RESULTS-BASED HEALTH PROGRAMS IN ARGENTINA AND BRAZIL:

PERFORMANCE ASSESSMENT REPORT

ARGENTINA

PROVINCIAL MATERNAL AND CHILD HEALTH SECTOR ADJUSTMENT LOAN (LN. 7199-AR)

PROVINCIAL MATERNAL AND CHILD HEALTH INVESTMENT APL1 (LN. 7225-AR)

BRAZIL

FAMILY HEALTH EXTENSION ADAPTABLE LENDING PROGRAM (LN. 7105-BR)

June 22, 2011

IEG Public Sector Evaluation
Independent Evaluation Group
Currency Equivalents (annual averages)

*Currency Unit= Argentina Peso
Currency Unit= Brazilian Real*

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Abbreviations and Acronyms

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<th>MDG</th>
<th>Millennium Development Goal</th>
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<td>ESW</td>
<td>Economic Sector Work</td>
<td>NEA</td>
<td>Northeast Region of Argentina</td>
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<td>FHAPL</td>
<td>Family Health Adaptable Program Lending</td>
<td>NOA</td>
<td>Northwest Region of Argentina</td>
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<td>FSR</td>
<td>Solidarity Redistribution Fund</td>
<td>OSN</td>
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<td>Global Program for Output-Based Aid</td>
<td>PEIR</td>
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<td>ICR</td>
<td>Implementation Completion Report</td>
<td>PHC</td>
<td>Primary Health Care</td>
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<td>IEG</td>
<td>Independent Evaluation Group</td>
<td>PPAR</td>
<td>Project Performance Assessment Report</td>
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<td>LAC</td>
<td>Latin America and the Caribbean Region</td>
<td>PSF</td>
<td>Family Health Program in Brazil</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
<td>RBF</td>
<td>Results-Based Financing</td>
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<td>Maternal-Child Health Insurance Program in Argentina</td>
<td>SECAL</td>
<td>Sector Adjustment Lending</td>
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<td></td>
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<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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Fiscal Year

Government (Argentina): January 1 – December 31
Government (Brazil): January 1 – December 31

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IEG Mission: Improving development results through excellence in evaluation.

About this Report
The Independent Evaluation Group assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank’s self-evaluation process and to verify that the Bank’s work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, IEGPS annually assesses 20-25 percent of the Bank’s lending operations through field work. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons.

To prepare a Project Performance Assessment Report (PPAR), IEGPS staff examine project files and other documents, visit the borrowing country to discuss the operation with the government, and other in-country stakeholders, and interview Bank staff and other donor agency staff both at headquarters and in local offices as appropriate.

Each PPAR is subject to internal IEGPS peer review, Panel review, and management approval. Once cleared internally, the PPAR is commented on by the responsible Bank department. The PPAR is also sent to the borrower for review. IEGPS incorporates both Bank and borrower comments as appropriate, and the borrowers’ comments are attached to the document that is sent to the Bank’s Board of Executive Directors. After an assessment report has been sent to the Board, it is disclosed to the public.

About the IEGPS Rating System
IEGPS’s use of multiple evaluation methods offers both rigor and a necessary level of flexibility to adapt to lending instrument, project design, or sectoral approach. IEGPS evaluators all apply the same basic method to arrive at their project ratings. Following is the definition and rating scale used for each evaluation criterion (additional information is available on the IEGPS website: http://worldbank.org/ieg).

**Outcome:** The extent to which the operation’s major relevant objectives were achieved, or are expected to be achieved, efficiently. The rating has three dimensions: relevance, efficacy, and efficiency. **Relevance** includes relevance of objectives and relevance of design. Relevance of objectives is the extent to which the project’s objectives are consistent with the country’s current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). Relevance of design is the extent to which the project’s design is consistent with the stated objectives. **Efficacy** is the extent to which the project’s objectives were achieved, or are expected to be achieved, taking into account their relative importance. **Efficiency** is the extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. The efficiency dimension generally is not applied to adjustment operations. **Possible ratings for Outcome:** Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

**Risk to Development Outcome:** The risk, at the time of evaluation, that development outcomes (or expected outcomes) will not be maintained (or realized). **Possible ratings for Risk to Development Outcome:** High, Significant, Moderate, Negligible to Low, Not Evaluable.

**Bank Performance:** The extent to which services provided by the Bank ensured quality at entry of the operation and supported effective implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of supported activities after loan/credit closing, toward the achievement of development outcomes. The rating has two dimensions: quality at entry and quality of supervision. **Possible ratings for Bank Performance:** Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

**Borrower Performance:** The extent to which the borrower (including the government and implementing agency or agencies) ensured quality of preparation and implementation, and complied with covenants and agreements, toward the achievement of development outcomes. The rating has two dimensions: government performance and implementing agency(ies) performance. **Possible ratings for Borrower Performance:** Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.
Preface

This report contains a comparative assessment of the performance of three health operations in Argentina and Brazil. The three operations introduced some form of results-linked financial incentive in the health sector.

The Project Performance Assessment Reports (PPAR) for each project are presented in Annexes A, B and C. Annex A presents the PPAR for the Argentina Provincial Maternal Child Health Sector Adjustment Loan (PMCH SECAL) (Loan Number 7199), approved on October 28, 2003 and closed March 31, 2007. The PPAR for Argentina Provincial Maternal-Child Health Adaptable Program Loan Phase 1 (PMCHAPL1), approved April 15, 2004 and closed July 31, 2010 is in Annex B, and Annex C presents the PPAR for the Family Health Adaptable Lending Program Phase 1 (FHAPL1) in Brazil (Loan Number 7105), approved on March 14, 2002 and closed June 30, 2007.

The report was prepared by the Independent Evaluation Group (IEG). The findings are largely based on a four-week mission to Argentina and Brazil from November 8 to December 3, 2010. The mission met with key-informants including central and local Government officials, Bank staff, beneficiaries, and representatives from research institutes. A list of persons met is given in Annex B and C. The mission also examined project appraisal and completion reports, the Loan Agreements, a review of Bank files and the published literature. The cooperation and assistance of all stakeholders as well as the support of the World Bank country offices in Argentina and Brazil is gratefully acknowledged.

Following standard IEG procedures, a draft of the main report and the respective PPARs were sent to each Borrower for comments before being finalized. The comments from the Government of Argentina were received and presented in Annex D.
Summary

This report assesses the performance of three health operations in Argentina and Brazil. The three operations comprise a Sector Adjustment Loan (SECAL) in Argentina which supported the Government in the implementation of its health sector reform program; and two first-phases of multiple-years Adaptable Program Lending (APL1) in Brazil and Argentina. All three operations assisted the Governments in developing reforms at the level of Primary Health Care (PHC).

The operations were prepared in the early 2000s, when Brazil was emerging from the 1999 economic crisis and the Argentina economy suffered one of its most severe crises in 2001/02. During this time, both governments aimed to modify basic health care to improve the efficiency in government spending, protect access to public services for the poor, and improve the performance of the basic health system as well as health outcomes.

Both governments embarked on fundamental reforms which changed the structure and incentive framework of the public PHC system. In Argentina, the Bank’s SECAL supported the Government’s health sector reform program which included core health policy actions and new legislation. The SECAL was supplemented by a ten year APL program. The APL 1 helped fund implementation of the key-reform package, namely the Maternal and Child Health Insurance Program (MCHIP) which is a supply-side subsidy to PHC providers. The APL1 targeted the nine Northern provinces with lagging health indicators and a large share of the poor population. The APL2 which is currently ongoing scales-up reforms nationwide. In Brazil, the APL1 supports the Government Conversion program which reorganizes traditional PHC into Family Medicine (PSF).

The three loans disbursed earmarked funds for PHC reforms in addition to the existing Government budget. They also introduced financial incentives to the health sector to change the incentive framework and reward health authorities and staff for better results. The two APLs were used to: (i) train medical staff in adherence to standard treatment protocols in family medicine, (ii) equip basic health facilities with medical material, (iii) invest in patient-level data collection in basic health care, analysis on provider performance, and independent audits, and (iv) build management capacity among health authorities in local governments.

Project Objectives

The three operations aimed to improve the provision of basic care, health outcomes, utilization and quality of care; modify the incentive framework; and target better provision and quality of basic care to the poor and uninsured individuals.

Project Supported Primary Health Care Reforms in Argentina and Brazil

The APL in Brazil supported the implementation of the PSF Conversion Program in 187 municipalities with more than 100,000 inhabitants, starting in the poorest areas (favelas) in the municipalities. Over the life of the project, PSF population coverage in the 187 municipalities in Brazil increased from 26.6 percent of the target population in 2003 to 34.4 percent in 2008.
Both, the SECAL and APL1 in Argentina funded the development and implementation of the Maternal and Child Health Insurance Program (MCHIP) which is a public program for the provision of reproductive, maternal and child health care in contracted public and private health facilities to uninsured children below six, pregnant women, and women up to 45 days post-partum. By August 2010, the nine supported Northern provinces had 565,550 beneficiaries enrolled in MCHIP, reflecting 84 percent of the target population. All nine provinces surpassed the 50 percent enrollment target.

Project Supported Institutional Reforms in Argentina

In Argentina, the SECAL supported the implementation of the health sector reform, which included a change in the incentive system for financing and delivery of basic health care in the poorest provinces. The SECAL disbursed against 30 health policy measures in support of the reform program. In light of fiscal austerity during the economic crisis, the SECAL ensured that basic and cost-effective health programs were introduced and financed including the law on the availability of sexual and reproductive health care services to improve access to family planning methods for low-income groups in public facilities, and the Maternal and Child Health Insurance Program in the Northern provinces. The SECAL also helped to re-establish COFESA the Central and Provincial Ministers of Health Committee, to coordinate health policy decision in a decentralized health system.

Modification of Incentive Framework in Argentina and Brazil

In Argentina, the SECAL-supported policy reforms initiated the change in the incentive framework in the health sector at three levels, which continues to be supported under the APL.

- First, the intergovernmental fiscal transfer from the central to nine Northern provinces was increased by the capitation amount based on the number of MCHIP members enrolled (60 percent of total additional transfer).

- Second, the remaining 40 percent of the health fiscal transfer is paid to provinces based on the results achieved in 10 maternal and child health indicators. This results-linked transfer to the provinces affects the mindset in local government and draws the attention of provincial policy makers to MCHIP enrollment and the ten most relevant basic health indicators.

- Third, the MCHIP transfers to contracted health care providers a fee-for-service price for services provided to MCHIP patients, thereby setting an incentive to increase the number of services.

In Brazil, the government with the support of the APL1 paid a reward in form of a bonus and performance prize to best-performing municipalities.

- The bonus went to 35 of 187 municipalities who (i) implemented at least 90 percent of conversion funds received from project based on implementation plans;
(ii) showed specific progress in achieving performance indicators; and (iii) presented accounting ledgers documenting expenditure use for at least 75 percent of funds.

- The performance prize was shared by 12 municipalities who met the targets for: (i) actual expenditures according to implementation plan; (ii) at least 70 percent population coverage for PSF; and (iii) compliance with fiduciary benchmarks.

Influence of Reforms on Delivery of Care and Health Outcomes

Both government reform programs - the MCHIP and PSF - were targeted to public health facilities in low-income areas where the poor seek care.

Utilization of basic health services increased

In Brazil, the APL1 supported the provision and quality of care by providing additional resources to the PSF conversion fund to finance the reorganization of primary care; and by training a large number of medical staff in family medicine. More than 80 percent of PSF teams received quality of care supervision. Comparative studies found better quality of care in family medicine than in the traditional primary health care model. Although Brazil did not add a financial incentive to the payment to providers, health service use in PSF centers increased.

In Argentina, the SECAL supported policy actions for the implementation of the health sector reform program, including the law on the availability of sexual and reproductive health services in public facilities, and the legal framework to develop and implement the MCHIP. It also protected the financing for essential health programs in the government budget during times of economic crisis. Consequently, service use of these programs remained on a high level and increased, such as DOTS TB treatment and HIV vertical transmission prevention treatment.

The APL1 in Argentina contributed to improved quality of care by increasing the financial resources available for basic care and by training a large number of medical staff in the adherence of 80 treatment protocols. Detailed patient-level data was collected and analyzed under the MCHIP and staff reminded to follow-up with individual patients who were not in compliance with treatment protocols. More than 90 percent of contracted health facilities employed medical staff specially trained to provide health care to indigenous population groups. The performance of ten relevant basic health indicators increased substantially over the project time.

There are no household survey data available to examine the distributional impact of the utilization increase in the two countries. However, in both countries these interventions and improvements took place in the poorest areas and in public health facilities where lower-income groups seek care. Thus, they benefited the poor who did seek care.
Health outcomes improved

In Argentina, household survey data are needed to better examine the direct impact of the MCHIP on infant mortality rates. However, MCHIP has substantially improved other health indicators such as infant weights and APGAR score at birth.

In Brazil, several studies associated PSF with improved health results: (i) a 10 percent increase in statewide PSF coverage was associated with a 4.6 percent decrease in infant mortality controlling for other health determinants (Macinko et al. 2006); (ii) higher levels of PSF coverage at the municipal level were associated with decreases in infant mortality, higher immunization rates and prenatal coverage and a reduction in hospital admissions; and (iii) higher municipal PSF coverage is associated with lower admission rates for preventable diseases in children (Guanais 2009; Macinko et al 2010).

Effect of Incentive Framework on Sectoral Governance

In both countries, the Bank disbursed to the Governments conditioned upon implementing explicit actions that were needed to implement health reforms. This conditioned disbursement helped to get the political buy-in on the highest level for politically sensitive reforms such as the reorganization of traditional primary care into family medicine in Brazil. It also provided continuity to reforms.

In Argentina, several of the 30 key policy actions which were disbursement conditions under the SECAL, were specifically targeted to strengthen governance and accountability, and institution building at a national level. Among them are the passing of laws, presidential decrees and ministerial decrees to implement the health sector reform, and the re-activation of COFESA as the federal health policy body. The APL1 conditioned disbursement to the Government was based on the number of individuals enrolled with MCHIP in nine provinces, which maintained the attention of the central government to the provincial level reforms. The fiscal transfer to the provinces was linked to MCHIP enrollment and results achieved in the ten indicators. To receive increasing funds, provinces had to increase MCHIP enrollment and achieve the indicator targets. The provinces had to invest in detailed data collection and analysis to show their progress towards targets. Results were audited by an independent private audit firm hired under the APL1. Provinces and providers were fined for incorrect data reporting.

In Brazil, the Bank disbursed to the Government based on the number of PSF teams joining the conversion fund in the target municipalities. Municipalities could win a bonus and performance price if they improved health administration and financial management and made progress in PSF implementation. Overtime, participating municipalities substantially improved their management performance and as well as PSF coverage rates.

Sustainability of Reforms

Bank co-financing of an existing Government program enhances the probability for sustainability of the supported reforms.
In Brazil the Bank-supported PSF reforms were institutionalized before the APL1 started and are thus likely to be sustainable. Adequate financing to support the expansion of PSF nationally has been problematic in some areas (Harris 2010). Similarly, in Argentina, the central and local governments would need to increase their current co-financing levels to sustain financing for recurrent expenditures of MCHIP.

**Both countries face similar challenges in sustaining these primary care reforms.** These include difficulties in the recruitment and retention of physicians trained appropriately in family medicine, variations in the quality of local care, patchy integration of primary care services with existing secondary and tertiary care, and in Brazil the slow adoption of the PSF in large urban centers. In both countries, the follow-up APL2 operations are supporting the Governments in addressing these challenges.

**Bank Performance**

**Bank performance** was highly satisfactory during preparation and supervision in both countries. While the three operations have introduced innovative financing features and health care reforms, it is equally important to highlight the support these operations gave to strengthening monitoring and evaluation of patient-level data, and building up of skills and institutional support, aspects that contribute to the sustainability of the reforms. The use and institutionalization of monitoring and evaluation of administrative health data was strong.

**Borrower Performance**

Both borrowers showed strong leadership and ownership for the reforms. Implementation was slowed down in Brazil by national and local government elections and in Argentina by the delays caused by the Government in passing one policy action related to insurance risk distribution which was also a disbursement condition. Both the SECAL in Argentina and APL1 in Brazil have satisfactory borrower performance. The performance under the APL1 in Argentina is rated moderately satisfactory due to misprocurement in three cases in the total amount of US$ 1.579 million (1.1% of the loan) that led to loan cancellation by this amount and a procurement action plan based on a procurement review. The Government implemented the required corrective measures.

IEG draws the following lessons:

- Following policy-based lending with an APL program can help the government staying the reform course; especially if reforms include challenging new financial arrangements and legal changes, and require a longer-term view for implementation.

- Reliable information systems, analysis and independent concurrent audits are prerequisites for allocating resources based on population needs and service use.

- Strategic and substantial upfront investments are needed if a country plans to modify the incentive system in health to stimulate better sector performance. These comprise investment in data analysis and reporting of results back to
providers; provider readiness including staff training and possibly recruitment of additional staff; institutional capacity building in budget and financial management; and management capacity of the health system. Depending on the country context, additional budget allocation may be needed to sustain reforms.

- Linking disbursement from the center to provinces to results can be an effective tool in decentralized health systems for central level governments to receive the relevant information from the local levels on the use of funds. Strong collaboration with local governments and providers is needed to ensure the timely information transfer to define the payment for results; and the implementation of corrective measures in management and the provision of care to improve results.

- Pooled funding approaches of Bank and Government funds can build capacity in governance but also increase transaction costs for Governments. Although Government systems are used for fiduciary tasks, Bank rules still apply. Depending on the country context, institutional and governance adjustments may be needed. If municipalities are the final recipients of pooled funds, administrative staff may need training in planning and budgeting to be able to plan, access and implement funds in a timely manner.

- Implementing sophisticated health reforms requires national leadership and ownership. Argentina had a reform champion with the Minister of Health who spearheaded the design and early implementation of reforms. Changes in political leadership at the end of 2007 slowed down the reform progress until 2010 when a new Minister was appointed who was part of the pre-2007 reform team. In Brazil, municipality and national elections led to staff changes in administration and substantial slow-down in project implementation.

- Expectations should be realistic about the amount of time it takes to implement complex health care reforms, before such reforms yield major results. Accordingly, a modest approach in the definition of indicators and targets make it easier to adjust the incentive system. A simpler incentive system is also easier for staff to understand, allowing staff to change their treatment patterns and contribute to better results.

Daniela Gressani
Deputy Director-General
Evaluation
1. Introduction

1.1 This evaluation reviews the experience and achievements of World Bank support for health sector reforms in Brazil and Argentina. Bank support in Argentina was through two operations, a Health Sector Adjustment Loan (SECAL) and the first phase of the Provincial Maternal Child Health Investment Adaptable Program Loan, and in Brazil through the first phase of the Family Health Extension Adaptable Program Loan (Table 1-1). Bank support continues in both countries (Table 1-3). The main body of this report looks at key aspects of the reform experiences, Bank support and results. Annexes A to C provide a detailed project performance assessment for each project.

Table 1-1. Projects by Country, Sub-sector Theme and Components

<table>
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<td>Project ID</td>
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<td>P071025</td>
<td>P057665</td>
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<td>Project Name</td>
<td>Provincial Maternal Child Health Sector Adjustment Loan (PMCH-SECAL, FY03)</td>
<td>Provincial Maternal Child Health Investment Adaptable Program Loan (PMCH APL1, FY04)</td>
<td>Family Health Extension Program Adaptable Program Loan (FHEP APL1, FY02)</td>
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<tr>
<td>Total IBRD loan (Actual, US$ million)</td>
<td>750</td>
<td>135.6</td>
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<tr>
<td>Health</td>
<td>Essential Priority Health Program Sexual and Reproductive Health</td>
<td>Communication and Community Outreach (17%)</td>
<td>Municipal Conversion and Expansion of Family Health Model (PSF), Decentralization and Performance Based Transfer Mechanisms (70%)</td>
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<td>Compulsory Health Finance</td>
<td>Maternal Child Health Insurance Program (MCHIP) National Health Insurance Regulation</td>
<td>Implementing MCHIP (68%)</td>
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<td>Central Government Administration</td>
<td>National-Provincial Health Policy Coordination (COFESA)</td>
<td>Strengthening National and Provincial Ministries of Health Stewardship (9%)</td>
<td>Monitoring and Evaluation (30%)</td>
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<td>Sub-national Government Administration</td>
<td>National-Provincial Health Policy Coordination (COFESA)</td>
<td>Program monitoring, evaluation and concurrent auditing system (3%)</td>
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Source: ICRs

1.2 The three operations were selected because of the innovative health financing reforms they support. All three operations aimed to assist the Governments in developing and implementing some form of financial incentive in one of three levels of fund flow in health, namely (i) from the Bank to the country’s health sector, (ii) from the central government to

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1 Since 2004, SALs and SECALs have been discontinued. The instrument of Development Policy Lending became available in 2004 with the approval of OP/BP8.60, which subsumed OD 8.60.
the provincial/state level, and (iii) from the local government to Primary Health Care (PHC) providers.

Project Setting

1.3 The Project Development Objectives according to the Legal Agreements are as follows (Table 1-2). The Project Documents (PAD) report identical objectives, with the exception of the Argentina APL1 PAD which aims to reduce infant mortality but does not mention reducing maternal mortality rates (in italics in Table 1-2).

Table 1-2. Project Development Objectives

<table>
<thead>
<tr>
<th>Project</th>
<th>Project Development Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina PMCH SECAL</td>
<td>The PMCH SECAL aims to: (a) respond to the urgent health needs of the poor, particularly uninsured mothers and children; and (b) simultaneously, assist the Government to modify the incentive framework for financing and delivery of health care services, starting in Argentina's poorest provinces.</td>
</tr>
<tr>
<td>Argentina PMCH APL1</td>
<td>The objective of the APL1 is to contribute to the reduction of the infant and maternal mortality rate in the Borrower’s territory, as well as to introduce changes in the incentive framework of health care providers in the participating provinces (NOA and NEA) through the implementation of the MCHIP. The three phase APL was to provide support to the Government’s PSF which sought to improve utilization and quality of publicly financed health services by: (1) increasing coverage to health services among urban populations, especially those with limited access to and utilization of basic health care, by expanding the Family Health Program, reorganizing service delivery and improving referral systems in participating municipalities of 100,000 residents or more; (2) improving the quality of basic care services nation-wide by supporting the training and preparation of health professional and workers in the Family Health Model; and (3) improving the performance and effectiveness of basic care services through supporting the development of monitoring and evaluation, information management and accreditation systems.</td>
</tr>
<tr>
<td>Brazil APL1</td>
<td></td>
</tr>
</tbody>
</table>

Source: Legal Agreements Schedule 2.

1.4 The three operations are of special interest for several reasons. First, in Argentina, the APL was developed to support the implementation of the Government health reform program which has been assisted under the SECAL. Second, the two APLs in Argentina and Brazil invested in monitoring and analysis and independent audits of health indicators and linked intergovernmental fiscal transfers to performance results. Third, the two APLs were spearheading a new fiduciary design as they disbursed earmarked funds for PHC reforms to the Government treasury, against independently verified results. The SECAL tranche releases to the Government budget were also earmarked as additional funds for basic health care to the health budget. Fourth, they provide lessons for future Bank operations in countries that are planning to link financial incentives to results.

1.5 The three operations were prepared in the early 2000s (Table 1-3), when Brazil was emerging from the 1999 economic crisis and the Argentina economy plummeted into one of the most severe crisis in 2001/02. The operations were closely aligned with the Country
Assistance Strategies (CAS) in the two countries, which in the early 2000 gave priority to reforms that incentivize more efficient service delivery through the fiscal transfer and build responsibility and accountability for service delivery at the decentralized levels.

1.6 The PPAR also considers progress under the PMCH APL2 in Argentina scheduled to close at the end of 2012; and the Brazilian APL2 which is scheduled to close in March 2013. The PMCH APL2 (US$300 million) was prepared to scale-up reforms in the 15 remaining provinces. In Brazil the APL2 (US$85 million) continues supporting family health reforms.

**Table 1-3. The Three Operations and Subsequent Bank Support**

<table>
<thead>
<tr>
<th>Country</th>
<th>Project Name</th>
<th>Approval Date</th>
<th>Closing Date</th>
<th>Subsequent Bank Research/Operation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Argentina</td>
<td>PMCH-SECAL</td>
<td>10/28/2003</td>
<td>03/31/2007</td>
<td>FY04 PMCH Investment APL1 (P071025)</td>
</tr>
<tr>
<td>Argentina</td>
<td>PMCH APL1</td>
<td>04/15/2004</td>
<td>07/31/2010</td>
<td>FY07 PMCH APL2 (P095515) FY11 Provincial Public Health Insurance Development Project (P106735)</td>
</tr>
<tr>
<td>Brazil</td>
<td>Family Health Extension APL1</td>
<td>03/14/2002</td>
<td>06/30/2007</td>
<td>FY08 Family Health Extension APL2 (P095626)</td>
</tr>
</tbody>
</table>

**Overview of Project Supported Health Reforms**

1.7 Both governments aimed to implement national health reforms with Bank support to improve efficiency in government spending, and protect access to public services for the poor. These goals were to be achieved by reorganizing the provision of basic care, training of health staff, additional medical equipment, investment in data collection and analysis, and adding to the health transfer from the central level to local governments a financial incentive that would reward health authorities for better results.

1.8 The three operations share several characteristics:

- IBRD loans were pooled with government budgets and earmarked for basic health.
- They address the health needs of the poor. Target populations are low-income groups; geographic targeting and targeting through patient self-selection into the program was used.
- They modified the incentive framework for health managers and administrators by specifying performance targets, and linking performance to financing.
- They developed monitoring and evaluation and independent audits; information management and accreditation systems to support transfers and interventions.
- There was substantial preparatory work and investment in improving quality of care to ensure service provision through investment in PHC.
- Follow on projects are currently under implementation and support the scale-up of the innovative approaches developed.
2. Results-Based Financing: Definitions and Experience

2.1 Whether financial incentives influence individual behavior and lead to better results has been discussed in many countries. To describe this concept, the Bank’s health group is using the term “Results-Based Financing” (RBF) which is defined as "a cash payment or non-monetary transfer made to a national or sub-national government, manager, provider, payer or consumer of health services after predefined results have been attained and verified. Payment is conditional on measurable actions being undertaken." (www.rbfhealth.org). RBF is thus an umbrella term that can comprise performance-linked fiscal transfers, provider payments, salaries and conditional cash transfers (CCT) to consumers. The three operations included in this PPAR all used some sort of RBF (Table 3-2), including an intergovernmental fiscal transfer tied to results, and provider payment in form of fee-for-service to providers in Argentina.

Fiscal Transfers and Provider Payments Tied to Results

2.2 Governments generally transfer funds to local levels based on line-item budgets to finance salaries, maintenance, and infrastructure etc. Line-items are rigidly defined which limits the reallocation of funds across budget lines to better respond to changes in performance levels. An increasing number of OECD and Latin American countries have therefore introduced budgeting that links disbursements to performance results of lower governments (Arizti, et al. 2010). If tied to results, fiscal transfers are expected to stimulate individual and organizational responsibility and accountability, by rewarding good governance performance such as transparency, citizens’ participation in budgeting, and planning and project implementation (UNCDF, 2010).

