



How to Ensure Quality Health Care and Coverage of Uninsured Populations

Argentina's Plan Nacer/ Programa Sumar



WORLD BANK GROUP

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PROJECT DATA

PARTNER ORGANIZATION:
World Bank

ORGANIZATION TYPE:
Multilateral

DELIVERY CHALLENGE:
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DEVELOPMENT CHALLENGES:
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South America

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APL-1: US\$135.8 million
APL-2: US\$300.0 million
PPHIDP: US\$400.0 million

ORGANIZATION COMMITMENT:
APL-1: US\$135.8 million
APL-2: US\$300.0 million
PPHIDP: US\$400.0 million

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Executive Summary

This case study examines a “silent revolution” in health care in Argentina. The country’s first national results-based financing program, Plan Nacer, was launched in 2004 as a voluntary, public insurance program for uninsured pregnant women and children in the poorest provinces in the Northern part of Argentina. At the same time, a dedicated team of public health reformers was working to change organizational culture by creating a system of incentives that spurred change at different levels of program implementation, while also laying down the foundation of a health delivery platform built on a unique information system that would facilitate coordination and smoother functioning of the whole health infrastructure. The case follows the program from its launch in 2004 as a targeted benefit program for mothers and children and examines its scale-up and transformation into a more expanded, comprehensive benefits program, now called Programa Sumar. It examines how the team involved in the design, implementation, and delivery of services through this program was able to bring this about.

The case authors were Daniel Ortega Nieto and Ipsita Parida. Many individuals contributed to this case study. Thanks are due to Vanina Camporeale, Andrew Sunil Rajkumar, Michele Gragnolati, Daniela Romero, Luis Orlando Perez, and Alfredo Perazzo, who provided generous assistance and feedback. Special thanks to Martin Sabignoso and the Plan Nacer/Programa Sumar team—Julieta Rey, Ricardo Izquierdo, Ana Salas, and Jose Priegue—for their insights and support. The Science of Delivery team provided critical input; thanks in particular to Jacob Bathanti, who revised and edited the case.

The impetus for the launch of Plan Nacer came from Argentina's experience in the financial crisis of 2001–02. With many people thrown into poverty due to unemployment and becoming part of the informal sector, thus losing their insurance and the overburdened public health system was stretched beyond its limits. This was shown perhaps most importantly in a spike in maternal and infant mortality rates. Faced with a clear problem, reform-minded specialists in the Ministry of Health in Argentina and the World Bank saw this as an imperative issue to confront, and also as an opportunity to innovate and experiment. Given that the threshold of expectations was already low from a system that was failing to deliver, it created the need to take a risk and thus maneuver a bold health sector reform idea like results-based financing which was outcome focused and, given the urgency of the situation, achieve necessary stakeholder support for implementing it.

The case focuses on the implementation of Plan Nacer/Programa Sumar and the ways in which delivery challenges were tackled. It analyzes how a results-based financing program for public health care provision was able to successfully scale and adapt to remain relevant and context specific over a decade without compromising quality or coverage. The case follows the development and creation of various mechanisms to address implementation challenges and examines key decisions made during this process. It investigates how initial program design and early definition of goals and objectives, followed by continuous iterations and adaptation, succeeded in setting long-term targets for beneficial health outcomes of the whole population.

Analysis of the case sheds light on how key elements were conceptualized, particularly in program design. It highlights the importance of team cohesion and leadership and shows how key targets needed for good health outcomes (“tracers”) were identified, provider-level data were collected, mechanisms and tools were created that incentivized and triggered behavior change by various levels of stakeholders, and health information systems and audit mechanisms were used to fine-tune the program.

Plan Nacer was unique in the way it embedded design into the program implementation process. The program design underwent several iterations (starting with a cost-effectiveness analysis that showed the efficacy the strategy) and course corrections

during implementation. The design became a sort of self-learning instrument that became more and more predictive and better at improving health outcomes. The team created a program with a solid framework based on results-based financing principles that was flexible enough to allow adaptation to the distinctive features of the different provinces.

The program developed an extensive audit system to ensure accountability and course correction. Having good data systems in place and being able to rely on them allowed certain program components to be made flexible. For example, the provinces allowed providers considerable autonomy in how they used the funds allocated for services, because they could depend on the data to track their progress and performance and penalize them if results were not achieved. This autonomy led to empowerment and ownership of the program by the staff at health centers, which proved instrumental for good health outcomes and clinic performance. The autonomy provided in the use of funds increased staff motivation at the clinic level and allowed for a health system that was much more responsive and connected to the needs of patients at the ground level.

Implementation required strong stakeholder collaboration and the reactivation of the relationship between the central government and the provinces. The definition of prioritized benefits for Plan Nacer began and ended with consensus building among key national and provincial stakeholders. Communication and coordination were critical to get initial provincial support, especially to overcome skepticism at the provincial level.

A results-based financing mechanism was key to success. Incentives ensured accountability and verification of information, and they helped the team collect the data it needed to measure health outcomes and program impact. The program's audit system increased transparency in the use of financial resources, monitored processes and field results, helped build human resources, and identified errors and constraints. The operational nature of some of the audits was critical for course correction and thus important in ensuring the success of the program. Adaptations were made in response to often-changing circumstances on the ground, and provinces were made to feel part of the program implementation process, giving them a sense of ownership.

Over time, the program broadened the scope of both beneficiaries and services. In 2012, the Ministry

of Health and the provinces expanded Plan Nacer to new population groups (children 6–9 years and adolescents 10–19 years) and women younger than 65 years without explicit health coverage) through a set of 400 prioritized benefits, transforming Plan Nacer into the program now known as Programa Sumar.

Plan Nacer/Programa Sumar achieved impressive results within just a few years, changing the lives of millions of Argentines. The programs have helped instill a culture of analysis and implementation and a focus on results throughout Argentina. They have driven important institutional changes, partly through effective participation and active communication across different levels of governments, and extended them to other parts of the health sector. They have reached more than 12 million previously uninsured people and financed the provision of more than 55 million services. As a result of the programs, the proportion of pregnant women receiving prenatal consultations before week 20 of pregnancy increased from 4 percent 2005 to 52 percent 2010 among the target population in the poorest Northern provinces. The percentage of women receiving four or more pre- and neonatal consultations increased from 10 percent to 40 percent in the target population; national immunization rates increased from less than 66 percent in to more than 94 percent of children under 12 months in 2007; and the proportion of newborns from eligible pregnant women weighing more than 2,500 grams reached more than 90 percent in 2012 from 47 percent in 2006. The case attempts to get at many such insights commonly and not so commonly observed in the nonlinear path to program delivery and highlights key iterations, course corrections, and program refinements made along the way that were critical for successfully implementing this results-based financing program.

Introduction

Julia was all of six weeks old when she was rushed to the hospital, limp, not breathing, in an ambulance. Her mother had immediately contacted emergency when Julia “turned blue from crying,” and she watched as the medics took her away. Julia had congenital heart failure as a result of septal defect in her heart and was in very critical condition.

Today her mother watches her as she skips around, a healthy five-year-old girl, rosy-cheeked and happy.

She can hardly believe that her little girl had once looked so limp and lifeless. She remembers that fateful night when her daughter was rushed to the nearest public hospital and how under the aegis of the Plan Nacer program, a supplemental public maternal and child health benefits scheme, Julia had an operation to correct the septal defect in her heart in one of the best public hospitals in the country. Julia was one of more than 5,000 children with cardiopathies who have received procedures since 2010. “If I see her today and it’s hard to believe that there was ever anything wrong with her, but I cannot thank the doctors and Plan Nacer enough to help in giving my daughter the gift of a healthy life. It is out of our financial reach to have privately availed the surgery and if it hadn’t been for Plan Nacer, we would have been on a waiting list for years, perhaps never seeing the color return to her cheeks.”

Mrs. Martinez herself had been a beneficiary of the Plan Nacer program, during her first pregnancy. She delivered her older daughter Natalia, similarly in her local public health care clinic. Recalling difficult times in the aftermath of Argentina’s economic crisis, she expresses gratitude for the support and care available through Plan Nacer. “I cannot be thankful enough,” she says, as she runs breathlessly after Julia who has raced ahead on her tricycle.

As rosy as Mrs. Martinez’s assessment of Plan Nacer was, Argentina’s public health system was not always able to provide such services in a timely manner. How did a system that had underperformed severely in the aftermath of the financial crisis change course to enable the provision of such effective and skilled care, while continuing to remain free of cost¹ to the patient? Moreover, how did a public health insurance program (Plan Nacer) initially started for basic maternal and child care services become successful in ensuring the provision of such high-quality, specialized care for treating complex heart conditions—an area well outside the original intent of the program—at no cost to the patient? Plan Nacer’s trajectory is impressive: from launching in a segmented and disconnected health system, to its scale-up and

¹ By law, all Argentines have public health coverage available to them free of cost; however, owing to sector fragmentation, neglect, and often poor standards of care provided much of the population is still left needing more targeted health care services and coverage. In addition, while services within the public network are theoretically free for those without health insurance coverage, many provinces have established payment systems through cooperatives or foundations linked to public assistance centers through a system of voluntary payment (World Bank 2003).

expansion into a comprehensive benefits program using an innovative financial delivery mechanism to ensure quality and coverage across Argentina. How did they manage to pull it off?

The case attempts to answer this question, by revealing the story of the “hows” and “whys” of the implementation process. We trace the road map of Plan Nacer from its genesis as a targeted results-based financing (RBF) program for maternal and child health in a crisis-struck environment, to its evolution into a more expansive and scaled-up effort while revamping public health care delivery systems. We analyze the factors contributing to program success and failures, focusing on the contextual conditions behind why key decisions were made and how these influenced the implementation process.

The Development Challenges

The economic crisis that erupted at the end of 2001 had visible and worrying consequences in Argentina. Increasingly precarious employment conditions and ballooning unemployment meant that different population groups lost their health insurance, placing a heavy burden on public health systems.² As a result, 48 percent of the population (and 65 percent of children) lacked health coverage as per Censo 2001. Out-of-pocket spending increased, costing poor families more than 9 percent of household income on average, and the poor showed the sharpest decline in health outcomes. Since October 2001, 5.2 million people had fallen below the poverty line, which led to 54.7 percent of the population being classified as poor (considerable heterogeneity was exhibited across the country; in one Northern province, this figure reached 78 percent). Those with unmet basic needs were 24.8 percent of the population, with 70.3 percent of this group being children.

