PRIMARY HEALTH-CARE REFORM PROGRAM: SALTA, LA PAMPA, AND CÓRDOBA

(AR-0120)

EXECUTIVE SUMMARY

Borrower and guarantor:	Argentine Republic	
Executing agency:	Ministry of Health and Welfare (MSAS)	
Amount and source:	IDB	US$100 million: (OC)
	Local:	US$ 67 million
	Total:	US$167 million
Financial terms and conditions:	Amortization period:	20 years
	Grace period:	5 years
	Disbursement period:	5 years
	Interest rate:	variable
	Inspection and supervision:	1%
	Credit fee:	0.75%
	Currency:	U.S. dollars, Single Currency Facility
Objectives:	Support the Argentine government's efforts to make for more efficient and equitable health-care delivery, introducing new primary health-care approaches in the selected provinces with a view to: (a) ensuring that health services reach the neediest, using specific targeting criteria; (b) moving from the current government-sponsored care-delivery systems to systems driven largely by user needs and preferences; (c) gradually replacing the fixed-salary system with fee-for-service arrangements, promoting financial incentives to reward quality care-providers; and (d) adopting family health-care approaches and more cost-effective health-care management models.	

Description: The program is divided into three components:

1. National component (US$22.3 million)

The aims of this component are to: (i) retrain health workers and devise basic primary health-care (PHC) training strategies for Family Health Teams in the provinces, adapting formal health-education systems and instruments; (ii) adjust the MSAS structure to the new model, particularly in the areas of information systems, public information programs, and institution-strengthening for implementation and monitoring of the new model; and (iii) provide funding and technical support for the design of PHC reform projects that the provinces request, for consideration in an eventual new operation. This national component is subdivided into three subcomponents:

a. Human resources training, retraining, and realignment (US$15.2 million): This subcomponent covers human resources retraining and the development of strategies to build PHC contents into all health-worker training and development processes, such as short-term training, undergraduate programs, PHC residencies, graduate studies, and continuing education. The main activities planned are: (i) support for the design of professional PHC training plans in the provinces; (ii) short-term PHC training, including the management systems area; (iii) devising Family Health Team professional profiles and certification and recertification mechanisms; (iv) rewriting the curricula of undergraduate training programs for doctors and other health professionals, to gear them to PHC and family medicine; (v) creation of PHC residencies for doctors and nurses at universities and training centers for health professionals; and (vi) development of continuing education PHC programs and instruments for Family Health Teams (graduate courses, distance education, rotation systems).

b. Adapting the MSAS structure involved in the new PHC model (US$3.3 million): The three activities comprising this subcomponent are: (i) a PHC information system; (ii) a public information program; and (iii) institution-strengthening of the MSAS.

c. Preparation of provincial projects (US$3.8 million): The MSAS will provide resources to prepare provincial projects, based on: (i) the province's request for the project and its undertaking to observe the principles of PHC reform; (ii) a

verification of conditions for the provincial project's implementation (situational diagnosis); (iii) a preparatory action plan for the project's implementation; (iv) selection of a consulting firm, in accordance with international competition requirements, to prepare the project; and (v) development of the project following the pre-established methodology.

2. Primary health-care reform in the province of Salta (US$35.8 million)

The object of this component is to implement PHC reform in the province of Salta. The project's central aims are to create Family Health Units built around new personnel compensation and incentive systems, adapt physical plant, bring in personnel training strategies with MSAS support, and strengthen the ministry institutionally for the tasks of regulating, managing, and evaluating the new model. The component is divided into five subcomponents:

a. Remuneration and incentive system (US$12.5 million): The focal point of this human-resources realignment will be an incentive system whereby provincial public-sector health workers will come under a new contractual, compensation and personnel management system. The aim is to gradually shift from the current fixed-salary system to a capitation-payment approach in which Family Health Teams will see their remuneration (which will depend on user preferences) tied to per capita income in urban areas and incentives for productivity, quality, and coverage in peri-urban and rural areas.

   The program will fund capitation payments for Family Health Teams who serve the program's target populations. These payments will be gradually phased out, to be progressively absorbed into the provincial health budget. Capitation payments for other client bases will be covered by the *Obras Sociales* employee-benefit plans, prepaid health-care plans, or directly by higher-income families. Capitation fees will be risk-adjusted for such factors as sex and age. The public and private sector and the *Obras Sociales* plans all may set up Family Health Units, following the organization model established by the program.

b. Infrastructure adaptation (US$10.2 million): This subcomponent will finance the repair, remodeling, and re-

equipping of government-run PHC plant, as required for each facility, with special emphasis on family medicine clinics and their equipment, and improvements in the referral network for PHC patients requiring more advanced treatment.

c. Information systems (US$4.7 million). This subcomponent will implement a user identification and registration system, apply mechanisms to target the program to low-income groups, produce morbidity and cost data to set up cost-recovery systems, institute quality monitoring and management services, and strengthen the provincial Health Ministry's information management capacity. Though the system will be free only for low-income clients (via targeting), the user identification system will take in the entire province. The new system will operate as a gateway to all levels of health care.

Health-service users will be identified through a system of magnetic health cards containing information on: (a) their socioeconomic status and (b) health plans to which they belong (*Obras Sociales*, prepaid health-care organizations, etc.). Once the PHC system is automated, a database of epidemiological data and health-services utilization can be constructed.

d. Public information (US$4.8 million): This subcomponent will finance strategies to communicate and publicize the new family-health model to stakeholders such as doctors and other health professionals, professional associations, universities, health-care providers and managers, Obras Sociales plans, and prepaid health-care organizations and clients of these services.

e. Institution-strengthening (US$3.6 million): Under this subcomponent, the provincial Health Ministry will commission studies and consulting services to map out the basic management structure for the new system's operation, administration, and monitoring.

3. Primary health-care reform in the provinces of La Pampa and Córdoba (US$101.5 million)

The La Pampa provincial government informed the MSAS of its interest in participating in the program, and developed its own project proposal to submit to the MSAS and the Bank for consideration. Though by virtue of that effort the province would

qualify for the program, the project design it presented was viewed as preliminary. The Province of La Pampa will develop its project following the methodology used to prepare the Province of Salta's project; the cost of preparing the La Pampa project will be defrayed with preinvestment funds (loan 925/OC-AR).

The new government of the Province of Córdoba informed the MSAS of its intention to join the program. At present, to qualify, it is working toward a preliminary project proposal to be presented shortly, following the Operating Regulations guidelines. Preinvestment funds under loan 925/OC-AR will be used to prepare this project as well.

Relationship of project in Bank's country and sector strategy:

In keeping with the national government's stated priorities and with Eighth Replenishment guidelines, the Bank is focusing on the following areas in its operations with Argentina: (i) deepen and consolidate modernization of the State at the central level and extend the process to provincial and municipal governments; (ii) reduce poverty and raise the standard of living through actions designed to create productive employment and broaden the coverage of social programs; and (iii) increase productivity and competition in the tradable-goods sectors with environmentally friendly approaches, providing support infrastructure and activities to help modernize the production apparatus and advance regional integration. The proposed program would address the first two of these objectives.

Environmental and social review:

To maximize the program's impact on its various target populations, the public information, infrastructure adaptation, and personnel training and realignment components include health strategies for women and aboriginal peoples. The Operating Regulations contain environmental protection measures to ensure that physical investments (first level) are environmentally viable. These environmental and social considerations will apply for the Province of Salta project. No environmental impact assessment was required in preparing the program (see paragraph 4.22).

Benefits:

Notable benefits of this program will be: (a) improved health of the population once primary-care coverage is broadened and targeted to low-income groups and the most vulnerable, like women and children; (b) more effective care delivery, by way of a guaranteed basket of core services; (c) better-quality care and greater patient satisfaction as competition mechanisms are introduced and people are able to choose their family doctor; (d) more efficient health care, as health personnel costs are

adjusted in the medium and long term and more flexible contracting systems are brought in; (e) a more equitable health-care system, when the costs of care delivered to members of *Obras Sociales* and prepaid health-care plans are recovered, whereupon public funds can be spent on those most in need; and (f) configuration of the health-care network coordinated with reforms under way in the country.

Risks:

a. Coordination with other reform projects: To be successful, the program described here must dovetail closely with other ongoing health-reform projects such as the World Bank-funded Autonomous Public Hospitals Program (PRESSAL), Maternal and Child Nutrition Program (PROMIN), and *Obras Sociales* Reform Program (PROS). To help assure such coordination, a preliminary arrangement has been worked out with the MSAS to adjust the PROMIN so it can help establish a demand-driven care system. The MSAS is coordinating with the PRESSAL and the *Obras Sociales* program to this same end.

b. Interest groups' acceptance of the model: The change in employment status that government health workers would undergo in the proposed program could move interest groups to resist the reforms. To counter this eventuality, the program offers financial incentives to win its acceptance and public information strategies to explain its merits and thereby reduce resistance to the changes.

c. Lack of coordination between training activities and implementation of the model: The project will require close coordination between the training tasks planned in the national component and personnel training needs in the provinces. To avert problems in this area, the program's central executing unit (CEU) and provincial executing units will together come up with a program evaluation and review (PERT) graph to sequence the joint, coordinated activities needed for PHC personnel training and realignment in each provincial project.

Special contractual clauses:

The following would be contractual conditions precedent to the first disbursement: (i) set-up of the CEU within the MSAS, duly organized and staffed, and (ii) entry into force, by MSAS order, of the program's Operating Regulations, previously agreed upon with the Bank (paragraph 3.3).

Special conditions precedent to the first disbursement of funds for the Salta, La Pampa, and Córdoba projects are: (i) signing by the borrower and the respective province of a subsidiary loan contract, by authority of a provincial borrowing law authorizing the provincial executing agency to take on the loan according to the terms and conditions of the proposed Bank loan contract (paragraph 3.42); (ii) set-up of a provincial executing unit within each participating provincial Health Ministry, duly organized and staffed (paragraph 3.27); (iii) entry into force of the program's Operating Regulations; and (iv) demonstration that the register of the target provincial population has been at least two-thirds completed by the Master System for Identification and Registration of Social Program Beneficiary Households (SISFAM) (paragraph 3.19).

The following are additional special conditions for the program's implementation: (i) the first disbursement of resources for the training subcomponent for each province will be conditioned upon presentation of the province's human resources training and reconversion strategy (paragraph 3.6); (ii) the first disbursement for activities to realign undergraduate medical, nursing, and other health professional programs to a PHC approach will not be released until the MSAS has prepared, to the Bank's satisfaction, profiles and protocols for health-worker certification, which would be financed in advance by the program (paragraph 3.12); (iii) for the model to operate, the provincial Health Ministries must sign management contracts with Family Health Teams and Family Health Units for health-care management; the model contract must have received the Bank's no objection (paragraph 3.38); and (iv) to institute the program monitoring mechanism, the contract will contain conditions governing the scheduling of monitoring and evaluation activities, as agreed with the borrower (paragraphs 3.49 to 3.51).

Poverty-targeting and social sector classification:

The proposed project classifies as an operation promoting social equity, as described in the key objectives for the Bank's activities in the Report on the Eighth General Increase in Resources. It also qualifies as a poverty-targeted investment (PTI) (see paragraph 4.32). The borrower will use the additional 10% financing (see paragraph 4.32). The project specifies explicit performance

benchmarks to measure poverty reduction and improvements in social equity. The operation classifies automatically as a PTI by virtue of the sector it addresses, as a primary health-care program targeted mainly to low-income families.

Exceptions to Bank policy: None.

Procurement: International competitive bidding is recommended for: (i) construction tenders worth over US$5 million, (ii) goods for adaptation of the health units and for institution-strengthening costing over US$350,000, and (iii) consulting-firm contracts over US$200,000.

