
PROFILE OF THE HEALTH SERVICES SYSTEM

ARGENTINA

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PROGRAM ON ORGANIZATION AND MANAGEMENT OF HEALTH SYSTEMS AND SERVICES

DIVISION OF HEALTH SYSTEMS AND SERVICES DEVELOPMENT

PAN AMERICAN HEALTH ORGANIZATION

EXECUTIVE SUMMARY

The Argentine Republic is a federal democracy in which the provinces retain all powers not expressly vested in the central government. The National Constitution is the supreme law of the land and all legislation, both national and provincial, must conform to its provisions. In addition to the autonomously governed Federal Capital, the country is comprised of 23 provinces and 1,600 municipalities.

The country has been in the throes of an economic recession during the past three years, which has had an impact on the productive sectors. This situation is not uniform throughout the country; for example, before the devaluation in 2001, per capita income in the city of Buenos Aires was in excess of US\$ 21,000, while in Formosa it barely exceeded US\$ 3,700. In December 2001, social unrest led to the resignation of President-Elect Fernando de la Rúa. Senator Eduardo Duhalde took office with a commitment to serve out the presidential term and not stand as a candidate in the new call for elections (2003). The current government repealed the Convertibility Law tying the national currency (the peso) to the U.S. dollar, which had been in effect for most of the 1990s. During 2002, the deepening economic crisis and its social and political impact led the government to declare a state of public emergency in health and social, economic, administrative, financing, and exchange rate matters. The restructuring of the public debt has also been proposed to the credit institutions and public debt holders.

According to the 2001 Census, the population was 36,027,041, 87.2% of which was urban. The population over 65 years of age represents 9.7% of the total, and that of children under 15, 27.9%. The birth rate fell by two percentage points between 1990 and 1999, with a narrowing of the gap between jurisdictions. Infant mortality in Argentina has steadily fallen for a number of years (down from 26.9 per 1,000 in 1986 to 17.6 per 1,000 in 1999), but the decline has not been equally distributed throughout the country. In 1989, the figure for the jurisdiction with the highest infant was 127% higher than that of jurisdiction with the lowest rate, while in 1999 this comparison yielded a difference of 207%.

Diseases of the circulatory system are responsible for the greatest number of deaths among the total population of the country. With a rate of 270.3 per 100,000 population, these diseases caused 36.9% of all deaths in 1999 (34.9% in men and 38.5% in women). In 1996, 97% of all live births were attended in health facilities (with variations ranging from 99.8% in San Luis to 83.0% in Formosa). The principal problems traditionally affecting the health situation or health services delivery have been the poor articulation of the sectors, inequality in the levels of financing and quality of care, and barriers to access (mainly economic) by some population groups to the services.

The health system reflects the special characteristics of a country with a federalist government, where the provincial jurisdictions have not vested matters pertaining to health care in the national government. The system consists of three large sectors: public, private, and social security (the last two strongly interconnected through the indirect system of services contracting).

In 1998, the various medical schools produced 108,000 physicians, representing an increase of 22.5% over a more than a five-year period.

Between 1995 and 1999, Argentina's health expenditure showed a cumulative net increase of 7.5% (an annual average for that period of 2.15%). Since 1995, the expenditure's share in the gross national product has fallen year after year; in the last 5-year period, the decline was 7.5%. Health expenditure as a percentage of GDP shows a similar trend, falling from 9.13% in 1995 to 8.45% in 1999. Argentina's deep recession, which began in 1998, has had a significant impact on health financing. Health expenditure estimates for 2001 show a strong retraction, and the most probable scenario is for the expenditure to continue to decline during 2002. This is likely to be compounded by the impact of the devaluation of the peso following the repeal of the Convertibility Law in January 2002. The result of the two phenomena is that Argentina has lost its status as the country with the highest per capita expenditure in the Region.

The *Obras Sociales* plans are the entities responsible for the management of social security. They cover a population of nearly 18.3 million people, distributed among close to 300 entities of varying scope and size. Thus, 20 entities (around 7%) cover 7,626,534 beneficiaries (slightly more than 40%) and another 43 *Obras Sociales* plans (around 15%) cover another 9,446,015 beneficiaries (slightly more than 51%).

