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ARGENTINA

CONDITIONAL CREDIT LINE FOR INVESTMENT PROJECTS (CCLIP) FOR THE PROGRAM FOR STRENGTHENING AND INTEGRATION OF HEALTH NETWORKS IN THE PROVINCE OF BUENOS AIRES
(AR-O0013)

FIRST OPERATION UNDER THE PROGRAM FOR STRENGTHENING AND INTEGRATION OF HEALTH NETWORKS IN THE PROVINCE OF BUENOS AIRES
(AR-L1312)

LOAN PROPOSAL

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CONTENTS

ANNEXES	
Annex I	Summary Development Effectiveness Matrix
Annex II	Results Matrix
Annex III	Fiduciary Agreements and Requirements

REQUIRED LINKS	
1.	Multiyear Execution Plan
2.	Monitoring and Evaluation Plan
3.	Environmental and Social Management Report

OPTIONAL LINKS	
1.	Project Economic Analysis
2.	Climate Change
3.	Operating Regulations
4.	Theory of Change and Estimated Cost
5.	Bibliographic References
6.	Disbursement-linked Indicator Matrix
7.	Safeguard Policy Filter

ABBREVIATIONS

AMBA	Área Metropolitana de Buenos Aires [Metropolitan Area of Buenos Aires]
AMBA Network	AMBA Public Health Network
CABA	Ciudad Autónoma de Buenos Aires [Autonomous City of Buenos Aires]
CAPS	Centros de Atención Primaria de la Salud [primary health care centers]
CCLIP	Conditional Credit Line for Investment Projects
DALY	Disability-adjusted life years
DLI	Disbursement-linked indicators
DPOMyFB	Dirección Provincial de Organismos Multilaterales y Financiamiento Bilateral [Provincial Directorate of Multilateral Agencies and Bilateral Financing]
EMCS	Emergency Medical Care System
FFF	Flexible Financing Facility
HCE	Historia clínica electrónica [electronic medical record]
ICAP	Institutional Capacity Assessment Platform
IDB	Inter-American Development Bank
LBR	Loan based on results
NPV	Net present value
PBA	Provincia de Buenos Aires [Province of Buenos Aires]
PIGH	Plan Integral de Guardias Hospitalarias [Comprehensive Hospital Emergency Room Plan]
WAL	Weighted average life
YPLL	Years of potential life lost

PROJECT SUMMARY

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<table>
<tr><th colspan="6">Financial Terms and Conditions</th></tr>
<tr><td colspan="4">Borrower: Province of Buenos Aires (PBA)</td><td colspan="2">Flexible Financing Facility[a]</td></tr>
<tr><td colspan="4">Guarantor: Argentine Republic</td><td>Amortization period:</td><td>25 years</td></tr>
<tr><td colspan="4" rowspan="3">Executing agency: Borrower, through the Ministry of Economy of the Province of Buenos Aires, with the Ministry of Health and the Ministry of Infrastructure and Public Services as the subexecuting agencies</td><td>Disbursement period:</td><td>3 years</td></tr>
<tr><td>Grace period:</td><td>5.5 years[b]</td></tr>
<tr><td>Interest rate:</td><td>LIBOR-based</td></tr>
<tr><td>Source</td><td>CCLIP (US$)</td><td>1st Operation (US$)</td><td>%</td><td>Credit fee:</td><td>[c]</td></tr>
<tr><td>IDB (Ordinary Capital)</td><td>600,000,000</td><td>150,000,000</td><td>100</td><td>Inspection and supervision fee:</td><td>[c]</td></tr>
<tr><td>Local</td><td>60,000,000</td><td>0</td><td>0</td><td>Original WAL:</td><td>15.25 years</td></tr>
<tr><td>Total</td><td>660,000,000</td><td>150,000,000</td><td>100</td><td>Currency of approval:</td><td>U.S. dollars</td></tr>
<tr><th colspan="6">Project at a Glance</th></tr>
<tr><td colspan="6">Project objective/description: The objective of the CCLIP is to help improve the delivery capacity and quality of primary, secondary, and tertiary public health care services in the PBA, integrating them as a service network that provides priority care to people with exclusive public coverage in order to reduce the number of years of potential life lost. The objective of the first operation under the CCLIP is to improve access and effective coverage of public health services for the PBA population. Its specific objectives are to: (i) improve access to and the effectiveness of primary care in a set of municipios in the Buenos Aires Metropolitan Area; (ii) increase the responsiveness of emergency services across the PBA; and (iii) dispense cancer and palliative drugs in a more timely manner across the PBA.</td></tr>
<tr><td colspan="6">Special contractual conditions precedent to the first disbursement of the loan: The borrower has provided, to the Bank's satisfaction, evidence showing (i) the entry into force of the program Operating Regulations (paragraph 3.6); and (ii) the hiring of the consulting firm or independent consultant for the external verification of outcomes, in accordance with the terms of reference previously agreed with the Bank (paragraph 3.4).
Special contractual conditions for execution: For social and environmental conditions, see Annex B of the Environmental and Social Management Report.</td></tr>
<tr><td colspan="6">Exceptions to Bank policies: None.</td></tr>
<tr><th colspan="6">Strategic Alignment</th></tr>
<tr><td colspan="2">Challenges:[d]</td><td>SI ☑</td><td>PI ☐</td><td colspan="2">EI ☐</td></tr>
<tr><td colspan="2">Crosscutting themes:[e]</td><td>GD ☑</td><td>CC ☑</td><td colspan="2">IC ☐</td></tr>
</table>

[a] Under the terms of the Flexible Financing Facility (document FN-655-1), the borrower has the option of requesting changes to the amortization schedule, as well as currency, interest rate, and commodity conversions. The Bank will take operational and risk management considerations into account when reviewing such requests.

[b] Under the flexible repayment options of the Flexible Financing Facility, changes to the grace period are permitted provided that they do not entail any extension of the original weighted average life of the loan or the last payment date as documented in the loan contract.

[c] The credit fee and the inspection and supervision fee will be established periodically by the Board of Executive Directors as part of its review of the Bank's lending charges, in accordance with relevant policies.

[d] SI (Social Inclusion and Equality); PI (Productivity and Innovation); and EI (Economic Integration).

[e] GD (Gender Equality and Diversity); CC (Climate Change and Environmental Sustainability); and IC (Institutional Capacity and Rule of Law).

I. Description and Results Monitoring

A. Background, problem addressed, and rationale

1.1 For approximately one third of Argentina's population, public health services are the only option for medical coverage.[1] As a federal country, responsibility for managing and financing these services falls mainly to the provincial governments and the Autonomous City of Buenos Aires (CABA). The differences in public expenditure per capita across these jurisdictions is considerable, creating significant geographic inequities in service access and quality [1].[2] Bodies that coordinate service delivery between jurisdictions are also scarce, which results in difficulties obtaining timely, comprehensive, and continuous access to health care services for the population that moves between them.

1.2 The population distribution and political structure of the Province of Buenos Aires (PBA) compounds the problem of fragmentation that characterizes Argentina's public health system. Forty percent of the country's population (17 million people) lives in the PBA, distributed across 135 politically independent municipios. Two-thirds of the population lives in 34 municipios adjacent to the CABA region, which together with the city is called the Buenos Aires Metropolitan Area (AMBA). Hospital management and financing are split between the provincial government and the municipios, whereas primary health care centers (CAPS) fall under the near-exclusive responsibility of the municipios. There are no formal bodies for planning and coordination between municipios or with the provinces.

1.3 In a 2017 analysis of 26 AMBA municipios, the PBA Ministry of Health found wide gaps in service delivery capacity, in addition to a high degree of disparity between health regions.[3] The widest service delivery gaps were found in primary care services, in pre-hospital and hospital emergency services, and in the dispensing of cancer and palliative drugs.

1.4 **Primary care.** These are low-complexity medical services with a broad territorial reach through CAPS. Evidence shows that these services can resolve around 80% of health care visits, which is why primary care is designed to be the gateway to the health system, through which continuity of care should be ensured for the population [2]. CAPS are also critical for implementing community-based health actions that promote health, prevent illness, or enable timely detection and treatment of diseases. Community health promotion and disease prevention actions are particularly crucial for the efficient and effective management of chronic noncommunicable diseases—the leading cause of death and disability in Argentina [3].

1.5 However, the PBA faces major challenges in guaranteeing primary care with adequate and uniform service delivery capacity among its health regions. This is in part because the health system financing structure has favored investment in high-complexity care, resulting in a lack of investment in primary care. Consequently, there are serious infrastructure, equipment, and human resource deficits associated with the availability of fiscal resources at the municipal level.

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1 Low-income population, around 15 million people.

2 See Bibliographic References in optional link 5.

3 The PBA is divided into 11 health regions, 5 of which (V, VI, VII, XI, and XII) include AMBA municipios.

This creates significant geographic inequities. The 2017 analysis showed that: (i) the number of clinics by health region ranged from 3.8 to 21 per 100,000 persons; (ii) 37% of CAPS had facilities in good repair and sufficient medical equipment; and (iii) the rates of general practitioners (2.6), pediatricians (1.6), nurses (3.7), and health workers (0.5) per 10,000 persons in CAPS were below international standards and the care model that the PBA is seeking to implement.

1.6 The variability of human resources across municipios is also due to disparities in remuneration and career development between professionals providing primary care and those providing higher-level care. For example, in early 2017, a physician's average monthly gross salary varied widely, with the municipio with the highest remuneration paying triple the salary of the municipio with the lowest. Public policies that regulate and strengthen employment and wage conditions could decrease such variability between municipios and increase human resources in primary care. This regulation is vital for creating a single service network. Comparable employment conditions and professional qualifications across the entire network are also necessary for compliance with the established standards and processes.

