SIMULTANEOUS DISCLOSURE

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

ARGENTINA

MULTIPHASE PRIMARY HEALTH CARE PROGRAM FOR MANAGING CHRONIC NON-COMMUNICABLE DISEASES FIRST OPERATION

(AR-L1142)

LOAN PROPOSAL

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ELECTRONIC LINKS

REQUIRED

1. AWP (Plan of activities for the first disbursement and the first 18 months of implementation)
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37028653
2. Monitoring and Evaluation Arrangements
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37027799
3. Complete Procurement Plan
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37033750

OPTIONAL

1. Economic Analysis
   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37027787
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   http://idbdocs.iadb.org/wsdocs/getDocument.aspx?DOCNUM=37027909

ABBREVIATIONS

AWP	Annual work plan
CNCDs	Chronic Non-communicable Diseases
COFESA	Consejo Federal de Salud [Federal Health Council]
FEAPS	Fortalecimiento de la Estrategia de Atención Primaria de la Salud [Program to Strengthen the Primary Health Care Strategy]
LIBOR	London Interbank Offered Rate
MINSAL	Argentine Ministry of Health
OR	Operating Regulations
PHCCs	Primary Health Care Centers
PJI	Proyecto Jurisdiccional de Inversión [Jurisdictional Investment Project]
RITA	Registro Institucional de Tumores de Argentina [Institutional Tumor Registry of Argentina]
SITAM	Sistema de Información de Tamizaje [Screening Information System]
TCR	Total cardiovascular risk
UFI-S	Unidad de Financiamiento Internacional del MINSAL [International Financing Unit of MINSAL]
WAL	Weighted average life
WHO	World Health Organization

PROJECT SUMMARY

ARGENTINA
MULTIPHASE PRIMARY HEALTH CARE PROGRAM FOR MANAGING CHRONIC NON-COMMUNICABLE DISEASES
FIRST OPERATION
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<table>
<tr><th colspan="5">Financial Terms and Conditions</th></tr>
<tr><td colspan="3" rowspan="4">Borrower: Argentine Republic

Executing agency: Argentine Ministry of Health</td><td colspan="2">Flexible Financing Facility*</td></tr>
<tr><td>Amortization period:</td><td>25 years</td></tr>
<tr><td>Original WAL:</td><td>14.75 years</td></tr>
<tr><td>Disbursement period:</td><td>42 months</td></tr>
<tr><td rowspan="2">Source</td><td colspan="2">Amount (millions of US$)</td><td>Rate:</td><td>LIBOR</td></tr>
<tr><td>PHASE I</td><td>PHASE II</td><td>Grace period:[1]</td><td>54 months</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>150</td><td>200</td><td>Inspection and supervision fee:</td><td>**</td></tr>
<tr><td>Local</td><td>50</td><td>100</td><td>Credit fee:</td><td>**</td></tr>
<tr><td>Total</td><td>200</td><td>300</td><td>Approval currency:</td><td>U.S. dollars from the Bank’s Ordinary Capital</td></tr>
<tr><th colspan="5">Project at a Glance</th></tr>
<tr><td colspan="5">Project objective: The general purpose of the project is to promote a care model for patients with chronic diseases using a primary care approach and operating integrated service networks. With an emphasis on the uninsured population, the project specifically proposes to: (i) continue the prioritization process at the primary care level; (ii) increase the population’s access to screenings so they can be classified according to health risk; and (iii) increase the percentage of the population with health risks continuously served by the health system (para.1.15).</td></tr>
<tr><td colspan="5">Conditions precedent to the first disbursement: (i) Operating Regulations are in effect under the terms previously agreed to with the Bank; and (ii) a ministerial resolution has been issued forming the Technical Unit and authorizing the executing unit for the Remediar+Redes Program (loan 1903/OC-AR) to be part of the Technical Unit (para. 3.5). Special execution conditions: The borrower, through the executing agency and in accordance with the terms established in the Operating Regulations, must demonstrate that: (i) the framework agreement between the Argentine Ministry of Health (MINSAL) and the respective jurisdiction has been signed before beginning expansion of Jurisdictional Investment Projects (para.1.35); (ii) the framework agreement between MINSAL and the respective jurisdiction has been signed prior to beginning execution of the pilot projects for developing diagnostic units and health care units for detection of colorectal cancer (para.1.38); and (iii) the framework agreement with the respective hospitals has been signed prior to beginning the process of expanding Argentina’s Institutional Tumor Registry (RITA) and the Screening Information System (SITAM) (para.1.44).</td></tr>
<tr><td colspan="5">Exceptions to Bank policies: None.</td></tr>
<tr><td colspan="5">Project consistent with country strategy: Yes [X] No [ ]</td></tr>
<tr><td colspan="5">Project qualifies as: SEQ [X] PTI [X] Sector [X] Geographic [ ] Headcount [ ]</td></tr>
</table>

* Under the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes in the amortization schedule as well as currency and interest rate conversion, always subject to the final repayment date and the original weighted average life (WAL). In considering those requests, the Bank will take market conditions and operational and risk management considerations into account.

** The credit fee and inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank’s lending charges, in accordance with the applicable policies. In no case may the credit fee exceed, in a given six-month period, 0.75% or the inspection and supervision fee exceed, in a given six-month period, the amount that would result from applying 1% to the loan amount divided by the number of six-month periods included in the original disbursement period.

[1] Date after which the borrower must pay the first amortization installment.

I. DESCRIPTION AND RESULTS MONITORING

A. Impact and risk factors of chronic non-communicable diseases

1.1 In nearly all countries in the world—and certainly in Latin America and the Caribbean—chronic diseases are the leading cause in the burden of disease.[1] In 2008 they were responsible for 62% of deaths worldwide, with 80% of these occurring in medium- and low-income countries.[2] For Latin America and the Caribbean, these indicators were 68% and 60%, respectively. The health impact of chronic diseases is primarily from non-communicable conditions (chronic non-communicable diseases—CNCDs), such as cardiac disease, cerebrovascular accidents, cancer, diabetes, and chronic respiratory diseases.

1.2 Chronic diseases inflict substantial financial costs, particularly for the low-income population. On the one hand, they hinder economic growth by reducing the labor supply, in that a significant portion of the burden of disease falls on the economically active population.[3] In addition, these diseases generate considerable fiscal costs in terms of both direct medical costs and loss of tax revenues.[4] On the other, they have a greater financial impact on the poor, who are usually more exposed to predisposing factors and have less access to health services.[5]

1.3 Most CNCDs share risk factors, four of which stand out: smoking, an unhealthy diet, a sedentary lifestyle, and harmful use of alcohol. These behaviors are associated with physiological and metabolic changes such as high blood pressure, overweight and obesity, hyperglycemia, and hyperlipidaemia, which are directly related to the development of CNCDs.[6] At the same time, there is strong evidence of the relationship between social determinants, particularly educational and income levels, and the prevalence of CNCDs.

1.4 As in the rest of the world, CNCDs are one of Argentina's principal health challenges. Cardiovascular diseases and tumors alone caused 46% of the deaths and 29% of the years of healthy life lost in 2009 in the population under 70.[7] Although CNCDs are more prevalent in urban centers and more developed areas, they are also the main cause of death in the country's poorest regions (Northeast and

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1 Burden of disease: Impact of a health problem in health and financial terms, generally measured by indices combining mortality and disease.

2 World Health Organization (WHO) (2011). *"Global Status Report on Non-communicable Diseases."*

3 Abegunde, et al. (2007). *"The Burden and Costs of Chronic Diseases in Low and Middle-income Countries."*

4 Instituto de Efectividad Clínica y Sanitaria (2011). *"La enfermedad cardiovascular en Argentina: carga de enfermedad e impacto en las finanzas públicas"* [Cardiovascular Disease in Argentina Burden of Disease and Impact on Public Finances].

5 WHO (2011), op cit.

6 WHO (2009). *"Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks."*

7 "Vigilancia de Enfermedades No Transmisibles" [Surveillance of Non-communicable Diseases] (2012). Argentine Ministry of Health's Health Promotion and Non-communicable Disease Control Directorate.