I. FRAME OF REFERENCE

A. Social and health conditions in Argentina

1.1 Compared with other Latin American countries, Argentina's social indicators are good. Per capita income among its population of some 35.7 million tops US$9,300, and life expectancy at birth is 72 years. Less than 4% of the population is illiterate.

1.2 Unemployment, which had risen to 17% of the economically active population in 1996, fell back to 13% in early 1998. In 1997 employment rose by 5.5%, but according to 1998 estimates the growth rate has slowed. Gross domestic product (GDP) growth has been strong (e.g. 8.3% in 1997). That same year, gross fixed investment climbed 27%, far outstripping the 7.7% rise in consumption. GDP growth fell somewhat in 1998, to an estimated 4.5%. But the low-income families that comprise much of the still-sizeable stock of unemployed and informally employed are pressing for social policies to ease their straits. On the basic sanitation front, 65% of homes have piped water and 58% have waste disposal systems.

1.3 Argentina's infant mortality rate of 19 per 1,000 live births is lower than the Latin American average but higher than figures in neighboring countries like Uruguay and Chile. Maternal mortality (38 per 100,000 live births) is on a par with those two countries' rates of 34 and 38 per 100,000, respectively. The most common causes of death are chronic diseases, notably cardiovascular and cerebrovascular diseases, cancers, and external causes. Communicable diseases account for an appreciable share of the burden of disease in the poorest provinces in the north, but are not taking as severe a toll as in nearby countries like Paraguay, Bolivia, and Brazil.

1.4 Health conditions vary considerably from one Argentine province to another. Maternal mortality is highest in the northern provinces, particularly Formosa (184 per 100,000 live births), and lowest in the more advanced regions like Buenos Aires and Córdoba (20 per 100,000). Differences in infant mortality rates are equally pronounced, ranging from 15 per 1,000 live births in the Federal Capital and Tierra del Fuego to 34 per 1,000 in Chaco. The poorest regions like Formosa also have fertility rates exceeding 3.5 children born per woman of childbearing age, compared to the Federal Capital rate of less than 1.6.

B. The Argentine health system

1.5 Table I.1 shows health spending in Argentina in 1995 by sector, representing a per capita outlay of more than US$550.00.

Table 1.1
Health spending in Argentina: 1995[1]

Health sectors	Expenditure (US$ million)	Expenditure as % of GDP	% share of total expenditure
Public sector	4,676.0	1.67	23.2
a) National	618.0	0.22	3.0
b) Provincial	3,296.0	1.18	16.4
c) Municipal	762.0	0.27	3.8
Obras Sociales health plans	7,055.0	2.51	35.0
a) Health Services Sup'cy	2,939.0	1.05	14.6
b) PAMI	2,392.0	0.85	11.9
c) Provincial	1,300.0	0.46	6.4
d) Others	424.0	0.15	2.1
Private sector	8,416.0	3.01	41.8
a) Health plans	3,874.0	1.38	19.3
b) User direct payments	4,542.0	1.63	22.5
Total	**20,147.0**	**7.19**	**100.0**

[1] Most recent data available.

1.6 The high incidence of chronic diseases in Argentina and the many ensuing premature deaths denote a lack of preventative care. Aggravating the situation is the prevailing hospital-centered health-care model, with sparse primary-care facilities. Rising health-care outlays thus are doing little to improve general health indicators. The country's health system consists of three sectors: public, *Obras Sociales* employee-benefit plans, and private.

1.7 Public health care is dispensed at federally run national referral hospitals administered by the Ministry of Health, and by provincial and municipal health systems. As Table I.1 shows, the provinces account for the lion's share of public health expenditure. Government-run health-care facilities serve the entire population with no cost-recovery; 85% of aggregate expenditure is for inpatient care. The system is funded out of national, provincial, and municipal budgets. The 24% of Argentinians who rely completely on the public system are the country's poorest. Some members of *Obras Sociales* plans also are obtaining free health care from government health services; this inefficient double funding of *Obras Sociales* members is driving up system costs.

1.8 The *Obras Sociales* are Argentina's leading health-care provider, covering 67% of the population. They were created in the 1940s as the social security system's industry-specific health-management organizations, administered by union representatives, with a mandate to cover all formally employed workers and their families. Comprising this sector are the national *Obras Sociales*, regulated by the Health Services Superintendency (SSS), their provincial counterparts that manage health services for provincial government employees, and the Instituto Nacional de Servicios Sociales para Jubilados y Pensionados [National Social Services

Administration for Retirees and Pensioners] (INSSJP/PAMI). Other *Obras Sociales* plans cover employees of companies that do not belong to the SSS system.

1.9 Private sector health care is delivered through prepaid health-care plans or is paid for directly by consumers. An estimated three million Argentinians (9% of the population) belong to such plans. This sector accounts for the heaviest health spending in the country, particularly in the form of direct household outlays for pharmaceuticals. Private-sector expenditure on health has soared in the 1990s as the quality of *Obras Sociales* services has declined.

C. The system's main problems

1. Public sector

1.10 The most serious problems in publicly funded health care are: (a) hospital-centered care with few facilities for prevention; (b) inefficient health units with heavily centralized operations; (c) no targeting or cost-recovery capacity, leading to cross-subsidization of higher-income groups who belong to *Obras Sociales* or private health maintenance organizations; and (d) no basket of core health services to help improve the success rate for the country's leading health problems, particularly for low-income mothers and young children.

2. Obras Sociales plans

1.11 These health-care plans are inefficient and, until recently, evidenced equal-access, coverage, and quality problems.[1] There were two root causes for this situation, which is now being remedied: (a) since the system was structured by industry with a captive client base, each plan had a monopoly, and there was pressure to lower quality and raise costs; and (b) the State had little regulatory power in the sector. Until very recently only a handful of *Obras Sociales* were organized for quality care delivery, so these plans were very inequitable, to the point where members of the weaker ones had to turn to publicly funded health services. The system also allowed dual coverage when each spouse in a household belonged, by virtue of their jobs, to different *Obras Sociales* plans.

3. Private sector

1.12 Two main problems confronted clients of private health-care services: (a) the lack of a core health-care package to assure quality care at minimum cost to the client, and (b) the lack of rules governing mobility for people wishing to switch plans.

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[1] The problems of the *Obras Sociales* and solutions were examined jointly by the IDB and World Bank. For a detailed analysis see "Argentina: Facing the Challenge of Health Insurance Reform", IDB/RE1 Discussion Paper No. 18, Washington, D.C., August 1997.

D. The government's health reform program

1.13 The government has a series of health-care reforms under way to target publicly funded services and deliver care more equitably, and to address problems of efficiency, equal access, coverage, and quality of the *Obras Sociales* plans.

1. Public sector

1.14 The following are the reform objectives for public-sector health care: (i) revamp the care-delivery model, making primary health care more universally available; (ii) give priority to mother and child care in the provinces; (iii) establish a program to give hospitals true autonomy, so they can run more efficiently and recover costs from members of the *Obras Sociales* and health maintenance organizations; (iv) gradually replace the supply-side health-care structure and system by one driven by user needs and preferences; and (v) promote and assure health-care quality through accreditation of health-care establishments, personnel performance appraisals, development of rules and procedures governing medical care, supervision, evaluation, and control of health services. To put through these reforms the government launched two programs funded by the World Bank: The Maternal and Child Nutrition Program (PROMIN) and the Autonomous Public Hospitals Program (PRESSAL).

1.15 The objective of PROMIN, which started in 1992, was to lower maternal and infant morbidity and mortality rates. Though the program has achieved noticeable changes, it was not intended to revamp the care-delivery mechanism: it is based on a traditional supply-side approach structured around public-sector health posts and centers, with little flexibility in personnel management.

1.16 PRESSAL was launched in 1995 to convert government-run hospitals into decentralized organizations that could freely hire and terminate staff, manage their budgets, recover costs from members of prepaid health-care plans and *Obras Sociales*, and reconfigure the health-care model by introducing more cost-effective practices (use of medical protocols, service audits).

2. Obras Sociales plans

1.17 Reform measures affecting these health plans are designed to allow their members to choose their service provider, the aim being to foster competition among plans and improve health-care quality and efficiency. The government's vehicle for these reforms was the World Bank-funded *Obras Sociales*/INSSJP/PAMI Reform Plan launched in 1996. The program's objectives are to reconfigure those health plans' management and institutional climate and establish a new regulatory framework to make certain they are technically and financially viable and make more efficient use of resources.

3. Private sector

1.18 The reform programs' aim in the private sector is to establish a regulatory policy governing health insurance. The policy is still in at the early negotiations stage.

E. Constraints for the reform program

1.19 Though the above-mentioned health reforms in Argentina mark the most sweeping transformation of a health system in Latin America in the 1990s, they alone cannot address all the areas needing attention: structural changes are needed in health-care delivery approaches in the provinces. At present these services are not part of any demand-driven care strategy or based on health promotion and disease prevention.[2] The program proposed here is intended to fill this gap by introducing a new primary health-care delivery model to supplement the revamping of the *Obras Sociales* and autonomous hospitals.

F. The primary health-care model

1.20 The primary health-care (PHC) model to be developed in the provinces will be the central pillar of Argentine health-care reform. It is based on a massive realignment of health-care workers, retraining them for PHC, the aims being to introduce health promotion and disease prevention approaches, cut down on unnecessary referrals to more specialized care providers, and revamp care-delivery strategies and management structures in health services.

1.21 The aim of health-worker training and realignment is to bring in new curricula and teaching strategies at every stage of these workers' training (undergraduate, residencies, refresher and professional development courses, graduate courses, and continuing education programs) to lay the professional foundations for a PHC strategy. Though the participating provinces will ascertain the demand for courses, the Ministry of Health and Welfare (MSAS) will foster the rewriting of curricula in universities and training institutions and be responsible for establishing certification, recertification and teacher-training systems and instruments for accreditation of programs and PHC training institutions. Table I.2 shows estimated PHC personnel training needs in Argentina and the targets set out in the proposed program for meeting those needs.

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[2] In a primary health-care context, demand-driven programs are those that allow users to choose their care providers and doctors are paid on a capitation basis. With a capitation payment system there is more control over costs, since the capitation fee is based on a defined, risk-adjusted basket of services. The expectation is that quality will improve when care providers have to compete for patients. Government-funded supply-side care, on the contrary, is delivered by salaried public servants; since their remuneration is not tied to the value or complexity of the services they provide, there is no incentive to lower costs.

Table I.2
Argentina: Estimated primary health-care personnel training requirement in 2004 and training capacity to be provided by the program

Professional category	Estimated requirement	Primary health-care workers to be trained in Argentina			
		Existing	To be trained or retrained	Total	% of requirement
Family doctors	5,194	369	4,155	4,524	87
Nurses	7,791	308	5,455	5,763	74
Social workers	5,194	0	4,068	4,068	78
Doctors-Support team	9,869	0	7,795	7,795	79
Community health workers	7,791	83	5,968	6,051	78
TOTAL	35,839	760	27,441	28,201	79

1.22 Provinces would be given incentives to set up Family Health Units to be managed autonomously by Family Health Teams, with funding by way of capitation models reflecting patient preferences. The Family Health Units will offer a basket of core primary health-care services to attend to families' main health and medical care needs.

1.23 The Family Health Unit will be the sole gateway to the system. It will be in charge of: (a) disease prevention and health promotion activities; (b) basic primary health-care delivery; and (c) patient referrals to more specialized care when necessary, and tracking and taking back patients referred from those levels when they have finished their treatment.

1.24 Funding for Family Health Units will depend on their capitation revenues. The provincial Health Ministries will fund capitation payments for low-income families identified by the SISFAM system.[3] The *Obras Sociales* organizations, for their part, may fund care for their member households through the Programa Médico Obligatorio [compulsory health plan] (PMO) or other arrangements. Higher-income families may use the system if they pay for primary health care, via contractual arrangements, out of their own pockets.