1.7 In addition to adequate service delivery capacity, health network integration requires: (i) a care model that clearly sets out the specific territory and population under the responsibility of primary care teams; (ii) a management model that standardizes care processes; and (iii) an information system that enables the various service providers to access patients' medical history. The 2017 analysis showed that CAPS did not have a defined geographic service area and that there was significant variation in care processes: one in five CAPS had no care programmed, fewer than one in three carried out community activities on a weekly basis, and just 9% had computers with Internet access at their points of care.

1.8 According to the international literature (optional link 4), the evidence-based actions that could resolve the causes of primary care problems in the PBA are to: (i) distribute CAPS according to specific territories and populations and entrust them with explicit responsibility for managing health through promotion, prevention, support, rehabilitation, and palliative care; (ii) invest in infrastructure and equipment and promote the availability of basic health care teams sufficient to guarantee CAPS' service delivery capacity; (iii) deploy strategies that promote community-based health activities and an active patient search; (iv) establish the interoperability of information systems by implementing the electronic medical record (HCE) to improve health integration and continuity of care in the PBA; and (v) establish a cofinancing strategy that, recognizing the primary care financing structure and the heterogeneous fiscal capacity of its municipios, promotes investment to maintain CAPS' service delivery capacity in the long term.

1.9 **Pre-hospital emergency services and emergency hospital medicine.** Emergency health services are divided into pre-hospital care (ambulances that respond to serious incidents on public roads) and emergency hospital medicine (emergency rooms that provide uninterrupted medical care to the general population). Both provide immediate medical assistance in an accident, at the sudden onset of a serious condition, or when a chronic illness worsens. These

situations are considered emergencies because they pose a clear danger to the patient's life.

1.10 Emergency services are important for reducing the burden of disease (years lost due to premature death or disability).[4] External injuries alone currently account for 12% of the disease burden in Argentina, affecting men in particular [3]. Evidence shows that the response time between the occurrence of an accident and admittance to the emergency room is a critical factor in reducing the burden of mortality. Studies shows that if five minutes or less elapses, the chance of survival increases by 10% to 11%.

1.11 According to a 2016 analysis, the PBA faced major challenges with emergency services: (i) virtually no municipio had formal public emergency care services; (ii) ambulance service availability was poor; (iii) teams responding to emergencies on public roads did not have the equipment or qualifications to take prompt and effective action; and (iv) there was no coordination between emergency responders and hospitals in terms of available emergency room capacity for timely care. In addition, the lack of availability and quality of care in CAPS creates demand for low-complexity outpatient care in emergency rooms, which are overwhelmed with these services. According a recent analysis of 30 emergency rooms in the PBA, 88% of visits are low-complexity and therefore suitable for care in CAPS.

1.12 The lack of coordination between municipios and other levels of government in responding to emergencies creates gray areas in health care responsibility and therefore leads to underinvestment. This has led to considerable deficits in: (i) the number of ambulances equipped to respond to emergencies and the availability of staff qualified to respond to them; and (ii) hospital infrastructure and equipment in many emergency rooms. The analysis found that 69 of the 80 provincial hospitals needed to be upgraded and that emergency rooms were crowded. This resulted in long wait times and failures in care [4]. This problem was compounded in part by the lack of a triage system, which improves treatment effectiveness in critical cases by giving them priority (optional link 4).

1.13 According to the international literature (optional link 4), the following actions would help improve emergency services in the PBA: (i) organize the capacity of emergency care teams on public roads based on population and logistical criteria; (ii) equip these teams with the necessary ambulances and equipment; (iii) train their operators to provide prompt and effective care; (iv) organize systematic coordination between emergency services and emergency rooms; (v) invest in infrastructure and equipment and promote the availability of sufficient trained health care staff to guarantee care capacity in emergency rooms; and (vi) implement a triage system. In addition, using the same system in all emergency rooms in the PBA would facilitate interoperability with primary care, making it easier to manage low-complexity cases at CAPS.

[4] Reducing premature mortality due to disease or accidents is one of the targets of the Sustainable Development Goals.

1.14 **Cancer and palliative treatment.** A higher life expectancy among Argentinians and an increase in other risk factors mean that there are more and more cancer diagnoses relative to the distribution of the country's burden of disease. The mortality rate attributable to neoplasms in 2017 was 22.3% nationally. In order of importance, the three most prevalent types of cancer are lung, colorectal, and prostate cancer for men and breast, lung, and colorectal cancer for women [3].

1.15 Cancers are caused by genetic, environmental, and behavioral factors (smoking, a sedentary lifestyle, an unhealthy diet, and stress). Changes in these behaviors can reduce the risk of contracting the disease by 76% for lung cancer, 55% for colorectal cancer, 25% for breast cancer, and 6% for prostate cancer. Through community-based health interventions, primary care services can play a key role in changing these behaviors and detecting cancers early. Regardless of the level of country development, international evidence has shown that early detection and treatment of cancer substantially increase survival rates and can reduce related health care costs [6].

1.16 There is considerable room for improvement in cancer screening rates. For example, according to the 2013 National Risk Factor Survey, in the past two years, 34% of women did not get screened for breast cancer and 75% of the population never got screened for colorectal cancer. For years, the national government and the PBA have been making efforts to promote smoking cessation and increase breast and cervical cancer screening, particularly through primary care. Efforts have recently also been made to increase screening for colorectal cancer at the primary care level, supported by the IDB (loans 2788/OC-AR and 3772/OC-AR).

1.17 Failure to detect cancer early also has social determinants. For example, screening for breast and colorectal cancer is less common among those in the first quintile of income than among those in the last quintile (49% and 83%, compared to 21% and 66%, respectively).[5] The fact that efforts to increase cancer screening are being implemented through national or provincial programs means that responsibility for these actions has yet to be incorporated into the routine actions of primary care teams, affecting the comprehensiveness of care for the population they serve.

1.18 In 2016, the PBA established the Provincial Cancer Control Plan by way of a ministerial resolution, to help reduce the burden of disease caused by malignant tumors in the PBA. The plan includes interventions to improve the medication purchasing and management process and the interoperability of information and communication systems. While the PBA is stepping up efforts to ensure cancer treatment availability, in conjunction with the Ministry of Health, the rate of timely access in 2017 was still 55%. The lack of coordination among jurisdictions, the small number of drug banks for the distribution of medication, and the under-reporting of patients due to the absence of a consolidated register are some of the main causes of poor access to cancer treatments in a timely manner.

1.19 Palliative care is a critical component of effective, humane cancer treatment. Its aim is to address the symptoms and side effects of the disease and its treatment as early on as possible, in addition to the associated psychological and social

[5] The National Risk Factor Survey concludes that behavioral factors associated with cancer are also more prevalent among the low-income population.

issues. Palliative care is indicated along the entire continuum of care for cancer, including care in the final stages of life when the goal of the care provided is no longer curative treatment, but rather quality of life. Evidence shows that, when integrated into ordinary cancer care, palliative care significantly reduces pain for 90% of patients [7].

1.20 As part of the Provincial Cancer Control Plan, pain management in cancer patients was established as a priority line of action for the PBA, and an opioid distribution network was implemented.[6] According to the Ministry of Health, the rate of timely access to palliative drugs in 2017 was still 33%. The insufficient availability of medication for pain management, physicians' reluctance to prescribe opioids, and people's lack of awareness of the existence of public coverage for pain management in cancer patients are the main causes of the low level of timely coverage.

1.21 According to the international literature (optional link 4), effective care for cancer patients depends on a sequence of health care services: prevention, early detection, diagnosis, referral, accessible treatment, monitoring, and palliative care. As the process to strengthen primary care services is implemented, national and provincial cancer programs will have to be integrated, which includes implementing palliative care[7] in programmatic primary care actions.

1.22 **AMBA Public Health Network (AMBA Network).** To close gaps in service delivery capacity and improve the effectiveness of services, the PBA developed the AMBA Network, an integrated health service network strategy with progressive care and a care model based on attributes recognized as necessary for effective and efficient health care [3, 8]. Given the political, technical, and financial complexity of building a service network with such characteristics, the PBA designed a three-stage implementation plan. The first stage focuses on: (i) better access to and effectiveness of primary care in 16 municipios;[8] (ii) better responsiveness by emergency services across the province through an Emergency Medical Care System (EMCS) and through upgrades to hospital emergency rooms; and (iii) more timely dispensation of cancer and palliative drugs. One crosscutting priority is the implementation of an HCE so that system practitioners can consult clinical information in an integrated manner. The subsequent stages will focus on expanding the AMBA Network to other municipios and strengthening the treatment capacity of the province's secondary and tertiary care levels for critical illnesses. The first individual loan operation under the CCLIP will help finance the first stage of AMBA Network implementation.

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6 Law 17.818/1968 regulates the prescription of opioids. Only licensed physicians, using an official form issued by the jurisdiction's competent health authority, can prescribe them. The prescription is for a maximum of 10 days and must be controlled by a pharmacist, who records this opioid use in an initialed register and keeps a copy of the prescription form. The health authority keeps a record of all prescriptions. Moreover, the provincial program has a management system that records the prescriptions and permissible use per patient, along with the diagnosis and information about the prescribing physicians.

7 With IDB financing (loan 3772/OC-AR), the National Cancer Institute of Argentina is implementing a pilot program for palliative care management through primary care.

8 See optional link 4 for criteria to add municipios.

1.23 **AMBA Network interventions to improve primary care.** In keeping with international best practices (paragraph 1.8), the strategy for improving primary care entails the following interventions: (i) implement the AMBA care model, defining the programmatic areas with the target population, registering recipients, and forming multidisciplinary health teams; (ii) upgrade and enhance CAPS facilities, equipping them with medical and computer equipment and furnishings; (iii) standardize service delivery capacity in CAPS with the AMBA Network standard (health care teams consisting of a physician, pediatrician, nurse, and health care worker); (iv) implement the AMBA Network management model through a micro participatory management plan; and (v) implement the HCE in order to shift care to prevention and monitoring.

