The Health System in Argentina

By Dr. Alice Gerges Geagea
Director of Health Education
Lebanese Health Society

The modern health system of Argentina was developed between 1945-1955, a period of economic bonanza characterized by industrialization, rapid urbanization and activist labor organizations. During the ensuing years it evolved in three sectors: public, social security and private, with separate services, population coverage and funding.
During the 1980s and 1990s, the health system has experienced further transformations, as neoliberal policies took hold in the country and dictated a reduction of state involvement in social services in favor of privatization and decentralization of health care. The result has been increased fragmentation, inequity and inefficacy, as health care is increasingly prey to the economic interests of private corporations, trade union bureaucracies and the medical professional and technology establishments. The expectation of popular sectors of society are that progressive polices will be followed with much needed public health policies based on equity and efficiency.

Introduction

Argentina, in the southern tip of South America, has a population of 40 millions. In the second half of the 19th century and first half of the 20th century, Argentina received a huge influx of immigration from virtually all countries of Europe, intermixing with the existing population. In recent times, immigration comes primarily from neighboring countries (Paraguay and Bolivia) with strong Amerindian ancestry. Currently, about 50% trace their origin to Italian immigrants and 25-30 % to Spaniards. The official language is Spanish and the majority of the population is nominally of catholic faith.

Politics and Economics

Argentina is a federal republic with a presidential system, with 24 political jurisdictions (23 provinces and the autonomous City of Buenos Aires, site of the National government). Each province has its own constitution and elects its governing officials. At the beginning of the 20th century, Argentina's economy boomed, but political and economic crises were recurrent. The economic crisis was eventually brought under control by 2004, and economic growth resumed. However, poverty and indigence continued to be very prevalent and the distribution of income remained highly unequal: in 2003 the poorest 10% of households had an average monthly income per person of USD 16, compared with USD 590 among the wealthiest 10% of households. Further, the poorest quintile's share of national income between 1992 and 2005 decreased from 4.8% to 3.1%, while that of the wealthiest quintile increased from 50.6% to 54.7%. The policies of the last quarter of the 20th century drastically changed the landscape of the health system, which regressed from that of a publicly funded health system, to one in which the interests of private for-profit corporations became prevalent.

Epidemiologic profile

Ukraine declared independence from the Soviet Union in Table 1 shows some key demographic, economic and health indicators of Argentina. Life expectancy is 75.24 years and crude mortality 8/10,000, of which 35%

Population (millions)	39,356,383
Gross National Product per capita (in current US dollars)	9,126
Urban population	89.5
Percentage of population under poverty (defined by a complex index of the Census Bureau to denote "unsatisfied basic needs")*	17.5
Literacy (percentage of population of 10 years of age or older who know how to read and write)	97.2
Population with drinking water (%)	77.0
Population with sewage drain (%)	42.5
Crude birth rate (per 1000 population)	17.5
Approximate annual number of live births	700,000
Annual population growth (per 1000)	10.1
Fertility rate	2.3
Life expectancy at birth	75.24
Crude general mortality rate (per 1,000)**	8
Maternal mortality rate (per 100,000 live births)^	44
Infant mortality rate (per 1000 live births)^^	13.3
Under-5 mortality rate (per 1000 live births)	15.6
Public expenditure in health, total (% of Gross National Product)	5.07
Expenditure in medical care in the public system (% of Gross National Product)	2.09
Expenditure in health care in the Obras Sociales (% of Gross National Product)	2.28
Expenditure in health care of retired citizens (% of Gross National Product)	0.70
Total number of hospital beds	53,065
Physicians (per 10,000 population)	32.1
Nurses (per 10,000 population)	3.8

*www.indec.mecon.gov.ar
**cancer: 35%; cardiovascular conditions: 20%; infections: 10%
^31% due to complications of voluntary abortion
^^70% of infant mortality rate occurs in the neonatal period; 60% is preventable;
perinatal conditions: 52%, congenital anomalies: 27%, respiratory conditions: 7%, infections: 4%

Table 1. Argentina. Basic demographic, socioeconomic and health indicators

is due to cancer, 20 % to cardiovascular diseases and 10% to infections. Diseases of poverty (infections and malnutrition) are still a major problem. Maternal mortality is unacceptably high (44 per 100,000), one-third of which is due to complications arising from illegal voluntary abortion. Infant mortality is 13.3 per 1,000), and its main causes are peri-natal conditions (52%) and congenital anomalies (27%).