Northwest), where they coexist with a high incidence of communicable, maternal, perinatal, and metabolic diseases.[8]

1.5 The 2005 and 2009 Risk Factors Surveys document risk factor behavior for CNCDs in Argentina. A notable achievement during this period was the reduction, albeit slight, in tobacco use (from 29.7% to 27.1%) and in exposure to second-hand smoke (52% to 40.4%). However, physical activity and food quality levels declined and other related risk factors increased. Obesity (18%) and overweight (35%) levels have become a serious public health challenge. In addition, 29% of the adult population suffered from high cholesterol, 9% from diabetes, and 35% from high blood pressure.[9] Risk factors in Argentina have a greater effect on the population with low educational and income levels. For example, while 54% and 40% of the population who did not complete primary and secondary school, respectively, reported having high blood pressure in 2009, only 26% of the population who completed secondary school reported having high blood pressure.

B. Policy options and challenges for preventing and treating CNCDs

1.6 The consensus is that the most significant reductions in morbidity and mortality due to CNCDs will be achieved through efforts to reduce the prevalence of their common factors. It is estimated that up to 80% of cardiac diseases, cerebrovascular accidents, and Type 2 diabetes cases are preventable.[10, 11] Achieving this means promoting healthy habits both on a mass level, through public health actions, and on an individual level, through family health services.

1.7 There are also evidence-based recommendations on how to treat those who already have or are at risk of developing a CNCD.[12, 13] These recommendations point to organizing a care model with a primary care focus through the operation of integrated health services networks. The primary care focus requires that low-tech and widely deployed services at the primary care level serve as the "gateway" to the health care system. To do this, they must attract the population seeking preventive[14] or curative care and resolve most medical visits at this level. This promotes the rational use of more specialized and costly medical personnel and makes timely, personalized, and continuous care feasible.

1.8 The operation of integrated health care services networks requires the alignment of medical practice at the various points in the health care process and comprehensive information on the individual all along the health care line. With this information,

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[8] Abriata and Barbieri (2010). "*Análisis de la situación de salud. Bases para el Plan Federal de Salud.*" [Health Situation Analysis. Foundations for the Federal Health Plan].

[9] The figures shown come from the 2009 Risk Factors Surveys, based on self-reporting.

[10] Ezzati, (2003). *"Estimates of Global Potential Health Gains from Reducing Multiple Major Risk Factors."*

[11] WHO (2008). "*Primary Health Care: Now More Than Ever."*

[12] Coleman, et al. (2009). *"Evidence on the Chronic Care Model in the New Millennium."*

[13] WHO (2012). *"Improving Chronic Illness Care through Integrated Health Services Delivery Networks."*

[14] Meaning directed to timely detection of health risks or problems and promotion of self-care.

population- or geography-based records can be developed to provide knowledge on the prevalence of diseases, their outcomes, and the effectiveness of different treatment options.

1.9 However, there are at least three obstacles to implementing these recommendations in Argentina. First, the country's health care system is highly fragmented, impeding the conduct of public health actions and the implementation of continuous health care lines. There are three coexisting health coverage subsystems—social works, private insurance, and public insurance—that overlap in terms of financing and the populations they serve and have different service guarantees. At the same time, although the national government is the guarantor of the population's health, the management and financing of public health services falls mainly to subnational governments. This multiplicity of managers, sources of financing, and subsystems creates regulatory gray areas that hamper the implementation of broad-based public health policies. They also make it difficult to move patients smoothly, comprehensively, and continuously along the health care lines according to their health condition.[15]

1.10 Secondly, a curative and specialized approach to the treatment of CNCDs predominates in the Argentine health system. This has fostered a disproportionate and passive routing of human and financial resources to more medically complex levels, to the detriment of primary care. This, in turn, reduces resolution capacity and hence demand for services at what should be the population's primary point of contact with the health care system. In addition, this emphasis on medical complexity has led to limited management capacity in the subnational entities in terms of preventive care for chronic diseases. In particular, most subnational entities do not have information systems on the care of such diseases with which to conduct epidemiological surveillance or evaluate health policies.[16]

1.11 Third, as in most countries in the region, a large part of the Argentine population, particularly those with lower income and education levels, does not usually have preventive health care checkups to identify their risk level in a timely manner. To some extent, this is because health services are perceived as being low-quality, but also because there are information gaps among the population about the risk factors for CNCDs, because these diseases initially develop asymptomatically, and because preventive services usually lack the flexibility to effectively serve the population with work-related limitations.[17]

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[15] CIPPEC (2011). "Retos del sistema de salud argentino para el próximo gobierno" [Challenges of the Argentine Health System for the Next Government].

[16] MINSAL (2010). "Enfermedades no Transmisible y Factores de Riesgo. Boletín de Vigilancia No. 2" [Non-communicable Diseases and Risk Factors. Surveillance Bulletin 2].

[17] In addition, the field of behavioral economics emphasizes the factor of "inconsistent preferences over time" for preventing CNCDs and seeking timely care. See, for example, Suhrcke, et al. (2006), *"Chronic Disease: an Economic Perspective."*

C. Argentina's strategy for preventing and treating CNCDs

1.12 The 2011-2016 Federal Health Plan led by the Argentine Ministry of Health (MINSAL) and approved—although it is not binding—by the Federal Health Council (COFESA) (made up of the jurisdictional Ministers of Health) presents the long-term vision for the sector in Argentina. The plan establishes health and management goals to be achieved by the country by 2016.

1.13 The Federal Health Plan sets out three strategies for guiding national and provincial plans and programs. They are to: (i) regionalize and strengthen the resolution capacity of health care networks; (ii) prioritize interventions to prevent and minimize the health problems that are responsible for the main causes of death and prevalent diseases; and (iii) promote coordination across sectors to address the social determinants of health.

1.14 Consistent with the Plan, in the area of CNCDs, MINSAL acts on the basis of three pillars: (i) population-level public health strategies that seek to reduce the prevalence of risk factors; (ii) epidemiological surveillance of these factors and their consequences in order to determine the effectiveness of public policies; and (iii) federal programs designed to promote changes in the jurisdictions' approach to managing CNCDs.

D. Objectives, project rationale, and alignment with the country strategy

1.15 This document presents the first of two operations under an investment loan for a multiphase program (document GN-2085-2) designed to help reach the Federal Health Plan's target on reducing morbidity and mortality due to CNCDs. At the federal level, both operations will promote the model of care for patients with chronic diseases based on a primary care approach and the operation of integrated health care services networks as described in paragraphs 1.7 and 1.8. Emphasizing the uninsured population, both operations propose to: (i) continue the process of prioritizing the primary care level; (ii) increase the population's access to screenings so they can be classified according to their health risk; and (iii) increase the percentage of the population with health risks who receive ongoing care through the health system. The first operation will focus on the population with cardiovascular risk while, as a result of the evaluations of this first operation, the second operation could extend to the population that is socially vulnerable and thus at a higher risk of not receiving a timely diagnosis of neoplasias for which there is evidence that early detection substantially increases the likelihood of being cured.

1.16 This project is based on operational developments and lessons learned to date from execution of the Program to Strengthen the Primary Health Care Strategy (FEAPS) (loan 1903/OC-AR). Discussed below are: (i) the main components of the FEAPS and its current status; (ii) results and lessons learned from that project; and (iii) the value added of the present operation compared to that of the FEAPS.

1.17 Approved in 2007, the FEAPS proposed to strengthen the networked operations of the subnational health services as part of the Primary Health Care Strategy. With

US$287.5 million in financing (US$230 million from the Bank) and the April 2014 original date for the final disbursement, the project has two main components: (i) the Redes Program; and (ii) the Remediar Program.

1. Expansion of the Redes Program

1.18 The Redes Program (hereinafter "Redes") proposes to change the approach that the country's health jurisdictions use to manage the health of their populations. It specifically aims to promote a model of care that integrates health care services along health care lines, starting with the active classification of the at-risk population and monitoring of the population at highest risk using specific treatment schemes. Based on the complexity of care and prevalence, the program uses high blood pressure and Type 2 diabetes as tracers of the provider networks that make up the health care lines.