The Health Services Authority (SSS) was established by Decree No. 1615/96 under the jurisdiction of the Ministry of Health and Social Welfare (MSAS) and is responsible for oversight of the *Obras Sociales* plans, compliance with the Compulsory Medical Plan (PMO) by health insurance entities, guaranteeing system quality and coverage, and cost recovery of public hospitals (now called Public Decentralized Hospitals).

The public hospitals provide coverage to the population on demand and, in fact, act as reinsurance for the *Obras Sociales* plans, since they maintain a flow of free care for the insured population (despite Decree 939/2000).

Deregulation of the *Obras Sociales* plans began in 1993, and its purpose was to increase competition among them. Since then, their number has been reduced (from 312 in 1994 to 275 in 1999). Decree 9/93 stipulated that beneficiaries can freely choose their *Obras Sociales* plan, and it applies to all national *Obras Sociales* plans. It does not allow the beneficiaries of union *Obras Sociales* plans to choose *Obras Sociales* plans for management personnel, but it does permit

beneficiaries of the latter to choose any *Obras Sociales* plan. Subsequently, Decree 292/95 formally eliminated dual coverage resulting from multiple employment and/or the direct family member of a worker being considered a dependent, obliging premiums to be made to a single *Obras Sociales* plan. Furthermore, retirees are free to choose *Obras Sociales* plans. Decree 1,141/1996 completed deregulation by providing the option of choosing among union *Obras Sociales* plans. Decree 84 of 3 February 1997 allows subscribers to change *Obras Sociales* plans once a year. In 2001, Decree 1400 guaranteed national *Obras Sociales* plans a minimum income of \$20 per capita for the subscriber and \$12 for each dependent. It also set up a regimen for the coverage of high-complexity services.

A health emergency (Decree No. 486/02) is currently in effect due to the country's social and economic situation. The response to this emergency includes an adaptation of the PMO to the available financial resources of the *Obras Sociales* plans and the redefinition of MSAS as the entity charged with establishing general policies in health, with the provinces responsible for public health services delivery.

1. CONTEXT

1.1. Political Context

The Argentine Republic is a democracy with a federalist form of government by virtue of which the provinces retain all powers not expressly vested in the central government. The National Constitution is the supreme law of the land, and all legislation, both national and provincial, must conform to its provisions. In addition to the autonomously governed Federal Capital, the country is comprised of 23 provinces and some 1,600 municipalities.

The principal problems traditionally affecting the health situation or health services delivery have been the poor articulation of the sectors, inequality in the levels of health care quality, and limited access by some population groups to the services. During the past year, the deepening economic crisis and its social and political impact led the government to declare a state of public emergency in social, economic, administrative, financing, and exchange rate matters.

1.2. Economic Context

In the past three years (1998-2001), the country has been in the throes of an economic recession that has impacted mainly on the productive sectors and has been manifested, among other things, in lower consumption and higher unemployment. Successive adjustment measures have been instituted, such as reductions in public salaries, higher taxes, reductions in salaries and pensions, the proposal of zero budget deficit, and the renegotiation of federal co-participation. Foreign debt has multiplied with the so-called “mega-exchange,” redefining amounts and due dates. Debt restructuring has been proposed to the credit institutions and public debt holders in order to limit the servicing of those commitments.

It should be emphasized that notwithstanding the sale and privatization of state companies and assets, public spending has increased. The provinces have their own structural problems, and the majority depends on federal assistance to meet their commitments, including state salaries. This situation is a source of chronic problems, with protests and strikes by public employees, including health and education workers, and competition between the provincial and national levels for available funds. Added to this are the problems of ensuring effective tax collection and the persistence of smuggling. Imbalances in MERCOSUR and a certain resurgence of protectionism are generating ill will and adversely affecting certain industries, such as the food industry.