2.3 Linking fiscal transfers to results has led to improvements in public management processes, including (i) administrative functioning (for example the record keeping and data management) in local governments; (ii) public financial management when performance indicators are linked to quality of the budget planning process, compliance with procurement regulations, timely accounting, audit processes, and outcomes; (iii) transparency and accountability; (iv) more effective capacity-building where performance results are used for identifying training needs; and (v) positive infrastructure and service-delivery outputs – in terms of allocative efficiencies, better implementation, cost efficiency and sustainability (Arizti, et al. 2010; Gomez et al. 2009).

2.4 Several challenges limit the implementation of results-linked transfers. First, fiscal transfers based on service-delivery outcomes (for example the mortality rate reduction, improved health status) are highly problematic given the attribution problems related to measuring service-delivery outcomes. Second, countries with weak management systems at the central level have experienced delays and uncertainties in implementation of results-based financing. Third, a lack of political will to implement the consequences of poor performance dilutes the effectiveness of financial incentives. Fourth, designing the assessment methodology including indicators and scoring system for defining the results-linked payment requires consistency to be credible (UNCDF, 2010).
2.5 Successful RBF schemes were found to have transparent definitions and payments and clear result indicators. In the US and the UK, PHC providers collect and report performance data for agreed quality measures, which are verified by an external auditor. Successful schemes ensure that health service providers have the required degree of autonomy to achieve results, functional reporting and monitoring systems, independent audits of results and national ownership for RBF (Eldrigde and Palmer, 2009). Additional characteristics include (van Herck et al, 2010):

- define targets on the basis of baseline room for improvement, refocus targets when goals achieved, and monitor old targets to preserve results,
- make use of process and (intermediary) outcome indicators as target measures and use risk adjustment for outcome indicators,
- involve stakeholders and communicate information about the program,
- focus on both quality improvement and achievement, and
- distribute incentives to the individual and/or team.

2.6 Several lessons emerge, including the need for institutional foundations, such as sound budget management, budget planning and implementation, accounting, monitoring, financial management, managerial capacity, independent audits of performance information, incentives that emphasize dialogue rather than control, and modest starts in defining results indicators and targets (Arizti, et al. 2010; Gomez et al. 2009). Technical assistance may be needed to build these capacities.

3. Country Context

Socio-Economic Context

3.1 Since the economic and social crisis in 2001-2002, Argentina has reported several years of strong economic growth of 8-9 percent. From 2003 to 2007, poverty dropped from 58 percent to 23.4 percent, and unemployment fell from 21.5 to 8.3 percent (World Bank 2009).

3.2 Brazil reports steady economic growth of around 5 percent since 2000. Unemployment fell from 12.3 percent in 2003 to 7.9 percent in 2008. The official poverty rate dropped from 32.9 percent in 2002 to 21.6 percent in 2008 (World Bank 2010).

Health Outcomes

3.3 The three operations focused on improving maternal and child health care which is provided in public primary health care centers that mainly serve lower income groups. During the past decades, infant mortality rates have decreased across the region, including Brazil and Argentina (Figure 3-1).
3.4 However, maternal mortality (Figure 3-2) remains a concern in many Latin American countries.

3.5 In addition, unequal access to health care and unequal health outcome is problematic in both countries. In Argentina, health care providers are unequally distributed across regions with wealthier regions reporting a higher provider density than poorer areas\(^2\). In

\(^2\) Ministerio de Salud Argentina 2009: Indicadores básicos.
2001, infant mortality in Argentina was almost twice as high in poorer provinces such as Tucuman, compared to Buenos Aires.

3.6 Based on Demographic Health Survey (DHS) data from 1996, poorest children in Brazil reported an Under-5 mortality rate three times higher than children from wealthiest income groups. Teenage fertility rate among poor girls was six times higher than among rich girls, and poor girls had a higher maternal mortality rate than girls from wealthy families. In the poorer Northern areas in Brazil, only 75 percent of childbirths were assisted by skilled birth attendants compared to 96 percent in Sao Paolo (DHS, 1996).

**Level of Health Financing**

3.7 Total health spending as a share of GDP has been increasing in Argentina and Brazil over the past decade (Table 3-1). About half of total health spending is from private sources including households and insurance. This level of private financing is high, suggesting that patients who can afford it seek care in the private sector. Public spending on health per capita has been growing in both countries.

**Table 3-1. Health Expenditure, Public and Private, 1999 - 2008**

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health expenditure, total (% of GDP)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>9.1</td>
<td>9.0</td>
<td>9.5</td>
<td>8.9</td>
<td>8.3</td>
<td>9.6</td>
<td>10.4</td>
<td>10.2</td>
<td>10.0</td>
<td>9.6</td>
</tr>
<tr>
<td>Brazil</td>
<td>7.1</td>
<td>7.2</td>
<td>7.6</td>
<td>7.7</td>
<td>7.5</td>
<td>7.7</td>
<td>8.2</td>
<td>8.5</td>
<td>8.4</td>
<td>8.4</td>
</tr>
<tr>
<td><strong>Health expenditure, private (% of total health expenditure)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>43.4</td>
<td>44.5</td>
<td>46.4</td>
<td>49.8</td>
<td>47.7</td>
<td>54.5</td>
<td>55.2</td>
<td>53.6</td>
<td>49.2</td>
<td>50.2</td>
</tr>
<tr>
<td>Brazil</td>
<td>57.3</td>
<td>60.0</td>
<td>59.5</td>
<td>58.1</td>
<td>58.7</td>
<td>56.7</td>
<td>59.9</td>
<td>58.3</td>
<td>58.4</td>
<td>56.0</td>
</tr>
<tr>
<td><strong>Health expenditure, public (US$ per capita per year, PPP adjusted)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Argentina</td>
<td>467</td>
<td>452</td>
<td>450</td>
<td>354</td>
<td>380</td>
<td>425</td>
<td>504</td>
<td>568</td>
<td>671</td>
<td>690</td>
</tr>
<tr>
<td>Brazil</td>
<td>202</td>
<td>202</td>
<td>220</td>
<td>237</td>
<td>235</td>
<td>271</td>
<td>279</td>
<td>319</td>
<td>348</td>
<td>398</td>
</tr>
</tbody>
</table>


3.8 Both countries have employer-provided health insurance to cover care in the private sector. About 25 percent of the Brazilian population has private insurance or pays out-of-pocket in private practice (Victora et al. 2010). In Argentina, about 44 percent of the population has Social Health Insurance (Obras Sociales), and approximately 14 percent is privately insured (Cavagnero 2008). In both countries, the uninsured (unemployed and informal sector workers) rely on the public system where care is provided at no fee for patients.

3.9 Compared to other countries at similar levels of GDP, total health spending per capita - including public and private spending - is relatively high in both countries (Figure 3-3).
Figure 3-3. Total Health Expenditures, per capita, by GDP per capita, in 2007, in Current US$, Log Scale


3.10 Public spending on health in Brazil is comparable to other countries at similar levels of GDP, but higher in Argentina (Figure 3-4).

Figure 3-4. Public Health Spending, per capita, by GDP per capita, in 2007, in Current US$, Log Scale


**Decentralized Health Systems**

3.11 The health systems in both countries are decentralized. Local governments (provinces, states and municipalities) are responsible for the provision of medical care and
co-finance care from their own revenues\(^3\). The central Governments pay fiscal transfers to the local governments to implement their health responsibilities. These transfers are block grants matched to some extent by local government funds, and defined based on population size and input factors (for example number of staff, pharmaceutical expenditures).

3.12 Fiscal decentralization in health carries the risk of exacerbating inequalities in health between regions. Variations in health management capacities across local governments lead to different performances and implementation effectiveness of services. The central levels often do not receive the necessary information to monitor how effectively transferred resources have been used by local governments. Thus, modifying the incentive framework in the intergovernmental fiscal transfer provides an opportunity to the federal government to receive information and monitor implementation effectiveness by local levels. This approach was selected by Brazil and Argentina to support primary health care reforms in states and provinces.

4. Government Health Reforms

4.1 In the early 2000s, when the projects were designed, the Governments of Argentina\(^4\) and Brazil\(^5\) started implementing similar health sector reforms:

- Reduce regional inequalities and improving access for the poor by targeting health services and health insurance to the poor
- Strengthen the leadership role of the central MOH in the formulation and implementation of national health policy
- Integrate the national health system with incentives for effective service provision
- Decentralization of primary health care and capacity building at local government
- Consolidate and restructure provincial health insurance funds
- Focus public health spending on basic health care.

Health Sector Reform Program in Argentina

4.2 In 2003, the Argentina Government started to implement the Health Sector Reform Program (HSRP). The program is targeted to the poor and aims to improve the effectiveness of public spending in the decentralized health system. The main HSRP objectives are (i) to increase access to basic services for the poorest mothers and children; (ii) to strengthen the stewardship and regulatory role of the National Ministry of Health in core areas of public health; (iii) to consolidate regulatory reforms in the social health insurance system to limit

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\(^3\) About 5,500 municipalities in Brazil and 24 provinces in Argentina are responsible for providing Primary Health Care services. Local governments have substantial political autonomy, although they remain highly dependent on transfers from higher levels of government and face significant constraints to raising own-source revenues, and financing their services. Revenue-raising capacity at the sub-national level is limited. In 2004 the Argentina central government raised tax revenue in the amount of 23 percent of GDP, considerably more than the provincial governments (3.8 percent of GDP).


negative spillovers in the public health sector in the provision of access to services for the poor and uninsured, and (iv) to change the relationship between the national and provincial governments, as well as between the provinces and health service providers.

4.3 The Federal Health Council (COFESA) coordinates the implementation of the Program in the provinces. One of the cornerstones of the HSRP is the Maternal and Child Health Insurance Program (MCHIP or Plan Nacer). Both, the SECAL and APL1 supported the development and implementation of the MCHIP, which is a public health insurance program that provides reproductive, maternal and child health care in contracted public and private health facilities to uninsured children below the age of six, pregnant women, and women up to 45 days post-partum. After the 45th day, mothers receive care through the Provincial Reproductive Health Program supported by the Reproductive Health Law.

**Family Medicine Reforms in Brazil**

4.4 The Brazilian government created the Unified Health System in the mid-eighties, and transferred management and organizational responsibility for health care to the municipalities and states (Dominguez Uga, 2007). The government also decided in the mid-nineties to scale-up nationwide the federal Family Health Program (PSF) with municipalities participating voluntarily.

4.5 The PSF Conversion Program in Brazil reorganizes traditional Primary Health Care (PHC) into Family Medicine units to target basic health services to low-income groups. PSF teams of family health professionals are assigned to geographical areas encompassing 3,500 inhabitants each. The typical family health team includes a physician, a nurse, a medical assistant, a social worker, and several locally hired community health workers. It focuses heavily on prevention and management of diseases, but it also serves a mechanism for continuity of care through referrals to other levels of care (Guanais 2010).

4.6 Initially, the PSF program was implemented in a “bottom-up approach”. Since 1994, the number of municipalities with at least one Family Medicine unit grew nationwide (Table 4-1). Initially, municipalities were more likely to participate in PSF Conversion if they were poor or had a mayor from a socialist party (Rocha, 2010). The APL1 focused on expanding PSF in large urban municipalities with more than 100,000 inhabitants.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of municipalities with at least 1 PSF unit</td>
<td>55.0</td>
<td>4,161.0</td>
<td>5,087.0</td>
</tr>
<tr>
<td>% of municipalities with at least 1 PSF unit</td>
<td>1.1</td>
<td>75.5</td>
<td>92.4</td>
</tr>
</tbody>
</table>

5. **Modifying the Incentive Framework in Health**

5.1 The three operations modified the incentive framework first from IBRD to the governments, second, from the central to local governments and third, to the provision of health care. Table 5-1 presents an overview.
### Table 5-1. Financial Incentives in Health in Brazil and Argentina

<table>
<thead>
<tr>
<th>Financial Flow</th>
<th>Financial Incentives Modified through Bank Operations</th>
<th>Argentina SECAL and APL1</th>
</tr>
</thead>
<tbody>
<tr>
<td>IBRD to Government</td>
<td>Pooled funding earmarked for PHC to co-finance PSF Conversion in municipalities.</td>
<td>Pooled funding earmarked for health SECAL disbursed against policy reforms to health budget</td>
</tr>
<tr>
<td></td>
<td>Disbursement into PSF Conversion Fund against Statements of Transfers issued by MOH and based on number of PHC units participating in PSF conversion program in municipalities.</td>
<td>APL1 disbursed to finance general expenditure categories (consultants, training, and goods) and capitation amount for MCHIP program to Provinces based on the number of members.</td>
</tr>
<tr>
<td>Intergovernmental fiscal transfer from central to local government</td>
<td>Co-finance PS conversion transfer (capitation) to municipalities.</td>
<td>APL1: Capitation based on MCHIP enrollment (60% of total capitation transfer to Borrower). Monthly payment to Provinces.</td>
</tr>
<tr>
<td></td>
<td>Additional <strong>bonus</strong> to municipalities in compliance with (i) execution of 90% of funds according to implementation plan; (ii) evidence of progress toward performance indicators particularly PSF coverage extension; (iii) presentation of accounting ledgers detailing expenditures for at least 75% of funds received. Additional <strong>performance prize</strong> paid to municipalities in compliance with: (i) spending aligned with implementation plan; (ii) at least 70% PSF coverage; (iii) compliance in fiduciary benchmarks.</td>
<td>APL1: Conditional transfer to Provinces in compliance with 10 health indicators (40% of total capitation transfer to Borrower). Payment to Provinces three times per year.</td>
</tr>
<tr>
<td>Local government to PHC providers</td>
<td>No change: Government line-item budget managed for providers by municipality.</td>
<td>APL1: Fee-for-service payment by MCHIP, in addition to line-item budget from government.</td>
</tr>
</tbody>
</table>

*Source: PADs and ICRs of SECAL and two APL1.*

**IBRD Disbursement to Central Governments**

5.2 The Bank disbursed the **Argentina SECAL** of US$750 million to the government budget in three tranches over a 26-months implementation period, conditioned on the government’s implementation of 30 policy actions in the health sector reform program (see Annex A Table A 1). The loan was earmarked for health, and additional to the governmental budget allocation to the health sector. The first tranche disbursed US$450 million after fulfillment of 12 policy actions included as tranche conditions; the second and third tranches each disbursed US$150 million once the 10 and 8 policy actions, respectively, were implemented.

5.3 IBRD disbursed both **APLs in Argentina and Brazil** to the government health budget. Part of the IBRD funds were pooled with central Government funds, and earmarked
for PHC to co-finance an intergovernmental fiscal transfer in health. The remaining loan funds financed goods and services following the traditional investment lending approach.

5.4 The Brazil APL1 of totally US$68 million disbursed US$46.4 million (68 percent of IBRD loan) to the Treasury earmarked as additional funds to the PSF Conversion Fund based on the number of PHC units that joined the PSF conversion program.

5.5 The Argentina APL1 of totally US$134 million disbursed US$96 million (71 percent) to the Government in form of an earmarked capitation amount to the MCHIP program based on the number of individuals enrolled in MCHIP in the nine Northern Provinces.

Health Transfer from Central to Local Governments

5.6 Fiscal transfers from the central government compensate a lower level of government for complying with central government mandates or implementing delegated activities.

5.7 In the mid-nineties Brazil defined the federal transfer to municipalities for the decentralized PHC system based on a population-based capitation amount. The government also introduced the PSF Conversion Fund to transfer funds to municipalities to finance the reorganization of traditional primary health care centers into family medicine teams. The APL1 increased the PSF Conversion Transfer by 30 percent to municipalities if they agreed to implement the PSF conversion reforms.

5.8 In addition, the Brazilian central government with the support of the APL1 paid a “bonus payment” and a “performance prize” to municipalities for achieving explicit governance and fiduciary actions (Table 5-1) to improve financial and performance management in PSF. The bonus was distributed in 2006 as a lump-sum to 35 of 188 municipalities who met the three criteria, reflecting 50 percent of the value of each municipality’s original PSF grant. The performance prize of totally R$6 million was shared by 12 municipalities in 2006. The prize was awarded during an official award celebration with the central government. A modified version of this result-linked scheme was included in the Health Covenants (Pactos de Saude) in 2006 (La Forgia 2008) and is being implemented with the support of the APL2. Both, the bonus and performance prize encourage states and municipalities to invest in municipality administration and fiduciary management.

5.9 In Argentina, the National Ministry of Health signed a performance contract with the nine Northern Provincial Governments to transfer funds from the APL1 and the central government to the provincial MCHIP based on (i) MCHIP enrollment and (ii) results achieved in 10 health indicators. First, 60 percent of the capitation transfer from the center to provinces is in form of a monthly capitation amount based on the monthly number of individuals enrolled in the MCHIP to set an incentive to provinces to increase the number of MCHIP members. The remaining 40 percent are a conditional transfer from the central government to provinces based on results achieved for MCHIP patients in 10 health indicators (Table 5-2). This conditioned payment method was expected to set an incentive to Argentina provinces to equip providers with the necessary resources (for example to prevent
stock-out in vaccines and contraceptives, etc) such that providers can influence the ten indicator results.

Table 5-2. Ten Health Indicators for Indicator Payment in Argentina

<table>
<thead>
<tr>
<th>Number</th>
<th>Health Indicators - Trazadoras</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First prenatal care checkup before week 20 of pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Newborns from eligible women with APGAR score higher than 6 at 5 minutes after birth</td>
</tr>
<tr>
<td>3</td>
<td>Percent of eligible infants weighting more than 2500g</td>
</tr>
<tr>
<td>4</td>
<td>Percent of eligible pregnant women receiving virology and molecular diagnostic and anti-tetanus vaccination</td>
</tr>
<tr>
<td>5</td>
<td>Medical audits of maternal and infant death</td>
</tr>
<tr>
<td>6</td>
<td>Measles vaccination rates, children less than 1 year</td>
</tr>
<tr>
<td>7</td>
<td>Sexual and reproductive health consultation rate among puerperal women</td>
</tr>
<tr>
<td>8</td>
<td>Well child care visit rate among eligible children up to 1 year</td>
</tr>
<tr>
<td>9</td>
<td>Well child care visit rate among eligible children ages 1-6 years</td>
</tr>
<tr>
<td>10</td>
<td>Percent of health facilities with medical staff specially trained for treating indigenous population</td>
</tr>
</tbody>
</table>

Source: PAD.

Payment to Providers

5.10 The third level is payment to providers for the provision of care. The provincial MCHIP offices in Argentina transfers to contracted providers a fee-for-service (FFS) amount for services provided based on the nomenclador of the MCHIP to MCHIP members. This FFS amount is additional revenue for providers on top of the line item budget from the government, and other FFS and capitation revenues from national and provincial insurers. Providers thus have an incentive to increase the number of services provided to MCHIP members similarly as for other FFS-reimbursed patients, and to increase the number of individuals enrolled with MCHIP.

5.11 In Brazil, the provider payment did not change. PHC providers are financed by the government line-item budget and did not receive financial incentive to increase the number of medical services provided to patients.
6. Evaluation Findings

6.1 This section assesses the evidence from the two countries and seeks to answer the four evaluation questions.

- To what extend have the project-supported reforms influenced the provision and quality of health care, utilization of services, access for the poor and health outcomes?
- To what extend did the change in the incentive framework in health financing – as introduced by the three operations – improve sectoral governance?
- Are the project-supported reforms in financing and delivery of basic care sustainable?
- How effective was Bank support to these two countries?

6.2 To identify the responses to these questions, key-informant interviews were conducted with Bank staff who had worked on the three projects. Field trips were conducted to Argentina and Brazil to interview representatives from the Governments who have worked in the design and implementation phase of the projects. In Argentina these interviews took place in Buenos Aires, two APL1 provinces (Salta and Tucuman) as well as in Cordoba which introduced MCHIP under the APL2. In Brazil, interviews were conducted with representatives from the current and former Ministry of Health in Brasilia, and representatives working in State and municipality health authorities in Bahia, Recife and Sao Paolo (see Appendices for a list of persons interviewed). Bank project documents were reviewed and the peer-reviewed literature was consulted.

6.3 Project performance was influenced by (i) growing economies, (ii) strong counterpart capacity, and (iii) cross-sector collaboration. In both countries, growing economies and formal sectors led a large share of the population out of poverty, reduced the projects’ target population, and resulted in higher public financing per individual who seeks care in the public sector, to which the three operations provided financial and technical support. Both APLs were enhanced by cross-sector collaboration. Since 2003, the Bolsa Familia Program in Brazil pays a conditional cash transfer to low-income families if they have their children immunized which is generally provided by a PSF provider. Similarly, to receive child support (AUH) in Argentina, infants have to be enrolled with their provincial MCHIP.

Influence of Reforms on Delivery of Care and Health Outcomes

6.4 The three operations aimed to contribute to improved provision of health care (Table 1-2). The Brazilian APL1 aimed to improve the provision of care by supporting the expansion of PSF reforms in large urban municipalities. Both operations in Argentina the SECAL and the APL1, sought to change the delivery of care by modifying the incentive framework for providers and decision-makers in local governments through the MCHIP. In addition, the Argentina APL1 aimed to improve health outcomes by reducing infant mortality rates.

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6 In 2008, Brazil spent R$ 11.1 billion for Bolsa Familia or 0.4 percent GDP.
6.5 **The three operations supported a comprehensive package of health reform measures.** Reforms included institution building, legal changes, reorganization of the care process, training of medical and administrative staff, modification of financial incentive framework, data collection and analysis, and regular feed-back of results to government units and providers. These combined measures were expected to influence the behavior of staff, and positively affect the provision of basic health care, particularly for mothers and children who seek care in public health facilities. Additional factors affected the provision of care, including a budget increase for basic care and cross-sector collaboration with social protection programs to enhance service use.

**Target population reached**

6.6 **In Argentina**, the SECAL supported the nationwide implementation of the health sector reform program. The reforms mainly affected the provision of care in public primary health care centers, where lower-income patients seek care. Measures included the law on the availability of sexual and reproductive health services in public facilities, the legal framework to develop and implement the MCHIP and the protection of financing for essential health programs in the government budget.

6.7 **The APL1 in Argentina** reached the target population through the MCHIP. MCHIP membership increased swiftly from about 10 percent of the target population in early 2005 to 50 percent just one year later (Figure B-2). By June 2010, MCHIP counted 558,103 members in the nine Northern provinces or 84 percent of the target population, and an additional 764,335 members (56 percent) in the remaining provinces supported under the APL2 (Ministerio de Salud 2010(c)).

6.8 **In Brazil** the APL1 helped to increase PSF coverage in large urban areas by supporting 187 municipalities with more than 100,000 inhabitants. PSF population coverage rate in these participating municipalities increased from 26.6 percent in 2002 to 34.4 percent in 2008 (Table C2).

6.9 Argentina and Brazil used cross-sector collaboration to reach out to the target population. Since 2009, the Argentina government made child support benefits for uninsured families conditional on MCHIP membership. In Brazil, low-income families have to have their children vaccinated to benefit from the Bolsa Familia Program.

**Effect on Delivery of Primary Care Services in Public Facilities in Low-Income Areas**

6.10 **By June 2010, MCHIP in Argentina** had contracted 2,124 of providers (70 percent of total providers) in the poorest nine Northern provinces. Provinces invested substantially in training of medical staff to adhere to 80 treatment protocols; in the availability of medical equipment and in IT to collect and analyze patient-level treatment data. Almost all Argentina health facilities (92 percent) added staff specially trained to attend indigenous patients. The additional financial resources (Figure B3) were used to improve the working environment in primary health care centers and purchase medical supplies.

6.11 **In Brazil**, the APL1 financed the conversion of 2,400 traditional PHC centers into family health teams in lower-income neighborhoods in 187 large urban municipalities. The
government used its own resources to finance structural improvements in 1,019 health units. The share of primary care staff trained in family health in the 187 municipalities increased from 28 percent in 2002 to 41 percent in 2008 (Table C4). In both countries, additional family health outreach staff visit patients at home, which has improved access for low-income groups who live further away.

**Effect on Quality of Care**

6.12 In both countries treatment quality improved as a large number of staff was trained in the adherence of treatment protocols. In Brazil, more than 80 percent of PSF teams received quality of care supervision. The PSF teams regularly self-evaluate their work to identify ways to improve performance.

6.13 In Argentina, treatment quality improved as detailed patient-level data was collected and analyzed under the MCHIP. Staff received regularly a report for follow-up with individual patients who were not in compliance with treatment protocols. Some providers (for example in Tucuman province) introduced patient satisfaction surveys in health facilities. Structural quality improved in health facilities that underwent upgrading of infrastructure and equipment.

**Effect on Service Use by Patients**

6.14 Although the incentive framework for Brazilian PSF providers did not change, utilization of services increased in municipalities with higher PSF population coverage (Table C3). Studies identified higher preventive health care use (prenatal care visits, vaccination rates) and reduced hospitals admission rates for conditions that can be treated at the less costly primary care level (such as diarrhea, respiratory infections) (Macinko et al. 2010). In Argentina, the nine provinces reported a substantial increase in service use for the 10 health indicators since 2005 (Table B3), though, initially this increase may have been driven by better data collection.

**Effect on Equity in Access to Care**

6.15 There is no household survey analysis on the impact of the reforms on equity in service use and health financing, or on inequalities in health outcomes. MCHIP providers in Argentina and PSF providers in Brazil primarily cater to lower-income groups, who do not have health insurance through employment. It is reasonable to assume that Argentina providers do not adjust their treatment patterns to patients’ insurance status. In both countries, patients do not pay user fees in public facilities, thus access could be equal across socio-economic groups. Still, other factors such as transport costs or lack of information could cause the poorest not to seek care if they are sick, independent of the facilities’ financing modality. This hypothesis should be tested based on household survey data in Brazil and Argentina.

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7 In Brazil about 25 percent of the population has health insurance mainly through their employers, and they seek care with private providers. In Argentina, about 40 percent of the population is insured through formal sector employment.
Effect on Health Outcomes

6.16 In Brazil, a 10 percent increase in PSF coverage was associated, on average, with a 4.6 percent decrease in infant mortality. Other factors contributed to better health outcome. Improving water access by 10 percent was associated with a 3 percent reduction, and increasing the number of hospital beds only led to a 1.35 percent reduction. Higher fertility and lower income per capita had a modest, positive association with infant mortality. Female illiteracy was the most important determinant: decreasing female illiteracy by 10 percent would reduce infant mortality by a greater amount than all other variables combined in the Brazilian study (Macinko 2006). The PSF program had the strongest impact on health outcomes in municipalities with worse initial conditions and in the poorest regions of Brazil (north and northeast) (Rocha 2010). The APL1 did not conduct an impact evaluation of the PSF in Brazil.

6.17 In Argentina, an impact evaluation was conducted based on administrative data to examine how the MCHIP affected health outcomes, the provision of services and utilization. The analysis is still under way when this PPAR was written, but preliminary findings confirm that service use among MCHIP members increased substantially over time. Administrative patient data do not include information on relevant individual characteristics such as patients’ socio-economic, educational and insurance-status background that influence individual care-seeking behavior; and they exclude information on individuals who did not seek care, or seek care with non-participating providers. The team will therefore launch a population-based household survey in August 2011 as part of a national impact evaluation of the MCHIP. The household survey analysis will allow comparing the treatment behavior of MCHIP members against eligible non-members while excluding individuals insured through their employers with national or provincial social health insurers (Obras sociales).