In addition, there was a severe overburdening of the already debilitated public health system, which is highly decentralized (given strong provincial autonomy in Argentina), fragmented, and heterogeneous, making provision for health care difficult. In the post-crisis environment the cost of drugs, consumables, infrastructure, and technology increased up to 360 percent. For example, drug prices increased close to 160 percent;

² By law, all Argentines have public health coverage irrespective of their employment status. Formal sector employees are covered and receive attention through the Obras Sociales system.

mortgage of capital and technology investments increased by 260 percent; and private insurance plans raised their premiums by 25 percent, becoming less accessible. As a result, access and quality gaps increased. Further, data for basic health indicators showed that infant and maternal mortality were affected,³ revealing a reversal in the trend to this point. It was becoming increasingly clear that there was an urgent need to improve the health benefits program with assured provision of the most urgent and basic maternal and childcare services.

The Delivery Challenges

The uninsured population’s only option was the public health care system, which had to tackle the needs of some of the most hard-to-reach populations. Argentina’s health system at this point was heavily underfunded, with significant division of national and provincial responsibilities, and regulatory gaps that prevented seamless functioning owing to the federal nature of the country, which limited sector coordination. Addressing rising infant and maternal mortality rates in this context required the development of health care networks with primary care as the cornerstone, and the provision of this care via an integrated public health system. The response to the challenge necessitated the design of a new health care model that could use common ground rules for the allocation of resources and a common set of norms and policy goals. But given the lack of coordination and underlying structural irregularities of the public health system, there was an urgent need to strengthen the health system infrastructure to be able to deliver quality care in a more equitable and responsive manner focused on the health care needs of the uninsured over the long term.

The key delivery challenge, then, was to overcome the profound inadequacies of the health care system, such as heavy fragmentation of service delivery, and important capacity constraints in a context of deep financial crisis that created an overflow of patients to the public health

³ IMR worsened during 2001 and 2002, increasing from the 16.3 infant deaths per 1,000 live births recorded in 2001, to 16.8 and 16.5 in 2002 and 2003, respectively (World Bank report IBRD-72250). In addition, there was regional disparity with provinces like Catamarca, Chaco, and Jujuy already reporting IMRs that were double the rate in the best performing province, while by 2003, ten provinces doubled this rate and there were at least 5 provinces that had tripled this rate with IMRs as high as 30 in some provinces (DEIS 2010).

system. Further, the absence of adequate regulatory mechanisms made it more difficult to coordinate and oversee the disbursement of finances and their effective utilization. There was an urgent need to attend the immediate needs of the population groups that were being most affected by the crisis (women and children), while orchestrating a cultural shift in organizational efficiency and management, all while coping with limited financial resources. In other words, the focus was on explicitly providing and improving health coverage and quality of care for mothers and children without social health insurance, while introducing a new model of health care delivery that would bring about a “silent revolution” of the Argentine system through the introduction of a public-health insurance plan. Thus the Ministry of Health, in partnership with provincial health officials, launched Plan Nacer in 2004 with its unique system of incentives and results-based financing model, as a strategy to achieve these two objectives.

The plan was to gradually sequence and scale up the program into a more comprehensive public health insurance program. Plan Nacer has thus constantly sought to gradually increase population and benefit coverage for the population, starting in nine Northern provinces and expanding to all 23 provinces and the autonomous city of Buenos Aires. Beginning with eighty primary health care services for pregnant women and children, it has expanded to provide high-complexity benefits for the comprehensive care of congenital heart disease and other complex procedures. In 2012, the Ministry of Health and the provinces further expanded Plan Nacer to new population groups (children 6-9 and adolescents up to age 19 and women under 65 without explicit health coverage) through a set of four hundred prioritized benefits, transforming Plan Nacer into the program now known as Programa Sumar (herewith referred to as Sumar).

The operationalization of a program of the magnitude and scope of Plan Nacer and later Sumar thus had to address complex implementation challenges. For instance, there was the need for developing strong regulatory mechanisms. At the time of launch, there was no legally binding and effective mechanism in place to ensure full functioning of the public health system as well as follow-through and coordination between national and provincial-level governments. In addition, Plan Nacer needed to build strong normative

mechanisms to facilitate good program delivery, like institutional efficacy, and internal checks⁴ on corruption. But similarly, at the time of launch there were no systematic mechanisms to ensure this, and there was an important “gap” in terms of incentives to bring about necessary behavior change to ensure smooth running of the program.

The Case and Key Questions

The case focuses on the implementation process of Plan Nacer/Programa Sumar and how the above mentioned delivery challenges, as well as those that emerged along its trajectory, were tackled. The case study traces the program’s path and analyzes how a results-based financing program for public health care provision was able to successfully scale and adapt to remain relevant and context specific over a decade, without compromising on quality or coverage. Three main research questions guide our analysis of the implementation process:

- 1) In a federal country with a fragmented, decentralized public health system, how was provision of maternal and child health-care services for vulnerable groups prioritized and ensured, in the aftermath of the economic crisis?
- 2) How was Plan Nacer able to maintain quality and coverage in the provision of these targeted maternal and child health services?
- 3) How did Plan Nacer expand and scale to constantly ensure wider coverage without compromising on quality and introduce a much more complicated and extensive menu of benefits?

These questions will help illustrate how a results-based financing mechanism was implemented and the numerous nontechnical challenges it faced throughout the past 10 years.

Context

Historically, Argentina’s highly decentralized public health system grants provinces the autonomy to make decisions on the organization of services and allocation of resources,

⁴ Following allegations of the lack of transparency in the procurement process in 2010 (which were eventually not substantiated), for example, the program devised a Governance Accountability Action Plan to allow more transparency in the bidding process which would act as an internal check mechanism to ensure open bids and hence prevent potential collusion.

while leaving the national government with little room to manage the system. In the 1990s, the government attempted to reform the Obras Sociales, social security insurance schemes covering workers in the formal sector and managed by occupational trade unions.⁵ The reforms attempted to liberalize and stimulate competition among almost 300 separate insurance funds managed by unions but contracted out to private companies. In the virtual absence of effective state regulation, this unregulated contracting and subcontracting of insurance funds led to deep fragmentation and corruption (World Bank 2003) of the insurance infrastructure. The reforms of the Obras Sociales also failed due to poorly designed policies which prompted widespread misuse of capitation fees.⁶ This led to providers losing income from provisioning for primary care services and spurred a high demand for specialized services, with little focus on primary care, since it was less lucrative for providers.

In the 2001 economic crisis the Obras Sociales system collapsed almost completely (World Bank 2003). As people lost their jobs and left the formal sector, the public health system was left to absorb the sudden massive influx of patients. The worst affected were the most vulnerable populations, who were most dependent on preventative and primary care services. This also highlighted preexisting failures of the health care system and exposed significant gaps in coverage and quality. Thus there was a strong need for a single, equal benefit insurance plan, targeted at pregnant women and children, homogenous in its provisions, and universally available. At the same time, however, the program had to respect the federal structure of the provinces. Thus, it needed also to design a system of incentives that would motivate provinces and build consensus to ensure their compliance towards the initial self-imposed targets that would eventually be homogenized across all provinces.

The economic crisis created a moment where there was a severe disruption that led to the questioning of the status quo. It shook incumbent logic and created a

situation where the roles and responsibilities of the key stakeholders were challenged and thus left the situation more open to change. In addition, evidence showing the worsening of basic health indicators catalyzed a process of introspection and analysis, leading to the conclusion that coordination failures were the greatest limiting condition to achieving sustained positive health outcomes. It became clear that focusing on fixing coordination failures and strengthening health-care systems while addressing the immediate challenge of poor access to healthcare for uninsured pregnant women and children were the most important needs. It created an authorizing environment for change agents who emerged to coordinate efforts across various stakeholder groups to experiment and propose alternative solutions that led to the introduction of Plan Nacer.

We now etch out the program timeline (see figure 1) for Plan Nacer before discussing the program implementation path. The case study in particular focuses on the period beginning 2004 with the inception of Plan Nacer, its first scale-up in 2007 to all provinces, the second scale-up in 2010, and finally its expansion and eventual transformation into Programa Sumar in 2014.⁷

Tracing the Implementation Process

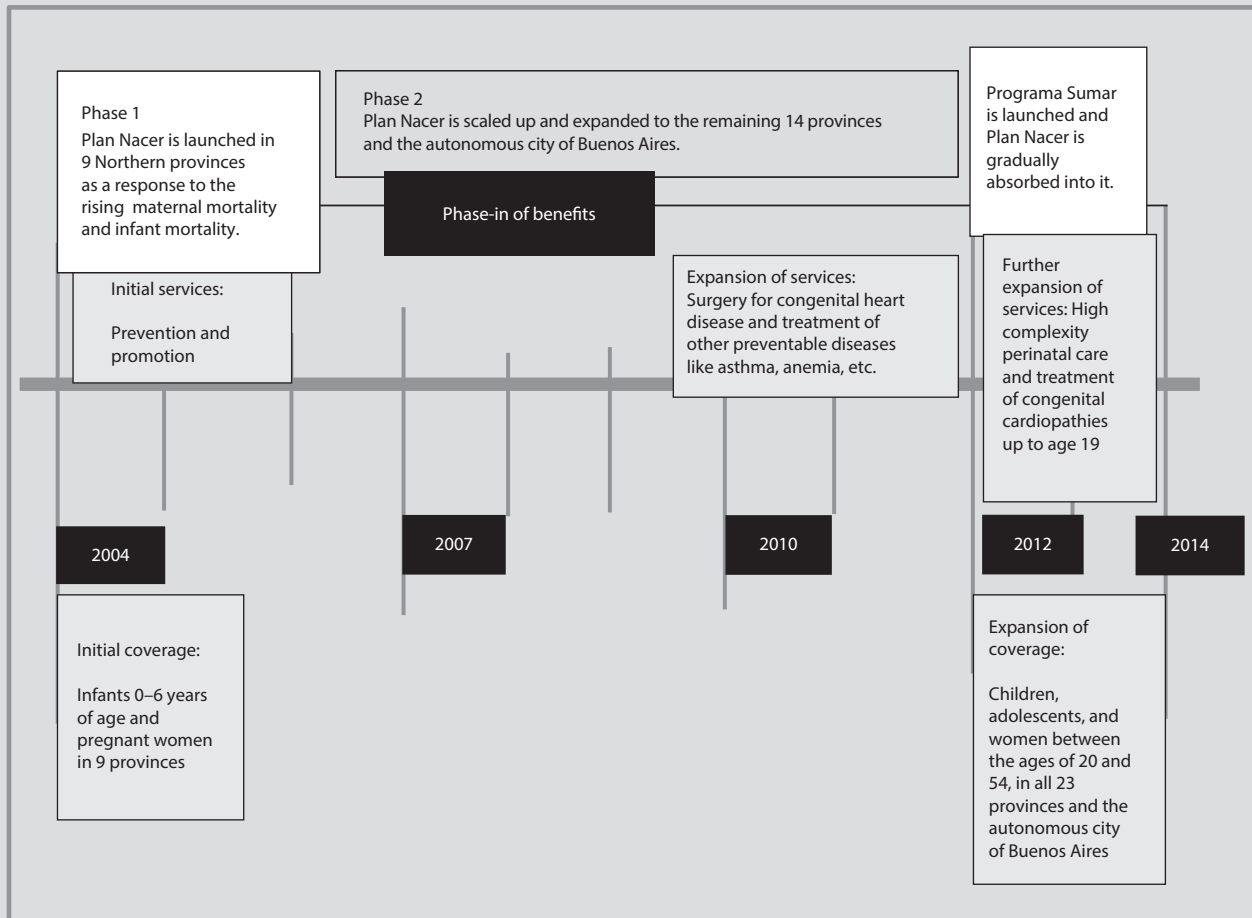
Initial Conceptualization of the Project

