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Report No. 37702-AR

PROJECT APPRAISAL DOCUMENT

ON A

PROPOSED LOAN

IN THE AMOUNT OF US$300 MILLION

TO

THE ARGENTINE REPUBLIC

FOR THE

PROVINCIAL MATERNAL-CHILD HEALTH INVESTMENT PROJECT

IN SUPPORT OF THE SECOND PHASE OF THE PROVINCIAL MATERNAL-CHILD HEALTH PROGRAM

October 6, 2006

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

CURRENCY EQUIVALENTS

Currency Unit: The Argentine Peso

EXCHANGE RATE

ARS$ 3.09 = USD$1

(Exchange Rate Effective 06/20/2006)

FISCAL YEAR

January 1 – December 31

ABBREVIATIONS AND ACRONYMS

AGN	*Auditoria General de la Nación* [Supreme Audit Institution of Argentina]
AIDS	Acquired Immune Deficiency Syndrome
APE	*Administración de Programas Especiales* [Special Programs Administration]
APL	Adaptable Program Lending
CAS	Country Assistance Strategy
CFAA	Country Financial Management Assessment
COFESA	*Consejo Federal de Salud* [FederalHealth Council]
CPAR	Country Procurement Assessment Report
EPH	*Encuesta Permanente de Hogares* [Current Household Survey]
ESW	Economic and Sector Work
FSR	*Fondo Solidario de Redistribución* [Solidarity Redistribution Fund]
GDP	Gross Domestic Product
GNI	Gross National Income
GOA	Government of Argentina
HIV	Human Immune-deficiency Virus
HSRP	Health Sector Reform Program
IDB	Inter-American Development Bank
IFC	International Finance Corporation
IFI	International Financing Institution
ILO	International Labor Organization
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INDEC	*Instituto Nacional de Estadística y Censos* [National Institute of Statistics and Census]
IPP	Indigenous Peoples Plan
IPPF	Indigenous Peoples Planning Framework
IUFR	Interim Unaudited Financial Report
LCSHH	Unit of Health, Nutrition and Population of the Latin America and the Caribbean Regional Office
MCHIP	Maternal and Child Health Insurance Program [Plan Nacer]
MDGs	Millennium Development Goals, United Nations
MMR	Maternal Mortality Rate
MMR	Measles, Mumps and Rubella Vaccine
MSN	*Ministerio de Salud de la Nación* [National Ministry of Health]
MSP	*Ministerio de Salud Provincial* [Provincial Ministry of Health]
NEA	*Noreste Argentino* [Northeast Region of Argentina]

NHSPT	National Health Services Purchasing Team
NOA	*Noroeste Argentino* [Northwest Region of Argentina]
OSN	*Obras Sociales Nacionales* [National Social Health Insurance Organizations]
OSP	*Obra Social Provincial* [Provincial Social Health Insurance Organization]
PAMI	*Instituto Nacional de Seguridad Social de Jubilados y Pensionados* [National Institute of Social Security for Pensions and Retirees]
PBS	Package of Basic Health Services
PDO	Performance Indicator
PHSPT	Provincial Health Services Purchasing Team
PMO	*Programa Medico Obligatorio* [Mandatory Medical Program]
PMCHSAL	Provincial Maternal-Child Health Sector Adjustment Loan
PMCHAPL	Provincial Maternal-Child Health Adaptable Program Lending
PRL	Provincial Reform Loan
PROMIN	Second Maternal and Child Health and Nutrition Project
REMEDIAR	Program for essential drugs to support the needs in provinces
SEA	Strategic Environmental Risk Assessment
SIP/CLAP	Comprehensive Health Information System
SOE	Statements of Expense
UFI-S	International Financing Unit, National Ministry of Health
VRDL	Virology and molecular diagnostics
WB	World Bank
WHO	World Health Organization

Note: For Argentine organizations and terms, the Spanish-language acronym is used in this document.

Vice President:	Pamela Cox
Country Manager/Director:	Axel van Trotsenburg
Sector Director:	Evangeline Javier
Sector Manager	Keith Hansen
Country Sector Leader	Jesko Hentschel
Task Team Leader:	Cristian C. Baeza

ARGENTINA
PROVINCIAL-MATERNAL CHILD HEALTH INVESTMENT PROJECT
(Second Phase Adaptable Program Lending)

CONTENTS

ARGENTINA
AR PROVINCIAL MATERNAL-CHILD HEALTH INVESTMENT PROJECT
(Second Phase Adaptable Program Loan)

PROJECT APPRAISAL DOCUMENT

LATIN AMERICA AND CARIBBEAN
LCSHH

Date: September 8, 2006	Team Leader: Cristian C. Baeza
Country Director: Axel van Trotsenburg	Sectors: Health (100%)
Sector Manager/Director: Keith E. Hansen	Theme(s): Health/Nutrition/Population
Project ID: P095515	Environmental screening category: C
Lending Instrument: Adaptable Program Loan (APL Second Phase)	

Project Financing Data

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

For Loans/Credits/Others:
Loan currency: United States Dollar (US$)
Total amount Bank loan: US$ 300.00 million
Proposed terms:Fixed-Spread Loan
Grace period (years): 5
Years to maturity: 15
Commitment fee: 0.75 percent
Front-end fee on loan: Executive Directors of IBRD approved a full waiver for loans approved by the IBRD Board on or after August 10, 2006 to the date on which the Executive Directors decide upon any front-end fee waiver for the Bank's fiscal year 2008.

Financing Plan (US$m)

Source	Local	Foreign	Total
BORROWER	346.30	0.00	346.30
INTERNATIONAL BANK FOR RECONSTRUCTION AND DEVELOPMENT	300.00	0.00	300.00
Total:	**646.30**	**0.00**	**646.30**

Borrower:
Republic of Argentina
Argentina

Responsible Agency:
National Ministry of Health
Mr. Walter Valle
Av. 9 de Julio 1925
Buenos Aires
Argentina
Tel: 5411-4384 6997 Fax: Fax: (54-11) 4384 6997
wvalle@msal.gov.ar

Estimated disbursements (Bank FY/US$m)									
FY	2007	2008	2009	2010	2011				
Annual	26.0	60.5	74.4	72.3	66.8				
Cumulative	26.0	86.5	160.9	233.2	300.0				

Project implementation period: Start: January 2007 End: December 2011
Expected effectiveness date: January 1, 2007
Expected closing date: December 31, 2012

Does the project depart from the CAS in content or other significant respects? **Ref. PAD A.3**	[ ]Yes [X] No
Does the project require any exceptions from Bank policies? **Ref. PAD D.7**	[ ]Yes [X] No
Have these been approved by Bank management?	[ ]Yes [ ] No
Is approval for any policy exception sought from the Board?	[ ]Yes [X] No
Does the project include any critical risks rated "substantial" or "high"? **Ref. PAD C.5**	[ ]Yes [X] No
Does the project meet the Regional criteria for readiness for implementation? **Ref. PAD D.7**	[X]Yes [ ] No

Project development objective **Ref. PAD B.2, Technical Annex 3**
The project development objectives are: (a) to increase access by eligible uninsured mothers and children to basic health services; (b) to strengthen the incentive framework for efficiency and focus on results between the national level and the Eligible Provinces and among Eligible Provinces and service providers by linking financing to both services actually rendered to the target population and to the achievement of the MCHIP results as reflected by the selected ten tracers of the *Trazadoras* Matrix

Project description **Ref. PAD B.3.a, Technical Annex 4**

Component 1: Implementation of the Provincial Maternal-Child Health Insurance Program
Component 2: Strengthening of Stewardship Capacity of National and Provincial Ministries of Health
Component 3: Communications and Community Outreach
Component 4: Program Monitoring, Evaluation and Concurrent Auditing Systems
Component 5: Project Management and Administration

Which safeguard policies are triggered, if any? **Ref. PAD D.6, Technical Annex 10**
Indigenous Peoples (OP 4.10)

Significant, non-standard conditions, **if any**, for: **Ref. PAD C.7**

Board presentation: No Board conditions.

Loan/credit effectiveness: No additional conditions of effectiveness.

Covenants applicable to project implementation:

It would be covenanted that all Umbrella Agreements contain a clause specifying the conditions under which an eligible province becomes a participating one and it would also include the conditions under which it would exit the MCHIP and cease to receive Government transfers. Only participating provinces would receive proceeds of the loan. Among other criteria, an eligible province would become a participating province when (i) it has signed and legally approved the Umbrella Agreement and the Annual Performance Agreement, (ii) it has implemented and fully staffed the PHSPT, and (iii) it has implemented the MCHIP enrollment system. Additionally, it will be covenanted that the provinces of Chubut, La Pampa, Mendoza, Neuquén, Río Negro, San Juan, and Tierra del Fuego will require Indigenous Peoples Plans to become participating provinces, in accordance to the Indigenous Peoples Framework. The contracting of the concurrent auditor would be a condition of disbursement against Capitation Payments.

A. STRATEGIC CONTEXT AND RATIONALE

1. Country and Sector Issues

1. The proposed project is the second phase of a seven-year Adaptable Program Loan (APL). Together with the first phase APL (APL-1)[1] and a health sector adjustment loan,[2] this project is the backbone of the World Bank support to the Health Sector Reform Program (HSRP) of the government of Argentina (GOA). All triggers for APL-II have been met.

2. The main goal of the APL-II is to support governmental efforts to improve access to basic health services for the uninsured population through the implementation of the Maternal and Child Health Insurance Program (MCHIP, "Plan Nacer") at the provincial level. This is a publicly financed program built around a defined package of health services for uninsured mothers and children rather than a contributory health insurance arrangement. The objectives of Plan Nacer are to improve access to basic health services for the target population, thereby helping to reduce Argentina's infant and maternal mortality, while simultaneously strengthening the incentive framework to improve efficiency in the use of public health funds.

3. The project appraisal document for the first phase APL had anticipated that the program would be rolled out over three phases. As stated in the Argentina Country Assistance Strategy[3] discussed by the Board on June 6, 2006, the proposed project merges the planned second and third phases of the APL-I into a single and final phase. This single and final phase would roll out the Plan Nacer to all 15 provinces not included in APL-I. Merging the two phases responds to strong demand and readiness for implementation in those 15 provinces. Moreover, the very positive assessment of implementation in the first 9 provinces justifies a more rapid extension of the program nationwide than originally planned. Details on the rationale and arrangements supporting a more rapid implementation and the merging are provided in section B.

4. ***Economic context and background:*** Argentina continues its rapid recovery from the deep economic crisis of 2001–02. However, poverty levels have not recovered to pre-crisis levels and continue to be high, affecting 31.4 percent of the population as of the first semester of 2006[4]. During the upturn, the unemployment rate also decreased consistently from 22 percent in 2002 to 10.9 percent in the first semester of 2006.

5. Since the peak of the crisis in 2002, the economic recovery has been robust; GDP growth averaged 9 percent between 2003 and 2005. The recovery was led by strong export earnings and increasing investment and was further aided by renewed consumer confidence. Prudent macroeconomic policies were key in the recovery, especially fiscal policies that generated primary surpluses for the consolidated government in 2004 and 2005 of 4.8 and 4.2 percent of GDP, respectively. Official forecasts for 2006 suggest a continuation of growth on the order of 8 percent[5]. The current principal macroeconomic challenge is to contain inflation, which has been running at an interannual rate of about 11 to 12 percent. The government is expecting that CPI index in 2006 will show an increase of 9.6 percent (according to the budget proposal recently sent

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[1] Argentina Provincial Maternal and Child Health Investment Project (Loan 7225-AR, Bank Approval April 15, 2004).

[2] Argentina Provincial Maternal and Child Health Sector Adjustment Loan (Loan 7199-AR, Bank approval October 28, 2003).

[3] Argentina Country Assistance Strategy (Report), paragraph 75.

[4] In the first semester 2006, the official extreme poverty line was roughly equivalent to US$1.4/day and the poverty line to US$3.0/day.

[5] The latest Market Expectation Survey (REM) conducted by the Central Bank of Argentina on August 2006 projects growth of 7.7 percent for 2006.

to the Congress). The market expectations are at 10.1 percent for 2006 and 10.8 percent for 2007.

6. ***Health Sector Organization and the Crisis:*** Historically, the health sector in Argentina has been highly fragmented. More than half of the population (52 percent) is served through the formal social security system (for the formal sector workforce and their families), with the public and private sector providing services for 39 percent and 9 percent of the population, respectively[6]. The social health insurance system is further fragmented into hundreds of insurers, not all of them regulated by the Health Superintendence which, by law, has no regulatory power over private health insurers.

7. In addition to this horizontal fragmentation, Argentina's federal structure assigns most health responsibilities (operational and policy) to the provinces. While this allows for greater efficiency and local adaptation in the delivery of individual health services, it has posed a complex challenge for national health policy formulation and implementation. The National Ministry of Health (MSN) is responsible for sector coordination (through the Federal Health Council, COFESA[7]), setting and enforcing quality standards and regulations, as well as the traditional areas of national public health (e.g. disease monitoring). But, before the crisis of 2002, it had limited legal and administrative influence over provincial health sector policy as it lacked the tools to influence provincial policy from the national level.

8. Despite Argentina's recent recovery, the impact of the 2001–02 crisis and the systemic problems it revealed in the health sector continue to affect the poorest segments of the population. Although the country has made steady progress through the implementation of Health Sector Reform Program (HSRP), Argentina needs to continue tackling structural problems in the health care sector. For example, formal insurance coverage has not expanded at the same rate as macroeconomic improvements, and much of the population has no formal health insurance coverage at all. Lack of insurance curtails access to health services, especially for the poor. Further, the need to improve the incentive framework to increase efficiency in the public sector is still a policy priority.

9. The effects of the institutional, financial, and economic crisis have fundamentally changed the realities and priorities of the health care system in Argentina. As a result, health policy goals in the short- to medium-term have been to urgently increase access to basic health services for the poor and socially excluded, while simultaneously introducing structural changes in the health care system to improve the incentive framework for efficiency, system performance, and good health outcomes over the medium and long terms.

10. Even before the 2001 crisis, Argentina's health system did not perform as well as those of other middle-income countries in the region (e.g., Costa Rica and Chile), although Argentina's was spending much more per capita on health care. Throughout the 1990s, encouraged by a growing economy, Argentina invested heavily in reform and expansion of social insurance programs, mainly for formal workers. These reforms generally met the health needs of people employed in the formal sector but were only marginally successful in reaching the uninsured and the poor. As a result, despite historically high national spending and installed capacity in the health sector, structural inequalities generated lower-than-expected general health outcomes.

11. ***Government's Health Sector Reform Program:*** Since 2003, the government has been responding to the new sector priorities through its HSRP[8], which comprises an integrated package

[6] Information from the SSS, MSN and CEDI (2002) for coverage of OSN/OSP and PAMI by province, from "The Health Sector in Argentina", WB report No. 26144-AR, July 21, 2003.
[7] National Health Council is abbreviated as COFESA by its acronyms in Spanish
[8] The final version of the HSRP was approved in March 2004 as a Federal Health Plan.

of complementary policy reforms and actions intended to increase the effectiveness of public subsidies in improving the health status of the poor. The main HSRP objectives are: (i) to increase access of the poorest mothers and children to basic services; (ii) to enable the National Ministry of Health in reassuming its stewardship and regulatory functions in core areas of public health (essential functions and programs); (iii) to consolidate regulatory reforms in the social health insurance system to avoid negative spillovers in the public health sector in the provision of access to services for the poor and uninsured, and (iv) to trigger significant changes in the relationship between the national and provincial governments, as well as between the provinces and health service providers. These changes help improve the incentive framework for efficiency and output/ outcome results in the health sector.

12. Development of this program was made possible by the leadership provided by the national Government during the crisis and its immediate aftermath, which revitalized the Federal Health Council (COFESA) as an effective coordinating mechanism between the federal and provincial levels[9]. To date, the Bank has supported HSRP through the Provincial Maternal-Child Health Sector Adjustment Loan (PMCHSAL), Ln. 71990-AR, approved by the Board of Executive Directors on October 28, 2003. The complementary investment operation, APL-I[10] was approved by the Board of Executive Directors on April 15, 2004. Both projects have successfully supported the implementation of the Maternal and Child Health Insurance Program (MCHIP, Plan Nacer). Further, and in addition to the proposed APL-II, the Government and the Bank are in the final stage of preparing the Essential Public Health Functions and Programs Project which would support another key objective of the HSRP. This project would be presented to the Board for consideration before the end of calendar year 2006.

13. The Plan Nacer, one of the cornerstones of the government HSRP, was developed by the MSN in close consultation with all provinces through COFESA. It recognizes that the institutional, financial, and economic crisis has fundamentally changed the realities facing the country and, with that, the priorities in the health system. The complex political and institutional history of reforms in the social health insurance system has greatly increased provincial health systems' responsibilities for service delivery. This, in turn, has accentuated the need to improve the efficiency of those provincial health systems now trying to deliver services to the uninsured.

14. By offering a defined package of guaranteed basic health services (PBS) supported with payment systems that reward performance, the Plan Nacer aims to alter fundamentally the delivery mechanism of health services in Argentina. The Plan Nacer is already helping, through the APL-I, the nine poorest provinces of Argentina (North West and North East regions) to reorient their approach from financing inputs to rewarding performance and making public subsidies in the health sector more progressive and effective. The government is eager to bring this change to the remaining 15 provinces with APL-II. Estimates suggest that upon full implementation, the Plan Nacer could help reduce infant mortality by at least 10 percent in the 15 APL-II provinces, for an overall (APL-I and APL-II) national reduction of infant mortality of 8 percent in the next five years.

15. ***APL-I implementation:*** APL-I demonstrated excellent implementation progress during its first two years of operations (see Annex 11). By end-August 2006, 49.2 percent of the eligible population (399,369 people) had been enrolled in all nine provinces. By June 2006, APL-I had financed more than 1.5 million well-child and pregnant women consultations[11] and more than

[9] COFESA serves as the coordinating mechanism among all provincial Ministries of Health and the National Ministry of Health. It meets periodically to discuss all important matters of health policy of national relevance and has closely monitored the implementation of Plan Nacer with the support of APL-I.
[10] Provincial Maternal-Child Health Investment Project, Report No 27892.
[11] Estimation based on payments to primary health care centers in Participating Provinces.

18,000 deliveries for the eligible population. APL-I also supported a significant increase in the provinces' coverage of key MCH programs, increasing, for example, the proportion of women with early pre-natal consultations from 10 percent of the eligible population to 40 percent (more than 80 percent of enrolled pregnant women).

16. In addition to increasing access to basic services, the implementation of Plan Nacer, supported by APL-I, introduces important structural changes in the way the national government provides health financing to the provinces and in the way provinces pay providers. For the first time in Argentina, the national government is linking financing strictly to output and outcomes, as verified through independent audits. The introduction of performance goals in APL-I for 10 key outputs and intermediary outcomes (*trazadoras* [tracers]) that determine 40 percent of all transfers from the national to the provincial level, has proven fundamental in reforming the way maternal and child policy is discussed at these two levels. The tracer system is described in the project description section below. The APL-I provinces have progressively achieved the tracer goals (Annex 11). Moreover, the provinces can use the funds only to pay for services actually rendered to the beneficiary population. Compliance with this condition, too, is subject to external audit.

17. To be able to link financing effectively to outputs and some intermediary outcomes, both the national government and the provinces have had to introduce performance contracts, implement cost and pricing systems at provider and provincial levels, significantly strengthen their output and outcome monitoring and reporting systems, and launch a large effort to train managers for performance-based financing. These structural changes in health financing are fundamentally changing the incentive framework for efficiency and inclusion of the poor in public health coverage.

18. Concomitantly with the implementation of Plan Nacer (supported by APL-I and PMCHSAL implementation), infant mortality was reduced by 12 percent in the nine provinces included in APL-I. An in-depth project evaluation is underway to determine how much Plan Nacer and APL-I contributed to this reduction, independently of the contribution stemming from improvements in the general economy. Details of APL-I implementation arrangements and preliminary results are presented in Annex 11. Details of the evaluation underway are presented in box 2.

19. All second phase triggers have been met (table 1). The current level of enrollment already exceeds the first-trigger condition. Similarly, more than US$37.5 million, 28 percent of the loan proceeds, has reportedly been disbursed as verified by the Financial Management Report (FMR), exceeding the trigger requirements.

Table 1. Summary of Status of Triggers for APL-II

Trigger	Indicator	Status as of August 31, 2006
Evidence that the program was implemented and is effectively functioning.	(a) At least 25 percent of the target population in each of at least four provinces of Northwest and Northeast Argentina have been enrolled in the program.	(a) All nine provinces have surpassed the 25 percent target. Average enrollment was 49.2 percent of the target population, for an APL-I aggregate total of 399,369 beneficiaries for all nine provinces, by August 31, 2006.
	(b) At least 20 percent of all loan proceeds have been disbursed.	(b) 28 percent (US$37.5 million) had been disbursed by August 31, 2006.
	(c) Annual auditing (financial and concurrent) of the project is satisfactory.	(c) The financial audit for 2005 was received by the Bank at the end of June 2006.The concurrent auditor has completed and submitted seven reports to the Bank. The Bank reviewed the audit reports and found them acceptable.
Evidence that at least five new provinces are ready to enter in the program.	(a) At least five new provinces are ready to sign an Umbrella Agreement, including the establishment of a Plan Nacer health service purchasing agency/unit.	(a) The Bank received copies of the letters of intent to join Plan Nacer, copies of the resolutions to create a Plan Nacer and Plan Nacer unit, and copies of resolutions naming the coordinator of the Plan Nacer units in five provinces not included in APL-I (Cordoba, Chubut, Entre Rios, La Pampa, and La Rioja). (b) Fourteen provinces, including the five provinces listed in "a" above, have made formal requests to the national Ministry of Health for inclusion in the next phase, including a committing to the contents of the draft Umbrella Agreement. They indicate that they are awaiting Bank-GOA agreement to proceed with the creation of Plan Nacer, the Purchasing Agency, and the signing of the draft Umbrella Agreement, which has been informally discussed with the provinces.

20. The proposed project would extend Plan Nacer coverage to poor and uninsured mothers and children in the 15 provinces that did not participate in APL-I (to an additional eligible population of about 1.7 million, resulting in a total eligible population of about 2.5 million uninsured mothers and children in the entire country). The extension of Plan Nacer to the remaining provinces is expected to introduce the same structural changes APL-I has supported in the northern provinces. In addition, APL-II would be complemented by a second World Bank lending operation for the Argentine health sector currently under the Essential Public Health Functions and Program Project, which would focus on supporting the HSRP by strengthening public health policy throughout the country, complementing the medical care focus of Plan Nacer.

21. ***Rationale for merging the second and third phases of the APL:*** In light of the strong demand from all provinces not included in APL-I and the positive assessment of the government and the Bank of APL-I implementation in the 9 northern provinces, the proposed project merges the originally planned second and third phases of the APL-I into a single final phase, APL-II. During APL-II, Plan Nacer would be extended to all 15 provinces that were not included in APL-I.

22. Merging the two phases is justified for several reasons: (i) program design and implementation have been successful, as evidenced by the promising output results of Plan Nacer under APL-I in its first 2 years of operations; (ii) strong demand for inclusion in the APL-II from all provinces not included in APL-I, which are well advanced in complying with all the requirements for participating in the program; (iii) the government is eager to extend the structural changes introduced by the APL-I to the entire country; (iv) including all remaining provinces at this stage would consolidate nationwide political support for Plan Nacer, essential for its long-term sustainability; and (v) the recent economic improvements in Argentina at both the national and the provincial levels, as well as the well targeted and modest cost of the benefits package (compared to the overall cost of the range of services in Argentina's public health sector), make for minimal fiscal impact, fully compatible with the need for "fiscal prudence," as discussed in the APL-I PAD (Annex 9). Additionally, project management and fiduciary arrangements are fully compatible with accelerated implementation of the program. These arrangements are deemed sufficient to address the challenge of nationwide implementation of Plan Nacer. The preparation of a merged APL-II has benefited from learning and experience under APL-I, which should expedite roll-out to a broader and faster implementation of APL-II.

23. The most important challenges and initial weaknesses of APL-I have been addressed in the preparation of APL-II. First, the implementation of Plan Nacer systems proved more technically and operationally demanding than originally expected. APL-I has substantially increased its technical and operational support to the provinces. The APL-II design includes expanded NHSPT capabilities and an increased technical assistance. This increased support, plus the greater institutional capacity of the new provinces, is expected to substantially address the capacity challenge. Second, APL-I underestimated the volume needed and the resulting cost of effective communications and outreach campaigns. This, too, was solved for APL-I, and APL-II provides for substantially more activities and financing for outreach.

2. Rationale for Bank Involvement

24. For more than a decade, the Bank has provided Argentina with financial and technical support to improve the efficiency of its health system. This has been a combination of adjustment and investment lending centered around three different strategic axes. First, the reform of the national social health insurance system was supported through adjustment and technical assistance lending. Second, the Bank has supported provincial health insurance and system reforms by incorporating the sector in a number of Provincial Reform Loans, as well as in the Provincial Health Sector Development Project. Third, two investment operations targeted maternal and child health care, including child nutrition, attention to reproductive health of mothers, and early childhood development, through financing investments in selected provinces.

25. In addition to these three areas, the Bank has recently provided important financial and technical assistance for the design and initial implementation of Argentina's HSRP through the PMCHSAL. This assistance supported the implementation of a new policy framework for the implementation of Plan Nacer (with support of APL-I). PMCHSAL implementation was very good —all but 1 of the 32 policy conditions have been met. The third tranche has not been released because: (i) the medium-term macroeconomic framework has been characterized by

continued uncertainties; and (ii) one of the 32 sector policy conditions of the program has not been met.

26. As a result of its long experience with Argentina's health sector, the Bank has significant comparative advantages in continuing to support government efforts that combine policy reform with investments to contribute to longer-term structural improvements in institutional performance in the health sector.

3. Higher-Level Objectives Furthered by the Project

27. The proposed operation is one of the centerpieces of the new Country Assistance Strategy for Argentina, which was discussed by the Board on June 6, 2006 (R2006-0068; IFC/R2006-0118). The overall objective of the CAS is to seek opportunities to build an investment partnership to support government efforts through the transition from crisis recovery to sustained, private sector–led growth with improved equity and reduced structural poverty. According to the CAS, the Bank would continue to seek engagement and provide lending for health care, notably for mothers and children but also including support for sectoral reforms. The CAS specifies that it seeks to build on improvements in health service delivery achieved under the Provincial Maternal-Child Health PMCHSAL and APL-I, with the second and third phases of the APL to be combined into a single operation. Additionally, the proposed project also complements the Essential Public Health Functions Project in preparation, which would endeavor to strengthen specific priority health programs beyond maternal and child health (e.g., HIV/AIDS prevention, epidemiological surveillance), building on the successful national-provincial incentive system that has been piloted through Plan Nacer.

28. The Plan Nacer (APL-I as well as the proposed APL-II) has a strong poverty focus. First, the program specifically targets uninsured households, where people are often unemployed or work in the informal sector. These groups are much more likely to be poor than the insured households. Second, the program is directed specifically to mothers and children, the most vulnerable groups (among the uninsured). Finally, in this second stage, the MCHIP would be implemented in the remaining 15 provinces in central and southern Argentina, the most populous provinces. They also include 25 percent of Argentina's indigenous population—traditionally a poor and excluded group (75 percent are already included in APL-I). The Plan Nacer would include special outreach activities to reach these groups.

B. PROJECT DESCRIPTION

1. Lending Instrument

29. The Bank's investment lending support for implementation of the nationwide extension of Plan Nacer would be a second-phase adaptable program investment loan (APL) to be implemented over a period of five years or less. The choice of an APL as the lending instrument allowed testing of the design and implementation of Plan Nacer in the northern provinces so that preliminary lessons could be derived from ongoing experience. These lessons have been derived and are being built into practices and norms to guide service delivery, reforms in the financing regime, and institution building in the Plan Nacer implementation for APL-I and for the design of the proposed APL-II. This was expanded to all the provinces, thereby ensuring program sustainability.

2. Program Objectives and Phases

30. The objective of this program, and the implementation of the Plan Nacer, is to improve access

to basic health services for the target population so as to help reduce infant and maternal mortality in Argentina. At the same time, the incentive framework is to be strengthened to improve efficiency in the use of public health care funds. This proposed loan is a second and last phase of the APL.

3. Project Development Objectives and Key Indicators

31. The main objectives of the second phase would be to: (i) increase access for uninsured mothers and children to basic health services known to effectively address the main causes of maternal and under-5 mortality in 15 provinces of Argentina; (ii) strengthen the incentive framework for efficiency and focus on results between the national level and the participating provinces and among provinces and service providers. The latter would be done by linking financing to both services actually rendered to the target population and to the achievement of program results as reflected by 10 tracers (e.g., the proportion of pregnant women that receive their first antenatal visit before the 20th week of pregnancy).

32. Thus, APL-II would continue to build on the APL-I and PMCHSAL contributions to Argentina's ability to meet the Millennium Development Goals (MDGs) for health by 2015. Key outcome indicators to be measured are the percentage of the target population enrolled, as well as measured changes in the national and regional infant mortality rates.

33. Key indicators include (see Annex 3 for details).

Project Developmement Objectives Indicators

Increased access to basic health services of the target population
- Proportion of pregnant women with first antenatal care visit before week 20th of pregnancy.
- Proportion of pregnant women who get VRDL test and antitetanic vaccine during pregnancy.
- Proportion of children less than 18 months old with coverage of measles vaccine or triple viral.
- Proportion of puerperal women that received Sexual and Reproductive Care consultations.
- Proportion of children 1 year old or less, with all normal child development consultations up to date.

Improve Critical Intermediary outcomes

- Proportion of newborns weighing more than 2,500 g.
- Proportion of newborns with APGAR score higher than "6"at minute 5.