1.25 The exact form the program will take will depend on the geographic location (urban, peri-urban, rural areas). In urban areas, where competition is possible, independently organized Family Health Units may be feasible; in that case, the provincial Health Ministry's role will be to: (a) provide funding for the targeted groups, to be identified through SISFAM records; (b) track epidemiological and health indicators of covered households, which Family Health Units will forward systematically to the ministries; and (c) accredit and do compliance checks of

[3] The Master System for Beneficiary Household Identification (SIEMPRO/SISFAM) is a program developed by the Office of the Deputy Welfare Secretary in the MSAS to identify poor families, to decide on subsidies for social programs.

Family Health Units by reference to the system's regulatory framework and monitor their operation.

1.26 In peri-urban and rural areas where competition is not practicable, Family Health Units may be autonomous organizations: the State will fix pay and incentives systems for health professionals, tied to productivity, quality of care, and patient satisfaction, the latter measured through ongoing surveys and success rates for the medical problems presented.

1.27 In provinces with too many specialists (particularly in hospitals), the program will devise incentives to retrain personnel for the new model, through labor agreements that will change the current employer-employee relationship.

1.28 The program has been designed for implementation in all Argentine provinces that demonstrate their intention and commitment to revamp their primary health-care model. In a nationwide survey the MSAS consulted Health Ministries of the country's 24 provinces; 17 of them signed a letter of adherence to the program (Corrientes, Chaco, Formosa, Misiones, Salta, Jujuy, Tucumán, Santiago del Estero, La Rioja, Catamarca, San Juan, La Pampa, Buenos Aires, Santa Cruz, Chubut, Mendoza, and Río Negro).

1.29 At the outset the program will operate in the provinces of Salta, La Pampa, and Córdoba.[4] A consulting firm was hired to develop basic guidelines for the program's implementation in Salta, to serve as an indicative project. The same procedure will be used in La Pampa and Córdoba. The MSAS is to hire the consulting firm following the guidelines outlined in chapter III of this proposal and in the Operating Regulations. The project design worked out for Salta is available for consultation to guide the preparation of other provincial projects.

G. Health conditions in the province of Salta

1.30 Compared to the Argentine average, Salta is a poor province. In 1996, half of its one million residents were rural dwellers and per capita income was 49% of the national average. Close to 34% of the population live in households with unmet basic needs. The 1998 infant mortality rate of 23.5 per 1,000 live births is almost 25% higher than the national average, and maternal mortality of 122 per 1,000,000 live births is more than triple the national rate.

1.31 Salta's most serious health problems are high morbidity and premature death rates from chronic diseases in adults, and high maternal and infant mortality rates because so few of the province's poor have access to health care, particularly in

[4] The newly elected government of the Province of Córdoba will take office in July 1999. The new government informed the Bank that it was prepared to quickly send a letter to the MSAS indicating its wish to take part in the national government's primary health-care program.

rural and peri-urban areas. These problems could be easily resolved through a carefully targeted strategy to bring primary health care to that population.

1.32 An estimated 16% of Salta residents belong to national *Obras Sociales* employee-benefit plans and 40% to the provincial *Obra Social*; 3% at most are members of private prepaid medical-care plans. The provincial government is supposed to cover the rest of the population, but in fact 20% of those who rely on provincially-run services are members of the provincial *Obra Social* and a further 5% belong to the national *Obras Sociales* or prepaid health-care plans. About 25% of the province's residents have no coverage or inadequate coverage. The model described in section F of this chapter was designed to address the problems that arise in situations like those documented in the province of Salta.

H. The Bank's strategy

1.33 In keeping with the national government's priorities and with Eighth Replenishment guidelines, the Bank is focusing on the following areas in its operations with Argentina: (i) deepen and consolidate modernization of the State at the central level and extend the process to provincial and municipal governments; (ii) reduce poverty and raise the standard of living through actions designed to create productive employment and broaden social-program coverage; and (iii) increase productivity and competition in the tradable-goods sectors with environmentally friendly approaches, by providing support infrastructure and activities to help modernize the production apparatus and advance regional integration. The proposed program would address the first two of these objectives.

1.34 The Bank's challenge in Argentina is to support the economic and social development of the provinces in their State-reform and fiscal-adjustment efforts and targeting of social programs to marginalized groups. The present project addresses these aims on the health-policy reform front.

1.35 The Bank's most recent health-sector operation in Argentina (loan 516/OC-AR) finished in 1996, the purpose of that 'first-generation' project having been to build 10 provincial hospitals. Only four hospitals were ultimately built, so part of the loan was cancelled, national priorities having changed when much of the responsibility for managing national-government hospitals was shifted to the provinces. The new project outlined here marks the Bank's first involvement in financing sector-reform projects in this sphere.

II. THE PROGRAM

A. Objective and purposes

2.1 The program's objective is to broaden health-care coverage, make for more equal access to care delivery, and improve the health status of the population by revamping primary health-care organization, delivery, and funding in the provinces, seeking gains in efficiency and effectiveness. The aims of these reforms are:

a. To ensure that health services reach the neediest, employing specific targeting criteria.

b. To move from the present health-care systems organized around government-supplied care to systems driven largely by user needs and preferences.

c. To gradually replace the fixed-salary system with fee-for-service arrangements, offering financial incentives for better-quality care.

d. To adopt family health-care models and more cost-effective health-care management systems.

B. Program components

2.2 The program will be implemented by the selected provinces under the leadership of the MSAS, which will be responsible for the national strategy for training PHC workers and for its financing and dissemination nationwide. To begin with, the program will be implemented in the provinces of Salta, La Pampa, and Córdoba. It has three components: (i) a national component, to modernize MSAS institutional mechanisms to implement the new PHC model, and reengineer health-worker training and development processes (US$22.3 million); (ii) the province of Salta primary health-care reform project (US$35.8 million), and (iii) the primary health-care reform project in the provinces of La Pampa and Córdoba (US$101.5 million). The program's Logical Framework is presented in Annex II-1.

1. National component (US$22.3 million)

2.3 The aims of this component are to: (a) retrain and realign health-sector human resources and devise training strategies for Family Health Teams in the provinces, adapting formal health-education systems and instruments accordingly; (b) adapt the MSAS structure associated with the PHC program to the new model, particularly in the areas of information systems, public information programs, and institution-strengthening for design, implementation, and monitoring of the new model; and (c) provide funding and technical support for the design of PHC reform projects that the provinces request, for subsequent implementation. This component is subdivided into three subcomponents: (i) human resources training,

retraining, and realignment; (ii) adaptation of the MSAS to the new PHC model; and (iii) preparation of provincial projects.

a. Human resources training, retraining, and realignment (US$15.2 million)

2.4 This subcomponent covers general training and retraining of health workers to prepare them for PHC delivery in the country. It also will address the need to train personnel to help set up the PHC model in the provinces of Salta, La Pampa, and Córdoba.

2.5 Activities in this subcomponent will touch on all PHC training and development processes, such as: (a) short-term training; (b) undergraduate programs; (c) PHC residencies; (d) graduate studies, and (e) continuing education. Table II.1 shows the main activities and their desired outcomes and costs.

Table II.1
Activities related to the Program's human resources training and reconversion process

Process	Activity	Target	Cost (US$ million)
1. Short-term training	1.1 Professional PHC training plans	Design of three provincial PHC plans	1.0
	1.2 Short-term PHC training	2,000 workshops for Family Health Units	5.0
1. Undergraduate programs	2.1 Development of Family Health Team professional profiles	Profile development	0.5
		Certification and recertification	1.5
	2.2 Review of undergraduate curriculum for health professionals	Funding for four national universities	0.9
3. Residencies	3.1 Creation of PHC residencies for doctors and other health professionals	500 residency fellowships (doctors and nurses)	3.0
4. Graduate and continuing education programs	4.1 Development of continuing education and graduate programs and instruments	Funding for graduate programs in 11 institutions	3.3
TOTAL			15.2

2.6 The main activities eligible for financing in this subcomponent are:

Short-term training

(i) Support for the design of PHC professional training plans in the provinces (US$1 million): With funding under the national component, plans and strategies will be devised for training Family Health Team professionals in the provinces taking part in the program, including the use of distance education facilities. The national component will pay only for activities relating to course work: fellowships for professionals selected for training will be funded by the provincial governments, which will also directly manage funds for the plans

(ii) Short-term PHC training, including the management systems area (US$5 million): Funding will be supplied for the design and delivery of approximately 2,000 workshops (one to two per Family Health Unit throughout the program) to help publicize PHC administration and management techniques and tools. Technical assistance for the workshops will take the form of development and distribution of materials and direct support to Family Health Units and health centers in the provinces of Salta, La Pampa, and Córdoba. The MSAS will transfer funds for these activities to the provinces to administer.

Undergraduate studies

(iii) Devising Family Health Team professional profiles and certification and recertification mechanisms (US$2 million): Using program funds, specialized consulting firms will be hired to: (i) draw up profiles for Family Health Team professionals (family doctors, nurses, PHC-focused social workers), to attain international PHC specialization standards (US$500,000) and (ii) prepare tests, examinations, and other evaluation activities for professional certification (US$1.5 million).

(iv) Rewriting curricula of undergraduate programs that train doctors and other health professionals, to gear the programs to PHC and family health care (US$900,000): Funding would be supplied to set up PHC curriculum modules to be built into undergraduate curricula in the health professions. Funds would go to four national public universities, the average amount per institution being US$225,000. Eligible expenditures for each project's preparation include consultants to develop instructional materials, teacher training courses, and equipment and other teaching media needed to prepare PHC courses for undergraduate programs.

Residencies

(v) Creation of PHC residencies for doctors and nurses at universities and training centers for health professionals (US$3 million): The program will fund some 500 fellowships for medical residents and nurses, shifting and increasing funding to family-medicine residencies for doctors and nursing personnel. This will be accomplished by redistributing the MSAS's current budget for health-profession residencies, to modify the specialization profile and future makeup of the corps of Argentine health professionals.[5]

Graduate studies and continuing education

(vi) Development of PHC continuing education programs and instruments (graduate courses, distance education, rotation system) for Family Health Teams (US$3.3 million): In this countrywide activity, funding will be supplied to specialized institutions offering graduate programs, for PHC-program initial outlays and curriculum and program adjustments, taking as a frame of reference the profiles devised for the certification system. An average of US$300,000 in funding will be available to 11 nationally renowned specialized institutions with proven experience in graduate training for health professionals. Qualifying expenditures for each project submitted by these institutions will be adaptations of plant, materials, and equipment, consulting services for curriculum and program design, and teacher training (courses, materials, travel and per diems).

b. Adjustment of the MSAS structure associated with the new PHC model (US$3.3 million)

2.7 Three activities comprise this subcomponent: (i) PHC information system; (ii) public information program, and (iii) MSAS institution-strengthening.

(i) PHC information system (US$1.7 million): This activity consists in monitoring the targeting, identification, and registration of low-income users of health services in the provinces; setting up an information system integrated with the provincial systems to compile morbidity and disease-cost data; devising PHC quality monitoring and management strategies by sampling; and institutional coordination with the provincial Health Ministries, to better equip them to compile, use, and report PHC-related information. The funding will be used to hire consulting firms to develop PHC information-system software (US$800,000), purchase hardware (US$300,000), and keep up those

[5] The MSAS regularly funds medical and nursing residencies, but not in family health or primary health-care programs.

activities for the life of the project (US$600,000). They subsequently will become part of the program budget.