1.24 To implement the AMBA Network, the Ministry of Health signs a collaboration and membership agreement with each participating municipio, which structures cofinancing between the parties according to the following breakdown: (i) from month 1 to 24, the Ministry of Health transfers 100% of the required funds to the municipio; (ii) from month 25 to 36, 75%; (iii) from month 37 to 48, 50%; and (iv) from month 49 to 60, 25%. After month 25, the municipio absorbs the share of expenditures that the Ministry of Health no longer covers. For accountability purposes, the municipios submit a report every four months on the assets and funds transferred.

1.25 **Interventions to improve pre-hospital emergency services and emergency rooms.** The international literature (paragraph 1.13) suggests the following interventions to improve pre-hospital emergency services: (i) organize the capacity of emergency care teams on public roads based on population and logistical criteria; (ii) equip these teams with the necessary ambulances, equipment, and gear based on density and land area criteria; (iii) standardize EMCS service delivery capacities by hiring staff with specific profiles and through training and supervision for the implementation of standardized protocols and intermunicipal coordination; (iv) set up a phone line for emergencies that could also be used for telephone-based triage; (v) implement an online platform to report the provision of emergency care; and (vi) improve intermunicipal coordination for implementing protocols.

1.26 To implement the EMCS, the Ministry of Health signs a 36-month collaboration and membership agreement with participating municipios. The agreement includes a decreasing structure of annual cofinancing between the province and the municipio (100%, 50%, and 25%), such that after month 36, the municipio absorbs all EMCS operating costs. For accountability purposes, the municipios submit a monthly report on EMCS operations.

1.27 The strategy to improve hospital emergency rooms entails the following interventions: (i) upgrading and enhancing emergency room facilities; (ii) purchasing medical and non-medical equipment as needed; (iii) putting in place a signage system to guide patients and improve communication; (iv) implementing a triage system to identify the need for and the urgency of care for each patient so that care can be prioritized; (v) setting up a monitor room with security cameras; (vi) implementing a computer-based patient register; and (vii) training emergency staff on the triage system, conflict management, equipment maintenance, biosafety, cost recovery, and mental health.

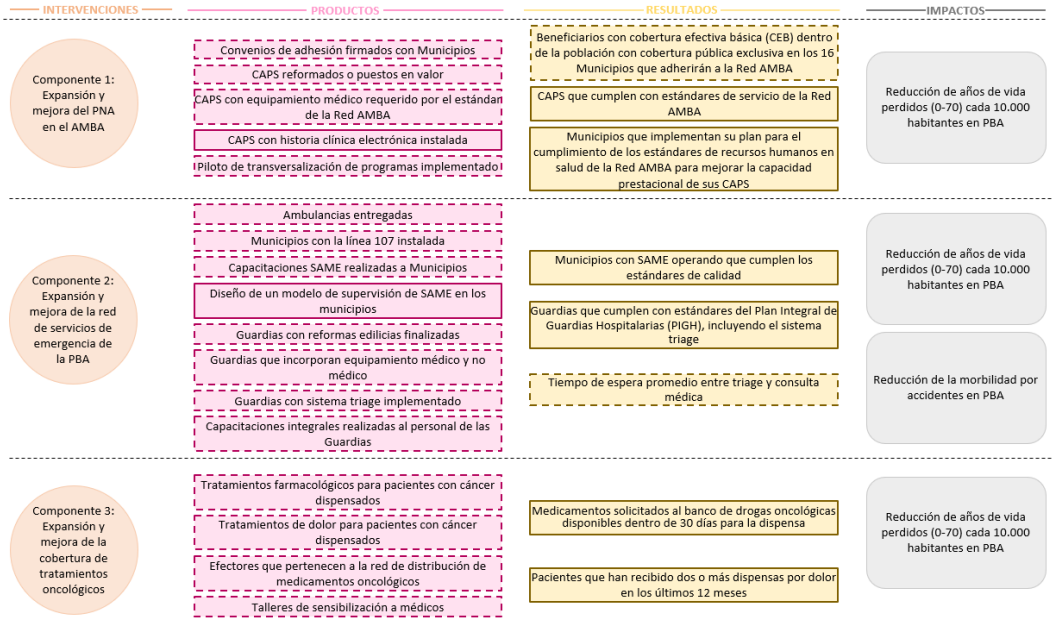
1.28 **Interventions to improve cancer treatment coverage.** The international literature (paragraph 1.21) suggests the following interventions: (i) improve the supply of cancer and pain management drugs; (ii) improve the drug management process; (iii) strengthen the interoperability of information systems and train staff on computer systems; (iv) raise awareness among and train physicians on the use of medication to manage pain; and (v) strengthen program communication on the existence of public coverage for pain management in cancer patients.

1.29 **Gender gap in premature mortality indicators.** According to the Health Statistics and Information Directorate, years of potential life lost (YPLLs)[9] in the PBA amounted to 589 years per 10,000 inhabitants in 2016. An analysis of the indicator by gender for the period 2010–2016 shows a wide gap averaging 332 YPLLs between men and women, favoring the latter. A breakdown of this gap by cause of death reveals that 45% of the difference in YPLLs between men and women is as a result of death due to external causes and 21% as a result of cardiovascular diseases (optional link 4). Deaths due to external causes account for 29.7% of YPLLs for men and barely 5.9% for women, suggesting that both emergency hospital medicine (emergency room) interventions and pre-hospital medical intervention can affect the gender gap, potentially reducing deaths that have a disproportionately greater impact on the YPLLs of men. Applying a gender focus to the detection and treatment of cardiovascular diseases in primary care, like in AMBA Network actions, could narrow this gap.

1.30 **Theory of change (optional link 4).** To improve health indicators for the population exclusively with public coverage in the PBA, service delivery capacity and quality must be improved for all care levels, particularly primary care, by integrating them as a service network based on the implementation of an HCE that is interoperable between care levels. Given the high prevalence of premature deaths in the PBA as a result of accidents on public roads and the high mortality rate due to cancer compared to developed countries, improving health indicators requires strengthening emergency services and cancer treatment. To achieve both objectives, that is, improving health indicators and reducing premature deaths, investments are needed to improve infrastructure, equipment, human resources, and care and service management models. Optional link 4 outlines the program's vertical logic, with evidence supporting the effectiveness of the proposed interventions, which are based on the corresponding World Health Organization and Pan American Health Organization guidelines.

[9] The YPLL indicator measures the loss suffered by society as a consequence of premature deaths (in this case, age 70 is the threshold). YPLLs measure the additional years that someone would have lived had they not died due to a given cause and are expressed as a rate per 10,000 inhabitants.

Figure 1. Program outcome chain diagram



Note: A box with a solid line indicates that the outcomes and outputs are part of the Disbursement-linked Indicator Matrix.

1.31 **Lessons learned.** The operation's design will include lessons learned from other operations financed by the Bank in this sector in the region:[10] (i) the use of external work supervision mechanisms when the executing agency is not directly responsible for monitoring the physical progress of the work (1700/OC-AR); (ii) the application of an approach to (re)order services into integrated networks, from primary to tertiary care, in order to generate efficiencies and a better continuum of care in a context where resources are limited (2137/OC-BR and 3051/OC-BR); (iii) the use of triage systems and their integration into the rest of the care network levels in emergency services and emergency rooms to improve the effectiveness of care (3400/OC-BR); and (iv) the use of the HCE to coordinate service delivery between municipios and make the provision of specialized care more efficient at the provincial level (2137/OC-BR and 3051/OC-BR). It also includes lessons learned from the implementation of other investment loans based on results (LBRs) (4290/OC-UR, 4329/OC-UR, 4658/OC-UR, 4553/OC-DR-1, and 4447/OC-ME), such as selecting disbursement-linked indicators (DLIs) that: (i) reflect a balance between the final and intermediate outcomes; (ii) ensure the predictability of funds; and (iii) are contained in State programs backed by an expenditure framework. In addition, monitoring focused on program preparation and execution will be conducted to identify and document lessons learned for future operations to be financed in Argentina using this instrument.

[10] Lesson (i) was incorporated into the program implementation arrangement; (ii) and (iv) were considered in Components 1 and 3; and (iii) was considered in Component 2.

1.32 **Strategic alignment.** The loan is consistent with the Update to the Institutional Strategy 2010-2020 (document AB-3008) and is aligned with the development challenge of Social Inclusion and Equality by promoting access to health services for all segments of the population. The program is also aligned with the crosscutting theme of: (i) Gender Equality and Diversity and is consistent with the Gender and Diversity Sector Framework Document (document GN-2800-8) by increasing access to quality public services through the improvements promoted by the AMBA Network, which include activities designed to close the gender gap in the use of preventive services[11] and in the prevalence of cancers,[12] and improve urgent care and emergency services, as well as facility standards relating to accessibility for individuals with limited mobility; and (ii) Climate Change and Environmental Sustainability by financing strategies that reduce emissions through improvements to the energy efficiency of hospital infrastructure. For this latter reason, it is consistent with the Climate Change Sector Framework Document (document GN-2835-8). Of the total operation resources, 3.14% will be invested in climate change mitigation and adaptation activities according to the joint methodology of the multilateral development banks for tracking climate finance. These resources contribute to the IDB Group's target of increasing the financing of climate change-related projects to 30% of all operations approvals by the end of 2020. It will also contribute to the Corporate Results Framework 2016-2019 (document GN-2727-6) by increasing the number of people who obtain health care services (2,721,871 people) and strengthening health care institutions and public health information systems. It is further aligned with the following strategies: (i) the IDB Group Country Strategy with Argentina 2016-2019 (document GN-2870-1) with the aim of strengthening the quality of primary care services for the prevention and early detection of chronic noncommunicable diseases; and (ii) the Strategy on Sustainable Infrastructure for Competitiveness and Inclusive Growth (document GN-2710-5), as it contributes to maintaining sustainable social and environmental infrastructure in order to improve access to health services and access for people with disabilities. Lastly, it is consistent with the Health and Nutrition Sector Framework Document (document GN-2735-7) by financing strategies that ensure the sufficiency and relevance of infrastructure, technology, inputs, and human resources necessary to organize health services networks and that build capacity and strengthen management of such networks. This operation is included in the 2019 Operational Program Report (document GN-2948).