1.19 The jurisdictional health ministries that voluntarily join Redes are eligible to receive financing for a 36-month Jurisdictional Investment Project (PJI) so they can purchase goods or services to strengthen the networked operation of their providers, within a territory that initially covers 30% of the jurisdiction's population. PJIs are financed on a capitated basis in order to incentivize the following health actions: (i) registration of the population without health insurance coverage and preliminary identification of their total cardiovascular risk (TCR);[18] (ii) clinical classification of the population with medium or high TCR according to the preliminary screening; and (iii) monitoring of patients with clinically determined high or medium TCR based on pre-determined treatment schemes. A medical audit externally verifies the fulfillment of these actions.

1.20 To date, Redes has helped establish tracking of the chronic disease epidemic as a health priority in most of the country's jurisdictions. It is estimated that by the end of 2012 the FEAPS target of at least 18 of the 24 jurisdictions having an approved PJI will have been met. In addition, the execution of this first Redes phase has yielded important lessons on the challenges involved in refocusing the management of CNCDs in the jurisdictions. For example, the predominantly maternal-child approach that forms the basis for health services operations within the jurisdictions results in serious operational limitations on proactively caring for nontraditional populations such as the economically active male population. In addition, reorganizing the health care approach of local health care services requires management capacity on the part of the jurisdictional health ministries, a capacity that is incipient in most cases. Moreover, the sustainability of the health care model promoted by Redes and its ready expansion requires the development or consolidation of jurisdictional information systems that reduce the administrative burden on the services and allow the strategic programming of actions, as well as their monitoring and evaluation. Lastly, in light of recently available information

[18] The concept of TCR is based on the recognition that there are common risk factors in different pathologies and comorbidities. It is defined as the probability that an individual will contract a cardiovascular disease in the next 10 years, based on the number of risk factors or taking into account the magnitude of each factor.

and updated international evidence for developing countries, it became obvious that the incentive scheme originally proposed by Redes was too demanding for the jurisdictions, regardless of their management capacity, leading to a vicious circle between slow financing of the PJIs and the performance of actions necessary to reach the agreed upon targets.

1.21 Based on these lessons, these operations propose to consolidate and expand the model of care promoted by Redes. Specifically, these operations will make it possible to strengthen jurisdictional management capacities through: (i) the strengthening of technical teams under the line structure of their health ministries; (ii) an on-site monitoring scheme led by MINSAL and focused in particular on operational aspects; (iii) training for health teams on critical primary health care issues and network management, informed by the operational monitoring of MINSAL; and (iv) development or consolidation of jurisdictional information systems for monitoring health care delivery to registered persons.

1.22 In addition, incentives will be developed for achieving the targets of the first phase of Redes and gradually expanding it. The incentives scheme for the expansion phase has been adjusted based on updated epidemiological and population projections directed not only to timely performance of health actions but also to the establishment of jurisdictional systems for the management of networked services such as referrals and counter-referrals and shift scheduling. The updated incentives scheme also gives greater weight to the model's most demanding challenge: continuous and ongoing monitoring of patients with high TCR, in fulfillment of health care standards. In particular, the proposed scheme will seek to incentivize the jurisdictions to continue caring for that population. Consistent with this new scheme, the scheme originally proposed by the FEAPS has been updated.

1.23 It should be noted that the technical cooperation operation on "Analytic Support for Integrated Management of Cardiovascular Diseases" (ATN/OC-13313-AR) was recently approved. It will, *inter alia*, make it possible to evaluate adjustments in the current organization of primary care services and unconventional strategies for reaching the male population in the most effective way.

1.24 The operations proposed herein will also make it possible to eventually expand the scope of Redes to include a group of neoplasias that have a major impact on the burden of disease, about which there is a knowledge gap in terms of how to detect them and ensure appropriate care. Parallel to other MINSAL initiatives for cancers, the timely detection of which substantially increases the likelihood of being cured (breast cancer and cervical and uterine cancers), this operation will facilitate the development and eventual expansion of an operational model for timely detection and appropriate treatment of colorectal cancer. Additionally, it will support the expansion of systems for characterizing neoplasias and monitoring their care, in accordance with pre-established parameters.

2. Consolidation of the Remediar Program as a tool for managing CNCDs

1.25 The Remediar Program (hereinafter "Remediar") seeks to increase resolution capacity at the primary care level, providing it with essential medicines to be dispensed free of charge. The medicines that currently make up the "Remediar Kit" allow the program to address more than 80% of the conditions for which patients seek primary care. They were selected with support from a committee of experts and national and international organizations, were approved by COFESA, and were most recently revised in 2010.[19] In the context of executing the FEAPS, all the financing resources for Remediar are already committed.

1.26 Through a centralized process for purchasing and direct distribution of medicines to nearly all of the country's Primary Health Care Centers (PHCCs), Remediar has helped to prioritize primary care in Argentina, significantly increasing the percentage of health care visits at that level. It has also achieved a savings of 80% on the cost of medicines, using as a reference the average cost in pharmacies.[20] In addition, the program has shown significant redistributive effects. About 75% of those who receive free medicines do not have health insurance and more than 68% of their households are in the first three income deciles.[21] Some evaluations indicate that Remediar has a positive impact on the available income of these households and reduces the impoverishing effects of disease events.[22, 23] At the same time, preliminary results indicate that Remediar has a significant health effect on prevention and the burden of disease from cardiovascular events in the population ages 40 to 64.[24]

1.27 In addition to helping to maintain the prioritization of primary care under a scheme of financing that decreases over time, the operations presented here will seek to make Remediar a key tool for comprehensive, continuous management of CNCDs. Both operations will finance the building of pharmacological management capacities at the jurisdictional level so that management can be decentralized, seeking to increase efficiency and control. In addition, the first operation will begin a process to computerize the dispensing of medicines, allowing higher level PHCC staff to perform proactive pharmacological monitoring of the population in their charge. The second operation will finance the expansion of this process. The first

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[19] In the context of this operation, a revision will be carried out in 2014 following the Health Prioritization approach.

[20] Remediar's essential medicines are purchased through international competitive bidding by front-line laboratories with quality guarantees at the generic name level.

[21] MINSAL's Directorate of Health Economics based on the 2011 Ongoing Household Survey.

[22] Apella, I. (2009). "Gasto de bolsillo en salud e impacto financiero sobre los adultos mayores en Argentina." [Out-of-pocket Health Expenses and Financial Impact on Older Adults in Argentina]. Annals of the Argentine Economic Policy Association.

[23] Maceira and Reynoso (2010). "Gasto financieramente catastrófico y empobrecedor en salud. Argentina 1997-2005" [Financially Catastrophic and Impoverishing Health Expenditure. Argentina 1997-2005].

[24] Health and Clinical Effectiveness Institute (IECS) (2012). "Impacto sanitario de Remediar" [Health Impact of Remediar]. Draft. Consult electronic link on Economic Analysis of the operation for more details.

operation will also finance, in a pilot phase, the distribution of new medicines for cholesterol reduction and second-line control of hypertension, eventually extending to the entire country in the subsequent operation. These medications are cost-effective[25] when prescribed correctly, which is the reason for their initial distribution in a pilot phase.

3. Economic analysis and alignment with Bank strategies

1.28 As discussed earlier and expanded upon in the Economic Analysis link, the strategies promoted with this operation are based on evidence regarding the effectiveness of both the Primary Health Care scheme and the Model of Care for Chronic Diseases through Integrated Health Services Networks. That link also extends the discussion on evidence specific to Argentina regarding the effectiveness of the pharmacological interventions financed in this operation, including a model simulating the joint impacts of the Remediar and Redes Programs based on the introduction of new medicines.

1.29 This operation will help to achieve the objectives of the country strategy and other Bank strategies. It is consistent with the objective of modernizing the management, monitoring, and evaluation mechanisms for social programs in the Country Strategy Update (document GN-2570). In addition, it is included in the 2012 Operational Program Report (document GN-2661-4). It is also in line with the sectoral priority of promoting social policies to foster equality and productivity and the priority objective of financing poverty reduction and equity enhancement operations under the Ninth General Increase in the Resources of the IDB (GCI-9, document AB-2764), focusing on the low-income population in Argentina, with an expected positive impact on that population's number of years of healthy life. The operation will contribute in particular to achieving the GCI-9 objective of increasing access to a basic (explicit) package of health care services.

E. Components and costs of the operation

1.30 This first operation has three components. The link for the Agenda of Studies and Evaluations describes the analytic work the program will finance, the cost of which has been assigned to the components.