Selected Economic Indicators

Indicator	1995	1996	1997	1998	1999	2000	2001
Per capita gross domestic product in 1993 pesos (1 peso=1 dollar)	6,994	7,286	7,778	7,976	7,610	7,458	6,565
Economically active population, urban areas (in thousands)	12,307	12,589	13,081	13,268	13,705	14,083	14,208
Total public expenditure, as a percentage of GDP	32.50	30.56	30.35	30.98	34.10	33.76	35.32
Social public expenditure, as a percentage of GDP	21.17	20.06	19.76	19.98	21.57	21.29	21.83
Total expenditure in health, as a percentage of GDP	9.1	8.7	8.4	8.5	8.9	8.8	8.4

Source: Secretariat of Economic Policy, Ministry of Economy; Programa de Investigación Aplicada-PIA Isalud

The contribution of each economic sector to the Gross Domestic Product is shown in the following table.

Contribution of the Economic Sectors to GDP, 2000

Agriculture, livestock, and fishing	5.37
Manufacturing industry	16.45
Electricity, gas, and water supply	2.43
Construction	5.78
Trade	13.40
Hotels and restaurants	2.57
Transport and communications	8.13
Financial mediation	6.16
Real estate and business activities	14.66
Public administration, defense, etc.	5.05
Education, health, social services	7.71
Other service activities	5.56

Source: INDEC. Anuario Estadístico de la República Argentina, 2000.

1.3. Demographic and Epidemiological Context

In the national census of 2001, Argentina's total population was 36,027,041 inhabitants. The census variation between 1991 and 2001 was 10.5%, with extreme values of -8% for the Autonomous City of Buenos Aires and +44% for Tierra del Fuego. In 1999, an estimated 87.2% of the population lived in urban areas, with the population over 65 years of age reaching almost 10% of the total and that of children under 15, 28%. The country's low overall population growth, with variations based on socioeconomic characteristics, is a known fact, meaning that the average figures conceal differences between the most highly-developed urban areas and those with depressed economies or low-income population groups.

Life expectancy at birth for the total population for the period 1995-2000 was 73.1 years² (69.7 for men and 76.8 for women). For the period 2000-2005, it is estimated at 77.7 years for women and 70.64 for men. The estimated annual population growth rate for that 5-year period is 11.9%, and the total fertility rate for 2001, 2.5.³

Life Expectancy at Birth

YEARS	1990-92	1995-2000	2000-2005
Total population	71.93	73.1	74.2
Women	75.59	76.8	77.74
Men	68.44	69.7	70.64

Source: National Office of Health Statistics, Ministry of Health.

The following table summarizes the evolution of some demographic and epidemiological indicators.

Selected Demographic and Epidemiological Indicators

	Years							
	1993	1994	1995	1996	1997	1998	1999	2000
Crude birth rate	19.8	19.7	18.9	19.2	19.4	18.9	18.8	19.0
Total fertility rate	ND	ND	2.7	ND	2.6	ND	2.5	2.44
Crude death rate	7.9	7.5	7.7	7.6	7.6	7.8	7.9	7.5
Maternal mortality rate	4.6	3.9	4.4	4.7	3.8	3.8	4.1	3.5
Infant mortality rate	22.9	22.0	22.2	20.7	18.8	19.1	17.6	16.6

Source: National Office of Statistics of the Ministry of Health.

Underreporting of infant mortality is estimated to be on the order of 3%, with variations by jurisdiction. Deaths from ill-defined causes accounted for 6.5% of the total for the year 2000.

Leading Causes of Death and Ill-defined Diseases, 1999-2000

Causes	1999		2000	
	Number	%	Number	%
All causes	289,543	100	277,148	100
Ill-defined	18,975	6.6	18,471	6.7
Cardiopulmonary	98,930	34.2	91,506	33.0
Malignant tumors	55,254	19.0	55,492	20.0
External causes	19,682	6.8	19,369	7.0
Communicable diseases	12,671	4.4	13,009	4.7
Other	84,031	29.0	79,301	28.6

Source: National Office of Statistics, Ministry of Health.