1.33 **Rationale for the conditional credit line for investment projects (CCLIP).** The achievement of AMBA Network objectives requires technical and operational coordination between the Ministry of Health, the Ministry of Infrastructure and Public Services, and the Ministry of Economy to narrow the gaps in service delivery capacity and enhance the integration of health care service levels through interventions that improve care, management, and service infrastructure. The AMBA Network is a promising platform for this coordination.

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[11] Strengthening of primary care is associated with: (i) better indicators of women's health; (ii) lower maternal mortality rates, unmet family planning needs, and cervical cancer rates; and (iii) a reduction in chronic illnesses affecting men at younger ages.

[12] This improvement contributes to the Gender Action Plan by optimizing the dispensing of medication for the treatment of breast, cervical, and ovarian cancers.

1.34 In this context, a CCLIP is the appropriate instrument for supporting the medium-term objectives of the PBA government within a time framework that is commensurate with the timeline established for achieving them, providing a frame of reference for financing resources with the same time horizon. The CCLIP proposed here will be implemented through the sectoral modality, in keeping with the modifications approved for the CCLIP in October 2016 (document GN-2246-9).

1.35 This first operation under the CCLIP will be structured as an LBR, as its components meet the requirements set out in the LBR instrument policy (document GN-2869-1) and in the guidelines for processing an LBR (document GN-2869-3): (i) they support State-run AMBA Network, EMCS, emergency room, and cancer programs in delivering results by financing their expenditure framework; (ii) they improve the performance of those programs by incorporating good practices and making them results-oriented; (iii) they promote the use of the fiduciary systems of the executing agency and subexecuting agencies, in keeping with the principles and good practices related to LBR use; and (iv) the institutional analysis of the executing agency and subexecuting agencies shows that they have management systems to guarantee the proper technical (monitoring) and fiduciary (procurement and financing) execution of the program. The instrument also strengthens results-based management, which contributes to solving the challenges identified in the operation's diagnostic assessment.

1.36 The use of an LBR in the first operation under a CCLIP entails a gradual process for improving the effectiveness of public health care services in the PBA through technical capacity-building and the development of information systems on which a results-based management model can be based. In this context, DLIs are designed as metrics for intermediate outcomes related to an increase in service delivery coverage consistent with attributes that, according to empirical evidence, are necessary for achieving the program's final outcomes in a sustainable manner. Independent consulting services will be retained for verification of DLI targets.

B. Objectives, components, and cost

1.37 **Objectives.** The Bank will support the implementation of the AMBA Network through a CCLIP. The objctive of the CCLIP is to help improve the delivery capacity and quality of primary, secondary, and tertiary public health services in the PBA, integrating them as a service network that provides priority care to people exclusively with public coverage in order to reduce YPLLs.

1.38 The primary objective of the operation under the CCLIP is to improve access and effective coverage of public health services for the PBA population. Its specific objectives are to: (i) improve access to and the effectiveness of primary care in a set of municipios in the AMBA; (ii) increase the responsiveness of emergency services across the PBA; and (iii) dispense cancer and palliative drugs in a more timely mannder across the PBA. The first operation will be divided into three components.

1.39 **Component 1. Primary care expansion and improvement in the AMBA (US$72.1 million).** The expected outcome of this component will be to increase effective public health service coverage for primary care in at least 150 CAPS across a minimum of 16 AMBA municipios and to finance the costs associated with

the following activities: (i) implement the AMBA care model (including defining programmatic areas with the target population, registering recipients, forming health teams, and assigning people under their responsibility); (ii) upgrade and enhance CAPS facilities; (iii) purchase, distribute, and install medical and computer equipment and furnishings; (iv) standardize CAPS service delivery capacities (assess the working conditions of health care workers and hire health care staff to comply with AMBA Network service standards); (v) implement the AMBA management model (hire coordinators and facilitators, train facilitators—with a focus on gender in the detection and treatment of diseases—and implement continuous improvement cycles); (vi) implement the HCE (purchase computer equipment and software licenses, upgrade servers, and train CAPS workers); and (vii) run a pilot to enhance synergies with national or provincial cancer programs with primary care programmatic actions.

1.40 **Component 2. Expansion and improvement of the emergency services and emergency room network in the PBA (US$41.2 million).** The expected outcome of this component will be to increase effective and timely coverage in secondary care and to finance the costs associated with the following activities: (i) implement EMCS in at least 59 municipios of the PBA, promoting the fact that this service meets service standards and operates in a provincial emergency services network; (ii) provide ambulances, equipment, and gear based on density and geographic area criteria; (iii) standardize EMCS service delivery capacities by hiring staff with specific profiles and through training and supervision for the implementation of standardized protocols and intermunicipal coordination; (iv) implement an online platform to report the provision of emergency care, which makes it possible to analyze response times; (v) upgrade, enhance, equip with medical and non-medical equipment, and put in place signage in at least 11 hospital emergency rooms so that they meet Comprehensive Hospital Emergency Room Plan (PIGH) standards; (vi) implement the triage system to reduce the average wait time for medium- and high-complexity cases; (vii) set up an emergency room registration computer system (software installation and staff training); and (viii) train emergency personnel on the triage system, conflict management, equipment maintenance, biosafety, cost recovery, and mental health.

1.41 **Component 3. Expansion and improvement of cancer treatment coverage (US$36.2 million).** The expected outcome of this component will be to increase effective coverage of cancer services in tertiary care and to finance the costs associated with the following activities: (i) improve the supply of cancer and pain management drugs through purchases and public production; (ii) improve the drug management process; (iii) enhance the interoperability of information systems and train staff on computer systems; (iv) raise awareness among and train physicians on the use of medication to manage pain; and (v) increase program communication regarding the existence of public coverage for pain management in cancer patients.

1.42 The program will also cover the costs of financial audits, external verifications of the attainment of the outcomes, an impact assessment of the interventions, and administrative expenses.

C. Key outcome indicators

1.43 The overall program impact will be measured using health indicators that illustrate the loss suffered by society as a consequence of premature deaths, such as YPLLs and deaths as a result of accidents.

1.44 The program DLIs are as follows: (i) for Component 1: (DLI1) CAPS that meet the AMBA Network service standards, (DLI2) CAPS with HCE installed, and (DLI3) municipios that implement their plan for compliance with the health care staffing standards of the AMBA Network to improve the service delivery capacity of their CAPS; (ii) for Component 2: (DLI4) municipios with an operational EMCS that meet quality standards, (DLI5) design of an EMCS monitoring model in municipios, and (DLI6) emergency rooms that meet PIGH standards, including a triage system;[13] and (iii) for Component 3: (DLI7) medication requested from the cancer drug bank available for dispensing within 30 days, and (DLI8) patients who were dispensed medication for pain two or more times in the past 12 months. The disbursement matrix included in Annex II specifies the indicators, targets, and related amounts. These indicators were selected because they are critical for the fulfillment of program objectives and because they strike the right balance between intermediate and final indicators and have information sources for monitoring and measurement.

1.45 **Cost-benefit evaluation.** An economic analysis was carried out of the operation's components (optional link 1) using a discount rate of 3%. For the AMBA Network, the benefits are derived from the increase in disability-adjusted life years (DALYs) saved, as a result of expanded coverage for health interventions in CAPS. With reasonable parameters on the effective expansion of coverage of these interventions (10%), the net present value (NPV) is US$250 million and the benefit-cost ratio is 3.1. For the EMCS, the benefit was estimated based on lives saved through the expansion of ambulatory emergency services using conservative assumptions regarding the effective incidence of mortality on public roads according to the international literature. The NPV is US$27 million and the benefit-cost ratio is 1.34. For emergency rooms, the estimated benefits arise from calculating the savings in the opportunity cost of patients and their families in terms of hospital wait times as a result of implementing a triage system. The NPV is US$2 million and the benefit-cost ratio is 3.03. For cancer treatment, the benefits are derived from an increase in DALYs saved due to breast cancer treatment with Trastuzumab, a drug considered to be effective. The NPV exceeds US$400,000 and the benefit-cost ratio is 1.02.

[13] The outcome indicator "Average wait time between triage and medical consultation" is not included in the DLI, since some emergency rooms in the PBA do not yet have the capacity to report this. The first operation under the CCLIP would create that capacity.

II. Financing Structure and Main Risks

A. Financing instruments

2.1 The CCLIP amount will be US$600 million in financing from the Bank's Ordinary Capital, through an LBR under the Flexible Financing Facility, and US$60 million in local contributions. The CCLIP will finance up to four individual operations over 10 years. The CCLIP amount reflects the resources necessary to finance the AMBA Network expansion phases. The amount of the first individual operation will be US$150 million. The borrower will be the program's executing agency, which will act through its Ministry of Economy, with the Ministry of Health and the Ministry of Infrastructure and Public Services as the subexecuting agencies. The Ministry of Economy will execute the program through the Provincial Directorate of Multilateral Agencies and Bilateral Financing (DPOMyFB).[14]

2.2 **CCLIP eligibility.** The requirements of the proposed modifications to the CCLIP (document GN-2246-9) are met if: (i) the executing agency and subexecuting agencies completed a similar program in the preceding five years for which the CCLIP was requested;[15] (ii) the previous programs complied with the terms of the loan contract, were executed in a satisfactory manner overall, involved financial statements that were submitted in a timely fashion without reservations, and maintained the investments made; (iii) the executing agency and subexecuting agencies have a solid performance history in executing their past programs and demonstrated that they have the capacity to maintain satisfactory performance in the aspects covered by the CCLIP; and (iv) the objectives and scopes that will be financed under the CCLIP are included in the country strategy priorities and are given priority in the 2019 Operational Program.