Effect on Efficiency in Provision of Care

6.18 Both primary care reform programs contribute to health system-level efficiency. This is mainly through better information on health care provision allowing providers to follow-up with patients, and adherence to treatment protocols for primary care resulting in fewer costly hospital admissions. A study in Brazil estimates that a municipality with 100,000 inhabitants, and an average PSF program coverage of 40 percent, should be expected to spend between US$ 1.2 million and US$ 1.9 million yearly to run the PSF program. This municipality would save a cumulative total of about 57 lives after 5 years of PSF implementation, and 150 lives after 8 years (Rocha 2010).

Summary

6.19 To sum up: Argentina sought to contribute to improved health outcomes and both countries aimed to improve the provision of care with the health reforms. Based on the data available, the impact on health outcomes cannot be clearly established. Both countries have been reporting decreasing trends for infant mortality rates over two decades.

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(Figure 3-1). However in the Northern Argentina provinces, the rate remained on a similar level since 2005 (Annex B Figure B1). Survey findings from Brazil highlight the difficulty in attributing the impact of an intervention on reduced infant mortality rates.

6.20 Service use in public primary care units has increased in both countries although Brazil did not modify the incentive framework for providers through fee-for-service payment (Annex Table B3 and Table C3). In Argentina, a household survey will be conducted to compare treatment behavior among MCHIP members and eligible non-members. In Brazil the APL1 did not compare service use among PSF and traditional PHC providers; however several studies found constantly better care compliance under PSF. Although there is no information available on the equity impact, the reforms were well targeted to poorest areas and public health facilities where lower-income groups seek care.

6.21 It is not possible to identify the marginal impact of different reform measures on health outcomes and the provision of care. The combination of measures may have contributed to results including (i) improved patient-level data collection, provider performance analysis and reporting results back to providers to improve treatment compliance, (ii) increased management attention to PHC by local and central governments, (iii) better trained staff, (iv) increased budget allocations for PHC, and (v) modifications in the incentive framework.

Effect on Sectoral Governance, Monitoring and Evaluation

6.22 The three projects did not explicitly aim to improve governance in their development objectives (Table 1-2). However, all three operations sought to strengthen the Government stewardship function through investments in monitoring and evaluation, information, and changes in the incentive framework for financing and delivery of care. The Argentina SECAL had a strong governance element with the support to the health sector reform program.

Effect of Financial Incentives on Local Governments

6.23 The improved data collection needed for the modified financial incentive framework to local governments introduced by both APLs drew government attention to the indicators tracked for disbursement. Overall 187 Brazilian municipalities met explicit eligibility criteria on their technical and institutional capacity to participate in the PSF conversion program. Municipalities improved public management in health to receive the additional funds from the “bonus payment” and “performance price”; they developed and implemented work plans, improved health data collection, monitoring and analysis, complied with accounting, procurement and financial management rules, invested in equipment and works in health facilities, and improved the collection of health indicators for all patients.

6.24 Similarly in Argentina, the intergovernmental transfer based on 10 health indicators (trazadores) drew government attention to these indicator results. The trazadores payment to provinces required first investment in data collection, monitoring and evaluation system to ensure reliable data for defining the indicator payment; and investment in medical
equipment and training of providers to ensure they are able to improve care assessed by the ten indicators. Results from this data evaluation show a substantial increase in the provision of services in the 10 indicators since 2005, suggesting that the provision of care has improved.

6.25 The pooled funding approach used by the three operations for Government and Bank financing supported governance in terms of fiduciary capacity building and better data management at the central and local government level. Both APLs in Brazil and Argentina invested in strengthening the Government procurement, financial management and disbursement system. The technical cadre was set up at the central level providing technical support to local governments in technical and fiduciary questions, which led to substantial capacity building in health administration in the municipalities and provinces in both countries, improved financial management and budget implementation.

6.26 The projects did not change governance of public PHC providers with regards of ownership, autonomy and hiring and firing of public employees. It is generally argued that providers need to have management autonomy to be able to respond to a modified incentive system and improve the provision of care. In Argentina and Brazil, primary care providers did not change governance to become autonomous through the reforms; they continue to be owned and managed by the local health authorities. The owner decides about hiring and firing of staff, procurement of drugs, and changing the scope of services within the framework of the national health planning.

6.27 In Argentina, health facility managers contracted by MCHIP have autonomy within the contractual agreement with the Government on the use of financial resources received from the Plan. PHC providers in Argentina used additional funds from MCHIP to pay for operational costs and contract additional medical staff (e.g. nutritionists) to take care of the increased patient load. Incentive payments to staff were regulated differently across provinces. The Misiones provinces paid salary mark-ups (incentives) to staff, and achieved best results in the ten health indicators, - but so did Tucuman province without incentive payments to staff.

Effect on Information Flow in Decentralized Health System

6.28 Both countries invested substantially in data collection, monitoring, analysis and audits, to ensure valid information for financial disbursement. The APL1 in Argentina spent US$6.5 million (about 5 percent of total project cost) for data collection, analysis and audits. In Argentina MCHIPs need detailed patient-level data (i) on services provided to patients to pay providers, and (ii) on progress made with respect to ten health indicators (trazadores) to define the result-linked financial transfer to the provinces. Public providers in both countries collect patient-level data (on paper). Data are sent to the local health authority where data is computerized. Independent auditors verify data entries and follow up with providers directly on compliance. Audit reports are sent to providers to implement corrective

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9 Including computers and information systems at the central level MCHIP office and in all nine provincial health authorities, training of M&E staff, and contract with independent private audit firm.
measures. Data quality substantially improved over time as providers made corrections based on audit results.

6.29 **Data is used to improve the provision of care in Argentina.** In Argentina, results from data analysis are communicated to providers to follow-up with patients. MCHIP regularly presents to providers detailed information on each patient. Detailed patient-level data help providers to systematically follow up on patients and improve care compliance. Other health insurers in Argentina do not provide this detailed data analysis.

6.30 **The improved information flow in decentralized health system contributed to transparency.** Both APLs helped strengthening the role of central against local governments in a decentralized context through better data and transparency. Both central governments use indicators when deciding on the health transfer to local governments. Local governments are thus kept accountable and may receive less funding if targets are not achieved.

**Summary**

6.31 **The Bank’s programmatic approach to support national programs for health reforms with conditioned disbursement to central government helped to get the political support on the highest level for politically sensitive reforms.** Several of the policy actions under the SECAL were specifically targeted to strengthen governance and accountability, and institution building at a national level.

6.32 **The operations effectively used data analysis to change the governance mindset and direct the political attention to basic health care reforms.** The modified incentive system in the results-linked transfer to local governments required better patient-level data in Argentina, and information on administrative performance in municipalities in Brazil. These improvements in monitoring and evaluation were achieved at a relatively low cost. The data management systems introduced under the APLs are institutionalized and used by the Governments to identify areas for improving system performance.

**Sustainability of Reforms**

6.33 There are some risks to the development outcomes. These risks are mainly related to government funding of reforms, possible provider payment implications, and human resources. The Bank continues to support these primary care reforms through the follow-up APL operations. Both countries continue to show their political support to the expansion of the reforms introduced under the three operations.

**Government Financing of Reforms**

6.34 **Although both governments have increased their health allocations (Table 3-1), basic health services risk being underfunded.** In Brazil, the PSF program is funded through federal transfers – the PSF Conversion Fund - and local government allocations. However, more than half of Brazil’s 26 states fail to meet the health funding targets of 12 percent of the total state budget. In addition, the broad definition of health spending means that states and municipalities may allocate health funds to other health priorities than PSF, risking the
program to be underfunded (Jurberg 2010). Since 2004, the annual budget law in Argentina includes a central government allocation for MCHIP, with the central government being the main financer of the MCHIP. But co-financing commitments by local governments have so far been slower than originally planned. The Northern provinces only increased their co-financing shares in January 2009 to finance 30 percent of total capitation in Northern Provinces leaving the remaining 70 percent to be paid by the central Government with the support of the APL. The Argentina provinces still need to show a stronger financial commitment to MCHIP to ensure its financial sustainability.\(^{10}\)

**Financial Implications of Fee-for Service Payment**

6.35 *The provider payment reform introduced under the APL in Argentina could pose a future financial risk and should be monitored carefully, especially when expanding MCHIP coverage and the benefit package.* Fee-for-service payment to providers does not pose a financial risk for MCHIP as it is only used to pay for preventive and basic primary health care services. However, the experience from OECD countries suggests that MCHIP could expect expenditure increases once fee-for-service is paid for curative care services. MCHIP expenditures will also increase if MCHIP membership is extended to all age groups among the non-insured groups, as currently discussed by the Government. Argentina should thus closely monitor the impact of the payment change on total health spending.

**Constraints in Human Resources**

6.36 *Both APLs invested in human resources for family medicine, but staff shortages remain a challenge.* Brazil faces difficulties in the recruitment and retention of doctors trained appropriately in family medicine, and variations in the quality of care. The MOH has developed several strategies to address the staff shortage, including salary increases and additional training to increase the profession’s attractiveness. In Argentina, relatively low salaries for medical doctors working in primary care, cause absenteeism in public facilities as physicians work in private practice while on the government payroll. Using funds from MCHIP, health facilities have contracted additional medical personnel. Both countries need to address these constraints in human resources to ensure the sustainability of family medicine reforms.

**Summary**

6.37 *In both countries, shortage in family medicine doctors remains a concern, as is co-financing of the reforms by local governments. It would be helpful to estimate the financial implications for MCHIP of expanding fee-for-service payment to curative services and a larger membership group before deciding on the future payment method.*

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\(^{10}\) The APL1 Loan Agreement was amended twice: first in July 2008, to maintain 100 percent national co-financing of MCHIP capitation payment until December 2008 and postpone the start of 60 percent provincial co-financing to January 2009; and second in October 2009, to reduce the share of provincial co-financing from 60 percent to 30 percent of the capitation amount.
Effectiveness of Bank Support

6.38  **Bank support to all three operations has been highly effective.** The Bank teams brought experience from other countries, and designed the project in collaboration with the government, drawing from analytical work and previous Bank operations. Good working relationships have been developed between the Governments and the Bank teams. In Argentina, activities have been coordinated with the IDB which through REMEDES supported the government pharmaceutical program.

6.39  **Project designs were well-anchored in the countries’ health strategies.** All three operations supported existing health reform programs adopted by the Government over a multiple-year timeframe. A long-term horizon for the APLs provided continuity to government reforms.

6.40  **The operations were kept flexible and responded to the changing context.** Both APLs and the SECAL were extended. The Government of Argentina needed more time than originally anticipated to implement the 30 policy actions. In Argentina, membership uptake in MCHIP, which was the disbursement condition for the APL1 - was initially slower than anticipated, leading to a 6-months project extension. A governmental change in Brazil caused the APL1 to increase the number of participating municipalities and change the components. A bonus and performance price was paid to best performing municipalities, and the originally planned performance-based provider payment was delayed to the APL2 due to constraints in data collection. There was also a need for more time to build a better understanding for performance-based payments among providers and local authorities. Both APLs spent considerably more funds on monitoring and evaluation than forecast at appraisal.

6.41  **The experience with PSF conversion and the Plan Nacer have been widely disseminated** in the peer-reviewed international health literature, the WBI flagship course, and international conferences. The Brazilian peer-reviewed literature mainly focuses on the PSF conversion (family medicine reform) while there are hardly any publications on the financial incentives introduced to municipalities with the bonus and performance price.

7. Conclusions and Lessons

7.1  **An important finding from this three-project assessment is the comprehensive and innovative approach used by IBRD to support existing government health reform programs.** Reforms included institution building, legal changes, reorganization of the care process, training of medical and administrative staff, modification of financial incentive framework, data collection and analysis, audits of performance data, and regular feed-back of results to government units and providers. These combined measures positively affected the provision of basic health care, particularly for mothers and children who seek care in public health facilities. Other factors contributed to improvements, including a budget increase for basic care and cross-sector collaboration with social protection programs to enhance health reforms.
7.2 **Both countries aimed to improve health outcomes and system performance with the reforms.** While the peer-reviewed literature identified various factors that have contributed to decreasing infant mortality rates – in addition to improved access to family medicine; both countries made substantial progress in advancing the health reforms. In Argentina, MCHIP enrollment increased to more than 80 percent of the target population, and the Brazilian PSF program covers now 35 percent of the population in the 187 municipalities. Several studies conducted indicate that PSF improved service use among patients compared to the traditional primary care model. Findings from Argentina point to increase in service use among MCHIP members.

7.3 **Modifying the incentive framework required upfront investment in data collection and analysis.** In both countries IBRD disbursed earmarked health funds tied to tangible results to the government to target existing health reform programs. The central governments applied the same approach to transfer additional health funds tied to performance targets to the local governments. The local governments used the additional financing to strengthen the provision of public health care in low-income areas. This modified financing mechanism required upfront investment in the validity of data collection and analysis to define the payment.

7.4 **The Bank-supported reforms improved the data flow in decentralized health systems.** Decentralized health systems struggle with the information flow. Often central governments are not informed about health performance in provinces and municipalities. Both countries used their health reforms to address this data-flow issue. The central governments receive information from the local governments on progress in specific indicators (for example the MCHIP enrollment, the number of PSF units joining the Conversion Program, provincial level results for health indicators, administrative compliance in health authorities). Reliable information systems, analysis and independent audits are prerequisites for allocating resources based on population needs and service use.

7.5 **Both countries improved transparency, management and accountability in the public health sectors, including:**

- MCHIP in **Argentina** informed each provider about performance results such that they could improve treatment of patients, and information was made available to all stakeholders;
- **Brazilian** municipalities updated their financial management including quality of the planning process, compliance with procurement regulations, timely accounting, and audit processes;
- Both countries improved capacity-building for health staff as performance results were used for identifying training needs to improve treatment compliance.

7.6 **There are lessons to be learned from Argentina and Brazil.**

7.7 **First, substantial upfront investments are needed in data and provider readiness if a country would like to introduce financial incentives to stimulate sector performance:**

- The APL1 in Argentina invested upfront in IT and software at central and provincial health authorities and facilities to collect and computerize patient level data on
treatment compliance. Independent auditors verified the validity and reliability of data collection. Results from data analysis are reported back to providers and local governments for actions. The consistent assessment methodology (indicators, scoring system, and audits) is credible for all stakeholders.

- Both countries upgraded provider readiness. They invested in treatment standards against which performance compliance is assessed, training of medical staff, and additional medical staff. Health facilities received additional medical equipment, material and pharmaceuticals to implement treatment standards.

- In Argentina purchaser capacity was built in national and provincial government purchasing units MCHIP. These units write and sign performance contracts with providers, receive data for analysis of indicator results and calculate the financial amount to be paid to providers and/or local governments. They contract and supervise work of the independent audit firm, and can also be in charge of financial management.

- Both countries had to develop and implement communication strategies to inform patients about reforms.

7.8 Second, fiscal transfers tied to targets highlight the need for strong institutional foundations. These include budget management, accounting, monitoring, financial management, managerial capacity, independent audits of performance information, incentives that emphasize dialogue between local and central governments rather than control, and modest starts. Brazil started modestly with simple measures including process and (intermediary) outcome indicators that first aimed to set up the fiduciary framework. The MCHIP in Argentina shows that targets should be defined on the basis of room for improvement. The initial indicator payment of 4 percent for full target achieved was difficult to achieve for several provinces and caused low disbursement; thus, a gradual payment was introduced to allow paying for partial achievement of targets. The MCHIP timely adjusted targets when goals were fulfilled. In the future, when new indicators will be introduced, old indicators and targets need to be monitored to preserve results.

7.9 Third, using outcomes as a result indicator to condition disbursement is highly problematic given attribution problems related to measurement (for example the mortality rate reduction, improved health status). Argentina is using several health status indicators to define the conditioned fiscal transfer to provinces, including weight and APGAR score of newborns. The attribution of these results to MCHIP is problematic. Whether results-linked financing has an impact on health outcomes and the provision of care is unknown. There is no study that identifies the marginal effect of the results-based payment over other factors.

7.10 Fourth, pooled funding approaches of Bank and Government finances can increase transaction costs for Governments. Although Government systems are used for fiduciary tasks, Bank rules still apply. Depending on the country context, institutional and governance adjustments may be needed. The Bank still conducts fiduciary assessments and requests procurement plans to implement the program through the Government, financial and performance analysis of program execution, and program audits. Detailed total and unit cost
analysis will be needed to define the disbursement criteria into the program. If municipalities are the final recipients of pooled funds, administrative staff needs to be trained on planning and budgeting to be able to access pooled funds in a timely manner.

7.11 *Fifth, political changes and resulting turnovers in government administrations can lead to delays and uncertainties in implementation.* Substantial reforms such as financial incentives linked to results require broad political support and country ownership that goes beyond the Minister of Health. Political will is needed to implement the consequences of poor performance (for example withhold or cut back funds) otherwise the effectiveness of the financial incentives is diluted.
Annex A. The Argentina Republic Provincial Maternal and Child Health Sector Adjustment Loan (SECAL)

Principal Ratings

ARGENTINA: PROVINCIAL MATERNAL AND CHILD HEALTH SECTOR ADJUSTMENT LOAN SECAL (LN. 7199-AR)

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* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEG product that seeks to independently verify the findings of the ICR.

Key Staff Responsible

PROVINCIAL MATERNAL AND CHILD HEALTH SECTOR ADJUSTMENT LOAN SECAL (LN. 7199-AR)

<table>
<thead>
<tr>
<th>Project</th>
<th>Task Manager/Leader</th>
<th>Sector Director</th>
<th>Country Director</th>
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<tr>
<td>Appraisal</td>
<td>Cristian Baeza</td>
<td>Ana Maria Arriagada</td>
<td>Axel von Trotsenburg</td>
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<td>Completion</td>
<td>Jose Pablo Gomez-Meza</td>
<td>Evangeline Javier</td>
<td>Pedro Alba</td>
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Summary

1. The Provincial Maternal and Child Health Sector Adjustment Loan (SECAL) was designed in 2001, when Argentina went through a severe economic and fiscal crisis. More than three-quarters of the poor depend on the provincial public health system. The SECAL was an earmarked IBRD loan of US$750 million to the Government health budget. The loan disbursed *additional funds* to the health sector in three tranches over a 26-month implementation period against 30 health reform policy actions. The first tranche disbursed US$450 million against 12 policy actions, the second and third tranches each disbursed US$150 million after the 10 and 8 policy actions, respectively, were implemented. The policy actions involved strong collaboration between the federal and the provincial Ministries of Health.

2. The development objectives of the SECAL were to (a) respond to the urgent health needs of the poor, particularly uninsured mothers and children; and (b) simultaneously, assist the Government to modify the incentive framework for financing and delivery of health care services, starting in Argentina's poorest provinces (PAD p 7).

3. The loan was to support five pillars of the Government’s 10-year health sector reform program: (i) the development and implementation of the maternal and child health insurance program to improve access to basic health care for uninsured mothers and children in the provincial health system; (ii) the national-provincial coordination in health policy through COFESA, the council of the central and provincial ministries of health; (iii) financial protection of essential priority health programs during the economic crisis; (iv) implementation of the sexual and reproductive health program; and (v) consolidation of the social health regulations to improve targeting of public subsidies to the poor.

4. The SECAL focused on responding to the health needs of the poor, particularly uninsured mothers and children. The 30 policy actions targeted the provision of maternal and child health care in public health facilities which are used by lower-income groups and the uninsured. The Government protected public health spending for essential health programs used by the poor, and passed legislation to improve the availability of basic reproductive health care services in public health facilities and the provincial maternal and child health insurance program in the nine poorest provinces (MCHIP or *Plan Nacer*). The SECAL-supported policy actions and program funding helped to maintain and increase utilization levels of basic health services mainly used by lower-income groups (measles vaccination, DOTS tuberculosis treatment, milk for malnourished children), and increase the share of HIV-positive mothers and their newborns treated for HIV vertical transmission.

5. The SECAL-supported policy actions were critical for setting up the institutional framework for health reform. SECAL helped to re-activate the Federal Health Council COFESA as the federal health policy body. COFESA is highly active, and since 2004 has negotiated annually

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with the central level the fiscal transfer to the provinces for essential health care programs such as the Sexual and Reproductive Health Program, the Maternal and Child Health Insurance Program, and the generic drug program *Remediar*.

6. The SECAL-supported health reforms initiated the change in the incentive framework in the health sector at three levels. These reforms were designed and initiated under the SECAL and implemented with the support of the APL1 (see Annex B). The reforms modified the transfer of the APL1 from the central government to the nine provinces. First, 60 percent of the intergovernmental health transfer is a capitation amount based on the total members enrolled with the maternal child health insurance program (MCHIP). Second, the remaining 40 percent of the transfer is paid to provinces based on the results achieved by the provincial health services with regards to 10 maternal and child health indicators. This results-linked transfer to the provinces draws the attention of provincial policy makers to MCHIP enrollment and the ten most relevant basic health indicators. Consequently, MCHIP enrollment increased swiftly already within the first 12 months from 5 to 50 percent of the target population constituted by the uninsured mothers and children. Similarly, utilization of the ten health services measured by the indicators increased strongly. Third, the MCHIP transfers to the owner of contracted health care providers a fee-for-service price for services provided to MCHIP patients, thereby setting an incentive to increase the number of services. The institutional and policy framework initiated under the SECAL was sustained under the APL1.

7. The SECAL also successfully introduced reforms in the social health insurance system (obras sociales) including insurance beneficiary databases to identify insured and non-insured individuals, invoicing systems in hospitals based on which hospitals send regular invoices to insurers for reimbursement of patient treatment, and – although with some delays – a risk-adjustment mechanism based on gender and age to redistribute part of the insurance financial risks across health insurers and reduce incentive for risk-selection by insurers.

8. IEG’s overall rating of project development outcome is *Satisfactory*, based on high relevance of objectives and design and high and substantial efficacy. The SECAL supported the implementation of policy actions that protected public funding of essential health programs delivered to low-income groups, and it changed the incentives in the financing and the provision of health care leading to more efficient and transparent service provision. Bank performance during preparation and supervision was highly satisfactory. The Government through the MOH showed strong ownership for this ambitious health sector program and delivered its implementation at a satisfactory level. The risk to development outcomes is rated as moderate given the government ownership for the reforms, the improved macro-economic and fiscal framework and the strong political support for the reforms from the provinces. The SECAL was strong with respect to M&E.

9. Several key-lessons emerge from this earmarked health sector policy loan:

a. The political context is important. Implementing sophisticated health reforms requires national leadership and ownership, and buy-in across different levels
of governments in a decentralized health system. Changes in political leadership at the end of 2007 (after the loan had closed) slowed down the reform progress until 2010 when a new Minister was appointed who was part of the pre-2007 reform team, and thus secured the continuity of reforms.

b. Following the SECAL with the ten-year APL program was a wise choice to sustain the reforms achieved under the SECAL over a longer time period.

c. The SECAL with conditional disbursement based on policy measures can help increase the attention of the government to politically more difficult reforms (for example, the laws on sexual and reproductive health), especially during times of fiscal crisis.

d. The modified intergovernmental incentive framework improves the information flow from the provinces to the central level. This can be an effective tool in decentralized health systems for central level governments to receive the relevant information from the local levels on the use of funds.
Background

1. Since the early 1990s the Bank has supported the Government of Argentina (GOA) with adjustment lending in health supporting the reform of the National Health and Provincial Health Insurance System (Obras Sociales Nacionales (OSN)), as well as through investment operations with supply-side interventions (for example, infrastructure and medical supplies) in maternal and child health care and early childhood development. The national insurance reform successfully introduced the beneficiary database and the mandatory benefit package. The formalization of the economy combined with economic growth expanded insurance coverage to half of the population in the mid-nineties. Provincial insurance reforms however, were less successful in covering the uninsured who are mainly lower-income groups.

2. In early 2000, three main lessons emerged from over a decade of collaboration between Argentina and the Bank in health. First, reforming the national health insurance system - which caters to formal sector employees and their families -, does not address health problems of the poor and informal sector workers who are not insured. Second, the poorest provinces were not reached through Bank support. Third, successful Bank support to health policy reforms would require a close link between policy-based lending and investment lending and technical assistance support (World Bank 2003(b)).

3. Based on these lessons and following the economic crisis in 2000/01, the Government with the Bank decided to focus new health sector operations through the Provincial Maternal and Child Health Sector Adjustment Loan (PMCH-SECAL) on two health reform policy goals. These included: (i) improving health care coverage for the uninsured and poor and (ii) providing an incentive system for provinces to deliver a basic health package to the most vulnerable among the uninsured.

4. The SECAL was prepared as a package together with the first and second phases of an Adaptable Program Loan (APL1 (see Annex B) and APL2, respectively). In April 2004, the Bank approved the first APL of US$134.8 million to finance technical assistance and implementation capacity for the Maternal and Child Health Insurance Program (MCHIP) (also called Plan Nacer) in the poorest 9 provinces in the north of Argentina (see Annex B).

Objectives and Structure of the SECAL

5. The development objective of the SECAL was to: (a) respond to the urgent health needs of the poor, particularly uninsured mothers and children; and (b) simultaneously, assist the Government to modify the incentive framework for financing and delivery of health care services, starting in Argentina’s poorest provinces.

6. The SECAL was designed to support the Government’s 10-year health sector reform program (HSRP) which emphasizes the provincial responsibilities of ensuring health service delivery for the poor. In Argentina, more than three-quarters of the poor depend on provincial health services. The HSRP aimed to alter the provincial delivery system through the Maternal and Child Health Insurance Program.
7. The MCHIP (*Plan Nacer*) is a publicly financed health program. It provides additional subsidies from the central government to the basic health benefit package provided in provincial health facilities to uninsured mothers and children. Potential members are easily identified as obras insured individuals have a membership card from a formal health insurer and predominantly seek care in the private sector. The obras insured are employed in the formal sector and are economically better off than the uninsured, who work in the informal sector. MCHIP membership does not create a change in out-of-pocket payments for patients as care is provided for free to patients in public health facilities. The MCHIP is thus primarily a provider subsidy. Each province has an MCHIP office staffed with government employees and consultants who are responsible for Plan management, including member enrollment, provider contracting and payment, data collection and provider performance analysis and member information. The MCHIP provincial office reimburses contracted providers a fee-for-service price for each service provided to patients enrolled with the MCHIP. Public providers are not financially autonomous but they received increased management autonomy for the fee-for-service funds received from MCHIP. Facilities are managed by their owners, the provincial or municipality health authorities.