New incentive environment for provinces and provincial providers
- Percentage of MSN-MSP annual performance agreements successfully implemented.
- Percentage of authorized providers under annual performance agreements.
- Percentage of *trazadora* targets achieved by the provinces in last year billing period.

4. Project Components

34. The proposed APL-II would closely follow the design of the APL-I, including:

(i) *Eligible population:* Enrollment in the Plan Nacer would be available, on a voluntary basis in the participating provinces in the central and southern regions, to all uninsured children up to their sixth birthday, to all uninsured pregnant women, and to all uninsured mothers for up to 45 days after the date of delivery or miscarriage.

(ii) *Eligible provinces for APL-II:* Ciudad Autonoma de Buenos Aires, Buenos Aires, Cordoba, Chubut, Entre Rios, La Pampa, La Rioja, Mendoza, Neuquen, Rio Negro, San Juan, San Luis, Santa Cruz, Santa Fe, and Tierra del Fuego.

(iii) *Benefits package:* The services included in the APL-II package of basic services would be the same as for APL-I and would be provided to the target population through authorized public and private providers. The PBS includes 80 health services most frequently needed to address the main causes of maternal and infant mortality and morbidity in Argentina. The composition of the package is described in Annex 1.

(iv) *Institutional responsibilities:* As in APL-I, the National Ministry of Health would have overall responsibility for meeting program goals and for bringing about change in the operational culture of the health system. However, the participating provinces would actually implement the Plan Nacer, while the MSN plays a supportive financing and technical advisory role through the Plan Nacer health services purchasing area. All 15 provinces are expected to be included in APL-II. However, to receive loan proceeds, eligible provinces would become participating provinces by: (i) signing an Umbrella Agreement with the MSN; (ii) signing the first Annual Performance Agreement, also with the MSN; (iii) implementing the Plan Nacer enrollment system; and (iv) designing and setting up a health services purchasing area in their respective Provincial Ministries of Health.

35. The project would include, as in APL-I, a conditional per capita transfer from the National Ministry of Health (MSN) to each participating province to finance up to 50 percent of the cost of the basic services package offered under the Plan Nacer. As in APL-I, disbursements would continue to be against the submission of audited enrollment lists (60 percent of the per capita transfer) and the achievement of 10 tracers or output goals (40 percent of the per capita transfer).

36. Umbrella Agreements would define the rules for both parties regarding the administration, financing, monitoring, auditing, and other specific requirements with which participating provinces would need to comply. They would include: (i) norms for the enrollment system; (ii) norms for billing capitation payments from the province to the MSN; (iii) the list of the 10 key health services to serve as tracers of Plan Nacer service delivery at the provincial level; and (iv) the list of eligible health services, operationalize the PBS into the multiple specific medical interventions and services (around 80) required to address the diseases and main clinical problems included in the PBS. Drafts of model agreements have been agreed and would be included in the project Operations Manual.

37. Annual performance agreements would specify: the yearly results and enrollment goals, the agreed targets for the tracers, agreed prices for the services included in the nomenclador for that year, the annual work programs (including outreach, staff development, investments), and the corresponding yearly projected budgets.

38. APL-II would cost an estimated US$646.3 million and cover 1.7 million additional beneficiaries. The Bank would finance about US$300 million of the total (including unallocated and front-end fees). The project would have the following five components:

Component 1: Implementation of the Maternal-Child Health Insurance Program (US$589 million; US$242.7 million of Bank financing)

39. This component would include financing to support:

(i) Capitation payments for Plan Nacer services by the National Ministry of Health (MSN) to participating provinces covering a declining share of the costs of the basic service package, calculated on a per capita basis (US$ 554.8 million; US$208.5 million of Bank financing);

(ii) Equipment (medical, transportation, and communications) for basic health care facilities that supply the Plan Nacer package—excluding civil works and complex medical equipment (US$ 14.8 million; US$14.8 million of Bank financing);

(iii) Technical assistance and training programs for the provincial Ministries of Health (MSPs) to develop systems, instruments, and skills necessary to implement and run the Plan Nacer. This would include: development of Annual Performance Agreements with the MSN and authorized providers; development and implementation of procedures for contracting and paying providers; development and implementation of outreach and service delivery strategies and mechanisms for rural dwellers, indigenous peoples, and other excluded populations (US$8.3 million; US$8.3 million of Bank financing);

(iv) Health service delivery training for providers delivering basic services under the Plan Nacer (US$1.7 million; US$1.7 million of Bank financing);

(v) Information technology equipment and consultant services to upgrade and expand information systems for monitoring the implementation of the Plan Nacer (US$4.8 million; US$4.8 million of bank financing), including tracer systems and provider delivery data; and

(vi) Technical assistance and training for the management of participating health service providers to strengthen areas including their billing capacity, development, and implementation of provider data systems (US$4.6 million; US$4.6 million of Bank financing).

Component 2: Strengthening National and Provincial Ministries of Health Stewardship Capacity (US$10.2 million; US$10.2 million of Bank financing)

40. The focus of this component would be to adapt the provincial Ministries of Health to meet the implementation requirements of Plan Nacer (information, managerial). It includes the essential and major structural change of separating the purchasing and provision of services and setting up and training national and provincial health service "purchasing" teams (PHSPT) in the respective Ministries of Health. These teams would act, for the duration of the project, as the implementation agency (unit) but, they would continue as "health service purchasing agents" for the provinces after program completion. In practice, these teams are the initial structure of what most provinces expect to become provincial public health insurance organizations. The proposed loan would finance consultant services and investments in office equipment and training services to improve the MSN and MSPs performance in exercising the sector stewardship functions. The component includes:

(i) Reorganizing participating MSPs in both staffing and interrelationships, as necessary;

(ii) Improving epidemiological information, financial, and human resource management systems; and

(iii) Completing studies essential for MSN policy formulation.

41. Annually, the MSN and each participating province would agree on a technical assistance program for the province and the specific resources needed for its implementation. Those agreements would be included in Annual Performance Agreements.

Component 3: Communications and Community Outreach (US$17 million; US$17 million of Bank financing)

42. To ensure the effectiveness of Plan Nacer, the government needs to see that the eligible populations, particularly those who have historically been marginalized, have enough knowledge about, and motivation to use, the services being offered. The proposed loan would finance consultant services, incremental ministry operating costs, event organization, and media communications services to support two main lines of communication:

(i) Dissemination of detailed information about the program among major stakeholder groups (provincial governments and their populations, the Federal Health Council (COFESA), the medical profession, and insurance agency managers and staff). Opportunities would also be provided for stakeholder feedback and dialog. This would be primarily the responsibility of the MSN and the participating provinces.

(ii) Community outreach to increase participation of the eligible population by providing practical information on (a) beneficiaries' rights to services; (b) the package of basic services under Plan Nacer; (c) methods of enrollment; (d) names and locations of participating providers and their office hours; (e) media communication campaigns to boost demand for enrollment; and (f) support to community contact groups responsible for disseminating information, as well as receiving and reacting to feedback to strengthen citizen control. It would also support the development and implementation of the communications and media campaign and its adaptation to the language and cultural needs of indigenous populations. Implementing the communications and media campaign would be mainly the responsibility of participating provinces. Provinces would provide details on their community outreach activities as part of their annual work programs, covered by Annual Performance Agreements with the MSN.

Component 4: Program Monitoring, Evaluation and Concurrent Auditing Systems (US$14.6 million; US$14.6 million of Bank financing)

43. The program would be expected to change the incentive structure for health services staff and facility managers and tighten their accountability for results. To support this, the national and provincial ministries' ability to monitor, evaluate, and audit performance would be strengthened. The proposed Loan would finance information technology design services, software and equipment, and training for MSN and MSPs staff to upgrade the monitoring of health provider performance in collecting and reporting information. It would also finance the cost of external concurrent auditing of key elements underlying transfers of capitation payments (as discussed below in the section on implementation arrangements). Lastly, this component would finance an in-depth project evaluation, including the completion of the baseline for impact indicators and project impact evaluations at mid-term and closing. APL-II would follow the same impact evaluation design being used in APL-I.

Component 5: Project Management and Administration (US$ 1.6 million; US$ 1.6 million)

44. Under this component, the project would finance operational expenses, such as travel costs to the provinces, travel and per diem costs for coordination meetings, mainly for the NHSPT activities.

5. Lessons Learned and Reflected in the Project Design

45. A number of lessons have been derived from overall Bank experience in Argentina in the last decade, as well as some preliminary lessons from the implementation of APL-I. Three essential lessons from the Bank's overall experience supporting Argentina's health sector over the past decade have been incorporated in the design of the Maternal and Child Investment Loan (APL-I and II) and the PMCHCAL.

46. First, the focus on reform of the national social health insurance system during the 1990s proved difficult and insufficient to address the health problems of the poor. As a result, coverage of the uninsured did not expand significantly. The government's HSRP and the APL-I, APL-II, and PMCHCAL that support it therefore focus directly on establishing a health care coverage mechanism for the uninsured and providing incentive systems for provinces to deliver a package of basic health care to the most vulnerable groups among the uninsured. Reaching the uninsured became an even higher priority as a result of the 2001-02 economic crisis, which caused 12 percent of the insured to lose their health coverage.

47. Second, previous projects and reforms insufficiently reached the poorest provinces where most of the uninsured live. The government strategy for introducing Plan Nacer therefore initially gave priority to the poorest nine provinces in the northeast and northwest regions of Argentina. Plan Nacer is now well advanced in those nine provinces, as demonstrated by the achievement of triggers for APL-II. The nationwide extension is therefore expected to strengthen the program.

48. Finally, the Bank's experience in supporting Argentina's health sector indicates that Bank's financing should be closely linked to results, both outputs (actual delivery of services), and, if possible, outcomes (improvement of final or intermediary health indicators). APL-I introduced significant innovations in output-based lending such as linking disbursement of loan proceeds to provinces to the achievement of 10 output and intermediary outcomes goals (e.g., the proportion of eligible pregnant women receiving early antenatal care and the proportion of eligible newborns scoring high in the post-delivery neonatal evaluation). In the first two years of use, these measures have shown excellent results.[12]

49. APL-I has also provided preliminary implementation lessons. First, the reforms introduced by Plan Nacer and APL-I are demanding, both technically and institutionally. Successful implementation has required substantial technical assistance as well as intense policy dialog and technical supervision by the Bank. Second, the introduction of an additional independent concurrent audit to verify and validate the compliance of the provinces with key elements of Plan Nacer has proven instrumental in the program's success. The proposed project includes substantial technical assistance and would continue to enlist the services of an independent concurrent auditor.

6. Alternatives Considered and Reasons for Rejection

50. The key strategic decision for APL-II is merging, at the request of the government, the previously envisaged second and third phases APL (a possibility foreseen during the preparation of the APL-I and stated in the Argentina CAS discussed with the Board in April 2006) into a single final phase that would include all remaining 15 provinces not participating in APL-I. The

[12] Building on this lesson, the Essential Public Health Functions and Programs Project, to be presented to the Board later this calendar year, would propose to include a financial transfer mechanism which is closely modeled according to the functioning of Plan Nacer.

need for merging the two phases was discussed above.

51. Given the strategic choices made at the outset of the APL program and the decision to merge the second and third phases, project design decisions have been motivated by: (i) best practices in the area of maternal and child care; (ii) experience with noncontributory health insurance systems in other countries and the region; (iii) experience with reforms in public health systems such as provider payment reforms, provider contracting and "purchaser-provider split," all adapted to Argentina's political and regulatory framework; and (iv) a need to accelerate implementation nationwide and bring the Plan Nacer and related structural reforms to all provinces in Argentina.

C. IMPLEMENTATION

1. Partnership Arrangements

52. Close coordination has been maintained with the Inter-American Development Bank (IDB) regarding activities in the health sector. The IDB currently supports the REMEDIAR program in Argentina (program of free essential medicines for the poor) and is preparing a new operation to strengthen primary care providers. To ensure close coordination, responsibility for both Plan Nacer and REMEDIAR, as well as the planned IDB operation, has been placed under the same Secretary of Health (Secretary of Sanitary Programs) in Argentina. The program has also been closely coordinated with the Pan American Health Organization (PAHO) through the preparation of the complementary investment operation supporting the HSRP (Essential Public Health Functions and Programs) to be presented to the Board later this calendar year.

2. Institutional and Implementation Arrangements

53. *Institutions*: The project would be implemented by the MSN through the Plan Nacer National Health Services Purchasing Team (NHSPT), created within the MSN to support APL-I. The NHSPT works directly under the Secretary of Sanitary Programs and would continue as the national "health service purchasing department" in the MSN after project completion. The MSN has legal responsibility for coordinating health policy and programs throughout Argentina. The NHSPT would be responsible for working with the participating provinces in the implementation of the Plan Nacer and APL-II. The participating provinces would be directly responsible for purchasing the PBS for beneficiaries from accredited health service providers.

54. The NHSPT would be responsible for ensuring that all technical, financial and administrative aspects of the project implemented by the Provincial Health Service Purchasing Team meet agreed quality standards and timeliness. The NHSPT would be the point of daily contact with the Bank for project implementation (technical supervision, disbursements, compliance with loan conditions). It would also provide technical advice and consider recommendations by the Federal Health Council (Consejo Federal de Salud, COFESA) related to the Plan Nacer. It would continue to be staffed with a manager (appointed by the National Minister of Health at the level of Secretary) and technical experts recruited for the technical aspects of the project. The NHSPT would be supported by the MSN International Finance Unit (UFI-S[13]) to manage financial and procurement requirements. APL-I has financed during start-up a core staff of about 30 for NHSPT that would grow to about 50 as all provinces entered the program. The proposed project would finance 100% of the NHSPT for the first two years of the project. Then, project financing will decrease to 70% in the third year, 50% in the fourth year, and 30% in the fifth year, with the MSN assuming full financial responsibility for NHSPT staffing in year six. To control

[13] An MSN unit specialized in financial management and procurement procedures for all multilateral projects being implemented by the Ministry (Annexes 7 and 8).

administrative costs, additional staffing needs beyond 50 employees would be met through short-term consulting contracts. Staff would be engaged to ensure the NHSPT monitoring, evaluation, programming, and relationship functions.

55. Simultaneously, the Ministries of Health of each participating province, which have legal responsibility for ensuring health care in their jurisdictions and for providing health care for the uninsured, would implement their respective activities through the Provincial Health Services Purchasing Teams, created as part of the structural reforms being introduced in health financing at the provincial level. The PHSPTs are expected to continue as the provincial health sector purchasing agency/department once the program is completed. Typically, PHSPTs would be responsible for (i) identifying beneficiaries and mobilizing their participation; (ii) identifying, authorizing, and contracting with service providers for the beneficiaries under their jurisdiction Plan Nacer; (iii) controlling the technical quality of services, financial management, and procurement at provincial level; and (iv) conducting relations with the NHSPT to obtain project technical, financial, and administrative support. The PHSPTs would be staffed with a director and about five full time specialized staff members, recruited either from existing services or externally to perform the required functions.

56. *Implementation arrangements*: The MSN/NHSPT would have overall responsibility for ensuring the implementation of the individual components as planned. It would have direct full implementation responsibility for Components 1, 2, 3(i), and 4 referred to above.

57. Implementation of the Plan Nacer and its directly supported activities (Components 1, 3(ii) and 4) would be governed by:

(i) Umbrella Agreements between the MSN and participating MSPs, covering all permanent technical, financial, administrative, and fiduciary aspects of provincial participation in the program including, the provincial program goals, establishment of the agencies and their responsibilities, operational guidelines, and financial and auditing relationships between the MSN, MSP, and the Bank.

(ii) Annual Performance Agreements between the MSN and participating provinces that would include annual targets for the tracer system, enrollment targets, work programs, and resource requirements.

(iii) Performance agreements and contractual or quasi-contractual agreements, as appropriate, between MSPs and authorized provincial health care providers (public and private) covering the package of basic services to be provided and their pricing; quality standards and control measures; payment mechanisms; expected results; reporting and document support requirements; and modalities for supervision and inspection by the concurrent auditors and the project supervision and monitoring units within the NHSPT and the PHSPTs.

58. An Operations Manual has been prepared and submitted for Bank review and found satisfactory by the Bank. Building on APL-I experience, it covers all aspects of the program's implementation. Prototype Umbrella and Annual Performance Agreements are also included in the Manual submitted to the Bank.

59. *Implementation capacity:* The MSN is well staffed to oversee program implementation in terms of experience and technical qualifications developed during implementation of other Bank-financed projects and the preparation and implementation of APL-I. The MSN has been reevaluated through Financial Management and Procurement Assessments and has been found to have an adequate experience, staff, and systems in financial management and procurement to

meet Bank requirements (Annexes 7 and 8). The loan would finance some incremental specialized contractual staffing and small equipment and operating costs to allow the staff to perform additional functions associated with program implementation.

60. Provincial Ministries of Health have varying degrees of technical experience with maternal and child health issues, generally sufficient to form core technical staffs of their respective PHSPTs. They also have administrative staff that could undertake, with training and supervision, the administrative and PBS purchasing functions required by their participation in this program. As learned from APL-I implementation, however, they will need strong technical and administrative advice from the NHSPT for the implementation of Plan Nacer, particularly during the first two years (this would be provided under the program). The Umbrella Agreement would include, as an Annex, operations guidelines [reglamento operativo] containing standard details of all implementation contents and procedures contained in the Operations Manual that are of specific relevance for implementation at the provincial level. Through these guidelines, provincial staff, with the aid of the NHSPT and hands-on technical assistance, would become familiar with implementation procedures. The loan would provide financing for further in-service staff training and consultations on specifics. The MSN/UFI-S would also conduct briefings and mentoring of NHSPT staff on financial management and procurement procedures and continue to supervise provincial performance in these areas during implementation.

61. Most provinces eligible for APL-II have closely monitored the implementation of APL-I through COFESA, and many of them have visited some of the best-performing provinces of APL-I. They have thus become familiar with systems and procedures necessary for their own implementation of Plan Nacer.

62. *Flow of funds and reporting*: Loan proceeds would be disbursed against the following expenditure categories according to the APL-I operational methods: (i) Consultant Services and Auditing (US$35.9 million); (ii) Goods: Basic Medical Equipment, Vehicles, Communications Equipment, Office Equipment, and Informatics Equipment and Software (US$35.6 million); (iii) Training (US$5.6 million); (iv) Capitation Payments for Plan Nacer Program Services (US$208.5 million); and (v) Operating Costs (US$0.4 million). No financing for civil works is contemplated under APL-II. An amount of US$14.0 million would remain unallocated to cover contingencies.

63. The package of basic health service defined by the government is highly cost-effective for the current maternal and child mortality profile of the country's poor. The interventions included in the PBS include visits with health care professionals, medications, normal and complicated delivery services, and community follow-up, all packaged and made available over time. These interventions are listed in the Plan Nacer Nomenclador (PBS Health Services List), agreed between the government and the Bank and which includes about 80 health interventions. The nomenclador would be mandatory for all participating provinces. Following APL-I, the Bank would include the Capitation Payment of Plan Nacer Services as a separate disbursement category.

64. Through an in-depth cost study, the average per capita cost was estimated for providing the PBS to the eligible population under APL-I which would also be used for APL-II. The cost of the service package was developed through analysis of the actual costs of its component parts, accounting for actual market prices for medical goods and services, technology improvements and efficiency standards, and expected economies of scale. These costs were brought to a per capita average basis, taking into account the size of the beneficiary pool. These costs are considered reliable proxies for actual costs of delivering the PBS.

65. The estimated total average cost of the PBS is about US$10.0 (per capita/month). Local counterpart funds will finance 50 percent of that cost directly. Additionally, participating

provinces would receive a grant transfer (Capitation Payment for Plan Nacer Services) from the MSN to finance the remaining 50 percent. During the first three years of the program, the grant transfer would amount to the entire remaining 50 percent needed to provide the services, but it would decline thereafter to 0 percent by year six. This grant transfer, to be financed by the loan on an average per capita basis, is conceptually equivalent to a contribution to finance the cost of the premium for a traditional health insurance scheme. However, to avoid confusion, because Plan Nacer is a publicly financed program rather than a traditional contributory health insurance arrangement, it is called "capitation" rather than "premium." Disbursements from the national government to the provinces (to be financed by loan proceeds) would be made on a capitation basis for each eligible beneficiary enrolled in the Plan Nacer.

66. To set correct incentives for the provinces to enroll, monitor, and ensure that providers actually deliver the services, the cash transfer of the capitation payment would be conducted in two installments. The first installment, 60 percent, would be disbursed immediately after the province sends in the register of enrollees each month and certification of the register by the capitation subunit of the National Plan Nacer Program in the NHSPT (through cross-checking with existing, up-to-date enrollee databases from the provincial and national social security systems). The register would constitute a quasi-bill. The second installment, 40 percent, would be disbursed periodically (in principle every four months) after verification and certification by the same unit that the province actually met the production targets for 10 types of tracer interventions. Achieving the production target for one of the 10 tracers would entitle the participating province to receive 4 percent of the capitation payment for each enrolled participant in the period. Achieving all 10 would mean that the participating province would receive the entire 40 percent of the capitation payment. Accordingly, disbursements of loan proceeds for the capitation payment expenditure category would be made against the certified quasi-bill and the certified tracer reports submitted by participating provinces. These would be certified by the NHSPT with verification through external concurrent audit. In consideration of the implementation complexity of the system, a grace period of six months (beginning at loan effectiveness) was extended to the first nine provinces that joined under APL-I. The same grace period would be extended under APL-II for full implementation of the tracer system for disbursements. During this initial six-month period after loan effectiveness, disbursements to any provinces participating at that time would be based entirely on enrollment. Both the quasi-bill submitted by the province on the basis of enrollment and the provincial report on target achievement would be audited, within three months by an independent auditing firm ("Concurrent Audit") and an internal oversight unit of the National Plan Nacer Program in the NHSPT.

67. PHSPTs would be responsible for consolidating their provincial financial accounts and providing this information to the NHSPT (supported by the UFI-S). PHSPTs would also be responsible for ensuring that their enrollment lists do not include beneficiaries already covered by the national or provincial social health insurance schemes (Obras Sociales Nacionales [OSNs] and Obras Sociales Provinciales [OSPs]). They would do so by checking their enrollment lists against the beneficiary registries of the OSNs and OSPs. The NHSPT would also verify the lists provided by the PHSPTs using the same method. For each erroneous enrollment report, a penalty of 20 percent of the capitation price would be deducted from the province's total capitation payment. Thus, if a PHSPT erroneously includes a beneficiary in the enrollee bill, from the next cash transfer, the NHSPT will deduct 100 percent of the capitation payment for that beneficiary and, as a penalty, an additional 20 percent of the individual capitation payment.

Box 1. APL-I Certification Process to Be Replicated for APL-II: Roles of NHSPT, PHSPT, and External Concurrent Auditor

Billings for both tracers (trazadoras) and enrollees are subject to certification and verification by the National Health Services Purchasing Team (NHSPT) and by the External Concurrent Auditor.

Each month, the Provincial Health Services Purchasing Team (PHSPT) would submit to the NHSPT (on behalf of the provincial Ministry of Health), a bill for all eligible enrolles. To submit the bill, the provinces analyze the eligibility of the population enrolled during the past month against the eligibility criteria and cross-check enrolled mothers and children against information from the social insurance systems databases provided and updated periodically (monthly) both by the National Superintendency of Social Insurance and by the respective provincial governments. The same process is used to confirm eligibility of individuals when reporting tracer achievements.

For each tracer, the NHSPT and PHSPT negotiate quarterly targets. The negotiated targets are always expressed as a function of the total eligible population. The provinces collect the clinical information associated with the performance on tracers. Data collected cover relevant information for each population group in five areas that correspond to each tracer: pregnancies, deliveries, well-child consultations, deaths of children and eligible mothers, and indigenous peoples.

The NHSPT provides each province with detailed instructions for reporting tracer data and achievements. Each province follows these instructions when to collect the data and converts the information collected into data files while verifying the existence and type of information contained in each required field. At the same time, the information in each field is analyzed for consistency with pre-established minimum and maximum requirements. Once the files are validated, a file of final data is generated.
Based on the number of eligible registrations, the province calculates, using the tracer system, the four monthly performance score. The system generates a sworn statement from each PHSPT that includes the negotiated goals for each period (numerator and percentage) and the score achieved by the province for each tracer. Registers of eligible beneficiaries supporting the results are included for the purpose of auditing clinical information.

Once the sworn statement is received, together with supporting documentation for each tracer as well as the monthly bill for enrollees, the NHSPT evaluates the eligibility of the registers (checking eligibility and cross-checking again with social security databases) and settles the payments associated with monthly list of enrollees and with the quarterly with achievement of the tracers against the results of the eligibility evaluation. The NHSPT produces a list of registered beneficiaries that supports the settlement of the tracer transfers in the period.

The external concurrent auditor receives the sworn statements from the provinces with the supporting documentation as well as the settlement (final net transfer) transferred by NHSPT with the list of registered beneficiaries. The concurrent auditor then carries out a validation of the system for the soundness of the field data, an analysis of the eligibility of the reported population repeating, independently, cross-checking the enrollee bills against the social security databases. Additionally, the auditor takes a sample of the registrations (enrollment and tracers) to verify in the field the existence of enrollees and their voluntary enrollment as well as the existence of clinical histories and of other supporting information for the tracers.

The NHSPT internal auditor receives the same information as the external auditor and conducts its own verification in the same manner.

68. The partial financing of the PBS by the national government (up to 50 percent initially but decreasing after the third year of implementation) and the flow-of-funds arrangements would ensure that the MSN sets the right incentive framework for the participating provinces and does not overfund the Plan Nacer. Proxies for "output" would be the 10 tracer interventions, which are statistically verifiable occurrences reflected in the provincial health service records. Therefore, the MSN transfer would be directly related to specific outputs received by intended beneficiaries.

69. Annually, the government and the Bank would hold discussions to review the experience and lessons of the previous year's capitation system operations in general and the capitation amount, the list of tracers, and the services covered. Any appropriate adjustments would also be decided at that time.

70. The government would open a Special Account in a financial institution acceptable to the Bank to receive an initial deposit based on projected needs during the first six months. Subsequent disbursements of loan proceeds would be based on the presentation of six-month forecasts, updated quarterly with the Financial Management Reports (FMRs). Loan proceeds would be disbursed to the Special Account against withdrawal requests supported by quarterly Financial Management Reports, comprising financial, technical, and procurement advance reports. Funds from the Special Account would flow to a project peso-operating account managed by the NHSPT through the UFI-S, as expenditures are incurred for: (i) direct payment by the NHSPT through the UFI-S for inputs of all components and reimbursement of the provincial Treasuries for inputs purchased and paid for by them other than the Plan Nacer capitation payment and (ii) transfers from the MSN to the provinces as capitation payments for Plan Nacer services, supported by certified lists of beneficiary subscribers as described above and by certified tracer bills. The NHSPT (with the support of the UFI-S) would be responsible for consolidating and maintaining project accounts (based on reports from provinces) and for having these accounts audited annually in accordance with terms of reference acceptable to the Bank (see details in Annex 7). Procedures utilized by the UFI-S that would support the NHSPT were found satisfactory by recent financial management and capacity assessments.

71. Provincial HSPTs would open project bank accounts, separate from the provincial consolidated fund, through which they would make expenditures for the Plan Nacer and receive Plan Nacer transfers from the NHSPT through the UFI-S.

3. Monitoring and Evaluation of Outcomes/Results

72. The project would track result indicators for level of coverage (proportion of enrolled eligible population), achievement of output, and intermediary outcomes included in the tracer indicators and would monitor the volume and the quality of services delivered. Details of monitoring and evaluation indicators are presented in Annex 3. Data on baseline tracer coverage would be generated by the baseline study being implemented nationwide under APL-I. It includes both, data gathering from provider-based information systems as well as household panel surveys that include biological impact markers (e.g., hemoglobin, height/weight measurement). The NHSPT would consolidate this information to monitor project coverage. Data on provinces and provider performance would be collected from periodic reports made by service providers from their service records as the basis for their payments. These would be consolidated by the NHSPT and evaluated against the tracer goals agreed in Umbrella Agreements and in Annual Performance Agreements. The NHSPT and the PHSPT would conduct periodic independent audits of the data, including surveys of beneficiary participation and satisfaction.

73. The vast majority of the hospitals and clinics that would be authorized as service providers under Plan Nacer have functioning medical record systems, adequate for generating basic data on beneficiary numbers and services rendered. MSPs currently compile such data for sector management purposes. However, additional assistance would be provided to these provinces and service providers to upgrade their recording and reporting systems to the level required to implement Plan Nacer, particularly to certify the achievement of tracers. Similarly, the MSN currently develops statistics on health care trends; however, the loan would finance upgrades and modifications of existing systems to accommodate program needs.

74. The loan would finance impact evaluations in participating provinces, as currently happens under APL-I. Such evaluations would include the definition of case and control groups. Baseline data have been collected under APL-I, an evaluation would be conducted at mid-term, and a full evaluation would be done in the last year of implementation. Details of the APL-I impact evaluation of are discussed in Box 2.

75. APL-II project implementation will also include a system to monitor the income, gender, ethnicity, and geographic characteristics of the eligible but unenrolled population. This information will allow the Bank team and the government to take corrective policy and managerial actions in case of any enrollment bias.

Box 2. APL-I and APL-II Impact Evaluation

Objectives: Project impact evaluations measure effects in three areas—changes in the behavior of providers delivering primary health care services to the eligible population before the changes in the payment method introduced by Plan Nacer; changes in the coverage and quality of primary health care services especially for pregnant women and children up to six years old; and changes in the health outcomes of the target population.

Methodology: The identification of program impact requires an understanding of the beneficiary population's situation without the program. The estimation of the implemented changes is measured using a longitudinal sample with data collected with three instruments: questionnaires for providers; questionnaires for mothers in households in the areas served by the selected providers; and questionnaires for mothers exiting providers. The impact evaluation takes place in three program periods: before the initiation of the program to measure the baseline or starting point; at the end of the first two years of program implementation to measure intermediate results; and six months after the end of the program to measure final results.