(ii) Public information (US$1.2 million): Program funds will defray the cost of commissioning specialized social-marketing firms to set in place information strategies to explain the new family health model to: (a) interest groups such as doctors and other health professionals, professional associations, universities, health-care providers and managers, *Obras Sociales,* and prepaid health-care organizations, and (b) users of health services, by way of radio and television programs, information pamphlets, information made available at health-care facilities, educational strategies in schools, and other media.

(iii) Institution-strengthening (US$400,000): An international consulting firm specializing in health-services organization and management would be engaged to review and propose changes in the MSAS's administrative structure. The aim is to integrate and dovetail the tasks of coordinating, monitoring, and evaluating the planned new PHC and family health-care programs in the provinces with other ongoing MSAS health-sector reforms.

c. Preparation of provincial projects (US$3.8 million)

2.8 The MSAS will fund the preparation of projects for provinces whose Health Ministry is committed to the reforms within the framework mapped out for this program. The estimated preparation cost per provincial project would range from US$250,000 to US$500,000. From 9 to 15 such projects could be prepared with the funds available. Once prepared, projects could be submitted to the Bank for consideration for an eventual future operation.

2. Primary health-care reform in the province of Salta (US$35.8 million)

2.9 The Salta Health Ministry prepared a PHC project with support from the consulting firm Ernst & Young. The project's central objective is to set up Family Health Units, with new personnel remuneration and incentives systems, infrastructure adaptations, new MSAS-supported personnel training strategies, and institution-strengthening of the provincial Health Ministry to equip it to regulate, manage, and evaluate the new model.

2.10 Outlays for training, construction, and equipment will be confined to health units that have changed over to the new model, as provided for in the program. Performance of this condition will be assessed through a set of program monitoring benchmarks appended to the loan contract.

2.11 In keeping with that strategy, the component has been divided into five subcomponents: (a) remuneration and incentives system; (b) infrastructure

adaptation; (c) information systems; (d) public information; and (e) institution-strengthening.

a. Remuneration and incentives system (US$12.5 million)

2.12 At the core of the planned realignment of health personnel is a new contracting and compensation system for provincial government health workers, the goal being in urban areas to gradually shift from the present fixed-salary arrangement to a capitation system, and in peri-urban and rural areas to offer incentives rewarding productivity, quality, and coverage.

2.13 The provincial Health Ministry will fund capitation payments for the target groups. The other capitation fees, even when covered by public Family Health Units, will be paid by *Obras Sociales* or prepaid health-care plan members or, in higher-income households, directly by health-service clients.

2.14 In locations with too few health workers to provide primary health care, new family health-care personnel may be hired in addition to the retraining and voluntary reassignment of existing workers.

2.15 Three activities comprise this subcomponent: (i) human resources retraining and realignment; (ii) introduction of incentives; and (iii) quality audits of the system.

(i) Retraining of human resources (US$6.1 million): Fellowships will be funded for personnel undergoing retraining to comprise Family Health Teams, for the duration of their training. The plan is to retrain/reassign about 300 doctors (with and without specialty accreditation), 1,100 nurses and 900 community health workers.

(ii) Introduction of incentives (US$5.6 million): The main activities eligible for funding are incentive payments to reward quality care and increased coverage in the planned family health-care systems. The incentives will be used to supplement, for the life of the program, the pay of about 900 doctors, 1,900 nurses and 1,800 community health workers in Family Health Units that operate under the new model. Program funding for these incentive payments will be phased out over the program's five-year life span; they would subsequently be absorbed in the regular capitation payments to be funded through the provincial budget.

(iii) Quality audits (US$800,000): Specialized firms will be hired to conduct, under the provincial Health Ministry's guidance, twice-yearly surveys to rate the quality of the new system, using criteria developed in the course of accrediting the new Family Health Units.

b. Infrastructure adaptation (US$10.2 million)

2.16 Program funds will be used to pay for construction, renovation, and adaptation of 25 health centers and some 200 Family Health Units, to re-equip 25 health centers and 120 Family Health Units, and to improve referral-network access systems (second- and third-tier hospitals) for patients referred by Family Health Units. The Operating Regulations set out basic rules and eligibility criteria for funding for these investments, which come out of a needs survey conducted by the Salta Ministry of Health in 1998.

c. Information systems (US$4.7 million)

2.17 With this funding, an epidemiological and management information system will be implemented to: (a) help in provincial health-care programming, supervision of health-care management, and cost-recovery; (b) improve mechanisms for accessing health care through the use of identification and cross-referencing systems based on magnetic cards issued to all provincial residents; and (c) identify low-income users so the program can be properly targeted. The main activities to be funded are:

(i) Purchase of software (US$1 million) and hardware (US$2.6 million) for systems and database implementation, to strengthen the provincial Health Ministry's information management capability.

(ii) Hiring of specialized consulting firms (US$700,000) for the logical design of the information systems and to train some 900 Family Health Unit professionals who will be hooked up to the new system, as users and feedback sources.

(iii) Creation of user identification systems based on magnetic cards. The plan is to issue cards to all one million of the province's residents, at a cost of US$200,000.

(iv) Identification of low-income users, building on the roster already begun in the province using the SISFAM record system. The province has already recorded two thirds of the households located in regions classed as having unmet basic needs, in the Federal Capital, Güemes, and Orán. US$200,000 is needed to register the other one third of residents living in rural and more inaccessible areas.

d. Public information (US$4.8 million)

2.18 Funding for this subcomponent will be used to: (i) commission a specialized firm to do a diagnostic study and design a provincial public-information strategy (US$100,000); (ii) contract media publicity for the PHC program: video production (US$300,000), advertising (US$100,000), television commercials (US$2 million) and radio spots (US$1.1 million), and production and distribution of literature (US$1 million); and (iii) hire consultants to organize health-education

events to promote personal responsibility and rational use of technology, community involvement, and development of materials and marketing manuals for community health workers and Family Health Teams (US$200,000).

e. Institution-strengthening (US$3.6 million)

2.19 These activities will strengthen health-care programming strategies and services. The bulk of funding will go to studies and consulting work for the provincial Health Ministry, to: (a) decide on and monitor the basket of core primary health-care services; (b) work out the institutional interface of epidemiological surveillance systems and primary-care strategies; (c) devise procurement and management systems for basic inputs (pharmaceuticals, vaccines, blood and blood products) and laboratory testing; (d) develop rules, incentives, and approaches for expanding the system and means of integrating primary health care with the autonomous hospitals, *Obras Sociales* and prepaid health-care plans; (e) map out a strategy for dovetailing the project with programs cofinanced by other agencies; (f) devise cost survey systems and new provincial health budgeting and budget management techniques; (g) establish a system of health-care reporting and quality assurance and medical audits for the program; and (h) commission an external evaluation to track the impact of the new capitation system.

3. Primary health-care reform in the provinces of La Pampa and Córdoba (US$101.5 million)

2.20 The La Pampa provincial government informed the MSAS that it wished to take part in the program, and drew up its own project proposal for submission to the MSAS and the Bank. Though by virtue of that effort the province would qualify for the program, the project design it presented was viewed as preliminary. Accordingly, using funds available for provincial project execution, La Pampa will produce its project following the guidelines outlined in paragraph 3.26, using as a model the project prepared for the Province of Salta. The cost of preparing the La Pampa project will be defrayed with preinvestment funds.

2.21 The new government of the Province of Córdoba informed the MSAS of its intention to implement a PHC program. At present it is working on a preliminary project proposal to qualify for the program, following the guidelines outlined in paragraph 3.26. Preparation of the Córdoba project will be financed with funds from the Project Preparation Facility referred to below.

C. Project Preparation Facility (US$1 million)

2.22 To expedite the program's preparation and execution, the Bank and Argentina are negotiating a Project Preparation Facility (PPF) operation that would fund the program's central executing unit (CEU) and the work needed to implement component 1 and prepare and supervise development of the La Pampa and Córdoba provincial projects while approval of the operation is being processed and the

borrower is fulfilling conditions precedent to the first disbursement. The PPF would have to be approved before the project would be considered by the Bank's Board of Executive Directors.

D. Administration and supervision (US$4.9 million)

2.23 The equivalent of US$4.9 million would be furnished to fund the CEU for four years. It has been agreed that IDB funding would be progressively phased out and the Ministry would build the cost of consultants hired for the CEU into its own cost structure. The loan proceeds would pay for remuneration (coordinators, specialists, technicians), consultants, basic equipment (computers, telecommunications, document reproduction and transmission), and travel and per diems needed to negotiate, monitor, supervise, and evaluate the provincial projects that will be prepared and/or implemented.

E. Cost and financing of the program

2.24 The estimated cost of the program is US$167 million equivalent, to be funded by a $100 million loan from the Bank's ordinary capital under the Single Currency Facility and a local counterpart contribution of US$67 million. The following table gives a cost breakdown by component.

Table II.2
Consolidated budget by component
(millions of U.S. dollars)

Item		Funding source			
		[illegible]	[illegible] contribution	Total	%
1.	Administration and supervision	2.5	2.4	4.9	2.9
2.	National component	13.4	8.9	22.3	13.4
2.1	Human resources training, retraining, and realignment	9.1	6.1	15.2	
2.1.1	Devising Family Health Team professional profiles	1.2	0.8	2.0	
2.1.2	Short-term training in PHC	3.0	2.0	5.0	
2.1.3	Continuing education in PHC	2.0	1.3	3.3	
2.1.4	Design of personnel training for PHC	0.6	0.4	1.0	
2.1.5	Additional PHC residencies	1.8	1.2	3.0	
2.1.6	Realignment of undergraduate programs	0.5	0.4	0.9	
2.2	Adaptation of MSAS structure involved with the new PHC model	2.0	1.3	3.3	
2.2.1	PHC information systems	1.0	0.7	1.7	
2.2.2	Public information program	0.7	0.5	1.2	
2.2.3	Institution-strengthening	0.3	0.1	0.4	
2.3	Preparation of provincial projects	2.3	1.5	3.8	
3.	PHC reform, province of Salta	21.4	14.4	35.8	21.4
3.1	Remuneration and incentives system	7.5	5.0	12.5	
3.2	Infrastructure adaptation	6.1	4.1	10.2	
3.3	Information systems	2.8	1.9	4.7	
3.4	Public information	2.9	1.9	4.8	
3.5	Institution-strengthening	2.1	1.5	3.6	
4.	PHC reform, provinces of La Pampa and Córdoba	60.2	41.3	101.5	60.8
5.	Project Preparation Facility	1.0	-	1.0	0.6
SUBTOTAL		98.5	67.0	165.5	99.1
6.	Associated costs (evaluation)	0.5	-	0.5	0.3
7.	Inspection and supervision	1.0	-	1.0	0.6
GRAND TOTAL		**100.0**	**67.0**	**167.0**	**100.0**

III. PROGRAM IMPLEMENTATION

A. Organizational arrangements for the program's implementation

3.1 The Ministry of Health and Welfare (MSAS) will be the program's executing agency for the national component, and will coordinate the overall program and work with the participating provinces. To do so, within its Health Care Bureau the MSAS has set up a central executing unit (CEU), which will also be able to call on the Ministry's formal organization units for assistance. The provincial Health Ministries of Salta, La Pampa, and Córdoba will set up provincial executing units (PEUs) to coordinate project execution in each of these provinces.

B. Operating framework

1. Execution of the national component

3.2 The CEU will be in charge of this component, with responsibility for its effective and timely execution. This unit will oversee planning and implementation of the component's technical, financial, and administrative elements, and its monitoring and evaluation. It must make certain the program dovetails with other externally-funded projects, and oversee the provincial projects to make sure they are attaining the program's objectives and targets.