8. The SECAL supported five pillars of the Government health reforms: (i) MCHIP implementation to improve access to basic health care for uninsured mothers and children; (ii) national-provincial coordination in health policy through COFESA the council of the central and provincial ministries of health; (iii) financial protection of essential priority health programs during the economic crisis; (iv) implementation of the sexual and reproductive health program; and (v) consolidation of the social health regulations to improve targeting of public subsidies to the poor (Table A1).
Table A 1. Argentina SECAL Prior Actions for Health Reform, 2003-2007

<table>
<thead>
<tr>
<th>HSRP Pillars</th>
<th>Summary of Key Prior Actions (full details in the Policy Matrix)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) Improving National-Provincial coordination for health policy formulation and revitalizing the role of the Federal Health Council (COFESA)</td>
<td>- Ministerial resolution mandating COFESA-agreed rates for resource distribution</td>
</tr>
<tr>
<td>(ii) Protecting essential priority public health programs</td>
<td>- COFESA agreement on MCHIP</td>
</tr>
<tr>
<td>(iii) Strengthening the MCHIP (Plan Nacer) including its start-up</td>
<td>- Public access to COFESA public accords</td>
</tr>
<tr>
<td>(iv) Implementation of the sexual and reproductive health law and program</td>
<td>- MOF allocates agreed budgetary funds to protect funding for essential health programs</td>
</tr>
<tr>
<td>(v) Consolidation of the national social health insurers (OSN) regulations and elimination of subsidies to the non-poor</td>
<td>- MCHIP implemented in 9 provinces and fully functional in at least 2 provinces with at least 2000 beneficiaries not formally insured in each province</td>
</tr>
<tr>
<td></td>
<td>- Sexual and RH law published and program implemented in OSN network as part of basic benefit package in at least 2 provinces</td>
</tr>
<tr>
<td></td>
<td>- Implement OSN regulations on beneficiary and provider management</td>
</tr>
<tr>
<td></td>
<td>- Eliminate non-poor subsidies</td>
</tr>
<tr>
<td></td>
<td>- Presidential Decree on risk-adjusted solidarity fund</td>
</tr>
</tbody>
</table>


Implementation

9. The SECAL in the amount of US$750 million was approved by the Board in October 2003, and disbursed in three tranches over a 26-month implementation period with 30 policy actions implemented by the Government. In 2003, according to the National Health Accounts (NHA), the Argentina government spent totally US$2.4 billion on health including financing from the central Government, provinces and municipalities. In November 2003 the first tranche disbursed US$450 million (18.6% of annual government health spending) after fulfillment of 12 policy actions included as tranche conditions; in June 2004 as originally planned the second tranche disbursed US$150 million (5.2% of total government health spending) once the 10 policy actions were implemented. All 8 actions for third tranche release in the amount of US$150 (3.5% of total government health spending) were met by December 2006.

10. The SECAL was extended twice, first by 12 months and second by an additional 3 months, and closed on March 31, 2007. The extensions were caused by the delay of completing one of the 30 policy actions which was part of the third tranche. It took considerably longer than originally anticipated to issue the Presidential Degree for the risk-adjustment mechanism to finance the solidarity distribution fund across insurers and reduce the incentive for risk-selection of lower-cost members by different health insurers.

11. Implementation responsibilities were clearly defined through COFESA, the Ministries of Finance, the Ministry of Health (MOH), and the Provincial Ministries of Health. The first tranche policy actions required the reconstitution of COFESA which had
not been functioning since the 1970s. The policy actions involved strong collaboration between the federal MOH and the provinces through COFESA. COFESA was institutionalized and meets monthly to coordinate federal and provincial health policy agendas. In this decentralized health system, COFESA serves as a platform for the policy dialogue across provinces and between provinces and with the central MOH.

12. Safeguards, procurement and financial management are not applicable to policy loans.

Relevance

**RELEVANCE OF OBJECTIVES**

13. The objectives of responding to the urgent health needs of the poor, and modifying the incentive framework for financing and delivery of health care services starting in the poorest provinces, was highly relevant during the economic crisis, and is still today of highest relevance to the country conditions and the Bank’s strategy. The 2001/2002 crisis caused unemployment to increase to 21.5 percent and with that 12 percent of the insured population to lose health insurance coverage. The growing number of uninsured was seeking care in the provincial health system, which was underfunded. The SECAL focused on the MCHIP implementation in the nine poorest provinces and provided additional financing to the provincial basic health system.

14. The SECAL development objective remains well harnessed in the Government’s 10-year health reform program. The project was highly relevant to the 2006 Country Assistance Strategy (CAS) which focused on social inclusion and improved governance through concurrent audits that were introduced under the SECAL. The Country Partnership Strategy (CPS) 2010-2012 highlights the contribution of the SECAL to the passing of the Sexual and Reproductive Health Law as an achievement in gender equality in the 2006 CAS (p. 20).

The IEG rates the relevance of objectives as **high**.

**RELEVANCE OF DESIGN**

15. The design was well-informed by the 2003 Public Expenditure Review and the Bank Sector Work on the Argentina health sector\(^{12}\) and by the experience of previous operations.

16. The SECAL design included three tranches and 30 policy actions, frontloading in finance and in the number of policy actions. The design was highly relevant to achieving the objectives addressing the health needs of the poor and modifying the incentive framework in financing and delivery of care. The design aimed to target health care to the poor by establishing and implementing the MCHIP (or Plan Nacer) in basic health care

centers where the poor seek care in the poorest provinces, and passing a legal framework to improve access in public health facilities to less costly generic drugs and to free sexual and reproductive health services. The design addressed issues of inequity in health by protecting governmental financing for the delivery of basic health care services targeted to the poor. The SECAL design modified the incentive framework. First, it conditioned loan disbursement to the implementation of the 30 policy actions. Second, it introduced through the MCHIP a conditional disbursement mechanism that linked the transfer of funds from central to the provincial government to the achievement of explicitly defined indicator targets.

17. The design was aligned to the Government Health System Reform Program (Table A1) and institutionalized COFESA. Thus, it supported the institutional framework in a decentralized system that would help getting the buy-in and ownership at the provincial level for reforms, thereby strengthening the sustainability of reforms. Conditional disbursements over three tranches with targets clearly linked to reform policy actions for each tranche, helped to keep a multi-tranche operation focused on the relevant health reform steps to achieve reform objectives over time.

18. The SECAL supported the health sector on the supply-side. It assisted the Government in setting-up the institutional framework for much needed reforms that were difficult to implement in a decentralized health system. The SECAL added earmarked funds for basic health care to the provincial health sectors. In addition, it modified the incentive framework for health authorities by disbursing against health policy conditions, which was expected to increase their attention to basic health care issues and trigger changes in policy decisions that would improve health service provision. On the demand-side, the SECAL supported the development and implementation of the MCHIP targeted to poor mothers and children.

19. The design of the SECAL was also relevant as its implementation created mainly “winners”; thus the design itself created incentives to the different stakeholders to implement the SECAL and thus achieve project objectives. The design provided additional funding earmarked for health to the provinces and the decision power to manage these funds. The design also supported the information flow to the central Government from the provinces on the use of funds; the center could thus influence the priorities for spending of the fiscal transfer. Providers received more money for more services provided through the government budget and the IBRD loan. Patients benefited too, as the legal changes passed under the SECAL (for example the reproductive health law, MCHIP legal framework) would support improved health care availability and delivery for women and small children.

IEG rates the relevance of the design as high.

Achievement of Objectives

20. The Government made substantial progress in implementing the 10-year health sector reform program adopted in 2003. The SECAL supported the HSRP implementation focusing on the five reform pillars as described above in Table A1.
**Objective:** “Responding to the urgent health needs of the poor, particularly uninsured mothers and children” (Rating – substantial)

21. While the Government went through a severe budget crisis, the SECAL responded to the health needs of the poor by protecting government funding for essential health services used by low-income groups nationwide and by developing and implementing the MCHIP in basic health facilities where the poor seek care starting in the poorest provinces.

22. The financing for the following three national government programs was protected from 2004 until 2007: (i) Remediар the generic drug program, (ii) the national maternal and child health program which provides milk and supplies to public health facilities, and (iii) the reproductive health program which provides contraceptives in public health facilities. Additional services were added to the essential service package including Hepatitis A, Influenza Vaccines and HIV/AIDS treatment coverage. To protect the essential public health program, the Government included in the 2004 budget AR$583.3 million (7% of total government health spending) for essential health (HIV/AIDS, tuberculosis, maternal and child health, sexual and reproductive health, nutrition supplement, essential drugs under the Remediар program). This amount also included AR$20 million for the launching and pilot testing of the Maternal-Child Health Insurance Program (COEFESA Resolution No. 249, 2003). The Government allocation for essential health services increased, meeting the target amount; however, as a share of total government spending on health from central, provincial and municipality sources, the allocation to the essential health program has decreased substantially (Table A2). COFESA continues to negotiate these annual allocations with the central Government to ensure continued central level funding to the provinces.


<table>
<thead>
<tr>
<th>Government spending</th>
<th>2004</th>
<th>2005/06 average</th>
<th>2007</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential Priority Health Programs, in million AR$</td>
<td>583.00</td>
<td>586.26</td>
<td>631.80</td>
<td>583.00</td>
</tr>
<tr>
<td>In % of total central, provincial and municipality health expenditures</td>
<td>7.00</td>
<td>5.50</td>
<td>4.50</td>
<td>No target set</td>
</tr>
</tbody>
</table>

Source: ICR and National Health Accounts Argentina. [www.who.int/nha](http://www.who.int/nha)

23. From 2004 until 2006, the protection of financing for the essential public health program ensured the continued provision of nutritional supplements (milk) to 1.3 million undernourished children (< 2 years of age), surpassing the annual target of 300,000. In addition, 4.7 million children were immunized against measles and 12,000 tuberculosis patients received DOT treatment nationwide; the results framework did not set a target for this indicator. With these services the government responded to the health needs of the poor as tuberculosis and malnourishment is concentrated among the poor. Since 2003, measles immunization and DOTS (directly observed short-course) TB treatment rates remained on a similar high level. The HIV-vertical transmission prevention treatment rate increased, meeting the target of 90 percent of mothers and newborn treated (Table A3).
24. The SECAL supported the passing of the **Law on sexual and reproductive health by Parliament in 2002, which is part of the health reform program.** In 2005, the MOH created a budget line and a federal program for reproductive health to support the availability of sexual and reproductive health services including free contraceptives and legal abortion in public health facilities where low-income groups seek care. Patients who can afford it or have health insurance seek care in the private sector (Cavagnero 2008). In 2006, the Government adopted two related laws, namely on access to surgical contraceptives in public health facilities and on comprehensive sexual education. The MOH also implemented a communication strategy to inform the population about sexual and reproductive health, and set up a national confidential 0800 phone help line that provides sexual and reproductive health advice (Ministerio de Salud de la Nación 2010(a)).

25. **These reproductive health reforms initiated under the SECAL have been sustained.** The MOH reports that from 2003 until 2009 totally 75.95 million non-surgical contraceptive treatments have been delivered throughout the public health system. There is no information available on whether the improved availability of sexual and reproductive health services responds to the population needs and reduced the number of abortions. The MOH reports the contraceptive use rate in age groups 15-24 years in the general population remained high with 61 percent in 2003 and 66 percent in 2007; however, use rates are not known across socio-economic groups. The MOH reports a similar maternal mortality rate of 4.4 per 10,000 live births over several years.

26. **The SECAL protected government financing for essential drugs provided under Remediar under the essential public health program.** In 2002, access to pharmaceuticals was problematic for a large share of the population. About 60 percent of the population said they could afford paying for only 64 percent of their pharmaceutical needs. In August 2002, the Government enacted the Law on Generic Drugs for public health facilities; in 2003, 57 percent of drug prescriptions were for generic drugs. Before 2002, patients had to pay out-of-pocket for drugs purchased in public health facilities. In 2002, the government and IDB launched the Remediar program to provide 36 essential primary care generic medicines at no cost in public health facilities to the estimated 15 million patients who needed drugs but were unable to afford higher cost medicines (Homedes 2006). The SECAL policy action to protect Government funding for essential health programs (Table A 2) also included drugs in public health facilities. The Remediar program co-financed by the IDB and the Government complements the MCHIP which does not include pharmaceuticals in its basic benefit package. Provinces and municipalities can use the funds received from MCHIP to complement Remediar and

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**Table A 3. Basic Service Indicators for MDGs in Argentina 1995, 2003-2007**

<table>
<thead>
<tr>
<th>MDG Indicators, national</th>
<th>1995</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles immunization rate</td>
<td>98.90</td>
<td>97.40</td>
<td>98.50</td>
<td>98.80</td>
<td>99.00</td>
<td>98.60</td>
<td>87.00</td>
</tr>
<tr>
<td>HIV vertical transmission prevention treatment rate</td>
<td>0.00</td>
<td>0.00</td>
<td>90.00</td>
<td>91.34</td>
<td>93.20</td>
<td>0.00</td>
<td>90.00</td>
</tr>
<tr>
<td>Tuberculosis DOTS treatment rate</td>
<td>70.20</td>
<td>80.60</td>
<td>80.60</td>
<td>81.80</td>
<td>81.80</td>
<td>80.40</td>
<td>n/a</td>
</tr>
</tbody>
</table>

*Source: MOH: Indicadores básicos, Argentina 2010*
purchase additional pharmaceuticals for health facilities. Household survey data would be needed to examine whether drugs have become more affordable for patients since 2002.

27. Additional SECAL-supported reforms were targeted to **implement the MCHIP** to improve maternal and child health care delivery in public health facilities that are used by lower-income groups and the uninsured. Patients with health insurance coverage (obras sociales) mainly seek care in private clinics and with their insurance network providers (Cavagnero 2008), and to a lesser extent in public facilities (mainly in rural areas where public facilities are the only providers). However, there are no recent household survey data that analyze whether the poor are excluded from care for reasons such as unaffordable additional expenses (for example the transport costs and out-of-pocket payments for pharmaceuticals and other services).

28. **The MCHIP (Plan Nacer)** was launched by a Presidential Decree and a national Ministerial Resolution, and enrollment started in early 2004 in the nine poorest Northern Provinces. In 2002, 55 percent of the population in these provinces lived in poverty. The poor include individuals working in the informal sector and indigenous groups. Since 2004, the annual budget law includes an allocation for MCHIP. The MCHIP provides additional financing to reproductive, maternal and child health care in contracted public and private health facilities. Eligible members for MCHIP enrollment are children below six, pregnant women and women up to 45 days post-partum without health insurance. After the 45th day, mothers receive care under the Provincial Reproductive Health Program supported by the Reproductive Health Law. In 2006, more than 400,000 mothers (65 percent of eligible women) participated in the public reproductive health program surpassing the target of 10 percent. At the end of the SECAL in 2007, all nine Northern provinces have issued decrees creating separate MCHIP units. All MCHIP units were fully staffed and structured in accordance with the MCHIP operational manual. Utilization rates for all 10 health indicators increased substantially for MCHIP members (see Table B3 next Chapter).

29. **SECAL supported the development and launch of the MCHIP which is extended nationwide with the support of the APL. At the end of the SECAL by June 2007, the MCHIP was fully operational in all 9 Northern provinces.** Totally, the program had 457,000 mothers and children enrolled (65 percent of target population which included uninsured mothers and children below the age of six), among them 12,700 indigenous individuals. Enrollment was considerably higher than targeted under the SECAL (4,000 members in two Northern provinces). There are no household survey data to evaluate equity in enrollment in MCHIP; however, the wealthier population groups would not want to enroll in MCHIP as they do not seek care in basic public health facilities. Service contracts between provinces and about 2,000 health care providers were signed to participate in the program. Of these providers, 1,100 started billing for services provided to be reimbursed a fee-for-service price. The MCHIP beneficiary database was developed and functioning in two of the nine eligible provinces. Service use increased for MCHIP which is discussed in more details in Annex B as the MCHIP received continued support under the APL1.
30. The Government issued regulations for the MCHIP to operate nationwide, which is currently under implementation with the support of the IBRD Adaptable Program Loan Phase 2 (APL2).

**Objective:** “Assisting the Government to modify the incentive framework for financing and delivery of health care services, starting in Argentina's poorest provinces” *(Rating – High)*

31. The SECAL supported measures that were critical for setting up the institutional framework for developing and implementing an incentive framework in health. These measures included the re-activation of the Federal Health Council (COFESA) as the federal health policy body. COFESA is functional\(^\text{13}\). The provincial Ministers of Health, through COFESA, coordinate and implement health policy reforms at the federal and provincial level, including the MCHIP. COFEAS met regularly since 2004 on average 10 times per year with more than 90 percent of members present; surpassing the SECAL target of at least 3 annual meetings with at least 75 percent of members present.

32. The SECAL worked closely with the APL1 (Annex B) to change the incentive framework in the health sector to finance the MCHIP. First, the intergovernmental health transfer from the central to the nine provinces includes now a capitation amount based on the number of MCHIP members (60 percent of the total additional intergovernmental transfer). Second, the remaining 40 percent of the health fiscal transfer is paid to provinces based on the results achieved by the provincial health services with regards to 10 maternal and child health indicators. This results-linked transfer to the provinces draws the attention of provincial policy makers to MCHIP enrollment and the ten most relevant basic health indicators. Third, the MCHIP pays contracted health care providers a fee-for-service price for services provided to MCHIP patients, thereby setting an incentive to increase the number of services. The SECAL supported the design of this incentive framework, whereas the APL continues to support its implementation (see next Chapter).

33. The SECAL supported activities of good governance. Contractual agreements were signed between the federal MOH and the Provinces to define the administrative, financial, monitoring and auditing rules for provinces and the annual performance targets to be reached in 2002. A concurrent auditing system was design under the SECAL and implemented with the support of the APL1 since 2005 to validate the results reported by contracted providers and provinces. The information generated under the MCHIP and the results-based funding from the national Government to provinces based on audited data is a structural change and has improved governance within the sector, as shown by the improved validity of patient level data identified in the audit reports.

34. The SECAL also supported policies to implement health insurance reforms that pertain to formal sector health insurance. The institutional subsidy to non-poor components was eliminated. The health insurance beneficiary database (obras sociales) was updated to improve transparency in billing and reduce fraud. Membership data are

distributed monthly to the provinces to enable the verification of insurance coverage of patients, facilitate cost-recovery by the public health system, and identify uninsured individuals who qualify for MCHIP membership.

35. Although with delays that led to the project extension, in December 2006, a Presidential Decree was issued to risk-adjust the capitation transfers to insurers by age and gender. While far from being perfect, this limited risk-adjustment was a first step to reduce to some extent risk-selection by health insurers who otherwise would have an incentive to exclude higher-cost patients (for example the diabetics) from coverage and treatment. The payment system for hospital invoices was strengthened in insurance companies and hospitals, leading to faster billing and reimbursement by national insurers, and higher cost-recovery rates in hospitals. The cost-recovery rates increased in the 3 largest hospitals in four Northern provinces (Chaco, Misiones, Tucuman, Salta) by more than 5 times from 2002 until 2006, surpassing the target of a 20 percent increase. The average reimbursement time from the insurers to hospitals is less than 45 days, as targeted.

**Efficiency**

36. Not applicable to policy loans.

**Outcome**

37. Based on the sub-ratings of high relevance and substantial and high outcomes, the project development outcome is rated as **satisfactory**.

**Risk to Development Outcome**

38. The Project Document in 2002 identified several high risks for the program to succeed and be sustainable. These included Argentina’s fragile macroeconomic situation, a possible lack of political support from the provincial governments for reforms proposed by the then new Government, and the high risk to fiscal stability of the public sector. If materialized these three risks would have had a negative effect on Government health spending on the planned reforms.

39. In assessing the risk to development outcomes which is responding to the health needs of poor mother and children and modifying the incentive framework for financing and delivery of care, a distinction can be drawn between the measures the Government has taken to implement and support the continuity of the health sector reforms, and the extent to which the operating and financial environment is conducive to sustainability.

40. The major risk to the sustainability of reforms is that the Government would change its reform agenda, introduce different strategies, abolish COFESA and stop funding of the basic health programs supported under the SECAL. This is most unlikely.

41. The HSRP is well enshrined in the health sector institutional and organizational framework with COFESA as the policy body for the national-provincial health dialogue.
Representatives from the central and provincial government and from MCHIP say the 2003 health sector program, including the laws passed under the SECAL, is being implemented and the procedures and new institutions and structures are in place. However, a change at the MOH leadership from 2007 until 2010 did slow down support to the HSRP, particularly the implementation and funding of the reproductive health law, but since a new Minister of Health has been appointed, the reforms continue to receive the necessary support.

42. Measures such as patient data collection supported under the SECAL are being applied to other programs and scaled up to more health care providers. The MCHIP through its financing reform has substantially improved patient-level data collection in health facilities. These data are used for analysis of provider performance in the provinces; and the analysis is fed-back to providers to take actions to be compliant with standard treatment protocols. COFESA uses this analysis for health policy decision. These are common health reforms implemented in middle-income countries, and it is unlikely that they would be abolished in Argentina.

43. The APL2 is supporting the Government in the national scale-up of the MCHIP. Although with substantial delays, the Northern provinces finally increased their co-financing shares since January 2009 (for example 30 percent of total capitation in Northern Provinces). The central and provincial governments still need to increase future allocations to MCHIP to ensure the system’s financial sustainability after the APL2.

IEG rates risk to development outcomes as moderate.

Bank Performance

Overall rating: highly satisfactory

44. Quality at entry – highly satisfactory: In the 1990s, health projects in Argentina focused on an array of activities. Several of these projects did not perform as expected. In early 2000 and in preparation for this SECAL, the Bank team conducted a thorough political analysis of the decentralized health system, as well as a program performance and risk analysis of the Argentina health portfolio, and came to the conclusion that the health portfolio should be consolidated, and funds used more efficiently by shifting the focus away from supporting hospitals and social health insurance (obras sociales). This led to a consolidation of lending instruments with investment lending through the APL program supporting the implementation of policy-based operations such as the SECAL; and to a shift in emphasis in Bank support from formal sector insurance programs and hospital reform to strengthening the financing and provision of basic health care services in the public system and in facilities that serve the low-income groups. Analytical work discussed the development of such a public health insurance scheme targeted to

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14 OED ICR review ratings for outcomes were “Unsatisfactory” for the Argentina Provincial Health Sector Development Project, “Moderately Unsatisfactory” for the Argentina Health Insurance Technical Assistance Project; and “Moderately Satisfactory” for the AIDS and STD control project.
vulnerable groups, to address inequities in health; improve health outcomes; and modify the incentives framework for service provision\textsuperscript{15}.

45. The Bank team took this very innovative SECAL within four months from Concept Note Review (July, 2003) to Effectiveness (November, 2003). The design was informed by the Public Expenditure Review, the Bank’s 2003 Health Sector analytical work, the Poverty and Social Impact Assessment and by previous Bank projects. The SECAL design also took into account the design of the APL1 and APL2 which were developed to support the implementation of the SECAL. The design was strong and well anchored in the Government’s 10-years HSRP. It focused on the needs of the lower-income groups during the economic and fiscal crisis.

46. The Loan design was innovative and comprehensive. It included the development and implementation of an institutional framework, quality, cost-control and auditing measures that were crucial for the payment reform to be sustainable. It supported the passing of a sexual and reproductive health law in a conservative context. The law improved the availability of these services in health facilities where low-income women seek care. During times of severe budget constraints it provided the institutional and analytical underpinnings to the Government to protect government spending for health services that are predominantly used by the poor.

47. \textit{Quality of supervision – highly satisfactory}: The Bank team provided high-quality supervision to the SECAL with a technically strong and professionally experienced team. The team maximized the impact of the SECAL by developing and implementing a parallel investment operation, the APL1 which complemented the SECAL. The APL1 provided funding for investment and technical assistance to expand the MCHIP in the Northern provinces. The risks to the SECAL, including the initially weak policy dialogue between the central and local governments in a decentralized system and the unequal availability of capacity at the provincial level were identified and carefully addressed during supervision. The Bank team set up a comprehensive M&E framework to evaluate progress made under the SECAL.

\section*{Borrower Performance}

Overall rating: satisfactory

48. \textit{Government Performance – satisfactory}: The IBRD loan supported the implementation of the Government’s health sector reform program. The implementation of this reform program was coordinated on behalf of the Government by three Ministries namely the national MOH, the Ministry of Economy and the Ministry of the Presidency. Representatives of these three ministries have formed a Steering Committee to oversee and monitor the achievement of the program’s objectives and compliance with tranche conditionality. This Committee was the point of contact for World Bank supervision of the loan. All policy actions were timely met by the Government. The exception was the Presidential Degree for the risk-adjustment mechanisms for the FSR. This delay was

\textsuperscript{15} World Bank 2003(b), Annex IV, p. 68.
politically motivated as the health insurance companies who had benefited from risk-selection had all interest to prevent this financing reform. However, this delay in passing the Presidential Degree caused the 15-months extension of the SECAL.

49. **Implementing Agency Performance: - satisfactory.** The MOH and COFESA, implemented the reforms supported under the loan at the national and provincial level. The MOH showed high commitment, ownership and strong leadership for implementing its reform agenda in health and protect health services for the poor against the impact of the economic and fiscal crisis. The strong ministerial leadership at the MOH was a prerequisite to institutionalize COFESA, to bridge the policy dialogue between the provinces and the center, launch new laws, reform health insurance, and ensure the collaboration of the Provinces in ambitious health financing reforms during times of fiscal constraints.

**Monitoring and Evaluation**

Overall rating: *substantial*

50. **Design:** The M&E design in the SECAL Program Document (Annex 3 and 7) is comprehensive and strong, with outcome and output indicators clearly and realistically linked to policy actions for each tranche, and data sources identified. Baseline and benchmark values are presented in Annex 7 of the Program Document which also describes the expected results from policy actions for the supported pillars. A reliable M&E and auditing framework was also developed for implementing the conditional fiscal transfer to finance health care for MCHIP beneficiaries.

51. **Implementation:** Data collection, monitoring and evaluation presented in the results framework were implemented and indicators tracked. The policy actions required substantial investment in patient-level data systems in hospitals, membership data systems in health insurance companies, the membership data based for MCHIP members, and provincial and national administrations on patient, beneficiary and provider data. These basic data sets were needed to identify women and children who are eligible for MCHIP membership.