2.3 **Eligibility criteria for the first individual operation.** The first individual operation meets the eligibility requirements set out in Section D.1.b. of document GN-2246-9 insofar as it: (i) is covered in the CCLIP components and sector; and (ii) was included in the Argentina Programming Document. Subsequent individual operations will have to meet the eligibility criteria set forth in Section D.1.b of document GN-2246-9.

2.4 **Cost and financing.** The budget by component and financing source is presented in Table 1 and in the Estimated Cost (optional link 4). The program disbursement period will be three years and will follow the schedule and tranches detailed in Table 2. This period is tied to the characteristics of the activities involved in this operation and the pace of achieving and implementing the outcomes, as well as the good institutional capacity of the executing agency and subexecuting agencies in project management.

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[14] The Operating Regulations will set out the functions, roles, and responsibilities of the Ministry of Economy, Ministry of Health, and Ministry of Infrastructure and Public Services.

[15] The Ministry of Economy, Ministry of Health, and Ministry of Infrastructure and Public Services all have at least one satisfactory experience executing projects that include components similar to those that will be executed under the CCLIP (4427/OC-AR and 1700/OC-AR).

Table 1. Estimated program costs (US$ millions)

Component	IDB	%
Component I. Primary care expansion and improvement in the AMBA	72.10	48.07
Component II. Expansion and improvement of the emergency service and emergency room network in the PBA	41.24	27.49
Component III. Expansion and improvement of cancer treatment coverage	36.22	24.15
Program administration and evaluation	0.44	0.29
Total	**150.00**	**100.00**

Table 2. Schedule and disbursement tranches (US$ millions)

	Year 1	Year 2		Year 3	Total
Component	**1**	**2**	**3**	**4**	
Component I. Primary care expansion and improvement in the AMBA	34.40	31.42	6.28	0.00	72.10
Component II. Expansion and improvement of the emergency service and emergency room network in the PBA	25.04	4.27	9.33	2.60	41.24
Component III. Expansion and improvement of cancer treatment coverage	20.62	7.80	7.77	0.03	36.22
Program administration and evaluation	0.44	0.00	0.00	0.00	0.44
Total	**80.50**	**43.49**	**23.38**	**2.63**	**150.00**

B. Environmental and social risks

2.5 Given that disbursements under an LBR are made based on the results already achieved, this type of operation is suitable for the use of country systems to manage environmental and social aspects, triggering Directives B.13 and B.16. Directive B.13 (policy-based loans and flexible lending instruments) of the Environment and Safeguards Compliance Policy (OP-703) establishes how safeguards are applied in an LBR, indicates that they may require alternative environmental assessment and management tools to determine their level of safeguard risks and operational requirements, and provides that the use of country monitoring and evaluation systems must be promoted for these operations. In that respect, according to the guidelines contained in Directive B.16 of OP-703, an analysis was conducted whether the country's systems are equivalent to and acceptable with respect to applicable Bank environmental and social safeguards. The gaps identified, and the means for closing them and adequately managing the social and environmental risks associated with the first program, are outlined in the corresponding Action Plan and Equivalence and Acceptability Analysis. The program has the potential to cause localized, short-term adverse environmental impacts, including related social impacts, for which specific mitigation measures are available as specified in the Environmental and Social Management Report (required link 3).

C. Fiduciary risks

2.6 In compliance with document GN-2869-1, the Bank applied the Institutional Capacity Assessment Platform, with satisfactory results. The results of the various assessments show that the Ministry of Economy of the PBA, along with the Ministry of Health and the Ministry of Infrastructure and Public Services, have sufficient fiduciary systems developed to manage the execution and achievement of the expected outcomes. The fiduciary risk is therefore low.

D. Other key risks and issues

2.7 Medium-high risks were identified for public management and governance: (i) a potential change in priorities at the provincial level following the October 2019 elections could lead to cuts in the budget available for the AMBA Network, EMCS, and Provincial Cancer Control Plan program operation, which would affect the fulfillment of the targets set for the disbursement-linked indicators related to those programs; and (ii) a potential change in priorities at the municipal level following the October 2019 elections could lead to cuts in the budget available for financing municipal participation in agreements with the AMBA Network and EMCS, which would affect the fulfillment of the targets set for the disbursement-linked indicators related to those programs. The mitigation action identified for both risks is to systematize the plans and evidence associated with the interventions, which are consistent with the commitments that Argentina made in connection with the 2030 Sustainable Development Goals in the area of health. This will enable robust political dialogue with future authorities to ensure the continuity of efforts in this respect.

2.8 **Sustainability.** The continuity of the AMBA Network and EMCS operation is backed by agreements voluntarily signed between the PBA and municipios, and which will gradually replace PBA resources with their own funds. This will allow municipios to plan long term and incorporate these resources into the municipal budget in a measured manner. The average fiscal impact of the AMBA Network operation on the total health expenditure of the municipios is 2%.

III. Management and Implementation Plan

A. Summary of implementation arrangements

3.1 **Borrower, guarantor, and executing agency.** The borrower will be the PBA, and the guarantor will be the Argentine Republic. The Argentine Republic will be the guarantor for the borrower's financial obligations, in accordance with the policy on guarantees required from the borrower (document GP-104-2) for loans to subnational entities. The borrower, through the Ministry of Economy of the PBA, will be the executing agency, with the Ministry of Health and the Ministry of Infrastructure and Public Services serving as the subexecuting agencies. The Ministry of Economy, through the DPOMyFB under the Finance Subsecretariat, will be in charge of overall program coordination. Its responsibilities will include guaranteeing fulfillment of the loan actions, managing financial resources, and acting as a direct counterpart to the IDB, liaising with the various program actors. The PBA Ministry of Health and Ministry of Infrastructure and Public Services will be the program's subexecuting agencies. The Ministry of Health, through the Cabinet of Advisors, will coordinate the planning and technical execution of the

planned program actions with the AMBA Network units and the Public Health Subsecretariat. It will also liaise with the Administrative Subsecretariat to follow up on administrative processes linked to compliance with the obligations and commitments established in agreements with municipios and to monitor the fulfillment of outcome indicators. The Ministry of Infrastructure and Public Services, through the Administrative Subsecretariat and the Provincial Architecture Directorate, will be in charge of contracting for renovations and enhancements to be carried out under the program. Program execution will be governed by the program Operating Regulations, which detail the roles and responsibilities of the executing agency and subexecuting agencies.

3.2 **Crosscutting coordination between actors.** There is a plan for crosscutting coordination between various stakeholders for the planning and execution of joint activities. The Ministry of Economy, Ministry of Health, and Ministry of Infrastructure and Public Services keep a schedule of monthly meetings on projects prioritized by the PBA and the Cabinet team. The Ministry of Health and Ministry of Infrastructure and Public Services meet weekly to press ahead with the programmatic lines of the AMBA Network and PIGH.

3.3 **Execution mechanism and program administration.** Program activities at the provincial level will be planned through a Multiyear Execution Plan shared between the Ministry of Economy, Ministry of Health, and Ministry of Infrastructure and Public Services under the current provincial crosscutting coordination plan. Program follow-up and monitoring will be coordinated between the various actors at regular meetings, as described above. This way, the Ministry of Economy will have the information necessary to track program progress, produce execution reports, and request disbursements from the Bank. Details of each agency's roles and responsibilities and the document circuit for reporting results will be provided in the Operating Regulations. The relationship between the province and the beneficiary municipios is governed by collaboration and membership agreements signed between the province's Ministry of Health and each member municipio.

3.4 **External verification of outcomes.** This verification will be performed by a specialized firm or an individual consultant acting as an external evaluator independent of both the borrower and the Bank. This firm or consultant will verify the fulfillment of the DLI targets and will be responsible for submitting an outcome verification report to the Bank prior to each disbursement request. The verification of the achievement of the outcomes will focus on two objectives: (i) issuing an opinion on the accuracy, reliability, and consistency of the outcome-related information; and (ii) determining the value of the outcome indicators established in each disbursement tranche, performing a calculation in cases where no automatic independent reports exist. The firm or consultant will be required to have experience in evaluating and monitoring projects, managing outcome indicators, and evaluating the reliability of information sources and methods used to produce them and will be hired pursuant to the terms of reference previously agreed with the Bank and in accordance with the Bank's Policies for the Selection and Contracting of Consultants (document GN-2350-9). **A special condition precedent to the first disbursement of the loan will be that the borrower has presented, to the Bank's satisfaction, evidence that the consulting firm or independent consultant responsible for the external verification of outcomes**

has been hired, in accordance with the terms of reference previously agreed with the Bank. Each disbursement will be subject to this independent verification.

3.5 **Disbursement mechanism.** Disbursements will be processed according to the following procedure: (i) the DPOMyFB will produce a progress report on the program's execution and on the outcome indicators to be used for the disbursements, as mentioned in paragraph 1.44 (optional link 6) and will submit said report for external verification of the outcomes, which will analyze their achievement based on the protocols established in the Monitoring and Evaluation Plan (required link 2); (ii) independent external evaluators will verify whether the outcomes have been achieved in accordance with the objectives stated in the previous paragraph and within the timelines set out in the terms of reference; and (iii) once this verification is complete, the DPOMyFB will submit the corresponding disbursement request and the Bank will, following the standard procedures and times, disburse into the account specified by the borrower the amount corresponding to each indicator, if and only if the external verification determines that the value of the indicator in question is equal to or greater than the established target. If that indicator is lower, the disbursement will be proportional to the target reached. Unused balances can be reprogrammed to subsequent disbursements.