Health System in Argentina

In contrast to the relative homogeneity and rather unified health systems prevalent in Western Europe, Latin America is characterized by the world's highest degree of inequality in income distribution, with coexistence of groups that are part of modern dynamic areas of the economy, with those with aged-old patterns of life, still relatively untouched by modern industry and commerce, and with the disenfranchised who live on the limits of survival. The significant economic setbacks of the 1990s increased concentration of wealth in fewer hands, affected employment and quality of life, and rendered health systems less able to provide equitable services to most people.

Like most countries in Latin America, Argentina has developed a mixed health system with a combination of: (a) remnants of an old welfare state with an extensive network of public hospitals and health centers, (b) a social health insurance system for formally employed workers, and (c) a concentrated for-profit private health insurance sector ('prepaid medicine'), providing services to middle-upper and upper classes.

The three major health sectors that exist today in Argentina (public, social security and private) evolved in a somewhat sequential manner, following political and economic circumstances.

1. The first stages of a public sector originated in religious and public charity hospitals of the 19th century, and it eventually developed into an extensive and centralized public system, through the building of many hospitals during the economic bonanza of post-world-wars periods (1918-1929 and 1946-1954). During the economic crises of the 1980s and 1990s, the International Monetary Fund and the World Bank imposed privatizations that weakened the public system by successive fragmentations, decentralizations, and dilution of responsibilities, while the social security and private systems hybridized and increased their complexity, to the benefit of the profit-seeking sector.

2. The social security system began to evolve during the mid-20th century as heir to the trade unionism of European immigrants. Designed by the state, it was inspired in Bismarkian and Franquist philosophies of "social peace", to prevent the radicalization of the working class. To accomodate the interests of organized labor, the delivery of medical care to people formally employed was put under the responsibility of the trade unions themselves, with funds contributed by employers and employees, and with some regulation from the state (these entities are called obras sociales).

3. Up to the 1970's, the private sector was relatively small, consisting of community hospitals for former immigrants (Spanish, Italian, British, German, French, Jewish hospitals) and numerous private offices and hospitals. This sector grew significantly in the 1980s as it was contracted by the obras sociales to provide medical care to their beneficiaries. In the 1990s, as neoliberal policies pushed privatizations further, the private sector took on an additional financial role, expanding even more, with two strategies: (a) setting up for-profit health insurance plans that catered to the upper classes, with differential coverage according to one's ability to pay; and (b) becoming the contractor for health services to the beneficiaries of the obras sociales, channeling funds from social security to the private sector.

Decentralization

According to the constitution, all 23 provinces and the Autonomous City of Buenos Aires are autonomous in deciding and implementing the public policies not delegated to the federal government, as is the case with health care. There is no common framework for the respective responsibilities and functions in health care of the national government and of the provinces. This fact, plus the lack of political will throughout the 20th century, allowed the primacy of the vested interests of private sectors and trade union bureaucracy to impede the development of a unified public national health system. During the economic crisis of the 1980s and 1990s, the public system was further reduced and health services further privatized and transferred to the provinces, increasing their fragmentation, segmentation and inequity. Reliance on the public sector is higher as income declines, and inversely for the private sector (Table 2).

While the Argentine Constitution does not explicitly include the right to health as such, it defines the right to medical care from the viewpoint of the consumer and it ratifies, at a constitutional level, international treaties such as the Universal Declaration of Human Rights, the Covenant on Economic Social and Cultural Rights and the Convention on the Rights of Children, which explicitly mention the right to health and the responsibility of the state to implement and safeguard it.