Sample design and field work: The sample plan would be constituted for towns in the participating provinces and for groups of towns foreseen as the control group. From a methodological perspective, the strategy pursued would monitor the cases of mothers and children over time with the principal objective of generating a base of longitudinal data. A control group is selected to evaluate what would have happened to the beneficiary group had it not received coverage under Plan Nacer. To select a control group, towns (that would enter the program at different times) are chosen in accordance with the Propensity Matching Score that enables a single indicator, a propensity score, to be derived from diverse similar indicators such as population, number of health centers, and infant mortality rates. The field work is divided in two parts—surveys of providers and household surveys.

To complement the impact evaluation of the APL-II program, an information system would be set up for continuous evaluation of the characteristics of the unregistered eligible population. This is essential to identify any reason for the nonregistration of certain subpopulations such as income, geographic area, ethnicity, or other factors, so that appropriate action could be taken. It is also essential for program management to allow for timely policy adjustments.

4. Sustainability

76. The government of Argentina and the provincial governments are fully committed to the program as demonstrated by the effective implementation of APL-I in its first two years of operations by the financial commitment of the provinces, which already finance 50 percent of the cost of the PBS. As mentioned, the provinces will pick up an increasing share of program financing beginning in the third year when Bank financing for the capitation category will begin to taper off.

77. As discussed in the economic analysis section below, the evaluation of fiscal impact at provincial level is moderate and deemed to be sustainable without Bank financing. It is thus fully compatible with a "prudent fiscal approach" envisioned in APL-I PAD, as shown in Annex 9.

78. Plan Nacer enjoys an unprecedented level of ownership and political support from the national and provincial governments (as stated unanimously and repeatedly by COFESA). This commitment is also demonstrated by the strong demand from the new provinces to enter the program and by President Kirchner's launching of the program at provincial level

5. Critical Risks and Possible Controversial Aspects

79. The proposed program shares the macroeconomic risks that attend the portfolio of Argentina in general and the inherent political risks associated with fiscal and institutional reform of national-provincial relationships. Mitigation measures are being taken to contain these risks. Implementation risks have been recognized from the experience of the APL-I and have been taken into account in the design of this second phase. These relate principally to the weak institutional capacity of provincial health ministries compared with the demanding technical requirements for the implementation of the Plan Nacer. APL-I has successfully mitigated this risk through technical assistance in the northern provinces. Consequently, to mitigate these specific risks, the new operation would also continue to focus on capacity building, enhancing good governance, and strong technical and administrative advice and support from the NHSPT and other technical experts. The program provides financing for significant technical assistance in all of its components to help provinces reinforce units responsible for the technical, institutional, and implementation aspects of the Plan Nacer. As a complement, measures have been designed to ensure adequate program governance. These include the continuous use of an independent external concurrent auditor for verification of enrollment lists, the introduction of the use of tracer results indicators to regulate flows of funds, and combined performance and financial auditing of program activities to ensure accountability. These provisions would, collectively, maintain moderate program risk during the first phase of implementation. Additionally, APL-II contemplates a moderate increase in the size of the NHSPT to handle the expanded scale under APL-II, particularly in financial management, oversight, and technical advice.

80. Table 2 summarizes the main risks, mitigation measures, and final risk rating for APL-II.

Table 2. Summary of Project Risks and Mitigation Measures

Risk	Risk mitigation measures	Risk rating with mitigation
Challenges to sustained economic growth and insufficient creation of formal sector employment	Prudent macroeconomic management and continuous initiatives by government to promote formal employment.	Modest/Substantial
Fiscal position of participating provinces might worsen (due to factors external to the program) and put pressure on continued program financing	Insurance program to reach broad sectors of the poor on strictly rights-basis, thus, creating a strong constituency that will incentivate the political community and provincial Governments to prioritize the program in a situation of fiscal restraint	Modest/Substantial
Failure to reach intended beneficiaries	Program-sponsored beneficiary identification and community-based information and outreach campaigns	Modest/Substantial
Unforeseen causes of mortality and morbidity	Program-sponsored environmental health risk and epidemiological studies leading to revision of the Basic Service Package of Interventions	Low
Slippage in overall program governance (including transparency) and effective	Concurrent audits, proven effective under the APL-I, to extended to the APL-II	Modest

administration		
Risk of program implementation in a pre-election period	Program to include clear eligibility criteria for beneficiaries and verification systems at the provincial and national levels.	Modest
Government health strategy may change	Consensus built for this program at the provincial level under the first and second phase. Successful implementation should ensure ongoing support and momentum for this program.	Low
Achievement component results		
Poor administrative, financial and contract management capacity in provinces	Program-sponsored institution building accompanied by modest annual reevaluation of results expectations	Modest
Preserving transparency and fidelity in establishing and maintaining enrollment lists and tracer system	Program-sponsored system development launched and piloted prior to effectiveness; concurrent auditing	Modest
Financial management failure to secure fiduciary controls	Basis of experience from APL-I for mitigating implementation problems. External audits to continue to provide an independent verification of financial management controls	Modest
Procurement risks	Standard Bank procurement rules applicable. No procurement problems associated with APL-I and the same process to be used for APL-II	Modest
Overall Risk		**Modest**

Note: "Modest" indicates a probability of between 25 and 50 percent that outcome/result would not be achieved.

6. Loan/Credit Conditions and Covenants

81. No conditions for effectiveness of APL-II would be included in the loan package. It would be covenanted that all Umbrella Agreements between the participating provinces and the national government contain a clause specifying the conditions under which an eligible province becomes a participating province. The agreements would also include the conditions under which a province could exit Plan Nacer and APL-II and cease to receive government transfers. Only participating provinces would receive loan proceeds. Among other criteria, an eligible province would become a participating province when it has (i) signed and legally approved the Umbrella Agreement and the Annual Performance Agreement, (ii) implemented and fully staffed the PHSPT, and (iii) implemented the Plan Nacer enrollment system. Additionally, it will be covenanted that the provinces of Chubut, La Pampa, Mendoza, Neuquén, Río Negro, San Juan, and Tierra del Fuego will require an Indigenous Peoples Implementation Plan to become participating provinces, in accordance with the Indigenous Peoples Planning Framework. The contracting of the concurrent auditor would be a condition of disbursement against capitation payments as well as a current Bank no objection for the prices to be set for the interventions in the *Nomenclador Unico* in each of the Participating Provinces.

82. The contracting of the Operational Concurrent Auditor will follow terms of reference similar to APL-I and acceptable to the Bank. The task will include: (i) an opinion on the veracity of the "billings" sent by participating provinces to MSN/NHSPT to justify the basic payment (60 percent) of the capitation; (ii) an opinion on the reliability of billings based on service production tracers (up to 40 percent of the capitation); (iii) an opinion on the management of capitation payment transfers to provinces; and (iv) conclusions on and recommendations for modifying the processes used to maintain and update enrollments and maintain valid information on coverage. Opinions, conclusions, and recommendations would be given every three months. Minimum qualifications of the team presented by firm to be selected would include experience supervising and auditing insurance schemes, public administration procedures, and financial institutions.

83. It would also be covenanted that: (i) no later than January 31, 2007, the MSN shall create and thereafter maintain throughout project implementation, specific budget line entries in its annual budget to track all expenditures and capitation payment transfers incurred during project implementation; (ii) the annual audited financial statements will be furnished to the Bank no later than six months after the end of each year; and (iii) quarterly Interim Unaudited Financial Reports (IUFRs) will be submitted to the Bank no later than 45 days after the end of each calendar quarter.

D. APPRAISAL SUMMARY

1. Economic and Financial Analyses

84. *Economic analysis:* The Plan Nacer's benefits package (PBS) was designed by the MSN, in coordination with COFESA, and the list of services includes about 80 cost-effective interventions. These interventions include those that target the main causes of infant mortality (diarrhea and acute respiratory diseases as well as malnutrition and inadequate prenatal care) and maternal mortality (hemorrhage and infections linked to unsafe deliveries and complications from unsafe miscarriage) among the poor in Argentina. The benefits package also includes cost-effective interventions for primary health care promotion and prevention, as well as reproductive health care after deliveries or miscarriages. An economic evaluation, made following accepted international standards for estimating the current value of avoided maternal and child deaths, has shown a substantial net present value (US$ 714 million) and rate of return (about 17 percent). Moreover, interventions are considered cost-effective, considering the significant importance of neonatal mortality as a determinant of infant mortality in Argentina: the estimated cost to avoid a year of life lost is about US$400, which is consistent with other countries in the region with similar mortality profiles and income profiles.

85. *Financial analysis:* The estimated average cost of the PBS would be about US$10 in the APL-II provinces (per capita per month). Of this, the MSN (through APL-II) would finance a maximum of 50 percent (US$5) of the per capita monthly cost during the first three years of effectiveness and then on a declining basis down to zero in year six. The Bank loan would finance 100 percent up to US$128 million (projected amount of capitation payments for the first three years of implementation), then 70 percent up to US$177 million (projected accumulated amount up to the fourth year) and 40 percent thereafter. With appropriate community outreach, it is expected that about 80 percent of the target population would be served by the fifth year of implementation. Based on these expectations (compatible with APL-I experience so far), the fiscal impact of the payments for the national health budget would amount to 8.7 percent of the MSN budget in the first year of implementation, increasing to 12.5 percent in the second year, and falling to zero impact in the sixth year. The contributions of the APL-II provinces to the cost of the PBS in the fourth year of implementation would amount to 1 percent of the average

provincial health budget and rise to about 3.2 percent after the fifth year. However, improved accounting and tracking of Obras Sociales beneficiaries would lead to improved cost recovery from the insurance industry, and services delivered are expected to increase in efficiency and effectiveness. Together, these gains should hold the increase to less than 2.5 percent of the public health sector budget at even the province with the largest impact. These increases are considered sustainable in the long term. Incremental costs of program administration are likely to be negligible.

2. Technical Features

86. The program includes two key technical features: first, a clearly defined package of basic health services and sustainable health financing arrangements; and second, output and intermediary outcome performance that would set the correct incentive framework for provincial providers. The elements of the basic benefits package have been assessed from a medical and population health perspective and correspond to best international practice. These interventions are listed in the nomenclador included in the Operations Manual. The health financing design reflects the latest lessons in the region on contracting and provider payment mechanisms. These mechanisms are at the core of the expected changes in the provincial and provider incentive frameworks for efficient provision of services to the uninsured and are expected to pave the way for the implementation of comprehensive provincial health insurance in the future.

3. Fiduciary Arrangements

87. As required by OP/BP 10.02 a Financial Management (FM) assessment of the arrangements for the second phase of the proposed APL was performed in line with the Financial Management Practices in World Bank–Financed Investment Operations, issued by the Financial Management Sector Board on November 3, 2005. The objectives of the evaluation were: (i) to determine whether the financial management arrangements already assessed as satisfactory for APL-I still function satisfactorily; and (ii) to identify potential room for improvement based on Financial Management implementation experience with the APL-I.

88. Like APL-I, APL-II is to be implemented by the MSN, through the Plan Nacer National Health Services Purchasing Team (NHSPT-Project Management). Operations will be executed by the NHSPT through the administrative processes described in the project Operations Manual, including those applied in the International Financing Unit (UFI-S) of the National Ministry of Health and covered in the UFI-S Operations Manual. The accounting and financial reporting, budgeting, and treasury operations of the APL-II follow the procedures applied to APL-I and other Bank operations implemented by the MSN with the support of the UFI-S, as outlined in its Bank-approved Operations Manual. These processes and systems were assessed and found acceptable for the APL-I.

89. For the assessment of the proposed APL-II, a Financial Management review was carried out on the ongoing APL-I arrangements to obtain reasonable assurance that the control framework is still in place and working as designed for APL-I. As part of the process, Financial Management reviewed the concurrent operational auditor's reports, the internal oversight over the provinces executed by the specialized team of the NHSPT, *Area de Supervision y Monitoreo (ASM),* outcomes of the annual financial audit issued by the Argentina Supreme Audit Institution (AGN) as well as visits to the UFI-S and some of the participating provinces where standard FM supervision procedures were undertaken. Details on the internal control framework are provided in Annex 7.

90. The assessment conclusion is that acceptable Financial Management arrangements of the APL-I should remain the same for the proposed APL-II. The project control framework is adequate and has been functioning effectively through the two years of implementation. For APL-I, the annual financial audit and concurrent operational audit were satisfactory. The Financial Management risk for the proposed APL-II is modest. Details on the audits and risk analysis are provided on Annex 7.

91. With respect to procurement, an in-depth assessment of the Borrower's capacity was carried out by the team and a detailed action plan was prepared to address all risks identified, as discussed in Annex 8. The overall procurement risk has been rated as Average. The key features of the procurement risk mitigation strategy for this project include: (i) Loan Agreement includes Special Procurement Conditions aimed at increasing transparency, competition, and civil society monitoring consistent with the Fiduciary Action Plan (FAP) agreed upon by the Government of Argentina and the Bank (e.g. publication on the web of procurement documents and feeding the Bank publicly accessible Procurement Plans Execution System, known as SEPA[14]), and at addressing the aspects of domestic legislations that are not consistent with Bank procurement policy; (ii) prior review thresholds consistent with average risk projects, and (iii) joint FM-Procurement supervision missions will be conducted in order to produce Integrated Fiduciary Performance Assessments (IFPAs) in the framework of the FAP.

4. Social Considerations

92. Argentina's population is characterized by ethnic and cultural diversity. In 2001, indigenous people represented 3 percent of the total population of the country, mostly belonging to the Kolla, Mapuche, Guarani, Wichi-Mataco, Toba, Chiriguano, and Diaguita peoples. While there is no specific information about the coverage of health services for indigenous peoples, they are generally uninsured and often without access to basic health care.

93. The proposed project triggers the World Bank's Policy on Indigenous Peoples (OP 4.10) because several communities of indigenous peoples are present in several of the provinces that will participate in APL-II. After an initial screening carried out in coordination with the Bank, the government prepared an Indigenous Peoples Planning Framework (IPPF) and submitted it for Bank review and approval (see List of Project Documents and a summary in Annex 10 of this PAD). This IPPF has been submitted to the Bank Infoshop and has been published by the Borrower in compliance with OP 4.10. Provincial screening undergone as part of the preparation of the IPPF determined that the provinces of Chubut, La Pampa, Mendoza, Neuquén, Río Negro, San Juan, and Tierra del Fuego will have to carry out Indigenous Peoples Plan (IPP) to become participating provinces, in accordance with the IPPF. As part of the Annual Performance Agreements, all IPPs will be subject to prior Bank no-objection. Indigenous communities in other provinces could be included in the project if future screening demonstrates that they meet the criteria for identification of indigenous communities established in OP 4.10.

94. The government is committed to assisting indigenous peoples and encouraging their participation as project beneficiaries through a number of specific actions aiming at including and reaching out to this sector of the population. APL-II will build on the experience and preliminary success of the first phase of Plan Nacer in the nine APL-I provinces. The IPPs detailing the individual strategies / activities for addressing the needs of the indigenous peoples will be carried out each year in any relevant province, as indicated by the IPPF, and will be included as a specific part of the annual performance agreements between the National Ministry of Health and the APL-II provinces, formalizing agreements to implement the Plan Nacer especially adapted for their

[14] Sistema de Ejecución de Planes de Adquisiciones.

indigenous communities. In fact, one of the tracers determining financial transfers to the provinces is directly related to the adaptation of Plan Nacer services to the needs of indigenous peoples in areas of high prevalence. Annual performance agreements continue to focus attention on the specific needs of the indigenous peoples by:

(i) Considering the results of studies underway financed by APL-I for improving health services delivery for these peoples.

(ii) Considering lessons learned from earlier World Bank projects such as PROMIN, VIGIA, and APL-I to effectively target the needs of indigenous peoples.

(iii) Financing training of health workers on the special needs of the indigenous populations so they can deliver Plan Nacer services in areas where many of these people live.

95. The communication and community outreach component of the project at the national and provincial levels would include the development of a strategy especially adapted to indigenous peoples. To ensure effectiveness, the communications strategy will include specific consideration for cultural sensitivity to align public campaign messages with locally accepted norms for indigenous communities. Additionally, communications material would be made available in the main indigenous languages such as Aymara, Quechua, Guarani, and others as necessary.

5. Environmental Considerations

96. The APL-II has been classified as a "C" category for environmental screening purposes. The second phase would benefit from the results of a Strategic Environmental Risk Assessment (SEA) financed under APL-I that advanced the MSN understanding of environmental risks, particularly for mothers and children. The SEA will inform government policies and programs in health, thus continuing to benefit this second phase of the program.

6. Safeguard Policies

Safeguard Policies Triggered by the Project	Yes	No
Environmental Assessment (OP/BP 4.01)	[ ]	[X]
Natural Habitats (OP/BP 4.04)	[ ]	[X]
Pest Management (OP 4.09)	[ ]	[X]
Cultural Property (OPN 11.03, being revised as OP 4.11)	[ ]	[X]
Involuntary Resettlement (OP/BP 4.12)	[ ]	[X]
Indigenous Peoples (OP/BP 4.10)	[X]	[ ]
Forests (OP/BP 4.36)	[ ]	[X]
Safety of Dams (OP/BP 4.37)	[ ]	[X]
Projects in Disputed Areas (OP/BP7.60)*	[ ]	[X]
Projects on International Waterways (OP/BP 7.50)	[ ]	[X]

97. In order to address social issues in an appropriate form, the APL-II is using the results of a broad social assessment carried out at the national level, as well as those of special surveys on the health conditions of indigenous peoples in participating provinces. In compliance with OP 4.10, it has also carried out a preliminary screening of provinces with indigenous communities that meet the criteria of identification established by OP 4.10. It has also prepared an IPPF, which was presented with the Indigenous Participation Council of INAI, and received approval from the

* By supporting the proposed project, the Bank does not intend to prejudice the final determination of the parties' claims on the disputed areas

Bank. Finally, in the relevant provinces, it will carry out the preparation and implementation of the corresponding IPPs.

7. Policy Exceptions and Readiness

98. The government and provinces have shown strong commitment to the program, as indicated by the rapid and successful implementation of APL-I during its first two years of operations.

99. The APL-II is ready to be implemented. The specification and costing of the basic package of services has been completed; methods for enrollment and updating beneficiary lists have been agreed; administrative, financing, monitoring, and evaluation systems have been designed. The Operations Manual has been completed and letters of expression of interest in joining the program and confirming agreement in principle with the content of the draft Umbrella Agreements satisfactory to the Bank have been received from 14 of the 15 eligible provinces. Furthermore, 5 of them have already created the PHSPT at their own risk to accelerate project implementation.

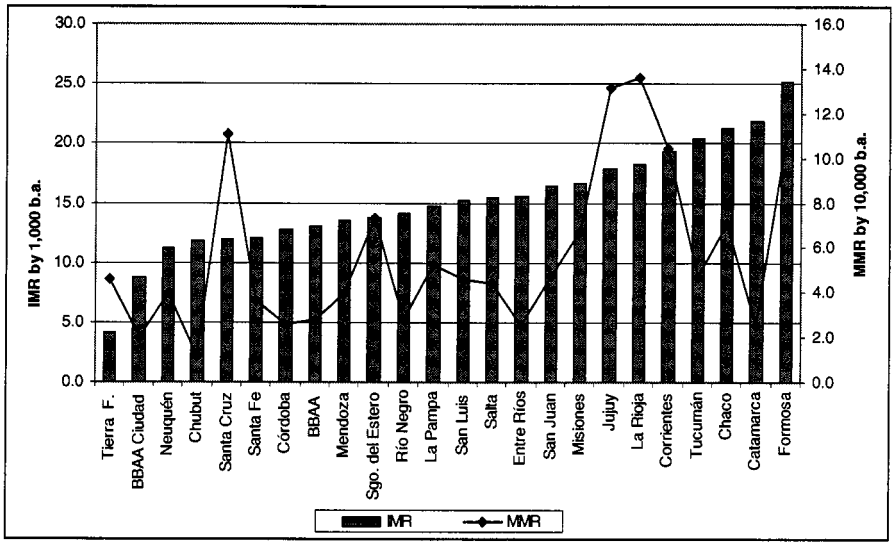
Annex 1: Country, Sector, and Program Background

The Health Sector

1. Even before the economic and social crisis of 2001–02, Argentina's health system did not deliver what Argentines needed to stay in good health and to be protected from the overwhelming costs of ill health. Throughout the 1990s, health outcomes in Argentina did not match its historically high spending and significant installed capacity in the health care sector. According to the World Health Organization (WHO), only 17 countries in the world reported higher health expenditures relative to GDP than Argentina in 2000. The number of physicians and hospital beds per capita were comparable to those in developed countries. However, wide differences in health status existed between provinces, and the poorest regions in the country had much higher mortality and incidence of maternal and child pathologies and infectious diseases than better-off areas.

2. Maternal and child health was particularly poor compared with other similar middle-income countries in the Latin America and Caribbean (LAC) Region. Even though infant mortality rates have fallen by 50 percent over the last 20 years, they are still high relative to countries such as Chile, Costa Rica, or Uruguay with similar levels of economic development and lower expenditures on health during the 1990s. Disparities between provinces are also high as seen in Figure A1.1. Alarmingly, most infant and maternal deaths in Argentina could be avoided through timely prevention, diagnosis, and treatment. Of the 7,650 neonatal deaths in 2000 (two thirds of all infant deaths in Argentina that year), 60 percent were considered avoidable with adequate controls during pregnancy. Of the almost 4,000 post-neonatal deaths the same year, 57 percent could have been avoided through prevention and timely treatment. Abortions explain about 29 percent of the approximately 300 maternal deaths that took place in 2001. Poor quality of health facility-based deliveries and the incidence of teenage pregnancy, particularly in the northern provinces, also contribute to high mortality rates. Furthermore, teenage pregnancies are strongly associated with low weight at birth and higher infant mortality.

Figure A1.1. Argentina: Infant and Maternal Mortality Rates, by Province, 2004



Source: National Ministry of Health "Estadísticas Vitales, Información Basica 2004," December 2005.
IMR Infant mortality rate; MMR maternal mortality rate.
Note: The MMR for Catamarca, La Pampa and Santa Cruz are based on 2003 statistics.

3. The unsatisfactory health indicators are evidence that too many Argentines (with and without insurance coverage) do not receive the type of health services they need. Two out of four Argentines—mostly poor—have no health insurance and rely almost exclusively on the services provided by provincial public health facilities. However, installed public sector capacity (e.g. hospital beds and doctors) is unequally distributed in the territory with a relatively high concentration in richer jurisdictions and those in which the private supply is the largest.

4. Health care, especially for the poor, is costly for the Argentine population, and among the insured, co-payments are high. Although Argentina has a mandatory health insurance package for the social security system (Programa Medico Obligatorio [PMO]), in practice, significant differences in the service package (and co-payments) between different insurers, which result in high out-of-pocket expenses. On average, Argentine households spend 7 percent of their income on health. This proportion is higher for lower-income families and constitutes a serious barrier to access, even for many people with insurance coverage.

5. *Institutional fragmentation.* Historically, the health sector in Argentina has been highly fragmented, limiting the system's capacity to reverse its weak performance. There is little coordination between systems supported through social security (slightly less than 55 percent of the population), the private sector (about 5 percent), and the public sector (about 40 percent of the population). The social health insurance system (see below) is further fragmented into hundreds of insurers, not all of them regulated by the Health Superintendence—which, by law, has no regulatory power over private health insurers. This fragmentation generates inequities, inefficiencies, and governance problems and makes it extremely difficult to ensure equity in financing. The dispersion of the population among too many small insurers reduces the size of risk pools, increases administrative costs, and generates persistent deficits requiring frequent official bailouts.

6. System fragmentation also generates poor cost recovery by providers. Depending on the proportion of insured population in each province, between 20 percent and 40 percent of patients treated at public facilities are covered by social or private health insurance, but only a very small fraction of the cost of providing such services is recovered from the respective health insurance organization. For example, in 2002 public hospitals recovered only AR$2 million per month, only about 3 to 4 percent of potential if systems, procedures, and norms worked efficiently. Key factors contributing to these results are (i) difficulties identifying beneficiaries; (ii) a cumbersome cost recovery process, (iii) inconsistencies in the nationally determined reimbursement rates; (iv) lack of incentives for public providers to pursue recovery, encouraged by fixed supply-side financing rather than production- and performance-based financing; and (iv) low management capacity in public hospitals. The government has increased its efforts to expedite cost recovery by public hospitals from social health insurance institutions since 2003.

7. Argentina's federal structure, which gives most health sector responsibilities (operational and on policy) to provinces, poses a unique and complex challenge for overcoming fragmentation. Because the national government has limited legal and administrative influence over provincial health sector policy, common national health targets, quality standards, or regulations for the establishment of new facilities have not been defined or adhered to by all provinces. This has severely hampered the effectiveness of national programs and projects. Provincial health authorities have also shown weak capacity in coordinating their internal health care systems. Only since 2003 has there been a major effort to revitalize the Federal Health Council (COFESA) to

facilitate policy dialog and coordination both among provinces and between the national and the provincial authorities.

8. *Social health insurance:* Argentina's social health insurance sector continues to fall short of securing health services and sufficient financial protection for a large and growing number of citizens, mostly poor. Its organizational model, based on formal sector employment, leaves too many working families out of the system, —an estimated 40 percent of the population. Additionally, the sector lacks effective risk-redistribution mechanisms and maintains regressive (and inefficient) cross-subsidies that further erode the provincial public health systems' already limited budgets. Under its current institutional arrangements and incentives, the social health insurance sector is also highly inefficient and fragmented into various subsystems and hundreds of insuring agents. Often poorly identified beneficiaries are dispersed in hundreds of small risk pools, with high levels of intermediation (and administrative costs) and persistent financial imbalances. Chronic deficits, requiring expensive periodic bailouts, are one result. Structural reforms should be consolidated to improve the efficiency of mechanisms such as the Solidarity Redistribution Fund and the Administración de Programas Especiales (APE) in charge of reimbursing insurers for high-complexity pathologies in the national health insurance system.

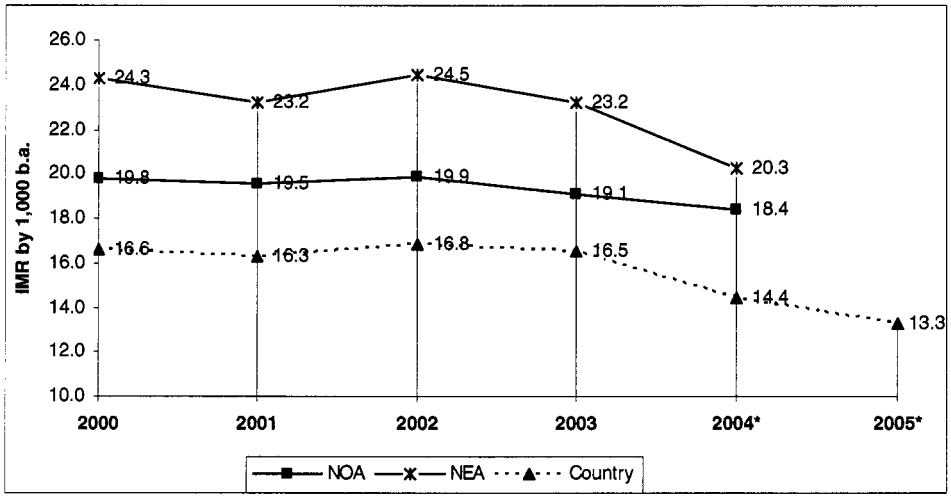
Argentina's Health Sector Reform Priorities and Program

9. Despite Argentina's recovery from economic crisis of 2001–02, the effects of the crisis and the systemic problems it revealed in the health sector continue to affect the poorest segments of the population. Although the country has shown steady progress in recent years through the implementation of Health Sector Reform Program (HSRP), Argentina needs to continue tackling structural problems in the health care sector. For example, formal insurance coverage has not rebounded with macroeconomic improvement, leaving a large proportion of the population, but especially the poor, without formal health insurance and limited or no access to health services. Further, the need to improve the incentive framework to increasing efficiency is still a priority for the sector.

10. The Plan Nacer, one of the cornerstones of the government HSRP, was developed by the MSN in close consultation with all provinces through COFESA. It recognizes that the institutional, financial, and economic crisis has fundamentally changed the realities facing the country and, with that, the priorities in the health system. The complex political and institutional history of reforms in the social health insurance system has greatly increased provincial health systems' responsibilities for service delivery. This, in turn, has accentuated the need to improve the efficiency of those provincial health systems now trying to deliver services to the uninsured.

11. By offering a defined package of guaranteed basic health services (PBS) supported with payment systems that reward performance, the Plan Nacer aims to alter fundamentally the delivery mechanism of health services in Argentina. The Plan Nacer is already helping, through the APL-I, the nine poorest provinces of Argentina (North West and North East regions) to reorient their approach from financing inputs to rewarding performance and making public subsidies in the health sector more progressive and effective. The government is eager to bring this change to the remaining 15 provinces with APL-II. Estimates suggest that upon full implementation, the Plan Nacer could help reduce infant mortality by at least 10 percent in the 15 APL-II provinces, for an overall (APL-I and APL-II) national reduction of infant mortality of 8 percent in the next five years (see recent trends in IMR in Figure A1.2).

Figure A1.2. Argentina: Trends in Infant Mortality Rate (IMR)
(Average non-weighted IMR)



Source: Nacional Ministry of Health.