52. **Utilization:** The M&E framework was used to track progress and decide on tranche release under the SECAL. Information collected became available to all stakeholders through COFESA. The conditional transfer to the Provinces required additional and reliable health information collected on a patient-level. Over time, this focus on using data to monitor and evaluate provider performance and link provider payment to performance results strengthened governance through (i) improved data availability, (ii) provider accountability for results; and (iii) provider adherence to standard treatment protocols. Hospitals used their improved patient data to bill insurers for services leading to higher cost-recovery rates in the public sector.
Lessons

53. This operation provides several lessons that are relevant in the context of results-linked financing:

   a. The political context is important and was well analyzed during the preparation of the SECAL, with clear identification of potential winners and losers who could possibly slow down reform implementation. Implementing sophisticated health reforms requires national leadership and ownership. Argentina had a reform champion with the Minister of Health who spearheaded the design and early implementation of reforms. Changes in political leadership at the end of 2007 slowed down the reform progress until 2010 when a new Minister was appointed who was part of the pre-2007 reform team.

   b. Implementing health reforms is a long-term process and requires regular adjustments. Combining the SECAL with the ten-year APL program was a wise choice to sustain the reforms achieved under the SECAL over a longer time period.

   c. Conditional disbursement based on policy measures can help increase the attention of the government on more difficult reforms (for example the laws on sexual and reproductive health), especially during times of fiscal crisis.

   d. The modified intergovernmental incentive framework improves the information flow from the provinces to the central level, when disbursement from the center to provinces is linked to results. This can be an effective tool in decentralized health systems for central level governments to receive the relevant information from the local levels on the use of funds.
Appendix 1. Basic Data Sheet Argentina – PMCH-SECAL

Argentina Provincial Maternal and Child Health Sector Adjustment Loan (Ln. 7199-AR)

Key Project Data (amounts in US$ million)

<table>
<thead>
<tr>
<th></th>
<th>Appraisal estimate</th>
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<td>Loan amount</td>
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Cumulative Estimated and Actual Disbursements

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Project Dates

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Staff Inputs (staff weeks)

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Lending and Implementation Support Team

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<tr>
<td>Cristian Baeza</td>
<td>Lead Health Policy Specialist</td>
<td>LCSHH</td>
<td>TTL - Health</td>
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<tr>
<td>Marcelo Becerra</td>
<td>Operations Officer</td>
<td>LCSHD</td>
<td>Operations</td>
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<tr>
<td>Maria Colchao</td>
<td>Senior Program Assistant</td>
<td>LCSHD</td>
<td>Assistant</td>
</tr>
<tr>
<td>Robert Crown</td>
<td>Consultant</td>
<td>LCSHH</td>
<td>Health Sector</td>
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<tr>
<td>Paula Giovagnoli</td>
<td>Junior Professional Associate</td>
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<td>Data Collection</td>
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<tr>
<td>Fernando Lavadenz</td>
<td>Senior Health Specialist</td>
<td>LCSHH</td>
<td>Health Sector</td>
</tr>
<tr>
<td>Febe Mackey</td>
<td>Program Assistant</td>
<td>LCSHD</td>
<td>Assistant</td>
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<tr>
<td>Natalia Moncada</td>
<td>Program Assistant</td>
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<td>Team Assistant</td>
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<tr>
<td>Fernando Montenegro</td>
<td>Consultant</td>
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<td>Health Sector</td>
</tr>
<tr>
<td>Mariana Montiel</td>
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<td>LEGLA</td>
<td>Legal</td>
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<tr>
<td>Maria Lourdes Noel</td>
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<tr>
<td>Daniel Oks</td>
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<td>Macroeconomics</td>
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<tr>
<td>Luis Orlando Perez</td>
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<td>Mariangeles Sabella</td>
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<td>Santiago Scialabba</td>
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<td>Juan Pablo Uribe</td>
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<td>Martha P. Vargas</td>
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**Supervision**

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<tr>
<td>Sarah Bailey</td>
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<tr>
<td>Gastón Mariano Blanco</td>
<td>Operations Officer</td>
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<tr>
<td>Tania M. Gomez-Carcagno</td>
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<td>Assistant</td>
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<tr>
<td>Jose Pablo Gomez-Meza</td>
<td>Senior Economist</td>
<td>LCSHH</td>
<td>Task Team Leader – Health</td>
</tr>
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<td>Fernando Lavadenz</td>
<td>Senior Health Specialist</td>
<td>LCSHH</td>
<td>Senior Health Specialist</td>
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<td>Febe Mackey</td>
<td>Program Assistant</td>
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<td>Luis Orlando Perez</td>
<td>Senior Public Health Specialist</td>
<td>LCSHH</td>
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Annex B. The Argentina Republic Provincial Maternal-Child Health Adaptable Program Loan 1

Principal Ratings

ARGENTINA: PROVINCIAL MATERNAL AND CHILD HEALTH INVESTMENT PROJECT APL1 (LN. 7225-AR)

<table>
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<th>ICR*</th>
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<td>Outcome</td>
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<td>Satisfactory</td>
<td>Satisfactory</td>
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<td>Risk to Development Outcome</td>
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<td>Moderate</td>
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<td>Bank Performance</td>
<td>Satisfactory</td>
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<td>Satisfactory</td>
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* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEG product that seeks to independently verify the findings of the ICR.

Key Staff Responsible

Provincial Maternal and Child Health Investment Project --APL1-- (Ln. 7225-AR)

<table>
<thead>
<tr>
<th>Project</th>
<th>Task Manager/Leader</th>
<th>Sector Director</th>
<th>Country Director</th>
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<tbody>
<tr>
<td>Appraisal</td>
<td>Cristian Baeza</td>
<td>Evangeline Javier</td>
<td>Axel von Trotsenburg</td>
</tr>
<tr>
<td>Completion</td>
<td>Rafael Cortez</td>
<td>Keith Hansen</td>
<td>Penelope Brook</td>
</tr>
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Summary

1. The Provincial Maternal-Child Health Adaptable Program Loan 1 (APL1) was a companion investment project to the SECAL to specifically support the implementation of the maternal and child health insurance program (MCHIP) in the nine poorest Northern provinces. The APL1 was designed as the first phase of a ten-year program starting in early 2005. The follow-up APL2 (final phase) became effective in May 2007 to help consolidate the Government health sector reform in the longer run, and scale up the MCHIP nationwide.

2. The main objective of the APL1 was “(i) to halt recent increases in the national rate of infant mortality, and (ii) change the dynamic of financing and providing health care services at the provincial level”.

3. The APL1 comprised five components, including the implementation of the MCHIP in the nine Northern provinces; institutional support to the national and provincial MOHs; communication and outreach programs to inform the population and providers about MCHIP; monitoring, evaluation and independent concurrent audits; and project management at the national and provincial level.

4. The health financing transfer was modified at three levels: (i) IBRD disbursed earmarked capitation payment to the government budget based on the number of beneficiaries enrolled in MCHIP; and the central government transferred the capitation amount to the provinces depending on provincial MCHIP enrollment, (ii) the central government added a results-link health transfer to provinces based on their results achieved by ten health indicators, and (iii) provincial MCHIP reimbursed providers a fee-for-service price for the services provided to MCHIP patients. These financial changes introduced new incentives that were expected to increase attention to basic care among health authorities and providers, and increase MCHIP enrollment.

5. By August 2010, the nine Northern provinces had 565,550 beneficiaries enrolled in MCHIP, reflecting 84 percent of the target population. All nine provinces have surpassed the 50 percent enrollment target. Enrollment varies from 56 percent in Salta province to 92 percent of the target population in Tucuman province.

6. Findings from administrative data suggest a substantial increase in the provision of care since 2005 in the Northeastern Regions (NEA) and the Northwestern Regions (NOA). However, in reality providers also provided these services before 2007 but they did not necessarily collect the data. Thus, the sharp increase in service use from 2005 to 2007 at least partially reflects better data collection. To improve care for indigenous groups, 92 percent of the contracted health facilities have added staff specially trained to attend to indigenous patients.

7. The infant mortality rate fell mostly before the APL1 started from 25 in 2003 to 16.7 in 2005, then it declined an additional 2-percentage points over four years until 2009. A combination of factors may have influenced the change in infant mortality, including an uptake in formal health insurance with more people working in the formal economy, higher household income levels as the economy was recovering, mothers being
better educated, improved resource allocations to health facilities (including finances, supplies and medical staff), and better provision of infant care in health facilities through staff training, and improved patient follow up by staff based on individual patient-level data.

8. IEG’s overall rating of project development outcome is Satisfactory, based on substantial relevance of objectives, high relevance of design, modest and high outcomes, and substantial efficiency. The risk to development outcomes is rated as moderate given the strong government ownership for the program but delays in provincial co-financing for MCHIP. Bank performance was rated highly satisfactory whereas the Borrower’s performance is rated as moderately satisfactory. The government shows strong commitment, ownership and leadership for implementing the MCHIP and COFESA supports the program nationwide; however, misprocurement led to loan cancellations, and delays in provincial co-financing for MCHIP cast some doubt on the program’s sustainability after Bank support comes to an end.

9. Several key lessons emerge from this first phase APL:

a. Supporting the implementation of a policy loan (in this case the SECAL) with a ten-year APL program can help the government staying the reform course over time.

b. Substantial upfront investments are needed to introduce financial incentives to different levels of government and providers. These investments comprised the institutional and legal framework established with the support of the SECAL, investment in data collection systems, monitoring, evaluation and independent concurrent audit systems; provider training and medical equipment, communication strategies to inform the population about benefits and progress made under the reform.

c. Financial transfers tied to results require strong institutional foundations. These include managerial capacity to plan, manage and implement the additional funds; standard financial management and accounting systems monitoring and independent evaluation systems and information transfer to providers such that they can follow-up on patients; and independent concurrent audits to ensure reliability of data from providers which are later used for calculating provider payments and results-linked payments to provinces.

d. It is easier to change the financial incentive system if the system is kept simple at the beginning with only few indicators that are easy to track. A transparent and simple incentive system is also easier for staff to understand such that staff feel they can change their treatment patterns and thus contribute to better health results for patients.

e. Results-linked payments can contributed to better data collection and analysis. Before the introduction of the fee-for-service payment reform, providers did not collect and report patient-level data on service provision at the same level of detail, and did not receive detailed analysis on treatment compliance for individual patients.
Background

1. The SECAL showed good implementation progress in 2004. All nine provincial MOH in the North had confirmed their support to the roll-out of the MCHIP. However, the nine provinces needed additional technical and financial support to implement the MCHIP. The Provincial Maternal-Child Health Investment Project (PMCHIP APL1) was developed by the Government in collaboration with the Bank team as a follow-on investment project to the SECAL to support the implementation of the MCHIP as of 2005. The APL1 was designed as the first phase of a ten-year APL program. The follow-up APL2 (final phase) became effective in May 2007 to help consolidate the Government health sector reform in the longer run, and nationwide.

Objectives and Components of PMCHIP APL1

2. The Legal Agreement states the development objective of the APL1 as “to contribute to the reduction of the infant and maternal mortality rate in the Borrower’s territory, as well as to introduce changes in the incentive framework of health care providers in the Borrower’s Participating Provinces, through the implementation of the MCHIP”.

3. The PAD (p. 36) describes the main objective of the project as “(i) to halt recent increases in the national rate of infant mortality (baseline at a national average of 16.8 per 1000 live births, and a NOA and NEA average of 25 per 1000) and then reduce it by at least 20 percent at the national level and at least 30 percent in the participating northern provinces over a period of 10 years, and (ii) change the dynamic of financing and providing health care services at the provincial level”. The PPAR uses the DPO as stated in the PAD which is congruent with the results framework. The ICR used the same approach.

4. The APL1 aimed to support the nine poorest provinces in the North, and to enroll 80 percent of the estimated target population in the MCHIP (more than 600,000 beneficiaries) at project closure (PAD, p. 7). The project was expected to strengthen provider payment and cost recovery systems; raise the financial sustainability of provincial health systems; and improve the national-provincial policy dialogue to focus on outputs and outcomes. Table B1 shows the project component costs.

---

Table B 1. Expected and Actual Costs of Project Components

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<tr>
<th>Components</th>
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<th>Actual Cost (US$ millions)</th>
<th>Implementation Ratio (B)/(A)\</th>
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<td>112.1</td>
<td>113.9</td>
<td>96%</td>
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<tr>
<td>b. National and provincial MOH</td>
<td>6.5</td>
<td>5.9</td>
<td>92%</td>
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<td>c. Communications and outreach</td>
<td>4.2</td>
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<td>d. M&amp;E, Auditing system</td>
<td>3.9</td>
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<td>e. Project management</td>
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<td><strong>Total IBRD loan</strong></td>
<td><strong>135.8</strong></td>
<td><strong>133.9</strong></td>
<td><strong>98%</strong></td>
</tr>
</tbody>
</table>

*Source: Ministerio de Salud. Informe de Gestión; Agosto 2010.*

5. The five project components comprised the following activities:

a. Implementation of MCHIP included (i) disbursement of capitation payment to the Government based on the number of beneficiaries enrolled with MCHIP, (ii) medical equipment for participating health facilities, (iii) technical assistance and training for provincial Ministries of health to manage MCHIP, (iv) training of health care providers, (v) information systems for providers.

b. Institutional support to strengthen national and provincial MOH included formation of MCHIP insurance/purchasing units who act as provincial PMUs, and administer the MCHIP program in each province. They serve as a link with the central MCHIP in Buenos Aires and the contracted providers in the provinces.

c. Communication and outreach to support implementation of MCHIP financed consultant services, events and communication services about the MCHIP.

d. Monitoring, Evaluation and Auditing included investment in national and provincial M&E and auditing performance, IT, software and training of staff in data management and analysis. This component also hired the private audit firm to conduct concurrent audits.

e. Project management at the national MOH and in nine provinces.

**Project Institutional Framework**

6. In Argentina’s decentralized health system, the national Ministry of Health (MOH) defines the strategic direction for health sector reform, including the MCHIP, and the intergovernmental capitation transfer for MCHIP services to provinces. The MCHIP project management unit (PMU) at the central level was in charge of project implementation for the SECAL and the APL, and collaborates closely with provinces. The PMU hired the private auditor firm to conduct concurrent audits in the provinces. The PMU was also responsible for communication strategies and developing quality of care improvement trainings for the provincial providers. The MOH International Finance Unit (UFI-S) conducts fiduciary activities for the PMU.
7. The provincial Ministries of Health (MSPs) provide health services through the public provider system in the provinces. All MSPs constitute the Federal Health Council (COFESA). The provinces implement the MCHIP through the provincial PMU. These provincial PMUs identify and enroll beneficiaries for MCHIP, contract providers to serve MCHIP beneficiaries, conduct fiduciary management, collect patient-level data from contracted providers and conduct analysis on provider performance, and transfer information to the national PMU.

8. Three contractual agreements govern the implementation of the MCHIP between center, provinces and providers. First, the umbrella agreement describes general terms of collaboration between the central MOH and participating provincial ministries of health. Second, annual performance agreement between the central MOH and the provincial governments set annual targets for ten health indicators, MCHIP enrollment, work programs and resource requirements. Third, performance agreements govern the relationship between provincial ministries of health and contracted providers.

9. The APL1 disbursed against general expenditure categories to finance contracts (consultants, goods, trainings) as is common in traditional investment lending operations. It also disbursed monthly to the Government health budget an earmarked capitation amount based on the number of eligible MCHIP members enrolled in the nine provinces. The MCHP enrollment information was audited by independent auditors. The capitation amount per MCHIP member was defined based on an actual cost analysis on the total cost to provide the MCHIP benefit package per beneficiary per month (US$8). The APL1 financed initially half of this per capita amount (US$4.0); the government finances the remaining 50 percent of the transfer. Since 2009 the provinces are co-financing this transfer.

Implementation

10. The APL1 closing date had to be extended by six months from its original date to July 30, 2010, due to a disbursement lag for capitation payments from IBRD to the Borrower. All components presented in the PAD were implemented. Adjustments were made to expenditure categories. Disbursement was lower than expected for the sub-component medical equipment (Table B1), as planned expenditures (for example the ambulances) were financed by other projects (H1N1). Consequently funds were reallocated across the components.

11. Since January 2010, the nine provinces co-finance the MCHIP implementation cost at 30 percent whereas the remaining 70 percent come from the center and the APL. The provincial contribution is expected to be increased gradually. The follow-up loan (APL2) continues to support these nine provinces while scaling up the MCHIP to the rest of the country.

12. Procurement was downgraded from satisfactory to moderately unsatisfactory in June 2008 when misprocurement in three cases was identified by the Bank team. This event caused staff turn-over in the procurement unit which slowed down the procurement function of the APL1 as well as the implementation of the procurement action plan developed by the Bank. However, the MOH played a pro-active role during these months.
and immediately called upon the Bank to conduct an investigation when procurement concerns occurred.

13. Financial Management was rated Satisfactory by the Bank during the entire APL1 implementation. In 2008 the Bank conducted a review of financial management and derived measures to enhance the control functions, which are being implemented by the Government. Audit reports were unqualified.

14. The APL1 did not involve construction and was thus categorized as Environmental Category “C”. Although not required, a Strategic Environmental Assessment was conducted, mainly to train the relevant capacity at the MOH. The Indigenous Peoples (OD 4.20) was triggered as the APL1 was implemented in areas with the highest indigenous people population density. An indigenous people implementation plan was developed by the Government to identify relevant aspects and actions for MCHIP. The M&E plan included specific indicators, however these were difficult to implement.

**Relevance**

**RELEVANCE OF OBJECTIVES**

15. The project objective of reducing infant mortality is relevant in the context of achieving the Millennium Development Goals (MDGs), and is a milestone in the CPS results framework for 2010-2012. The project objective is in line with the CPS 2010-2012 which proposes a continued focus to provincial health to address the inequities in the health system as expressed by a three times higher infant mortality rate in the provinces compared to the city of Buenos Aires (p. 25). The objective is also relevant to address the challenges identified in the CPS 2010-2012, including for indigenous population groups who face higher levels of infant mortality and infectious diseases and are considerably less likely to be insured.

16. However, establishing any direct impact of the APL1 on the reduced mortality rate is difficult because – in addition to access to basic health care -, many factors affect a country’s infant mortality rate including economic growth and mothers’ education level. Also, the mortality rate has been declining in Argentina as in other countries since the early 90-ties (Figure 3-1), thus a continuous decline during project time can be attributed as well to the continuation of an ongoing trend.

17. The CPS 2010-2012 is performance-based and projects have to include incentives to achieve their development outcomes. Accordingly, the project objective of changing the incentive framework through the health financing mechanisms with the introduction of MCHIP is highly relevant for the CPS. The MCHIP is also part of the Government’s health strategy reform program. The APL objective is in line with the CPS 2010-2012 which describes a continued focus on strengthening provincial health systems through the expansion of the MCHIP, and concurrent audits to support the system fiduciary performance and transparency.

The IEG rates the relevance of objectives as *substantial*. 
RELEVANCE OF DESIGN

18. The four components of the design (including the implementation of the MCHIP, institutional support to strengthen the national and provincial MOHs, communication and outreach to inform about MCHIP, monitoring, evaluation and auditing) were highly relevant to achieve the project objective of reducing infant mortality and changing the dynamic of financing and the provision of basic health care.

19. The design’s first component incorporated substantive supply-side strengthening among providers to improve health care delivery for babies and mothers, which is expected to reduce the infant mortality rate.

20. The design introduced incentives through the first component and the necessary M&E and auditing system through the third component. In the traditional line-item fiscal transfer system, the central government transfers funds to the provinces based on budget lines (for example the salaries, maintenance); however, the central MOH does not receive data from the provinces about the use of funds in the provision of care. The APL modified the health financing transfer at three levels: (i) IBRD disbursed earmarked capitation payment to the government budget based on the number of beneficiaries enrolled in the MCHIP; and the central government transferred the capitation amount to the provinces depending on provincial MCHIP enrollment, (ii) the central government added a results-linked fiscal transfer to provinces based on the results achieved by ten health indicators (Table B2), and (iii) provincial MCHIP reimbursed providers a fee-for-service price for the services provided to MCHIP patients. These financial changes would introduce new incentives.

21. Capitation payment set an incentive to the central government and the provinces to increase the number of MCHIP beneficiaries. Fee-for-service payment to providers creates an incentive to deliver more services to MCHIP patients, and the indicator payment to provinces incentivizes compliance with 80 standard treatment protocols introduced under the MCHIP (Nomenclatura). The resulting behavioral changes among providers and health authorities were expected to improve health performance as measured by the ten health indicators (Table B2).

Table B 2. Ten Health Indicators - Trazadoras

<table>
<thead>
<tr>
<th>Number</th>
<th>Health Indicators - Trazadoras</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First prenatal care checkup before week 20 of pregnancy</td>
</tr>
<tr>
<td>2</td>
<td>Newborns from eligible women with APGAR score higher than 6 at 5 minutes after birth</td>
</tr>
<tr>
<td>3</td>
<td>Percent of eligible infants weighting more than 2500g</td>
</tr>
<tr>
<td>4</td>
<td>Percent of eligible pregnant women receiving virology and molecular diagnostic and anti-tetanus vaccination</td>
</tr>
<tr>
<td>5</td>
<td>Medical audits of maternal and infant death</td>
</tr>
<tr>
<td>6</td>
<td>Measles vaccination rates, children up to 1 year</td>
</tr>
<tr>
<td>7</td>
<td>Sexual and reproductive health consultation rate among puerperal women</td>
</tr>
<tr>
<td>8</td>
<td>Well child care visit rate among eligible children up to 1 year</td>
</tr>
<tr>
<td>9</td>
<td>Well child care visit rate among eligible children ages 1-6 years</td>
</tr>
<tr>
<td>10</td>
<td>Percent of health facilities with medical staff specially trained for treating indigenous population</td>
</tr>
</tbody>
</table>
22. The project was designed as the first phase of a 10-year APL. This longer-term approach secured government commitment to the health sector reform program which was also supported under the SECAL. Longer-term political and financial commitment was needed for prioritizing the MCHIP first to the poorest regions while maintaining interest among the remaining provinces to participate in the follow-up phase. The design incorporated lessons learned from past projects, notably the SECAL and earlier health insurance projects, and analytical work on health financing reforms.

23. The design included three innovative parts. First, more than half of the loan was disbursed to the Borrower as a capitation amount earmarked for health based on the number of beneficiaries enrolled in MCHIP. Second, the borrower would transfer the capitation amount to the provinces that could use the funds received to finance their investment needs using their own procurement and financing systems. Third, participating provinces had to sign an agreement to co-finance the capitation amount at an increasing rate when entering APL2. The traditional part of the project design financed the necessary investments (for example IT technology and data collection, audits of data, training of administrative and medical staff, etc) to support project implementation.

24. The design was kept flexible. Initially, the payment for the ten indicators (Table B2) from the central government to provinces was “all or nothing” resulting in 4 percent payment for each indicator goal achieved, or no payment if not met. This was changed to a gradual payment leading to 2 percent payment per indicator if the minimum goal is reached and 4 percent for reaching the maximum goal. The design was adjusted when the government requested to expand the MCHIP benefit package to include cardiopathies under the APL2.

IEG rates design relevance as high.

Achievement of Objectives

25. This report assesses whether the expected outcomes as identified in the results chain, materialized. The results chain is used from the Project Document (p. 36). The project’s objectives and components were not changed and the project was not formally restructured.

Objective: To halt recent increases in the national rate of infant mortality (baseline at a national average of 16.8 per 1000 live births, and a NOA and NEA average of 25 per 1000) and then reduce it by at least 20 percent at the national level and at least 30 percent in the participating northern provinces over a period of 10 years. (Rating – modest)

26. Infant mortality is dropping nationwide, as it is in other countries (see Figure 2.1 in Chapter 2). The difference in infant mortality between the Northern provinces in NOA and NEA and the national average has decreased (Figure B1). The rate fell mostly before the APL1 started from 2003 to 2005. Then it leveled off to decline 2-percentage points in NEA and NOA over three years until 2009. From 2005 until 2009 over four years, the rate declined 12.6 percent, suggesting that the northern provinces were not on track to meet the APL program target of a 30 percent reduction over ten years at the time of
closure of APL1. The national rate has declined 9 percent since 2005 (Figure B1), and with the support of the APL2 (which scales up the MCHIP nationwide), could eventually reach the 20 percent reduction objective over ten years. These average infant mortality rates are based on data from MCHIP beneficiaries and non-members, including insured and uninsured children.

Figure B 1. Infant Mortality Rate in NEA, NOA and Argentina Average, 2003-2009

27. Several factors affected the decline in infant mortality before 2005 and thereafter. By June 2005, the MCHIP had just started. At the end of 2005, about 40 percent of the target population was enrolled (see Figure B2). The MCHIP benefit package includes maternal and child care services that help to reduce the infant mortality rate. However, in 2005 and 2006, these relevant health indicators were still low, among them well-child visits below the age of 1 year, APGAR score, prenatal care visit rates (Table B3). These indicators only increased since 2007. Thus, given the low indicator performance, it is difficult to establish a link between MCHIP membership and the infant mortality rate before 2007. Since 2007, the mortality dropped from 16.3 to 14.6 in 2009, at the same time MCHIP membership increased substantially as did the performance of the relevant health indicators (Table B3). Cardiopathy diseases are one of the causes of infant mortality; therefore, under the APL2, the MCHIP benefit package has been extended to provide surgical and non-surgical treatment to infants who suffer from cardiopathies.

28. In Argentina, an impact evaluation was conducted based on administrative data to examine how the MCHIP affected health outcomes, the provision of services and utilization.\textsuperscript{17} The analysis is still under way when this PPAR was written, but preliminary findings confirm that service use among MCHIP members increased substantially over time. Administrative patient data do not include information on relevant individual characteristics such as patients’ socio-economic, educational and insurance-status background that influence individual care-seeking behavior and health outcomes; and

\textsuperscript{17} Evaluación de Impacto Plan Nacer. Resultados de la Promoción Intensiva sobre Tasas de Inscripción en Provincias de la Fase II. Versión Preliminar para Comentarios. Junio 2010.
they exclude information on individuals who did not seek care, or seek care with non-participating providers. The team will therefore launch a population-based household survey in August 2011 as part of a national impact evaluation of the MCHIP. The household survey analysis will allow comparing the treatment behavior of MCHIP members against eligible non-members while excluding individuals insured through their employers with national or provincial social health insurers (Obras sociales).

29. In Argentina, a decrease in the overall infant mortality rate was probably influenced by a combination of factors, including an uptake in formal health insurance with more people working in the formal economy, higher income levels as the economy was growing, better education levels among mothers, improved resource allocations to health facilities (including finances, supplies and medical staff), and better provision of infant care in health facilities through staff training and adherence to treatment protocols.

30. A household survey conducted in Brazil found that female illiteracy was the most important determinant several factor for infant mortality. Decreasing female illiteracy by 10 percent would reduce infant mortality by a greater amount than all other variables combined in the Brazilian study. A 10 percent increase in family medicine coverage was associated, on average, with a 4.6 percent decrease in infant mortality. Improving water access by 10 percent was associated with a 3 percent reduction, and increasing the number of hospital beds only led to a 1.35 percent reduction. Higher fertility and lower income per capita had a modest, positive association with infant mortality (Macinko J. et al. 2006). There is no similar study that would explain the determining factors for a decreasing infant mortality in the MCHIP context in Argentina.

**MCHIP enrollment**

31. **Enrollment in MCHIP has increased steadily** (Figure B 2). The MCHIP was available to the target population of uninsured pregnant women, children up to 6 years and women up to 45 days after delivery, in all nine provinces of northern Argentina. These are the poorest provinces, with the highest proportion of uninsured. About 75 percent of Argentina’s indigenous population lives in these provinces; they are traditionally a poor and excluded group. Additional enrollment criteria are (i) being a resident in one of the nine Northern provinces, and (ii) having a national identification document from Argentina. The national identification requirement improved the registration and vital statistics of undocumented children and women, mainly among indigent groups.
Figure B 2. MCHIP Enrollment Rate in NEA and NOA, 2005-2010

Source: Ministerio de Salud de la Nación, 2010(b).

32. The MCHIPS in the nine provinces have enrolled more beneficiaries than originally planned\(^\text{18}\) (50 percent of target population) and by 2010 signed contracts with 6,163 providers, who provide the MCHIP benefit package to patients following the 80 standard treatment protocols. During the past seven years, economic growth has resumed and unemployment rates decreased which led to a decrease in the number of uninsured - the target population. By August 2010, the nine Northern provinces had 565,550 beneficiaries enrolled in MCHIP, reflecting 84 percent of the target population. All nine provinces have surpassed the 50 percent enrollment target. Enrollment varies from 56 percent in Salta province to 92 percent in Tucuman province. There are no household survey data to identify the socio-economic differences between MCHIP members and non-members.