1.31 **Component 1: Expansion of Redes (US$43 million)**. The objective of this component is to help ensure that the management of CNCDs is strengthened within the jurisdictions and that formal service and health care networks are developed and consolidated. The component will finance the expansion of the PJIs based on health activities and milestones, which may be consulted at the electronic link for Operating Guidelines, the accomplishment of which will be certified by an external medical audit paid for with program funds.

1.32 Jurisdictions that, based on their original PJIs, achieve 60% and 30% of the registration and classification targets, respectively, will be able to proceed with a

[25] *Global Status Report*, op cit. (2010).

second 18-month phase, with financing from the first operation of this project. During this period, the aforementioned jurisdictions will: (i) continue to receive reimbursements for meeting their remaining original classification and monitoring targets; (ii) have financing to extend the Redes population base from 30% to 40% of the population; and (iii) receive continued financing for monitoring chronic patients both from the original project and those identified in this Redes expansion phase.

1.33 Jurisdictions that do not meet those targets upon completion of the first stage of the PJI, but that are interested in moving on to a second phase, will not receive financial recognition for the equivalent of the population enrolled and classified in the first phase of Redes, but: (i) they can continue to receive financing for monitoring the chronic patients identified, both in the original stage and second stage of Redes; and (ii) they will receive financial recognition for the equivalent of the registration and classification targets for the additional 10% of the population in the jurisdiction.

1.34 Those jurisdictions that upon completion of the 18 months in their second phase reach 90% and 60% of their registration and classification targets, respectively, with a population base of 40%, would be eligible to proceed with a third 18-month phase, possibly with financing from the second operation. During this period, they would: (i) continue to receive disbursements for meeting their remaining classification and monitoring targets from the previous phases; (ii) have financing to extend the Redes population base to 60% of the population; and (iii) receive continued financing for monitoring chronic patients both from the earlier phases and those identified in the second Redes expansion phase.

1.35 As a special condition for execution, the borrower, through the executing agency, must show, prior to expansion of the PJIs mentioned above, that a framework agreement has been signed between MINSAL and the respective jurisdiction, according to the terms and conditions established in the Operating Regulations (OR).

1.36 In addition, the component will finance training for officials in the jurisdictional health ministries and PHCC health personnel on subjects related to primary health care or the development of services networks. It will also finance MINSAL technical teams that will provide "enabling supervision" to the jurisdiction.

1.37 Lastly, the component will finance the implementation and evaluation in two provinces of a pilot program to develop diagnostic units and integrate care and services networks for detecting colorectal cancer. Training for health care providers, the purchase of detection kits, and equipment for performing colonoscopies will be eligible for financing.

1.38 As a special condition for execution, the borrower, through the executing agency, must show, prior to beginning execution of the pilot projects mentioned in the preceding paragraph, that a framework agreement has been signed between

MINSAL and the respective jurisdiction, according to the terms and conditions established in the OR.

1.39 **Component 2: Provision of strategic services (US$141 million)**. The objective of this component is to promote rational access to essential medicines for medical visits at the primary care level, guaranteeing in particular care for and pharmacological monitoring of patients with moderate or high TCR. The component will finance the purchase of essential medicines included in the vade mecum approved by the Bank and the services of the Remediar logistics operator. The vade mecum will include statins and Amlodipine, to be distributed exclusively in PHCCs covered by the Redes medical audit.

1.40 The component will finance consulting services for developing an action plan for certifying key Remediar operating procedures based on the ISO 9000 standard and facilitating implementation of the National Medications, Food, and Medical Technology Administration (ANMAT) regulations on the traceability of medicines. It will also finance minor construction and basic equipment for medicines management units in order to comply with good storage practices.

1.41 In addition, the component will finance consulting services to train health staff on the rational use of medicines, rational primary care treatment, and the handling of medicines.

1.42 **Component 3: Consolidation of public health information systems (US$7 million)**. The objective of this component is to facilitate information analysis to improve health and administrative management at the provider, jurisdiction, and national government levels. The component will finance a registry of all PHCCs in the country in order to identify their capacity to provide care and computerize their processes; the implementation of technological solutions for computerizing and integrating the processes implemented in at least one thousand PHCCs, particularly for recording the prescribing and dispensing of medicines (including developing a module for monitoring chronic patients based on the dispensing of medicines by Remediar); and registration, classification, and monitoring procedures.

1.43 The component will also finance computer equipment, scanning services, and health personnel training for consolidation of two information systems for neoplastic pathology. The Institutional Tumor Registry of Argentina (RITA) examines cases diagnosed or treated in hospitals in terms of demographic characteristics, description of the tumor, description of treatments administered, and events that occurred. RITA is now being pilot tested in two hospitals. With financing from this operation, it will be expanded to cover 12 hospitals treating 30% of neoplastic pathologies. The Screening Information System (SITAM) allows for recording the profile of results in neoplastic screening services and monitoring their performance in terms of service quality. It is now being used in hospitals in the five provinces with the highest mortality due to cervical and uterine cancer.

Through this operation, SITAM will be expanded to include hospitals in 12 provinces.

1.44 As a special condition for execution, the borrower, through the executing agency, must show, prior to beginning the process of expanding RITA and SITAM as noted in the preceding paragraph, that a framework agreement has been signed with the respective hospitals, according to the terms and conditions established in the OR.

1.45 Table I-1 shows a breakdown of the costs of the operation by component and source of financing. The source of financing ratio approved for Remediar in the FEAPS was 80% from IDB financing and 20% from local contributions. For this first operation, this ratio will be reduced to 65% and 35%, respectively, and later reductions in the percentages are envisaged for the second operation.

Table I-1 Summary of Program Costs (thousands of US$)

Component	IDB	Local	Total
Component 1	43,000		43,000
Component 2	91,000	50,000	141,000
Component 3	7,000		7,000
Administration	6,500		6,500
Fees	500		500
Contingencies	2,000		2,000
Total	**150,000**	**50,000**	**200,000**

F. Outcome indicators and milestones triggering the second operation

1.46 The operation's impact indicators are related to morbidity and mortality due to CNCDs: age-adjusted mortality rate due to CNCDs; and years of life lost due to disability or premature death caused by CNCDs. The outcome indicators measure progress made in implementing the Model of Care for Chronic Diseases through Integrated Health Services Networks. In this respect, the operation monitors people without health insurance coverage classified according to TCR, the percentage of these who are male (as they have a higher risk and it is a challenge to reach them at the primary care level), and persons classified with high or medium TCR who are monitored according to the medical care guidelines. Notable intermediate outcome indicators include the percentage of uninsured persons who receive free medicines when they are prescribed for them (which is an approximation of the contribution to increasing the resolution capacity of PHCCs), the registered population (measure of networks' effectiveness), and the capacity of information systems to generate health information to facilitate planning and decision-making.

1.47 To trigger the second operation of the program, at the end of the first operation, the executing agency must submit, to the Bank's satisfaction, evidence that it has met

the following triggers: (i) at least 50% of the financing was disbursed or 75% was committed; (ii) the action plan for certification of critical Remediar processes was approved at the ministerial level; (iii) at least 15 provinces successfully registered 80% and classified 40% of the Redes target population, with a provincial population base of 30%; (iv) the priority evaluations indicated in the Agenda of Studies and Evaluations were completed; and (v) at least 400 PHCCs are able to transfer nominal information on the dispensing of medications and/or monitoring of patients to the MINSAL systems.

II. FINANCIAL STRUCTURE AND RISKS

A. Financing instrument and executing agency

2.1 This is the first in a series of two operations to be financed in two phases of a multiphase investment loan totaling US$500 million. Financing for the first operation will amount to US$150 million, with a local counterpart contribution of US$50 million. Contingent upon achievement of the triggers for the second operation, this instrument would make it possible to continue and quickly expand the scope of the first operation, while at the same time allowing the maturation of technical and operational lessons learned so as to consolidate the design of planned interventions.

2.2 MINSAL will be the executing agency on behalf of the national government. It will exercise this function through the Secretariat of Health Promotion and Programs (SPPS) in its capacity as the National Project Directorate and the Director will be responsible for general coordination. The Technical Unit and the International Financing Unit of MINSAL (UFI-S) will report to this Secretariat. The Technical Unit will be responsible for health actions and technical evaluations of the operation and will consist of: (i) the current executing unit for the Remediar+Redes Program; (ii) the Directorate for Health Promotion and Control of Non-Communicable Diseases; and (iii) the National Cancer Institute. The UFI-S will be responsible for fiduciary aspects and administrative and financial management. The OR will specify the basic functions of the UFI-S and the Technical Unit.