3.3 The CEU will report directly to the program's general manager, the Deputy Secretary for Health Care. The manager will chair the Consultation and Coordination Committee made up of directors of each MSAS area involved in the program. The committee's mandate will be to foster and maintain coordination between the CEU and the formal MSAS organization for program-implementation purposes. At the head of the CEU will be a general coordinator assisted by three area coordinators for project design and appraisal; information systems, and operations and administration and finance. The CEU also will have a legal advisor, a specialist in monitoring and management control, and advisors/consultants in such specific areas as public relations and information, institution-strengthening, plant and equipment, and environmental matters. As conditions precedent to the first disbursement of program funds, it must be demonstrated that the CEU has been duly set up, organized, and staffed in accordance with terms of reference approved by the Bank, and that the program's Operating Regulations, previously agreed on with the Bank, have been placed in effect by order of the Ministry of Health and Welfare.

3.4 The following is an overview of how the national-component activities will be implemented.

a. Human resources training, retraining, and realignment

3.5 The training and retraining programs to be delivered throughout the life of the program will be targeted to doctors, nurses, social workers, other health-care aides, and health-care system administrators.

3.6 As the following paragraphs explain, some activities in this subcomponent will be countrywide while others (though developed as part of the national component) will supplement activities planned in the provinces of Salta, La Pampa, and Córdoba. The first disbursement of resources for the activities of this subcomponent for each province included in this program will be conditioned upon prior approval of the province's human resources training and reconversion strategy by the MSAS and the Bank.

(i) Basic training and retraining for Family Health Teams

Short-term training

3.7 Support for the design of PHC professional training plans in the provinces. Each province will draw up its own training strategy using national-component funding and, in pursuit of that strategy, will run training programs using funds of its own. Consultants will be hired to develop the provincial training plans and strategies and individual training plans for Family Health Team professionals, including distance education programs. The MSAS will decide with each province, according to its needs, whether individual consultants or consulting firms will be engaged.

3.8 Short-term PHC training and new management systems. The program will retain these services through international competitive bidding, inviting offers from specialized training and management organizations which must prove that they have experience in managing family health units or in comparable areas.

Undergraduate programs

3.9 Devising profiles for Family Health Team professionals, and certification and recertification mechanisms. This nationwide activity will take place in the framework of the National Commission on Professional Certification and Recertification, created by Decree 1424/97. This body is coordinated by the coordinator of the National Health-Care Quality Assurance Program; other members are the Deputy Secretaries for Health Care and for Regulation and Compliance Monitoring, a Ministry of Culture and Education representative, two members of the Federal Health Council on the Standing Advisory Board and, also from that board, representatives of the National Academy of Medicine and the Association of Argentine Medical Schools.

3.10 To set in place a certification and recertification system, a consulting firm will be hired to develop PHC certification and recertification procedures. As it devises evaluation instruments it will work with the provinces to reach a consensus on

them, and establish systems for their implementation and operation. The profiles produced and minimum standards decided on must be adhered to in all training activities funded by the project.

3.11 Realigning undergraduate training programs for doctors and other health professionals toward primary health care. To be eligible for the subsidies, universities must present a project proposal outlining their funding needs. The MSAS, through the CEU, will evaluate proposals and allocate the requisite funds.

3.12 Preference will be given to the Buenos Aires, Córdoba, Rosario, and La Plata national universities, which have been selected from among the seven national public universities because they train most doctors who practise in the provinces of Salta, La Pampa, and Córdoba.[6] Nevertheless, these universities will have to present proposals that satisfy the quality criteria and other program requisites. Before funds can be disbursed for this activity, the borrower must have fulfilled the special conditions precedent to the first disbursement and the MSAS must have completed, to the Bank's satisfaction, the preparation of profiles and certification protocols for health workers referred to in paragraphs 3.8 and 3.9 of this proposal.

Residencies

3.13 The three provinces will select professionals to participate in the program from government health services, *Obras Sociales*, or private health plans. If a candidate is a provincial government employee, the government will have to agree to keep the individual on contract with his or her salary throughout the residency. In a contract to be signed with the provincial Health Ministry each such employee must undertake to work for the provincial government for three years after completing the residency, in the specific field in which the employee received training.

Graduate and continuing education

3.14 Development of continuing education programs and instruments for primary health care: Graduate programs, distance education, and rotation systems for Family Health Teams. The CEU will establish an accreditation system for institutions specializing in graduate programs, and then select the 11 institutions offering the best proposals. In their proposals the institutions must furnish professional profiles and certification schemes that meet the standards set for the program described here, and guidelines for managing the new family health systems, shifting skill-sets to the new health-care delivery approach and offering elements and tools for Family Health Unit management. The proposals must address such elements as evolution of health-care systems, development and administration policies, evaluation

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[6] The other national public universities with medical schools are Corrientes, Cuyo (Mendoza), and Tucumán. The latter institution already focuses heavily on PHC, so it does not need subsidizing. The province of Mendoza would not be part of the proposed program because it has its own PHC program. Subsidization for the University of Corrientes could be considered in future if that province joins the program.

techniques, management tools, human resources administration, health economics, data management, and health-care technology.

3.15 Eligible graduate specializations will be family medicine and family nursing care, PHC for social workers, PHC for other health-team professionals, intended for physicians specializing in fields other than family medicine (dentists, psychologists, biochemists, pharmacists, etc.); the shift from specialized practice to family medicine, with preference to specialists in pediatrics, clinical medicine or obstetrics and gynecology, and interdisciplinary training for primary health-care teamwork. Candidates for these programs will be health professionals in the provinces, who will be chosen by reference to selection and funding criteria in the respective provincial project proposals.

3.16 A specialized firm will be hired through an international call for proposals to set up and begin operating a distance education network. The firm will design, develop, and administer a distance education system for primary-care interdisciplinary-team professionals. Candidates must have demonstrated experience in implementing distance education systems and in health-worker training. Program funds for the network will be phased out over two years, thereafter becoming an MSAS responsibility. As of that point the distance education network will fund itself through user fees.

3.17 Managing the rotation system will entail the systematic implementation of the following routines: (a) identify in each province the number of rotation candidates and the Family Health Units or Teams that will be rotation training centers; (b) reach agreement with these centers as to the minimum activities in which individuals chosen for rotation would engage and arrangements for supervising and evaluating the program; (c) in each center, assign rotation tutors and supervisors; (d) evaluate the rotations' outcome and report findings to the provincial health authorities; and (e) administer and pay for travel, per diems, accommodation, and any incentive payments to which the trainee is entitled.

3.18 There will be provision in the rotation system for professionals who are assigned to rural or peri-urban areas to do periodic one-week internships in PHC centers of excellence, to help raise the standard of care in poorer parts of the province. A specialized consulting firm to be selected through an international call for proposals will set up the rotation system development project and implement it in the provinces of Salta, La Pampa, and Córdoba. Once the project is in place it will be administered by the MSAS in coordination with the provincial governments. Firms submitting proposals must show that they have experience in training-system organization and management.

b. Adaptation of the MSAS structure involved in the new PHC model

(i) Primary health-care information system

3.19 The information system will be the basis for targeting the program by identifying provincial residents who do not have health-care coverage, using SISFAM/PHC records. To that end, as a condition precedent to disbursement of funds for the provincial projects, the provincial governments must have signed agreements with SIEMPRO. This will entail resgistration of at lesast two-thirds of the target population as a condition precedent to the first disbursement. Within one year of the effective date of the contract, the provinces must have completed registration of their entire target populations.

3.20 Consultants will be hired for this activity, on contracts of about 12-18 months. Proposals will be invited and contracts signed during year 1 of the program, in accordance with terms of reference cleared by the Bank which include technical guidelines for the provinces to devise their respective systems and for human-resources training needed for their operation. Once the consultants' findings are at hand, a separate international public tender will be organized to purchase hardware to set up the interconnected system.

3.21 After prospective beneficiaries have been recorded using SISFAM/PHC data, they will enter the system by way of a magnetic identification card. This will add their names to the different health-care delivery modules and the cost-recovery system's operation and management.

(ii) Public information program

3.22 By the end of year 1 the program design is expected to be 100% complete, so central- and provincial-level executives have access to the National Public Information Plan and the Rules and Procedures Manual.

3.23 One feature of the planned public information strategy are refresher events, workshops, and working symposia to strengthen cross-sectoral and cross-disciplinary interface in areas involved with PHC. Specifically, there would be refresher sessions in public-information program planning, management, and evaluation; meetings with provincial government external relations offices to systematize outputs, highlighting achievements and weak points, and adjust future action plans; and PHC workshops for media representatives. Over the life of the program the plan is to organize 50 two-day events at the central level and 50 in the provinces to strengthen cross-disciplinary and cross-sectoral coordination in PHC-associated areas, and 25 central and 25 provincial symposia with media representatives.

3.24 A consulting firm specializing in corporate communications with health-sector experience, preferably in the primary health-care area, will be hired for the above-

described activities. Work on rules and procedures and development of publicity and evaluation and monitoring methods will be done during the first two years of the program; the refresher events and workshops will be held throughout the planned five-year implementation period.

(iii) MSAS *institution-strengthening*

3.25 Work for this component will follow a strategic strengthening plan to be drawn up during year 1 of the project. Support for developing the strategic plan will be provided by a consulting firm specializing in the health sector and with experience in developing and designing organization and management plans. The firm will be selected through an international call for proposals. The aim of these activities is to analyze the current management model and its problems and come up with possible solutions, bearing in mind resource availabilities (human, physical, and funding). Implementation of the strategic plan will begin in year 2 of the project, in the form of information workshops and the start of the planned actions.

c. Preparation of provincial projects

3.26 The stages in preparing provincial project proposals are: (i) Prerequisites: the province submits a letter of adherence to the program and the provincial governor's formal written request to the national Minister of Health to join the program; (ii) situational diagnosis: the CEU sends an identification mission to the province to draft a preliminary document describing the project's basic features; (iii) preparatory action plan for the project: the CEU and provincial Health Ministry together map out an action plan to tackle the problems pointed up in the situation diagnosis and to prepare the province's PHC plan; (iv) initial assistance agreement between the provincial Health Ministry and the MSAS to launch the preparatory action plan, by hiring a consulting firm, launching the public information activities, devising training structures and apportioning responsibility between the provincial and national governments; the methodology guidelines agreed on with the Bank must be followed in preparing provincial projects; and (v) evaluation and final documentation to seek approval of the provincial project: the provincial project proposal prepared by the consulting firm will be reviewed and given provincial and CEU approval; the Bank's no objection is required for final acceptance of the project. When the proposal is approved, the provincial government will negotiate passage of the provincial borrowing bill and arrangements for a subsidiary loan agreement with the federal government.

2. Salta project implementation

3.27 The provincial executing unit (PEU) will be in charge of implementing the province's project in coordination with the CEU. The PEU, to be created by a ministerial order, will report directly to the provincial minister. It will have a general coordinator, three technical coordinators (for human resources retraining/realignment, plant and equipment, and monitoring and management

control), and a coordinator of administration and finance. Like the CEU, the PEU can draw on support from the provincial ministry's permanent structure to coordinate work for the various project activities. Demonstration that the PEU and Operating Regulations have been established will be special conditions precedent to the first disbursement of funds for provincial projects. This condition will apply to the other two provinces as well.

3.28 The following are the Salta project implementation guidelines.

a. Remuneration and incentives system

3.29 Human resources retraining/realignment. The PEU will allocate fellowships for PHC specialization and training courses in accordance with the demand forthcoming from Family Health Teams and Units. Courses will be contracted out to specialized institutions through international competitive bidding (see paragraphs 3.7 and 3.8).

3.30 Introduction of incentives. The incentives system is to be replaced gradually by a capitation system. To prepare for that shift, the PEU will need to develop specific plans in the provincial project to ensure that the transition will take account of the province's specific needs and features. Methodology guidelines agreed on with the Bank for the approved provincial project must be followed in implementing this system.