33. About 16 percent of the target population in the nine Northern provinces did not enroll with MCHIP. Among them are illegal immigrants and those who are difficult to reach such as women who live in remote areas in large rural provinces like Salta. However, they are not excluded from health care, as public care is provided for free to all patients independent of their MCHIP membership. The only difference is that providers will not receive a fee-for-service price for services provided to non-MCHIP patients as this is the case for MCHIP patients.

34. Membership enrollment takes place in health centers when women seek care, and during outreach activities by providers. As public health care is provided for free to patients, women do not necessarily have a price advantage if they sign up with MCHIP. Also, women may not see the benefits of the improved data management system implemented under MCHIP, which helps providers improve compliance with treatment

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\(^{18}\) The Project Document aimed to enroll more than 600,000 members by the end of the APL1 (p. 7), whereas the Document’s results framework aimed to enroll 50 percent of the target population.
standards. Some women may thus not see a reason to enroll in MCHIP. In 2009, the government decided to reinforce enrollment by making access to universal child support (AUH) conditioned on MCHIP membership. Since early 2010, MCHIP enrollment increased by about 10 percent points (Figure B 2). This suggests that additional measures are needed to increase MCHIP enrollment if individuals do not perceive a difference in price and benefits with or without MCHIP membership.

Objective: To change the dynamic of financing and providing health care services at the provincial level. (Rating – high)

35. MCHIP has changed the dynamic of financing. The central MOH disburses the capitation amount received from the IBRD loan to the provinces in two installments. First, 60 percent of the capitation amount from the APL1 to the Government is a monthly capitation amount based on the number of MCHIP members. As shown above in Figure B2, the nine provincial MCHPs enrolled the majority of the target population. Second, 40 percent of the APL1 capitation transfer to the Government is based on ten health indicators (Table B2) assessed for all patients. The transfer is made to the provinces every four months based on the results achieved in these indicators. For each of the ten health indicators the maximum payment of 4 percent can be achieved. Since 2008, provinces receive 2 percent for achieving the minimum performance level per indicator. Third, an additional fee-for-service payment is made from MCHIP to providers.

36. The projected funded about 175 consultants who work in MCHIP purchasing units in the provinces and in the central MCHIP. They manage the entire MCHIP membership, benefits and payment administration, and conduct data analysis of provider data for health indicator payments. The central MOH and provinces have developed and implemented communication activities to inform the population about the MCHIP. All provinces have implemented the requested safeguard policies for communication with indigenous groups.

Payment to provinces based on ten health indicators

37. The transfer payment to provinces based on 10 health indicators required first investment in data collection, monitoring and evaluation system to ensure reliable data for defining the indicator payment. Results from this data evaluation conducted by the MCHIP show a substantial increase in the provision of services in the 10 indicators since 2005 (Table B3), suggesting that the provision of care has changed.

38. However, these results should be interpreted with some caution. It is unlikely that providers did not immunize children or provide preventive care services to women before 2007. Rather, it is possible that these basic services were already provided to some extend in 2005, but providers did not collect the data, as they do it now under the MCHIP. Thus, the sharp increase in service use from 2005 to 2007 possibly reflects better data collection, and not necessarily better service provision. Nonetheless, health service provision and health indicators such as the APGAR score and low birth weight improved substantially from 2007 until 2009.
Table B 3. Health Indicators I-X Results, NOA and NEA, 2005-2009

<table>
<thead>
<tr>
<th>Selected Indicators</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>First prenatal care visit &lt;week 20, NEA</td>
<td>4.5</td>
<td>23.4</td>
<td>44.2</td>
<td>45.0</td>
<td>48.4</td>
</tr>
<tr>
<td>First prenatal care visit &lt;week 20, NOA</td>
<td>4.7</td>
<td>23.6</td>
<td>36.0</td>
<td>40.8</td>
<td>44.4</td>
</tr>
<tr>
<td>% newborn APGAR &gt;6, NEA</td>
<td>15.0</td>
<td>48.8</td>
<td>66.5</td>
<td>80.3</td>
<td>97.3</td>
</tr>
<tr>
<td>% newborn APGAR &gt;6, NOA</td>
<td>25.3</td>
<td>52.8</td>
<td>72.8</td>
<td>89.3</td>
<td>79.8</td>
</tr>
<tr>
<td>% newborn weighting &gt;2500gr, NEA</td>
<td>13.9</td>
<td>46.7</td>
<td>63.4</td>
<td>75.8</td>
<td>92.8</td>
</tr>
<tr>
<td>% newborn weighting &gt;2500gr, NOA</td>
<td>23.9</td>
<td>50.7</td>
<td>69.7</td>
<td>85.1</td>
<td>75.9</td>
</tr>
<tr>
<td>Vaccination rate pregnant women, NEA</td>
<td>6.5</td>
<td>33.2</td>
<td>56.8</td>
<td>64.6</td>
<td>82.0</td>
</tr>
<tr>
<td>Vaccination rate pregnant women, NOA</td>
<td>6.6</td>
<td>40.0</td>
<td>54.5</td>
<td>68.7</td>
<td>72.9</td>
</tr>
<tr>
<td>Medical audits mother/child death, NEA</td>
<td>7.8</td>
<td>28.8</td>
<td>42.0</td>
<td>72.1</td>
<td>90.6</td>
</tr>
<tr>
<td>Medical audits mother/child death, NOA</td>
<td>3.8</td>
<td>13.3</td>
<td>59.0</td>
<td>83.7</td>
<td>96.7</td>
</tr>
<tr>
<td>Immunization rates &lt;18 months, NEA</td>
<td>6.4</td>
<td>30.5</td>
<td>56.5</td>
<td>75.5</td>
<td>64.5</td>
</tr>
<tr>
<td>Immunization rates &lt;18 months, NOA</td>
<td>10.2</td>
<td>33.9</td>
<td>58.1</td>
<td>64.7</td>
<td>52.7</td>
</tr>
<tr>
<td>SRH consultation rate, NEA</td>
<td>5.3</td>
<td>39.7</td>
<td>62.7</td>
<td>70.2</td>
<td>90.5</td>
</tr>
<tr>
<td>SRH consultation rate, NOA</td>
<td>3.6</td>
<td>38.4</td>
<td>55.4</td>
<td>75.3</td>
<td>64.3</td>
</tr>
<tr>
<td>Complete healthy child visit &lt;1 year, NEA</td>
<td>0.0</td>
<td>0.0</td>
<td>14.2</td>
<td>30.0</td>
<td>32.7</td>
</tr>
<tr>
<td>Complete healthy child visit &lt;1 year, NOA</td>
<td>0.0</td>
<td>0.0</td>
<td>12.9</td>
<td>31.9</td>
<td>35.1</td>
</tr>
<tr>
<td>Complete healthy child visit 1-6 year, NEA</td>
<td>0.0</td>
<td>8.9</td>
<td>32.7</td>
<td>41.5</td>
<td>40.7</td>
</tr>
<tr>
<td>Complete healthy child visit 1-6 year, NOA</td>
<td>0.0</td>
<td>11.0</td>
<td>31.4</td>
<td>49.6</td>
<td>45.5</td>
</tr>
<tr>
<td>% of providers with staff trained in indigenous care, NEA</td>
<td>7.6</td>
<td>35.1</td>
<td>61.0</td>
<td>97.5</td>
<td>92.1</td>
</tr>
<tr>
<td>% of providers with staff trained in indigenous care, NOA</td>
<td>1.9</td>
<td>27.7</td>
<td>62.6</td>
<td>88.0</td>
<td>97.9</td>
</tr>
</tbody>
</table>


39. The provision of care did not improve for all indicators. Three indicators are lagging behind and increased not as much as the other seven indicators (Table B3). These include (i) first prenatal care visit <20 weeks which did increase but is still relatively low, (ii) complete healthy child visit <1 year started only to take off in 2007; and (iii) complete healthy child visit 1-6 years increased but appears to level off since 2008.

40. The indicator on indigenous care was difficult to assess as patients were hesitant to share information on their indigenous heritage. To improve care for indigenous groups, 92 percent of the contracted health facilities have added staff specially trained to attend to indigenous patients. In 2008, the nine provinces achieved on average the minimum level in 7.4 of 10 indicators, receiving at least 2 percent payment for each of these indicators. Only one Northern Province – Catamarca – did not meet the indicator targets and as a result faced a temporary suspension in indicator payment during the project time. Since April 2010, the MCHIP benefit package has been extended under the APL2 to treat cardiopathies among children, which is one of the main contributors to infant mortality when rates decline to 10 and less.

41. Since 2005, the change in the dynamic of financing - based on capitation and indicator-linked transfers – has led to an increase in additional health financing to the nine Northern NEA and NOA provinces. However, this increase in financing has remained on a similar level during the last two years of the APL1 (Figure B3).
Finally, some methodological issues still need to be addressed in defining the indicator payment to provinces. The payment is defined based on the estimated eligible population group, which is problematic, as the provinces do not know the actual number of the eligible population. Currently, the eligible population is estimated based on projections made by the central government using estimated fertility rates, the 2001 and now 2010 census and annual household budget surveys. However, these surveys do not identify individuals’ formal insurance status. Thus, provinces may be financially disadvantaged if their eligible population group is overestimated. Then again, including all uninsured in the denominator puts additional pressure on provinces to increase enrollment and treat all patients equally, independent of their MCHIP membership.

**Fee for Service Payment to Contracted Health Facilities**

The third change in the dynamic of financing is the introduction of fee-for-service payment from MCHIP to the owners of contracted providers. By August 2010, the nine provincial MCHIP signed contracts with 2,145 public and private providers to deliver care to MCHIP beneficiaries. Mainly public providers were contracted, as MCHIP aims to strengthen the public health care system. The fee-for-service payment for services provided to MCHIP patients is an additional revenue source for providers to the line-item budget from the government. MCHIP pays higher FFS prices to rural providers given their higher outreach cost.

The provision of care has changed. Providers have discretion on how to use the funds from FFS revenue from MCHIP. They have contracted additional staff, investments were made to improve working conditions and improve the availability of medical material. From June 2007 to June 2008 providers in the nine provinces used the additional funds of US$28.4 million from the MCHIP to pay for maintenance and investment (30.5 percent), incentive payments (25.9 percent), professional services (24.7 percent), medical goods (7.2 percent) and other goods and services (11.7 percent).
salaries of additionally contracted staff (for example the nutritionists) are paid from the category “professional services“.

45. Public providers also treat patients insured with other insurance companies. National and provincial insurers and MCHIP pay different prices to providers for the same services. It is thus not clear whether providers have different financial incentives in treating MCHIP patients or patients insured with other insurers.

**Data Collection and Analysis, Audits and Management**

46. The objective to change the financing mechanism and the provision of care created the need to collect detailed information on the number of MCHIP beneficiaries, progress made to achieve health indicator targets, and services provided to patients. Provinces had to report this information to the central MOH in order to receive the additional funding from capitation and health indicator payment. Providers had to send invoices to the provincial MCHIP office documenting the number and kind of services provided to each patient to receive FFS payments. The MCHIP office would then reimburse providers based on the verified invoices. The new financing mechanism thus pays provinces and providers for collecting better data and for reporting this information to the central level.

47. Each provider collects patient registry and treatment data that are forwarded to the provincial MCHIP for analysis. Providers have to maintain registries for beneficiaries and patients. Provincial MCHIP identify in their analysis for each provider all patients who are not in compliance with treatment protocols. This information is passed on regularly to providers who will follow-up with non-compliant patients through their outreach programs. The additional information received from the MCHIP helps providers to improve service provision by adhering to the standard treatment protocols.

48. An independent audit firm has been contracted under the project to conduct concurrent audits of provider performance and enrollment of beneficiaries. Initially, auditors detected relatively high error rates of about 23 percent of the provincial transfer in 2005, which decreased to 8.2 percent in August 2010 (Ministerio de Salud, Informe de Gestion Agosto 2010). This erroneous amount was then deducted as a fine from the capitation payments to the provinces. Errors mostly occurred due to incomplete supporting information, eligibility criteria did not apply or health services were not provided as specified. The provincial MCHIPs made the corresponding deductions to the payments of providers who had caused the errors.

49. According to Argentina’s Country Program Strategy 2010-2012, the concurrent audits are designed to ensure fiduciary standards of the Bank-financed MCHIP, and have gradually become the auditing standard for the health insurance scheme at the national level. It is envisaged to adopt concurrent audits in future Government programs in other sectors.

50. Financial and administrative management capacity has been built among providers and provincial MCHIP units. The Tucuman MCHIP management unit was awarded ISO 9002 certification for having met international standards in management.
Hospitals are financially autonomous, but PHC providers are owned and financially managed by the municipality or province.

**Efficiency**

51. Project funds were implemented efficiently on time with only a six-month project extension. Project spending focused on primary and preventive care services provided in basic health facilities, helping to avert higher cost hospital admissions in the nine Northern provinces, which are the poorest areas in Argentina and have the highest rate of indigenous groups. The APL1 funded several efficiency-enhancing activities, including better patient level data to improve the adherence to standard treatment protocols.

52. At appraisal, an economic analysis was conducted, estimating the current value of avoided maternal and child deaths. The net present value of the APL1 was estimated at US$670 million with a rate of return of about 18.1 percent over ten years. The ICR conducted a follow-up efficiency analysis and estimates a substantially higher rate of return of 31.6 percent and a benefits/cost ratio of 2 over 6 years. The ICR estimates are twice as high as in the PAD, because the ICR based its calculations on data on the probability of dying at birth collected in the Tucuman province only. Results were extrapolated for all nine provinces, based on their performance in three relevant proxy indicators. However, the efficiency analysis conducted in the ICR does not seem plausible, given that the rate of return is twice as high in the ICR than estimated at appraisal although the appraisal was based on higher reduction in the infant mortality rate than actually happened.

IEG rates efficiency as **substantial**.

**Outcome**

53. Based on the sub-ratings of substantial relevance of objectives, high relevance of design, modest and high outcomes, and substantial efficiency, IEG’s overall rating of project development outcome is **satisfactory**.

**Risk to Development Outcome**

54. The MCHIP is well received by the population and supported by the current central and provincial political leadership. MCHIP has been expanded nation-wide based on the experience from the nine provinces. In 2010, the remaining 14 provinces in Argentina, supported under the APL2, counted 890,552 MCHIP members or 64 percent of the target population. The government also decided to expand the MCHIP benefit package to include curative care services and to increase the target population to include all children up to 18 years. The ministerial members of COFESA have already signed an agreement that will lead to the expansion of the MCHIP to become a Provincial Health Insurance. These decisions show strong government ownership for the program.

55. The fiscal impact of the MCHIP was expected to be minimal. In 2009, the MCHIP transfer from the central to the provincial governments reflects 9.4 percent of the total amount for all centrally funded government health programs. For example, the allocation
to the MCHIP is less than the 12.3 percent of the total central government transfer to provinces earmarked for HIV/AIDS programs.

56. Argentina’s strong economic performance as well as the high ownership by COFESA for the reforms will make it unlikely that the Government would change its reform course to abolish MCHIP. However, provincial governments differ in their political and financial support to MCHIP as suggested in the delay in program co-financing; which may affect the future sustainability of the program on a provincial level. These questions are currently addressed under the APL2.

IEG rates risk to development outcome as moderate.

**Bank Performance**

Overall rating: highly satisfactory

57. **Quality at entry – highly satisfactory**: The APL program was designed to strengthen the implementation of specific aspects of the Government health reform program supported under the SECAL, namely the MCHIP. The program was underpinned by analytical work prepared under the SECAL and based on a franc assessment of the political context in a decentralized health system and previous Bank support that recommended a shift from hospital to basic care. The team together with the Government developed a comprehensive design including health financing reforms, strong data collection, monitoring and evaluation and auditing, and investment in the provision of care, that responded to the implementation needs for the Government’s 10-years reform program. It focused on the health services used by lower-income groups during the economic and fiscal crisis and targeted the poorest provinces in the North. The Loan was innovative as it was the first time that a Bank health sector operation added a fiscal transfer for health to include a results-linked component which set an incentive for health authorities to focus on health service delivery for poor patients.

58. **Quality of supervision – Highly Satisfactory**: The Bank team provided high-quality supervision under the APL1 with a technically strong and professionally experienced team. The team maximized the impact of the APL1 by complementing parallel investment operations and preparing the scale-up to APL2. The Bank team immediately responded to the Government request to conduct an investigation about the adherence to Bank procurement rules. The Bank procurement team identified and confirmed misprocurement and took the required steps to correct the situation including cancellation of funds and development and implementation of a detailed procurement plan.

59. The Bank team took actions when design adjustments were needed and set up a comprehensive M&E framework to evaluate progress made. This has influenced the institutionalization of M&E and auditing systems at the national and provincial level. Later, the team was proactive again and secured limited Trust Funds to evaluate the impact of the MCHIP based on administrative data. Preliminary findings from this impact

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19 Dirección de Economía de la Salud en base a información solicitada a los Programas Sanitarios. 2009.
evaluation suggest a substantial increase in service use among members of the MCHIP. However, findings from this analysis have to be interpreted with caution due to the limits of the data sources and methodology. Therefore, the Bank team under the APL2 has secured funds to conduct a household survey in August 2011 to examine the impact of the MCHIP. The experience with the MCHIP/Plan Nacer has been disseminated internationally, and is used to inform other countries interested in health financing reforms.

**Borrower Performance**

Overall rating: moderately satisfactory

60. **Government Performance – satisfactory**: The Government has implemented the APL1 at the national and provincial level. Despite changes in leadership at the end of 2007, the central MOH continued to show commitment, ownership and leadership for implementing the MCHIP. COFESA supports the MCHIP development and scale-up in other provinces. The initial delays in enrollment led to the six-month loan extension. Low enrollment rates were swiftly addressed by the Government by making MCHIP membership compulsory for child benefit recipients.

61. However, the provincial governments have been less forthcoming than originally expected in co-financing their provincial MCHIP. The APL1 Loan Agreement was amended twice: first in July 2008, to maintain 100 percent national co-financing of MCHIP capitation payment until December 2008 and postpone the start of 60 percent provincial co-financing to January 2009; and second in October 2009, to reduce the share of provincial co-financing from 60 percent to 30 percent of the capitation amount. To ensure the MCHIP sustainability after the APL program comes to an end, the government would have to increase resource allocations to MCHIP. The government could also take a more decisive role in improving the insurance membership data base to timely update changes in membership and clarify the size of the MCHIP target population, and also introduce insurance invoicing systems in all basic health facilities to increase cost-recovery rates, as this was done for MCHIP patients, and in hospitals with the support of the SECAL.

62. **Implementing Agency – moderately satisfactory**: The PMUs at the national and provincial levels are all strong and well trained. The national PMU provided substantial technical assistance to both provincial MCHIPs and providers, especially in provinces with weaker institutional capacity. The national PMU benefited from continuity in technical and management leadership which ensured strong collaboration with all stakeholders. The provincial PMUs played a crucial role in managing the MCHIP offices, conducting data analysis and provider relations including contracting and payments, and following up on audit results.

63. The procurement function in the international procurement unit at the central MOH was temporarily weak. In 2008, the MOH became concerned about the procurement unit’s adherence to Bank procurement rules. The MOH immediately contacted the Bank and requested an investigation into procurement. The Bank procurement team conducted an investigation and identified misprocurement in three
cases in the total amount of US$ 1.579 million (1.1 % of total loan). The APL1 loan amount was cancelled by this amount and a procurement action plan was prepared based on the procurement review. The MOH implemented the required corrective measures.

**Monitoring and Evaluation**

64. **Design.** The APL1 includes a strong M&E design with explicit objectives, input and output factors and expected results to assess progress and outcomes. The project supported the implementation of this design with substantial investment in data systems, collection and analysis. Results were used to make adjustments to the project design (for example change the health indicator payment).

65. **Implementation and use of data.** The project invested substantially in the collection and management of valid and reliable patient level data in health facilities. Data are analyzed at the MCHIP office based on information transmitted from providers. The MCHIP analysts conduct a patient-level data analysis to assess provider performances. Results are reported monthly to each provider who uses the information to identify patients not in compliance with treatment protocols. Together with the independent audit system, this provider performance analysis is a particularly strong and unique feature of the health project.

66. An impact evaluation based on administrative data is being conducted, and preliminary findings are available. However, due to limited data quality and limits in the methodology the findings cannot be used for policy recommendations. A household survey will be conducted in August 2011 to address these constraints. The Government decided to scale-up MCHIP to all provinces under the APL2, before the preliminary results from this impact evaluation became available. Thus, the policy relevance of the impact evaluation is not clear.

IEG rates monitoring and evaluation as **high**.

**Lessons**

67. Several key lessons emerge from this innovative APL1:

   a. Following a policy loan with a ten-year APL program can help the government staying the reform course; especially if health sector reforms include challenging new financial arrangements and require a longer-term view for implementation.

   b. Substantial upfront investments are needed when introducing financial incentives to different levels of government and providers. In Argentina, the SECAL invested in setting up the institutional and legal framework to implement MCHIP. The APL1 then substantially invested in monitoring, evaluation and independent concurrent audit systems; providers were trained to adhere to 80 standard treatment protocols and equipped with the necessary medical material to provide care to all patients; and a communication strategy was launched. The communication strategy can regularly inform the
population about the change and benefits, for example through public reporting of health indicator results to inform the population about progress made under the reform.

c. Financial transfers tied to results require strong institutional foundations. These include managerial capacity to plan, manage and implement the additional funds on a provincial and provider level; standard financial management and accounting systems as implemented in the provincial MCHIPs; monitoring and independent evaluation systems and information transfer to providers such that they can follow-up on patients; and independent concurrent audits to ensure reliability of data from providers which are later used for calculating provider payments and indicator payments to provinces.

d. Modest starts make it easier to change the financial incentive systems as this was the case under the MCHIP when they changed from 4 percent of nothing payment per health indicator to a gradual payment when a minimum target was achieved. A modest and simpler incentive system is also easier for staff to understand such that staff feels they can change their treatment patterns and thus contribute to better health results for patients.

e. Results-linked payment is a powerful tool to improve data collection and analysis, and use findings to improve the provision of care. Before they were paid fee-for-service fees, providers were not requested to collect and report patient-level data on service provision.
Appendix 1. Basic Data Sheet Argentina PMCHIP APL1

Provincial Maternal-Child Health Investment Project – APL (Ln. 7225-AR)

Key Project Data (amounts in US$ million)

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*SW from completion of Negotiations to Board approval not included.
**Completion report was prepared because most SWs were charged to FY budget even though project closed in July 31, 2010.
# Lending and Implementation Support Team

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<tr>
<td>Cristian C. Baeza</td>
<td>Sector Director</td>
<td>HDNHE</td>
<td>TTL</td>
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<tr>
<td>Luis Orlando Perez</td>
<td>Senior Public Health Specialist</td>
<td>LCSHH</td>
<td>Health</td>
</tr>
<tr>
<td>Fernando Lavadenz</td>
<td>Senior Health Specialist</td>
<td>LCSHH</td>
<td>Health</td>
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<tr>
<td>Marcelo Becerra</td>
<td>Senior Economist</td>
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<td>Robert W. Crown</td>
<td>Consultant</td>
<td>EASPR</td>
<td>Consultant</td>
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<tr>
<td>Natalia Moncada</td>
<td>Senior Executive Assistant</td>
<td>LCSHD</td>
<td>Assistant</td>
</tr>
<tr>
<td>Yewande Aramide Awe</td>
<td>Senior Environmental Engineer</td>
<td>ENVHD</td>
<td>Safeguards</td>
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<td><strong>Supervision/ICR</strong></td>
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<tr>
<td>Rafael Cortez</td>
<td>Senior Economist (Health)</td>
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<tr>
<td>Jose Pablo Gomez-Meza</td>
<td>Senior Economist (Health)</td>
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<td>Vanina Camporeale</td>
<td>Operations Officer</td>
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<td>Mariana Margarita Montiel</td>
<td>Senior Counsel</td>
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<td>Marta Elena Molares-Halberg</td>
<td>Lead Counsel</td>
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<tr>
<td>Keisgner De Jesus Alfaro</td>
<td>Senior Procurement Specialist</td>
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<td>Ana Maria Grofsmacht</td>
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<td>Alejandro Roger Solanot</td>
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<td>Gaston Mariano Blanco</td>
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<td>Daniela Romero</td>
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<tr>
<td>Paul J. Gertler</td>
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<td>Santiago Scialabba</td>
<td>Program Assistant</td>
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<td>Sarah Bailey</td>
<td>Junior Professional Associate</td>
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## Other Project Data

**Borrower/Executing Agency:** National Ministry of Health

### Follow-on Operations

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Appendix 2. Persons Interviewed for Argentina SECAL and APL1

Washington D.C.

World Bank

- Rafael Cortez, Sr. Economist Health, LCSHH
- Gaston Mariano Blanco, Sr. Social Protection Specialist, LCSHS
- Cristian Baeza, former Lead Health Policy Specialist for LCSHH and Task Team Leader, current Sector Director (HDNHE)
- Jesko Hentschel, former HD Sector Coordinator based in Buenos Aires, LCSHD, current Sector Manager (ECSHD)
- Juan Pablo Uribe, ICR Author, current Sector Manager (EASHH)
- James Parks, former Lead Economist PREM (LCSPE), Advisor to the Managing Director
- Ariel Fiezbein, former Lead Economist LCSHD, current Chief Economist HD
- Charles Griffin, former Sector Manager LCSHH
- Fernando Lavadenz, Sr. Health Specialist, LCSHH

Buenos Aires

World Bank

- Penelope Brook, Country Director for Argentina, LCC7C
- Luis Orlando Perez, Sr. Public Health Specialist, LCSHH

Ministry of Health

- Dr. Maximo Diosque, Secretary, Secretariat of Outreach and Sanitary Programs, Ministry of Health
- Dr. Martin Sabignoso, National Deputy Coordinator, “Plan Nacer”, Secretariat of Outreach and Sanitary Programs, Ministry of Health
- Dr. Ricardo Izquierdo, Coordinator, Supervision Unit, Secretariat of Outreach and Sanitary Programs, Ministry of Health
- Lic. Veronica Ferraris, General Coordinator, International Finance Unit, Ministry of Health
- Dr. Ana Maria Sala, Head, Monitoring and Evaluation, Health Department, “Plan Nacer”, Secretariat of Outreach and Sanitary Programs, Ministry of Health
- Lic Humberto Silva, Head, Technical Unit, “Plan Nacer” Secretariat of Outreach and Sanitary Programs, Ministry of Health
- Lic. Tomas Pippo Briant, Economist, Health Economics Directorate, Ministry of Health
- Dr. Ana Cristina Pereiro, Health Practitioner
- Lic. Alfredo C. Perazzo, Consultant, “Perazzo & Asociados” Firm
Cordoba

- Dr. Andrea Ferri, Coordinator, Provincial Health Insurance Implementation Unit, “Plan Nacer”, Ministry of Health
- Lic. David Strasorier, Technical Director, Provincial Health Insurance Implementation Unit, “Plan Nacer”, Ministry of Health

Tucuman

- Dr. Silvina Marcela Rivero, Coordinator, E.P.C.S.S. “Plan Nacer”
- Patricio Alejandro Vincent, Head, Unit Administrative Unit, E.P.C.S.S. “Plan Nacer”, Ministry Health

Salta

- Dr. Oscar Mulki Collados, Coordinator, “Plan Nacer”
Annex C. Brazil Family Health Extension Adaptable Program Lending APL1

Principal Ratings

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* The Implementation Completion Report (ICR) is a self-evaluation by the responsible Bank department. The ICR Review is an intermediate IEG product that seeks to independently verify the findings of the ICR.