12. *Policy priorities:* The policy priorities in Argentina's health sector include the need to: (i) increase access to basic health care for the uninsured, especially mothers and children, by defining and delivering a package of basic health services; (ii) provide improved, effective national-provincial health policy coordination; (iii) shift public subsidies to the poor from the nonpoor through effective program targeting and regulation; (iv) change the incentive framework to improve effectiveness and efficiency in the financing and management of health service delivery at the provincial level; and (v) ensure an effective regulatory framework by the government. These policy priorities, together with the government's program of reforms to address those priorities, are described in detail below. The government has already implemented almost all key policy actions[1] that change the regulatory environment and facilitate the implementation of the Plan Nacer under the PMCHSAL. The implementation of APL-I has confirmed the government's approach to introducing the Plan Nacer as a vehicle not only to ensure urgent improvements in basic health services for the poor but also to introduce much needed structural changes in the provincial health systems. The proposed APL-II would allow the government to extend countrywide the changes introduced under the APL-I.

13. *Delivering a basic health services package:* To guarantee access to a package of basic health services by the uninsured mothers and children, national and provincial governments are transforming the existing service delivery arrangements to serve the health needs of this population. APL-I is beginning to show these important changes. The proposed APL-II would allow the government to introduce these changes countrywide.

14. With about three quarters of the poor depending on public health services, delivery of basic care is largely a provincial responsibility. Meeting that challenge has required agreement among provinces and the national government on the definition of the package of services to be guaranteed, the establishment of necessary financing mechanisms, and setting of incentives to provincial health service purchasing agencies and providers to act accordingly. The Maternal-

[1] By November 2005, 31 out of 32 policy actions had been fully implemented.

Child Health Insurance Program (MCHIP) is the central pillar of the government's Health Sector Reform Program. It is the main focus of the current proposed project (Annex 4). This phase of Plan Nacer implementation, as in the case of APL-I, would be financed jointly by the provincial and by the national governments. National government contributions would be made through conditional grants to provinces with increasing counterpart financing from the participating provinces. Service delivery would be the responsibility of provincial health systems, including authorized public and private providers. The Plan Nacer would allow provinces to provide uninsured mothers and infants with a package (PBS) of essential prevention, diagnostic, and treatment health services, purchased from authorized public and private health services providers. Enrollment in the Plan Nacer would be available, on a voluntary basis, to all uninsured children up to their sixth birthday, to all uninsured pregnant women, and to all uninsured mothers for up to 45 days after the date of delivery or miscarriage.[2]

15. The new provinces in APL-II would play a central role in the implementation of the Plan Nacer, with the MSN playing a financing and technical advisory role. To promote efficiency, financial transfers from the national to the provincial governments under the Plan Nacer would be linked with improvements in outreach and utilization of services by the uninsured. Financing from the MSN would be based on enrollments in the provincial system on a "capitation" basis. The cash flow would be adjusted according to the achievement of agreed levels of service production for a few (10) key interventions (*trazadoras* [tracers]) selected from the PBS and closely related to the main causes of avoidable infant mortality. Participating provinces would sign an Umbrella Agreement with the MSN, defining the rules for both regarding the administration, financing, monitoring, auditing, and other specific requirements with which the province would need to comply to participate in the program. Participating provinces would also sign an Annual Performance Agreement, specifying the yearly results and enrollment goals, and corresponding yearly expected budget. Throughout the program, the MSN would provide technical assistance for implementing the Plan Nacer in the participating provinces.

16. Notwithstanding the MSN's stewardship and oversight role, provinces would enjoy sufficient autonomy to set up contractual and payment mechanisms with authorized public and private providers as well as to experiment with alternative health service delivery models. The only restriction would be that all payment mechanisms between the provinces and the provincial providers would need to be based exclusively on interventions actually delivered to the target population rather than on the basis of financing inputs.

17. The Plan Nacer's package of basic services are included in a list (*nomenclador*) that specifies about 130 cost-effective specific clinical interventions, including those that target the main causes of infant mortality (diarrhea and acute respiratory diseases as well as malnutrition and inadequate perinatal care) and maternal mortality (hemorrhage and infections linked to unsafe deliveries and complications from unsafe abortions). It includes cost-effective interventions for primary health care promotion and prevention, as well as reproductive health after deliveries. The inclusion of outreach activities designed specifically for indigenous populations and the adaptation of service delivery to the special needs of indigenous mothers and children is a special feature of the PBS. The PBS, as operationalized in the nomenclador, would be mandatory for all participating provinces. Table A1.1 summarizes key interventions and pathologies included in the PBS.

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[2] Mothers, 45 days after pregnancy, would be referred to the Sexual and Reproductive Health Program. This is another integral component of the government's HSRP, to be further supported by the Essential Public Health Functions Project under preparation for Bank financing.

Table A1.1. Key Interventions and Pathologies in the Package of Basic Services

Interventions for children under 6 • Local bacterial infections (babies < 2 months) • Regular vaccination (MMR, BCG, DPT, Polio, other) • Acute respiratory diseases • Diarrhea • Nutrition and development (anemia, parasitism) • Other neonatal interventions	*Interventions for pregnant women* • Pre- and post-natal care • Deliveries (including induction and Cesarean sections) • Pre-eclampsia/eclampsia • Hemorrhage in the first half of pregnancy (prevention and care) • Hemorrhage in the second half of pregnancy • Puerperal hemorrhage and infections • Sepsis • Perinatal care including, as vertical transmission of HIV
Interventions after pregnancy and after miscarriage • Sexual and Reproductive health counseling • Treatment of STDs (syphilis, gonorrhea, clamidia, triconomiasis and candidiasis)	*Laboratory analyses and other services during pregnancy* • Blood group and Rh, complete hemogram, urine analyses, baciloscopy (tuberculosis), Glicemia, Creatinine, Bilirrubina, Transaminasas, Proteinuria, RPR (Syphilis), HIV • Echography • Incubator
Other activities covered • Programming the primary health interventions • Supervision and monitoring of health interventions	*Indigenous population* ▪ Visits by specially trained health personnel to indigenous families and communities without access to health facilities

Annex 2: Major Related Projects by the Bank and Other Agencies

Table A2.1. World Bank Projects: Completed, Ongoing and Planned

Sector Issue	Project	Latest Supervision (PSR) Ratings (Bank-financed projects only)	
Bank-financed		**Implementation Progress (IP)**	**Development Objective (DO)**
Health Sector	Argentina Health Insurance Reform Loan - Loan 4002-AR and Loan 4003-AR	Completed (S)	S
Health Sector	Argentina Health Insurance TA - Loan 4004-AR	Completed (S)	S
Health Sector	Maternal and Child Health and Nutrition (PROMIN I and II) – Loan 3643-AR and Loan 4164-AR	Completed (S)	S
Health Sector	Public Health Surveillance and Disease Control (VIGI-A) – Loan 4516-AR	Completed (S)	S
Health Sector	Provincial Maternal-Child Health Sector Adjustment Loan (PMCHSAL) - Loan 7199-AR	Ongoing (S)	MS
Health Sector	Provincial Maternal-Child Health Investment Project (APL-I) - Loan 7225-AR	Ongoing (S)	S
Health Sector	Essential Public Health Functions and Programs - P090993	Planned	
Social Protection	Social Protection VI Project – Heads of Household – Loan 7157-AR	Completed (S)	S
Social Protection	Heads of Household Transition Project – Loan 7369-AR	Ongoing (S)	S
Other Agencies			
Health Sector	Remediar – IDB 1193/OC-AR	Ongoing	
Social Protection	Support for Plan Familias I – IDB 1669/OC-AR	Ongoing	

Lessons learned from related projects

1. In the second half of the 1990s and in line with government policy at that time, the Bank supported Argentina's health policies with a mix of adjustment and investment lending along

three strategic axes:

(i) Reform of the national social health insurance system with adjustment loans and technical assistance

(ii) Provincial health insurance reforms with a number of Provincial Reform Loans (PRLs) and the Provincial Health Sector Development Project

(iii) Maternal and child health care, including child nutrition, attention to reproductive health of mothers, and early childhood development through two investment operations in selected provinces.

2. *Reforming the National Health Insurance.* The main focus of health policy in Argentina during the last decade was on the formal social health insurance system, particularly on the National Social Health Insurance [Obras Sociales Nacionales (OSN)]. Expectations of a booming economy in the 1990s and increasing formalization of the economy, coupled with already high coverage of the social health insurance system (50 percent of the population in 1997), led most policy makers to believe that the health insurance system's role as a provider of services should be expanded. To play a more inclusive and comprehensive role, the social health insurance system urgently needed structural reforms to improve efficiency and equity and to extend its coverage to the self-employed and other groups. Adjustment and technical assistance lending accompanied this reform.[17]

3. Reforming the national health insurance system proved much more difficult than envisioned. Some important gains were achieved, but reforms were only moderately successful. A national OSN beneficiary database was established and a mandatory benefits package was introduced for all OSNs (Programa Medico Obligatorio [PMO]). With the closing of two projects in 2001, [18] the insurance reform agenda was reasonably on schedule. Outstanding issues relate to the need to consolidate progress rather than modify policies. In contrast, complementary and the much-needed reforms at the provincial level were only marginally addressed. It was expected that after the successful completion of the OSN reforms, the government and the Bank would address the challenging structural problems of the provincial health systems, but economic crisis and the inherent difficulty of the issue combined to prevent the government from following through.

4. *Provincial reforms.* The Bank supported several provincial health system reforms through support to provincial development projects and reforms loans.[19] Although the reforms were technically well designed, the results proved incomplete and insufficient to resolve the structural problems of the provincial health sector and to improve its performance.[20] Three reasons are responsible for this result: (i) the provincial health system reforms included in the PRLs were only part of a broad provincial structural reform, and the priority assigned to the health component, as well as the ownership by the respective Ministries of Provincial Health (MSPs), was soon lost; (ii) provincial governments lacked commitment to programs and reforms largely

[17] Argentina Health Insurance Reform Loan (Loan 4002-AR and Loan 4003-AR); supported by Argentina Health Insurance Technical Assistance Project, (Loan 4004-AR)

[18] Health Insurance Technical Assistance Project, Ln 4004-AR; Implementation Completion Report (No. 24326-AR), June 2002.

[19] Argentina Provincial Reforms Loans Santa Fe (Loan 4575-AR); Catamarca (Loan 4578-AR), Cordoba (Loan 4634-AR), Rio Negro (Loan 4218-AR), Salta (Loan 4219-AR), San Juan (Loan 4220-AR); and Tucuman (Loan 4221-AR).See also "Argentina Provincial Health Sector Development Loan (Loan 3931-AR).

[20] Argentina: Implementation Completion Report for Provincial Health Sector Development Loan (Report No.: 24325-AR).

designed and managed by the national government; and (iii) the focus of the National Ministry of Health (MSN) on the OSN reform demanded most of its political and managerial capacity, marginalizing provincial health reform in the national agenda.

5. *Provincial investments for maternal and child health care.* The Bank also financed two investment projects to improve maternal and child health in selected provinces, one completed in 2000 and one at the end of 2005.[21] The support comprised assistance for largely supply-side interventions, including the financing of investments for facilities and basic supplies, which were managed by the central government (MSN). While physical works have proceeded well under both projects, the next important next step will now be to introduce the necessary incentive environment for purchasers and providers. The ongoing APL-I project contains the pilot testing of well-integrated health care delivery model in maternal and child health in several provinces. Preliminary results are encouraging, but the final results are still out.

6. *Provincial Maternal Child Health Sector Adjustment Loan; Ln 7199-AR (2003).* The Board approved the PMCHSAL, a sector adjustment loan, on October 28, 2004. The APL-I is a follow-on and a necessary complement to the PMCHSAL. The key features of the program have been discussed in the preceding sections of this document. Since effectiveness in early November 2003, the PMCHSAL has shown good implementation, completing all conditions for second tranche release in June 22, 2004. The government has implemented all but one of the health sector reforms under the PMCHSAL. This is a reflection of the ownership and commitment by the government to rapidly improve health conditions in Argentina. The implementation of PMCHSAL has greatly facilitated the implementation of Plan Nacer and also consolidated the necessary regulation of Obras Sociales. The pending health policy condition (the implementation of risk adjustment in the Solidarity Fund of Obras Sociales) has no effect on the implementation of Plan Nacer.

7. Three lessons drawn from the Bank's experience with Argentina's health sector over the past years were essential for the design of the Maternal and Child Investment Loan (APL-I and APL-II).

(i) Focusing reform on the national social health insurance system proved difficult and insufficient to address the health problems of the poor. Although structural reforms were moderately successful, coverage of the uninsured did not expand significantly. The government's Health Sector Reform Program and the APL-I and APL-II supporting it therefore set about establishing a direct health care coverage mechanism for the uninsured and providing incentive systems for provinces to deliver a package of basic health care to the most vulnerable groups among the uninsured. Reaching the uninsured became an even higher priority when the economic crisis caused 12 percent of the insured to lose their health coverage.

(ii) Previous projects and reforms did not reach the poorest provinces in the northeast and northwest where most of the uninsured live. The government strategy for introducing the Plan Nacer therefore prioritized reforms in Argentina's nine poorest provinces.

(iii) Bank financing had to be closely linked to results, output (actual delivery of services to the population), and outcomes (improvement of final or intermediary health indicators). APL-I introduced significant innovations in output-based lending and they have shown

[21]Maternal and Child Health and Nutrition Project; Ln 3643-AR (1994); Second Maternal and Child Health and Nutrition Project, Ln 4164-AR (1997).

excellent results.

8. Implementation of APL-I has also provided preliminary lessons. First, the reforms introduced by Plan Nacer and APL-I are demanding, both technically and institutionally. Its successful implementation has required substantial technical assistance as well as intense policy dialog and supervision. Second, the introduction of an additional independent concurrent auditor has proven essential for verifying and validating the indicators for disbursement and the compliance of the provinces with key elements of Plan Nacer. The proposed APL-II includes substantial technical assistance and would continue the APL-I design of an additional independent concurrent auditor.

9. The proposed APL-II is an appropriate follow-up to fast and effective implementation of the APL-I. The APL-I has displayed good implementation of policy actions. All 15 new provincial Ministers of Health have confirmed the interest of their respective provinces in participating in the Maternal and Child Health Insurance Program. The government complied with all triggers for moving to a second phase by mid-August 2006. It is still too early to derive lessons from the APL-I—except that it has facilitated unprecedented multisectoral coordination and has significantly sharpened focus on key health sector policies and on output and outcome results on the ground.

Annex 3: Results Framework and Monitoring

1. The beneficiary population of the proposed APL-II project includes, on a voluntary basis in the participant provinces, all uninsured children up to their sixth birthday, all uninsured pregnant women, and all uninsured mothers for up to 45 days past their date of delivery or miscarriage. The target population is the beneficiary population in the 15 provinces in central and southern Argentina.

2. The main project objectives (table A3.1) are to: (a) increase access for uninsured mothers and children to basic health services known to address effectively the main causes of maternal and under-5 mortality in Argentina; (b) strengthen the incentive framework for efficiency and focus on results between the national level and the provinces, and among provinces and service providers, by linking financing to both services actually rendered to the target population and to achieving program coverage results in the form of 10 tracers (e.g., the proportion of pregnant women that receive their first antenatal examination before the 20th week of pregnancy.

3. Thus, APL-II would build on the APL-I and PMCHSAL contributions to Argentina's ability to meet the Millennium Development Goals (MDGs) for health by 2015. Key outcome indicators to be measured include the percentage of the target population enrolled and the increased access to basic health services of the target population.

4. **The project will also monitor the evolution of maternal and infant mortality in participating provinces** and will attempt to evaluate the contribution of the project on those trends. Project estimations suggest that APL-II could help reduce IMR in participating provinces by up to an average of 10 percent.

5. APL-II project implementation will include a monitoring system for income, gender, ethnicity, and geographic characteristics of the eligible but unenrolled population. This information will allow the Bank team and the government to take corrective policy and managerial actions.

Table A3.1. Specific Performance Objectives and Intermediary Objectives: Indicators and Project Goals

PDO And Intermediary Objectives	Indicator	Baseline (national) [v]	Target End of Project	Source of Data
Implementation of Plan Nacer	▪ Proportion of eligible population voluntarily enrolled in the program in 15 provinces	0%	▪ 80% Eligible women ▪ 80% Eligible children	▪ *Plan Nacer enrollment system and INDEC national statistics*
Increased access to basic health services of the target population	▪ Proportion of eligible pregnant women with first antenatal care visit before week 20th of pregnancy	23 %	70 % of eligible pregnant women	▪ *Tracer (Trazadora) information system*
	▪ Proportion of enrolled pregnant women with first antenatal care visit before week 20th of pregnancy	45 %	80 %	
	▪ Proportion of eligible pregnant women who get VRDL during pregnancy and antitetanic vaccine previous to delivery	45 %	90 %	
	▪ Proportion of enrolled pregnant women who get VRDL during pregnancy and antitetanic vaccine previous to delivery	70%	95%	
	▪ Proportion of eligible children less than 18 months old with coverage of measles vaccine or triple viral	45 %	95 %	
	▪ Proportion of enrolled children less than 18 months old with coverage of measles vaccine or triple viral	75%	98%	
	▪ Proportion of eligible puerperal women that received at least one Sexual and Reproductive Health Care consultation	27 %	60%	

[v] To be confirmed or modified by baseline study to be completed during the first 12 months of effectiveness for each eligible province.

	▪ Proportion of enrolled puerperal women that received at least one Sexual and Reproductive Health Care consultation ▪ Proportion of eligible children 1 year old or less, with all well child consultations up to date (percentile of weight and height) ▪ Proportion of enrolled children 1 year old or less, with all well child consultations up to date (percentile of weight and height)	48 % 13 % 20 %	85 % 50 % 70 %	
Improve Critical Intermediary outcomes	• Proportion of newborns from eligible pregnant women weighing more than 2,500 g • Proportion of newborns from enrolled pregnant women weighing more than 2,500 g ▪ Proportion of newborns, from eligible pregnant women, with "Apgar score higher than '6'at minute 5" ▪ Proportion of newborns, from enrolled pregnant women, with "Apgar score higher than "6"at minute 5.	47 % 70 % 47 % 70 %	85 % 90% 92 % 98 %	*Tracer (Trazadora) information system*
New incentive environment for provinces and provincial providers	▪ Percentage of MSN-MSP annual performance agreements successfully implemented. ▪ Percentage of authorized providers under annual performance agreements and provider payment mechanism with its respective participant province. ▪ Percentage of *trazadora* targets achieved by the participant provinces in last year billing period.	0% 0% 0%	▪ At least 60 % of all participant provinces at the end of APL-II ▪ At least 50% of all authorized providers in each participant province ▪ At least 70 % of all participant provinces at the end of APL-II	▪ Verification that the health sector structural reforms aiming at improving targeting and efficiency are being implemented.

Intermediate Component Results	Component Results Indicators	Baseline	Component Results End of Project	Use of Outcome Monitoring
Component 1: Sustainable functioning of the *Plan Nacer*	▪ Capitation payment occurring according to approved enrollment lists and *trazadora* systems	0%	▪ In at least 9 eligible provinces in central and southern regions at the end of APL-II	▪ Tracking the effectiveness of program implementation and evolution towards sustainability of provincial programs; serving as a basis for modifying *Plan Nacer* design at provincial levels. ▪ Modifying the incentive system by adjusting payment flows to follow performance (see tracer indicators, following table)
	▪ PHSPT and NHSPT function effectively according to concurrent and financial audits.	0%	▪ In at least 50% of all participating provinces	
	▪ Number of authorized providers receiving the basic medical equipment / vehicles / communication equipment according to the annual performance agreement	0%	▪ At least 50% of those for whom an investment project was approved	
Component 2: Stewardship function performance of MSN, MSPs improved	▪ Number of PHSPTs established and functioning, capable of preparing and negotiating MSP-MSN and MSP-authorized providers annual performance agreements.	0%	▪ At least 60 % of all participant provinces	▪ Tracking expected capacity building outcomes of the HSRP; providing basis for renewed policy decisions concerning improving the health status of the population
	▪ NHSPT is established and functioning, capable of preparing and negotiating MSN-MSP annual performance agreements.	n/a	▪ One National Direction for purchase of medical services has been established	
Component 3: Broad awareness and ownership of the *Plan Nacer*, and informed participation of target population and their subgroups in the program	▪ Regular information process among stakeholders on maternal-child health care issues in general and entitlements in the *Plan Nacer* in particular	n/a	▪ Information and dissemination campaign launched at national level and in at least 80 % of all participating provinces	▪ Monitoring and assuring ownership, understanding and commitment to the program among policy makers, officials, service providers and beneficiaries ▪ Assuring responsiveness of the *Plan Nacer* to needs of
	▪ Targeted groups increase, knowledge of their entitlements under the program and participation in *Plan Nacer*, and report satisfaction with process and results	n/a	▪ At least 70% of eligible population reports (in surveys) knowledge of *Plan Nacer*	
		n/a	▪ At least 50% of	

			enrolled population reports (in surveys) that is satisfied with the *Plan Nacer* program	beneficiaries
Component 4. Availability of regular and verified program information, audits and project evaluation	▪ Project implementation reports available as agreed, including financial reports supporting the capitation payments. Satisfactory reports from Concurrent and annual financial auditor ▪ Project evaluation implemented: (i) baseline at the end of PY2; mid term impact evaluation at the end of PY3; and final impact evaluation at the end of last year of APL-I	n/a n/a	▪ At least 80% of the reports	▪ Monitoring project implementation as basis for evaluating project performance and making modifications ▪ Monitoring and facilitating flow of project funds and fiduciary obligations
Component 5. Satisfactory project implementation according to GOA-WB Loan agreement; MSN-MSP umbrella agreements	▪ Performance indicators (PDO) ▪ Loan disbursements	n/a n/a		▪ Monitoring and evaluating project status

INDEC National Institute of Statistics and Census; VDRL syphilis test; PHSPT Provincial Health Services Purchasing Team; NHSPT National Health Services Purchasing Team; MSN National Ministry of Health; MSP Provincial Ministry of Health; PY project year; GOA Government of Argentina.

6. Additional tracers (table A3.2) have been designed to track the effectiveness of the basic service package (technical evaluation) and the performance of the service provider system, as well as to determine the capitation payment for the respective provinces. In addition to evaluating performance as a basis for making system improvements, the tracers would be used (i) to monitor performance of providers by the MSPs (contract obligations) and (ii) manage transfers (40%) from the MSN to the provinces. Achieving the production target for each of the 10 tracers would entitle the participating province to receive 4 percent of the capitation payment for each enrolled participant in the period. Achieving all 10 would mean that the province receives the entire 40 percent associated with the tracer system.

Table A3.2. Key Health Interventions (Tracers) for Participating Provinces

Tracer	Description	Possible sources and frequency of reporting
1. Timely inclusion of eligible pregnant women in prenatal care services	Number of eligible pregnant women with at least one prenatal care service before 20th week / Number of eligible pregnant women.	Administrative registries of authorized health facilities with SIP/CLAP. Every four months
2. Effectiveness of early neonatal and delivery care	Number of newborns, from eligible pregnant women, with "Apgar score higher than "6"at minute 5 / Number of newborns from eligible pregnant women.	Maternity registries and "II level" registries; with SIP/CLAP. Every four months
3. Effectiveness of prenatal care and prevention of premature births	Number of newborns from eligible pregnant women weighing more than 2,500 g. / Number of newborns from eligible pregnant women.	Maternity registries and "II level" registries. Every four months
4. Quality of prenatal and delivery care	Number of eligible pregnant women who get VRDL during pregnancy and antitetanic vaccine previous to delivery / Total number of deliveries from eligible pregnant women.	Maternity and "II level" registries. Every four months
5. Medical auditing of maternal and infant death	Number of medically audited deaths of eligible mothers and children (1 year of age or younger) / Total number of deaths of eligible women and children (1 year of age or younger).	Maternity and "II level" registries. Fourmonthly
6. Immunization Coverage	Number of eligible children less than 18-months old with measles vaccine or triple viral coverage / Number of eligible children less than 18-months old.	Provincial Public Health Information System cleared by MSN. Every four months
7. Sexual and Reproductive Health Care	Number of eligible puerperal women receiving sexual and reproductive health care consultations / Number of eligible puerperal women.	Maternity registry. Every four months
8. Well-child care (1-year old or younger)	Number of eligible children 1-year old or less, with all well-child consultations up to date (percentile of weigh and height and cephalic perimeter) / Total eligible children 1-year old or less.	Provincial Public Health Information System cleared by MSN. Every four months
9. Well child care (1 to 6 years old)	Number of eligible children 1 to 6 years of age, with all well child consultations up to date and percentile of weigh and height / Total eligible children 1 to 6 years of age.	Provincial Public Health Information System cleared by MSN. Every four months
10. Including indigenous population	Number of health facilities delivering services to eligible indigenous population in which there are Sanitary Agents (basic health care personnel) specially trained to treat indigenous population / Number of health facilities delivering services to eligible indigenous population.	Provincial Public Health Information System cleared by MSN. Every four months

SIP/CLAP Comprehensive health information system; MSN National Ministry of Health; VDRL syphilis test;

7. **Monitoring Arrangements.** MSN would organize and supervise the project monitoring system through the PHSPT with the support of the existing technical teams, relying on the MSPs and the service providers to generate and analyze basic data on project outputs. MSN has been improving the general capacity of the Directorates for Epidemiology and of the Maternal and Child Care Program via the Public Health Surveillance Project (VIGIA-P055482), closed in May 2006, from which a subset of information on the specific outcomes of the Plan Nacer would be derived. Data on the size of the population eligible for program coverage have been generated, agreed, and presented by the PHSPTs. This information would be revisited in the annual review with the Bank and adjusted as appropriate. The NHSPT would consolidate this information to monitor project coverage. Data on provider performance would result from their periodic billing reports from their service records, the basis of their payments to the provinces. These would be consolidated by the NHSPT. The NHSPT with the PHSPTs would conduct periodic independent studies and surveys of beneficiaries' participation and satisfaction.

8. Most of the hospitals and clinics that would be authorized as providers of the package of basic maternal-child care have functioning medical record systems, adequate to generate basic data on beneficiary numbers and services rendered. For others, installing a minimum acceptable system would be part of the authorization process. MSPs currently compile such data for sector management purposes and are being assisted in upgrading these systems through the Public Health Surveillance Project.

9. However, to continue to improve epidemiological and health management information, the project would provide additional assistance to these provinces and service providers to further upgrade their recording and reporting systems. Similarly, while the MSN develops statistics on health care trends, the project would provide for upgrading and modifying current systems to accommodate the needs of improved health care management.

Project Evaluation

10. *Objectives*: The project impact evaluation focuses on measuring impact in three areas: (i) changes in the behavior of providers delivering primary health care services to the eligible population before the changes in the payment method introduced by Plan Nacer; (ii) impact on the coverage and quality of primary health care services, especially for pregnant women and children between 0 to 6 years; and (iii) changes in the health outcomes of the target population as they correlate and result from the application of the program.

11. *Methodology*: The identification of program impact requires an understanding of the beneficiaries' situation without the program so changes can be measured. Implemented changes are measured using a longitudinal sample with data collected through three instruments: (i) questionnaires for providers; (ii) questionnaires for mothers in households in the areas of the selected providers; (iii) questionnaires for mothers exiting providers. Impact is measured and evaluated at three points in the program: (i) before the initiation of the program, for the baseline; (ii) at the end of the first two years of program implementation, for intermediate results; and (iii) six months after the program ends, for final results.

12. *Sample design and field work*: The sample plan would be constituted for towns in the participating provinces and for groups of towns foreseen as the control group. From a methodological perspective, cases of mothers and children would be monitored over time to generate a longitudinal data base. A control group is selected (based on towns entering the Plan Nacer program at different times) to evaluate what would have happened to the beneficiary group without Plan Nacer coverage. To select a control group, towns are assigned a propensity matching

score based on a diversity of similar indicators such as population, number of health centers, and infant mortality rates. The field work is divided into two parts: provider surveys and household surveys.

13. To complement the impact evaluation of the APL-II program, an information system would be set up to continuously evaluate the characteristics of the unregistered eligible population to better understand obstacles to program access. Reasons for nonregistration might include income, geographic area, ethnicity, or other factors of exclusion. This knowledge would allow management to devise appropriate policy adjustments and remedial actions to incorporate the unregistered population.

Annex 4: Detailed Project Description

1. The project, with a total cost of US$646.3 million (US$300 million Bank financing, including US$14 million unallocated) would include the following components and activities:

Component 1: Implementation of the Maternal-Child Health Insurance Program (US$589 million; US$242.7 million of bank financing). The Plan Nacer is considered the key to implementing the HSRP. Experience has shown that introducing similar mother-child health insurance programs requires assuring the operation of a set of mutually interdependent functions. The component would include financing for all of the activities necessary to achieve this outcome. Resources would be provided to assure:

(i) Reimbursement from MSN to each participating MSP, in the form of a capitation payment, for enrollment and provision of services in the *Plan Nacer* for eligible population. (US$554.8 million; US$208.5 million of Bank financing);

(ii) Improvements in basic physical capacity of primary care and ambulatory care providers at the local level and in areas where shortages of supply might hamper the capacity to deliver the services included in the PBS, primarily through providing new and upgraded medical equipment, basic patient transport vehicles, and communications equipment that supports the delivery of the Plan Nacer package (US$14.8 million; US$14.8 million of Bank financing). This does not include any investments in hospital infrastructure or complex equipment. MSN own resources would be directed as needed towards infrastructure improvements;

(iii) Technical assistance and personnel training programs for MSPs to cover skills not generally associated with traditional health program management (US$8.3 million; US$8.3 million of Bank financing). This would include skills such as: the setting of contracts; managing payment mechanisms to providers on a performance basis: identifying and updating the pool of eligible beneficiaries; establishing and validating subscriber lists; and managing proactive and culturally appropriate outreach and service delivery to excluded population (including indigenous people);

(iv) Training for health care professionals and providers in diagnosis and delivering the Plan Nacer services (US$1.7 million; US$1.7 million of Bank financing) including: protocols; technical practices in maternal and child care practices; use of equipment; adaptation of practices to the needs of indigenous peoples; and creation of opportunities for inter-provincial and international exchange of experiences and program lessons;

(v) Upgrading and expanding the information systems at the MSN and provincial levels for monitoring the implementation of the Plan Nacer including technical equipment and contractual services, software and training services (US$4.8 million; US$4.8 million of Bank financing). Activities would build on experiences gained in APL-I.