3.31 Quality audits. Health-care quality will be rated through a combination of classic audit methods (review of case histories, compiling of indicators, benchmarking) and modern quality-assurance techniques (tracers, satisfaction surveys, quality circles, etc.). A specialized international firm will be hired, following procedures agreed on with the Bank, to develop the audit system. The PEU will evaluate implementation proposals with costs and timetables. This activity will take place during year 1 of the project.

b. Adaptation of plant, equipment procurement, information systems, public information, institution-strengthening

3.32 The planned investments in plant are to pay for designs and construction work to renovate, upgrade, expand, and build PHC facilities (health centers and posts, clinics and outpatient facilities in which Family Health Units will operate).

3.33 The following equipment purchases will be eligible for funding: (i) devices, machines, and instruments intended for use exclusively in PHC services in health centers, which must meet provincial standards and follow the recommendations of the consultants' studies, and (ii) computer hardware and software for the information systems, which must be compatible with provincial government agency networks and systems and with networked information management technologies; both hardware and software must come with warranties and maintenance support.

3.34 Because the investments in plant will be geographically scattered and the cost per establishment will be modest, there are no plans to hold international competitions for construction contracts. However, international competitive bidding will be used to purchase hardware and software packages worth over US$350,000, to seek economies of scale.

3.35 International competitive bidding will be required to retain the consulting services referred to in paragraph 2.17(ii) for the logical design of information systems.

3.36 As for consulting services and purchasing of advertising, television and radio spots and production and distribution of literature for the public information subcomponent, there will be international calls for proposals (for consultants) or local calls for proposals (for publicity/media services) adhering to Bank rules, as set out in the Operating Regulations.

3.37 Funding will not be released for the studies listed in paragraph 2.19 for the institution-strengthening subcomponent until the Bank has cleared their terms of reference, whereupon the work can be put out to international tender.

c. Management contracts for health-care delivery

3.38 The model will be put into practice by way of management contracts to be executed between the provincial Health Ministries and Family Health Teams and Units. Basic elements to be addressed in these contracts will be services to be delivered, professional specialization, health-aide specializations, pay and incentives systems for Family Health Teams and Units, work schedules, location and clientele, and operations evaluation mechanism. Particular attention will be paid in these contracts to the employment status of medical personnel and aides on the health teams: they may be provincial public servants and thus governed by the Health Workers Act, or personnel who join after the system starts up, and therefore governed by other contractual arrangements. The Bank's no objection must be obtained for the model management contract the provincial Health Ministry proposes to use. This condition will apply also to the other provincial projects.

3. Implementation of the La Pampa and Córdoba projects

3.39 These projects will be executed following each set of Operating Regulations agreed on by the MSAS , these provinces, and the Bank. The entry into effect of these regulations will be a condition precedent to the first disbursement of funds for these provincial projects.

3.40 The Operating Regulations govern the following elements of provincial project implementation: (i) organizational framework for the project's implementation (setting up PEUs, assembling interdisciplinary teams for Family Health Units and Teams, deciding on a basket of core services, its cost and financing, and a pay and incentives system); (ii) general project-implementation requirements: eligibility criteria for training institutions, for professional training programs, for investments

in plant and equipment; (iii) contracting procedures; and (iv) monitoring, audit, and evaluation arrangements. Appended to these regulations will be the methodology agreed on with the Bank for preparing provincial projects.

C. Administration of program funds

3.41 The program's Operating Regulations also prescribe how program funds are to be administered and spell out CEU and PEU responsibilities. The sources of the program funds will be the proposed IDB loan, the national counterpart (Argentine Treasury) and provincial counterpart contributions (provincial treasuries). The regulations also provide guidelines and restrictions on expending the loan proceeds and counterpart funds.

3.42 Other stipulations in the Operating Regulations concern program fund disbursement mechanisms (for the national and provincial executing agencies), special accounts to be opened for the program, accounting records, and terms and conditions for transferring funds to the provinces. In regard to this last-named condition, the regulations require the borrower to pass on program funds to the provinces as subloans; Salta, La Pampa, and Córdoba thus will have to sign subsidiary loan agreements with the Nation, following guidelines agreed on in advance with the Bank. As one condition in these contracts, the provincial governments must offer their federal revenue share-outs to the federal government as security for repayment of their loan and for the timely allocation of the local counterpart for the respective provincial project. Demonstration that these contracts have been signed will be a condition precedent to the first disbursement of funds for the respective provincial project. The loan proceeds are to be onlent to the provinces on the same terms as the Bank's loan to the Argentine Republic. To secure the repayment of principal and payments of interest and fees on these subloans, the federal government will require the provinces to pledge their federal tax revenue share-outs or such arrangement as may replace that system.

D. Procurement and contracting

3.43 Goods, related services, and construction work will be contracted for following the Bank's standard procedures. International competitive bidding will be mandatory for construction contracts worth over US$5 million and goods and related services costing over US$350,000. Procurement of items below those thresholds will be governed by Argentine law. Consulting services and studies for the program will be commissioned following the Bank's usual procedures. The procurement timetable for the program is in Annex III-1.

3.44 The CEU and PEUs will be assisted by procurement and contracting specialists in every facet of this program activity. Where necessary, the specialists can call on the central and provincial governments' permanent units for help with tendering.

3.45 Firms or institutions wishing to bid on services in a local or international call for tenders for the program must go through a prequalification process that will evaluate their technical, administrative, financial, and legal capacity, by reference to criteria specified in the Operating Regulations (financial strength, experience of firm/institution, experience of trainers, management support systems, capacity to perform the planned activities in the provinces). Proposals will be received from individual firms or institutions or from consortia formed with other Argentine or foreign institutions. Proposals for national activities will be evaluated by the CEU, those pertaining to provincial projects by the respective PEU.

3.46 To expedite the program, prior Bank approval will be required only for: (i) contracts for courses worth more than US$1 million; (ii) service contracts of more than US$50,000 for individual consultants and more than US$100,000 for consulting firms; and (iii) purchases of equipment for adaptation of the health units and institution-strengthening costing more than US$350,000. Supporting documentation for procurements below those thresholds will be reviewed by ex post sampling. The specific documentation necessary for those bidding processes that are to be reviewed ex post by the Bank should be kept by the MSAS and made available to the Bank during the program execution period.

E. Disbursement timetable

3.47 The program would run for five years, from the second half of 1999 through the first half of 2004. A revolving fund not to exceed 5% of the loan proceeds would be established for the operation. The following is the estimated disbursement timetable.

Table III.1
(US$000)

Source	Year 1	Year 2	Year 3	Year 4	Year 5	TOTAL
IDB	10,860	33,754	26,064	17,376	11,946	100,000
Local counterpart	7,240	22,836	17,376	11,584	7,964	67,000
Total	18,100	56,590	43,440	28,960	19,910	167,000
PERCENTAGE	**11.0**	**34.0**	**26.0**	**17.0**	**12.0**	**100.0**

F. External audits

3.48 The executing agency, on behalf of the borrower, will submit the program's financial statements to the Bank each year during the life of the program. External audits will be performed by an independent auditing firm acceptable to the Bank.

G. Monitoring and evaluation system

3.49 Within 30 days after the end of each six-month period during the program, the MSAS will submit a semiannual report to the Bank describing progress on the program. The report that coincides with the end of each year of program implementation must also include an operating plan for that year, the program's financial statements, and a report on procurement the previous year and procurement plans for the ensuing year. For purposes of monitoring and evaluating program outcomes, these yearly reports will include a comparative status report for a set of progress benchmarks selected by mutual agreement between the Bank and the MSAS.

3.50 Each year, within 30 days after the date of submittal of the six-month progress report coinciding with the end of a year of program implementation, the Bank will conduct an evaluation to review, with the MSAS, the information presented, assess progress on the program, and examine problems encountered and how to resolve them.

3.51 As part of the program evaluation process there would be two impact evaluations - one interim and one final - based on impact indicators to be agreed on between the MSAS and the Bank. The findings of the first evaluation are to be submitted to the Bank when 50% of the program funds have been committed or 42 months after the effective date of the loan contract, whichever occurs first. The aim will be to assess the program's status and track attainment of the agreed targets, pinpoint problems, and take in-process corrective measures to ensure that the program's ultimate objectives are achieved. The final evaluation is to be conducted within the six months preceding the deadline for disbursement in full of the loan; its findings will be submitted to the Bank with the final disbursement request.

IV. PROGRAM VIABILITY AND RISKS

A. Technical considerations

4.1 The central aim of the primary health-care strategy proposed in the program is to make basic health care more universally accessible and, in so doing, to help prevent chronic diseases and offer better medical care to pregnant women and to children. The strategy would reduce morbidity from chronic diseases, make for safer pregnancies, and lower the risk of infant mortality. Against that backdrop, one of the program's expected effects, particularly in the poorer provinces, would be to bring down maternal and child mortality rates.

4.2 Additional benefits of the program will be to: (i) make the health-care system more equitable by improving the health status of low-income groups and (ii) lower the average costs of primary care.

4.3 The program also will change the nature of health services, making primary health care (PHC) accessible to more people, improving PHC units' treatment success rates, and keeping health-service users from going directly (without referrals) to more specialized care facilities and hospitals and cutting down on unnecessary referrals of patients to such facilities.

4.4 To achieve the equity objectives, the program's strategy will be to target low-income groups and bring in systems to recover the cost of government-funded health-care services used by members of *Obras Sociales* and prepaid medical-care plans. Today, few members of those plans use government PHC services because of their poor quality, but as these services improve they will become more competitive. And as the *Obras Sociales* are transformed into managed-care providers and service purchasers, the public sector will become more active in health-care delivery. The additional revenues this will generate for the system will help assure the new model's sustainability.

B. Economic and financial analysis of the program

4.5 To estimate the impact of the PHC program as a whole a cost-effectiveness analysis was done for the Salta project, for which designs are complete. The findings of this analysis can serve as guidelines for refining the Córdoba and La Pampa project designs.

4.6 The program's effectiveness can be measured by the following health-status improvement indicators: (a) increase in coverage; (b) improvements in quality of coverage; (c) reduction in maternal and infant mortality rates; and (d) reduction of hospitalization rates and rates of referral of patients to more complex treatment facilities.

4.7 The provincial projects would have the following effects on costs: (a) an increase in PHC costs in step with the growing demand for these services on the part of Argentinians without coverage, and the ensuing impact on personnel costs (capitation or incentive payments in PHC units in rural and peri-urban areas), and costs of pharmaceuticals and basic inputs; (b) in the medium term, a reduction in hospital-care costs, as primary health care becomes more efficient and effective and fewer patients are referred unnecessarily to hospitals; and (c) the impact of recovering costs of services provided to members of *Obras Sociales* and prepaid health-care plans. Each project's impact on the provincial budget can be gauged by balancing out items (a) and (c).

C. Financial and economic analysis: province of Salta

4.8 The Salta Health Ministry's financial showing has been positive in the past four years thanks to its efforts to rationalize spending, but the proposed program is needed to raise low coverage levels. In Salta as in Argentina's other poorer provinces efforts to broaden coverage will mean higher costs, though improvements in health-care effectiveness will be proportionally higher than the cost increases.

4.9 Table IV.1 presents the findings of the analysis of the project's effectiveness. The following assumptions were adopted for the analysis: (a) coverage: in the with-reform scenario, PHC services would be available to all residents of the province who are currently without coverage, and the ensuing costs would be recovered; and (b) existing health centers and posts would be converted and new ones built as needed in rural and peri-urban areas. As Table IV.1 shows, these two actions have an impact on the population's access to health care (Gini coefficient), on maternal and child mortality rates (per 1,000 and 100,000 live births, respectively), and on hospital discharge rates (percentage of patients seeking treatment first in a hospital). From those three rates an overall effectiveness ratio was constructed.