Key Staff Responsible

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Summary

1. The Family Health Extension Adaptable Program Lending 1 supported the implementation and scale up of the federal PSF Conversion Program of traditional primary health care to family medicine units. The APL1 was designed as the first phase of a seven year program starting in early 2003. The APL introduced innovative fiduciary reforms by disbursing earmarked funds for the PSF Conversion Program to the government budget. Implementation slowed down after the elections led to change in the administration, and the APL was restructured to increase the number of targeted municipalities from initially 44 to 187. The follow-up APL2 became effective in October 2009 and continues to provide support to the family medicine conversion program in large, urban municipalities.

2. The main objective of the APL1 was to (i) increase coverage among population in urban centers with populations of 100,000 or greater, especially among those with limited access to and utilization of basic health care, through expansion of and conversion to the PSF approach, development of a referral and counter-referral system, and improvement in the management and organization of basic health services; (ii) improve the quality of family health service provision through developing and strengthening in-service and pre-service training of human resources in the PSF model; and (iii) improve the performance and effectiveness of basic health care services through strengthening monitoring and evaluation, information management and accreditation systems.

3. The APL1 included three components, which were implemented in 187 municipalities. The first component disbursed to the government budget earmarked financial support to the PSF conversion. The APL1 increased the PSF conversion transfer to participating municipalities by about 5 percent. In addition, municipalities could win a bonus and a performance prize, if they achieved specific targets in public administration and health reforms. The second component supported human resource development activities; however, this component was fully financed by the government. The APL1 funded the third component – monitoring and evaluation – to document progress made under the PSF reforms. The APL is being implemented through the Ministry of Health staff, thus project management is funded by the Government.

4. PSF population coverage in the 187 municipalities increased from 26.6 percent in 2003 to 34.4 percent in 2008, meeting the target of 35 percent. Totally 120 municipalities achieved 48 percent population coverage. By the end of 2010, PSF expansion reached 36.2 percent population coverage in the target municipalities. Appointment centers were established in 94 percent of municipalities and referral systems were implemented in 87 percent of PSF teams.

5. Several studies have identified a positive association between PSF and health outcomes. Guanais (2009) finds the PSF expansion is associated with lower post-neonatal mortality, as are other factors such as improvement in clean water supply and lower illiteracy rates. From 2002 to 2006, the post-neonatal mortality rate in Brazil decreased from 8.68 to 6.92 per 1,000 live births. But mortality rates are highest for municipalities with low level of decentralization and PSF coverage, whereas best results are achieved in municipalities with higher PSF coverage. Comparative studies found that family
medicine units outperform traditional primary care providers in terms of preventive care, utilization rates, and health status of children as reported by parents.

6. The government with the support of the APL1 paid a bonus and performance prize to best-performing municipalities. The bonus went to 35 of 187 municipalities who (i) implemented at least 90 percent of conversion funds received from project based on implementation plans; (ii) showed specific progress in achieving performance indicators; and (iii) presented accounting ledgers documenting expenditure use for at least 75 percent of funds. The performance prize was shared by 12 municipalities who met the targets for: (i) actual expenditures according to implementation plan; (ii) at least 70 percent population coverage for PSF; and (iii) compliance with fiduciary benchmarks.

7. The APL1 prepared for the development and implementation of performance agreements between states and municipalities with explicit target indicators. The APL2 continues to support the performance-based management system, which was shifted from the APL1 to APL2 as more time was needed for investment in data collection and analysis.

8. IEG’s overall rating of project development outcome is Satisfactory, based on high relevance of objectives and design, high, substantial and high efficacy and substantial efficiency. The risk to development outcomes is rated negligible given that the PSF program is fully managed and financed by the Government.

9. Several key-lessons emerge from the PSF program in Brazil:

   a. Earmarked disbursement to a specific government program is an innovative way for the Bank to provide complementary financial support to reforms and increase the political attention for the reforms. A pooled funding approach can also strengthen government fiduciary systems.

   b. It can take longer than originally planned to implement performance-linked financing as countries often first need to set up reliable data collection analysis systems to define performance and related payments. However, the experience with the bonus and performance prize in the municipalities shows, that financial incentives based on process indicators can be used to help guide reforms in the desired direction (for example reliable budget preparation and budget execution according to standard rule; progress towards reforms objectives). This could be particularly interesting in decentralized health systems with unequal health management capacity across local governments.

   c. Additional structural reforms may be needed to strengthen the PSF performance and address issues such as shortages in family medicine physicians and frequent staff changes in PSF units.

   d. In Brazil, two-year elections and related staff changes in municipalities and states slow down reforms. Frequent staff turnover may lead to a loss of information, which to some extent can be limited by institutionalizing information management in public sector administration.
Background

1. The Brazilian Family Health Program (PSF) is a federal program that provides financial support to the conversion of traditional Primary Health Care (PHC) centers into Family Medicine teams. Initially, the program started in a “bottom-up approach” with municipalities participating voluntarily. In 1994, the federal Government decided to scale-up the PSF program nationwide.

2. From 1994 to 2002, the number of municipalities with PSF grew from 55 to 4,161 (reaching 75 percent of all municipalities). Municipalities were more likely to participate in PSF conversion if they were poor or if they had a mayor from a socialist party. Municipalities with at least eight years of PSF experience reported a considerably higher reduction in infant mortality rate (difference of 5.4 per 1,000 live births) than in non-participating municipalities. Highest impacts were reported in the two poorest regions in the North of Brazil. Between 2002 and 2005, PSF coverage increased nationwide from 75 to 90 percent of municipalities and from 32 to 45 percent of the population. Fifty percent population coverage has been achieved for municipalities under 100,000 inhabitants, and for nearly all rural areas. Coverage lags (approximately 30 percent) in the 250 large, urban municipalities where over 90 million people reside (about 60 percent of the population) (Rocha and Soares 2010).

3. The experience from this first decade suggests that PSF was easier to implement in rural areas than in larger urban areas. Implementation was challenged by an inadequate referral system from PHC to hospitals, different management capacities across municipalities, and uneven quality of care across municipalities due to shortages in medical goods and insufficient human capacity.

4. The PSF program is funded through federal transfers – the PSF Conversion Fund - that vary according to levels of population coverage, and these resources are complemented by local government allocations. However, not all states meet the funding targets for health and the broad definition of health spending means that states and municipalities may allocate funds to other health priorities than PSF, risking the program to be underfunded.

5. In 2002, the Government requested Bank support for the nationwide scale-up of PSF reforms through an Adaptable Program Lending (APL). With an APL, the Government wanted to focus PSF expansion to large urban areas, convert the PSF model into an outreach family health model, implement performance-based financing in federal-municipal agreements and strengthen municipal capacity to manage health services and fiduciary tasks.

6. In 2002, the Bank’s Board approved the seven-year US$550 million Brazil Family Health Extension APL Program (PROESF) to be implemented in three phases. The first phase financed through APL 1 in the amount of $68 million became effective on December 13, 2002 and was completed on June 30, 2007, is the subject of this PPAR. The second phase (APL2) is under implementation since September 1, 2008. The APL1 supported municipalities in the set-up for performance based payment but the actual payment is only implemented since July 2010 under the APL2.
Objectives and Components

7. According to the Loan Agreement and the Project Appraisal Document, the Project Development Objectives of the APL during Phase 1 are to: (i) increase coverage among population in urban centers with populations of 100,000 or greater, especially among those with limited access to and utilization of basic health care, through expansion of and conversion to the PSF approach, development of a referral and counter-referral system, and improvement in the management and organization of basic health services; (ii) improve the quality of family health service provision through developing and strengthening in-service and pre-service training of human resources in the PSF model; and (iii) improve the performance and effectiveness of basic health care services through strengthening monitoring and evaluation, information management and accreditation systems (World Bank 2002).

8. The APL1 included three components, which were initially targeted to 40 of the 223 urban municipalities with populations of 100,000 or greater (World Bank 2002):

   a. **PSF municipality conversion and expansion** including (i) family health extension and basic care program to increase coverage from about 10 to 35 percent of the municipality population; (ii) PSF conversion involving institutional modernization of municipalities to implement performance-based management agreements, strengthening of municipal information systems, and improving health service provision.

   b. **PSF human resource development** including training of PSF medical and management professionals.

   c. **Monitoring and evaluation (M&E)** comprising (i) consolidation and standardization of monitoring systems for basic health care, (ii) evaluation of PSF implementation to measure impact of training, (iii) accreditation of health facilities, and (iv) support to research and evaluation of PSF.

9. After the first project year, the Government changed. The new Administration requested an amendment to the Loan Agreement (amended on August 31, 2004) to reflect changes in project scope. The PDO remained the same. The restructured APL1 was to co-finance PSF implementation in 231 municipalities with populations over 100,000 instead of 40 municipalities, though this number was later adjusted to 188 municipalities.

10. The new administration decided to finance the human resource development (2\textsuperscript{nd} component of the APL) and project management from its own resources. IBRD financed the expanded M&E (3\textsuperscript{rd} component) to build M&E capacity at the state-level, and a larger first component which now included the PSF roll-out in the additional municipalities. Table C1 shows the total project costs for the first and third components financed by the Government and the IBRD loan of totally US$68 million. Brazil does not conduct detailed National Health Accounts, thus there is no detailed information available on Government spending for the second and fourth components. However, total co-financing by the Government was estimated to have increased by at least $18 million from originally $68 million to $86 million, resulting in total project costs of $153 million at
project closure. This additional amount was used to finance the implementation of the second and fourth components.

Table C 1. Expected and Actual Costs of Project Components APL1

<table>
<thead>
<tr>
<th>Components</th>
<th>Expected Cost (US$ millions)</th>
<th>Actual Cost (US$ millions)</th>
<th>Implementation Ratio (B)/(A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSF municipality conversion and expansion</td>
<td>80.5</td>
<td>92.9</td>
<td>115%</td>
</tr>
<tr>
<td>2. PSF human resource development</td>
<td>34.5</td>
<td>15.5</td>
<td>45%</td>
</tr>
<tr>
<td>3. Monitoring and evaluation</td>
<td>6.5</td>
<td>41.6</td>
<td>640%</td>
</tr>
<tr>
<td>4. Project management</td>
<td>3.5</td>
<td>3.5</td>
<td>100%</td>
</tr>
<tr>
<td>Contingencies</td>
<td>10.4</td>
<td>0.0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total Project Costs</strong></td>
<td><strong>135.4</strong></td>
<td><strong>153.5</strong></td>
<td><strong>113%</strong></td>
</tr>
</tbody>
</table>

*Source: PAD and ICR.*

11. The APL1 had originally allocated 25 percent (US$17.08 million) to PSF conversion subprojects in eligible municipalities (1st component). After project restructuring, the actual PSF conversion amount disbursed by IBRD to this first component increased to US$46.4 million or 68 percent of the APL1. This amount was disbursed to the Treasury, as an additional amount to PSF reflecting 30 percent of the total PSF transfer to municipalities for PSF Conversion Subprojects. The Government financed the remaining 70 percent. Municipalities co-financed PSF subproject implementation with their own investment resources.

**Project Institutional Framework**

12. The central MOH signed agreements with eligible states and municipalities to participate in PSF Conversion Subprojects, based on which local governments could receive and implement Conversion Subproject transfers. Participating municipalities had to meet related performance benchmarks; they were responsible for procurement and had to utilize proceeds of the PSF Conversion transfers based on agreed procedures. The Bank reviewed the accounts of the municipalities. The MOH had the right to suspend disbursements to municipalities not in compliance with their obligations set forth in the PSF Conversion Subproject implementation agreement. The MOH contracted a research entity to implement research activities under the M&E component of the project. The Project Coordination Unit (PCU) at the MOH managed project implementation.

13. Bank funds were earmarked for PHC and advanced into the PSF grant transfer system against the governments Statements of Transfers. Municipal expenditures incurred against jointly agreed PSF subproject implementation and procurement plans described in the federal-municipal contracts.

14. A fiduciary assessment deemed the Government’s procurement and financial management system as robust to include Bank funds in the PSF pool. To mitigate the risk, fiduciary oversight and control measures were applied to the federal transfer pool,
and the Bank worked with the federal Government to supervise and strengthen municipal fiduciary processes. Regular audits were conducted by the Federal Secretary of Control, an independent audit unit of the Government.

**Implementation**

15. The APL1 became effective on December 13, 2002. The closing date was extended by 18 months from its original date to June 30, 2007, due to delays during implementation related to changes in government administration. The loan disbursed almost fully with 99.87 percent. The project was co-financed by the Government at 50 percent of total project costs. The project was restructured in 2004 as the new Government decided to highlight its support to capacity building and therefore use its own funds under the project to finance the implementation of Components 2 and 4. Accordingly, IBRD funds were reallocated (i) to pool with the Government PSF Conversion Subprojects under Component 1 (increase from US$17.08 million to US$46.6 million) and (ii) to finance the Research Subprojects under Component 3 (increase from US$2.7 million to US$13.6 million).

16. The APL introduced innovative fiduciary features. The IBRD Loan disbursed earmarked to the MOH PSF Conversion Fund. Disbursement was a fixed amount for each PHC unit that would join the PSF Conversion program. IBRD funds were earmarked against statement of PSF transfers issued by the government. The additional financing from the APL1 represents a small portion of federal PSF financing (about 5 percent). Participating municipalities complement the financing for the Conversion fund with their own investment resources. All states and municipalities maintained an accounting and financial management system for the specific purpose of recording PSF information. Bank funds were used to finance eligible expenditures as approved in the yearly *Plano de Operação Anual*, or Annual Operating Plans.

17. Government expenditures were audited annually by the internal auditing system. In 2007, a Financial Management supervision mission confirmed that the APL1 financed less than 30 percent of the Federal Government’s 2003-2006 transfer to the PSF.

18. Although the governmental procurement and financial management system were used to implement the APL1, Bank fiduciary rules applied. Thus, investments were needed on the central and local government side to meet Bank fiduciary requirements.

19. The APL1 did not trigger any Bank Safeguard Policy. The operation did not involve any construction and was rated as Environmental Category C.

**Relevance**

**Relevance of Objectives**

20. The project objectives of increasing PSF coverage in large urban municipalities with a population of at least 100,000 inhabitants, improving quality of care and strengthening monitoring and evaluation were and continue to be highly relevant for Brazil. The PSF has been a core effort of the federal Government since 1994 to improve
primary care and raise per capita health expenditures in municipalities. The new Administration which took office in 2010 considers expanding PSF coverage in urban areas as a Government key-priority. Findings from various studies published in peer-reviewed journals associate PSF in Brazil with better provision of basic health care and effective targeting of poorer areas (Guanais 2009; Macinko 2010; Macinko 2006; Rocha and Soares 2010).

21. The APL program is in line with the strategic focus of the Country Program Strategy (CPS) Progress Report 2010, which aims to support the Government administrative reforms from 2006 known as health covenants (Pactos por Saude). The reform provides increased flexibility to sub-national entities to design, organize and manage their health delivery system in the context of results-linked budget allocations. The Bank continues to support these reforms through several health operations including the APL2 and the federal Qualisus Rede Swap project (CPS 2010; p. 8).

IEG rates the relevance of objectives as high.

RELEVANCE OF DESIGN

22. The design was innovative, kept flexible and provided lessons that were helpful to other projects in Brazil and elsewhere. The project design included the PSF conversion in target municipalities, PSF human resource development and monitoring and evaluation nationwide. These activities were highly relevant to achieve the project objective of expanding PSF conversion in large urban municipalities, improving quality of care and strengthening monitoring and evaluation.

23. The design was innovative as for the first time, a Bank loan in Brazil agreed to pool loan funds with Government funds. Thereby it increased the federal PSF transfer to municipalities by 10 percent annually over seven years.

24. The APL1 added to the federal PSF transfer a “bonus prize” and a “performance prize”. These prizes were paid to municipalities that implemented explicit governance and fiduciary actions which are critical dimensions in the implementation of municipality administration of the PSF program. A modified version of this results-linked scheme was included in the Health Covenants (Pactos de Saude) in 2006.

25. The design considered the political context. It focused on introducing PSF in the politically important large municipalities where it was also more difficult to implement PSF conversion. Bank support to the Program helped getting the political buy-in from mayors for PSF.

26. The APL1 is among the first Bank operations with a results-linked financing component. The APL1 invested substantially in management capacity in municipalities to help staff prepare budget implementation plans and fund management. It supported the government in getting the political buy-in from large municipalities to implement PSF. The design included “non-traditional project disbursement methods” but still followed the

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Bank procurement and financial management rules. These lessons were helpful to prepare the road for other lending with results-based financing components.

Based on these factors, IEG rates design relevance as **high**.

**Achievement of Objectives**

27. Efficacy assesses to what extent the project’s stated objectives were materialized based on the chain of expected inputs, outputs and outcomes presented in the PAD. The results frameworks divides the PDO (World Bank 2002; p. 7) into three parts:

28. **Objective: Increase coverage among population in urban centers with populations of 100,000 or greater, especially among those with limited access to and utilization of basic health care through expansion of and conversion to the PSF approach, development of a referral and counter-referral system, and improvement in the management and organization of basic health services.** *(Rating – high)*

29. **Increased PSF coverage:** Overall 188 of 223 municipalities with >100,000 inhabitants signed PSF conversion agreements, received additional funds from the project, and implemented coverage extension and conversion plans. Only one municipality did not execute the conversion agreements, and the MOH sought reimbursement. Thus, 187 municipalities actively participated in PSF conversion. Of the 187 municipalities, 70 percent fully implemented the “PSF expansion and conversion” agreements, and complied with performance indicators. In these municipalities, the APL1 financed the conversion of 2,400 traditional PHC facilities to PSF health units, whereas 1,300 units remain unconverted.

30. The 187 municipalities funded under the APL1 increased PSF population coverage to 34.3 percent largely meeting the target of 35 percent in 2008 (Table C2). Overall 120 of 187 municipalities had on average 48 percent of their population covered by PSF. Consequently, about 28.9 million inhabitants were covered by PSF in 2008 in the project-supported municipalities. The APL1 reached populations with limited access by starting the PSF conversion in the poorest districts within a city (favelas). These favelas were identified based on municipality socio-demographic and health data including human development and health indicators. Referral systems were implemented in 87 percent of PSF teams (target: 50%). The APL2 continues to provide support to the PSF program.
Table C 2. PSF coverage in Bank- supported urban municipalities, 2003-2008

<table>
<thead>
<tr>
<th>PSF coverage</th>
<th>2003</th>
<th>2008 actual</th>
<th>2008 target</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of population covered by PSF in Bank-supported urban municipalities</td>
<td>26.6</td>
<td>34.3</td>
<td>35</td>
</tr>
</tbody>
</table>

31. The MOH monitors the expansion of PSF nationwide. By 2009, nationwide 95.6 million people (52 percent of the population) were served by the PSF program. PSF coverage is still lower in urban areas (47 percent of urban population) than in rural areas (73 percent of rural population). Highest coverage is reported in the poorer northeastern region, (72 percent of population), and lowest in the wealthier southeastern region (36 percent), suggesting that the expansion worked best in poorer and rural areas (Guanais 2010). Expanding PSF in urban areas is more challenging, given the higher availability of private providers and political support to specialists and hospitals.

32. The Ministry of Health\(^\text{21}\) reports that utilization of services in PSF facilities (including DPT vaccination, prenatal care visit compliance, household visits by health teams) increased substantially; while hospitalization rates decreased for cases treated in PSF facilities\(^\text{22}\). Child immunization rates have constantly been on a relatively high level (95 percent). The indicator targets for compliance of care were largely met during the project period, with the exception of the 70 percent target among pregnant women with six visits (Table C3).

Table C 3. Basic Health Care under PSF in 187 municipalities, 2002 - 2007

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>Actual 2007</th>
<th>Target 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women attended by PSF teams who had 6 prenatal care visits and all basic laboratory exams recommended by the PNC protocol</td>
<td>57%</td>
<td>61%</td>
<td>70%</td>
</tr>
<tr>
<td>DPT Vaccination Rates</td>
<td>94%</td>
<td>99%</td>
<td>100%</td>
</tr>
<tr>
<td>Tetanus vaccination rates, pregnant women</td>
<td>91%</td>
<td>95%</td>
<td>100%</td>
</tr>
<tr>
<td>% of PSF teams supervised</td>
<td>0%</td>
<td>84%</td>
<td>50%</td>
</tr>
</tbody>
</table>


33. Higher PSF coverage was associated with higher service use. Project municipalities with over 60 percent PSF coverage showed a 12 percent increase in the number of mothers with 7 or more prenatal visits, compared to an average of 2 percent increase for all municipalities. The increase in the coverage of tetanus vaccination for pregnant women was up to three times higher in municipalities with over 40 percent PSF coverage than the average increase for all participating municipalities (La Forgia, 2008).


\(^\text{22}\) For example, in Vitoria Municipality the hospital admission rates for PHC cases decreased from 32 in 2002 to 18 per 1,000 inhabitant in 2009 while PHC visit rates increased ten-fold to 4 visits per capita per year.
34. **The management and organization of basic health services improved.** PSF appointment centers were established in 94 percent of participating municipalities (target: 50%) to better manage patient flow. The APL1 trained 2,823 professional in planning, management and organization; an additional 4,850 professional were still in training (target: 3,000 professionals). Action plans to address health issues in catchment areas were developed by 74 percent of the PSF teams (target: 50%), and 84 percent of the teams were supervised compared to a target of 50 percent. The APL1 funds were used to build management skills and monitoring and evaluation capacity in municipalities in budget preparation and management to qualify for the bonus and performance price (see below). The APL1 also prepared municipalities and the MOH with M&E investment and management for implementing a simple performance-based system, which is currently under implementation with the support of the APL2.

35. As highlighted in the CPS Progress Support 2010, the APL1 prepared for the implementation of the Government health administrative reforms from 2006 known as health covenants (Pactos por Saude) with several activities, including (i) the performance contracting between the MOH and municipalities which required municipalities to negotiate targets for basic care compliance with providers; (ii) the strengthening of PSF; and (iii) the investment in computers, software and monitoring and evaluation of medical care. The reform provides increased flexibility to sub-national entities to design, organize and manage their health delivery system in the context of results-linked budget allocations.

36. **Objective: Improve the quality of family health service provision through developing and strengthening in-service and pre-service training of human resources in the PSF model.** *(Rating – substantial)*

37. **Structural and treatment quality improved through staff training and investment in service provision.** PSF training and quality of care ranks highly on the Government health reform agenda. To express its strong ownership and commitment to PSF training, the MOH decided to fully finance the project activities related to human resources with counterpart project funds. The project monitored the implementation of these training activities. Overall 40 family health specialist training programs were established (target: 30); 22 new family health residency programs (target: 5); and 98 new training centers (target: 15). From 2002 until 2008, the share of primary care staff trained in family medicine increased from 28 percent to 41 percent. Structural quality improved in the 1,019 health units which were upgraded with government resources (World Bank 2007, Ministerio de Saude 2011).

38. **To increase the attractiveness for family medicine, a medical specialty for family medicine was created for medical doctors.** Bi-annual innovation fairs were organized for family medicine staff to meet and exchange their experience and innovations to improve quality of care. To achieve and maintain a unified quality standard, the MOH launched an accreditation program for PSF, which is being scaled-up nationwide. It comprises a quality monitoring system to examine the quality of care in PSF facilities and regional training centers (polos) offering continuous education for family medicine teams.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>Actual 2007</th>
<th>Target 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff (physicians, nurses, community health agents) with continuing education in PSF</td>
<td>0</td>
<td>11,774</td>
<td>10,000</td>
</tr>
<tr>
<td>Number of nurses and physicians graduated in PSF specialization</td>
<td>0</td>
<td>3,624</td>
<td>500</td>
</tr>
<tr>
<td>Number of dental technicians graduated in PSF</td>
<td>0</td>
<td>1,900</td>
<td>500</td>
</tr>
<tr>
<td>Number of scholarships to family health residents</td>
<td>0</td>
<td>1,558</td>
<td>100</td>
</tr>
</tbody>
</table>


39. Several comparative studies examined the effectiveness of PSF in project supported municipalities as well as in other municipalities. These studies found that PSF outperformed the traditional PHC model in terms of service production, population utilization, supply of preventive activities, and parents’ reports on health status of infants (Macinko 2010; Macinko 2006; Harris 2010). In this sense, the APL1 invested in the right health strategy. Using data from 2004, Macinko (2007(b)) found that the dimensions of gate-keeping comprehensiveness, family and community orientation were significantly higher for PSF users than for users of traditional PHC services (P<0.05). The PSF users reported about a 20 percent higher overall evaluation of their primary care experience than those in the traditional primary care services (P<0.05). Both types of clinics scored poorly in terms of access. Based on interviews with a small sample of women, PSF services were rated significantly superior in terms of access to vaccination coverage, hospital maternity care, drug access, home visits and quality of care as expressed by patient satisfaction (Medina 2009).

40. The MOH conducted a matched comparison of performance for basic care indicators in 10 project-supported PSF municipalities and 10 non-participating PSF municipalities. Findings point to higher levels of PSF coverage, pre-natal care service use, and reduced hospital admissions in project supported PSF areas than in the control areas. These results indicate that support under the APL1 has improved the quality of care provided under PSF (World Bank 2008).

41. **Objective: improve the performance and effectiveness of basic health care services through strengthening monitoring and evaluation, information management and accreditation systems. (Rating – high)**

42. The APL1 supported the implementation of M&E systems for PSF on a municipality level nationwide and not just in the 187 municipalities. All 27 states approved the new PSF M&E system and in 26 states the system was fully implemented. Totally 25 state-level M&E centers were established (target: 5); 26 states had M&E plans approved, and 22 states implemented the plans. Overall the APL1 funded 84 research projects related to PSF nationwide (target: 13). The share of project-supported municipalities with the M&E system linked to the national system (needed for performance-based management) increased from 16 percent in 2002 to 88 percent in 2007 (target: 30%). With this nationwide data collection, the APL1 contributed to a large
body of research on the effectiveness of PSF. Data were used by researchers and published in the international peer-reviewed literature.

43. **The performance and effectiveness** of the basic health care system improved through the introduction of the PSF nationwide. Several studies associated PSF with improved health results: (i) a 10 percent increase in statewide PSF coverage was associated with a 4.6 percent decrease in infant mortality controlling for other health determinants (Macinko et al. 2006); (ii) higher levels of PSF coverage at the municipal level was associated with decreases in infant mortality, higher immunization rates and prenatal overage and a reduction in hospital admissions; and (iii) higher municipal PSF coverage is associated with lower admission rates for preventable diseases in children (Guanais 2009; Macinko et al 2010). PSF expansion has been associated with lower post-neonatal mortality, as are other factors such as improvement in clean water supply and lower illiteracy rates. From 2002 to 2006, the post-neonatal mortality rate in Brazil decreased from 8.68 to 6.92 per 1,000 live births. Mortality rates are lowest for municipalities with high level of PSF coverage and decentralization (Medina 2009).