The country was reeling in the aftermath of the economic crisis in 2001–02. Given the urgent need for immediate financial transfers to the Argentine economy, the Ministry of Health assumed strategic importance, since it was a legitimate and justifiable source for international finance from international institutions such as the World Bank. The long-standing engagement of the World Bank with the Ministry of Health further created the environment for change to be introduced and executed. President Nestor Kirchner had appointed Gines Gonzalez Garcia—an astute leader with a long-term strategic vision—as the new Minister of Health in 2003. “Gines Gonzalez Garcia was a fantastic communicator and great at political dialogue, getting buy-in of the other ministries and other players for support,” says Alfredo

5 Health-related social security includes national insurance providers (Obras Sociales) and the National Institute of Social Security for Retired Persons and Pensioners (INSSJR, or PAMI) under the jurisdiction of the national government. They are financed through mandatory employee-employer contributions (and from pensioners).

6 Under a capitation system, providers are paid a set amount, on a set schedule, for each patient they enroll. The amount of this payment is based on the average expected health care utilization of that patient, with greater payment for patients with significant medical history.

7 Refer to annex A for a more detailed overview of the program timeline and key inflection and annex B for adaptation points.

Figure 1 The Implementation Timeline for Plan Nacer/Programa Sumar

Perazzo, one of his early collaborators. Gonzalez Garcia assembled a team with vast experience in the public and private health sector. In the period between the creation of this team (in late 2002 to early 2003) and Plan Nacer's launch in November of 2004, the team worked closely with World Bank health specialists to design a program that could help Argentina deal with the massive challenge of rapidly reducing infant and maternal mortality. The early designers and implementers of the program also identified that the only way to ensure the provision of such care to bring about a lasting change in health outcomes was through the creation and sequenced development of a public health insurance program across Argentina. However, first they had to address the immediate need for care by the most vulnerable sections of the population, which then could set the stage for delivery of a comprehensive public-health insurance plan.

Minister Gonzalez Garcia and his close team of collaborators along with the Task Team of the World Bank were able to craft a response to this immediate challenge of designing a maternal and child health program for the uninsured, but also fit in a long-term vision for more sustained institutional and organizational change, through the results-based financing platform. It became clear that from the get go, a sound technical team from the Ministry and the World Bank was key for success. More importantly, there was familiarity between team members, as many of the World Bank team members had already worked with each other and also with the Ministry. This helped build a relationship of mutual respect where the Ministry acknowledged the technical competence of the World Bank and the World Bank members in turn had good faith in the political leadership.

The genesis of Plan Nacer and its results-based financing model was the idea of the first group of Ministry and World Bank experts, who had some degree of experience with such programs. As a result of this experience, they foresaw the need for strengthening the public health delivery system to make it a good foundation to implement a public health insurance program in the long run. For example, the World Bank's team leader, Cristian Baeza, had prior experience in designing and implementing a similar results-based financing insurance program in Chile and felt strongly for the team in Argentina. "I could see myself in their shoes," he recalled. He knew well the tough decisions that needed to be taken and the challenges that implementing such a program would face. Just as Minister Gonzales Garcia formed a team, so did Baeza, who involved, among other experts, Luis Orlando Perez in the early design and rollout of the program. Dr. Perez had been the director of hospitals in Mendoza Province; therefore prior experience of the team members with insurance and results-based financing schemes all contributed to the effort.

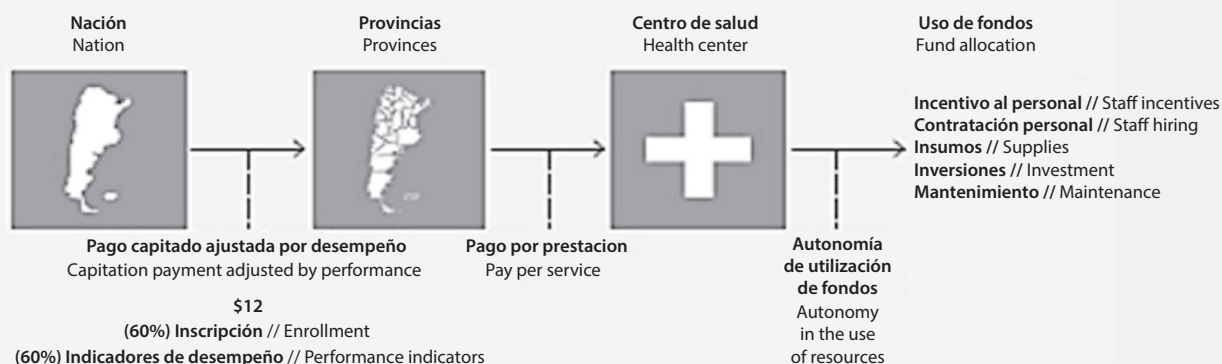
In interviews, all team members recall intense discussions taking place. There wasn't always concurrence and many ideas and alternatives were debated and challenged, but given the high degree of trust and professional respect amongst team members, it was easy to agree and work towards a common plan of action. In addition, the crisis created a unique window of opportunity. "The crisis was a critical moment to rethink how to do things differently and hence the unique situational context triggered room for innovation and redesign," said Martin Sabinoso, the current National Coordinator of Plan Nacer/Sumar. The situation demanded different thinking about health sector reform, and a particular set of circumstances (urgency, good leadership, strong team, willingness to innovate) aligned to bring about the strategic shift in health sector reforms in Argentina. The crisis created an unusual moment that enabled the team to be experimental and innovative due to scant resources almost in the spirit of "necessity being the mother of innovation." According to Alfredo Perrazzo, the former Plan Nacer's technical coordinator the team communicated and internalized that, from the top leadership to the lowest-level implementers, they were "going to have to be willing to experiment and be prepared for errors and course correction to fix those errors," releasing the team from the pressure of preset

expectations. Since these team members were uniquely selected and brought on board to participate in this new idea, they really invested themselves in it, creating a sense of personal motivation and ownership for the idea. Further, the fact that the initial focus was on decreasing infant and maternal mortality proved to be an additional motivation.

A fundamental decision had to be made with respect to policy directions. Three main alternatives were considered: (i) scaling up the traditional maternal and child program implemented by the public sector; (ii) a combination of the traditional strategy with a continuation of the ongoing World Bank-financed Second Maternal and Child Health and Nutrition Project (SECAL); or (iii) assistance to the provinces through a results-based financing (RBF) scheme of Plan Nacer. The economic evaluation of the alternatives strongly supported the Plan Nacer strategy, given that provinces had limited economic capacity due to the financial crisis, while the central government had more capacity and resources to guide the process. Also, the first two alternatives were shown to be insufficient to reach the poorest provinces effectively in small pilots done in these regions. The RBF seemed the least financially constraining, and allowed for using the institutional resources available within the system to generate results through improved efficiency. Moreover, the team designing Plan Nacer, Ministry staff, and World Bank interlocutors all advocated for the use of results-based financing as a delivery platform, with its instruments of a strong information and audit system, to buttress the foundation of the public health system.

Program Design

Design is generally thought of as outside the domain of discussion of the implementation process. However, Plan Nacer was unique in the way it embedded design into the program implementation process. In fact the program design itself underwent several iterations—starting with a cost-effectiveness analysis that showed the efficacy of the strategy—and course corrections constantly through the program implementation process. The design became a sort of self-learning instrument that kept getting more predictive and better at guaranteeing better health outcomes. In fact, as it will be explained, throughout the implementation process

Figure 2 Results-Based Financing Scheme in Argentina

Source: <http://www.plannacer.msal.gov.ar>.

Table 1 List of Plan Nacer Tracers

Health goals		Description of tracer
I	Early detection of pregnant women	Detection before the 20th week of pregnancy
II	Effectiveness of childbirth and neonatal care	Newborn's physical condition after delivery (APGAR—Appearance, Pulse, Grimace, Activity, Respiration—score >6 at 5 minutes after birth)
III	Effectiveness of prenatal care and prevention of prematurity	Infant birth weight >2500 g
IV	Effectiveness of prenatal care and childbirth care	VDRL—Venereal Disease Research Laboratory—test and immunization for mothers against tetanus
V	Audit of mother and child deaths	Audit process in case of mother or child death seeks to evaluate and improve the current level of care
VI	Immunization coverage	Triple viral and measles immunization for children under 18 months
VII	Sexual and reproductive care	Provision of information on contraceptive and sexual health services during puerperium
VIII	Follow-up of healthy children up to one year of age	Provision of health care and checkups for children up to one year of age
IX	Follow-up of healthy children from 1 to 6 years	Provision of health care and checkups for 1- to 6-year-old children
X	Inclusion of indigenous people	Health care provision for indigenous population

Source: Sixth plenary meeting of the Leading Group on Solidarity Levies to Fund Development, Argentina.

the Ministry of Health and World Bank team were able to create a program with a solid framework based on RBF principles, but one that was also flexible enough to allow adaptation to the distinctive features of the different provinces. Figure 2 shows the basic elements of Plan Nacer's results-based financing mechanism (UNICO; World Bank 2009).

Since service delivery was tied to health outcomes and outputs, it needed a system of “tracers” or indicators to effectively capture these objectives and track progress and improvement (or lack thereof). Hence, formulating the tracers, and getting buy-in, was fundamental, because while provinces had different targets⁸ (i.e., targets set in

the Annual Performance Agreement), the tracers used to measure these needed to be homogenous across provinces, and aligned in the achievement of these set targets as indicators for program performance (See table 1). So, as stated above, the tracers were key from both the design and implementation point of view. It was difficult to get consensus and agreement on the tracers that were to be decided, while ensuring that provinces were not overwhelmed with too many measurements at the outset. Thus the tracers that were picked had to be representative enough of successful health outcomes achieved and not be repetitive. Again, the importance of having an experienced team with local knowledge was key, since one of the key developers for the tracers, Dr. Luis Orlando Perez, conceived the idea from his experience in Mendoza.

⁸ This was true at the beginning. Later, all provinces had the same targets to receive funds for the program.