3.6 **Program Operating Regulations.** The program Operating Regulations, currently being prepared (optional link 3), will set out the execution strategy for the operation, including: (i) the program's organizational structure; (ii) the technical and operational arrangements for its execution; (iii) the outcome programming, monitoring, and evaluation mechanism; (iv) the LBR operational guidelines; and (v) a detailed description of the outcome indicators, especially those related to disbursements and their verification protocols. **A special contractual condition precedent to the first disbursement of the loan will be that the borrower has presented, to the Bank's satisfaction, evidence of the entry into force of the program Operating Regulations.** This condition is critical, as the Operating Regulations contain criteria for the external verification of program outcomes. The Bank's experience in the region has shown that approving the Operating Regulations before the first disbursement contributes to the executing agency's internal organization for program execution.

3.7 **Retroactive financing of outcomes.** The first individual operation under the CCLIP involves financing previously achieved outcomes at a rate of 15% (US$22.5 million) of the loan amount. This financing will be applied to the outcomes achieved between the date on which the project profile was approved (26 March 2019) and the loan eligibility date. The Bank reviewed the progress in achieving the targets, the technical specifications of the outputs, the expenditure dates, the main activities undertaken, and the respective unit costs in order to determine whether they fall within the scope of the proposed operation. The Bank also reviewed the costs associated with the achievement of previous outcomes under the program's expenditure framework. Disbursements against previous outcomes will be subject to an independent external verification of said outcomes.

3.8 **Initial disbursement.** Upon fulfillment of the conditions precedent to the first disbursement, the executing agency will have the option of requesting an advance of up to 10% of the loan amount permitted under the LBR policy (document GN-2869-1) to finance activities necessary for achieving the most immediate outcomes related to Components 2 and 3. The initial disbursement amount requested was estimated according to target, output, activity, and expenditure planning, with their respective procurement processes.

3.9 **Fiduciary agreements and requirements.** Annex III sets out the financial management and procurement execution guidelines that will be applied to the program. Program execution entails the use of the executing agency's procurement systems, in accordance with the requirements established for an LBR (document GN-2869-1). Procurement will be carried out directly by the PBA and governed by the executing agency's policies and systems, validated by the Bank.[16] The estimated costs of the outcomes will be covered according to the procedures established in the Operating Regulations.

3.10 **Financial audit.** A Bank-eligible independent audit firm will audit the costs associated with the outcomes obtained under the program based on the terms of reference agreed with the Bank. During program execution, audited financial statements will be submitted annually not later than 120 days after each fiscal year end or the date of the last disbursement for the final audited financial statements. The final audited financial statements will include an analysis of the possible differences between actual program costs and the amounts disbursed.

B. Summary of arrangements for monitoring results

3.11 **Monitoring arrangements.** The program will adopt the Bank's supervision mechanisms. The program monitoring plan will include: (i) a definition of protocols for the external verification of the achievement of the disbursement indicators; (ii) at least two meetings per year, attended by the relevant institutional actors and the Bank, for the technical and operational review of program progress, problem resolution, and risk mitigation (including a risk analysis update), followed by the dissemination of the management agreements reached; (iii) semiannual reports on the achievements and problems encountered in each component and on program performance, according to the agreed Results Matrix (Annex II); and (iv) the use of management tools referred to in the Monitoring and Evaluation Plan (required link 2) and agreed in the kick-off and planning workshop in order to have instruments for planning the activities and processes required to achieve the physical outputs and the intermediate and final outcomes.

3.12 **Arrangements for evaluating outcomes.** The program evaluation plan includes an assessment of the final impact of primary care in the AMBA Network, including an analysis of the percentage of the target population receiving basic health care services in CAPS, calculated based on exposure to treatment. During implementation, the possibility of conducting the following two additional studies will also be explored: (i) assessment of the EMCS's impact on deaths as a result of accidents in accordance with a quasi-experimental difference-in-differences methodology; and (ii) assessment of implementation of the triage system and how

[16] The institutional capacity assessment for procurement execution provided for in the project was carried out using the OECD/DAC Methodology for Assessing Procurement Systems – simplified version.

it affects wait times in hospital emergency rooms, overall patient satisfaction, and the number of primary care visits handled in emergency rooms, based on an experimental design.

Development Effectiveness Matrix		
Summary	AR-L1312	
I. Corporate and Country Priorities		
1. IDB Development Objectives		
Development Challenges & Cross-cutting Themes	-Social Inclusion and Equality -Gender Equality and Diversity -Climate Change and Environmental Sustainability	
Country Development Results Indicators	-Beneficiaries receiving health services (#)* -Public registries strengthened (#)*	
2. Country Development Objectives		
Country Strategy Results Matrix	GN-2870-1	Strengthening the quality of first-level health services for the prevention and early detection of chronic noncommunicable diseases
Country Program Results Matrix	GN-2948	The intervention is included in the 2019 Operational Program.
Relevance of this project to country development challenges (If not aligned to country strategy or country program)		
II. Development Outcomes - Evaluability		Evaluable
3. Evidence-based Assessment & Solution		9.5
3.1 Program Diagnosis		3.0
3.2 Proposed Interventions or Solutions		4.0
3.3 Results Matrix Quality		2.5
4. Ex ante Economic Analysis		9.0
4.1 Program has an ERR/NPV, or key outcomes identified for CEA		3.0
4.2 Identified and Quantified Benefits and Costs		3.0
4.3 Reasonable Assumptions		1.0
4.4 Sensitivity Analysis		2.0
4.5 Consistency with results matrix		0.0
5. Monitoring and Evaluation		10.0
5.1 Monitoring Mechanisms		2.5
5.2 Evaluation Plan		7.5
III. Risks & Mitigation Monitoring Matrix		
Overall risks rate = magnitude of risks*likelihood		Medium
Identified risks have been rated for magnitude and likelihood		Yes
Mitigation measures have been identified for major risks		Yes
Mitigation measures have indicators for tracking their implementation		Yes
Environmental & social risk classification		B.13
IV. IDB´s Role - Additionality		
The project relies on the use of country systems		
Fiduciary (VPC/FMP Criteria)	Yes	Financial Management: Budget, Treasury, Accounting and Reporting. Procurement: Information System, Price Comparison, Contracting Individual Consultant.
Non-Fiduciary	Yes	Monitoring and Evaluation National System.
The IDB's involvement promotes additional improvements of the intended beneficiaries and/or public sector entity in the following dimensions:		
Additional (to project preparation) technical assistance was provided to the public sector entity prior to approval to increase the likelihood of success of the project	Yes	It will be supported through a Technical Cooperation

Note: (*) Indicates contribution to the corresponding CRF's Country Development Results Indicator.

The Strengthening and Integration of Health Networks Program of the Province of Buenos Aires is the first operation of a Conditional Credit Line for Investment Projects with the objective of improving the capacity and quality of the public health services at the primary, secondary and tertiary levels of care in the Province of Buenos Aires (PBA). The investments seek to integrate services as a network that prioritizes the population with exclusive public coverage to reduce the years of potential life lost. The operation is structured as a Loan Based on Results (LBR) and has the objective of improving the accessibility and effective coverage of public health services for the PBA population. Its specific objectives are: (i) to improve the accessibility and resolution of the first level of care in a group of municipalities in the Metropolitan Area of Buenos Aires (AMBA); (ii) increase the response capacity of emergency services throughout the PBA; and (iii) improve the opportunity for the dispensation of cancer and palliative medications throughout the PBA.

The loan proposal presents a solid diagnosis, as well as evidence of the effectiveness of the interventions to be financed. The vertical logic of the program is described in detail and is consistent with the results matrix. The results matrix includes SMART indicators at the level of impacts, outcomes and products.

The economic analysis of the project includes independent cost-benefit analysis for the components of the program, including investments in the AMBA network, investments to improve the coverage of cancer treatments, expansion of emergency services, and the implementation of a triage system. The cost-benefit analysis demonstrates the positive returns of these interventions under conservative scenarios

The indicators linked to disbursements under the LBR are identified and clearly defined. The monitoring and evaluation plan proposes an impact evaluation of the improvement of primary health services through CAPS on the proportion of beneficiaries with exclusive public coverage who access a set of basic health benefits. Two evaluations are proposed in Component 2 to measure the impact of pre-hospital emergency services on deaths from accidents, and an evaluation of the impact of the implementation of the comprehensive plan of hospital guards and triage on appropriate care in hospital wards, reduction in the waiting time and patient satisfaction.

RESULTS MATRIX

Program objective:	To improve accessibility and effective coverage of public health care services for the population of the Province of Buenos Aires (PBA).

EXPECTED IMPACT

Indicators	Unit of measure	Baseline		End of project		Means of verification
		Value	Year	Value	Year	
Years of potential life lost (0–70) per 10,000 inhabitants in the PBA – Men	Years	733	2016[1]	600[2]	2021	Health Statistics and Information Directorate and National Statistics and Census Institute
Years of potential life lost (0–70) per 10,000 inhabitants in the PBA – Women	Years	444	2016[1]	400[2]	2021	Health Statistics and Information Directorate and National Statistics and Census Institute
Deaths as a result of accidents in the PBA	Number of people	1,369	2017	1,315	2021	Health Information Directorate – Ministry of Health – PBA

(1) Most recent data available. (2) Calculated based on projection of 2010–2016 trend.

EXPECTED OUTCOMES

Expected outcomes	Unit of measure	Baseline		Year 1	Year 2	Year 3	End of project	Means of verification	Disbursement-linked indicator
		Value	Year						
Recipients with effective basic coverage among the population exclusively with public coverage in the 16 municipios in the AMBA Network[1,2]	%	26	2018	28	30	32	32	SUMAR program report	No
Primary health care centers (CAPS) that meet AMBA Network service standards[3]	Number of CAPS	0	2018	90	150	150	150	Technical audit report	Yes
Municipios with an implemented plan for meeting the health care staffing standards of the AMBA Network to improve service delivery capacity for their CAPS	Number of municipios	0	2018	14	16	16	16	Sworn statements	Yes

1 Corporate indicator, “Recipients of health care services.”

2 A recipient has effective basic coverage if he or she received at least one health care service in the past 12 months within a set of 200 primary care services.