B. Program risks

2.3 This has been classified as a category "C" operation. The project team will ensure compliance with the Environment and Safeguards Compliance Policy (OP-703) and the Indigenous Peoples Policy (OP-765) during program design and execution.

2.4 The IDB Project Risk Management methodology was used to analyze the operation's risks. Fiduciary risks were identified, and the Risk Mitigation Matrix was developed. Fiduciary risk was determined to be medium, and only one case involving delays in accounting for expenses incurred by the jurisdictions was classified as high. To mitigate this risk, provisions were made to strengthen the central and jurisdictional teams in the area of fiduciary management, centralize

purchasing whenever possible, and monitor the level of expenses committed in the provinces compared to planned expenses.

2.5 The two principal nonfiduciary risks identified and the respective mitigation measures are presented below. First, as mentioned above, experience with Redes showed that the provinces have significant deficiencies in health management, requiring timely implementation of the PJIs; these deficiencies could delay implementation if they continue. Actions for mitigating this risk have been described throughout this document. Second, incomplete or untimely inputting to program-financed information systems by administrative and health personnel was identified as a risk. To mitigate this risk, provision was made for monitoring and temporary financing of scanners, so that the very availability of the information may lead providers to gradually adopt the system. In turn, MINSAL will evaluate the possibility of introducing an incentives system, using resources from other current programs intended to promote improvements in management.

III. IMPLEMENTATION AND ACTION PLAN

A. Arrangements for implementation

3.1 The executing agency will be responsible for implementing the components of this operation. To carry out Component 1 at the local level, the jurisdictions will form Jurisdictional Management Units, the basic characteristics, functions, and duties of which will be established in the framework agreements to be signed by MINSAL and the respective jurisdiction and in the OR. These units should be coordinated by a line organization official from the jurisdictional ministries, with the assistance of up to five consultants paid for with operation funds (medicines management, primary health care, information systems, and up to two persons in administrative functions).

3.2 The executing agency will be responsible for implementing the Program Monitoring and Evaluation Plan, as described in the link on Monitoring and Evaluation.

3.3 Annex III presents the fiduciary arrangements for execution in terms of disbursement methods, financial administration and procurement systems, and auditing arrangements. Both the procurement of works and goods and the contracting of consultants, charged against the operation's financing, will be in accordance with the Bank's policies and procedures as established in documents GN-2349-9 and GN-2350-9, respectively.

3.4 For the execution of Component 1, the eligibility of expenditures of up to 50% of the provincial projects' amount will be verified through a medical audit[26] and a capitated reimbursement will be considered for registration, classification, and monitoring actions carried out by the provinces in accordance with the provisions

[26] Firm specializing in the conduct of health services delivery audits. It will verify completion of registration, classification, and monitoring actions as well as the achievement of milestones reported by jurisdictions.

of the OR. For the remaining 50%, the accounting of expenditures charged against program financing should verify the eligibility of expenditures incurred by the provinces and the procurement procedures they used, in addition to verification through the medical audit of the milestones achieved.

3.5 **Conditions precedent to the first disbursement: (i) the OR are in effect in accordance with terms previously agreed to with the Bank; and (ii) a ministerial resolution has been issued forming the Technical Unit and authorizing the executing unit of the Remediar+Redes Program (loan 1903/OC-AR) to be part of that Technical Unit.**

B. Monitoring and evaluation arrangements

3.6 Every six months the executing agency will submit reports with information on: (i) performance in achieving the objectives and results agreed to in each annual work plan (AWP) and in the Program Monitoring Report (PMR), including the analysis and monitoring of risks affecting them and mitigation measures; (ii) the execution status and status of the procurement plan; (iii) compliance with contractual conditions; and (iv) the financial execution status of the program budget. In addition, the second half-yearly report in each calendar year will include: (i) the AWP for the following year; (ii) the updated procurement plan; and (iii) actions planned for implementing the recommendations from the external audit, as applicable.

C. Key design issues after approval of the operation

3.7 Execution of the Monitoring and Evaluation Plan will make it possible to continuously identify options for improving the targets and incentives scheme for financing the provincial projects. These options include: (i) make differential payments for the registration, classification, and monitoring of males, given the operational difficulties in reaching that group; (ii) focus Redes actions on the age groups where TCR is concentrated; and (iii) expand the focus of Redes to the entire population and not just the uninsured, since a percentage of the insured population uses the public subsystem. Possible changes in the targets and incentives scheme must be based on empirical evidence and approved through an administrative mission and reflected in the OR.

Development Effectiveness Matrix			
Summary			
I. Strategic Alignment			
1. IDB Strategic Development Objectives	Aligned		
Lending Program	i) Lending for poverty reduction and equity enhancement.		
Regional Development Goals			
Bank Output Contribution (as defined in Results Framework of IDB-9)	i) Individuals receiving a basic package of health services, and ii) Municipal or other sub-national governments supported.		
2. Country Strategy Development Objectives	Aligned		
Country Strategy Results Matrix	GN-2328-3	Improve health services coverage and quality for the poorest populations.	
Country Program Results Matrix	GN-2661-4	The operation is included in the 2012 Country Program Document.	
Relevance of this project to country development challenges (If not aligned to country strategy or country program)			
II. Development Outcomes - Evaluability	Highly Evaluable	Weight	Maximum Score
	9.9		10
3. Evidence-based Assessment & Solution	9.6	25%	10
4. Ex ante Economic Analysis	10.0	25%	10
5. Monitoring and Evaluation	10.0	25%	10
6. Risks & Mitigation Monitoring Matrix	10.0	25%	10
Overall risks rate = magnitude of risks*likelihood	Medium		
Environmental & social risk classification	C		
III. IDB´s Role - Additionality			
The project relies on the use of country systems (VPC/PDP criteria)	Yes	Financial management: accounting and reporting; external control, and internal audit. Procurement : information system; shopping method, and use of some national sub-system for public bidding.	
The project uses another country system different from the ones above for implementing the program			
The IDB's involvement promotes improvements of the intended beneficiaries and/or public sector entity in the following dimensions:			
Gender Equality			
Labor			
Environment			
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	Tecnical cooperation number AR-T1087 was financed.	
The ex-post impact evaluation of the project will produce evidence to close knowledge gaps in the sector that were identified in the project document and/or in the evaluation plan.	Yes	Effectiveness of incentives to provinces to improve care for chronic diseases. Operational effectiveness of screening tests for colorectal cancer.	

The operation is the first project of a multiphase investment loan. It is a loan to the Government of the Republic of Argentina for $ 200 million, financed with funds from the Bank's Ordinary Capital ($ 150 million) and the local counterpart (U.S. $ 50 million). The project aims to promote treatment of chronic diseases with a focus on primary care and integrated health services.

The loan proposal presents a proper diagnosis. It identifies the prevalence of chronic diseases as the problem to be addressed by the project, and presents evidence that such diseases are the cause of a high proportion of deaths in the country. The document argues that different risk factors are associated with the problems identified. Specifically, it presents information on levels of smoking, sedentary lifestyle and obesity, as well as on negative health conditions caused by high cholesterol, diabetes and hypertension, to support this claim. The proposed policy options are clearly related to the problems identified in the diagnosis. The loan proposal cites evidence, both in the main document and its attachments, on the effectiveness of the primary care approach and the integrated health services, in improving health outcomes of the target population. The document also describes the challenges for the implementation of these interventions in the country, given the fragmentation and predominantly curative focus of the Argentine health system and the low proportion of the population that regularly attends preventive consultations.

The results matrix follows a solid vertical logic. Impacts, expected outcomes and outputs are clearly defined and the proposed indicators are SMART. The monitoring and evaluation mechanisms are properly planned and budgeted. The evaluation plan includes studies with experimental and quasi-experimental designs that will allow measuring the effectiveness of the proposed interventions in terms of health outcomes and access to services. An ex-ante cost-effectiveness analysis of the project was performed based on reasonable assumptions.