After many consultations in the provinces to help understand the local context, the team felt the need to have two legal frameworks because different provinces had different implementation capacities. Thus, implementing a twin structure of the legal framework that allowed for both rigidity and flexibility ensured a successful addressing of this challenge. Umbrella agreements were undertaken between the national government and participating provincial governments. These were nonnegotiable, and covered all permanent technical, financial, administrative, and fiduciary aspects of provincial participation in the program, including the provincial program goals, establishment of the agencies, and their responsibilities, operational guidelines, and financial and auditing relationships. But the Annual Performance Agreements between the national government and participating provinces, which would include annual targets for the tracer system, enrollment targets, work programs, and resource requirement targets, were to be negotiated annually, province-by-province. This allowed provinces with a weaker health system to *initially* aim for lower targets than better-off provinces and keep improving till they reached comparable targets.

Finally, to implement and roll out the program, given its highly technical nature, it was decided to create a separate unit for Nacer's implementation. A dedicated task force was exclusively created for operational and technical support at both the national and provincial levels. The design mandated the creation of separate implementation units that were under the national ministry, but worked with relative autonomy. The Minister would exercise his role as coordinator of national policy directly, and his responsibilities for achieving program outcomes through a specific project implementation unit (PIU) under his direct supervision through the Program Coordinator. Similarly the provinces had a provincial project implementation unit (PPIU) that mirrored to some degree the functions of the national PIU with the broad mandate of undertaking the purchasing function, identifying beneficiaries, and mobilizing their participation; identifying, authorizing, contracting service providers to serve the beneficiaries, ensuring technical quality of services, financial management, procurement at their level, and monitoring the performance of ministries in exercising sector stewardship functions of both the national and participating provincial ministries of health (MSPs). This ensured a degree of

institutional autonomy at the province level facilitating exchanges with counterparts at the national level while simultaneously enabling execution of tasks in a timely manner. In the early stages of the program, the National PIU team recalls that this parallel structure met with some resistance⁹ from other department heads with similar job roles. It was natural that the people previously in charge of infant and maternal mortality were reluctant to see a parallel structure. Nevertheless, since Plan Nacer had the support of the Minister of Health, they were able to overcome these initial tensions, and eventually the results legitimized the program. Furthermore, this structure also helps explain how Plan Nacer has been able to function for a decade with a degree of insulation from administrative and political instability.

Stakeholder Collaboration and Provincial Support

Argentina's federal structure posed as a unique and complex challenge for overcoming fragmentation. The national government had only limited legal and administrative influence over provincial health sector policy, and the Ministry of Health had been questioned in light of the poor infant and maternal health outcomes. However, the alarming increase in infant and maternal mortality triggered the need for an "urgent" response in which the national government had to "step in." Martin Sabignoso recalled that the way the team was able to engage again with provinces was that "the program [Plan Nacer] was clearly targeting child and maternal mortality, and thus it was possible to bring all members on board and rally support." In addition, the provinces were also in a place where they were open to change and to achieving a working solution to address the problem of the dying mothers and infants. Focusing on a maternal and child health strategy helped getting buy-in, since no one could object to saving the lives of "mothers and babies." Further, data showed that this was a genuine problem. In addition, since pediatricians and licensed midwives are present in most health centers,

⁹ The provincial project implementation unit (PPIU) was originally envisioned to function as an ancillary structure primarily responsible for purchasing functions that would continue after project closing and the Directorate of Maternal and Child health was to be held responsible for regulation and direction setting of maternal and child health strategy. However, given that both Units were working with the same target group, there was some overlap of functions in early stages of the Program to the point where the PPIU teams under Nacer became more central and assumed a greater role in the administration and implementation of Nacer.

this strategy was not resource-heavy. And while Nacer was a small sum—representing only 1 percent of the total provincial health expenditure budget—in the post-crisis context it was an important source for scarce financial resources.

The Minister of Health knew that getting provincial consent and support for Plan Nacer was the cornerstone of the program. Thus the team implementing Plan Nacer realized that the Federal Council of Health (COFESA)¹⁰ could be the ideal forum to get buy-in from provincial stakeholders because, while it had diminished in importance since its founding in 1983, it was the only well-established forum where all provincial Ministers of Health gathered. The Ministry and the World Bank team agreed that the loan¹¹ would promote the “reactivation” of COFESA to bring together all provinces and enable implementation of the umbrella agreements.¹² By working with COFESA, the team gained a solid and transparent forum for debate and consensus building around sector policies, partly also because the loan mandated that the minutes of the event be made public. It functioned as a tool for decision making and monitoring and control, by making all agreements public and thereby holding provinces accountable, and simultaneously giving the Ministry of Health the authority to run with the implementation of the program.

By November of 2004, the foundation was all in place, the mechanisms had been set up, and the program was ready to go live. The Ministry had determined during the early design process in 2002 that the program would initially focus on the nine poorest provinces to target those most urgently in need of the program. Thus the initial design of Plan Nacer incorporated a three-tranche adjustable loan disbursement format from the World Bank, which gave the government the advantage of supporting a national program through a long-term period, and the possibility of focusing on the poorest provinces first without losing leverage with the rest of the provinces. It gave all the provinces represented in COFESA the incentives to support the poorest nine provinces with the implementation of Plan Nacer, so as to accelerate their own participation in the project. Lastly, it allowed the government to learn and confirm

the effectiveness of Plan Nacer before embarking on a nationwide project: using lessons from implementation in the “pilot” provinces as a blueprint for scaling up.

Going Live

Nacer has had numerous implementation challenges, as would any program of this size. However, three main issues during the implementation process seem particularly relevant:

First, weak institutional capacity of provincial health ministries made data collection very hard. In response the program created and developed its unique information system.¹³ Prior to Nacer there was no information available on who the uninsured were since this population is generally very volatile. There were frequent movements of this population across the insurance systems, joining and leaving the Obras Sociales, for example. Hence Nacer had to create a massive information system for analysis, to use it as an administrative tool, for billing and reporting information, and for enrolling beneficiaries.¹⁴ For the first time primary care clinics used a homogenized and standardized system of clinical guidelines and protocols for data entry. In addition, information systems were responsible for creating the unique process of “nominalization,” a method of identifying the beneficiaries and tracking exactly which services they were using to enable better tracking, monitoring, and usage data for program improvement. This was a hitherto untested concept and entailed significant capacity requirements, but Plan Nacer started using feedback from audits to make the information system functional, a process that is currently being improved.

Like one of the Plan Nacer coordinators rightly remarks, “It is hard to believe that until a few years ago we kept our registry in pencil; so many opportunities open up with the information system.” Further, the system had a direct impact on the way services were delivered at the clinic level. For instance, in one of the more advanced primary care centers in municipality of Lomas de Zamora they used the system to track pregnant women and provide postpartum care and follow-up. As a nurse candidly

10 COFESA was created in 1983, but its significance diminished substantially afterwards.

11 A World Bank Adjusted Program Loan is a financial instrument that can trigger policy reforms.

12 Elaboration on umbrella agreements to be discussed in detail below.

13 This is an ongoing process with information systems still being put in place in several provinces.

14 The process of introducing electronic billing is a unique innovation of the Plan Nacer program; it is still an ongoing process. It was largely implemented at scale under Sumar after 2010.

put it in an interview, “we now know which mother to run after in the neighborhood, and when to advise her that her checkup is coming.” As it will be mentioned, other government programs saw the value add of the information system, which offered a unique opportunity to piggyback off its platform. Since the RBF model needed constant data to identify the beneficiaries, this created a platform that other programs and departments could use as well, and hence all provinces saw the value add for, among other things, identifying beneficiaries to offer services, observing take-up and follow-through.

Second, the program developed an extensive audit system to ensure accountability and course correction. One of the key functions of audits was to recommend Nacer’s PIU the implementation of monetary penalties and/or sanctions defined as part of the Program’s rules. This feature meant that it was possible to guide health teams towards the desired behaviors by means of an effective monetary penalty. The External Concurrent Audit (ECA) provided an independent and binding opinion for the program, both on the national and provincial levels. Incidentally this served to strengthen the relationship between the National and Provincial levels and encouraged proactive responses. For example, when findings showed any deviation from the Plan Nacer guidelines both teams were able to buy time and course correct by staving off political pressure citing that the findings were on account of an independent audit agency. Another distinctive feature was its recurrent nature. This means that it took place systematically and its role was to provide formal opinion and offer management recommendations. The audits greatly contributed to building a strong control environment and transparency in the provinces, to improving the regulatory framework, and to promoting health rules and organizational practices in health facilities. The feedback from the audits was used to correct any mismanagement and improve the program’s functioning. The result was an innovative management mode of results-based financing program and effective control and monitoring system to deliver results. In addition, the audits served as an effective learning tool. The audits were also used as a mechanism to change behavior amongst staff teams. These created a culture of data sharing and course correction based on the audit reviews. One staff member at a health center recalls how they would enter data incorrectly into the information system and did not realize the value of height and weight information. This practice was changed when

a performance audit pointed out the need for such data and how to enter it correctly.

Finally, audit systems proved critical for the functioning of a key feature of Plan Nacer, the flexibility that health care providers have with respect to the use of the funds they receive. Clinics have latitude to decide how to best use the money that they receive for achieving results with the broader categories designated by the provincial ministry of health. For example, one clinic decided to invest in a bridge since it was clear that accessibility was an important problem (Página12 2014). Others could choose to provide monetary incentives to staff, among others. Flexibility in the use of resources by local providers also spurred innovative ideas to improve service provision. One of the newest beneficiary groups in the program are adolescents between 10 and 19 years of age. This is a notoriously difficult group to get involved and committed towards health interventions.¹⁵ To bridge this gap, the team made the creative decision to engage a tae kwon do teacher, who taught physical fitness to adolescents. This martial arts connection immediately caught the attention of this age group, improving their involvement in the program, increasing awareness of important health issues. This idea was so successful that tae kwon do teachers have been hired at 15 other provinces for service provision. In short, the audits largely facilitated greater transparency in the process of using the financial resources of the program, improved program accountability, and allowed flexibility for innovation. In addition, the autonomy provided in the usage of funds also increased staff motivation at the clinic level and allowed for a more responsive health system, much more connected to the needs of the patients at the ground level.