Health governance

Although weakened by successive transfers of facilities and services to the provinces, the national Ministry of Health, as the highest health authority in the country, is enticed with the following functions:

1. Global health system planning and preventive medicine programs in coordination with health authorities of the provinces and municipalities, and the social security and private sectors.
2. Regulation of the practice of medicine, dentistry and allied health professions, and guidelines of medical care quality.
3. Oversight of the medical care provided by social security and the private sector.
4. Oversight of production, distribution and commercialization of medicines, drugs and medical equipment.

To accomplish these tasks, the Consejo Federal de Salud (COFESA, Federal Health Council) was created in 1981 within the National Ministry of Health, headed by the minister and constituted by the ministers of health of the provinces and the Autonomous City of Buenos Aires. However, because of differences in resources and political views among the provinces, COFESA has not been fully able to fully implement public health policies at the national level.

The Superintendencia de Servicios de Salud (SSS, Superintendency of Health Services) is an autonomous agency within the national Ministry of Health, in charge of supervision, oversight and control of the health insurance system, which comprises the social security services managed and/or provided by the obras sociales, and the services provided by the private for-profit insurance system (pre-paid medicine). In the 1990s the SSS defined a Programa Médico Obligatorio (PMO, Mandatory Medical Program), which establishes the minimum package of services that all insurance plans (social security and private) must provide to their members. Despite SSS's legal authority, the private sector is largely unregulated and SSS only intervenes in cases of overt irregularities. The SSS has no jurisdiction in the public sector, except to monitor the payments that the obras sociales make to public hospitals for services rendered to their members.

The *Administración Nacional de Medicamentos, Alimentos y Tecnología* (ANMAT, National Administration for Drugs, Food and Technology), under the National Ministry of Health, has as its main functions:

I. control of safety, quality and efficacy of all drugs, chemicals, reagents, pharmaceuticals, medicines, diagnostic products, biomedical and biotechnology products, and any other product used in human medicine;
II. registry and accreditation of all individuals or companies involved in supplying, producing, fractioning, import/export, deposit and marketing of products described above;
III. market regulation (price control). ANMAT's budget is insufficient to enforce its regulations, and often obtains funds from the pharmaceutical and food industries, that is, the very players that it is charged with regulating and controlling.

Structure of the Health System in Argentina

The Health Workforce

The latest survey of health professionals was conducted in 2004 from national census data of 2001. There were about 300,000 health professionals with university degrees in 11 different professions, of which 121,076 were physicians (32.1 per 10,000 at the time of the survey) and only 12,614 were certified nurses. This strikingly inadequate 10/1 ratio improved to 1/1 when all categories of nurses were considered, which is still woefully inadequate. While the

Health care coverage	I	II	III	IV	V	Total Population
Obra social	34.6	49.0	60.4	67.8	64.5	56.0
Private	3.5	4.7	6.9	10.5	23.1	10.1
Public	61.4	45.8	32.2	21.6	12.1	33.5
Unknown	0.5	0.5	0.5	0.1	0.3	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Table 2. Percentages of types of health care coverage by income quintiles, 2005. (Quintile I is the poorest, quintile V is the wealthiest.

number of physicians was high, its geographic distribution was markedly inequitable, ranging from 11.1/1000 in Buenos Aires to 1.5/1000 in the province of Santiago del Estero.

Most physicians work part-time in the public sector and in their own private practices, with a dual allegiance that leads to a lack of commitment towards the public system and the patients' interests, including the unethical practice of siphoning patients, able to pay with their own funds, away from public hospitals to their private practices. While organized medicine has consistently opposed full-time employment in public hospitals, many young physicians are joining the growing movement for a national unified health system.

Hospital Network

Of a total of 153,065 hospital beds, about 50% belong to the public sector (76,885 beds in 1,319 hospitals). About a thousand public hospitals are run by the provinces, while the remainder are run by municipalities. The national ministry of health administers only four national hospitals. Forty seven percent of hospital beds are in the private sector, while the remaining 3% belong to obras sociales.

The public hospital network is open to anyone and nominally free of charge, covering 47% of the population. However, for the past several decades little has been done to strengthen the public system, which is clearly underfinanced and deteriorated, with numerous access barriers and low quality of care. Still, there are some niches of excellence in specific specialties, which are sought even by middle and upper classes. In fact, one-third of the patients that receive care in the public sector have some type of social security coverage, and 5.2% are covered by private health insurance.