3 See definition in optional link 4.

Expected outcomes	Unit of measure	Baseline		Year 1	Year 2	Year 3	End of project	Means of verification	Disbursement-linked indicator
		Value	Year						
Municipios with an operational Emergency Medical Care System (EMCS) that meets quality standards[4]	Number of municipios	76	2018	25	49	59	135	Sworn statements	Yes
Emergency rooms that meet the standards established in the Comprehensive Hospital Emergency Room Plan (PIGH), including the triage system[5]	Number of emergency rooms	35	2018	11	11	11	46	Technical audit report	Yes
Average wait time between triage and medical consultation[6]	Minutes	359.28	2018	164.13	130	100	100	Provincial Hospital Directorate report	No
Medication requested from cancer drug bank available for dispensing within 30 days	Percentage of medication	75	2018	85	90	N/A	90	Medication Management System	Yes
Patients who were dispensed pain medication two or more times in the past 12 months	Number of people	2,000	2018	3,000	4,500	6,000	6,000	Register of opioids dispensed	Yes

[4] Idem.

[5] Idem.

[6] The outcome indicator "Average wait time between triage and medical consultation" is not included in the DLI, since some emergency rooms in the PBA do not yet have the capacity to report this. The first operation under the CCLIP would create that capacity.

DISBURSEMENT-LINKED INDICATOR MATRIX

Indicators	Unit of measure	Year 1		Year 2				Year 3	
		Disbursement 1[7]		Disbursement 2		Disbursement 3		Disbursement 4	
		Target	Amount (US$)	Target	Amount (US$)	Target	Amount (US$)	Target	Amount (US$)
Component 1: Primary care expansion and improvement in the AMBA									
CAPS that meet AMBA Network service standards	Number of CAPS	90	28,600,000	50	14,916,667	10	2,983,333	0	0
CAPS with electronic medical record (HCE) installed, by year	Number of CAPS	90	1,500,000	50	583,333	10	116,667	0	0
Municipios with an implemented plan for meeting the health care staffing standards of the AMBA Network to improve service delivery capacity for their CAPS	Number of municipios	14	4,300,000	1	15,916,667	1	3,183,333	0	0
Component 2: Expansion and improvement of the emergency service and emergency room network in the PBA									
Municipios with an operational EMCS that meets quality standards	Number of municipios	25	11,000,000	8	4,273,120	16	9,326,880	10	2,500,000
Design of an EMCS monitoring model in municipios	Protocol	0	0	0	0	0	0	1	100,000
Emergency rooms that meet the standards established in the PIGH, including the triage system	Number of emergency rooms	11	14,044,716	0	0	0	0	0	0
Component 3: Expansion and improvement of cancer treatment coverage									
Medication requested from cancer drug bank available for dispensing within 30 days	%	85	20,583,200	87	7,800,984	90	7,740,428	0	0
Patients who were dispensed pain medication two or more times in the past 12 months	Number of people	3,000	36,201	0	0	4,500	29,414	6,000	28,237

[7] Includes retroactive financing.

OUTPUTS

Outputs	Unit of measure	Baseline		Year 1	Year 2	Year 3	Target	Source of verification
		Value	Year					
Component 1: Primary care expansion and improvement in the AMBA								
Membership agreements with municipios signed, by year	Number of agreements	0	2018	16	8	0	24	Agreements with municipios
CAPS that complete upgrades or enhancements, by year	Number of CAPS	0	2018	90	60	0	150	Technical audit report
CAPS that have the medical equipment required by the AMBA Network, by year	Number of CAPS	0	2018	90	60	0	150	Technical audit report
CAPS with HCE installed, by year	Number of CAPS	0	2018	90	60	0	150	Technical audit report
Program mainstreaming pilot implemented[8]	Pilot	0	2018	0	0	1	1	Evaluation report
Component 2: Expansion and improvement of the emergency service and emergency room network in the PBA								
Ambulances delivered, by year	Number of ambulances	0	2018	72	63	41	176	Delivery records
Municipios with emergency service telephone line 107 installed, by year	Number of municipios	0	2018	25	24	10	59	Sworn statements with municipal EMCS production data
EMCS training in municipios completed, by year	Number of training sessions	0	2018	25	24	10	59	Training certificates
EMCS supervision model in municipios designed	Protocol	0	2018	0	0	1	1	Protocol developed and team formed
Emergency rooms with completed upgrades, by year	Number of emergency rooms	0	2018	11	0	0	11	Technical audit report
Emergency rooms that added standard medical and nonmedical equipment, by year	Number of emergency rooms	0	2018	11	0	0	11	Technical audit report
Emergency rooms with an implemented triage system, by year	Number of emergency rooms	0	2018	11	0	0	11	Technical audit report
Comprehensive training given to emergency room staff, by year	Number of training sessions	0	2018	11	0	0	11	Technical audit report
Component 3: Expansion and improvement of cancer treatment coverage								
Drug treatments for patients with cancer provided, by year	Number of treatments	0	2018	10,000	12,000	14,400	36,400	Medication Management System
Pain management for patients with cancer provided, by year	Number of treatments	0	2018	3,500	5,000	6,500	15,000	Register of opioids dispensed
Health care providers that joined the cancer medication distribution network, by year	Number of providers	0	2018	60	10	10	80	Medication Management System
Awareness workshops for physicians given, by year	Number of workshops	0	2018	6	6	6	18	Participant list

[8] Idem.

FIDUCIARY AGREEMENTS AND REQUIREMENTS

Country:	Argentina
Project number:	CCLIP, AR-O0013; First Operation, AR-L1312
Project name:	Conditional Credit Line for Investment Projects (CCLIP) and First Operation under the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires
Executing agency and subexecuting agencies:	Province of Buenos Aires, through the Ministry of Economy of the Province of Buenos Aires, with the Ministry of Health and Ministry of Infrastructure and Public Services
Fiduciary team:	Marilia Santos and Teodoro Noel (FMP/CAR)

I. EXECUTIVE SUMMARY

1.1 The amount of the conditional credit line for investment projects (CCLIP), in its sectoral modality, will be US$600 million in financing from the Bank's Ordinary Capital and US$60 million in local contributions. The CCLIP will finance up to four individual operations over 10 years. The amount of the first individual operation will be US$150 million, and it will use the investment loan based on results (LBR) instrument.

1.2 The borrower will be the Province of Buenos Aires (PBA), which is the program's executing agency and will act through its Ministry of Economy and, as subexecuting agencies, through its Ministry of Health and Ministry of Infrastructure and Public Services. The Ministry of Economy will execute the program through the Provincial Directorate of Multilateral Agencies and Bilateral Financing (DPOMyFB).

1.3 The fiduciary agreements and requirements established for this program are based on the PBA's history as an executing agency for loans 2210/OC-AR and 3256/OC-AR and for the loans whose execution is about to begin, namely 4416/OC-AR, 4427/OC-AR, and 4435/OC-AR.

1.4 The Bank also applied the Institutional Capacity Assessment Platform (ICAP), with satisfactory results. Fiduciary assessments were carried out according to the LBR policy (financial management and procurement). The assessments found that the PBA Ministry of Economy, along with the Ministry of Health and Ministry of Infrastructure and Public Services, have sufficient fiduciary systems developed to manage the execution and achievement of the expected outcomes.

II. THE EXECUTING AGENCY'S FIDUCIARY CONTEXT

2.1 According to the ICAP results, the most noteworthy considerations are as follows:

a. The legal and regulatory framework to which the executing agency and subexecuting agencies are subject enables effective, efficient, and transparent execution.

b. The regulatory framework in force provides the executing agency and subexecuting agencies the competencies necessary to assume responsibility for the program.

c. The executing agency and subexecuting agencies have the staff numbers and distribution to facilitate program implementation and sustainability.

d. The executing agency has knowledge and previous experience in administering institutional projects or programs and in executing loans with multilateral lenders (IDB, World Bank, and Development Bank of Latin America).

e. The executing agency and subexecuting agencies have documented guidelines for evaluating the results of their projects.

f. The governance structure of the executing agency and subexecuting agencies fosters effective and efficient management of procurement in the projects they execute.

g. The executing agency and the Ministry of Infrastructure and Public Services have extensive experience in managing Bank procurement policies and are able to fulfill this role.

h. Financial management staff has extensive experience in using the policies and procedures of international financial institutions, such as the IDB, World Bank, Development Bank of Latin America, and River Plate Basin Development Fund (FONPLATA). It should be noted that this staff also has experience in programs with executing agency participation.

III. FIDUCIARY RISK EVALUATION AND MITIGATION ACTIONS

3.1 The fiduciary risk is considered low and only requires minor measures to mitigate any weaknesses, which are suggestions for the efficient and effective administration of program resources. As detailed in the ICAP:

a. An action plan is recommended so that the executing agency and subexecuting agencies formalize their procedures for program risk management. Existing dashboards in ministerial meetings of the PBA Cabinet should be adapted and formalized into one that includes the most data and interventions possible in order to monitor and evaluate issues associated with the measurement of progress, achievement or failure to achieve targets, programming and tracking of milestones, identification of deviations, and determination of risks and action timelines. An e-learning training course on risk management available, on the Bank's training platform, is also recommended.

IV. Considerations for the Special Provisions of Contracts

4.1 **Exchange rate:** The exchange rate to be used for reporting in dollars will be that of the effective date of payment, with details provided on the conversion method as stated in Article 4.10 of the General Conditions of the Loan Contract.

4.2 **Audited financial statements:** These statements must be submitted within 120 days after each fiscal year end. The audit firm must be acceptable to the Bank and the terms of reference must be agreed with the Bank, specifying the submission deadline referenced in Article 7.03 of the General Conditions of the Loan Contract.