The risk matrix identifies and rates project risks. It proposes mitigation measures and includes indicators to monitor their implementation.

RESULTS MATRIX

Project objective: To help reduce morbidity and mortality related to chronic non-communicable diseases (CNCDs)	1. Reduce the mortality rate due to cardiovascular and cerebrovascular events from 213.6 per 100,000 inhabitants in 2007 to 180 per 100,000 inhabitants in 2016.[1]

Outcome indicators	Baseline (2013)[2]	Target, 1st operation (2015)	Target, 2nd operation (2017)
1. Persons with public coverage only (40-64) classified according to TCR	56,024	74,699	112,048
2. Males with public coverage only (40-64) classified according to TCR	26,976	35,968	53,952
3. Persons with high TCR closely monitored following the Health Ministry's medical care guidelines for TCR	14,006	18,675	28,012

[1] 2010-2016 Federal Health Plan target. The Argentine Ministry of Health's Directorate of Statistics and Information calculates this indicator annually based on hospital records from the entire country.

[2] The baseline calculation for the outcome indicators is a projection of the target to be met through the Program to Strengthen the Primary Health Care Strategy (loan 1903/OC-AR, AR-L1020).

Component 1: Provincial projects to strengthen the health services	Baseline	2013	2014	2015	Target	Comments
Outcomes Registered population over 6 with public coverage only.		1,685,012	1,023,553	1,820,418	4,528,983	Medical audit reports
Outputs						
1. Provincial "Redes 2" projects approved	0	0	5	10	15	Project records signed
2. Provinces executing provincial "Redes 2" projects	0	0	5	10	15	Reports from Redes Management
3. Team personnel and health staff trained	0	0	3,000	0	3,000	Report from executing agency
4. Evaluation report on colorectal cancer pilot completed.	0	0	1	1	1	Report from National Center Institute and presentation.
5. Quali-quantitative evaluation of the determinants of implementation and compliance with rules for evaluating TCR in primary care level providers finalized	0	0	1	0	1	Report from executing agency and presentation.
6. Evaluation of provincial case studies on innovative networks strategies finalized.	0	0	3	7	10	Report from executing agency and presentation.

Component 2: Provision of strategic services	Baseline	2013	2014	2015	Target	Comments
Intermediate outcome % of patients in Primary Health Care Centers (PHCCs) with public coverage only who were prescribed medicines provided free of charge.	88			95	95	Survey of PHCC patients financed by the operation.
Outputs						
1. Treatments with essential medicines distributed	0	30,866,880	31,000,000	31,000,000	92,866,880	Remediar administrative records (RAR) RAR
2. New treatments (statins and Amlodipine) distributed	0	0	33,750	67,500	101,250	RAR
3. Kits distributed	0	181,000	190,000	190,000	561,000	RAR and inspection visits
4. Units equipped for improved clinical management	0	0	544	816	1,360	MINSAL report
5. Report identifying critical processes needed to achieve certification of Remediar processes approved by MINSAL.	0	0	1	0	1	MINSAL report
6. Action plan to improve critical processes needed to achieve certification of Remediar processes approved by MINSAL.	0	0	0	1	1	RAR
7. Health personnel trained in rational use of medicines, rational treatment in primary health care, and medicines management.	0	1,300	2,700	0	5,000	RAR and presentations

8. Studies and evaluations finalized:						
a. Prioritization of the primary care level (demand, patients)	0	0	0	1	1	
b. Health impact of providing essential medicines	0	0	0	1	1	
c. Provincial survey of existing capacities, human resources, and service networks technologies available for primary care level	0	0	0	1	1	
d. Analysis of logistical operation processes used	0	0	0	1	1	
e. Provincial survey for improvement of joint planning	0	0	0	1	1	
f. Evaluation of Remediar vade mecum finalized	0	0	1	0	1	
9. External operational evaluation of Remediar	0	0	1	0	1	MINSAL report
Component 3: Consolidation of health information systems	**Baseline**	**2013**	**2014**	**2015**	**Target**	**Comments**
Intermediate outcomes						
PHCCs with capacity for reporting nominalized delivery of medicines dispensed and/or patient monitoring	0	0	400	350	750	Executing agency reports
% of patients input to Institutional Tumor Registry of Argentina (RITA)	0	10	0	15	25	

Reports on monitoring of patients with tumors issued by the Screening System (SITAM).	0	0	0	1	1	
Outputs						
1. Report on survey of PHCCs finalized.	0	1	0	0	1	
2. PHCCs computerized	0	0	400	600	1,000	
3. Hospitals reporting to RITA	2	0	12	0	12	
4. Provinces where hospitals have been incorporated in the SITAM	5	0	7	0	12	

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Argentina
Project number:	AR-L1142
Name:	Multiphase Primary Health Care Program for Managing Chronic Non-communicable Diseases
Executing agency:	Argentine Ministry of Health (MINSAL)
Fiduciary team:	Ignacio Vinocur (PDP/CAR), Gumersindo Velázquez (FMP/CAR), and Natalia Benasso (CSC/CAR)

I. EXECUTIVE SUMMARY

1. The Program Risk Management (PRM) methodology was used to evaluate fiduciary management. MINSAL will be the executing agency, exercising this function through the Secretariat of Health Promotion and Programs (SPPS), in its capacity as the National Project Directorate, and its Director will be responsible for general coordination. The Technical Unit and the International Financing Unit (UFI-S) of MINSAL will report to that Secretariat. The Technical Unit will be responsible for health actions and the technical evaluations of the operation and will consist of: (i) the current executing unit of the Remediar+Redes program; (ii) the Directorate for Health Promotion and Control of Non-communicable Diseases; and (iii) the National Cancer Institute. The UFI-S will be responsible for fiduciary aspects and for administrative and financial management. The Operating Regulations (OR) will specify the basic functions of the UFI-S and the Technical Unit. Both the SPPS and the UFI-S have experience in and installed capacity for executing Bank-financed loans.
2. Inherent weaknesses and fiduciary risks were identified based on the supervision of loans currently being executed by the executing agency. These elements were set out in the proposed supervision plan. Country fiduciary management systems were evaluated in the fiduciary note to the country strategy, while at the executing agency level they were evaluated using the procedures mentioned in Section I.1, the conclusion being that these systems were adequate but should be strengthened.
3. The program does not include financing from other multilateral organizations. There are sub-executing agencies, and the UFI-S will be responsible for consolidating the financial information.

II. FIDUCIARY CONTEXT OF THE EXECUTING AGENCY

The executing agency's fiduciary systems are considered satisfactory although they will require some strengthening measures that will be included in the risk mitigation matrix (RMM).

III. FIDUCIARY RISK EVALUATION AND MITIGATION MEASURES

The Bank's PRM methodology was used to analyze the program's fiduciary risks; it identified and rated fiduciary risks, and the program's RMM was prepared. The program's fiduciary risk was determined to be medium. However, individual risks were detected along with their respective mitigating actions. No high impact, irremediable risks were found that would impede the effective execution of the program.

IV. CONSIDERATIONS FOR THE SPECIAL CONDITIONS OF CONTRACTS

a. *Conditions precedent to the first disbursement:* The first disbursement of the loan is contingent on the borrower having met, through the executing agency and to the Bank's satisfaction, the following requirements:

   (i) The OR must be in effect in accordance with the terms previously agreed to with the Bank; and

   (ii) A ministerial resolution must have been issued creating the Technical Unit and authorizing the executing unit of the Remediar+Redes program (loan 1903/OC-AR) to be part of that Technical Unit.

b. *Special conditions for execution:* The borrower, through the executing agency, in accordance with the terms established in the OR, must show that:

   (i) The framework agreement between MINSAL and the respective jurisdiction has been signed prior to beginning expansion of the Jurisdictional Investment Projects;

   (ii) The framework agreement between MINSAL and the respective jurisdiction has been signed prior to beginning execution of the pilot projects for developing diagnostic units and health care networks for detecting colorectal cancer;

   (iii) The framework agreement between MINSAL and the respective hospitals has been signed prior to beginning the process of expanding the Institutional Tumor Registry and the Screening Information System.

The executing agency will submit annual financial statements for the project, audited by an independent auditing firm acceptable to the Bank based on the terms of reference (TOR) agreed to in advance with the Bank.