Table IV.1
Province of Salta
Program effectiveness ratios

Ratio	Definition	Baseline (1998)	Without-project scenario (2003)	Scenario A (best case) (2003)	Scenario B (worst case) (2003)
Coverage	Residents covered by the system as a % of total population (1)	64%	69%	89%	84%
Accessibility	Number of PHC units (2)	464	489	888	784
	PHC concentration index (3)	0.331	0.345	0.194	0.221
Effectiveness	Infant mortality (4)	23.5	23.5	21.8	22.8
	Maternal mortality (5)	122	116	44	72
	Hospital discharge rate (6)	12.6	15.0	8.8	9.5
	Effectiveness ratio (7)	100.0	98.3	142.8	135.0

Notes: (1) Coverage refers to the total provincial population. The assumption is that, with the reform, PHC services will become accessible to all residents currently without coverage in the baseline and part of the population covered by other health-care plans, recovering the costs incurred by the system. (2) Includes existing health centers and posts (to be converted) plus units that need to be built in rural and peri-urban areas. (3) Gini coefficient of the spatial concentration of health centers relative to the population, using the district as unit. The coefficient ranges from 0 to 1, where 0 denotes maximum distributional equity. The data were constructed by reference to planned PHC units in the province, outlined in the Salta project proposal. (4) Rate per 1,000 live births. (5) Rate per 100,000 live births. (6) Percentage of residents who go to a hospital for primary care plus patients referred unnecessarily to second and third-tier facilities by PHC providers. (7) The arithmetic average of the inverse of changes in maternal and child mortality rates and the hospital discharge rate.

4.10 The assumption in the without-project scenario is that infant mortality rates hold stable and maternal mortality rates decline, following the historical trend of the past five years (an average of 1% annually). Two with-project scenarios were examined. In the best-case scenario, the province: (i) attains its target of 89% population coverage with the new system, by way of a decided shift to a PHC approach and broadening of the PHC network; (ii) the province's infant and maternal mortality rates approach national figures; and (iii) the number of patients referred unnecessarily to more specialized care is reduced significantly. In the worst-case scenario the province: (i) falls short of its coverage and accessibility targets; (ii) achieves a modest improvement in infant and maternal mortality rates; and (iii) slightly reduces patient transfers to second- and third-level care.

4.11 As Table IV.1 shows, the effectiveness ratio in the without-project scenario is lower than the baseline situation. Though infant and maternal mortality rates do fall, continuing the historical trend in the system, patient referrals to hospitals increase. In the two with-project scenarios, effectiveness in the best-case and worst-case scenarios in 2003 is 43% and 35% higher, respectively, than the baseline.

4.12 Table IV.2 illustrates the project's effects on the health budget. The line items most affected by the new model are permanent staff (78% cost reduction) and a new line with a US$96.7 million budget to hire professional support services for PHC, for capitation payments (complete or partial) and incentive payments.

Table IV.2
Province of Salta
Primary health-care budget with and without project
(millions of U.S. dollars)

Budget items	Baseline (1998)	Without project (2003) (1)	With project (2003) (2)	Change (2)/(1)
Total expenditure	**112.8**	**149.6**	**157.6**	**5.3%**
Permanent staff	89.5	114.2	25.5	-77.7%
Pharmaceuticals (*)	16.9	23.5	23.5	-
Services	3.5	8.4	8.4	-
Capital goods	0.5	0.7	0.7	-
Transfers	2.4	2.8	2.8	-
Contracts	-	-	96.7	-
Total revenues	**112.8**	**149.6**	**157.6**	**5.3%**
Budget	112.8	149.6	135.0	-8.1%
Recoveries - Visits	-	-	11.3	-
Recoveries - Services	-	-	11.3	-
Budget index	**100.0**	**132.6**	**119.6**	**-9.8%**

(*) Does not include the program's possible effect on pharmaceutical costs for in-patient care.

4.13 As this table shows, instituting a user-identification and cost-recovery system will slightly raise revenues from outpatient visits (US$11.3 million) and other services (US$11.3 million). In other words, in a scenario of expanded coverage like the one planned for the province of Salta the health budget can only be reduced if the costs of visits and other services can be recovered as envisaged in the new system. Only in the with-project scenario will the provincial Health Ministry have an information and user identification system to record health-care costs in individual accounts and be able to offer a standard of care high enough to attract members of *Obras Sociales* and prepaid health-care plans.

Table IV.3
Summary of cost-effectiveness indicators

	Without-project scenario	With-project scenario (best case)	With-project scenario (worst case)
1. Increase in effectiveness over base year 1998	-1.7%	42.8%	35.0%
2. Increase in budget allocation	32.6%	19.6%	19.6%

4.14 A comparison of effectiveness data and budget expenditure (Table IV.3) reveals that in the two with-project scenarios effectiveness gains outstrip budget cost increases; this is not the case in the without-project scenario. Thus, the Salta project as designed can be considered cost-effective, since it will reduce unit costs of outpatient visits and other health-care services, delivering more services for the same expenditure units as the sector becomes more productive.

4.15 Not factored into this analysis are other project effectiveness considerations which are difficult to gauge a priori, such as indirect effects on hospital cost reductions and lower expenditure on pharmaceuticals and medical supplies, as hospitalization rates drop and the social product of a healthier population rises.

D. Institutional viability of the program

4.16 The program's overall institutional viability hinges on the MSAS's ability to steer and monitor PHC reform measures and to duly coordinate these with other reforms currently under way as part of other projects funded by the World Bank. The institutional viability of this operation also will depend on the particular circumstances in each province in terms of: (i) institutional stakeholder acceptance of the program's principles (provincial Health Ministry, autonomous public hospitals, *Obras Sociales*, prepaid health-care organizations, private clinics and hospitals, and medical and other health professional associations) and how well they collaborate in the program's implementation; (ii) the provincial Health Ministry's management capabilities; and (iii) success in involving the provincial *Obra Social* and prepaid health-care organizations in implementing the model.

4.17 As for the MSAS's capacity to guide the reform process, with a CEU set up in the Health Care Bureau and the planned activities to adapt the ministry's structure to the new PHC model, it should be able to ensure the effective and timely implementation of the national component and help the provinces implement their projects. The institution-strengthening activities proposed for year 1 of the program, in particular, will build capacity in the MSAS in areas and functions associated with PHC policy concepts, standards, and information aspects (see paragraphs 3.30 and 3.31). The PHC information system to be developed will give the ministry an indispensable management tool to better compile, manage, and track health statistics. As well, by way of the planned nationwide public information activities the MSAS will raise the awareness of and mobilize stakeholders, creating a receptive climate for the new PHC model.

4.18 In the case of the Salta project there is express political support for the program on the part of the provincial Health and Economic Affairs ministries and from medical associations, which had active input into its design. The provincial ministry has successfully encouraged hospitals to become part of a PHC system and has worked closely with the provincial *Obra Social* to set up a provincial health insurance plan as a way of channeling funding for health care for the province's residents. This partnership with the provincial *Obra Social* is a strategic alliance, since that

organization's founding mandate is concordant with the guiding principles behind PHC system reform in Salta, giving insured residents freedom to choose their health-care establishment and paying primary-care providers through capitation systems.

4.19 To equip the provincial Health Ministry with the requisite management capability, the planned PEU will be staffed by permanent employees of the ministry who have successfully conducted many health programs and have launched reforms that have yet to be tackled by other provinces. This in-house team has experience in implementing projects on this scale, having worked with World Bank-funded operations like the Autonomous Hospitals Program (PRESSAL) and the Maternal and Child Nutrition Program (PROMIN). As well as the program funds it will receive for institution-strengthening for the same purposes as the MSAS, the Salta Health Ministry will benefit from all the activities relating to retraining and basic training for Family Health Teams (see paragraphs 3.8 to 3.18). It thus will have the trained health workers it needs to implement the model. The provincial Health Ministry is currently pilot-testing the project, to try out the organizational and institutional interfaces devised for the program's implementation.

4.20 As to the task of involving the provincial *Obra Social* and prepaid health-care plans in instituting the model, the planned new contracting arrangements, expansion of the market, and possibility of risk-sharing with the public sector should be sufficient incentive. Bringing in the *Obra Social* plan will help put an end to its present subsidization (see paragraph 1.11) and thereby enhance the system's efficiency.

E. Environmental and social impacts and proposed measures

4.21 The program will greatly benefit the population, improving the health status of residents of few means. Its benefits will be felt particularly by women and, in some provinces like Salta, by aboriginal communities (see paragraphs 4.1 to 4.4 and 4.28). To maximize the program's impact in those quarters, targeting strategies have been worked out for the public information and personnel training components.

4.22 The program aims to improve health conditions of Argentina's aboriginal population, giving them access to and involving them in the program, with respect for their cultures and due regard to their socioeconomic circumstances. Specifically, the program will supplement two ongoing MSAS operations: the Health Program for Aboriginal Communities and one component of the IDB-funded Program of Support for Vulnerable Groups (loan 1021/OC-AR, 996/SF-AR, aboriginal population support component). The aims of the provincial project's strategy for aboriginal groups are to: (i) assist in PHC initiatives for aboriginal communities to address priority health problems: alcoholism, comprehensive health care for women, malnutrition, sexually transmitted diseases, and dental health; (ii) make the health system more accessible to aboriginal communities;

(iii) encourage aboriginal communities to become involved in the organization and management of health programs that serve them; and (iv) provide opportunities for intercultural dialogue that are receptive to aboriginal traditional medicine. In addition, both the CEU and the PEUs will be required to have a specialist on aboriginal issues on whose expertise they can draw.

4.23 The physical facilities and equipment to be funded by the program are for primary care, and thus are relatively simple and inexpensive. Outpatient clinics, health posts and centers, and Family Health Units will be built, expanded, or adapted. Services may include nursing care, pediatrics, medical clinics, surgical clinics, obstetrics and gynecology, and dental care. Since the small-scale, straightforward construction work planned in this infrastructure adaptation component can be completed quickly and the equipment to be purchased poses little risk, the program's environmental impact should be negligible. The following will be the conditions for a project's approval: (i) it must satisfy the criteria listed in paragraph 3.42; (ii) it must meet the National Technical Standards in the Solid Waste Bill (MSAS 1991) and National Technical Standards on the handling of pathological waste from health-care facilities (Secretarial Order 394/94); (iii) the PHC team must be given training in medical-waste issues; and (iv) a chapter on environmental sanitation must be included in the Community Health Worker Manual, covering *inter alia* the handling and safe disposal of medical waste. Sanitary and environmental education for householders, duly defrayed, must also be addressed in the manual and in the appropriate components of the provincial project.

F. Anticipated benefits

4.24 Notable benefits of this program will be: (a) an improvement in PHC coverage, particularly for low-income groups and the most vulnerable, like women and children, thanks to effective targeting; (b) more efficient PHC programs, when residents have a guaranteed basket of cost-effective core health-care services; (c) better-quality care and greater patient satisfaction as competition mechanisms are introduced and people are able to choose their family physician; (d) a reduction in the cost of medical care as health-worker costs are adjusted in the medium and long term and more flexible contracting systems are brought in; (e) a more equitable health-care system, when costs of services delivered to members of *Obras Sociales* and prepaid health-care plans can be recovered, whereupon public funds will be freed up to spend on those most in need; and (f) configuration of the health-care network coordinated with reforms under way in the country.

4.25 What is innovative about the project is that it introduces a capitation approach and a demand-based structuring of health services in the area of primary health care, which has hitherto been managed by the public sector from the supply side, with lackluster results in terms of efficiency and coverage, sound use of resources, and improvements in health indicators.