Third, implementation processes across provinces varied significantly and it was necessary to allow variation across provinces in tracer target achievement. The original rigid framework was amended to be more context sensitive and to be mindful of the implementation capacity of each province. It had been observed that historically most provinces reported very high numbers for their existing maternal and child care services, like antenatal visits and vaccinations, since there was no system to corroborate such data. According to one of the team members, they decided to keep the original

¹⁵ This example refers to Programa Sumar.

threshold for achieving the initial tracer targets low. The provinces had been reporting high numbers which were self-reported and mostly incorrect (this happened in the very initial stages before the health information systems were set up). The idea was to keep these targets so low, that all the provinces would at least cooperate to make sure they achieved this (and be verified by the audits), because it would look quite bad if they did not even achieve this very low target. Once the data collection systems were in place, the team could quickly raise the threshold of the tracers and adopt them to the reality of each province. In the original design the tracer target achievement for payment was binary (achieved or not), but on observation it was decided to allow for some leeway based on the capacity. Thus, the tracer target achievement levels were set at three thresholds ranging from low to high, and while full payment was made contingent on achieving the highest threshold, incremental payments were made on graduating from one to the next – creating good incentives for achieving results.

Going to Scale

Plan Nacer had shown good results: it had reached almost 64 percent of the target population in the Northern provinces by 2006, providing access to close to half a million uninsured pregnant women and children. In 2007 the program reached a key inflection point, since there was mounting pressure from the provinces to expand the program across the country. This was the first scale-up proposed of the program when it expanded operations from the initial nine provinces to the entire country. However, scaling up was not without its problems. Many of the provinces that had been recently included under Plan Nacer's second phase showed low rates of coverage. The quality assessment reports showed there was low transfer of finances from provinces to providers for services required, which meant that not many services were being reported (most likely since the program was new, these services were probably not being billed or reported even if they were being provided). There was a need for another “push” to provide health services. This led to the development of the Government Rapid Action Plan to boost uptake and course correct.

A major focus of the Action Plan was addressing the reporting, billing, and information capture issues, including substantial improvements in existing information systems. The PIU substantially increased

the frequency of supervision visits to the provinces, and regional meetings were held regularly. Different selected individuals in the national team were each “assigned” to one province. As part of the Annual Performance Agreements signed between the national team and the provincial teams, a list of the larger health providers was identified in each province, and the provincial teams committed to follow these providers closely. Eventually coverage increased, but the stakeholders realized that scaling would require additional efforts. Another remarkable strategy much later, in November 2009, was the synergy established with the Universal Child Allowance (Asignación Universal por Hijo) and Universal Allowance for Pregnant Women (Asignación por Embarazo) programs. These conditional cash transfers proved critical in expanding coverage. These programs had a new important conditionality: enrollment in Plan Nacer. Nacer gained a lot from the programs, and correspondingly these saw the information systems and patient tracking from Nacer as an important asset.

The program saw another roadblock when in 2008 there were allegations of lack of transparency¹⁶ and misprocurement of resources.¹⁷ This led to significant turmoil in the management and leadership across all institutional levels in the program. As the new President, Cristina Fernandez de Kirchner, came to power, so did a new Health Minister with an agenda focused on anti-corruption and transparency, leading to a change in priorities. There was limited financial and budgetary support for Plan Nacer. Many members of the staff team had even gone without pay for months. In addition the program also supported strong reputational losses as a consequence of the controversy, and its profile diminished considerably. However, Plan Nacer's staff again showed immense resilience to address these difficulties. This happened in two main ways: First, there was provincial buy-in, in part due to a number of financial incentives that were put in place to ensure sustained demand from the provinces. It was still a dependable source of revenue in a financially complex setting. Secondly, the program had shown measurable results, which helped to increase the enthusiasm of provincial governments.

16 As per findings in the Implementation and Completion report for the provincial maternal-child health investment project in support of the second phase of the provincial maternal-child health program highlighted under the “Implementation Weaknesses Identified in QALP-2 Report (June 2010) and MTR (Nov. 2011).”

17 These allegations eventually were not proved conclusively after investigation and there was no evidence generated to support the claims.

This led to the provinces reacting and pressuring the national government to keep Nacer. Also the World Bank team reacted proactively and effectively to develop a Government Accountability Action Plan to improve the transparency of the procurement function. Among other measures, this introduced more transparency in the bidding and procurement process. Finally, Nacer was able to rebound with a change of the leadership at the Ministry. With the appointment of Maximo Diosque as the new Vice Minister for Health, the program saw again support from the top level, particularly since Mr. Diosque had been the coordinator for Nacer in the province of Tucumán. His presence was also relevant for the expansion of the benefit package of Nacer.

The program continued its expansion, this time in the type of services provided. In 2010, President Kirchner convened all ministers of health and while lauding them for their exemplary work, also threw them a challenge: bring down the infant mortality rate to a single digit. This led to an investigation into the lead cause of infant death, and DEIS (the Directorate of Statistics and Health Information, Dirección de Estadísticas e Información de Salud) data showed that (a) congenital heart disease (CHD) was a major factor underlying child mortality in the country; and (b) additional services were found to be needed in the package. Thus that year the package of services covered under Plan Nacer was expanded to also include CHD treatment and additional complex maternal health services. This was not an easy task, since it represented moving from mostly primary care services to more complex procedures.

Due to the complexity of the new subpackage of CHD services, there was an accumulation of funds in the CHD account; with data showing that a very small fraction of services were being utilized. Between 2010 and 2012, however, a better-functioning network for providing CHD treatments was gradually created—the first Federal network of health facilities of 17 public hospitals with provincial referral centers that were responsible for identification and enrollment of beneficiaries. As a result, the number of surgeries to treat CHD rose from 1,217 in 2010 to 1,443 in 2013.¹⁸ This was done by increasing the human resource task force trained in performing these surgeries, by

training doctors from other provinces and health centers, and having them conduct procedures in more hospitals. In addition, incentives were put in place to make sure that provinces would transfer patients from one province to the other, in case they had the need for the treatment and could not provide it in their own. So by improving allocation of cases to hospitals with available beds wherever they were located, the efficiency and responsiveness of the whole health system was improved.

Expansion to Programa Sumar

By 2011, the foundation had been laid for Plan Nacer and all provinces had incorporated it with the requisite information systems, audits, and institutional support structure. The program was a huge success and had won several awards being recognized internationally and nationally.¹⁹ Now that the base had been set up, Plan Nacer was ready to broaden its scope. With all the provinces primed and on board, and all the processes set and ready to go, it was time to revisit the “silent revolution” again. The program’s early designers had at the very outset conceived Plan Nacer to be a platform for a much larger insurance benefits program for all provinces in Argentina. Thus, the government now decided that it was time to direct the program towards Universal Health Care coverage, focusing on the uninsured, and provision to strengthen and extend its social policies. With this underlying objective, the government dramatically expanded the benefits available under Plan Nacer (80 services) to launch Programa Sumar (400 services). See Table 2 for comparison. The proposed Programa Sumar represented an incremental reform to reach out to broader uninsured populations through an expanded set of services.

Launching a program at such scale entailed numerous implementation roadblocks. Implementation of the program has required substantial technical assistance from the project coordination unit at the center to provincial units and health care providers, as well as intense technical supervision by the World Bank throughout implementation. The need for political ownership and guidance at central and provincial levels

¹⁸ Compared with 2003, the waiting list for patients fell by more than 80 percent with the total number of operations conducted increasing from 930 in 2003 to an average of 1,400 every year until 2013.

¹⁹ Among other honors was the Good Practice Project Award 2011 awarded by the Independent Evaluation Group of the World Bank, the University I-Health, and various international agencies. In addition, Programa Sumar was honored at the 2014 Geneva Health Forum.

Table 2 Comparison between Plan Nacer and Programa Sumar

	<i>Plan Nacer</i>	<i>Programa Sumar</i>
Target population	Infants up to six years of age, pregnant women up to 45 days post delivery or miscarriage	Infants 0–6 years of age Children and adolescents between 10 and 19 years of age All women in the reproductive age group and beyond from 19 to 64 years of age
Health service provision	Basic maternal and child health services focused on promotion and prevention, although the program eventually offered services for treating congenital cardiopathies	Complex cardiac care for congenital cardiopathies Complex perinatal care for complicated deliveries Services directed at provision of adolescent care focused on counseling for sexual education, etc. Increased focus on other related secondary and tertiary care ailments in the target population like bronchial asthma and leukemia in children and anemia in mothers
Coverage	Initially launched in the poorest 9 provinces of Argentina	Expanded to remaining 15 provinces of the country including the autonomous province of Buenos Aires with simultaneous rollout of Programa Sumar in all provinces
Criteria for enrollment	To be considered a Plan Nacer beneficiary the uninsured person had to be enrolled in the program	To be considered a Programa Sumar beneficiary the person must receive a health intervention in the corresponding age group, billed and authorized by the program within a definite period.
Tracer indicators	Plan Nacer had 10 tracers that were related to maternal and child well-being.	Additional tracers added to encompass the new population groups being covered, like tracers for adolescent health checkup and also to cover an increased array of services being provided
Electronic information systems	The program looked at setting up tracer tracking and roster management in all provinces	Programa Sumar now has enrollment and billing systems in addition to the tracer tracking and roster management systems.
Integration with other projects at the Ministry of Health	Plan Nacer was integrated successfully with programs like the Universal Mother and Child Allowance.	Programa Sumar looks at using the health information system to expand outreach and enrollment, while benefitting other programs. It has also been linked with Progresar and Remediar programs at both national and provincial levels.

were necessary conditions to sustaining provincial health insurance schemes. Thus, Sumar has focused on the design of new provider level incentives.

Plan Nacer also showed the importance of creating a sound procurement action plan focused on improving capacity and communication with suppliers about bidding opportunities, and a Governance Accountability Action plan to reduce potential corruption. Sumar incorporated an extra internal concurrent audit that verifies the reported achievements at both the provincial and health care provider levels, which was formalized as a process during the final leg of Nacer when they had hired independent consultants to conduct this extra audit.

In addition, the experience with Nacer showed the need to focus on provider-side incentives for ensuring motivation and participation in the program. Sumar has an ambitious plan to strengthen supply and boost human resources by introducing long-distance training courses and providing scholarships to ensure more attractive incentives for doctors/providers that can ensure their participation. Also to improve implementation of complex procedures, Sumar employs “facilitators,” who are medical doctors and act as consultants to simplify administrative issues and explain process to other

physicians, as well as “navegadoras” who help local providers become fully proficient with the program.

A number of challenges remain and progress is being made toward achieving them. Building on Nacer’s legacy, strengthening the links between primary health care centers and hospitals will make the health networks and referral systems more effective. Similarly, an effort is being made to add health services that will focus on prevention of chronic diseases, cervical and breast cancer, and neonatal interventions, while reducing wait times and certifying providers’ qualifications to ensuring quality coverage and greater access. Another complication is that in some of the largest provinces such as Buenos Aires and Cordoba, municipalities are directly responsible for the public health system, aside from provincial level governments, and therefore the system of incentives needed to be reconfigured for municipal governments to ensure direct provision of incentives for performance to these municipalities instead of the provincial governments.