V. AGREEMENTS AND REQUIREMENTS FOR PROCUREMENT EXECUTION

1. Procurement execution

The March 2011 Policies for the procurement of goods and works financed by the Inter-American Development Bank (document GN-2349-9) and the Policies for the selection and contracting of consultants financed by the Inter-American Development Bank (document GN-2350-9) will be applied. In addition, the executing agency has agreed to use the Procurement Plan Execution System (SEPA) to administer and manage the program's procurement planning.

a. **Procurement of works, goods, and nonconsulting services:** Works, goods, and nonconsulting services contracts[1] under the program and subject to international competitive bidding (ICB) will be executed using the standard bidding documents (SBDs) issued by the Bank, both for goods in general and for medicines. Those subject to national competitive bidding (NCB) will be executed using national bidding documents agreed upon with the Bank. Review of the technical specifications for procurement while selection procedures are being prepared will be the responsibility of the program's sector specialist. The procurement plan to be submitted by the executing agency should identify the selection procedures for direct contracting.

b. For Component 1. Expansion of Redes, the objective of which is to help jurisdictions strengthen the management of CNCDs and develop and strengthen formal health services and care networks. Jurisdictional investment projects will be financed to help improve the networks' resolution capacity, with provision for equipment, systems, services, and improvements to their facilities as well as other measures. The eligibility of expenditures up to 50% of the amount of the provincial projects will be verified through a medical audit, and capitated reimbursement will be considered for registration, classification, and monitoring actions carried out by the provinces, in accordance with the OR. For the remaining 50%, accounting for expenses charged against program financing should verify the eligibility of expenses incurred by the provinces and the procurement processes they use, and verify achievement of the milestones by the medical audit. To do this, the jurisdictions will apply Bank policies as well as their local regulations for goods, works, and nonconsulting services for those purchases where the estimated budget is below the thresholds for national competitive bidding (according to subparagraph 2 of this document). This will be detailed in the project OR. Procurements in excess of those thresholds will be carried out centrally by the executing agency, applying Bank policies.

c. **Selection and contracting of consultants**: Consulting services contracts under the program will be executed using the standard request for proposals

[1] Policies for the Procurement of Goods and Works Financed by the Inter-American Development Bank (document GN-2349-9), paragraph 1.1: Nonconsulting services are treated in the same way as goods.

(SRP) agreed to with the Bank. The procurement plan will detail the selection procedures for direct contracting.

- **Selection of individual consultants**: In cases identified in the approved procurement plans, the contracting of individual consultants may be publicized through local and/or international notices in order to assemble a shortlist of qualified individuals and through invitations of a slate of candidates, as established in document GN-2350-9, Section V, paragraphs 5.1 to 5.4. In lease-of-service cases, consultants will submit a midterm or final report to the executing agency as requested by the latter, and no final reports will be submitted for Technical Unit or UFI-S consultants. Since this project will be executed by the same personnel as in the executing unit for loan 1903/OC-AR and recognizing that current personnel have been performing functions related to its execution, provision is made for direct selection of the same personnel. For this purpose and for purposes of contract renewal, approval of the performance evaluation with a minimum satisfactory rating by the competent authority will be sufficient. There will be a single evaluation once a year in order to facilitate approval by the corresponding authorities. In these latter cases, when execution begins on this project, the executing agency will present the terms of reference for each position, in effect for the duration of the project, with provision for annual recording by contract. In the event of any change of the consultant for a position, the executing agency must follow the competitive selection procedure for a new consultant as indicated at the start of this paragraph.

- **Training:** The Procurement Plan details the purchases applicable to the program components. This includes training components that are contracted as consulting services and nonconsulting services. In particular, post-graduate courses are provided for training human resources in health, to be conducted through agreements with national public universities. These post-graduate courses are specifically designed for the different subjects covered in the project, and thus will use the direct contracting method.

d. **Recurring expenses:** Recurring expenses or operating and maintenance expenses required during the program will be: travel, per diems, transport, service and equipment rentals, office maintenance and expenses, stationery and training expenses, graphic arts products, printing, publications and reproduction, courier and mail services, cleaning services, data-processing consumables, insurance, telephone service, and incidentals needed to operate the Technical Unit and UFI-S. These expenses will be financed by the program and executed according to the executing agency's administrative procedures, which will be detailed in the program's OR. Operating costs do not include salaries for civil servants.

e. **Advance procurement/Retroactive financing**: There is no provision for advance procurement or retroactive financing.

2. Table of thresholds (US$ thousands)

Works			Goods			Consulting	
International competitive bidding	National competitive bidding	Shopping	International competitive bidding	National competitive bidding	Shopping	International competitive bidding	Shortlist 100% National
≥5,000,000	< 5,000,000 ≥350,000	< 350,000	≥ 500,000	< 500,000 ≥100,000	< 100,000	>200,000	<500,000

Threshold for ex post review Consulting services			
Works	Goods	Consulting services	Individual consultant
< 5,000,000	< 500,000	< 350,000	< 50,000

Note: The thresholds established for ex post review are applied on the basis of the executing agency's fiduciary execution capacity and may be modified by the Bank in the corresponding procurement plan to the extent that this capacity changes.

3. Major procurements

Activity	Type of bidding	Estimated start date	Estimated amount US$ (in thousands)
Goods			
Essential medicines for Primary Care Level I	ICB	08/2012	41,000
Essential medicines for Primary Care Level II	ICB	01/2013	51,000
Essential medicines for Primary Care Level III	ICB	01/2014	7,500
Essential medicines for treating CNCD I	NCB	11/2012	490
Essential medicines for treating CNCD II	ICB	11/2013	710
Facilities and logistical equipment for PHCCs	ICB	09/2013	3,500
Computer equipment for management of pharmaceutical services	ICB	06/2013	3,000
Nonconsulting services			
Logistical operation	ICB	08/2012	35,000
Data entry, R 2014 forms	ICB	12/2013	600
PHCC register	NCB	11/2012	350
Firms			
Improvement of critical processes at central level	QCBS	06/2013	150
Improvement of critical processes at central level	QCBS	03/2013	250
Evaluation study (medical services, medicines management)	QCBS	2014	480
Operational evaluation	QCBS	2013	571
Medical audit	QCBS	2013	1,993
Individuals			
Networks Management and Medicines Planning (104 consultants)	NICQ	05/2014	3,374
SITAM development, implementation, and monitoring (50 consultants)	NICQ	2013	1,556

4. Procurement supervision

Procurement will be supervised on an ex post basis with the exception of ICB and direct contracting, if any, which will be reviewed ex ante. Ex post review visits will be conducted at least once per jurisdiction every 12 months. Ex post review reports will include at least

one physical inspection visit,[2] selected from the procurement processes subject to ex post review. It is important to note that at least 10% of the reviewed contracts will be subject to physical review during the program.

5. Records and files

The executing agency will maintain a standardized central filing system with its respective procedures and original documentation and, as appropriate, in the jurisdictions in the provinces that are program beneficiaries. Project reports should be prepared and filed using the forms or procedures that have been agreed to and described in the program's OR. Originals are filed by the executing agency or the provincial sub-executing agencies, depending on who does the procurement.

VI. FINANCIAL MANAGEMENT

1. Programming and budget

The executing agency's budget has programmatic categories and other classifications based on spending categories (items). These are expenditures for personnel, consumer goods, nonpersonnel services, fixed assets, transfers, financial assets, debt service and payments on other liabilities, and other expenses. Depending on their economic nature, items are classified as current expenditures, capital expenditures, and financial applications. Moreover, domestic sources of financing may be the national treasury, the agency's own funds, specific allocations, and domestic transfers. External financing includes external transfers and external loans.

No problems are expected in terms of the management and timeliness of local counterpart funds or delays affecting execution.

2. Accounting and information systems

The executing agency will use the UEPEX system as its financial management system. Cash basis accounting will be used, and the International Financial Reporting Standards (IFRS) will be followed when applicable in accordance with established national criteria. Required financial reports will be: (i) financial execution plan for up to 180 days following the advance payment request, (iii) external audit report regarding procurement and disbursement procedures for the first half of each year, (iv) annual disbursement projections, and (v) other reports to be requested by the fiduciary specialists.