(vi) Technical assistance and training for the management of participating health service providers at the provincial level (US$4.6 million; US$4.6 million of Bank financing). The objective is to strengthen their capacity in areas including billing and development and implementation of provider data systems.

Component 2: Strengthening National and Provincial Ministries of Health Stewardship Capacity (US$10.1 million; US$10.1 million of Bank financing). The goal of this component would be to improve the performance and focus of ministries of health at the national and provincial levels to implement the Plan Nacer and purchase health services for beneficiaries. For this, the ministries would need to improve their planning, supervision, regulatory and basic operational research capacity as well as implement transformations in both the structure and operating norms of a variety of agencies and areas of these ministries, acting in close cooperation. Project resources would be provided to finance a number of strategic policy studies (e.g. Strategic Environmental Assessment, Burden of Disease Assessment), consultant services in management and organizational studies, investments in office equipment, and training services to improve the performance of the MSN and the MSPs participating in the project in exercising their sector stewardship functions including:

(i) Reorganization of services' mandates, staffing and relationships. Activities would include ongoing support for the NHSPT of the MSN. In addition, the component would provide assistance for provinces to build up their own PHSPT dedicated to technical management and contracting (purchasing) associated with provincial programs, which would initially be focused on managing the *Plan Nacer* in their province. Creating a PHSPT would be part of the conditions of an umbrella agreement between the MSN and a participating province, and annual performance agreements would include budgets, activities and performance benchmarks for respecting this condition;

(ii) Improving epidemiological information, financial and human resource management systems; and

(iii) Completing studies essential for MSN policy formulation.

Component 3: Communications and Community Outreach (US$17 million; US$17 million of Bank financing). GOA would undertake specific steps to improve the coordination of national health policy and commitment to health programs. It would also develop a communications campaign to ensure demand for enrollment in Plan Nacer, as well as to inform and empower eligible populations regarding their entitlements. Project financing would secure consultant services, event organization, and communications services to support two main lines of activity so as to build awareness of and participation in the Plan Nacer including:

(i) dissemination of detailed information concerning the program among major stakeholder groups (provincial governments and their populations, COFESA, the medical profession, insurance agency managers and staff) including providing opportunities for feedback and dialogue on resolving program issues. This would be, primarily, the responsibility of the MSN.

(ii) community outreach to increase participation of the target population by providing them with practical information on their rights to services, services available, methods of inscription, sites, times and names of providers; organizing and supporting community contact groups responsible for disseminating information and receiving and reacting to feedback to provide an element of citizen oversight of the program. This would be mainly the responsibility of provinces, which would develop their own strategies to be discussed and agreed with the MSN. Provinces would

provide details of their community outreach activities as part of their annual work programs, covered by annual participation agreements with the MSN.

Component 4: Program Monitoring, Evaluation and Concurrent Auditing Systems (US$14.6 million; US$14.6 million of Bank financing). The implementation of Plan Nacer, with a key focus on empowering and protecting beneficiaries' entitlements and rights in the program, requires a significant change in the incentive structure facing staff and facilities, to raise their accountability for achieving results. This change in incentive structure is an important goal being promoted through the Plan Nacer.

To be effective, however, the ability of ministries' to monitor, evaluate and audit performance would be strengthened. Project financing would be deployed for information technology design services, software and equipment, training for staff at the MSN and MSPs to upgrade the monitoring of health provider performance, aggregation and reporting of information used for gauging project performance, as well as used to make transfers to provinces. In addition to being a renewed basis for health policy and program, the system is also expected to generate tracer information that would be accounted for in managing financial flows under the project. While NHSPT/PHSPT staff would monitor results and enrollment on a monthly basis, an independent audit (concurrent auditing) of the veracity of this information would be conducted by a firm with qualifications in health systems administration, insurance, and information technology.

2. The auditors would provide an independent opinion on:

(i) the veracity of the "billings" sent by participating provinces to NHSPT justifying the basic payment (60 percent) of the "capitation";

(ii) the reliability of "billings" based on service production targets ("trazadoras") (up to 40 percent of the "capitation");

(iii) the compliance of the province in question with agreements in the Umbrella Agreement to establish contracts and payments of providers of the BBP based on (a) the provision of services, not the supply of factors of production; (b) only for services included and agreed in the "nomenclador" at approved prices; and (c) respecting an overall limit on payments to providers on a capitation basis of 35 percent maximum of the total annual payments for services;

(iv) the effectiveness of PHSPT management and results of the transfer of capitation payments to provinces; and

(v) recommendations for improving the capitation payment process.

3. Opinions, conclusions and recommendations would be given quarterly thereafter during the life of the project. The format of the report of the Auditor would be agreed with the Contractor.

4. Lastly, this component would finance the project evaluation activities, including the completion of the baseline for impact indicators, and a midterm and end of project impact evaluation. APL-II would follow the same impact evaluation design under implementation in APL-I.

Component 5: Project Management and Administration (US$ 1.6 million; US$ 1.6 million of Bank financing)

5. Under this component, the project would finance minor operational expenses, such as travel costs to the provinces, travel and per diem costs for coordination meetings, mainly for the NHSPT activities.

Annex 5: Project Costs

Table A5.1. Project Cost Summary by Component; US$ millions

Component	Indicative Cost (US$M)	% of Total	Bank financing (US$M)	% of Bank financing from total in Category
1. Implementation of the Maternal-Child Health Insurance Program	**589.0**	**91.1%**	**242.7**	**41.2%**
i. Capitation Payment for *Plan Nacer*	554.8	85.8%	208.5	37.6%
ii. Investments in basic equipment	14.8	2.3%	14.8	100.0%
iii. Technical assistance for PHSDP	8.3	1.3%	8.3	100.0%
iv. Training for health service personnel	1.7	0.3%	1.7	100.0%
v. Investment in information systems	4.8	0.7%	4.8	100.0%
vi. Technical assistance for provincial health service providers	4.6	0.7%	4.6	100.0%
2. Strengthening National and Provincial Ministries of Health Stewardship Capacity	**10.1**	**1.6%**	**10.1**	**100.0%**
3. Communications and Community Outreach	**17.0**	**2.6%**	**17.0**	**100.0%**
4. Program Monitoring, Evaluation and Continuous Auditing	**14.6**	**2.3%**	**14.6**	**100.0%**
5. Project Management and Administration	**1.6**	**0.2%**	**1.6**	**100.0%**
Total Base Cost	**632.4**	**97.8%**	**286.0**	**45.2%**
Unallocated Funds	**14.0**	**2.2%**	**14.0**	**100.0%**
Total Base Cost	**646.3**	**100.0%**	**300.0**	**46.4%**

Annex 6: Implementation Arrangements

Framework

1. Project implementation would fall into three broad categories; related to (i) implementation of the project, (ii) the implementation of the Plan Nacer as health service management and delivery within a typical province, and (iii) implementation of project and program monitoring and evaluation functions. The latter arrangements are described in detail in Annex 3.

Project Implementation

2. **Agencies, Roles and Responsibilities:** The project would be implemented through the following agencies:

(a) *Ministry of Health, National Level (MSN)*: which through the Minister, would have overall responsibility for meeting national goals for maternal and child health and mortality. The minister would exercise his role as coordinator of national policy directly, and his responsibilities for achieving program outcomes through the National Health Service Purchasing Team (NHSPT) under his direct supervision through the MSN's Secretary of Sanitary Programs. Through these means, he would redirect the role of the ministry towards establishing policy and program directions, monitoring results of the work of provinces, and supporting (and sanctioning) performance. He would sign the umbrella agreements with his provincial counterparts to establish the *Plan Nacer* in their jurisdictions, and the annual performance agreements for the participating provinces.

(b) *Federal Health Council (COFESA):* is a council of all provincial health ministers, chaired by the national Minister of Health, charged with coordination among the provinces on policy and operational guidelines. It would be responsible in addition, for recommending on the content and operational norms of the *Plan Nacer.* COFESA is being re-dynamized as part of the Health Sector Reform Program (HSRP).

(c) *National Health Service Purchasing Team (NHSPT):* would be responsible for daily management of the project and the longer term program. During the project it would be responsible for establishing and monitoring umbrella agreements and annual performance agreements with participating provinces, providing technical assistance to provinces on maternal and child health issues, supporting provincial outreach and communications activities and making the decisions regarding financial flows for project components including the certification of billing from participant provinces and the capitation payments, as well as the financial flow between the national treasury, World Bank and provinces. The NHSPT would be assisted by International Finance Unit (UFI-S) for financial management and procurement to capitalize on the experience of this staff with World Bank financed projects. Staffing of the NHSPT would be completed to include expertise in monitoring and evaluation, and outreach and communications. The NHSPT would be responsible for monitoring results and the Minister of Health on issues and options for maintaining an effective program. The NHSPT has been created and initially staffed as part of the HSRP implementation supported by the adjustment operation, and is led by a Director (appointed by the Minister). It currently draws on staff of the national ministry's technical areas for work on technical aspects of the *Plan Nacer.*

(d) *Provincial Ministries of Health (MSP):* would be responsible for entering into agreements with the MSN covering their participation in the *Plan Nacer*, and for establishing and maintaining the provincial team (PHSPT) responsible for implementing the program.

(e) *Provincial Health Services Purchasing Teams (PHSPTs):* would be established by MSPs according to the regulations in effect in the province, and following staffing, reporting and chains of accountability that was adapted to the province's financial circumstances and existing administrative practices. PHSPTs would be accountable for achieving results in terms of enrollment of eligible population and contracting with authorized providers for delivering the PBS as agreed in annual performance agreements under their provincial umbrella agreement. At a minimum, a typical PHSPT would be responsible for identifying and maintaining a registry of eligible participants (enrolled), establishing and supervising performance of contracts with authorized health care providers; assuring the viability of facilities, availability of supplies, payments to providers and practice of sound financial management and procurement. A PHSPT would maintain close working relationships with the NHSPT for program administration, quality control and the achievement of program results. PHSPTs would be responsible, with the clearance of the HSPD at the MSN and through the corresponding provincial government agencies, to set the provider payment fees schedule (prices of services of the *nomenclador*) in the province for the services included in the PBS. The same fee would apply to the same service in any of the authorized providers.

(f) *Providers:* would be health centers, hospitals, clinics, public or private, authorized under the authority of the MSP following quality and accreditation criteria set forth by the MSN equally mandatory for private or public providers to offer the basic package of services under the *Plan Nacer*. They would be responsible for maintaining proactive contact with beneficiaries who elect to seek their services, providing quality services, maintaining and submitting auditable accounts and bills of services of their services, clientele and any record requested by the PHSPTs and/or NHSPT related to the *Plan Nacer*.

3. **Responsibilities for Project Components:** In addition to being responsible for assuring that all project components are implemented, the MSN/NHSPT would be directly responsible for implementing activities for the implementation of the Maternal Child Insurance – Plan Nacer (Component 1); to strengthen the stewardship role of the MSN and participating MSPs (Component 2); overall management of the implementation of Plan Nacer (Component 1); the program of information dissemination and communications concerning the program (Component 3, (i)); and the overall management and administration of the project (Component 5). Participating MSPs would be responsible for implementing the Plan Nacer within their jurisdictions, under agreements with the MSN (Component 1), including relevant community outreach programs to increase enrollments in the program (Component 3 (ii). Both MSN and MSPs would collaborate to implement project monitoring, evaluation and auditing, with MSN taking the lead (Component 4).

4. **Procedures and Relationships:** The processes and procedures governing project implementation are outlined in detail in the Project's Operations Manual. Procedures governing the basic relationship between the Government and the World Bank, mainly covering financial management and procurement are detailed in Annexes 7 and 8 respectively and the NHSPT would be assisted in this matter by the UFI-S, which has vast experience with Bank financed projects. Norms and procedures guiding the daily exercise of responsibilities of staff of the NHSPT are also detailed in the Operations Manual.

5. To conform to Argentina's federal structure, project implementation would be managed through umbrella arrangements between the MSN and MSPs, and between MSPs and provincial providers of maternal and child health service. Model agreements are in the Operations Manual and are generally structured as follows:

(a) Between MSN-MSP: Ministries at the national level and participating provinces would establish:

(i) ***an umbrella agreement*** under which the Province would participate in the *Plan Nacer*. Under this agreement the province and the MSN would agree on all permanent project norms regarding, inter allia, enrollment procedures, auditing procedures; beneficiary and service provision validation procedures, reporting procedures, financial management, procurement, communication and dissemination, reimbursement rules, approval of the Project's Operation Manual.

The MSN would:

- establish the norms and requirements of the *Plan Nacer* to be applied in each province;
- agree to the care standards provincial package of basic services and results to be achieved by the province;
- provide technical assistance and financial resources according to the provinces' demonstrated needs; and
- provide financing resources (through the capitation payment) for the implementation of *Plan Nacer* according to enrollment levels and achievement of key production goals (*trazadoras*) by participating provinces, and for technical assistance, consulting services and goods that were justified to build provincial implementation capacity.

The MSP would:

- maintain a unit dedicated to managing the *Plan Nacer* according to agreed standards;
- establish and maintain a comprehensive list of enrolled participants and assure its regular updating and accuracy in reflecting the true beneficiary population;
- if applicable according to the IPPF, develop and implement an Indigenous People Plan;
- establish contracts/agreements with authorized health care providers to provide the PBS;
- provide adequate and auditable accounts of services rendered, their quality and costs; and
- obey by all financial management and procurement requirements of the project as set forth by the Bank-GOA agreement.

(ii) ***annual performance agreements*** that would establish*:*

- the expected level of enrollment of the overall eligible beneficiary population and the resulting budget for the year (the actual cash flow would be determined by the actual monthly enrollment) ;

- the specific quarterly production goals for the key health interventions (*trazadoras*);
- If applicable, annual activities to be carried out under an IPP.
- the work program covering services to be delivered, promotional and community outreach activities and other program related activities; and
- the annual program budget (including the cost of services, incremental investments, training, staffing).

(b) Between MSPs/PHSPTs and authorized Providers: Parties would establish a multi-year service provision agreement/contract, that would remain in force subject to good performance and the maintenance of accreditation on the part of the provider in which would be detailed:

- services to be provided conforming to the PBS through the "Nomenclador", and the price of component services (*nomenclador*) that is to be paid for these services;
- quality standards and quality control measures, including any adjustment necessary in relevant provinces with IPP;
- practices for building and maintaining enrollment of beneficiaries, if the particular provider would perform such activity;
- results to be accomplished;
- modalities for supervision of activities by the PHSPT, reporting and payment.

MSPs and providers would also establish annual performance agreements.

(c) Between MSN, MSP, and COFESA: COFESA would serve as a forum for evaluating the overall effectiveness of the *Plan Nacer* given the health care needs of the provinces. It would discuss the lessons derived from the implementation of the *Plan Nacer* in light of experience and suggest solutions.

Implementing the MCHIP

6. Provinces would be responsible for the daily implementation of the Plan Nacer. Basic administrative rules, procedures and criteria for making administrative decisions are contained in guidelines annexed to their respective Operational Guidelines [reglamento operativo]. Procedures would cover the following steps:

(i) Enrollment and updating of beneficiaries rolls;
(ii) Identification, authorization, contracting and payment of providers;
(iii) Recording and reporting of results, and initiating transfers from the NHSPA;
(iv) Updating service requirements (CBP and nomenclador) and pricing;
(v) Beneficiary follow-up and evaluation;
(vi) Information and dissemination campaigns.

Annex 7: Financial and Disbursement Arrangements

Summary of the Financial Management Assessment

1. As required by OP/BP 10.02 a Financial Management (FM) assessment of the arrangements for the second phase of the proposed APL was performed in line with the Financial Management Practices in World Bank- Financed Investment Operations, document issued by the FM Sector Board on November 3, 2005. The objectives of the evaluation are: (i) to determine whether the financial management arrangements already assessed as satisfactory for the first phase of the APL continue in place and functioning satisfactorily; and (ii) to identify potential room for improvement based on FM implementation experience of the APL-I.

2. Similar to APL-I, the second phase of the project is to be implemented by the MSN, through the Plan Nacer National Health Services Purchasing Team (NHSPT-Project Management). Operations executed by the NHSPT through the administrative processes applied in the International Financing Unit (UFI-S) of the National Ministry of Health and covered in the Operational Manual of the UFI-S. The accounting and financial reporting, budgeting, treasury operations of the APL-II follow the procedures applied to APL-I and other Bank operations implemented by the MSN with the support of the UFI-S as outlined in its Bank approved operational manual. These processes and systems were assessed and found acceptable for the APL-I and are now in place for APL-II.

3. For the assessment of the proposed second APL, a FM review was carried out on the ongoing APL-I arrangements to obtain reasonable assurance that the control framework continues in place and is well performing. As part of the process, FM reviewed the concurrent operational auditor's reports, the internal control over the provinces executed by the specialized team of the NHSPT, Area de Supervision y Monitoreo, (ASM) outcomes of the annual financial audit issued by Argentina Supreme Audit Institution, AGN as well as visits to the UFI-S and some of the participating provinces where standard FM supervision procedures were undertaken.

4. The assessment conclusion is that acceptable FM arrangements of the APL-I continue in place and will remain the same for the proposed APL-II; the project control framework is adequate and has been functioning effectively through the first year and a half period of implementation. It can also be concluded that for APL-I, annual financial auditing and concurrent operational audits were satisfactory (details on the audits are provided in paragraphs below).

Country Issues

5. The Country Financial Accountability Assessment (CFAA) prepared by the Bank in 2003-2004 states that at the central level, the Government of Argentina has a fully integrated budget, accounting, treasury, and public debt financial management system. These systems control the funds received by the Central Government from any source and provide sufficient information to determine if the funds have been utilized as planned.

6. The Country Assistance Strategy (CAS)23, which was discussed by the Board on June 6, 2006, includes a Fiduciary Action Plan (FAP) to help strengthen the operating environment for Bank projects in Argentina. The FAP basically consists of three components: raising public awareness, bolstering Bank fiduciary monitoring and increasing transparency and competition practices in public procurement. Regarding FM the Plan aims at: (i) improving timeliness of

[23] Argentina Country Assistance Strategy. Period 2006-2008; May 4, 2006; Box 8.

external audit compliance for Bank-financed operations; (ii) increasing strategic focus and coverage of supervision tools assessing fiduciary risk in operations; and (iii) complementary actions such as support streamlining and harmonization of fiduciary processes and reliance on country systems when these meet adequate fiduciary standards.

Incremental Fiduciary Control Framework

7. Given the characteristics of this operation and Argentina portfolio performance, complementary measures on standard FM arrangements are part of the APL-II fiduciary control framework. Incremental control measures are described below.

8. Fiduciary Action Plan (FAP). Fiduciary measures of the APL second phase are consistent with the pillars of the Fiduciary Action Plan included in the Argentina Country Assistance Strategy. Specific measures for the APL are the combined role of the concurrent operational auditor and the internal oversight exercised by the ASM, *Area de Supervision y Monitoreo*. These measures will contribute to maintain an appropriate fiduciary control environment throughout implementation and to help support the APL execution. The concurrent audit will also contribute to ensure that annual financial audits are received by the Bank on time.

9. Concurrent Audit. Capitation payments and appropriate use of the loan proceeds including the practices followed in enrollment and reporting enrollment will be concurrently audited by an external private audit firm acceptable to the Bank. The concurrent operational audit will have a continuous engagement from the beginning of the project. It is a center piece of the APL fiduciary control framework and will focus mainly on: (i) the validation of the "billing" by the province on the basis of enrollment and (ii) the production or outputs (trazadoras) reported by the provinces on the level of service attained. Reports of the concurrent auditor will be made available to the Bank for review. The same as for APL-I the contracting of the concurrent auditor will be a condition of disbursements for the Capitation Payment expenditure category. The contracting of the Concurrent Auditor will follow terms of reference acceptable to the Bank Financial Management Specialist (FMS), and will include:

(i) An opinion on the veracity of the "billings" sent by participating provinces to MSN/NHSPT justifying the basic payment (60 percent) of the "capitation";

(ii) An opinion on the reliability of "billings" based on service production goals ("trazadoras") (up to 40 percent of the "capitation");

(iii) An opinion on the management of the transfer of capitation payments to provinces; and

(iv) Conclusions on, and recommendations for, modifying the processes used for maintaining and updating enrollments and for maintaining valid information on coverage. Opinions, conclusions and recommendations would be given every 3 months The team presented by the firm to be selected would have as a minimum requirement, experience in supervising and/or auditing insurance schemes, public administration procedures and financial auditing.

10. In order to ensure the audit firm's independence, the terms of reference for the Concurrent Auditor shall include a clause stating that the concurrent auditor is not allowed to provide non-audit services to the MSN during its tenure as concurrent auditor for the Project.

11. Internal Oversight. The NHSPT of Plan Nacer includes the Oversight, Monitoring and Audit Group, Supervision and Monitoring Team -- *Area de Supervision y Monitoreo (ASM)* which will exercise supervision on both the technical and the financial side of the provinces. This group is coordinated by a professional with a degree in accounting and composed of professional staff that is qualified for the position they occupy. The ASM will prepare annual planning to carry out agreed upon audit procedures that will cover inter alia: (i) reconciliation of the provincial project account where the Loan resources will be transferred, (ii) assessing the debits and credits to services' providers, (iii) using sample control techniques with respect to the process for comparing social security databases at the national and provincial level, and (iv) review of supporting documentation of the billings of the services' providers. The ASM will visit the provinces and produce periodic reports including recommendations on findings on the work performed. All of the nine participating provinces of APL-I were visited by the ASM at least twice since the beginning of the implementation and all of the reports have been received by the Bank. The ASM will continue exercising its effective control over the participating provinces of APL-II. In order to deal with additional workload of the APL-II, the team of inspectors of ASM should be reinforced accordingly.

Implementing Entity

12. The National Ministry of Health (MSN) will have overall responsibility for project implementation through the NHSPT with the support of the International Finance Unit (UFI-S) for financial management and procurement. The UFI-S has experienced staff and expertise in the implementation of WB-financed projects.

13. Assisting the NHSPT, UFI-S will be in charge of project budgeting, disbursements, accounting and financial reporting as well as treasury operations including payments for project expenditures and transfers to the provinces.

Risk Assessment and Mitigation

14. The FM risk assessment process aims at identifying FM risks so as to take appropriate measures mitigating identified project risks. This enables the Bank to make decisions on the appropriate level of supervision intensity allocating FM resources in a manner consistent with assessed risks. The overall FM risk was assessed as *modest*. Two major factors taken into consideration for the risk assessment are the project environment as well as the specific fiduciary control framework, which includes: (i) UFI-S institutional capacity on FM; comprising processes and systems for budgeting, accounting, financial reporting and treasury operations; (ii) the combined role of the concurrent operational auditor and the internal oversight exercised by the ASM. A detailed risk assessment is provided below:

Table A7.1. Risk Assessment and Mitigation Measures

Risk	*RiskRating* [after mitigation measures]*	*Risk Mitigating Measures embedded in Project Design*	*Condition*
Inherent Risk			
▪ Country Level	Modest	Enhanced Control through the FAP	
▪ Entity Level UFI-S has qualified accounting staff that has experience in WB-financed operations.	Modest		
▪ Project Level Large number and wide geographical distribution of beneficiaries.	Modest	- Operational concurrent audit under TOR and by audit firm acceptable to the Bank - Effective internal oversight by the ASN, visiting the provinces and covering both technical and financial aspects	Legal covenant

Control Risk			
▪ budgeting	Low	Separate Program budget line in MSN budget system (SIDIF) to allow tracking budget resources.	Legal covenant
▪ Accounting Minor observations on accounting in APL-I	Modest	UFI-S system will be used	
▪ Internal Control	Modest	- Operational concurrent audit under TOR acceptable to the Bank - Effective internal oversight by the ASN, visiting the provinces and covering both technical and financial aspects.	Legal covenant
▪ Funds Flow	Modest		
▪ Financial Reporting No material issues in APL-I.	Modest		
▪ Auditing	Modest	- Acceptable audited financial statements received by the Bank on time in APL-I; as result of additional concurrent audit.	Legal covenant
Overall Residual Risk rating	Modest		

(*) L= Low M= Modest S= Substantial H= High

Accounting and Financial Reporting

15. The same as for the ongoing APL-I, the UFI-S will be responsible for the project accounting and will produce the requisite annual financial statements following the International Accounting Standards (IAS). Key UFI-S FM staffs are qualified for the position they occupy and capable of fulfilling the accounting and reporting needs of APL-II.

16. The UFI-S will follow the administrative processes and procedures covered in its Operational Manual, which were assessed and found acceptable for APL-I. During APL-II

preparation it was confirmed that no significant changes were made to the Manual. An initiative of the Government of Argentina aims at using of the UEPEX[24] system for financial management of multilateral-financed projects at federal level. Instead UFI-S will continue to use its own system to maintain the accounting records on a cash basis accounting.

17. The MSN will make the arrangements to set a separate line for the program in the annual budget for tracking budget resources execution.

18. UFI-S will be responsible for preparing the annual financial statements with the chart of accounts reflecting the project categories, components and source of funding. Project chart of accounts and format of financial reporting would be similar to the ongoing APL-1.

19. UFI-S will also prepare six months forecasts of project expenditures to request advances supported by quarterly Interim Unaudited Financial Reports (IUFR), as follows:

- Source and uses of funds, for each quarter and cumulative (uses by component), and uses of funds by category; accompanied by a statement of movements in the designated account.
- Physical progress: providing a comparison between actual number of beneficiaries enrolled in each province to projected estimations for the period.

External Audit Arrangements

20. Annual Financial Audit. The project annual financial statement will be audited under Terms of Reference prepared in line with Bank Guidelines to be performed by an independent auditor and following auditing standards acceptable to the Bank. It is expected that the audit be conducted by the Argentine Supreme Audit Institution, *Auditoría General de la Nación (AGN)* as was the case in the ongoing APL-I. For audit purposes, the fiscal year will be the calendar year.

21. Concurrent Operational Audit. A private audit firm acceptable to the Bank will be contracted under TORs agreed with the Bank. The concurrent audit will give an opinion on the validation of the "billings" based on the enrollment databases and on the service outputs *(trazadoras)* sent by each province, and will also render an opinion on the management of the transfers for capitation payments to provinces and compliance by each province with the umbrella agreement and the Loan agreement clauses. Concurrent audit reports should be submitted and made available to the Bank quarterly.

22. APL-I Audit Results. An acceptable auditor report for the year 2005 was received by the Bank on time. The audit complied with most Bank reporting requirements and cash receipts from the Loan account agree with the Bank disbursements records. It is important to note that AGN financial audit outcomes relied upon work done and reports issued by the concurrent operational auditor. Although the nature of auditors' qualifications did not relate to the uses of funds, the auditors' observations were raised by the Bank and addressed with the NHPST during APL-I supervision. As a result, the concurrent operational auditors were requested to perform additional auditing procedures; and satisfactory concurrent audit reports were given on August 4, 2006 on the veracity of the negative enrollees databases (PUCO) and other minor issues were properly addressed as well. Concurrent audits of APL-I have been performed under TORs acceptable to

[24] UEPEX: Information and Accounting Software, *Unidades Ejecutoras de Proyectos con Financiamiento Externo*

the Bank. All of the concurrent auditor's reports were received by the Bank. A review of the concurrent auditor's reports was performed as part of the APL-I supervision.

Table A7.2. Audit Reports' Schedule

Audit Report	Due Date
1) Project Specific Financial Statements	June 30
2) Special Opinions	June 30
▪ Summary Reports (IUFRs)	June 30
▪ Designated Account (Special Account)	June 30
3) Concurrent Operational Audit Report	Quarterly

Funds Flow and Disbursement Arrangements

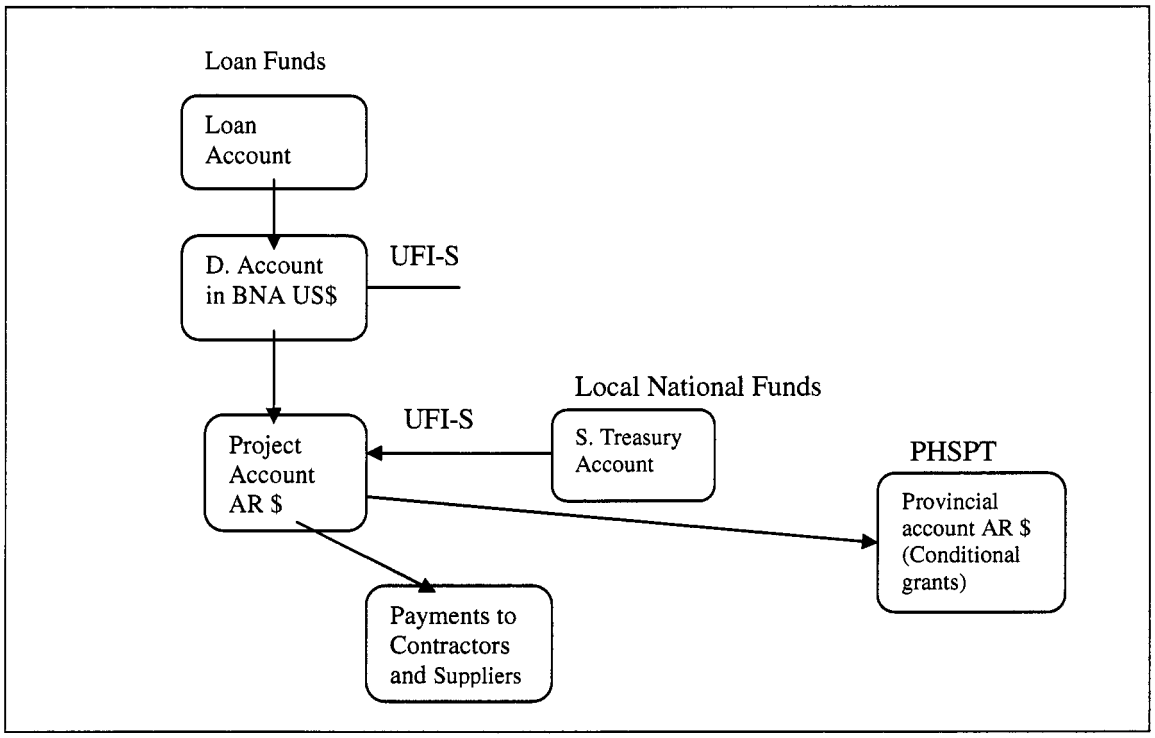
23. The following Disbursement Methods may be used under the Loan:

- Reimbursement
- Advance
- Direct Payment

24. Equivalent to APL-I, the advance method for disbursements will be used. Advances will be made on the basis of a six month forecast of project expenditures supported by quarterly Interim Unaudited Financial Reports (IUFR). Similarly, reporting on the use of advances will be supported by IUFR. All supporting documentation of expenditures and records will be retained by UFI-S for at least one year after the Bank has received the final audited financial statements.