As Sumar moves on toward achieving universal health coverage, it is important to look back and reflect on key implementation issues that have been overcome. These made it possible for President Cristina Fernandez de Kirchner to celebrate and praise the program for its

achievements during its 10th anniversary on October 15, 2014. At the time of writing, important discussions regarding the sustainability of the program are taking place to ensure that the foundations of transformation of the health care system are well established.

Development Outcomes

Plan Nacer/Programa Sumar has helped instill a culture of analysis and implementation, and a focus on results throughout the country. It has been able to drive important institutional changes, partly through effective participation and active communication among different levels of government, and extended them beyond the scope of the Program to other parts of the health sector (Cortez et al. 2009). In addition, it reached more than 12 million previously uncovered people across Argentina, and financed the provision of more than 55 million services.²⁰ As a result of the programs, the proportion of eligible population voluntarily enrolled in program” was at the level of the country as a whole (97 percent), as well as for the Phase 1 and Phase 2 provinces individually (99 percent and 96 percent, respectively). The proportion of pregnant women receiving prenatal consultations before week 20 of pregnancy increased from 4 percent 2005 to 52 percent 2010 among the target population in the poorest Northern provinces. The percentage of women receiving four or more pre- and neonatal consultations increased from 10 percent to 40 percent in the target population; national immunization rates increased from less than 66 percent in to more than 94 percent of children younger than 12 months in 2007. Proportion of newborns from eligible pregnant women weighing more than 2,500 grams reached more than 90 percent in 2012 from 47 percent in 2006 and proportion of eligible new borns with Apgar score > “6” at minute 5” increased to 93 percent from a baseline value of 47 percent in 2006. Between 2002 and 2012, the infant mortality rate fell from 16.8 to 11.1 per 1,000 live births. (Source: Plan Nacer Phase II ICR: Page 54). Decline was more rapid in the poorest provinces, so the gap with the rest of the country was narrowed. According to data compiled by Plan Nacer, more than 5,000 children received congenital heart disease surgery since 2010.

In 2011, the program conducted an impact evaluation (World Bank 2011a) in the provinces of Misiones and

Tucumán using administrative data. These results are documented on the basis of the study conducted during the period from 2004 to 2008. The study showed the following achievements:

- With Plan Nacer the probability of having the first prenatal care before the 13th week increased by 8.5 percent on average throughout the provinces, and there was an increase of 17.6 percent in the probability of having the first prenatal care before the 20th week for beneficiary pregnant women as opposed to nonbeneficiaries.
- A reduction in the risk of newborn mortality with an improvement of APGAR scores (with an increase of 0.067 percentage representing a modest increase of less than 1 percent).
- A reduction of 26 percent in the risk of low birth weight of babies born to beneficiaries.
- An increase of 17 percent in the number of prenatal checkups of pregnant women as Plan Nacer beneficiaries in comparison with women who do not have Plan Nacer.
- An improvement in prenatal care was also evidenced as measured by an increase in the number of ultrasounds and tetanus vaccinations. (An increase of 38.3 percentage points was observed in ultrasound, representing an increase of 58 percent compared with the control (only for Misiones). In the case of tetanus vaccination, results show an increase of 8.8 percentage points or 11 percent compared with the control (effect mainly found in Tucumán Province).
- Average birth weight increased by 70 grams for those who have Program coverage.
- A significant increase in children’s checkups has also been observed, especially during the first 6 months. (The probability of well-child checkups increases by approximately 7 percentage points for the first three medical visits established by the protocol for children between 45 and 200 days old (Tables 15 to 17 in the program document), which represents an increase of 32.7 percent in the use of services for children between 45 and 70 days old, 21.5 percent for children between 70 and 120 days old and 18.2 percent for children between 120 and 200 days old).

In addition, another impact evaluation (Gertler, Giovagnoli, and Martinez 2014) identified the impact of Plan Nacer—today Programa Sumar—on a set of final and intermediate health results, using birth information from 6 provinces in the North of Argentina for the period 2004–08 showing that Nacer increased the use

²⁰ Plan Nacer-Programa Sumar: Una década por la inclusión y la salud pública. Unpublished document (10th anniversary meeting, Buenos Aires, 2014).

and quality of prenatal care as measured by number of visits and the probability of receiving a tetanus vaccine. It reported an increase of 16 percent in the number of average prenatal checkups for beneficiary women and an increase of 48 percent in the application of tetanus vaccination for beneficiary pregnant women compared to the women who need it. In final results the study found

- A reduction of 32 percent in the risk of newborn mortality (at big maternity clinics)
- A reduction of 23 percent in the risk of low birth weight (newborn babies to beneficiary mothers)
- A reduction of 74 percent in the risk of neonatal death risk (newborn babies to beneficiary mothers)
- A reduction of 25 percent in C-sections (in beneficiary mothers)
- Finally, the impact evaluation shows that the cost of saving a disability-adjusted life year through the program is highly cost-effective.

Lessons from the Case Study

In a federal country with a fragmented, decentralized public health system how was provision of maternal and child health-care services for vulnerable groups prioritized and ensured, in the aftermath of the economic crisis?

In light of the pressing need to address rising trends in infant and maternal mortality, a program that could tackle this problem was urgent. It was possible to design and implement such a program because of good political leadership and team cohesion since the original conceptualization of the program. The original developers of Plan Nacer included several visionary health experts from both the Government of Argentina and the World Bank, who had experience in the provinces and in, at the time, emerging results-based financing schemes. As a result, the response had strong technical design and a long-term vision to overhaul the healthcare system. Further, the solid relationship built between the government and the World Bank enabled a long-term engagement that was able to outlive administrative cycles and kick-start a “silent revolution” of the Argentine health system.

The economic crisis of 2001 also created a particular juncture that generated a unique opportunity to restructure the health system by focusing, at an early stage, on a concrete issue: infant and maternal mortality. Furthermore, the lack of financial resources in the country and the possibility to access funding

by coming together for a common cause also played a fundamental role. In addition, the implementation of Plan Nacer required strong stakeholder collaboration and a reactivation of the relationship between the central government and the provinces. Thus, the definition of prioritized benefits for Plan Nacer began and ended with consensus building among key national and provincial stakeholders. Communication and coordination were critical to get initial provincial support, especially to overcome skepticism at the provincial level.

How was Plan Nacer able to maintain quality and coverage in the provision of these targeted maternal and child health services?

Plan Nacer created a unique results-based financing mechanism to reinforce inclusion of the target population and improvements in the quality of services. The incentives of this scheme were key in ensuring accountability and verification of information, while simultaneously collecting the needed data to measure health outcomes and program impact. Thus the program included an audit system, which was a fundamental management tool as it allowed for transparency in the use of financial resources, for monitoring processes and field results, for training critical human resources, and for warning against the main errors and constraints. Moreover, the operational nature of some of the audits was critical for course correction through feedback provided, and was thus important in ensuring the success of the program. Adaptations were made in response to often-changing circumstances on the ground and provinces were made to feel a part of the program implementation process, giving them a sense of ownership.

In addition, a strong information system was incorporated at both the central and provincial level. It nominalized²¹ the beneficiary, enabling easier tracking and follow-up and better targeting. This required a strong IT capacity that was not present at sufficient depth in some provinces, necessitating substantial investment in implementation and adaptation of the information systems. Also, Nacer created a sense of empowerment, owing to flexibility that was allowed for in the use of funds by providers. A robust data-based information

²¹ Nominalization refers to the ability to track individuals' utilization of services and improvement of healthcare outcomes. As opposed to aggregated data, this enables specific tracing and targeting of beneficiaries.

system allowed Plan Nacer to work with this autonomy, as they could monitor if the program was on track in terms of both enrollment and service provision.

The implementers of Nacer had a deep understanding of the different provincial contexts and were in constant dialogue with local stakeholders. Provincial capacity varied widely and therefore the team designed two legal frameworks that allowed for both rigidity with respect to key principles of the program and flexibility to adapt to local circumstances. Implementing a twin structure of the legal framework ensured that this challenge did not interfere in the quality and coverage of the program.

How did Plan Nacer expand and scale to constantly ensure wider coverage without compromising on quality and introduce a much more complicated and extensive menu of benefits?

Constant programmatic support and supervision was provided for provinces that were identified as weak, and there were opportunities created to arrange meetings where staff could learn from other teams that had succeeded in successful implementation of the program. Lessons from the first nine pilot provinces were fundamental to fine-tune the rollout of the program to the rest of the country. However, lower levels of commitment of some of the larger provinces, and their slow acceptance of the new institutional arrangements and performance incentives was another roadblock. This issue was partly due to the complication of municipalities being directly responsible for the public health service provision (in the larger provinces such as Buenos Aires, Cordoba, and Santa Fe), thus the system of incentives needed to be regeared. Eventually, as a result of political leadership, these provinces and municipalities got on board. Negotiations were successfully managed by virtue of having able coordinators and successful communicators amongst the program staff to facilitate dialogue and exchange.

Political changes at the highest levels threatened to slow down the program's expansion. While the impact of leadership at the center impacts overall program support and implementation at the provincial level, this was largely addressed by transferring ownership of the program to the provinces, which rallied behind the program's continuity. Further, the technical capacity of the Nacer team, as well as the reliable data system and indicators that demonstrated impact, proved critical for stability. This enabled the program to shield itself from

political and administrative turmoil. Team continuity was also ensured through every leg of the program and this created a corpus of institutional memory that was tapped and utilized to keep the program afloat even through tough times.

Changing a medical culture to follow through on working under an incentive system along with the recruitment and retention of physicians trained appropriately in family medicine is another issue that Plan Nacer/Sumar has tried to address. There are on-the-ground activities to boost provider and physician engagement by incorporating distance-learning programs in family medicine, scholarships, and other incentives to encourage staff support. In addition, it has attempted to create a measure of social accountability by strengthening the communications program through more community outreach activities, but still has a long way to go in terms of demand generation and creating sustained behavior change in beneficiaries.

How the Case Informs the Science of Delivery

Relentless Focus on Citizen Outcomes

From the very beginning, Plan Nacer focused on the end objective of creating a program that would be able to provision delivery of care, to as much of the population in need, as effectively as possible. From the choice of the tracer targets to define most effectively the program outcomes, to the point of installation of information and auditing systems to enable effective tracking of this data, Plan Nacer has designed every step of its delivery chain with a focus on the end-point user. Finally, the program is still trying to fill gaps in cultural-cognitive needs of the population, since effective implementation depends on a population that is able to demand their rights and the poorer and marginalized populations in Argentina still have some way to go before they consistently demand their rights.