4.26 Apart from the program's expected benefits for mothers' health (a priority target), it will encourage the training and hiring of women for the new family health model. This is entirely feasible in the proposed operation because women comprise the majority of health-program graduates, a younger segment of the population less wedded to traditional forms of health-sector employment, and are more willing to buy into the strategies charted for the program. Accordingly, the program may do much to help change gender relations in the health-sector labor force.

G. Risks and special issues

4.27 Coordination with other reform projects. To be successful, the proposed program will need to dovetail closely with other ongoing health-reform projects, to pave the way for the future integration of the provincial public system, *Obras Sociales*, and prepaid health-care plans, by way of resource transfers and purchase of services. To help assure the necessary coordination, a preliminary arrangement has been worked out with the MSAS to adjust the Maternal and Child Nutrition Program (PROMIN) so it can help establish a demand-driven care system. The MSAS has also been coordinating efforts with the Autonomous Public Hospitals Program (PRESSAL) and with the *Obras Sociales* Reform Program to this same end. To make certain that the programs are being duly coordinated among the institutions in question, impact indicators will be monitored during annual reviews of the program.

4.28 Interest groups' acceptance of the model: The change in employment status that government health workers would undergo in the proposed program could cause interest groups to resist the reforms. To counter this eventuality, the program offers financial incentives to win its acceptance and public information strategies to explain its merits and thereby reduce resistance to the changes.

4.29 Lack of coordination between training activities and implementation of the model: The project will require close coordination between the training initiatives planned in the national component and personnel training needs in the provinces. To avert problems in this area, the CEU will work with each PEU to produce a program evaluation and review (PERT) graph, to sequence the joint, coordinated activities needed for PHC personnel training and realignment in the respective province. Furthermore, as design work begins in each case, the CEU will appoint an officer to oversee the processing of each provincial project, including the PERT model and adjustments, to keep the program on track and avoid costly delays.

H. Beneficiaries

4.30 The program's chief direct beneficiaries, in the short term, will be the most vulnerable Argentinians who have no health coverage, particularly low-income mothers and children. These groups will be provided with a quality PHC package offering health promotion and preventive care, treatment, and rehabilitation.

4.31 Indirectly, the program will benefit the entire population of the provinces taking part in the program, who will gain better access to better-quality health care. In the end this may well raise their life expectancy, as preventive activities that are nonexistent in Argentina's current treatment-focused health-care system become available.

4.32 The proposed operation classifies as a project promoting social equity, as described in the key objectives for the Bank's activities in the Report on the Eighth General Increase in Resources. It also qualifies as a poverty-targeted investment (PTI). The borrower will use the additional 10% financing. The project specifies explicit performance benchmarks to measure poverty reduction and improvements in social equity. The operation classifies automatically as a PTI by virtue of the sector it addresses, as a primary health-care program targeted chiefly to low-income families.

PRIMARY HEALTH-CARE-REFORM PROGRAM: SALTA, LA PAMPA, AND CÓRDOBA (AR-0120)
Logical Framework

MMARY OF OBJECTIVES	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
AL ealth-care delivery more t and equitable by introducing new health-care (PHC) approaches.	(i) Improvement in maternal and child health indicators and in the morbidity rate for chronic diseases. (ii) Increase in PHC expenditure as a percentage of provincial health spending.	(i) Provincial health information system records. (ii) External audits of the program.	Stakeholders and beneficiaries understa and buy into the new PHC system.
RPOSES gram can achieve the expected by: (a) targeting health services eediest; (b) increasing patient tion through mechanisms to permit freely choose care providers; ng health workers' efficiency and ivity by training/ retraining them, centives and a new capitation	(i) Increase in health coverage in the provinces, particularly among low-income groups. (ii) Number of PHC units allowing clients to choose their providers in urban areas as part of PHC units in each participating province. (iii) Increase in number of health professionals trained for PHC.	(i) Provincial health information system records and SISFAM/PHC data. (ii) Provincial Health Ministries' administrative records and external audits of the program. (iii)Medical school enrollments; certificates conferred by health-care training establishments and training contracts with the provinces.	The incentives devised are sufficient to attract professionals to the new system. The number of health professionals entering the new system is adequate for needs.
MPONENTS l component: (a) Health-worker , retraining, and realignment; otation of the MSAS organization d with the new PHC model; aration of provincial projects.	Quantitative targets to be set out in a monitoring benchmark matrix. Completion of 9 to 15 provincial projects.	Physical and financial monitoring of program targets by the central executing unit (CEU).	The special contractual conditions enumerated in the executive summary o the program proposal were fulfilled.
ial components (Salta, La Pampa, a): (a) remuneration and incentive (b) infrastructure adaptation; rmation systems; (d) public tion; (e) institution-strengthening.	Indicators defined in detail in the Salta program's Logical Framework.	Physical and financial monitoring of program targets by the provincial executing units (PEUs) and CEU.	

MMARY OF OBJECTIVES	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
TIONAL COMPONENT TIVITIES worker PHC training, retraining, lignment evelopment of professional profiles d certification and recertification echanisms. ort-term training. ntinuing education programs. pport for training strategies in the ovinces. crease in number of residencies. ewriting of undergraduate curricula r health professionals. tion of the MSAS organization d with the new model: HC information system. blic information programs. stitution-strengthening. eparation of provincial projects	Detailed program budget is in Table II.2 (cost table) in chapter II of the loan proposal.	Physical and financial monitoring of program targets by the PEUs and CEU.	The special contractual conditions enumerated in the executive summary the program proposal were fulfilled. Budget funds for the program are duly allocated each year in the national budg and in the budgets of the three province involved.

PRIMARY HEALTH-CARE REFORM PROGRAM: SALTA, LA PAMPA, AND CÓRDOBA (AR-0120)

Logical Framework for the Salta Provincial Project

MMARY OF OBJECTIVES	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
AL ealth-care delivery more t and equitable by introducing new health-care (PHC) approaches.	(i) Reduction in the infant mortality rate to the national average, and reduction in maternal mortality to 70 per 100,000 live births in five years. (ii) Increase in PHC expenditure as a percentage of provincial health spending. (iii) Cost-recovery funds account for over 10% of provincial Health Ministry's budget expenditure.	(i) Provincial Health Ministry information systems and administrative records. (ii) External audits of the program.	Beneficiaries and stakeholders understa and buy into the new PHC system. Adherence to the jurisdiction of the National Health-Care Quality-Assuranc Program and the National Standard PH Area Plan for Autonomous Public Hospitals. Interface with other health programs.
RPOSES gram can achieve the expected by: (a) targeting health services eediest and (b) increasing patient tion through mechanisms giving eir choice of health-care providers.	(i) Percentage of population with PHC access rises from 64% to 89% in five years. (ii) 400 new PHC units built and another 400 converted. In at least 60% of the units patients can choose their providers.	(i) Provincial health information system records and SISFAM/PHC data. (ii) Provincial Health Ministries' administrative records and external audits of the program.	Legal framework for the reform is set i place, including the Borrowing Act and provincial counterpart. Provincial Budget Act is adjusted to reflect the changes.

MMARY OF OBJECTIVES MPONENTS	VERIFIABLE INDICATORS	MEANS OF VERIFICATION	
eration and incentives	276 doctors retrained as family physicians; 1,140 nurses and 908 community health workers retrained for PHC.	Provincial Health Ministry's administrative records. External audits.	Interest groups buy into the model. Human resources subcomponent of the national component is operative.
ructure adaptation	25 health centers, 197 family medicine units and outpatient clinics built; 2,550 sq. meters of facilities renovated; 25 health centers and 120 family medicine units and outpatient clinics equipped.	Construction completion certificates, inspections of facilities, purchase invoices, PEU documentation.	Using non-project provincial funds, 12 other Family Health Units are built and over 198 outpatient clinics are equippe
ation system	Hardware: central server and systems software for 1 million case histories; 1,000 applications licenses in five years; 822 computer kits in five years; server and kits for 123 health centers; cards for 1 million people in four years; implementation, training, Internet connection services and support for the five-year life of the project.	PEU records, facility inspections, certification by public accountant, surveys.	Power supply and/or substitutes are adequate.
information	Implementation of the provincial public information plan for the PHC strategy, with different focuses for groups without coverage and segments from whom costs are to be recovered.	Physical and financial monitoring of program targets.	Support of stakeholders and consensus-building with them.
tion-strengthening	Set-up of the PEU; introduction of basket of core health services and monitoring; adaptation of the procurement and basic-inputs management system and diagnosis, interface with other health subsystems; devising of protocols for the use of epidemiology in audit models; annual reports on the new program's impact; development of an integrated provincial health-care costing, reporting, and budgeting system.	Physical and financial monitoring of program targets. Audited accounting records.	The new model is operational.

PRIMARY HEALTH-CARE PROGRAM: SALTA, LA PAMPA, AND CÓRDOBA
(AR-0120)
Procurement Table

rocurement items for the project	Financing (US$000)			Procurement method	Prequalification	Special Procurement Notice publicat		
	IDB	Local	Total			Year	Press	
							Intern.	Loca
al component	**5,500**	**2,510**	**8,010**					
lth-worker training and ignment	2,600	400	3,000					
ign of provincial PHC plans nsultants)	600	400	1,000	ICB	Yes	2000	Yes	Yes
gn of profiles for PHC profess. nsultants)	500	-	500	ICB	Yes	2000	Yes	Yes
tific. & recertific. systems nsultants)	1,500	-	1500	ICB	Yes	2000	Yes	Yes
rmation systems	800	650	1,450					
gnosis/survey/development nsultants)	200	150	350	ICB	Yes	1999/2000	Yes	Yes
dware and software	600	500	1,100	ICB	Yes	2000	Yes	Yes
lic information	400	300	700					
thodology - Publicity (consultants)	300	-	300	ICB	Yes	1999	Yes	Yes
thodology - Rules and procedures nsultants)	-	200	200	ICB	Yes	2000	Yes	Yes
thodology - Eval./monitoring nsultants)	100	100	200	ICB	Yes	2000		
itution-strengthening	200	160	360					
posed structural changes nsultants)	200	160	360	ICB	Yes	2000/2001	Yes	Yes
vincial project preparation	1,500	1,000	2,500			2000/2001/ 2002	Yes	Yes
ing services for project tion	1,500	1,000	2,500	ICB	Yes			

eform, province of Salta	**5,480**	**3,920**	**9,400**					
itution-strengthening	600	600	1,000					
nagement systems (consultants)	600	400	1,000	ICB	Yes	2000/2001	Yes	Yes
lic information	2,400	1,600	4,000					
licity campaigns (services)	2,400	1,600	4,000	ICB	Yes	1999-2004	Yes	Yes
rmation systems	2,480	1,920	4,400					
dware and software	2,000	1,600	3,600	ICB	Yes	2000-2004	Yes	Yes
abases	480	320	800	ICB	Yes	2000-2004	Yes	Yes
L	10,980	6,430	17,410					

Bid calls for the La Pampa and Córdoba projects will be arranged as each of those provincial projects is prepared.
nternational competitive bidding

PROPOSED RESOLUTION

ARGENTINA. LOAN /OC-AR. NACION ARGENTINA
PRIMARY HEALTH CARE REFORM: SALTA, LA PAMPA AND CORDOBA

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Nación Argentina, as Borrower, to grant it a financing to cooperate in the execution of a Primary Health Care Reform: Salta, La Pampa and Córdoba. Such financing will be for the amount of up to one hundred million dollars of the United States of America (US$100,000,000) from the Single Currency Facility of the Ordinary Capital resources of the Bank and will be subject to the "Financial Terms and Conditions" and the "Special Contractual Conditions" of the Executive Summary of the Loan Proposal.