Primary Health Care

In the early eighties Argentina developed a primary health care (PHC) strategy for its public sector to provide care to the poor and the uninsured, structured around 6,290 PHC centers throughout the country, funded by provinces or municipalities. Centers in rural areas follow a geographic and demographic perspective and are staffed by community health workers (non-physicians). Those in slums and poor neighborhoods of large cities count on physicians and follow a model of care based on demand and supply, with little idea about their population and its epidemiology. PHC centers provide ambulatory care and refer patients to secondary and tertiary levels of care according to need, without much regionalization nor coordination, and with the shortcomings characteristic of a fragmented system. Recently there has been a revival of the PHC strategy at the national Ministry of Health, which funded a program which trained several thousand physicians in community health, with the goal of staffing existing centers. Primary care has been strengthened recently by the national Ministry of Health's Remediar program, which supplies medicines for free to all 6,290 centers of the country. There has been very little PHC development in the private and the social security sectors.

Medical Care to Senior Citizens

The *Programa de Asistencia Médica Integral* (PAMI, Comprehensive Medical Care Program) was created in 1971 to concentrate health services to retired citizens under a single, universal and mandatory coverage. It currently provides health insurance to about 4 million people, including about 91% of the population older than 65 years, the disabled, the beneficiaries of pensions, and the war veterans. The PAMI is financed by general taxation to salaries of employees and to incomes of retired citizens, as well as subsidies from the government. Primary care services, specialty care and hospital admissions are provided by private physicians and hospitals under contract with the PAMI administration by the system of capitation. In addition, there are separate contracts for other types of services, such as drug benefits, dentistry and mental health.

Drug Benefits

In the public sector, medicines are free to patients admitted in hospitals, although the prescribed medications are often not available and the patient has to buy them in the private market. Until recently, there were no free medications in public sector ambulatory centers. To correct this, the National Ministry of Health recently created the program Remediar, by which a standard package of common medications are delivered periodically and free of charge to the 6,290 ambulatory health centers throughout the country.

Preventive Medicine

As one of its main functions, the national Ministry of Health is responsible for preventive medicine programs nationwide that are negotiated at COFESA for their implementation in the provinces. These programs include prevention of maternal and infant mortality, of cervical cancer, of AIDS and sexually transmitted diseases, of addictions, of epidemic or endemic infections such as tuberculosis, dengue and Chagas disease, and many others. The Ministry of Health is also responsible for the national immunization program.

Discussion

Argentina has a tradition of excellence in academic medicine and biomedical research. However, there is a high degree of fragmentation of the health system, with poor coordination between subsystems and lack of stewardship at the national level (Table 3). The distribution of health expenditure is highly inequitable, with per capita spending in the public sector much lower than in the social security system, and both much lower than in the private sector. The latter serves the uppermiddle and upper classes, who enjoy a level of medical care similar to that found for the wealthy in developed countries. The obras sociales run by trade unions imply too much economic and political power to labor bureaucrats frequently engaged in corrupt practices.

The segmentation and fragmentation of the health system of Argentina are the main factors behind its low efficiency and its inequities in access and in quality of care. At the same time, it would seem that segmentation and fragmentation has been the environment that the different players (organized medicine, owners of private hospitals, obras sociales, private health insurers, pharmaceutical and medical technology industries and others) have found and thrived on, maintaining the status quo and preventing the development of a unified national health system.

- Fragmentation and multiple decision-making bodies
- Relative excess of highly skilled physicians, hospital beds and medical technology in big cities.
- Deficiency of primary care professionals and nurses and other allied health personnel
- Lack or deficient regulation of private for-profit sector (private hospitals and "prepaid medicine").
- Concentration of economic and political power in the trade unions as administrators of the *obras sociales* with little or no oversight and margin for corruption.
- Inequity between the private, social security and public sectors
- Demographic growth with increasing loss of coverage
- Under-financing and lack of improvement in the public sector, particularly of hospitals
- The three health sectors are increasingly overlapping, with potential conflict of interests of health professionals

Table 3: Characteristics of the health system of Argentina.