Multidimensional Response

Argentina's federal structure and decentralized health system required that the architects and implementers of Nacer incorporate multiple stakeholders from the outset, especially since the program aimed to revamp the entire

healthcare apparatus. Buy-in and consensus to install a complex results-based finance mechanism that changed incentives across the healthcare provision system was crucial for success at different levels of government. In addition, close collaboration with other social protection programs proved critical in expanding coverage and favorably exploiting synergies that have had a positive impact across the country.

Evidence to Achieve Results

Plan Nacer was one of the first programs in Argentina to embed a monitoring and evaluation system that included constant impact assessments alongside the implementation process. External audits and the information system have played an important role in the context of Nacer/Sumar, not only by verifying that what was promised was actually carried out and that the payments were justified, but also in terms of the training they have represented for teams at the provincial level and at health facilities. The concurrent external audit generates an environment of control that limits unwanted behaviors from the different participants involved in Nacer's transfer mechanisms. It also promotes the application of standards defined by existing guidelines and protocols.

Leadership for Change

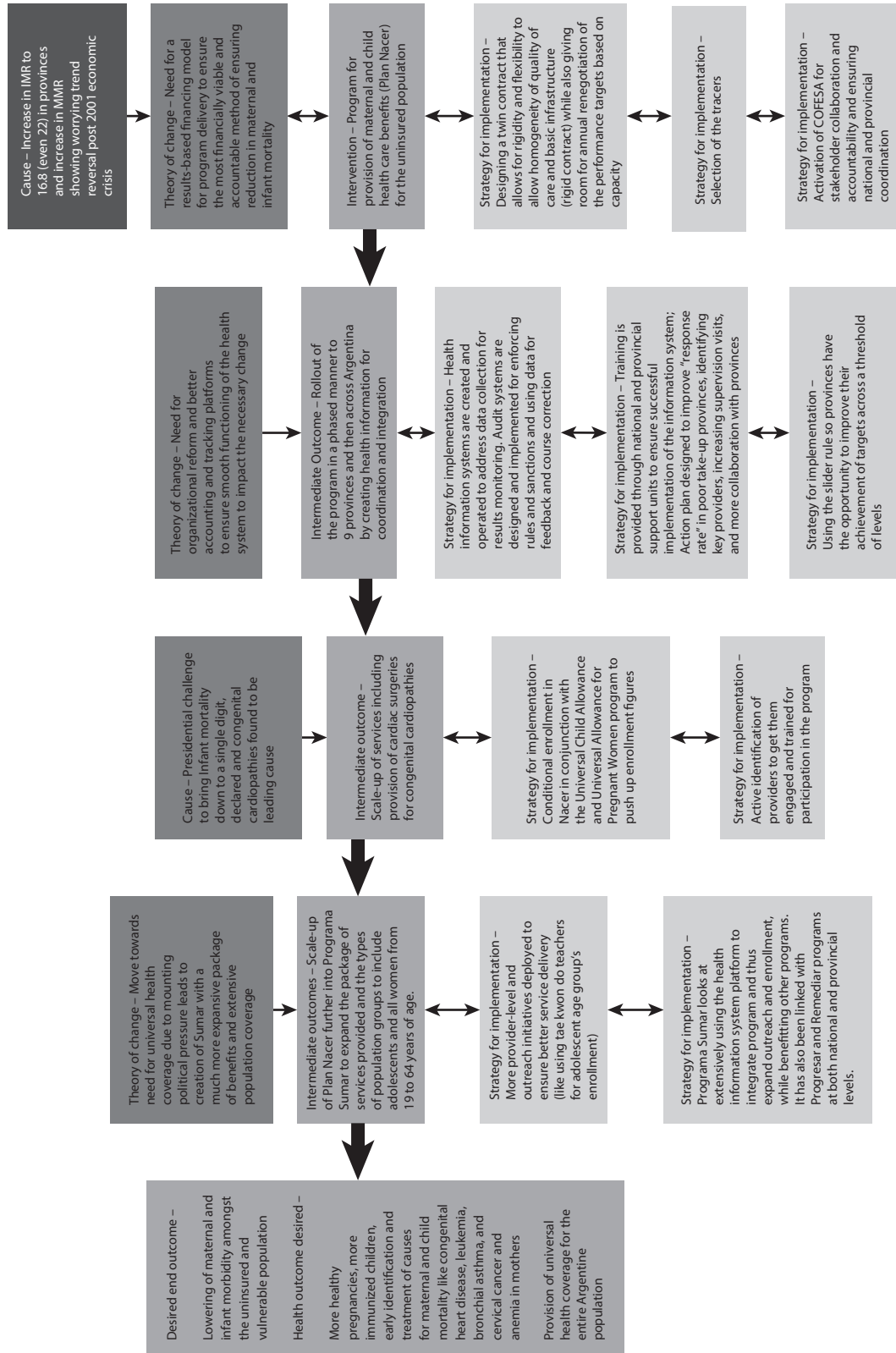
Having a team that was politically and technically well-supported established cohesion that enabled better program design and implementation. Solid experience and continuity of staff at the government level as well as the World Bank enabled program implementation, especially at the early stages of the project. In addition, individual leadership of some of the early team members who were

invested in the project brought in a long-term vision and focus worth highlighting. The team's familiarity with each other—having worked together in previous contexts before—helped in creating synergies. Plan Nacer benefited from their substantial experience and prior familiarity with insurance models and health sector reform. Team members also worked to harness institutional memory to ensure successful implementation of the program. There was significant investment in developing future leaders and team members who would learn and be familiar with the program from the very outset.

Adaptive Implementation

Institutional capacity of health ministries varied considerably across provinces. Recognizing early on the need to adapt to different local contexts was important for implementation and for designing a scheme that would allow flexibility while establishing solid and non-negotiable principles. Further, piloting the program in the nine poorest provinces brought numerous lessons for scaling up to the rest of the country, and allowed important fine-tuning through iterations of the scheme. In addition, the audit and information systems provide constant data for improving and adapting the program. However, without a proper environment to enable course correction based on evidence, the data collected through such systems would have been mostly obsolete. That is, the Nacer/Sumar team realized early on that having data is not sufficient to adapt, but that fostering an institutional environment that allows acting upon such data is also critical. Finally, the World Bank team showed a significant capacity to adapt to the changing circumstances and adjust to the needs of the client and beneficiaries.

ANNEX A Process-Mapping Diagram



ANNEX B Key Inflection Points, 2001–14

<i>Date or time period</i>	<i>Event</i>	<i>Justification for inclusion/relevance</i>	<i>Remarks</i>
2001–02	Economic crisis	Increase in IMR to 16.8 (even 22) in provinces and increase in MMR showing worrying trend reversal	Inflection point
2003–04	Conceptualization of Plan Nacer	The idea is generated and consensus building and stakeholder collaboration activities start before the actual launch of the program	The crisis triggers innovation
2003–04	Selection of a results-based financing model for program intervention	Cost-effectiveness and cost-benefit analysis done to devise the most financially sound method for program delivery	Feedback loop
2003–04	Selection of the tracers	Critical to program success in determining key health outcomes and selected based on previous experiments in smaller pilots in hospitals	Feedback loop
2003–05	Program design and building in course correction	Designing a twin contract that allows for rigidity and flexibility to allow homogeneity of quality of care and basic infrastructure (rigid contract) while also giving room for annual renegotiation of the performance targets based on capacity	Adaptation
2003–07	Launch of the Federal Health Plan	Necessary because it gave the ministry the legitimacy to roll out an RBF scheme in the provinces	Enabling mechanism
2004	Stakeholder collaboration and accounting mechanism	Activation of COFESA which gave the National MOH the legitimacy to launch Nacer and held provinces accountable through public documentation	Facilitating tool
2004	Plan Nacer is launched in 9 northern provinces (in the NOA and NEA). Initial pilot and test run	Inflection point for the first rollout of the program. It is a maternal and child health benefit plan for mothers after 45 days of delivery and children until 6 years of age.	Feedback loop
2004–07	Information systems are created and operated to address data collection for results monitoring.	Primary care units follow a standardized and homogenous method of documentation and diagnosis.	Organizational change
2004–07	Audit systems are designed and implemented for enforcing rules and sanctions.	Brings about implementation of the system of incentives that guides desired outcomes. Recurrent nature of the process creates room for feedback and course correction.	Behavioral change Feedback loop
2004–07	Enabling flexibility through the slider	The payments for reaching the targets have been adjusted since the Plan Nacer was introduced. At the beginning, the payments for reaching the targets were all-or-nothing; that is, provinces only had incentives to reach targets, not to exceed them. But since 2008, payments have been made according to a sliding scale of two or more steps: the full 4 percent is paid only for reaching relatively high targets, while smaller rewards of 1 to 3 percent are paid for lower ones. Compared to the original scheme, the newer targets motivate providers to aim for higher targets rather than reduce their efforts once targets are reached. Thus, the more targets a province meets, the more revenue the province receives under the Plan and the more funds it has for the FFS payments to providers.	Adaptation
2007	Program is launched in all the remaining 15 provinces	Due to high demand and political pressure, the program is rolled out to the rest of the provinces and cross-country implementation is put in place	Inflection point
2007–09	Action plan designed to improve “response rate” in poor take-up provinces, identifying key providers, increasing supervision visits and more collaboration with provinces	Institutional complexities of the larger provinces which led to the involvement of non-contractual stakeholders (municipalities) in Program implementation. Other provinces had capacity constraints.	Adaptation
2008	Lack of transparency allegations and controversy leading to change of program staff and loss of program support	Critical inflection point to study how the team bounced back and how Nacer was able to maintain its ground despite such political and institutional turmoil.	Inflection point/ Pain point
2008	Creation of the Government action accountability and procurement plan	Response to implementation weaknesses and a measure to ensure more transparent procurement process	Adaptation Organizational change

continued

<i>Date or time period</i>	<i>Event</i>	<i>Justification for inclusion/relevance</i>	<i>Remarks</i>
2008	Change of guard and appointment of Maximo Diosque as vice minister for Health	Instrumental for realigning support and championing for Nacer, since Diosque had been a coordinator for Nacer in Tucumán	Inflection point
2010	Expansion of the benefits package to include Congenital Heart Disease and some high-risk maternal delivery and neonatal intensive care conditions	Presidential challenge to bring Infant mortality down to a single digit declared. Political support for expansion.	Inflection point
2010	Conditional enrollment in Nacer in conjunction with the Universal Child Allowance and Universal Allowance for Pregnant Women program	Pushed enrollment rates for Plan Nacer exponentially and helped in making the program see full enrollment of all beneficiaries	Inflection point
2011	Conception of Programa Sumar as a separate program but expanding Nacer's package of services and benefits	Move toward need for universal health coverage due to mounting political pressure and leads to creation of Sumar	Inflection point
2012	Programa Sumar launched	Critical inflection point entailing the launch of the program, expanding the beneficiary group to include children 6–9 years, adolescents 10–19 years, and women younger than 65 years, with focus on 49 service lines and 400 benefits (including cancer care, congenital cardiopathies, etc.)	Inflection point
2012– Ongoing	More provider-level and outreach initiatives to ensure better service delivery (like using tae kwon do teachers for adolescents)	Scaling up and expanding with the extensive menu of benefits provided under Sumar, requires innovative incentives to involve the new stakeholders.	Adaptation