44. **Monitoring and evaluation and information management strengthened at the municipal level.** Improved data were used in decision-making for example to allocate the use of additional funds received from the PSF program. In addition, the wealth of information on PSF provided data to research institutes. Several researchers used this data to evaluate PSF performance. The Government with the support of the APL1 established accreditation systems for family health units and training institutions for staff.

45. Loan funds were disbursed to the Research subproject pool to finance M&E capacity building nationwide in all 27 Brazilian states. The national PSF information and the government health M&E system were strengthened by adding 50 indicators to measure the impact of PSF on health outcomes. In addition, eight research institutions were contracted to carry-out baseline studies for all municipalities with more than 100,000 inhabitants. A prenatal information system was implemented for monitoring of the referral network.

46. In 2006, the APL1 paid a one-time award to the best performing among the 187 municipalities; consisting of a bonus payment (50% of PSF transfer) and a performance prize. The bonus payment was distributed as a lump-sum to 35 of 187 municipalities who met the three performance criteria (i) implement at least 90 percent of conversion funds received from project based on implementation plans; (ii) show progress in achieving performance indicators; and (iii) municipality accounting ledgers present expenditure use for at least 75 percent of funds. The performance prize of totally R$6 million was shared by 12 municipalities who met the three performance criteria: (i) actual expenditures according to implementation plan; (ii) at least 70 percent population coverage for PSF; and (iii) compliance with fiduciary benchmarks. The awards were presented to the winners during an official award celebration in Brasilia with the central government. Disbursement based on these management indicators did affect the mindset in municipalities. Authorities had to prepare implementation plans to execute the additional financing received from the PSF Conversion Fund, adhere to financial management standards and strengthen their fiduciary management systems.
47. The award was disbursed to the municipality budget as health facilities are owned and managed by municipalities; facilities are not financially autonomous. Municipalities used the award to finance expenditures for staff training, equipment and consultants. However, it was not possible to use the award to pay salary increases or financial incentives to staff.

48. The APL2 continues the reforms started under the APL1. It supports the implementation of a performance-based management system (Pacto de Atencao Basica) which was originally planned for implementation under APL1, but then shifted to APL2 as more time was needed to set up the necessary monitoring, evaluation and management capacity in health faculties and municipalities.

Efficiency

49. At appraisal an economic analysis estimated that over ten years, the APL will yield a net present value of US$2.1 million and produce an internal rate of return of 91 percent. The total implementation cost of the program was estimated at US$2.76 billion (World Bank 2002). The ICR of APL1 did not prepare an updated efficiency analysis. However, the ex-ante economic analysis for the APL2 estimates that the PSF program is expected to avoid 264,000 hospital admissions over ten years at a total cost of US$244 million. Additional direct and indirect benefits are estimated resulting in an internal rate of return of 47 percent over ten years (World Bank 2008).

50. The APL1 disbursed against federal government transfers to municipalities; this transfer was based on a procurement plan which was approved by the Bank to ensure “best buys” of project funds. The “best buys” package included least-cost basic health care services with highest outcomes such as preventive care; it did not fund construction (World Bank 2002, Box 3 p. 82). Project funds were used efficiently as municipalities with higher PSF coverage reported lower hospitalization rates. Treating patients at a less costly primary care level than in a hospital or in an Emergency room leads to lower costs and higher efficiency. However, elections and resulting changes in administrative staff caused a project slow-down and extension of the project closing date by 18 months.

51. Both, the bonus and performance price, which were unique project features contributed to efficiency and transparency in the use of project funds that pooled with local resources. Administration staff in all 187 municipalities developed and used activity plans to implement the additional budget funds they received from the project through the PSF conversion funds; municipalities had to proof accuracy in their accounting ledgers on the use of project funds, including budget implementation according to the approved plan and compliance with fiduciary standards. This control function of project funds managed by local governments is unique in this project, and contributed to professional and transparent resource management in municipality administration.

IEG rates efficiency as substantial.
Outcome

52. Based on the sub-ratings of high relevance of objectives and design, high efficacy on two objectives and substantial on the third and substantial efficiency, IEG’s overall rating of project development outcome of the APL1 is satisfactory.

Risk to Development Outcome

53. The PSF program is owned by the Government, as shown by the growing budget support for PSF. The program is well received by the population, endorsed by mayors and rolled-out in 95 percent of all municipalities (Rocha 2010). The Government’s vision is to continue expanding the PSF throughout the country and reconcile fragmented financing for PSF to strengthen the program’s impact. There are concerns about the low number of physicians available to work as family medicine doctors, - as is the case in many countries. The MOH is addressing these issues, and increased salaries for staff working in Family Medicine, as well as introduced institutional reforms in medical training to increase the attractiveness for medical staff to work in PSF.

54. The follow-up APL2 operation is supporting the Government in confronting the challenges that still exist nationwide in PSF reforms. They include difficulties in the recruitment and retention of doctors trained appropriately in family medicine, variations in the quality of local care, patchy integration of primary care services with existing secondary and tertiary care, and the slow adoption of the PSF in large urban centers. Furthermore, adequate financing to support the expansion of PSF nationally has been problematic in some areas (Harris 2010).

IEG rates risk to development outcome as moderate.

Bank Performance

Overall rating: highly satisfactory

55. **Quality at entry – highly satisfactory:** The analytical work carried out by the Bank teams including the political assessment of the decentralized health system, informed the preparations of the operation. In Brazil, analytical work conducted based on household surveys in 1996 and 2000 identified substantive inequities in health. Based on these findings the Government decided to support the proactive family health delivery system and provide financial incentives to municipalities that manage and deliver public health services.23

56. The design responded to the request of the Government to co-finance an existing federal transfer for PHC to municipalities (PSF Conversion Fund). The APL was highly innovative. The APL1 is among the first Bank operations with a results-linked financing component. The Bank team ensured that the APL1 invested substantially in management capacity in municipalities to help staff prepare budget implementation plans and fund management. It supported the government in getting the political buy-in from large

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23 World Bank 2003(c) and La Forgia 2008.
municipalities to implement PSF. The design included “non-traditional project disbursement methods” but still followed the Bank procurement and financial management rules. These lessons were helpful to prepare the road for other lending with results-based financing components,

57. The design was underpinned by strong technical work published by different authors on PSF. It supported an existing government program that showed promising results in the peer-reviewed literature. The Bank conducted a fiduciary assessment of the government procurement and financial management system. The preparation required close collaboration between the Bank’s health and fiduciary teams to harmonize the technical and disbursement design with the Bank’s financial and procurement rules. The design was kept flexible.

58. Given the long-term view of the PSF reform agenda, a multi-phase APL was a good choice to support a clearly defined government program. The APL works through the MOH and with municipalities and is well embedded in the decentralized health system. The APL is well structured. The APL1 focuses on two components namely building the technical and information systems; it also introduces a simple reward system for good management in municipality administration. These concepts were new for the public sector. The APL2 builds on the first phase experience and introduces payments based on performance results to municipalities which is expected to lead to improved PSF coverage and quality of care in PSF facilities (World Bank 20008).

59. Quality of Supervision – highly satisfactory: The Bank supervision team (including task team leader and senior operations officer) was based in the Brasilia office and available to work closely with the MOH and municipalities on the implementation of the APL1. The team provided intensified supervision when initial implementation slowed down due to a Government change and high staff turn-over at the MOH.

60. The team was proactive and restructured the APL to adjust the project design to the requests of the new Government. When the Government changed after the first year of project implementation in 2004, the design was changed and funds reallocated to focus on (i) increasing the number of participating municipalities from 44 to 188, and (ii) building M&E capacity. The Government used its own funds to finance the Human Resource component. During the Mid-Term-Review when progress had not materialized it developed with the Government an emergency plan to strengthen implementation.

61. The Bank procurement and financial management experts conducted special missions to ensure that fiduciary arrangements were in place and Bank rules followed. As this was the first loan that used Government fiduciary structures, the Bank teams learned important lessons in financial and procurement management. These lessons now facilitate the design and implementation of other Bank loans which disburse and pool funds with the Government budget.
**Borrower Performance**

Overall rating: *satisfactory*

62. **Government Performance – satisfactory**: All three levels of Government are supporting the implementation of PSF. Despite the changes in central Government in 2004 and 2010, there is continued support for expanding the PSF model throughout the country. The new government increased budget allocations for PSF annually; allocating about 20 percent of the Government health budget to basic health care in 2010. Since July 2010, the Government has started the monitoring of performance indicators to pay a performance incentive to providers under the APL2.

63. **Implementing Agency – satisfactory**: Project management was entirely financed by the Government. The performance of the implementing agency consisting of MOH staff was at times limited by staff turn-over, which is a general problem in the public sector in Brazil, even more so when government administrations change after elections. The team was particularly challenged when the Government decided to increase the number of participating municipalities from 40 to 188. In 2005, the Bank ISR downgraded implementation progress to moderately unsatisfactory. Realizing these weaknesses the MOH worked closely with the Bank team on an emergency action plan that laid out clear steps at Mid-Term-Review to ensure implementation progress. Implementation of this plan was successful and today, the central team is technically strong and well experienced.

**Monitoring and Evaluation**

64. The project M&E design was strong and progress towards development objectives was assessed. The fourth component supported the Government in strengthening its health information system for PSF and conduct research and analysis on the progress and impact of PSF. It included a grant transfer system to the states to support monitoring and evaluation of the PSF. In addition, the MOH contracted a number of academic institutes to evaluate the impact of PSF, and implemented an instrument to certify the quality of the family health teams.

65. The ICR reports the national system did not include the output and process measures needed for downstream municipal decision-making to improve performance. Few municipalities had developed M&E systems to measure provider performance although they were responsible for PSF implementation and management. The APL2 is supporting municipalities in computerizing data on care management.

The IEG rates monitoring and evaluation as *substantial*.

**Lessons**

66. Several key-lessons emerge from the PSF program in Brazil:

a. Earmarked disbursement to a specific government program is an innovative way for the Bank to provide complementary financial support to Government
reforms and increase the political attention for the reforms. A pooled funding approach can strengthen government fiduciary systems.

b. It may take longer than originally planned to implement performance-linked financing as countries often first need to set up reliable data collection and analysis systems to define performance and related payments. However, the experience with the bonus and performance prize in the Brazilian municipalities shows that modest starts with payment linked to tangible public sector management indicators can help building the necessary data and management capacity for a results-based financing system. Where data and monitoring and evaluation capacity is weak, financial incentives based on process indicators (for example reliable budget preparation and budget execution according to standard rules) can be used to help guide reforms in the desired direction. This approach could be particularly interesting in decentralized health systems with unequal health management capacity across local governments, and in countries with relatively weak data and health management systems.

c. Additional structural reforms may be needed to strengthen the PSF performance and address issues such as shortages in family medicine physicians and frequent staff changes in PSF units.

d. Frequent elections and related staff changes in government administrations may slow down reforms and negatively affect the availability of information. Institutionalizing data collection and management in public sector administration may help smoothen the impact of such changes on data availability and evaluation.
Appendix 1. Basic Data Sheet Brazil FHE APL 1

Family Health Extension Adaptable Program Lending 1 (Ln. 7105-BR)

Key Project Data (amounts in US$ million)

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<tr>
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<th>Appraisal estimate</th>
<th>Actual or current estimate</th>
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Cumulative Estimated and Actual Disbursements

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Date of final disbursement: 11/07/2007

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Staff Inputs (staff weeks)

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## Lending and Implementation Support Team

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<th>Responsibility/Specialty</th>
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<tr>
<td>Nicolas Drossos</td>
<td>E.T.C.</td>
<td>LCSFM</td>
<td>Financial Management</td>
</tr>
<tr>
<td>Flavio Alberto de Andrade Goulart</td>
<td>S.T.C</td>
<td>LCSHH</td>
<td></td>
</tr>
<tr>
<td>Claudio Mittelstaedt</td>
<td>S.T.C.</td>
<td>LCSFM</td>
<td>Financial Management</td>
</tr>
<tr>
<td>Olga Pane Mena</td>
<td>S.T.C.</td>
<td>LCSHH</td>
<td></td>
</tr>
<tr>
<td>Daniela Pena de Lima</td>
<td>Operations Officer</td>
<td>LCSHH</td>
<td>Operations</td>
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<tr>
<td>Anemarie Guth Proite</td>
<td>Procurement Specialist</td>
<td>LCSPT</td>
<td>Procurement</td>
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<tr>
<td>Trajano Quinhoes</td>
<td>E.T.C.</td>
<td>LCSHH</td>
<td></td>
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<tr>
<td>Suzana Abbot</td>
<td>Lead Operations Officer</td>
<td>LCSHD</td>
<td></td>
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<tr>
<td>Lerick Kebeck</td>
<td>Sr. Program Assistant</td>
<td>LCSHD</td>
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<tr>
<td>Gerard La Forgia</td>
<td>Sr. Public Health Specialist</td>
<td>LCSHH</td>
<td>Task Team Leader</td>
</tr>
<tr>
<td>Marta-Morales-Halberg</td>
<td>Sr. Counsel</td>
<td>LEGLA</td>
<td>Counsel</td>
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<tr>
<td>Omowunmi Ladipo</td>
<td>Sr. Financial Management Specialist</td>
<td>LOAG3</td>
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<td>Isabella Danel</td>
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<td>Health Specialist</td>
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<td>Rosita Estrada</td>
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<tr>
<td>Carmen Hamann</td>
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<td>Maria Madalena dos Santos</td>
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<td>Efraim Jimenez</td>
<td>Procurement Specialist</td>
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<td>Livio Pino</td>
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<tr>
<td>Daniel Dulitzki</td>
<td>Economist</td>
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## Other Project Data

Borrower/Executing Agency: Ministry of Health

### Follow-on Operations

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<td>83.45</td>
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</table>
Appendix 2. Persons Interviewed (Brazil)

Washington D.C

World Bank
- Joana Godinho, Sector Manager, LCSHH
- Gerard Martin La Forgia, Lead Health Specialist and Task Team Leader, former LCSHH, now SASHN
- Andre Medici, Senior Economist (Health), LCSHH

Brasilia

World Bank
- Makhtar Diop, WB Director for Brazil
- Boris Utria, Country Operations Adviser
- Michele Gragnolati, Sector Leader, LCSHD
- Tarisila Velloso, PSM Specialist
- Sinue Aliram, Procurement Specialist
- Daniela Pena de Lima, Operations Officer, LCSHH
- Tito Cordello, Lead Economist
- Roberto Rocha, Consultant and Researcher on PSF

Ministry of Health
- Claurana Schiling Mendonca, Director, Primary Health Care Department, Secretariat of Health Care, Ministry of Health
- Ezau Pontes, Executive Secretary, Budget and Planning Department, Secretariat of Health Care, Ministry of Health
- Allan Nuno, Coordinator, PROESF, Secretariat of Health Care, Ministry of Health
- Patricia Leal, former project coordinator at the Ministry of Health

Other Agencies
- Heloiza Machado de Souza, former Head of Cabinet at the MOH, now HEMOBRA

University
- Professor Dr. Maria Fatima de Sousa, Coordinator, Public Health Study Unit, Health Faculty, University of Brasilia

Sao Paolo

Ministry of Health Municipality of Sao Paolo
- Sonia Dias Lanza, DAB Coordinator
- Silvia Tannus, Secretaria Municipal da Saúde
- Cecilia Seiko Kunitoke, Secretaria Municipal da Saúde
- Rosana C. SantAnna, Secretaria Municipal da Saúde
Municipality of Guarulhos
- Eneida da Silva Bernardo, DAB Coordinator for Guarulhos municipality and health team working on PSF reforms

Other Agencies
- Geraldo Biasoto Junior, Executive Director, FUNDAP (Administrative Development Foundation)
- Sonia Venâncio Instituto de Saúde
- Bernard Couttolenc, President Director, INSTITUT PERFORMA, worked on the economic analysis of the 2nd phase APL

Bahia

Ministry of Health
- Ricardo Heinzelmann, Primary Health Care Department, Secretariat of Health Care, Ministry of Health
- Health team working on APL2 implementation in State of Bahia, Primary Health Care Department, Secretariat of Health Care, Ministry of Health
- Visit to Unidade de Saude da Familia Irma Dulce in Lauro de Freitas

Recife and Pernambuco

Ministry of Health
- Rodrigo Lima, Coordenador da Atenção Básica no Estado
- Health team in Vitoria Municipality and health center
- Health team in Jaboatoa Municipality and health center
Annex D. Borrower’s Comments (Argentina)

Habiendo recibido el Project Performance Assessment Report (PPAR) del Provincial Maternal Child Health Investment Project APL1 (LN 7225AR) realizado por el Grupo de Evaluación Independiente (IEG) del Banco Mundial, hemos procedido a su análisis con el fin que el mismo refleje de manera más adecuada los logros alcanzados por el Plan Nacer durante su implementación en términos del logro de los objetivos del proyecto, los desafíos y las lecciones aprendidas.

Comentarios generales:

Sin perjuicio de conocer que han sido equipos diferentes los que han llevado adelante la evaluación del Programa en el ICR y PPAR, y que los criterios de evaluación no son idénticos, como primer comentario, expresamos que ha llamado la atención del equipo del Plan Nacer los diferentes ratings otorgados en las evaluaciones mencionadas, recibiendo en el ICR la calificación “Highly Satisfactory”.

En segundo lugar, se menciona en que la evaluación bajo análisis, el equipo del Plan Nacer ha notado que se realiza una descripción del Programa que no concuerda exactamente con su diseño y normas operativas, lo cual puede constituir una clara limitación para toda evaluación.

A continuación se presentan los comentarios específicos al documento PPAR:

Página ix, 3er párrafo. Debería corregirse la denominación del proyecto, donde se lee “Mother and Child Health Insurance Program”, debería ser “Maternal and Child Health Insurance Program”.

Página xiii, Borrower Performance. Referido a la frase “APL1 in Argentina is rated moderately satisfactory due to misprocurement that led to cancellation of part of the loan”.

Se sugiere su revisión para reflejar más apropiadamente el proceso de procurement revision realizado por el Banco Mundial, explicitando que la cancelación representó el 1.1% del monto total del préstamo, como se encuentra reflejado en el Punto 74 del Anexo B.

Página 10, Párrafo 4.3. Se sugiere la reformulación de la frase “After the 45th day, mothers are transferred to the Provincial Reproductive Health Program supported by the Reproductive Health Law”, teniendo en cuenta que en Argentina todas las mujeres (incluidas aquellas sin cobertura formal de salud) reciben atención en materia de salud sexual, el Plan Nacer invierte recursos adicionales para reforzar esa cobertura pública a través de los Seguros Provinciales de Salud para las mujeres embarazadas y puérperas sin obra social o seguro privado de salud.

Página 11, Table 5-1. En las líneas “Intergovernmental fiscal transfer from central to local government” y “Local government to PHC providers”, debería especificarse que las características descriptas sólo corresponden al APL 1 y no al SECAL.
Página 12, Párrafo 5.9. Dónde se lee "Federal Ministry of Health (FMOH)", debería decir "National Ministry of Health (MSN)".

Además, se sugiere mejorar la explicación del mecanismo de transferencias bajo Programa APL1, considerando la siguiente descripción:

Inicialmente, los fondos se trasfieren mensualmente desde la Nación a las Provincias en un 60% del valor de la capita en función del número de individuos de la población elegible inscriptos en el Plan Nacer y el restante 40% del valor de la capita acumulado se transfiere cada cuatro meses por el desempeño medido a través de diez indicadores sanitarios, denominados “trazadoras”.

Página 13, Párrafo 5.10. Se sugiere mejorar la explicación del mecanismo de transferencias, considerando la siguiente descripción:

Las Provincias trasfieren fondos a los proveedores de salud bajo convenio a través del pago por prestaciones incluidas en el Nomenclador del Plan Nacer brindadas a la población inscripta (fee for service).

Se sugiere eliminar el comentario al pie (nota n°7) por incorrecto, pues el paquete de servicios de salud del Plan Nacer es único para todo el país, por tanto no es definido en forma particular entre la Provincia y cada proveedor.

Página 13, Table 5-2. Se sugiere re-expresar las trazadoras de acuerdo a la siguiente definición, basada en su descripción del PAD:

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<tr>
<td>1. Timely inclusion of eligible pregnant women in prenatal care services (detection of pregnant women before the 20th week).</td>
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<td>2. Effectiveness of early neonatal and delivery care (newborns from eligible pregnant women, with APGAR score &gt; 6 at minute 5 after birth)</td>
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<tr>
<td>3. Effectiveness of pre-natal care and prevention of premature births (newborns from eligible pregnant women weighting more than 2,500 g.)</td>
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<td>4. Quality of pre-natal and delivery care (eligible pregnant women who get VRDL during pregnancy and antitetanic vaccine previous to delivery)</td>
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<td>5. Medical Auditing of Maternal and Infant death</td>
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<td>6. Immunization Coverage (eligible children less than 1 year old with coverage of measles)</td>
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<td>7. Sexual and Reproductive Health Care</td>
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<td>8. Well child care (eligible children 1 year old or less with all well child consultations up to)</td>
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<td>9. Well child care (eligible children 1 to 6 years of age with all well child consultations up to)</td>
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<tr>
<td>10. Inclusion of Indigenous Population (health facilities delivering services to eligible indigenous population with Sanitary Agents specially trained for treating indigenous population)</td>
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Página 17, Párrafo 6.18. Es incorrecta la descripción de la metodología de evaluación de impacto. Esta modalidad de evaluación utiliza una metodología que parte de la identificación de impactos a partir de la comparación de grupos de individuos inscriptos y no-inscriptos en el programa, siendo ambos grupos (grupo control y grupo tratamiento)
parte de la población elegible del Programa, es decir población sin cobertura explícita de salud (obra social, prepaga, otros).

**Página 18, Párrafo 6.20.** Son inexactas las afirmaciones contenidas en el párrafo, ya que demuestran una inadecuada distinción de los grupos tratamiento y control, y por ende una incorrecta interpretación de los resultados de la evaluación.

**Página 20, Párrafo 6.27.** El párrafo no refleja adecuadamente los mecanismos de transferencias Nación - Provincias y de pagos desde la provincia hacia los proveedores de salud, confundiendo las transferencias a la provincia por desempeño en las 10 trazadoras, con el uso de fondos recibidos por parte de los establecimientos.

**Página 20, Párrafo 6.29.** La afirmación es inexacta ya que el Plan Nacer sí ha generado una mejora en términos de gobernanza, ya que por primera vez todos los establecimientos públicos del subsector público de salud reciben recursos financieros (además de instrumentos de gestión) y por primera vez son los propios establecimientos de salud los que deciden el destino final de la inversión de acuerdo a sus necesidades particulares y las necesidades de las redes que integran. El programa ha regulado y tutelado a través de una auditoría externa concurrente que las normas sobre la libre disponibilidad de los recursos por parte de los establecimientos se cumplan. En efecto, el Seguro Materno Infantil Provincial celebra un compromiso de gestión con los proveedores públicos donde se explicitan y formalizan los roles, responsabilidades, derechos y obligaciones de cada una de las partes. Estos modelos contractuales que reciben no objeción del gobierno nacional y del equipo técnico del Banco Mundial, respetan las normas del proyecto y su cumplimiento es auditado de manera continua tanto por la auditoría interna del Plan Nacer como por su auditoría externa concurrente.

El empoderamiento del Plan Nacer de los establecimientos de salud ha demostrado ser decisivo para renovar la motivación de los equipos de salud y así contribuir a alcanzar las mejoras organizacionales y el fortalecimiento del modelo atención que son promovidas por el programa.

Antes de la implementación del Plan Nacer las necesidades de recursos de los establecimientos impedían determinar metas más ambiciosas de cobertura de salud o un plan de trabajo continuo para mejorar el desempeño del establecimiento. El mecanismo de transferencia del Plan Nacer posibilitó aportar recursos financieros al mismo tiempo que se definían nuevas metas de atención y cobertura. De esta manera, la autoridad sanitaria recuperó su capacidad de liderazgo y conducción para determinar las prioridades y agenda de trabajo de los establecimientos. Se subraya nuevamente que el hecho de participar en la decisión de la inversión de los recursos aportados por el Plan Nacer genera en los equipos de salud un compromiso adicional en cada uno de los involucrados, porque no pueden generarla ajena a sus intereses o valoraciones.

Por otra parte, en términos de gobernanza se destaca que sin dudas el Plan Nacer y sus mecanismos de pago por desempeño constituyen una estrategia efectiva para generar información de manera oportuna, que permite:
Identificar más fácilmente problemas y ajustar la estrategia adecuadamente (Indicadores de procesos y de resultados),

Conocer desempeños relativos y progresos que realiza la oferta pública de atención.

Retroalimentar el diseño e implementación del programa y de la política sanitaria global.

Por su parte, el Nomenclador del Plan Nacer y su matriz de calidad, no sólo constituye una herramienta para efectuar las transferencias de fondos a los establecimientos sino que además constituye un instrumento de rectoría, regulación y ordenamiento de la oferta pública de salud. Es ampliamente reconocido por las autoridades provinciales como por los equipos de salud que el Plan Nacer ha dinamizado al sistema público de salud y ha modificado positivamente la relación entre las provincias y el gobierno nacional, las provincias y los establecimientos de salud, y entre los ciudadanos y el Estado en el ámbito de la salud. El Plan Nacer complementó el sistema tradicional de financiamiento basado en insumos y presupuestos fijos con un mecanismo de financiamiento basado en resultados, direccionó adecuadamente los incentivos y ha dado a los establecimientos un espacio de participación nunca antes otorgado a este nivel de organización. Como resultado, se ha dotado al sistema de una mayor transparencia, eficiencia, y así mejorar la ejecución pública en el sector salud que se visualiza en el nivel central como en la red de establecimientos que conforman la oferta pública.

Página 21, Párrafo 6.36. La descripción del párrafo no refleja el carácter superador de los cambios realizados en la norma de cofinancimiento provincial.

Bajo el esquema de financiamiento del Plan Nacer, la Nación asume la carga superior del financiamiento a fin de legitimarse en su rol de rectoría y de conducción. La modalidad de financiamiento por resultados y su carácter de principal financiador le han otorgado a la Nación mayor capacidad de influencia para introducir cambios superadores en el modelo de gestión y atención de la salud de los sistemas provinciales del subsector público. Los ajustes al esquema de cofinanciamiento fueron realizados en acuerdo con el equipo técnico del Banco Mundial en la búsqueda de un mecanismo de financiamiento que haga posible que el Gobierno Nacional conserve su capacidad de rectoría para que todas las jurisdicciones lleven adelante un proceso de fortalecimiento de la cobertura pública que aporte mejores y más equitativos resultados de salud.

Annex A y B. Se sugiere la revisión de los siguientes párrafos ya que no describen adecuadamente el diseño y aspectos operativos del Programa, los resultados de su evaluación de impacto y su contribución a la reducción de la mortalidad infantil:

Annex A: Párrafos 16; 36; 37

Annex B: Párrafos 7; 9 punto e; 35; 36; 37; 38
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