3. Disbursements and cash flow

The Financial Management Policy for IDB-financed Projects (document OP-273-1) and the Financial Management Operational Guidelines for IDB-financed Projects (document OP-274-1) will be used.

Financing resources requested from the Bank as advances will be deposited in an account in dollars that will be converted to pesos according to operational needs in a special project account, which will be used to pay project expenses and investments according to plan. The

[2] The inspection will verify the existence of procurements, leaving the sector specialist to verify quality and compliance with specifications.

executing agency will maintain strict and proper control over the use of the funds advanced, with mechanisms designed to verify and reconcile any available balances in its records with the equivalent balances in the Bank's records (LMS1 Report).

E-disbursements—the IDB web-based system—will be adopted, allowing the executing agency to prepare and send disbursement requests to the Bank electronically, thus reducing transaction costs and allowing the Bank to review and process requests remotely.

Exchange rates agreed to with the executing agency: the exchange rate to be used is established as follows:

1. Reimbursement of incurred expenses: The exchange rate indicated in Article 4.09(b)(i) of the General Conditions will be used.
2. Rendering of accounts (advances): The exchange rate indicated in Article 4.09(a)(i) of the General Conditions will be used.
3. Counterpart funds: The exchange rate indicated in Article 4.09(b)(i) of the General Conditions will be used.
4. Disbursements in currencies other than United States dollars and Argentine pesos: In cases of direct payment and letter of credit guarantee reimbursement, the loan currency equivalent will be determined based on the amount actually disbursed by the Bank.

a. Other specific requirements regarding project financial management that may need to be established in the contract or agreement to be signed with the Bank: Disbursements will be issued in accordance with the provisions of Articles 4.03, 4.05, 4.06, and 4.07 of the General Conditions.

4. Internal control and internal audit

The General Accounting Office (Governing Body of the Internal Control System) carries out internal control by conducting periodic internal audits of the different government agencies.

A structure will be created at the central level to assist the Jurisdictional Management Units and verify an appropriate control environment as well as proper compliance with established administrative procedures.

An Administrative Procedures Manual governing the procedures and routing to be carried out in the context of the program should be developed and implemented.

5. External control and reports

External control is performed by the Office of the Auditor General of the Nation (Governing Body of the External Control System). It may conduct external audits of all national government agencies. For purposes of the program, preference for using the services of a firm of independent auditors is established.

The TOR for the external audit must consider the nature and scope of the audits to be performed on the Provincial Executing Units.

6. Financial supervision plan

The initial financial supervision plan is based on the risk and fiduciary capacity evaluations performed on the basis of the onsite and desk reviews planned for the project, and includes the scope of operational, financial, and accounting activities, compliance and legal considerations, frequency, and identification of the persons responsible.

7. Execution arrangements

MINSAL will be the executing agency for the operation on behalf of the national government. It will exercise this function through the Secretariat of Health Promotion and Programs in its capacity as the National Project Directorate, and its Director will be responsible for general coordination. The Technical Unit and the International Financing Unit (UFI-S) of MINSAL will report to that Secretariat. The Technical Unit will be responsible for health actions and the technical evaluations of the operation and will consist of: (i) the current executing unit of the Remediar+Redes program; (ii) the Directorate for Health Promotion and Control of Non-communicable Diseases; and (iii) the National Cancer Institute. The UFI-S will be responsible for fiduciary aspects and for administrative and financial management. The OR will specify the basic functions of the UFI-S and the Technical Unit.

The UFI-S will provide administrative, financial, purchasing, contracting, and legal advisory services as well as planning and monitoring services. The mission of the UFI-S, created by MINSAL Resolution 98, dated 27/01/2000, is to coordinate with MINSAL the various external contributions and guide their execution in accordance with policies and strategies established by MINSAL. In addition, its objectives include: (i) coordinating the portfolio of projects with external financing in the health sector for greater efficiency; and (ii) achieving greater efficiency in managing that portfolio. The first objective seeks to ensure synergy and complementarity among the various projects as well as to guarantee that their execution corresponds to and is consistent with national policies. The second objective would involve setting up a centralized unit providing administrative, financial, purchasing, contracting, legal advisory, as well as planning and monitoring services. This makes it possible to achieve economies of scale and sounder procedures, without affecting managerial integrity and the substantive aspects of the various program and project executing units.

The SPPS will supervise the agreement and the flow of financial resources needed to execute it.

The structure of the SPPS, in addition to its line directorates, includes program executing units with external financing, such as the Plan Nacer and the Essential Public Health Functions and Programs project financed by the World Bank; the Program to Strengthen Primary Health Care financed by the European Union; and the Remediar+Redes Program currently being financed by the IDB in the context of the FEAPS (loan 1903/OC-AR), the structures of which will be integrated into the structure of this program.

The executing agency will be responsible for implementation of the operation’s components. To carry out the different components at the local level, the jurisdictions will set up Jurisdictional Management Units, the basis characteristics, functions, and duties of which will be established in the framework agreements to be signed by MINSAL and the

respective jurisdiction and in the OR. The units must be made up of the line agency of the jurisdictional ministries and may be supported by up to five consultants whose compensation is charged to the operation's financing (medicines management, primary health care, information systems, and up to two persons in administrative functions).

The executing agency will be responsible for implementing the program's Monitoring and Evaluation Plan, as described in the Monitoring and Evaluation link.

Operating Regulations (OR). The program will be governed by the OR, which will establish the program's eligibility and selection criteria, and the organization, operational procedures, and responsibilities of the executing agency and the participating entities. The OR will include: (i) a description of the program, its purpose, objectives, and components; (ii) the structure and organization of the executing agency, including its organizational chart, functions, responsibilities, and procedures; (iii) a description of the execution cycle phases, including flow charts; (iv) financing terms and conditions, bidding, contracting, and disbursement rules; and (v) monitoring and evaluation. The OR annexes will include profiles and TORs for contracting Technical Unit and UFI-S employees, models for the framework, supplemental and transfer agreements, and the environmental manual. The loan contract will include a contractual condition precedent to the first disbursement whereby MINSAL agrees to submit evidence, to the Bank's satisfaction, that the program's Operating Regulations are in effect.

Disbursements. Advances will be disbursed according to a financial plan covering a maximum of 180 days, accounts for which will be rendered when at least 80% has been spent. For the disbursements request, the disbursement request form, the execution status, and the financial plan for the next 180 days will be requested. The financial management specialist may require additional information such as: (i) a breakdown of commitments; and (ii) estimated financial physical progress reports on the project. The frequency and time to be covered by the advance may not exceed 180 days. Accounting for advances must be submitted to the Bank with the following information: (i) disbursement request form; (ii) project execution status; (iii) reconciliation of Bank funds; (iv) payments breakdown; (v) and other reports that help to show progress made in the project. The accounting will not be required to be accompanied by documentation supporting expenses and payments made, which does not signify Bank approval of expenses incurred. Original supporting documentation on expenses must be available for Bank review at its request.

Program monitoring. The program will be monitored using the Bank's supervisory tools based on the preparation of a Program Execution Plan, the Procurement Plan, and the Results Matrix. Each year the executing agency and the Bank will agree on an annual work plan (AWP). Every six months, the executing agency will submit reports with information on: (i) performance in meeting the objectives and results agreed upon in the AWP and in the Program Monitoring Report (PMR), including analysis and monitoring of risks affecting them and mitigating measures; (ii) the status of execution and of the procurement plan; (iii) compliance with contractual conditions; and (iv) the financial execution status of the program budget. In addition, the report in the second half of each calendar year will include: (i) the AWP for the following year; (ii) the updated procurement plan; and (iii) actions planned for implementing the recommendations from the external audit, as applicable.

Audit and oversight. Each year during execution, the executing agency will submit the program's audited financial statements. The external audit of the program will be carried out by the Office of the Auditor General of the Nation, in accordance with the policies and requirements stipulated in the Guidelines on Financial Reporting and External Audit of Operations Financed by the Inter-American Development Bank. It will be contracted in accordance with the procedures established in the document on external audit bid solicitation (AF-200). All costs for these audits will be financed with program funds.

Ex post evaluation. The borrower will compile the data needed to evaluate achievement of project targets in order to facilitate the potential evaluation of the project's efficiency and effectiveness in achieving the proposed objectives and to utilize the lessons learned.