25. Loan proceeds would be disbursed into a segregate designated account (Special Account in the old terminology) to be opened in the *Banco de la Nación Argentina* in dollars, which would be used only to deposit advances for the project. As expenditures arise funds would be converted to local currency and deposited in an project account under the control of the NHSPT through the UFI-S which would meet the project costs either as direct payment to suppliers, reimbursements of costs incurred and authorized by participating provinces, or as transfers as conditional grants to the participating provinces. Funds transferred to the PHSPTs would be deposited to a project account separate from the provincial consolidate fund, from which the PHSPT will only make payments to services' providers of the health package.

Graph A7.1. Proposed Flow of Funds



26. The minimum value for applications for direct payment and reimbursement would be established at the amount of US$50,000. Retroactive financing of up to 10 percent of the loan amount is being considered.

Uses of Funds

27. Uses of funds; comprise (i) payment to suppliers and consultants for all components outside of the MCHIP capitation payment and (ii) transfers to participating provinces as conditional grants through the MCHIP capitation payment. All uses would be processed in the UFI-S and supported by external third party documentary evidence and the related goods and services procured in line with Bank guidelines in the case of supplier payment and billings by the participating provinces supported by enrollment listings in the case of the transfers. The arrangements for the implementation of payment to suppliers are now in place. The MCHIP conditional grant transfers to the provinces (capitation payments), on the other hand, are to be made on a per capita basis of the enrolled population; these uses would be recorded as transfers and supported by enrollment lists from the provinces and they are subject to penalty for performance under the targeted benchmarks *(trazadoras).* The fund's use, control, recording and reporting by the province of the conditional grants are governed by a specific Nation-Province Umbrella Agreement which is supported by a detailed regulation *(reglamento operativo).* Additionally, a uniform enrollment system (in use for APL-I) would be installed in each participating province to control and report enrollment. Appropriate use of the loan proceeds paid

as conditional transfers would be assured through auditing by the concurrent auditor, the practices followed in enrollment and reporting enrollment and the outputs from the insurance program and monitoring by the Insurance Program Unit, *(Area de Supervision y Monitoreo, ASM)* in MSN, as well.

28. The transfers fund a portion of a package of basic health services (PBS) defined by GOA/MSN, which is highly cost-effective for the current maternal and child mortality profile in the provinces. The interventions included in the PBS include consultations with health care professionals, medications, normal and complicated delivery services, community follow-up, all packaged and made available over time. These interventions are listed in the MCHIP PBS Health Services List *(Nomenclador)*, which has been agreed between GOA and the Bank, and include about 80 health interventions. The nomenclador would be mandatory for all participating provinces. The nomenclador does not logically fit into any standard category of expenditures (such as works, goods, equipment or consultants). The same as for APL-I the Bank would, therefore, include the Capitation Payment of MCHIP Services as a separate disbursement category.

29. Disbursement to a particular province would depend on the implementation of acceptable Umbrella Agreement covering all permanent technical, financial, administrative and fiduciary aspects of the provincial participation in the program; and the installation of the Insurance Program software that would inter alia, indicate that the province was effectively participating in the program, and therefore, be eligible to receive the grants. Minimum fiduciary requirements to start disbursements to a participating province will include: opening a separate project account where capitation transfers from the MSN will be deposited; installation of the software to control enrollment databases; appointment of qualified staff responsible for FM duties that will make a statement that she/he is aware of all the fiduciary requirements for the operation.

30. The project estimated, through an in-depth study that considered actual costs of inputs to the PBS services, the average per-capita cost for providing the PBS to the eligible population. The cost of the benefit has been developed through analysis of the actual costs of its component parts, accounting for actual prices that prevail in the markets for medical goods and services, technology improvements and efficiency standards, and expected economies of scale. These costs have been brought to a per-capita average accounting for the size of the beneficiary pool. These costs are considered to be reliable proxies, on average, for actual costs of delivering the PBS.

31. The estimated average cost of the PBS is about US$10.0 (per-capita/month). The GOA and the participating provinces would directly finance 50 percent of that cost. Additionally, participating provinces would receive a grant transfer (Capitation Payment for MCHIP Services) from the MSN to finance the remaining 50 percent required to provide the services for the first three years of the MCHIP and on a declining basis thereafter. This grant transfer, to be financed by the loan on an average per-capita basis, is conceptually equivalent to a contribution to finance the cost of the premium for a traditional health insurance scheme. However, to avoid confusion, as MCHIP is a publicly financed program rather than a traditional contributory health insurance arrangement, it is called "Capitation" rather than "premium". Disbursements from the national level to the province (to be financed by loan proceeds) would be made on a capitation basis for each eligible beneficiary actually enrolled in the MCHIP.

32. To set correct incentives to the provinces to enroll and to monitor closely and ensure that providers actually deliver the services, the cash flow of the capitation would be done in two installments: (i) 60 percent would be disbursed immediately after the province sends the register ("quasi-bill") with the enrollees each month and after such register has been certified (through cross-checking with existing up to date enrollee databases from the provincial and national social

security) by the auditing subunit of the National MCHIP Program in the NHSPT; and (ii) 40 percent would be disbursed periodically (4 months) after verification and certification by the same unit that the province actually met the production targets for 10 types of interventions selected as tracers of service production *("trazadoras")*. Achieving the production target for each of the 10 tracers *("trazadoras")* would entitle the participating province to receive four percent of the capitation payment for each enrolled participant in the period. Achieving all 10 would mean that the participant province receives the total 40 percent associated to the "trazadora system". Accordingly, disbursements of loan proceeds for the Capitation Payment expenditure category would be made against the certified "quasi-bill" and the certified "trazadoras" reports submitted by participating provinces. Both the "quasi-bill" submitted by the province on the basis of enrollment and the provincial report of achieving the targets would be audited, with a delay of 3 months, by an independent auditing firm ("Concurrent Auditor") and the ASM team of inspectors. In consideration of the implementation complexity of the "trazadora" system, during the initial six month period after project effectiveness, disbursements to participating provinces would be made 100 percent on the basis of enrollment.

33. The partial financing of the PBS by the national level (only up to 50 percent and descending) and the flow of funds method would assure that the MSN sets the right incentive framework to the participating provinces and does not over-fund the MCHIP. Proxies for "output" would be the 10 PBS interventions *("trazadoras")* which are statistically verifiable occurrences reflected in the provinces health service records. Therefore, the MSN transfer would be directly related to specific outputs received by intended beneficiaries. Loan disbursements would be made on a declining percentage basis after the third project year for each participating province.

34. Annually, GOA and the Bank would hold discussions about the experience and lessons of the previous year implementation of the capitation system in general and about the capitation amount, the list of "trazadoras" and the services included in the Nomenclador in particular and would decide about specific adjustments as appropriate.

35. PHSPTs would be responsible for consolidating their provincial financial accounts and providing this information to the NHSPT/UFI-S. PHSPTs would be responsible for performing a first "cleaning up" of the enrollment list to be submitted as "quasi-bills". They would do so through comparing enrollment lists of the MCHIP with those of the National Obras Sociales and those of the Provincial Obra Social. The NHSPT would also perform a verification of the lists provided by the PHSPTs.

36. The uses of the funds by the PHSPTs to pay providers of the PBS would be based on payment mechanisms agreed between the province and the provider, for services actually performed (at a uniform pre-set price, applied across the province). In case of primary health care providers, the PHSPTs could pay them on the basis of capitation, however, capitations for provider payment can not account for more than 35 percent of monthly MCHIP expenditures in the province. PHSPTs would be responsible for consolidating their provincial financial accounts and providing this information to the NHSPT with the assistance of the UFI-S. Provincial documentation would be held by the PHSPTs with copies held by the NHSPT at the UFI-S. The NHSPT at the UFI-S would retain documentation of consolidated financial operations for annual audits and periodic Bank inspection although these are not used for justification of the transfers to the provinces. UFI-S would also perform a desk review of the control framework in PHSPA of each participating province. Results of the reviews should be documented and held by the UFI-S for periodic Bank supervision.

37. The UFI-S will continue accessing the Bank's Client Connection website to download the 1903 Form and to perform the reconciliation process periodically between their bank account and the resources received from different sources.

38. Loan proceeds would be disbursed through the following disbursement categories:

Table A7.3. Disbursements per Expenditure Category

Category	Amount of the Loan Allocated (US$M)	Percentage of Expenditures to be financed
(1) Consultants' services including auditing services for the Project	35.9	100%
(2) Goods	35.6	100%
(3) Training	5.6	100%
(4) Capitation Payment (*)	208.5	100% until disbursements under this category have reached an amount of US$128 million, 70% until disbursements have reached an amount of US$177 million, and 40% thereafter
(5) Operating Costs	0.4	85%
(6) Unallocated	14.0	
Total Project Loan	**300.0**	

(*) The Capitation represents only up to 50 percent of the total average cost of the PBS during the first 3 years and then it would be a declining proportion of such cost. The rest would be financed by local counterpart funds.

Supervision Plan

39. The initial supervision planning is presented in the table below. The supervision scope will be defined and adjusted by the assigned FMS according to the APL-II fiduciary performance and updated risk.

Table A7.4. Financial Management Supervision Plan

Type	Timing	Mechanism	Objective
On-site Visit	General Supervision: Once a year.	Integrating supervision missions at least once each year.	♦ Review FM performance. ♦ Follow up on External Auditors recommendations/ raised issues. ♦ Review staffing. ♦ Update assigned risk.
IUFRs Review	With each report	Over the IUFRs submitted to the Bank for disbursement purposes.	♦ Review IUFRs information consistency. ♦ Raise issues disclosed in IUFRs.
Financial Audit Review	Once a Year	Over the Audit Report submitted to the Bank	♦ Review Audit Report. ♦ Raise issues disclosed in Audit
Concurrent Audit Review	Quarterly	Over the Concurrent audit report	♦ Review issues disclosed by the concurrent auditor.

Annex 8: Procurement Arrangements

A. General

1. Procurement for the proposed project would be carried out in accordance with the World Bank's "Guidelines: Procurement under IBRD Loans and IDA Credits" dated May 2004; and "Guidelines: Selection and Employment of Consultants by World Bank Borrowers" dated May 2004, and the provisions stipulated in the Legal Agreement. The various items under different expenditure categories are described and summarized below. For each contract to be financed by the Loan, the applicable procurement methods or consultant selection methods, the need for pre-qualification, when necessary, estimated costs, prior review requirements, and time frame are agreed between the Borrower and the Bank in the Procurement Plan dated August 30, 2006. The project would be implemented in accordance with the Fiduciary Action Plan (FAP) agreed upon by the Government of Argentina and the Bank, as per the indications of this document and the pertinent provisions of the Legal Agreement.

2. **Procurement of Goods:** Goods procured under this project would include medical equipment and instruments, software, IT, communications and office equipment. All goods estimated to cost over $500,000 shall be procured using International Competitive Bidding (ICB) procedures and Bank's standard bidding documents (SBD). Goods estimated to cost less than $500,000 may be procured in accordance with National Competitive Bidding (NCB). Contracts for goods which cannot be grouped into larger bidding packages and estimated to cost less than $100,000 per contract may be procured using Shopping. The procurement will be done using National SBD and Requests for Quotations agreed with or satisfactory to the Bank.

3. **Procurement of non-consulting services:** Services procured under this project would include advertisement for dissemination campaigns and possibly behavioral surveys. All non-consulting services estimated to cost over $500,000 shall be procured using International Competitive Bidding (ICB) procedures and Bank's standard bidding documents (SBD). Non-consulting services estimated to cost less than $500,000 may be procured in accordance with National Competitive Bidding (NCB). Contracts for services which cannot be grouped into larger bidding packages and estimated to cost less than $100,000 per contract may be procured using Shopping. The procurement will be done using National SBD and Requests for Quotations agreed with or satisfactory to the Bank.

4. *Advertisement:* All procurement notices and bidding documents shall be published in *"Oficina Nacional de Contrataciones" (ONC)* web page. ICB procurement notices and contract award information shall be advertised in *UN Development Business online (UNDB online)* and in the *Development Gateway's dg Market.* ONC shall also be used to publish information on awarded contracts in accordance with provisions of paragraphs 2.60 of the Procurement Guidelines.

5. **Selection of Consultants:** Consultants Services procured would include technical assistance and studies, trainers for MSN and MSPs staff and for health care providers, IT systems design, concurrent audit and incremental staff. **Firms:** all contracts for firms would be procured using Quality-and Cost-Based Selection (QCBS), except for small contracts for assignments of standard or outing nature and estimated to cost less than $100,000 equivalent or less per contract that would be procured using Consultants' Qualifications (CQ). Least Cost Selection (LCS) may be used under the conditions stipulated in the Consultant Guidelines. Short Lists of consultants for services estimated to cost less than US $500,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines. Individuals would be selected through comparison of CVs.

6. *Advertisement:* ONC shall also be used to advertise a request of expression of interest for consulting firms or individuals, and to publish information on awarded contracts in accordance with provisions of paragraphs 2.28 of the Consultants Guidelines and as mandated by local legislation. Contracts expected to cost more than US$ 200,000 shall additionally be advertised in *UNDB online* and in *dgMarket.*

7. **Operating Costs:** Operating Costs such as expenditures for rental fees of training facilities, books, seminar fees and services for delivering training expected to cost less than the equivalent of $3,000 each may be procured using the following local procedures: (a) revolving fund ("*Fondo Rotatorio*"), for items costing $3,000 equivalent or less, and (b) petty cash ("*Caja Chica*"), for items costing $1,000 or less. Both procedures should be described in the Operational Manual. The implementing agency's administrative procedures were reviewed and found acceptable to the Bank. Bank procedures should be followed for items whose cost exceeds the amount of $3,000.

8. **Others:** Procedures regarding the conditional grants to the Provincial governments to fund the per capita cost of providing Maternal Child Health Insurance Program (MCHIP) coverage to the target population are not dealt with in this Annex since the above-mentioned grants would not follow procurement rules. The above, notwithstanding, information on conditional grants should be included in the Bank's publicly accessible Procurement Plans Execution System (SEPA), according to formats and procedures to be specified in TORs to be attached to the Minutes of Negotiations.

9. The procurement procedures and SBDs to be used for each procurement method, as well as model contracts for goods, non-consulting services and consultants' services procured, will be presented in the project's web page: www.nacer.gov.ar within thirty days of receiving no-objection by the Bank.

B. Assessment of the agency's capacity to implement procurement

10. Procurement activities, at the national level, will be carried out by the National Ministry of Health (MSN), through the International Finance Unit (*Unidad de Financiamiento Internacional del Ministerio de Salud* - UFI-S). The MSN technical staff would be responsible for preparing terms of reference and technical specifications of the contracts to be let and for the timing of such acquisitions, for providing technical input into bid evaluation procedures and for verifying that goods and services received match technical specifications. UFI-S would be responsible for consolidating procurement plans, preparing bidding documents, seeking prior review and no-objections as needed, conducting procurement processes, managing contracts and payments, and retaining documentation. UFI-S would also advise and train PHSPT at the request of the NHSPT on the procurement arrangements to be followed under the project, and supervise their procurement performance in implementing the annual MCHIP performance agreements between the MSN and MSPs.

11. At the provincial levels, under terms of the umbrella agreements, PHSPTs would incorporate a small "procurement and purchase unit" with responsibilities similar to those of the UFI-S, but would deal with the World Bank only through the NHSPT with the assistance of the UFI-S. PHSPTs would be authorized to hire individuals and to undertake shopping procedures and would obtain prior review and clearance from the NHSPT with the assistance of the UFI-S for all contracts for consulting and training services.

12. The UFI-S is staffed by a General Coordinator, to whom the following areas report (i) Procurement, (ii) Financial Management and (iii) Project Coordination and Management. The professional staff of all these three (3) areas has adequate education and background. UFI-S even

has its own Legal Advisor. UFI-S' structure and functions are described in detail in its Operational Manual, which got the Bank No Objection in January 15, 2004, the manual has been updated in July 2006.

13. The procurement function is staffed by: one (1) coordinator, five (5) consultants and two (2) assistants. Some of these consultants have broad experience in Bank procurement.

14. An assessment of the capacity of the Implementing Agency to implement procurement actions for the first phase of the project was carried during Appraisal of APL-I, in 2004. The assessment reviewed the organizational structure for implementing the project and the interaction between the project's staff responsible for procurement Officer and the Ministry's relevant central technical units and the PHSPTs.

15. The key issues and risks concerning procurement for implementation of the project that were identified during the assessment of the first phase of the project, such as: (1) inadequate procurement information system and (2) the omission of specifics on procurement procedures in the UFI-S Operational Manual, have already been implemented. External audits and procurement reviews have also provided evidence of the capacity of the UFI-S. None of their reports present serious deviations but some common deficiencies that are present in other projects in Argentina.

16. UFI-S has a good record keeping system in place. There is a separate room for keeping the files and one person is in charge of its integrity. IT infrastructure is adequate: all staff have computers, e-mail and good Internet access. UFI-S has also an intranet.

17. In addition to the above, there are a few issues that UFI-S needs to improve. The corrective measures which have been agreed upon are:

- To establish a tool within the information system to alert staff when the procurement processes are exceeding the required time.
- To ensure that each procurement staff takes responsibility of filing procurement documents related to the procurement process under his/her responsibility.
- To provide to the technical staff feedback on lessons learned in previous contracts to improve technical specifications and/or terms of reference.
- To coordinate with the technical staff the preparation and completion of the Procurement Plans at the beginning of each calendar year.
- To include individual contract data in the information system.
- To create a list of firms that had bad performance for future reference.

18. Additionally, the following country risks concerning procurement have been identified:

(a) Local procurement law, regulations and practices are not fully consistent with Bank rules and the Government and the Bank agreed on the need for assuring transparency, competition and civil society monitoring. The Bank and the government are addressing this through the development and implementation of the Fiduciary Action Plan (FAP) for the Bank portfolio in Argentina.
(b) The Government has determined not to resort International Arbitration as a conflict resolution mechanism.

19. Though the issues listed above have had no impact on the performance of the UFI-S thus far, preventing measures have been agreed to mitigate any potential risk. These measures are respectively the following:

(a) The Loan Agreement would include the Special Procurement Conditions consistent with the FAP and listed in Section F, which are aimed at eliminating conflicts between local regulations and at ensuring increased competition and civil society monitoring through: (a) electronic publication of procurement notices, bidding documents, requests of expressions of interest, contract award reports and Procurement Plans, and (b) feeding the Bank publicly accessible Procurement Plans Execution System (SEPA), both tasks to be accomplished according to formats and procedures to be specified in TORs acceptable to the Bank.
(b) All Project Standard Bidding Documents and Requests for Proposals will include adjudicator clauses acceptable to the Bank.
(c) The project financial auditor will include in its reports lists of contracts signed under the project and such lists will be certified by the project financial management auditor. If the project financial auditor is not able to do it, the MSN through UFI-S will provide a sworn statement attaching the list of contract signed under the project.

20. The overall project risk for procurement is *average*.

C. Procurement Plan

21. The Borrower, at appraisal, developed a procurement plan for project implementation which provides the basis for the procurement methods. An acceptable Procurement Plan, dated September 8, 2006 was furnished by the Borrower to the Bank for disclosure to the public. It was agreed that the Borrower will update the information contained in said Procurement Plan every six months during Project implementation, and present to the Bank the updated information in the format to be included in the Operational Manual, also for public disclosure by the Bank.

D. Frequency of Procurement Supervision

22. In addition to the prior review supervision to be carried out from Bank offices, the capacity assessment of the Implementing Agency has recommended one supervision mission a year to visit the field to carry out post review of procurement actions, (1) out of ten (10) contracts signed should be reviewed. Joint FM-Procurement supervision missions will be conducted in order to produce Integrated Fiduciary Performance Assessments (IFPAs) in the framework of the FAP.

E. Details of the Procurement Arrangements Involving International Competition

1. Goods and Non Consulting Services

(a) List of contract packages to be procured following ICB and direct contracting:

Ref. N°	Contract (description)	Estimated cost	Procuremnt Method	P-Q (yes/ no)	Domestic Prefe-rence (yes/no)	Review by Bank (Post/ prior)	Expected Bid-opening date	Comments
1	Ambulancias	1,815,000	ICB	No	Yes	Prior	05/22/2007	
2	Instrumental médico	10,608,000	ICB	No	Yes	Prior	06/22/2007	
3	PC, Servidores e Impresoras	1,989,000	ICB	No	Yes	Prior	04/24/2007	
4	Vehículos (4 x 4)	1,089,000	ICB	No	Yes	Prior	05/22/2007	
5	Espacios de difusión en TV -1 (Buenos Aires-CABA)	3,025,000	ICB	No	Yes	Prior	05/22/2007	
6	Espacios de difusión en radio -1 (Buenos Aires-CABA)	1,512,500	ICB	No	Yes	Prior	05/22/2007	
7	Espacios de difusión en TV -2 (Santa Fe-Entre Ríos-Córdoba)	1,210,000	ICB	No	Yes	Prior	05/22/2007	
8	Espacios de difusión en radio -2 (Santa Fe-Entre Ríos-Córdoba)	605,000	ICB	No	Yes	Prior	05/22/2007	
9	Espacios de difusión en TV -3 (La Pampa-Río Negro-Neuquén-San Luis)	605,000	ICB	No	Yes	Prior	05/22/2007	
10	Espacios de difusión en TV -4 (Mendoza-San Juan-La Rioja)	605,000	ICB	No	Yes	Prior	05/22/2007	
11	Espacios de difusión en TV -5 (Chubut-Santa Cruz -Tierra del Fuego)	605,000	ICB	No	Yes	Prior	05/22/2007	
12	Equipamiento informático	541,450	ICB	No	Yes	Prior	05/22/2007	
13	Material gráfico	544,500	ICB	No	Yes	Prior	05/22/2007	
14	Equipamiento médico	1,048,314	ICB	No	Yes	Prior	05/22/2007	

(b) Contracts estimated to cost above $500,000 per contract, direct contracting above $50,000 and the first contract procured under each procurement method will be subject to prior review by the Bank.

(c) Thresholds for ICB and NCB procedures for Goods and Non-Consulting Services are respectively the following: $500,000 and $100,000.

2. Consulting Services

(a) List of consulting assignments with short-list of international firms.

Ref. N°	Description of assignment	Estimated cost	Selection Method	Review by Bank (Post/prior)	Expected Proposals Submission date	Comments
20	Auditoría Externa Concurrente	3,872,000	SBCC	Prior	10/29/2006	En trámite de No Objeción
21	Unidades de Gestión de Seguro Provincial	968,000	SBCC	Prior	06/09/2007	
22	Fortalecimiento de las Unidades de Producción	907,500	SBCC	Prior	05/31/2007	
23	Estudio de Reestructuración	1,452,000	SBCC	Prior	11/02/2007	
24	Evaluación del Proyecto	1,113,200	SBCC	Prior	10/17/2006	En trámite de invitación
25	Encuesta de satisfacción	484,000	SBCC	Prior	10/28/2007	

(b) Consultancy services estimated to cost above $350,000 per contract, single source selection above $50,000 of consultants and the first contract procured under each selection method will be subject to prior review by the Bank.

(c) Short lists composed entirely of national consultants: Short lists of consultants for services estimated to cost less than $500,000 equivalent per contract may be composed entirely of national consultants in accordance with the provisions of paragraph 2.7 of the Consultant Guidelines.

F. Special Procurement Provisions.

23. The following "Special Procurement Provisions" would be included in the Loan Agreement (LA) and shall apply to procurement under the project:

(a) Foreign and local service providers, consultants and suppliers shall not be required: (i) to register; or (ii) to establish residence in Argentina or in a Province; or (iii) enter into association with other national or international bidders as a condition for submitting bids or proposals.

(b) Invitations to bid, bidding documents, minutes of bid opening, requests for expressions of interest, and contract award reports of all goods and services,

including consultants' shall be published in the web page of the Oficina Nacional de Contrataciones, the Borrower's National Contracting Board (ONC), in a manner acceptable to the Bank. The bidding period shall be counted from the date of publication of the invitation to bid or the bidding documents, whichever is later, to the date of bid opening.

(c) Witness prices shall not be used as a parameter for a bid evaluation or contract award.

(d) Bidders and consultants shall not be allowed to review or make copies of others bidders' bids or consultants' proposals, as the case may be.

(e) The Borrower: (i) shall feed the Bank's publicly accessible Procurement Plans Execution System (SEPA) within 30 days of Negotiations with the information contained in the initial Procurement Plan and (ii) shall update the Procurement Plan at least biannually or as required to reflect the actual project implementation needs and progress and shall feed the SEPA with the information contained in the updated Procurement Plan immediately thereafter.

(f) A two-envelope system for procurement will not be used for procurement of goods and services (other than consultant services).

(g) For contracts for goods and services, other than consulting services, "the most convenient" bid shall be the one that has been determined to be substantially responsive and has been determined to be the lowest evaluated bid, provided that further the bidder is determined to be qualified to perform the contract satisfactorily.

(h) The lowest evaluated bidder shall not be required to reduce its bid as a condition of contract award.

(i) National Competitive Bidding procedures would be modified in order to make them identical to International Competitive Bidding procedures, exception made of the following features: (a) advertisement may be limited to the national press or official gazette, and the ONC website; (b) the Borrower's currency may be used for the purposes of bidding and payment; (c) the bidding period (from the date of publication of the invitation to bid or the date that the documents are available, which ever is later, to the date of bid opening) may be reduced to 30 days; and (d) the INCOTERM clause Delivery Duty Paid (DDP) may be used for the procurement of goods.

(j) Consultants shall not be required to submit bid or performance securities.

24. **Procurement records.** Detailed procurement records, reflecting the Project's supply of goods, non-consultant services and consultant services, including records of time taken to complete key steps in the process and procurement activities related to supervision, review, and audits, would be maintained by the UFI-S. These records would be maintained for at least two years after the Project's closing date. The records for goods and non-consultant services would include public notices, bidding documents and addenda, bid opening information, bid evaluation reports, formal appeals by bidders and outcomes, signed contracts with related addenda and amendments, records on claims and dispute resolutions, and any other useful information. The records for consultant services would include public notices for expression of interest, request for proposals and addenda, technical and financial reports, formal appeals by consultants and outcomes, signed contracts, addenda and amendments, records on claims and dispute resolution

and any other useful information. The participating Provinces would retain all invoices, price comparisons, bids received, bid evaluation reports, and all of the documentation required under the law and ensure that it is readily available. The filing, record keeping, auditing, reporting, post-review, and monitoring of the smaller procurement activities are crucial for the successful application of the funds for ensuring economy, efficiency, and transparency.

Annex 9: Economic and Financial Analysis

Economic Analysis

1. The elements of the basic services package of activities (to be undertaken by provinces) have been selected to account for their cost-effectiveness as demonstrated through international experience. The *Plan Nacer's* benefit package (PBS) was designed by the MSN, in coordination with COFESA, and the list of services (*Nomenclador*) includes about 80 cost-effective interventions, including those that target the main causes of infant mortality (diarrhea and acute respiratory diseases as well as malnutrition and inadequate prenatal care) and maternal mortality (hemorrhage and infections linked to unsafe deliveries and complications from unsafe abortions). The benefit package also includes cost-effective interventions for primary health care promotion and prevention, as well as reproductive health after deliveries or miscarriage. An economic evaluation of the project, made following accepted international standards for estimating the current value of future avoided maternal and child deaths and the current value of future reduced maternal and child morbidity rate, has shown a substantial net present value (US$ 714 millions) and rate of return (about 17 percent) using a discount rate of 10 percent. Moreover, interventions are considered to be cost effective considering the significant importance of neonatal mortality as a determinant of infant mortality in Argentina, in that the estimated cost per year of life lost prevented is about US$ 400, which is consistent with other countries in the region with similar mortality profiles and programs.

Financial Analysis

2. **Cost of the PBS (Package of Basic Health Services)**: MSN estimated the average cost of the PBS in 2004, based on an analysis of actual costs in one of the APL-I provinces. Under the methodology employed, actual costs of component parts of the basic package were calculated, accounting for rates of use of the service by the beneficiary population, cost differences across the province and the difficulty in accessing the services. These costs were aggregated to account for the frequency of use recommended by medical science, and brought to a per capita cost per beneficiary. MSN updated the cost of the basic package at the end of the first year of implementation of the APL-I, due to variations in the cost of component parts of the basic package since 2004, and updated estimations of rates of use of the service. The actual average per capita monthly cost of the package is US$10.0 (about AR$ 30), which is in line with other LAC countries implementing similar packages. MSN decided that the average per capita monthly cost of the package in the APL-I provinces would be the same for the APL-II provinces.

3. **Cost of the Program in APL-II provinces**: The MSN would finance a maximum of 50 percent (US$5.0) of the per-capita monthly cost of the PBS. The relevant capitation cost for the purposes of the project is US$5.0 with the rest of the cost of introducing the program being non-Bank financed. With appropriate community outreach and experience, it is also expected that about 80 percent of the target population would be served by the third year of project implementation.