In 1999, diseases of the circulatory system (with a rate of 270.3 per 100,000 population) were responsible for 34.2% of total deaths. Tumor diseases ranked second, with an overall rate of 151.3 per 100,000 population and higher values in the southern area of the country (adjusted rates between 180 and 160 per 100,000 population). Communicable diseases were the third leading cause of death (67.2 per 100,000 population), representing 9.3% of total deaths and 9.4% of total years of potential life lost. In 1999, 11,871 deaths from TB were reported, many of them linked to AIDS. The problem of bacterial resistance among the treated population and treatment dropout rates should be noted. The fight against AIDS continues, with higher reporting levels and greater community awareness about prevention and treatment, although difficulties have periodically arisen in obtaining easy access to specific drugs through official channels.

The greatest number of years of potential life lost in 2000 was due to violent accidents.⁴ Together with adolescent pregnancy and addictions, accidents and violence are the pathologies with the highest incidence among youth. Addictions are growing and the starting age continues to fall. Alcoholism remains the pathology with the greatest impact. The recorded number of cocaine and heroin addicts has increased.

For several years, infant mortality has exhibited a steady downward trend, dropping from 26.9 per 1,000 in 1986 to 17.6 per 1,000 in 1999. Average infant mortality in the period 1990-1999 declined by 31.3%, with marked differences between jurisdictions. For example, in 1999 the infant mortality rate in Tierra del Fuego was 7.8 per 1,000, while in Chaco, Formosa, and Jujuy, it was 29. The provincial values also conceal internal disparities within the provinces.⁵ In 1998, mortality in children under 5 included 248 deaths from diarrhea and 1,999 from ARI.

2.4. Social Context^f

In 1991, the percentage of the population below the poverty line in the suburbs of Buenos Aires was 21.5%, and the population below the indigence line was 3.5%. In 1999, those same indexes were 26.7% and 6.7%, respectively. For 2001, the poverty indicator was 35.4%, and the indigence indicator, 12.2%.⁷

Urban unemployment began to rise in 1991, moving from an average annual rate of 7% to 17.3% in 1996. The decline in employment was greatest in the suburbs of Buenos Aires and less so, on average, in the cities of the interior. By 1999, unemployment had risen to 14.5%. By the end of 2001, the persistent recession had placed this indicator at 18.3%.

Selected Social Indicators, 1991-2001

Year	Population below the indigence line (GBA)	Population below the poverty line (GBA)	Unemployment (urban areas)
1991	3.0	21.5	6
1992	3.2	17.8	7
1993	4.4	16.8	9.3
1994	3.5	19.0	12.2
1995	6.3	24.8	16.6
1996	7.5	27.9	17.3
1997	6.4	26.0	13.7
1998	6.9	26.7	12.4
1999	6.7	25.9	13.8
2000	7.7	28.9	14.7
2001	12.2	35.4	18.3

Source: SIEMPRO, based on EPH INDEC

2. HEALTH SERVICES SYSTEM

2.1. General Organization

By constitutional mandate, the provinces are the technical administrative units responsible for the health care and protection of the population⁸. The municipalities, particularly those with the greatest economic power and demographic weight, usually administer their own resources and have the authority to program and carry out health actions independently. The Federal Health Council (COFESA) is the institutional forum for consensus-building, setting goals, and adopting common policies and decisions among sectors and jurisdictions. The National Government maintains a presence in the provinces through delegations of the Ministry of Health, the Health Services Authority, the Occupational Hazards Authority, and the Authority of Associations of Retirement and Pension Funds. Law 25,233 modified Ministries Law No. 24,190 and established the organizational structure and objectives of the Secretariats and Departments operating under the Nation's Presidency, the Leadership of the Cabinet of Ministers, and the Ministries. The Ministry of Health was organized into two Secretariats and five Departments in order to manage the institutional workload, but the health emergency (Decree No. 486, 2002) has altered this structure.