4.3 **Retroactive financing:** The operation involves financing previously achieved outcomes at a rate of 15% (US$22.5 million) of the loan amount. This financing will be applied to the outcomes achieved between the date on which the project profile was approved (26 March 2019) and the loan eligibility date. Disbursements against previous outcomes will be subject to an independent external verification of said outcomes.

V. Agreements and Requirements for Procurement Execution

5.1 The fiduciary agreements and requirements for procurement establish the applicable provisions for carrying out all procurement planned under the operation.

A. Procurement execution

5.2 Since this is an LBR, the executing agency's procurement and contracting systems will be used.[1] The institutional capacity assessment for procurement execution provided for in the program was carried out using the OECD/DAC Methodology for Assessing Procurement Systems (MAPS) – simplified version. The assessment results are as follows:

a. **Use of the executing agency's procurement system:** The procurement system of the executing agency and subexecuting agencies, established under Law 13.981 and its Regulatory Decree 1300 59/2019, was assessed by the Bank and deemed consistent with internationally accepted principles, practices, and standards for all procurement methods and open to bidders from all countries. The system will be used for the procurement of goods, works, nonconsulting services, and consulting services (firms and individuals) under the responsibility of the executing agency and subexecuting agencies, as applicable.

b. **Strengthening measures:** In keeping with the findings of the evaluation report and agreements with the executing agency concerning publicity and the widespread dissemination of bidding documents, the supplier register, the confidentiality of processes, and the fragility of the regulatory bases for dealing with corruption, fraud, conflicts of interest, and ethical conduct, it was agreed that the Core MAPS would be implemented to promote and support the regulatory changes necessary for ensuring progress and observing the good

[1] As the government level is the same, the executing agency and subexecuting agencies are covered by and operate under the same procurement system.

practices of the international market. To improve contract administration, it was agreed that a specialized entity would be hired to assist in supervising the work and achieving the program results.

B. Records and files

5.3 The executing agency and subexecuting agencies have systems for recording and filing supporting documentation stemming from procurement and contracting for works, goods, and consulting services that:

a. Directly reference and identify the procedures followed during bid opening;

b. Directly reference and identify the transactions performed;

c. Control the purchases received and reflect them in the inventory system; and

d. Are available for review.

5.4 The executing agency and subexecuting agencies have computer systems that track all procurement processes.

C. Special provisions

5.5 **Integrity risk management.** The integrity risks of the executing agency and subexecuting agencies were analyzed as required by the LBR policy (document GN-2869-1) and operational guidelines (document GN-2869-3). This analysis identified three risks that have already been mitigated by the project: (i) drug inventory management in health centers; the project finances drugs dispensed in hospitals where there is greater control; (ii) institutional capacity to contract and supervise works; the MAPS yielded good institutional capacity, and services were contracted to enhance supervision of works; and (iii) eligibility of retroactive expenditures; the Operating Regulations include the obligation for firms and individuals sanctioned by the Bank for having engaged in prohibited practices to be excluded from the procurement process.

VI. FINANCIAL MANAGEMENT

A. Programming and budget

6.1 The executing agency's and subexecuting agencies' budget has programmatic categories and other classifications by item of expenditure (main items), which are expenses on staff, consumer goods, non-personnel services, fixed assets, transfers, debt service, and decrease in other liabilities, other expenses, and figurative expenses. Depending on their economic nature, items are current expenses, capital expenses, or financial applications. Internal financing sources can be the provincial treasury, credit, and own resources.

6.2 The budget allocation should be made in advance to ensure that the operation is executed within the established time frame.

B. Treasury

6.3 Payments for Components 1 to 3 are made with local funds through the General Provincial Treasury (TGP), and reimbursements are subsequently handled based on achievement of the outcomes. For administrative expenses, the TGP will also be the paying agency, and payments will be made using loan proceeds.

6.4 The Finance Subsecretariat reimburses the necessary costs for obtaining the audited balance. The DPOMyFB handles the bank account in dollars opened for the exclusive and separate management of loan proceeds. It is also responsible for checking the balance of the special account in dollars on a monthly basis and reconciling it.

C. Accounting and information systems

6.5 The executing agency will use the External Loan Execution Unit (UEPEX) system and the Comprehensive Financial Management and Administration System (SIGAF) as the financial administration systems. Accounting will be on a cash basis, and International Financial Reporting Standards will be followed when applicable in accordance with established national accounting criteria.

6.6 The executing agency's accounting system (UEPEX and SIGAF): (i) is automated; (ii) is integrated into other systems used by the institution; (iii) identifies program transactions by financing source; (iv) identifies program transactions by investment category; (v) identifies program transactions separate from the entity's other activities; and (vi) provides the information necessary to produce the financial reports required by the Bank.

6.7 The Accounting Department is responsible for carrying out the following activities for all programs: (i) keeping accounting entries in the UEPEX system and a record of supporting documentation for posted payments, invoices, and receipts for other payment history; (ii) carrying out monthly bank account reconciliations; and (iii) preparing loan financial statements and submitting them to the External Audit Office so that it can prepare the corresponding reports.

6.8 The timely and reliable issuance of DPOMyFB financial information is governed by the accounting standards of the Provincial Accounting Office (CGP) and the Provincial Budget Directorate. Financial Administration Law 13.767 and the CGP standards establish the mechanisms for entry accounting, accountability, and financial reporting that define the timelines for (i) the preparation of financial statements and reports; and (ii) the publication of financial statements and reports as well as account and budget reconciliations.

6.9 Accounting information is channeled through a chart of accounts that entails classification by expenditure category, component, and financing source according to the structure in the loan financing matrix agreed upon during negotiations.

D. Disbursements and cash flow

6.10 The PBA will use its own resources for program execution to achieve the outcomes, which, once verified and approved by the Bank, will enable the release of the corresponding disbursements in accordance with the Disbursement-linked Indicator Matrix agreed with the Bank. Four disbursements are planned during program execution. Expenditures need not be justified for the respective disbursements to be processed.

6.11 The Bank loan proceeds will be made available to the PBA for linking intermediate results and achieving the targets proposed in the Disbursement-linked Indicator Matrix.

6.12 The e-Disbursements modality will be adopted. This is the IDB's Web-based system enabling the executing agency to prepare and send disbursement requests to the Bank electronically, lowering transaction costs and allowing the Bank to review and process requests sent remotely.

E. Internal control and internal audit

6.13 The CGP is in charge of controlling and properly recording public expenditures. It intervenes before each contract is awarded and compares the budget execution against the authorized budget and the approved modifications.

6.14 The executing agency has satisfactory internal control mechanisms for financial resource management, which are under the responsibility of the State Prosecutor's Office, the CGP, and the Provincial Audit Office.

F. External control and reports

6.15 The external audit of the program will be conducted by one of the Bank-eligible independent audit firms.

G. Financial supervision plan

6.16 The financial supervision plan includes participation in sessions for periodic follow-up on the program's risk matrix and reviewing the annual audit report, which could result in on-site visits in order to update knowledge of institutional internal systems.

H. Execution mechanism

6.17 Program activities at the provincial level will be planned through a Multiyear Execution Plan shared between the Ministry of Economy, Ministry of Health, and Ministry of Infrastructure and Public Services under the current provincial crosscutting coordination plan. Details of each agency's roles and responsibilities and the document circuit for reporting results will be provided in the Operating Regulations. For more information, see paragraph 3.3 of the loan proposal.

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/19

Argentina. Conditional Credit Line for Investment Projects (CCLIP) for the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires (AR-O0013)

The Board of Executive Directors

RESOLVES:

1. To authorize the President of the Bank, or such representative as he shall designate, to enter into such agreement or agreements as may be necessary with the Province of Buenos Aires, as borrower, and with the Argentine Republic, as guarantor, to establish the Conditional Credit Line for Investment Projects (CCLIP) for the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires (AR-O0013) for an amount of up to US$600,000,000 chargeable to the resources of the Bank's Ordinary Capital.

2. To determine that the resources allocated to the above-mentioned Conditional Credit Line for Investment Projects (CCLIP) for the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires (AR-O0013), as mentioned on the previous paragraph, shall be used to finance individual loan operations in accordance with: (a) the objectives and regulations of the Conditional Credit Line for Investment Projects approved by Resolution DE-58/03, as amended by Resolutions DE-10/07, DE-164/07, and DE-86/16; (b) the provisions set forth in documents GN-2246-9 and GN-2564-3; and (c) the terms and conditions included in the Loan Proposal for the corresponding individual operation.

(Adopted on __ _____ 2019)

LEG/SGO/CSC/EZSHARE-1044359933-17807
AR-O0013

DOCUMENT OF THE INTER-AMERICAN DEVELOPMENT BANK

PROPOSED RESOLUTION DE-___/19

Argentina. Loan ____/OC-AR to the Province of Buenos Aires. Conditional Credit Line for Investment Projects (CCLIP) for the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires (AR-O0013). First Operation under the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires (AR-L1312)

The Board of Executive Directors

RESOLVES:

That the President of the Bank, or such representative as he shall designate, is authorized, in the name and on behalf of the Bank, to enter into such contract or contracts as may be necessary with the Province of Buenos Aires, as borrower, and with the Argentine Republic, as guarantor, for the purpose of granting the former a financing to cooperate in the execution of the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires, which constitutes the first individual operation under the Conditional Credit Line for Investment Projects (CCLIP) for the Program for Strengthening and Integration of Health Networks in the Province of Buenos Aires approved on _____ 2019 by Resolution DE-___/19. Such financing will be in the amount of up to US$150,000,000, from the resources of the Bank's Ordinary Capital, and will be subject to the Financial Terms and Conditions and the Special Contractual Conditions of the Project Summary of the Loan Proposal.

(Adopted on __ _____ 2019)

LEG/SGO/CSC/EZSHARE-1044359933-17806
AR-L1312