4. **Payments from the MSN to Provinces and Fiscal Impact**: MSN would reimburse all of the 50 percent of the per capita monthly cost of the PBS for the first three years and a decreasing share of the cost thereafter, ending its contribution after 5 years. On these assumptions, the cost of the transfers to provinces would increase from 8.7 percent of the MSN budget in the first project year to 12.5 percent of the budget in the second year before falling to 0 in the 6th year.

5. **Provincial Fiscal Impact**: For the APL-II provinces, on average, in the fourth project year, their contribution to the cost of the basic package would amount to 1.0 percent of the average MSP budget and rise to about 3.2 percent after year 5. The impact variation between provinces

shows a range from 0.6% of the City of Buenos Aires to 5.1% of the Province of Buenos Aires (Table A9-1). However, improved accounting and tracking of beneficiaries would lead to improved cost recovery from the insurance industry, and services are expected to gain in efficiency and effectiveness, which together would contain this increase to about 2.5 percent of the health budget. These increases are considered to be sustainable in the long term.

6. The provincial fiscal impacts include the following criteria: (i) the eligible population use the population projection by age and sex for each province from INDEC and the health coverage of the first semester of 2005 from the INDEC Permanent Household Survey; (ii) there are no changes projected in the structural poverty, unemployment or informal employment situations, all being factors which could affect the eligible population; (iii) the cost of the PBS is maintained at the same level for all the years of the project; (iv) the projection for the National Ministry of Health's expenditure use a nominal increment in AR$ of 10% in 2007 and 6.5% in the following years; and (v) the projection for the Provincial Ministry of Health's expenditure use a nominal increment in AR$ of 6.5% in all years.

Table A9.1. Impact of the provincial contribution to the incremental cost of the PBS
Percentage of the projected budget with the program

	PYR1 (2007)	PYR2 (2008)	PYR3 (2009)	PYR4 (2010)	PYR5 (2011)	2012
National	**8.70%**	**12.51%**	**12.43%**	**8.66%**	**6.72%**	**0.00%**
Provinces	**0.00%**	**0.00%**	**0.00%**	**0.9%**	**2.0%**	**3.2%**
Buenos Aires				1.5%	3.3%	5.1%
City of Buenos Aires				0.2%	0.4%	0.6%
Chubut				0.4%	0.9%	1.4%
Cordoba				1.5%	3.2%	5.0%
Entre Rios				1.0%	2.2%	3.4%
La Pampa				0.5%	1.1%	1.7%
La Rioja				0.8%	1.7%	2.6%
Mendoza				1.4%	3.1%	4.9%
Neuquen				0.3%	0.7%	1.2%
Rio Negro				0.7%	1.5%	2.4%
San Juan				1.2%	2.6%	4.1%
San Luis				1.1%	2.4%	3.7%
Santa Cruz				0.2%	0.5%	0.7%
Santa Fe				1.4%	3.0%	4.6%
Tierra del Fuego				0.2%	0.4%	0.6%

Note: PYR = Project Year

7. **Incremental costs of program administration costs.** These are likely to be negligible.

Annex 10: Safeguard Policy Issues

1. This Annex presents background information regarding indigenous inhabitants and a summary of the Indigenous Peoples Planning Framework[25]

2. Estimations of the number of indigenous inhabitants in Argentina vary significantly, illustrating the difficulties of identification and complexities of ascertaining ethnic backgrounds. Several sources have published estimations of indigenous inhabitants mounting up to one million (3 percent of the population). A Population Census was carried out by the National Institute for Statistics and Population Census (INDEC) in 2001, and for the first time, it includes a question to the households regarding indigenous self-identification criterion for persons living in it. In the census, 2.8 percent of households answered the question positively. The census included a complementary survey on indigenous households, carried out during 2004-2005. It includes 57,000 households that were asked 72 study questions addressing education level, distance to school, mothers' language, availability of transportation etc., to produce a systematic assessment of their size and composition. It also generated data on their living conditions and livelihoods. To reduce the level of misclassification, representatives of each target population were included as trainers to sensitize the team of research workers to the cultural environment and norms. It was finished by December 2005, and showed an estimated number of 402.921 indigenous inhabitants.

3. The Government, through the MSN under the first phase of the Plan Nacer, has embarked on one subsequent survey complementing the census data. It targets health and other social conditions for a comprehensive poverty analysis. Additionally, the MSN will carry out during the 2006-2007 period, a broad micro ethnographic study in indigenous communities. These studies will provide much needed information for all the provinces in order to capture the human development perspective and define development indicators to monitor the health process during implementation of APL-II.

Health status of indigenous peoples

4. In the absence of health statistics broken down by ethnicity, only rough estimations based on regional patterns and poverty figures can be given on the health conditions of indigenous peoples in Argentina. The census results highlight two significant health hazards common in indigenous households (i) the use of combustible fuels for cooking, and (ii) lack of adequate plumbing and sewage systems. In the absence of a ventilation system the first contributes to the high level of respiratory infections and the second to diarrhea and other intestinal problems.

5. Several barriers, both physical and mental, prevent indigenous communities from accessing conventional health care services. An important number of indigenous families reside in rural areas and lack means of transportation to reach the far off facilities, some due to inability to pay for the journey. Furthermore, indigenous individuals are often more comfortable with their communities own traditional medical care and many have experiences of disrespectful or discriminating treatment in public health care centers. Health seeking behavior of indigenous women is additionally influenced by strong gender norms, which define reproductive issues as taboo and limit women's decision-making power. The fact that many women experience the triple burden of reproductive, domestic and productive labor explains why they often have a higher morbidity rate than men.

6. To address any of these problems, the MSN has been implementing the Maternal Child Health Insurance Program (MCHIP) in nine of the poorest provinces, at the Northern region. The

[25] This annex presents a summary of the original IPPF presented by the Borrower in Spanish (see Project Files).

first phase of the insurance health program had a particular subcomponent that addressed the health condition of indigenous communities through the developing of tailor-made culturally-sensitive health plans. The extension of the Plan Nacer to all the country provinces will allow it to address these problems in all of those that meet the screening criteria.

Indigenous Peoples Planning Framework summary

7. The National Law 23.302 (Indigenous Policy and Strengthening the Aborigines Communities), published in the Official Bulletin of November 12/1985 and its correspondent Decree N° 155/89, in the articles 18 to 21, explain the position of the national Government with respect to the provision of health services for the indigenous population in Argentina: (i) creation of medical transport units to reach the dispersed indigenous population, (ii) free distribution of medicines, (iii) provision of essential public health services (sanitation, water, control of vector borne diseases), and (iv) provision of maternal and child heath care. The same decree refers to some other aspects of health care for the indigenous population, specifically the respect of traditional medicines and values, the education of indigenous peoples as primary health care auxiliaries, doctors and nurses, and the planning and monitoring of those actions in the original territory.

8. The Constitutional Reform of 1994 establishes in Article 75, among other things: respect for the cultural identity of indigenous peoples and their right to a bilingual and inter-cultural education, recognition of the juridical personality of their communities, and the communal possession and ownership of traditionally-held lands. It also establishes the need to ensure their participation in the management of natural resources. Argentina, as many other Latin American countries, has ratified International Labor Organization Convention 169.

9. **Description of the type of activities related to indigenous peoples to be financed by the project.** This proposal has been made from a perspective of social inclusion, which allows the action of MCHIP to be even more efficient and equitable for this sector of the population which has been historically excluded and dispersed over different provinces in the country. MCHIP intervention in this second phase of implementation includes instruments to ensure that project benefits are extended to indigenous peoples, with a more specific attention to their cultural values.

10. In the framework of phase 1 of MCHIP, several studies and actions have been planned and carried out in order to contribute to the design of the Indigenous Peoples Plans in the provinces which activate OP 4.10 in phase 2 of the project, among them:.

- Study of the Social Evaluation of the Indigenous Population of the NOA and NEA Regions (completed);
- Survey of Mother-Child Health Conditions in Indigenous peoples communities for the whole country (in process);
- Micro-ethnographic studies in indigenous peoples communities (in planning process);
- Diffusion of the findings of the studies in the provinces;
- Development and implementation of communication, diffusion and education strategies for Health adapted to the indigenous peoples' culture, including material in native tongues;
- Structuring of a surveillance service and monitoring of health conditions among indigenous peoples, whose indicators will come out of the mother-child health conditions survey and which would be implemented within the framework of the Ministry of Health's National Epidemiological Surveillance System (to be carried out);

- Statistical information from MCHIP about beneficiaries recognized as indigenous peoples, enrolled on MCHIP's register;
- Training for health service providers who consider a framework of respect and integration of cultural differences.

11. Although MCHIP's proposal is not specifically designed for indigenous people, as its target population is all pregnant women and children under the age of 6 who have no explicit health coverage in the country, the project proposes a particular focus which allows one to approach and act on the indigenous question from an intercultural standpoint. This is more appropriate to the social context of the indigenous people, which would be of more mutual benefit to the population and the program's objectives.

12. The Government is committed to the social inclusion of indigenous peoples, encouraging their participation as beneficiaries of the project. This phase of the program will build on the success of the first phase of Plan Nacer in the nine Northern provinces. The individual IPPs, with strategies and activities for addressing the needs of indigenous peoples in a given province will be included in the Annual Performance Agreements between MOH and these provinces, to implement the Plan Nacer specially adapted for the indigenous communities.

13. The Communication and Community Outreach component of the project at the national and provincial level will include strategies and activities specially adapted to indigenous peoples. To ensure effectiveness, the Communications Strategy will include specific consideration for cultural sensitivity to align the public campaign messages with locally accepted norms for indigenous communities. Additionally, communication material will be available for main indigenous languages such as Aymara, Quechua, Guarani and others, as needed.

14. **Possible effects and mechanisms for optimizing results**. Given the nature of the project, negative impacts are not expected. However, there is a possibility that complaints may arise from the population. A set of measures have been adopted in order to contribute to preventing conflicts as well as to their adequate resolution, should these arise.

15. For this, priority will be given to the following measures:

- In the event that complaints should be made about actions carried out by the project, the regular mechanisms for dealing with complaints put in place by the Provincial Ministries of Health will be used, and those planned by the project, on both national and provincial levels.
- Mechanisms such as user satisfaction surveys will form part of the project's regular activities. These surveys will be used to analyze the quality of attention seen from the user's point of view. MCHIP has the support of processes to improve quality in health services as part of its activities.

16. **Consultations**. On July 13, 2006, the Ministry of Health presented MCHIP, Plan Nacer and the original Spanish version of the IPPF to the Indigenous Participatory Council of INAI, including activities carried out in phase one of Plan Nacer in the nine Argentine provinces of the Northern Region. The Ministry of Health and INAI agreed to collaborate in order to optimize the smooth operating of the program at the provincial level, and to carry out a participatory process which guarantees access to the provisions of Plan Nacer for all the indigenous beneficiaries.

17. **Identification of Provinces that trigger the World Bank's Policy on Indigenous Peoples (OP 4.10).** Even though in the 15 provinces which make up the second phase of Plan Nacer there

are members of indigenous populations, not all of them are within the bounds set by the criteria of OP 4.10. to be considered indigenous peoples for its purpose. Many people have migrated to the cities for economic reasons and are not members of communities, from the sociological standpoint. For example, in the province of Buenos Aires and in the Autonomous City of Buenos Aires one can find Kolla families and/or individuals which ancestrally were located in Salta and Jujuy, as well as Tobas from Chaco, etc.

18. The procedure which was followed in order to define which provinces trigger OP 4.10 was the following: A first necessary step was to identify those provinces where, according to the available information, there are indigenous people who meet the criteria established in the OP 4.10 (para. 4). Three identified sources of information were analyzed:

1. *National Institute of Indigenous Affairs* - Instituto Nacional de Asuntos Indigenas (INAI): has registers of indigenous communities enrolled in the *National Indigenous Communities Register* (Registro Nacional de Comunidades Indígenas, RENACI), according to national and provincial level regulations.
2. The territories historically inhabited by these people, and where currently communities remain and have a collective attachment to the land.
3. Information from the 2001 National Census, particularly on self identification of individuals as indigenous.

19. Based on the criteria established in OP 4.10, at the present time and with the available information, the provinces that trigger the policy are: Tierra del Fuego, Chubut, Río Negro, Neuquén, La Pampa, Mendoza and San Juan.

20. In the Umbrella Agreement, to be signed with the MoH for the implementation of MCHIP, all provinces, both the provinces now triggering the application of OP 4.10 and those that might in the future, will be committed to the terms of the Umbrella Agreement to proceed to the social evaluation of the indigenous people meeting the identification criteria of OP 4.10 in their respective provinces and, if necessary, to prepare the Indigenous Peoples Plans according to the regulations in the IPPF.

21. These Framework Agreements will also reflect the obligation of the provinces, if this were the case, to: (a) reach the necessary inter-institutional arrangements in agreement with the corresponding provincial indigenous entities; and (b) incorporate the recommendations made by the national studies of Mother-Child Health Conditions among indigenous peoples (survey and micro ethno graphics), in the second year of execution of the Annual Performances Agreements between the Nation and each province which are a requirement of transferal of funds to the respective provinces.

22. On the basis of the information provided by the 2001 Census, it is estimated that there are 195,000 indigenous people in the provinces identified, corresponding to an estimated target population for PLAN NACER (children under 6 years old and pregnant women) of 26,700.

23. **General guidelines for the social assessment**. The Social Evaluation on Indigenous Populations which each identified province carries out according to Annex A of the OP 4.10, will be based on all the available information, avoiding duplication of efforts, and will additionally specify the following information:

- Demographic characteristics: age band – with special focus on children under 6 years of age and women of fertile age, gender, urban/rural, fertility rates, migration, masculinity.

- Aspects related to health: maternal mortality rate; child mortality rate; prevalent diseases; existing assistance network for attention in indigenous communities; supply and demand evaluation; health coverage; geographic, cultural and economic accessibility; different health and sickness concepts; traditional system of knowledge and practices in health and disease: gender relations; sexual and reproductive behavior; institutional childbirth; health indicators for the indigenous population.

24. **General guidelines for the preparation of Indigenous Peoples Plans (PPI).** As stated above, in those provinces where OP 4.10 is triggered due to the presence of indigenous communities that meet the criteria of identification of such policy, IPPs will be prepared following the guidelines given in OP 4.10 (Annex B).

25. In the preparation of provincial plans the different stages will be taken into account: enrollment, implementation, follow up and evaluation of the dissemination strategies and specific and adequate communication for indigenous people which guarantee complete knowledge of the Project. In each particular case the following will be anticipated: (i) material in native language; (ii) employing agents who have been trained to enroll these populations; (iii) diffusion of information campaign; (iv) consultation and complaints mechanisms on a national as well as provincial level; (v) training for health service provider's staff in order to assist the beneficiaries belonging to the communities and (vi) a specific description of Plan Nacer service delivery foreseen in each community.

26. The provincial plan could also include activities that the province could develop for or together with their communities in order to improve the quality and access to health for that population. Financing of the IPP will be from proceeds of the loan.

27. **Diffusion of the IPPF.** For the diffusion of the IPPF mechanisms of participation and information will be used, together with the national and provincial authorities, using the existing institutional framework regarding indigenous populations. A detailed description of this institutional framework is included in the original IPPF presented by the Government. The diffusion must be registered and will serve as input for the creation of the IPP for the identified provinces.

28. Taking into account the criteria established by the descriptive regulations of each provincial government, the identified provinces must design mechanisms for participation and prior consultation on project implementation of the indigenous peoples in their respective provinces. In the same way they must anticipate some mechanism in order to disseminate Indigenous Peoples Plans that have been prepared, with means for adequate verification (such as participative evaluation, agreements, reports, interviews, photographic and audio records and others) that contain suggestions and/or demands that could arise from the different communities, in such a way that they could be used as a basis for future training and inputs for the monitoring and evaluation system.

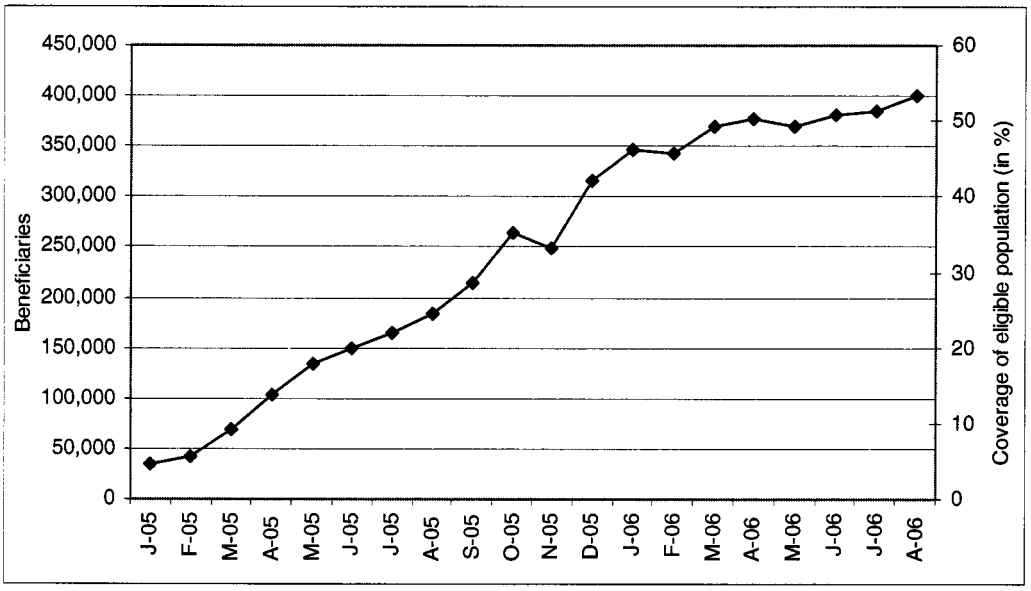
Annex 11: Principal findings of APL-I implementation

1. The APL-I became effective in November 2004. Since that time all nine northern project provinces have introduced Maternal and Child Health Insurance (*MCHIP or Plan Nacer*) and put in place the system to execute the requirements of this program including payment arrangements between the central government and the provinces, provider contracting at the provincial level, and the *trazadoras* system (performance goals).

Evolution of Enrollment

2. The project has shown very good implementation progress with 399,369 enrollees at the end of August 2006 or 49.2 percent of the eligible population. Since March 2006 enrollment has begun to grow at a low rate mainly related to the slow implementation of the communications component of the project.

Figure A 11.1. Enrollment of Target Population

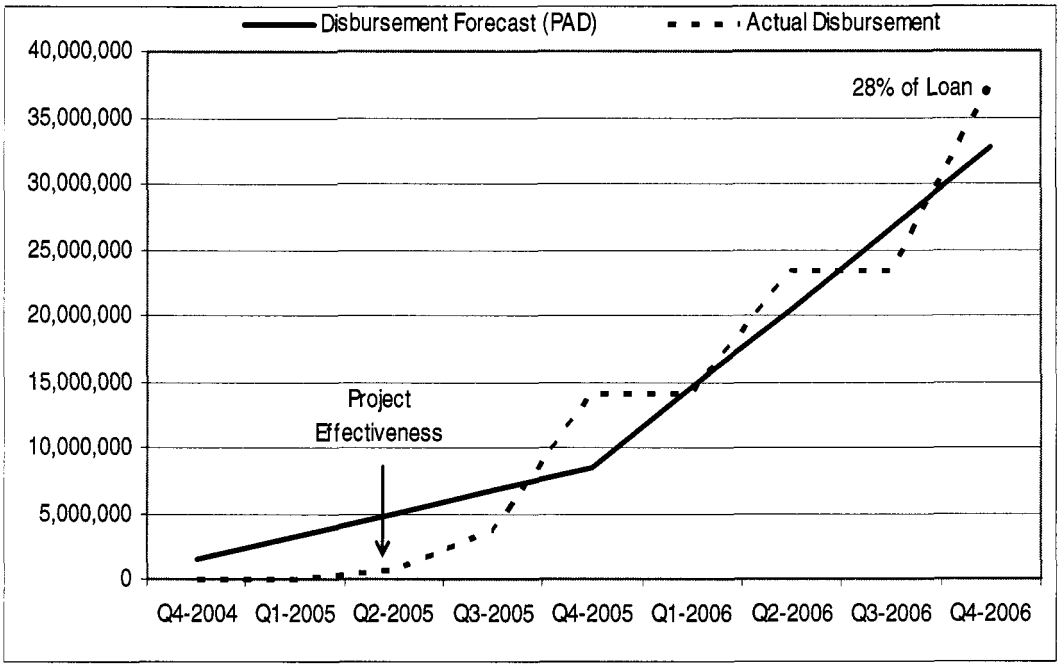


Source: MSN, NHSPT, Plan Nacer, 2006

Evolution of Project Disbursement

3. APL-I had disbursed US$37.5 million by the end of August 2006 or 28 percent of loan proceeds. The actual disbursements have surpassed forecasts (Figure A11.2). ARS$35.6 million of net transfers have been received by the provinces from the GoA, of which ARS$5.1 million is accounted for by the complementary financing (trazadoras) in addition to the monthly transfers. Contracting and payment systems have also become more effective. Invoicing has also increased and to date ARS$12.1 million has been invoiced.

Figure A 11.2. Project Disbursement: Forecasts and Actuals



Source: WB

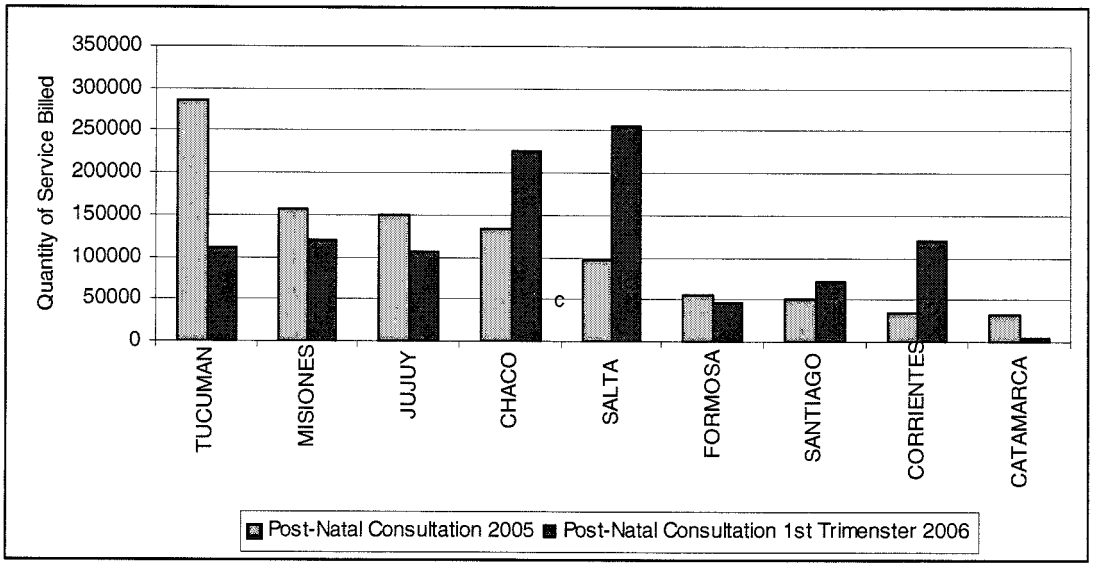
4. The checks and balances introduced in the system to verify results (internal audit, concurrent audit) have proved effective in both identifying errors but also providing an incentive to improve performance. For example, the number of errors identified per capitated month declared decreased from a peak of 30 percent in the first trimester of 2005 to 0.13 percent for the same period of 2006. Fines related to adjustments on monthly transfers have also decreased from ARS$15,400 in the first trimester of 2005 and were ARS$4,100 in the same period of 2006.

Evolution of Services

5. The level of service deliveries is increasing in all participating provinces. The payment mechanisms were implemented smoothly in 2005. The number of executed service deliveries has increased since the last quarter of 2005 (by end of June, 2006), 18,000 newborns from eligible pregnant women and almost 2,000 prenatal ecographys. Also, the system delivers more than 1.5 million of well-child and pregnant consultations26. Data shows that the level of services billed in the first trimester of 2006 was almost as high and in some cases higher than for all 2005 (figures A11.3 and A11.4). There is wider variation in the level of services billed across the provinces with Tucuman being amongst the most successful.

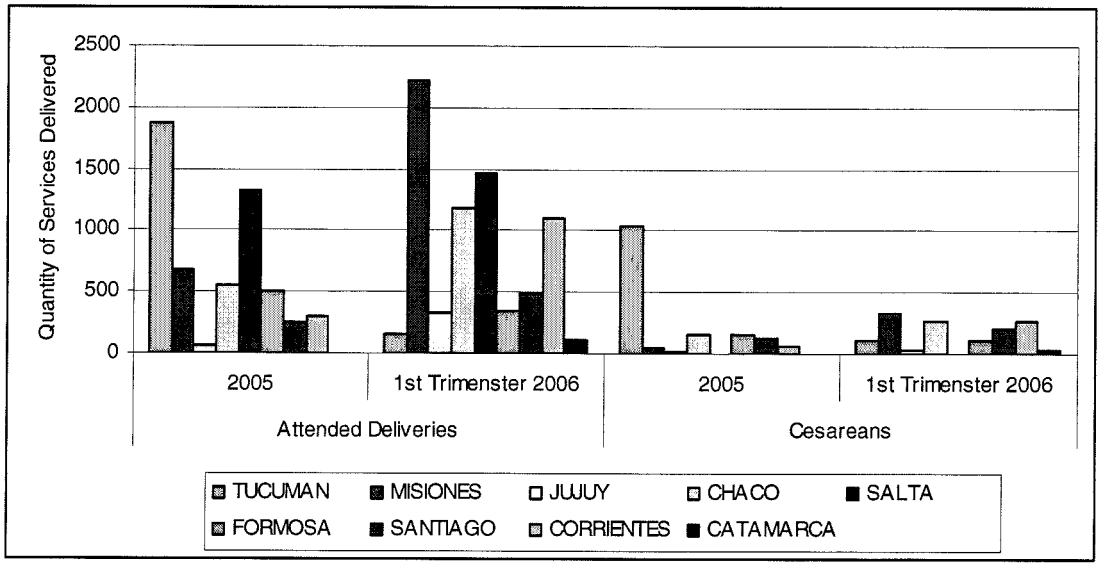
[26] Estimation based on capitation payments to primary health care centers in Participating Provinces

Figure A 11.3. Quantity of Pre-natal Consultation Services Billed



Source: MSN, NHSPT, Plan Nacer, 2006

Figure A 11.4. Quantity of Attended Deliveries and Cesareans



Source: MSN, NHSPT, Plan Nacer, 2006

Trazadoras results

6. The *trazadoras* system was implemented in June 2005. The provinces negotiate production targets for 10 tracers quarterly. To date, results have been obtained for three time periods between June 2005 and April 2006. The implementation of the system has been demanding for the provinces and the negotiated goals for each of the 10 *trazadoras* have been initially much lower than expected.

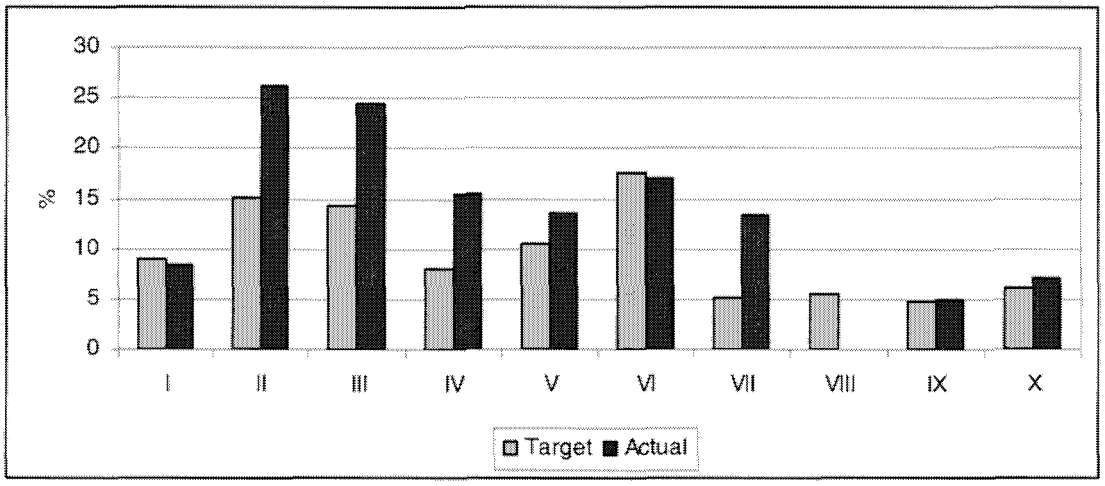
7. The *trazadora results* have shown permanent increases since the first period. Table 1 shows that there were significant increases in the achievement of *trazadoras* between the first and second time period measured (June-August 2005 and September-December 2005) while the achievement was maintained in the third period (January-April 2006). The average achievement of the 10 *trazadoras* has increased from three in the first time period to 7 in the two subsequent time periods evaluated. Further, Figure A11.5 compares the average *trazadoras* goals to actual results. For almost all *trazadoras* the actual results were either almost equal or higher than the targets. One exception is for tracer VII -well child care (1 year old or younger) - where there has been a general under achievement of this tracer in all provinces.