MSAS includes various decentralized agencies, such as the National Drugs, Food, and Medical Technology Administration (ANMAT), the National Administration for Laboratories and Health Institutes (ANLIS), the National Institute for Central Coordination of Ablations and Implants (INCUCAI), the National Center for Social Reeducation (CENARESO), and the National Institute for Rehabilitation and Support of the Disabled. The Health Services Authority (SSS), created in 1996 by Decree No. 1,615, also reports to MSAS and is responsible for monitoring and overseeing compliance with the rule granting system beneficiaries the right to freely choose their *Obras Sociales* plans, supervising the PMO, and ensuring that the payment obligations of system entities with regard to Decentralized Hospitals are met. Finally, the following are included under MSAS as remnants of the hospital decentralization policies: the Baldomero Sommer National Hospital, the Professor A. Posadas National Hospital, and the Dr. Manuel Montes de Oca National Facility⁹ and, the largest entity in the *Obras Sociales* system, the Social Services Administration for Retirees and Pensioners, whose budget has been reinserted in the National Budget as of 2002.

The health system in Argentina is structured around three principal sectors: a) the *public sector*, publicly financed and maintained, consisting chiefly of provincial and national administrative structures at the ministerial level (responsible for sectoral management in their respective jurisdictions) and the public hospital network. The public sector has been decentralized in recent decades, transferring the administration of national public hospitals to the provincial and municipal levels. Other agencies and institutions have responsibilities in health; their place in the structure and

their degree of linkage with the ministries of health varies with the jurisdiction. Thus, environmental health tends to be part of the ministerial responsibility in the provinces but represents only a very specific sector at the national level under a State Ministry responsible for environmental issues. The Armed Forces have their own health care structure, with each branch administered separately, and they produce some inputs such as drugs. The education area is responsible for undergraduate and graduate training in health through the universities and university hospitals. It also maintains school health services for disease prevention and health promotion actions. The agriculture and livestock areas are responsible for food protection and animal health, including efforts to combat epizootics such as foot-and-mouth disease¹⁰; b) a *compulsory social security sector* based on the *Obras Sociales* plans (OS) that group workers according to their line of work. Supervisors and managers also fall under different OS, called management-level OS, with the same characteristics and functions as those of non-management employees. Other public agencies, such as the Armed Forces and the legislative and judicial branches, have their own OS. In addition, each province offers an *Obras Sociales* plan to cover the civil servants of its jurisdiction. Most OS deliver services by subcontracting to third-party providers, since their own facilities' capacity is very limited; c) the *private sector*, made up of independent health professionals and facilities (private hospitals, clinics, etc.) that provide services to private patients, but especially to OS beneficiaries through individual and group agreements that include different modalities of payment for services. Furthermore, the private sector includes voluntary insurance plans called prepaid health companies. In 1994, there were some 300 of these, covering 2 million beneficiaries and handling a total of U.S.\$ 2.5 billion¹¹. This market has also been consolidated; according to a study in 2001, 196 prepaid health companies are currently in operation (of these, 58% are in the Federal Capital, 19% in the rest of metropolitan Buenos Aires, and 23% in the interior) and their billing has been reduced to U.S.\$ 2.1 billion¹². Sixty-five percent of the subscribers are individual members and the rest participate through corporate plans. Approximately 46.3% of the billing and 41% of the demand are concentrated in the 10 leading companies in the market. Furthermore, the largest companies have an average monthly income per beneficiary double that of the smallest.

Finally, it should be mentioned that a new system for protection against occupational hazards was designed between 1995 and 1996, based on the operation of private enterprises (Occupational Hazard Insurers) that meet prevention and compensation needs with respect to occupational injuries. The Occupational Hazards Authority, under the Ministry of Labor and Social Security¹³ oversees the system.

The coexistence of the three sectors described above is not problem-free. It has been argued that public service delivery indirectly subsidizes the inefficiencies of the other sectors. At present, public

sector demand has increased because of growing unemployment, the economic crisis, and the breakdown in the chain of payment in the private and social security sectors.

2.2 System Resources

Human Resources^{14 15}

The number of medical graduates declined by 12.2% between 1992 and 1998, from slightly over 4,000 graduates to fewer than 3,800¹⁶. During the same period, the number of graduates in dentistry also declined slightly, while the number of psychology graduates increased. Five hundred nurses were trained annually until 1989, when the number of nursing graduates began to rise, reaching some 1,000 per year¹⁷. Information on expected trends for the immediate future is not available.