ANNEX C Tracer Indicators for Nacer and Sumar

	<i>Asunto sanitario que valora</i>	<i>Measured health issue</i>	<i>Descripción</i>	<i>Description</i>
1	Captación temprana de mujeres embarazadas	Early detection of pregnant women	Mujeres embarazadas con control prenatal de primera vez antes de la semana 20 de gestación	Pregnant women with first prenatal checkup before week 20
2	Efectividad de atención del parto y atención neonatal	Effectiveness of delivery and neonatal care	Recien nacido con APGAR a los 5 minutos mayor a 6	Newborns with APGAR higher than 6.5 minutes after birth
3	Efectividad de cuidado prenatal y prevención de prematuridad	Effectiveness of neonatal care and prematurity prevention	Peso al nacer superior a los 2.500 gramos	Birth weight higher than 2,500 grams
4	Efectividad de atención prenatal y del parto	Effectiveness of prenatal and delivery care	Madres con VDRL en el embarazo y vacuna antitetánica previas al parto	Mothers with VDRL during pregnancy and tetanus vaccination before delivery
5	Auditoría de muertes infantiles y maternas	Maternal and child death audit	Evaluación del proceso de atención de los casos de muertes maternas y de niños menores de 1 año	Evaluation of the attention process in the case of death of mother and children younger than 1 year of age
6	Cobertura de inmunizaciones	Immunization coverage	Aplicación de vacuna antisarampionosa o triple viral en niños menores de 18 meses	New measles or MMR vaccine in children younger than 18 years of age
7	Cuidado sexual y reproductivo	Sexual and reproductive care	Consulta de consejería de salud sexual y reproductiva a puérperas dentro de los 45 días post-parto	Sexual and reproductive health care of postpartum women 45 days after delivery
8	Seguimiento de niño sano hasta 1 año	Healthy child follow-up to 1 year	Niños menores de 1 año con cronograma completo de controles y percentiles de peso, talla y perímetro cefálico	Children younger than 1 year of age with full scheduled checkups and weight, height, and head circumference percentiles
9	Seguimiento de niño sano de 1 a 6 años	Healthy child follow-up from 1 to 6 years	Niños entre 1 y 6 años con cronograma completo de controles y percentiles de peso y talla	Children between 1 and 6 years of age with full scheduled checkups and weight and height percentiles
10	Inclusión de la población indígena	Inclusion of Aboriginal populations	Efectores que prestan servicio a la población indígena con personal capacitado en el cuidado de dicha población	Health providers who provide services to Aboriginal populations with trained staff in the care of such population

ANNEX C Tracer Indicators for Nacer and Sumar (continued)

 <p>1 ATENCIÓN TEMPRANA DE EMBARAZO EARLY PREGNANCY CARE <i>Mujeres embarazadas atendidas antes de la semana 13 de gestación.</i> <i>Pregnant women seen before week 13.</i></p>	 <p>8 COBERTURA DE INMUNIZACIONES A LOS 24 MESES IMMUNIZATION COVERAGE AT 24 MONTHS <i>Niños de 2 años que recibieron las vacunas cuádruple bacteriana (oquintuple) y antipoliomielítica entre 1 ½ y 2 años.</i> <i>Children at 2 who received quintuple and polio vaccines between 1½ and 2 years of age.</i></p>
 <p>2 SEGUIMIENTO DE EMBARAZO PREGNANCY FOLLOW-UP <i>Realización de al menos 4 controles prenatales en mujeres embarazadas.</i> <i>At least 4 prenatal checkups in pregnant women.</i></p>	 <p>9 COBERTURA DE INMUNIZACIONES A LOS 7 AÑOS IMMUNIZATION COVERAGE AT 7 YEARS OF AGE <i>Niños de 7 años que recibieron las vacunas triple o doble viral, triple bacteriana y antipoliomielítica entre los 5 y los 7 años.</i> <i>Children at 7 who received triple or double viral, triple and polio vaccines between 5 and 8 years of age.</i></p>
 <p>3 EFECTIVIDAD DEL CUIDADO NEONATAL EFFECTIVENESS OF NEONATAL CARE <i>Sobrevida a los 28 días de vida de los niños con peso al nacer entre 750 y 1.500 grs.</i> <i>Survival of 28 days of children with birth weight between 750 and 1,500 grams.</i></p>	 <p>10 SEGUIMIENTO DE SALUD DEL ADOLESCENTE DE 10 A 19 AÑOS FOLLOW-UP OF ADOLESCENTS BETWEEN 10 AND 19 YEARS OF AGE <i>Realización de al menos un control de salud anual entre los 10 y 19 años.</i> <i>At least one annual checkup between 10 and 19 years of age.</i></p>
 <p>4 SEGUIMIENTO DE SALUD DEL NIÑO MENOR DE 1 AÑO FOLLOW-UP OF CHILDREN YOUNGER THAN 1 YEAR OF AGE <i>Realización de al menos 6 controles de salud antes del año de vida, de acuerdo a agenda.</i> <i>At least 6 checkups before the first year of age, as scheduled.</i></p>	 <p>11 PROMOCIÓN DE DERECHOS Y CUIDADOS EN SALUD SEXUAL Y/O REPRODUCTIVA PROMOTION OF SEXUAL AND/OR REPRODUCTIVE HEALTH RIGHTS <i>Adolescentes entre 10 y 19 años y mujeres hasta 24 años que participan en talleres sobre cuidado sexual y/o reproductivo (intra o extra muro).</i> <i>Adolescents between 10 and 19 years of age and women up to 24 years of age who take part in sexual and/or reproductive health workshops.</i></p>
 <p>5 EQUIDAD INTRAPROVINCIAL EN EL SEGUIMIENTO DE SALUD DE MENORES DE 1 AÑO INTRAPROVINCIAL EQUITY IN THE FOLLOW-UP OF CHILDREN YOUNGER THAN 1 YEAR OF AGE <i>Evalúa la igualdad en la cobertura del seguimiento de salud en menores de 1 año entre grupos de departamentos en una misma provincia.</i> <i>It measures equality in terms of health follow-up of children younger than 1 year of age in the different regions of the same province.</i></p>	 <p>12 PREVENCIÓN DE CÁNCER CÉRVICO UTERINO PREVENTION OF UTERINE CERVICAL CANCER <i>Mujeres de 25 a 64 años con lesiones de alto grado o carcinoma de cuello uterino diagnosticados en el último año.</i> <i>Women between 25 and 64 years of age with high-degree lesions or uterine cervical carcinoma diagnosed in the past year.</i></p>
 <p>6 CAPACIDAD DE DETECCIÓN DE CASOS DE CARDIOPATÍA CONGÉNITA EN EL MENOR DE 1 AÑO DETECTION CAPABILITY OF CONGENITAL HEART DISEASE IN CHILDREN YOUNGER THAN 1 YEAR OF AGE <i>Niños menores de 1 año con diagnóstico de cardiopatía congénita y con denuncia al Centro Nacional Coordinador de Derivaciones.</i> <i>Children younger than 1 year of age with congenital heart disease diagnosis reported to the National Coordinating Referral Center.</i></p>	 <p>13 CUIDADO DEL CÁNCER DE MAMA BREAST CANCER CARE <i>Mujeres hasta 64 años con diagnóstico de cáncer de mama efectuado en el último año.</i> <i>Women up to 64 years of age with breast cancer diagnosed in the past year.</i></p>
 <p>7 SEGUIMIENTO DE SALUD DEL NIÑO DE 1 A 9 AÑOS FOLLOW-UP OF CHILDREN BETWEEN 1 AND 9 YEARS OF AGE <i>Realización de al menos 9 controles de salud entre el año y los 9 años, de acuerdo a agenda.</i> <i>At least 9 checkups between 1 and 9 years, as scheduled.</i></p>	 <p>14 EVALUACIÓN DEL PROCESO DE ATENCIÓN DE LOS CASOS DE MUERTES INFANTILES Y MATERNAS EVALUATION OF THE ATTENTION PROCESS OF THE CASE OF MATERNAL AND INFANT DEATH <i>Evalúa el proceso de atención de los casos de muerte materno-infantiles.</i> <i>It evaluates the attention process of maternal and infant death cases.</i></p>

ANNEX D Names and Designations of Interviewees

<i>Name</i>	<i>Designation</i>
Vanina Camporeale	Task Team Leader, Plan Nacer/Sumar, World Bank
Daniela Romero	Operations Analyst, Plan Nacer/Sumar, World Bank
Andrew Sunil Rajkumar	Task Team Leader, Plan Nacer/Sumar, World Bank
Michele Gragnaloti	Human Development Sector Manager for Argentina, Paraguay, and Uruguay, World Bank
Raphael Cortez	Health Economist, World Bank
Luis Orlando Perez	Senior Health Economist, World Bank
Ricardo Izquierdo	Coordinator of Supervision of Audits
Martin Sabignoso	National Coordinator, Plan Nacer
Ana Salas	Medical Service Head, Plan Nacer
Jose Priego	National Procurement Head, Plan Nacer
Alfredo Perazzo	Former Technical Coordinator, Plan Nacer
Luis Martinez	Minister of Health, Santiago del Estro
Julieta Rey	Municipal Coordinator, Lomas de Zamora
Cristian Baeza	Professor of Global Health, University of Washington
Daniel Gollan*	Secretary of Community Health, National Ministry of Health
Pier Paolo Balladelli*	Representative of OPS/OMS for Argentina
Saul Flores*	Ministry of Health, Jujuy Province
Arnaldo Medina*	Executive Director of the Hospital "El Cruce-Nestor C. Kirchner"
Antonio La Scaleia*	President of the Council of Provincial Social Services and Works of the Republic of Argentina (COSSPRA)
Pedro Kremer*	National Director of International Relations of the National Ministry of Health
Cristela Bozas*	Coordinator, Programa Sumar, La Rioja Province
Juan Carlos Nadalich*	Secretary of Management and Institutional Coordination of the Ministry of Social Development
Nicolas Krepalak*	Vice Secretary of Community, Maternal, and Infant Medicine, National Ministry of Health
Adolfo Rubenstein	Institute of Clinical and Sanitary Effectiveness
Patricia Alba	Obstetrician, Lomas de Zamora Clinic
Juana Chavez	Clinic Administrator, Lomas de Zamora

* Refers to presentations made during the 10th anniversary event of Plan Nacer, Buenos Aires 2014.

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