Table A11.1. Trazadora goals accomplished per province between June 2005-April 2006

Provinces	First Period (June-August 2005)	Second Period (September-December 2005)	Third Period (January-April 2006)
CATAMARCA	0	6	6
CORRIENTES	2	8	8
JUJUY	0	8	5
SALTA	0	5	6
SANTIAGO	6	7	8
TUCUMAN	7	8	9
CHACO	6	9	7
FORMOSA	3	8	8
MISIONES	3	7	7
Average	**3**	**7**	**7**
Total	**27**	**66**	**64**

Source: MSN, NHSPT, Plan Nacer, 2006

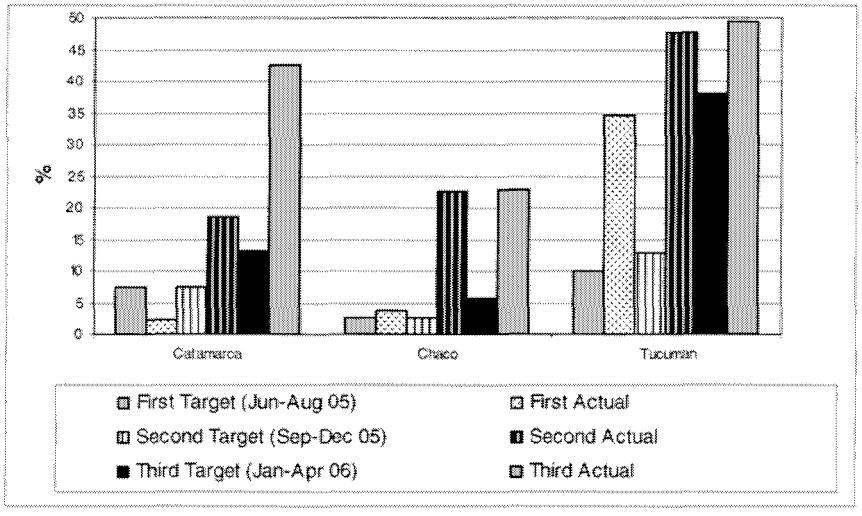
Figure A 11.5. Average accomplishment of *trazadors* comparing targets to actual results



Source: MSN, NHSPT, Plan Nacer, 2006

8. The trend for achievement over time can be clearly observed when examining tracer data by province. For example, Figure A11.6 shows the results for *trazadora* II in the provinces of Catamarca, Chaco and Tucuman compared to targets. The trend is for increasing achievement of this indicator over time. Tucuman showed strong results early on and continues to lead APL-I implementation and achievement of results. Catamarca on the other hand, after a slow start, has shown good progress. MSN has certified the fulfillment of *trazadoras* goals for these periods and transferred to provinces their respective performance based proportion of their financing. For the first time in Argentina's health sector, national financial transfers to the sector were linked to verifiable results.

Figure A 11.6. *Trazadora* Results (Apgar score) Proportion of eligible births with Apgar scores higher than 6 at minute 5 in selected provinces June 2005 – April 2006



Source: MSN, NHSPT, Plan Nacer, 2006

Concurrent Auditor

9. The concurrent auditor has delivered bimonthly audits since June 2005. The concurrent auditor also carried out a retroactive audit of the capitation payments paid by local funds from January to May 2005. The opinion on the veracity of the "billings" sent by participating provinces to MSN justifying the basic payment (60 percent) of the "capitation", have been an effective tool for the MSN in improving the systems to control the enrollment. Also, the opinions and recommendations on the payment mechanism to providers selected by the provinces have helped them to introduce some corrections in order to maintain the project objectives.

Lessons learned from APL-I

10. There are four main lessons learned from the experience thus far in the implementation of APL-I that would be applied to APL-II:

(i) *Need to further strengthen provider technical capacity for tracer system*: APL-I had anticipated the complexity and challenges of implementing the *tracer* system due to the limited capacity of the provider production information systems. Implementation has confirmed this expectation and experience thus far has indicated that additional technical support is required and the GoA is taking action to increase technical support to providers under APL-I. Given this experience, APL-II would also include a sub-component to specifically focus technical assistance to strengthen service provider capacity to collect and comply with the *tracer* system.

(ii) *Extension of concurrent audit for the duration of the project*: The external concurrent auditor has proven to be an extremely valuable tool in the implementation of APL-I both in auditing but also in the identification of system management and policy challenges. APL-I would extend the concurrent auditor through the entire duration of the project. APL-II would include loan proceeds to finance the concurrent auditor for the whole duration of the project.

(iii) *Incorporation of health purchasing teams as permanent units of national and provincial MoHs:* A central hypothesis in the design of APL-I was that the creation of the national and provincial health purchasing teams would be an effective strategy to change the incentive framework for efficiency in the public health sector. Although no final evaluation was available, preliminary evidence has suggested that indeed it has changed the efficiency framework. First, these teams have appropriately increased the focus on results in the policy dialogue between the provinces and the central government regarding financial transfers. Second, these have made evident, particularly at the provincial level, the limitations of their past knowledge about quality and quantity services provided to the population, as well as the limited usefulness of paying providers on the basis of production as a tool to monitor productivity. As a result, the Bank and GoA have decided that by the mid-term review of APL-I, the government would present to the Bank a plan to include the purchasing teams as permanent units of the national and provincial MoHs. Accordingly APL-II would support the implementation of Provincial Health Service Purchasing Units including also their inclusion as permanent units in their respective provincial health ministries by the mid-term review of APL-II.

(iv) *Adequate resources essential for implantation of an effective communication campaign:* An effective information campaign is essential to boosting the demand for participation

in the Maternal and Child Health Insurance. The implementation of the communication and information campaign has been slower than anticipated. In retrospect, not enough resources were allocated to the associated component for these activities under APL-I. Consequently, APL-I would increase resources to this component from unallocated funds. APL-II would substantially increase resources available for this component.

Annex 12: Project Preparation and Supervision

	Planned	Actual
PCN review	05/24/2006	05/24/2006
Initial PID to PIC	06/12/2006	06/12/2006
Initial ISDS to PIC	06/13/2006	06/13/2006
Appraisal	08/28/2006	08/28/2006
Negotiations	09/07/2006	
Board/RVP approval	10/24/2006	11/02/2006
Planned date of effectiveness		
Planned date of mid-term review		
Planned closing date		

Key institutions responsible for preparation of the project: National Ministry of Health, Argentina

Bank staff and consultants who worked on the project included:

Name	Title	Unit
Cristian C. Baeza	Lead Health Policy Specialist (TTL)	LCSHH
Luis Orlando Perez	Sr. Public Health Specialist	LCSHH
Monique Francine Mrazek	Health Economist	LCSHH
Gaston Mariano Blanco	Operations Officer	LCSHS
Jose Pablo Gomez	Senior Economist	LCSHH
Marta Molares-Halberg	Lead Counsel	LEGLA
Natalia Moncada	Program Assistant	LCSHD
Martha P. Vargas	Team Assistant	LCSHD
Paul Gertler	Chief Economist	HDNVP
Jorge Uquilias	Senior Sociologies	LCSEO
Emiliana Vegas	Education Economist	LCSHE
Antonio Blasco	Sr. Financial Management Specialist	LCSFM
Maria Lucy Giraldo	Sr. Procurement Specialist	LCOPR
Xiomara Morel	Sr. Finance Officer	LOAG1
David Peters	Sr Public Health Spec. (Peer Reviewer)	HDNHE
Pablo Gottret	Sr. Economist (Health) (Peer Reviewer)	HDNHE
April Harding	Sr. Economist (Health) (Peer Reviewer)	LCSHD
Juan Sanguinetti	Consultant	
Isabel Tomadin	Consultant	
Alejandro Solanot	Consultant	LCSFM

Annex 13. Documents in the Project File

1. Project files used for the Provincial Maternal-Child Health Investment Project – APL-I. March, 2004.
2. Operational Manual of APL-I. Ministry of Health. November, 2004.
3. Draft of Operational Manual for the APL-II. Ministry of Health. September, 2006.
4. Fiscal Impact of Plan Nacer in APL-II Provinces. WB Project Preparation Team. August, 2006.
5. "Estadísticas Vitales, Información Basica 2004," Ministry of Health. December 2005.
6. "Informe de Gestion APL-I". Ministry of Health, NHSPT. July and August, 2006.
7. Financial Management Reports of APL-I (1 to 4). Ministry of Health, NHSPT.
8. Concurrent Audit Reports of APL-I, from January 2005 to April 2006. Private Firm.
9. Indigenous Peoples Planning Framework. Ministry of Health. September, 2006.
10. "Eligible Population of APL-II" (Spanish). Ministry of Health. July, 2006.
11. Argentina Country Assistance Strategy. Period 2006-2008. World Bank. May, 2006.

Annex 14: Baseline for Tracers ("Trazadoras") denominators

(Source, National Ministry of Health, 2006)

	2007	2008	2009	2010	2011	2012	2013
Elegible Women							
Buenos Aires	164,878	163,115	161,371	159,645	157,938	156,249	154,578
City of Buenos Aires	15,631	15,368	15,110	14,856	14,607	14,362	14,121
Chubut	4,044	4,010	3,976	3,942	3,908	3,875	3,842
Cordoba	33,112	32,749	32,391	32,036	31,685	31,338	30,994
Entre Rios	14,273	14,142	14,012	13,884	13,757	13,630	13,506
La Pampa	3,187	3,163	3,139	3,115	3,091	3,068	3,044
La Rioja	3,378	3,382	3,385	3,388	3,392	3,395	3,398
Mendoza	19,282	19,108	18,935	18,764	18,595	18,427	18,260
Neuquen	6,102	6,081	6,060	6,039	6,018	5,998	5,977
Rio Negro	6,379	6,290	6,202	6,115	6,029	5,945	5,862
San Juan	9,925	9,870	9,816	9,762	9,709	9,655	9,602
San Luis	5,688	5,702	5,715	5,729	5,742	5,756	5,770
Santa Cruz	1,753	1,750	1,748	1,745	1,742	1,740	1,737
Santa Fe	29,891	29,507	29,128	28,755	28,385	28,021	27,661
Tierra del Fuego	806	814	822	830	839	847	856
SubTotal	***318,329***	***315,051***	***311,810***	***308,605***	***305,437***	***302,306***	***299,208***
Elegible Children 1 year of age or younger							
Buenos Aires	123,112	123,471	123,830	124,190	124,552	124,914	125,278
City of Buenos Aires	11,570	11,584	11,598	11,612	11,626	11,640	11,654
Chubut	3,220	3,236	3,253	3,269	3,286	3,302	3,319
Cordoba	24,261	24,286	24,310	24,335	24,360	24,385	24,410
Entre Rios	11,935	12,005	12,076	12,147	12,218	12,290	12,363
La Pampa	2,573	2,595	2,616	2,638	2,660	2,682	2,704
La Rioja	2,855	2,903	2,952	3,002	3,053	3,105	3,157
Mendoza	15,973	16,119	16,267	16,416	16,566	16,717	16,871
Neuquen	4,674	4,725	4,777	4,829	4,882	4,936	4,990
Rio Negro	5,222	5,222	5,222	5,222	5,222	5,222	5,222
San Juan	7,531	7,587	7,643	7,700	7,757	7,814	7,872
San Luis	4,425	4,500	4,577	4,654	4,734	4,814	4,896
Santa Cruz	1,202	1,216	1,231	1,246	1,260	1,276	1,291
Santa Fe	24,700	24,778	24,856	24,934	25,012	25,091	25,170
Tierra del Fuego	656	673	690	708	726	745	764
SubTotal	***243,909***	***244,900***	***245,898***	***246,902***	***247,914***	***248,933***	***249,961***
Children 1 to 6 years old							
Buenos Aires	601,079	602,828	604,582	606,341	608,106	609,875	611,650
City of Buenos Aires	56,487	56,555	56,624	56,692	56,761	56,829	56,898
Chubut	15,720	15,800	15,880	15,961	16,042	16,124	16,205
Cordoba	118,450	118,571	118,692	118,813	118,935	119,056	119,177
Entre Rios	58,269	58,612	58,958	59,305	59,655	60,006	60,360
La Pampa	12,564	12,669	12,774	12,880	12,987	13,095	13,203
La Rioja	13,939	14,175	14,415	14,659	14,907	15,159	15,416
Mendoza	77,986	78,700	79,420	80,147	80,880	81,621	82,368
Neuquen	22,818	23,069	23,322	23,579	23,838	24,100	24,365
Rio Negro	25,494	25,495	25,495	25,496	25,496	25,497	25,498
San Juan	36,768	37,040	37,315	37,592	37,871	38,151	38,434
San Luis	21,603	21,971	22,345	22,725	23,111	23,505	23,905
Santa Cruz	5,869	5,939	6,010	6,081	6,154	6,228	6,302
Santa Fe	120,595	120,975	121,355	121,736	122,119	122,503	122,888
Tierra del Fuego	3,203	3,285	3,370	3,457	3,546	3,637	3,730
SubTotal	***1,190,844***	***1,195,684***	***1,200,557***	***1,205,464***	***1,210,409***	***1,215,386***	***1,220,399***
Total	***1,753,082***	***1,755,635***	***1,758,265***	***1,760,971***	***1,763,760***	***1,766,625***	***1,769,568***

Annex 15: Statement of Loans and Credits

As of June 20, 2006

Closed Projects 104

IBRD/IDA *

Total Disbursed (Active)	1,395.14
of which has been rep	259.81
Total Disbursed (Closed)	17,215.33
of which has been rep	12,077.73
Total Disbursed (Active + Clo	18,610.47
of which has been rep	12,337.54
Total Undisbursed (Active)	2,123.90
Total Undisbursed (Closed)	3.84
Total Undisbursed (Active + C	2,127.75

Active Projects

Project ID	Project Name	Last PSR Supervision Rating DO	IP	FY	Original Amount in US$ Millions IBRD	IDA	GRANT	Cancel.	Undisb.	Difference Between Expected and Actual Disbursements */ Orig.	Frm Rev'd
P088220	AR (APL1)Urban Flood Preven&Draina	S	S	2005	130				123.3085	24.92	
P093491	AR (APL2)Urban Flood Prev.&Drainag	#	#	2006	70				70		
P039584	AR B.A.URB.TSP	S	HS	1997	200				26.5929066	26.5929066	26.592907
P060484	AR Basic Municipal Services Project	#	#	2006	110				110		
P083982	AR ECONOMIC RECOVERY SUPPORT	MU	MU	2004	500				500	500	
P006052	AR FLOOD PROTECTION	S	S	1997	200				3.50520641	3.50520641	-31.494794
P057473	AR INDIGENOUS COMMUNITY DEVELC	S	S	2001	5				0.84089238	0.84089238	0.8408924
P092836	AR Inst. Strengthening - ANSES II TA	S	S	2006	25				25	4	
P040808	AR N.FOREST/PROTC	MS	MS	1997	19.5				6.78506391	6.78506391	6.7850639
P088153	AR National Highway Asset Managem	U	U	2004	200				88.0674402	78.0774402	
P070374	AR PROFAM LIL	S	S	2002	5				0.66729724	0.66729724	0.6672972
P006010	AR PROV AG DEVT I	S	S	1997	125				23.8676419	23.8676419	23.867642
P037049	AR PUB.INV.STRENGTHG	S	S	1996	16			5.7	0.06738273	5.76738273	0.2673827
P006043	AR RENEW.ENERGY R.MKTS	MS	MU	1999	30				22.3642405	22.3642405	14.197375
P070963	AR Rural Education Improvement Proje	S	S	2006	150				150	6.7	
P006041	AR SMALL FARMER DV.	S	S	1998	75				3.48766352	3.48766352	0.3770056
P089926	AR Solid Waste Management Project	#	#	2006	40				40		
P057449	AR State Modernization	S	S	1999	30.303				14.1789311	14.1759311	-9.9240689
P070448	AR Subnational Gov Public Sec Moderi	#	#	2006	40				40		
P006046	AR WATER SCTR RFRM	U	U	1999	30				14.4559443	14.4559443	14.455944
P088032	AR(CRL1)Buenos Aires Infrastr SIDP('	S	S	2005	200				194.406649	91.4066487	
P064614	AR- Second Secondary Education Pro	S	S	2001	56.99				9.73653849	9.73653849	
P055483	AR-Heads of Household Transition Prc	S	S	2006	350				244.125	-105.87493	
P072637	AR-Prov. Maternal-Child Hlth Adj PMCH	S	MS	2004	750				150	150	
P071025	AR-Provincial Maternal-Child Hlth Inv Li	S	S	2004	135.8				112.445028	9.32002812	
P070628	AR-Provincial Road InfrastructureProje	S	S	2005	150				150	13.66	
P078143	GEF AR Enabling Act. Conv. Climate Cl	S	S	2004			1.14		0.20948401	-0.1205928	
P039787	GEF AR-BIODIVERSITY CONSERVATIC	S	S	1998			10.1		4.68629703	4.67629703	4.2173625
P049012	GEF AR-Marn.Poll.Prevention	S	S	2001			8.35		4.41394399	3.02415027	2.6891503
P045048	GEF AR-RENEWABLE ENERGY IN RUR	MS	MU	1999			10		8.62072999	8.62072999	3.1049913
P005920	MP/AR-REDUCTION OF OZONE D	S	S	1997			25		6.69792005	6.69792005	6.6979201
Overall Result					3643.593		54.59	5.7	2148.5307	927.354401	63.342072

Argentina
Statement of IFC's
Held and Disbursed Portfolio
As of 04/30/2006
(In US Dollars Millions)

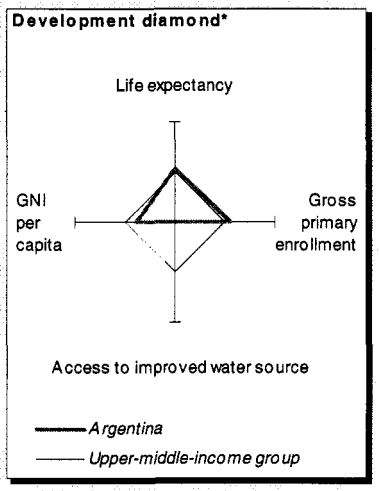
		Held				Disbursed			
FY Approval	Company	Loan	Equity	Quasi	Partic	Loan	Equity	Quasi	Partic
2000	ASF	3.76	0	0	3.85	3.76	0	0	3.85
1998	AUTCL	3.95	0	0	0	3.95	0	0	0
2004	Aceitera General	50	0	20	30	50	0	20	30
2006	Arcor	70	0	0	210	70	0	0	210
2000	BACS	0	6.25	0	0	0	6.25	0	0
2006	BACS	50	0	0	0	0	0	0	0
1999	Banco Galicia	61.78	0	0	41.17	61.78	0	0	41.17
2004	Banco Galicia	3.75	0	0	0	0	0	0	0
2005	Banco Galicia	40	0	0	0	5	0	0	0
1997	Bunge-Ceval	0	0	5	0	0	0	5	0
2006	CAPSA	50	0	0	20	0	0	0	0
1995	CEPA	3	0	0	1.2	3	0	0	1.2
1998	F.V. S.A.	1.5	0	4	0	1.5	0	4	0
	Grupo Galicia	0	3.06	0	0	0	3.06	0	0
1998	Hospital Privado	8.4	0	0	0	8.4	0	0	0
1992	Huantraico	0	27	0	0	0	0	0	0
2004	Jumbo Argentina	0	39.12	0	0	0	39.12	0	0
	LD Manufacturing	7.93	0	5	0	7.93	0	5	0
	Milkaut	0	1.23	0	0	0	0	0	0
1997	Milkaut	5.33	0	9.44	1.44	5.33	0	9.44	1.44
1993	Molinos	0	2.46	0	0	0	2.46	0	0
1994	Molinos	0	0.71	0	0	0	0.71	0	0
1996	Neuquen Basin	0	26.4	0	0	0	0	0	0
1999	Neuquen Basin	0	5	0	0	0	0	0	0
2006	Noble Argentina	18	0	0	18	15	0	0	15
1993	Nuevo Central	0	0.15	0	0	0	0.15	0	0
2005	PAE - Argentine	105.5	0	15	135	103.53	0	15	135
1998	Patagonia	1.76	0	1	0	1.76	0	1	0
1998	Patagonia Fund	0	9.22	0	0	0	2.25	0	0
1999	S.A. San Miguel	3.59	0	0	0	3.59	0	0	0
2005	S.A. San Miguel	20.3	0	0	10	16.96	0	0	8.33
1995	SanCor	8.68	0	19.84	0	8.68	0	19.84	0
	Socma	7	0	0	0	7	0	0	0
1995	Socma	0.94	0	0	15	0.94	0	0	15
1998	Suquia	0	0	10.5	0	0	0	10.5	0
1997	T6I	3.33	0	5	3.75	3.33	0	5	3.75
1997	Terminal 6	3.33	0	0	1.63	3.33	0	0	1.63
1995	Terminales Port.	0.5	0	0	0	0.5	0	0	0
2000	Tower Fund	0	0.85	0	0	0	0	0	0
1995	Tower Fund Mgr	0	0.05	0	0	0	0.05	0	0
1996	Transconor	20.29	0	17.87	157.58	20.29	0	17.87	157.58
2001	USAL	9.27	0	0	0	7.27	0	0	0
1997	Vicentin	0.94	0	0	0	0.94	0	0	0
2005	Vicentin	20	0	15	0	0	0	0	0
1993	Yacylec	0	2.52	0	0	0	2.52	0	0
	Total Portfolio:	582.83	124.02	127.65	648.62	413.77	56.57	112.65	623.95

Approvals Pending Commitment

		Loan	Equity	Quasi	Partic
2001	ITBA	7	0	0	0
2001	Gasnor	21	0	0	20
2006	Arcor Swap	1.1	0	0	0
2004	Banco Rio TFF	20	0	0	50
2005	Vicentin Exp.	0	0	0	50
	Total Pending Commitment:	49.1	0	0	120

Annex 16: Country at a Glance

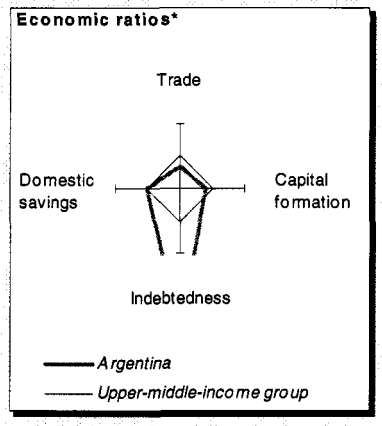
POVERTY and SOCIAL	Argentina	Latin America & Carib.	Upper-middle-income
2004			
Population, mid-year *(millions)*	38.2	541	576
GNI per capita *(Atlas method, US$)*	3,720	3,600	4,770
GNI *(Atlas method, US$ billions)*	142.2	1,948	2,748
Average annual growth, 1998-04			
Population *(%)*	1.0	1.4	0.8
Labor force *(%)*	1.9	0.9	-0.9
Most recent estimate (latest year available, 1998-04)			
Poverty *(% of population below national poverty line)*	..	..	..
Urban population *(% of total population)*	90	77	72
Life expectancy at birth *(years)*	74	71	69
Infant mortality *(per 1,000 live births)*	17	28	24
Child malnutrition *(% of children under 5)*	..	..	..
Access to an improved water source *(% of population)*	..	89	93
Literacy *(% of population age 15+)*	97	89	91
Gross primary enrollment *(% of school-age population)*	119	123	106
Male	120	126	108
Female	119	122	106



KEY ECONOMIC RATIOS and LONG-TERM TRENDS

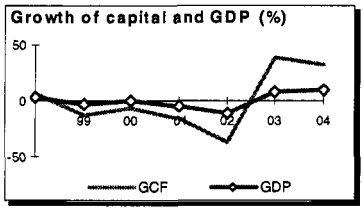
	1984	1994	2003	2004
GDP *(US$ billions)*	79.1	257.4	129.6	151.5
Gross capital formation/GDP	20.0	19.9	15.1	17.7
Exports of goods and services/GDP	7.6	7.5	25.0	23.4
Gross domestic savings/GDP	22.8	16.9	25.9	22.5
Gross national savings/GDP	..	15.6	20.7	17.9
Current account balance/GDP	-3.2	-4.3	6.1	0.9
Interest payments/GDP	4.1	1.2	1.0	1.0
Total debt/GDP	61.8	29.1	128.2	109.5
Total debt service/exports	63.4	25.2	38.5	30.9
Present value of debt/GDP	..	..	143.9	..
Present value of debt/exports	..	..	512.4	..

	1984-94	1994-04	2003	2004	2004-08
(average annual growth)					
GDP	2.4	0.3	8.8	9.0	2.7
GDP per capita	0.9	-0.7	7.8	8.0	1.7
Exports of goods and services	5.3	5.7	6.0	3.5	3.2

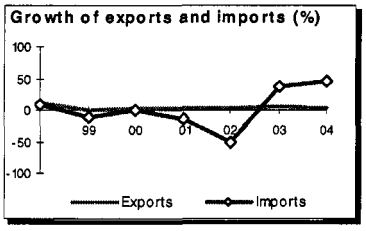


STRUCTURE of the ECONOMY

	1984	1994	2003	2004
(% of GDP)				
Agriculture	8.3	5.5	11.0	11.2
Industry	39.7	29.0	34.7	34.8
Manufacturing	29.7	19.3	23.9	23.9
Services	51.9	65.5	54.3	54.1
Household final consumption expenditure	..	70.0	62.7	69.7
General gov't final consumption expenditure	..	13.2	11.4	7.8
Imports of goods and services	4.8	10.6	14.2	18.7



	1984-94	1994-04	2003	2004
(average annual growth)				
Agriculture	1.9	2.1	6.9	7.0
Industry	1.6	-0.6	16.5	7.0
Manufacturing	1.3	-1.0	16.0	7.0
Services	2.2	0.8	7.4	5.0
Household final consumption expenditure	..	-0.3	8.8	6.2
General gov't final consumption expenditure	..	1.1	1.5	9.5
Gross capital formation	3.3	-3.3	38.2	32.9
Imports of goods and services	13.8	-2.3	37.6	45.4



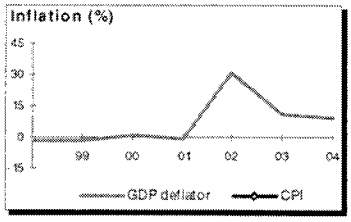
Note: 2004 data are preliminary estimates.

This table was produced from the Development Economics LDB database.

* The diamonds show four key indicators in the country (in bold) compared with its income-group average. If data are missing, the diamond will be incomplete.

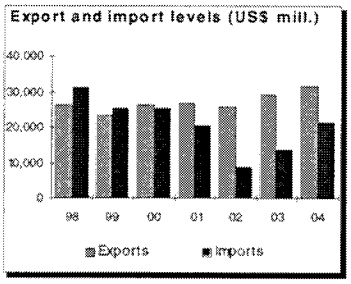
PRICES and GOVERNMENT FINANCE

	1984	1994	2003	2004
Domestic prices				
(% change)				
Consumer prices	626.7	..	..	..
Implicit GDP deflator	606.7	2.8	10.5	9.2
Government finance				
(% of GDP, includes current grants)				
Current revenue	0.0	18.4	20.5	22.4
Current budget balance	0.0	0.7	1.3	3.3
Overall surplus/deficit	0.0	0.0	0.5	2.4



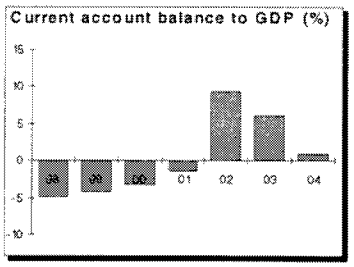
TRADE

	1984	1994	2003	2004
(US$ millions)				
Total exports (fob)	..	15,866	29,376	31,746
Food	..	1,333	2,597	2,807
Meat	..	918	1,043	1,127
Manufactures	..	4,489	8,752	9,458
Total imports (cif)	..	21,524	13,813	21,323
Food	..	..	..	..
Fuel and energy	..	674	395	610
Capital goods	..	10,806	6,445	9,949
Export price index *(2000=100)*	..	96	107	110
Import price index *(2000=100)*	..	105	101	99
Terms of trade *(2000=100)*	..	91	106	111



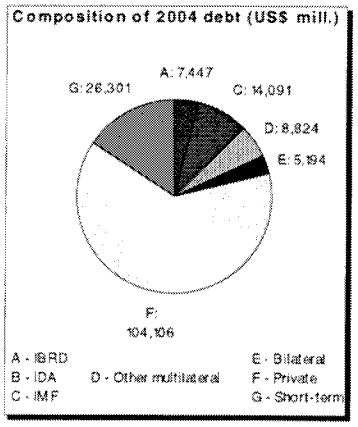
BALANCE of PAYMENTS

	1984	1994	2003	2004
(US$ millions)				
Exports of goods and services	9,607	19,387	33,231	35,504
Imports of goods and services	5,961	27,305	18,485	27,154
Resource balance	3,646	-7,918	14,746	8,350
Net income	-6,143	-3,680	-7,425	-7,592
Net current transfers	..	..	..	..
Current account balance	-2,497	-11,100	7,941	1,421
Financing items (net)	2,469	11,100	-7,941	-1,421
Changes in net reserves	28	..	..	..
Memo:				
Reserves including gold *(US$ millions)*	1,243	14,327	14,153	..
Conversion rate *(DEC, local/US$)*	100E-5	1.0	2.9	3.0



EXTERNAL DEBT and RESOURCE FLOWS

	1984	1994	2003	2004
(US$ millions)				
Total debt outstanding and disbursed	48,857	74,846	166,086	165,963
IBRD	503	4,109	7,508	7,447
IDA	0	0	0	0
Total debt service	6,281	5,750	14,007	12,119
IBRD	132	709	3,350	1,065
IDA	0	0	0	0
Composition of net resource flows				
Official grants	5	16	37	..
Official creditors	-22	731	-733	-212
Private creditors	14	6,477	85	-2,254
Foreign direct investment (net inflows)	268	3,635	1,020	..
Portfolio equity (net inflows)	0	3,116	65	..
World Bank program				
Commitments	100	509	1,850	336
Disbursements	96	548	1,963	771
Principal repayments	76	425	2,968	832
Net flows	20	123	-1,005	-61
Interest payments	56	284	382	234
Net transfers	-36	-161	-1,387	-295



Note: This table was produced from the Development Economics LDB database. 8/24/05

MAP SECTION

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APRIL 1998