19/96
E-mail	Arg – Health Insurance Reform - Loan Supervision BTO	05/12/97
Office Memorandum	AR HIR and TA Projects (Loans 4002 AR and 40\04 AR) Supervision Report	06/16/97
Text	World Bank Mission 12.- 19/11/97	11/30/97
Office Memorandum	AR HIR and TA Projects (Loans 4002/3 AR and 4004 AR) Supervision Report	01/20/98
Office Memorandum	AR HIR and TA Projects (Loans 4002/3 AR and 4004 AR) Supervision Report	04/20/98
Office Memorandum	AR HIR and TA Projects (Loans 4003 AR and 4004 AR) Supervision Report	07/24/98
E-mail	Argentina - HIR Loan - Third Tranche Supervision Mission, July 13-17, 1998	07/24/98
Letter	LN4004 -AR General correspondence	29/9/99
Office Memorandum	AR- HIR TA Project (AR-PE 45687) Supervisión Misión BTO Report	8/11//99
e-mail	Aide Memoire 27/03/00 to 01/4/00	4/3/2000
e-mail	AR - CALT BTOR: Megasal.PROS, Basal LN 4004 - General Correspondence	4/6/200
Text	Proyecto de Reforma de Obras Sociales e Instituto Nacional de Servicios Sociales	07/30/01
Inform.	Implementation Completion Report: Health Insurance Technical Assistance Project	10/01/02

Additional Annex 8. Summary of the Evaluation Status of Participating OSs in PROS

SSS Syndicature Program (last updated in October 2001)

The Syndicature Committee carried out an evaluation on the status, to date, of OSs participating in the PROS. The study was conducted in agreement with the general management and in view of the need to assess the framework of the software application and the database results accumulated through the program. Also, the evaluation study was considered of relevance for the new PROS administration. The evaluation study applied the risk assessment as established by the program's perspectives, as well as a review of all available information, including the results of the Oct. 2001 field audit report.

The total number of insurance agents participating in PROS is 30 OS; however, because the Syndicature Program did not have any field action in the OS Rnos 1-2290 of Santa Fe province nor in 1-2150 of Córdoba province, the study evaluated only 28 OS. ***Thus, the evaluation study contemplates 93.4% of the participants.*** It is worth mentioning that the 28 OSs on-going agreements with PROS: 19 of them since 1997; 8 of them since 1998; and 1 since 1999.

In order to accurately assess the status of OSs, the program identified high, middle and low ratings for the criteria under each area and evaluated them individually. There are 50 variables in total, which are periodically evaluated through external meetings, following established criteria and based on available documentation. The Syndicature Committee then evaluates the consistency of the reports, calculates the final assessment and assigns a risk rank in accordance with the program's standpoint. Those results are incorporated into a database, which yields an integral, singular, and dynamic evaluation for each agent and, at the same time, an overall rating of all agents within the system. This method yields a score in accordance with the risk of OSs; listing them in order of risk assessment; building profiles depending on the OS size or nature; and permits studying the behaviour of each variable in the overall system.

By utilizing this assessment tool, it was possible to find that:

- **64%** were identified as high risk (18 OSs)
- **7%** were identified as important risk (2 OSs)
- **29%** were identified as medium risk (8 OSs).

If compared to the risk profile obtained for all OSs under the SSS Monitoring Program on that same time (October 2001; 205 OSs involved), evidence shows that in the latter group, OS in high or important risk involved 59 % of the agencies and 78 % of beneficiaries, while in the group of OS under PROS, during the same period, the proportions reach ***71%*** and ***87%***, respectively.

Additional Annex 9. Summary of Studies Under the Policies Component

The following list is a summary of the studies carried out under the Policies Component of the Project.

a) Social Communication Campaign for the dissemination on freedom of choice among OS.

b) Technical Assistance to improve the tracking of beneficiary transfers, including systematic data collection and validation, and cross-reference with historical databases. Reports analyzing the trends of transfers between OSs, by region and provinces, wage ranges, and the financial requirement changes of the different OSs, were made available to the SSS authorities.

c) OSs Beneficiaries Satisfaction Survey .

d) Studies based on simulation of changes in the assigned standards per client and household. Reports on the basis of automatic distribution of the FSR, including tendencies and impact.

e) Redesigning of APE record keeping.

f) Studies on expenditures of service use and single costs rates for the delivered services, in order to define a changes draft on the original PMO.

g) Draft of a law on the regulation of private health insurers.

h) Beneficiaries Census: first registry model.

i) Construction of use, expenditures and financing matrices of the health sector for 1997 (along with the MOE) establishing the basis for methodical calculation.

j) Technical Assistance to Hospital Production and Morbidity Statistics, in order to develop a Health Management Information System in the provinces.

k) Implementation of two Health Management Information System workshops, bringing together representatives from provincial health ministries, from CBA government , and people in charge of the Health Statistic Area.

l) Compilation of current situation of the provinces' health information systems through drafting and dissemination of guides and technical assistance to three jurisdictions.

m) Technical Assistance to the SSS, help to strengthen the analytical, regulatory and controlling capacity; draft status reports; simulate alternative policies and carry on analysis on regulation weaknesses. In June 2000, the working team functions were incorporated into the organizational structure.