EVOLUTION OF HUMAN RESOURCES IN THE HEALTH SECTOR¹⁸

Type of Resource	1992	1995	1996	1997	1998	1999	2000
	Total physicians	88,800	ND	ND	ND	108,800	ND
Total dentists	21,900	ND	ND	ND	28,900	ND	29,231
Total nurses (incl. aux + appren.)	69,000	ND	ND	ND	86,000	ND	140,000
Total mid-level laboratory technicians	ND	ND	ND	ND	ND	ND	ND
No. graduate degrees in public health awarded	ND	ND	ND	ND	ND	ND	ND
Ratio of physicians/10,000 pop.	26.8	ND	ND	ND	30.2	ND	ND
Ratio of professional nurses/10,000 pop.	5.4	ND	ND	ND	8.1	ND	ND

Sources: PAHO, Basic Indicators 1998; M. Brangold: "Administración Estratégica y Servicios de Salud" Organización Panamericana de la Salud "Desarrollo de enfermería en Argentina. 1985-1995. Análisis de situación y líneas de trabajo.", Buenos Aires, Publicación No. 43, 1995; PAHO/WHO, Human Resources in Health, September 2000.

Training in public health and health administration is conducted in a wide variety of institutions. In 1999, there were more than 60 institutions with graduate programs in these areas (academic institutions in the health sciences, as well as other university, professional, hospital, and governmental areas, and others). For the most part, these studies are paid for directly by the professionals themselves.

Drugs and Other Health Products

In 1997, spending on drugs accounted for 25% of the health expenditure (\$5.812 billion) and amounted to nearly \$150 per inhabitant or \$13 per inhabitant per month. Of the total spending on drugs, it is calculated that 73% is direct household expenditure and 27% institutional (clinics, prepaid health care companies, Obras Sociales plans, and the National Social Services Administration for Retirees and Pensioners (INSSJyP))¹⁹.

Drug prices have risen steadily since 1991, due to direct price increase, the introduction of new products, or the indirect reduction of package contents. While 482 million units valued at US\$ 2.575 billion were sold in 1992, only 406 million units were sold in 1996, at a cost of US\$ 3.644 billion. That is, a 41.51% increase in cost corresponded to an 18.72% decrease in the number of units sold, meaning that the average unit price rose from US\$5.34 in 1992 to US\$8.98 in

1996 (a 68.16% increase). The expected trend in the immediate future is for prices to continue to rise due to the effects of the exchange rate depreciation. In general, the high cost of drugs is a barrier to system access and has a serious impact because of its share in total and individual health expenditures. According to a recent study, there are many more barriers to drug access than to health services' access. A full 84% of the population under the poverty line has access only to public services, and when these individuals purchase drugs, 45% do so with their own resources²⁰. This fact ties in with the lack of a drug policy in recent years for effective price control and the incorporation of new products. Reversal of this situation began in 2002 with the MSAS' very active drug policy agenda. Owing to the devaluation of the peso, the laboratories have increased their prices to the public. Within the framework of the health emergency, the National Government has reached an agreement with the industry to maintain the prices of a basket of 250 products at December 2001 levels. Governments and private organizations have donated some critical supplies such as insulin. The Antineoplastic Drug Bank, which provides drugs free of charge to the needy population without coverage, has been maintained, as has the provision of AIDS drugs. In this area, conflicts with users are chronic when certain products are temporarily unavailable. The free provision of tuberculosis drugs is also planned. Significant changes have been made in the policy on generics. The historical trend has been toward the use of brand-name drugs and limited price competition among them. Decree N°486/02 on the Health Emergency promoted the compulsory use generic prescriptions and permitted pharmacists to make substitutions. Furthermore, the reformulated Compulsory Medical Plan (PMO) includes a compendium of nearly 200 essential drugs by their generic name, with a reference price established for each. These measures are expected to produce greater price competition and an expansion of the generics sector.