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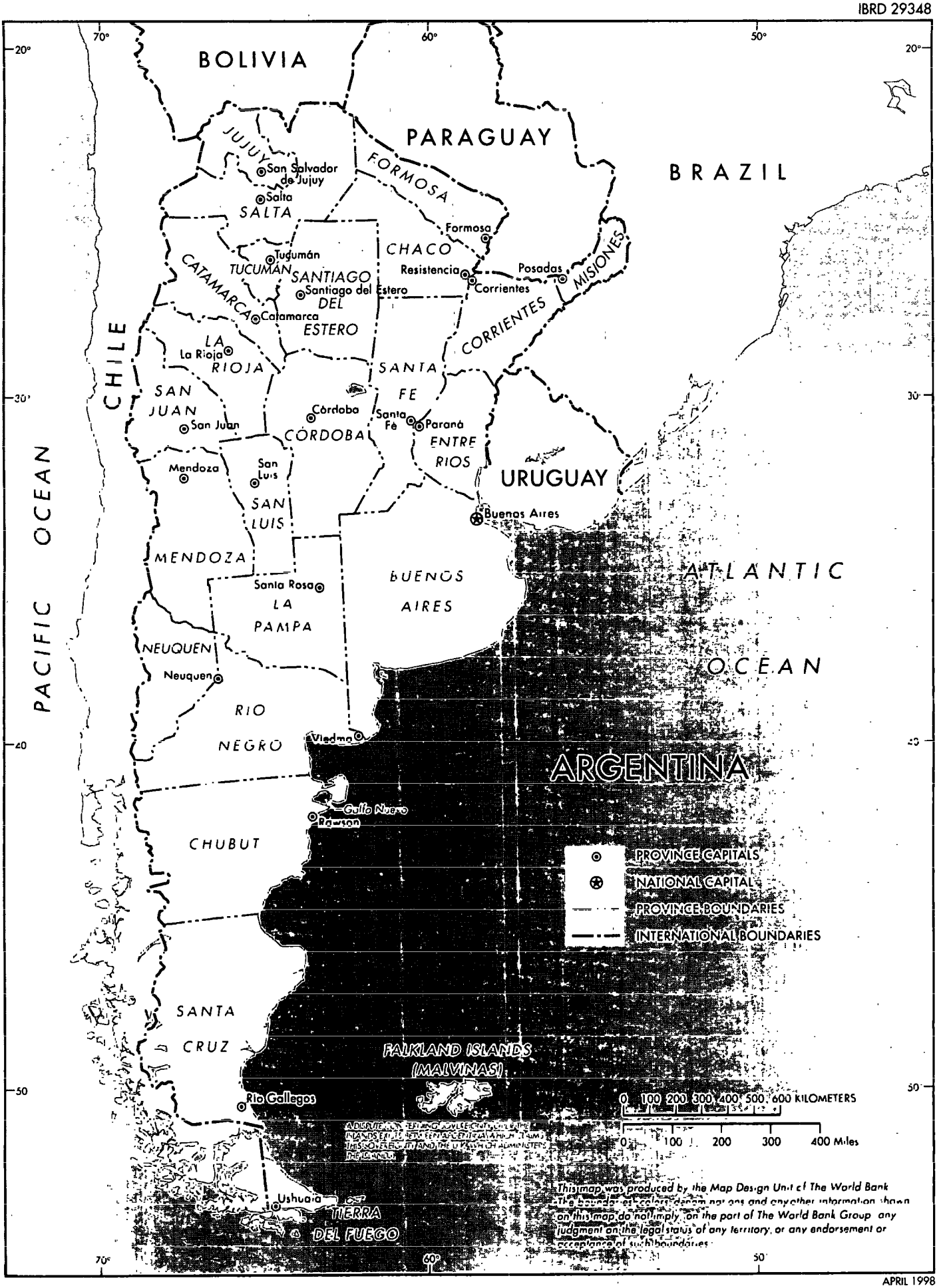

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