Social security partially finance drugs for people receiving outpatient care and totally finance drugs administered in hospitals and those for diseases where the costs are high and the prevalence low. In public hospitals, the drugs administered are financed and drugs used for outpatient care are partially financed, as supplies permit. Private insurance coverage varies with the plan contracted, with coverage as high as 80% for outpatient drugs and 100% for drugs administered in the hospital, with certain exclusions. Under the Maternal and Child Program, which is part of the PMO, 100% coverage should be provided to mother and children during pregnancy and the first year of life.

The preparation and application of treatment protocols are moving forward. MSAS has prepared treatment standards for various pathologies, the use of which is required under the reformulated Compulsory Medical Plan (PMO).

All public, private, or social security pharmacies must have a professional pharmacist in attendance.

Equipment and Technology. In 1997, the estimated expenditure in therapeutic equipment and other durable goods was \$506 million (2.1% of the total health expenditure). Imports of medical equipment and other non-durable inputs (except drugs), estimated at \$248 million in 1997, declined over time with the recession to \$194 million in 2001.²¹

New diagnostic and treatment technologies have been adopted, especially in the private sector. Public sector procurement involved the construction of new facilities financed with international loans and the remodeling and rehabilitation of the facilities included in World Bank-funded programs (Program for Transformation of the Health Services System). The last equipment census was conducted in 1998. The database covers only 14 jurisdictions, which do not include the city or province of Buenos Aires, where most of the complex equipment is concentrated. Some sectors, like the hemodialysis sector, have confined their equipment purchases to a few companies through systematic purchasing from the traditional groups of specialists. The information available refers to facilities with and without hospitalization, and to the distribution of beds by type of property.

Number of Hospital Beds per Administrative Unit, 1980 and 1995

<i>Overall Data</i>	1980	1995
Overall Total	145,690	155,749
Public Sector Total	62.50%	54%
<i>Obras Sociales</i> Plans Total	5.50%	2.80%
Private Sector Total	32%	43%
Other Miscellaneous	NA	0.05%
<i>Public Sector</i>	1980	1995
Overall Public Sector Total	91,034	84,094
National	11.60%	2.80%
Provincial	62.20%	65.70%
Municipal	18.57%	24%
Others	7.60%	7.60%

Source: Guía de Establecimientos Asistenciales de la República Argentina. Dirección de Estadística e Información de Salud.

The movement of public sector beds toward the private sector is evident. Within the public sector, there has been a clear decrease in the number of national beds and a concomitant increase in the number of provincial beds based on the transfer of facilities and services. The trend in the distribution between outpatient facilities and hospitals by sector is shown in the following tables.

Health Care Facilities by Administrative Unit: 1980, 1990, and 1995

	Without Hospitalization (20)		With Hospitalization	
	1980	1995	1990	1995
Overall Total	6,038	12,775	3,013	3,310

Public Sector Total	57.50%	45%	39%	37.20%
<i>Obras Sociales</i> Plans Total	4.15%	1.30%	3.75%	1.66%
Private Sector Total	38.35%	53.60%	57%	61%
Other Miscellaneous	NA	0.12%	NA	0.09%

Source: National Ministry of Health. Office of Statistics.

Health Care Facilities by Administrative Unit: Public Sector

	Without Hospitalization		With Hospitalization	
	1980	1995	1990	1995
Overall Public Sector Total	3,471	5,740	1,177	1,231
National	0.77%	0.16%	2.04%	0.57%
Provincial	76%	65.71%	73.80%	69.53%
Municipal	19.85%	30.76%	18.18%	19.25%
Others	3.37%	3.36%	5.90%	10.64%

Source: National Ministry of Health. Office of Statistics.

Decentralization has increased the municipal administration of facilities during the period examined. This trend was heightened in 1999. No information is available on the state of equipment maintenance, nor on the operating budget for the conservation and maintenance of equipment at the national level.

Equipment maintenance is being contracted out, having deteriorated under the facilities' own personnel, whose only training has been on-the-job.

Total Facilities	Facilities with Hospitalization				Facilities Without Hospitalization				Average Beds Available			
	Total	National	Provincial	Municipal	Total	National	Provincial	Municipal	Total	National	Provincial	Municipal
7,428	1,286	5	900	381	6,142	2	3,899	2,241	76,363	1,594	52,526	22,243

2.3. Functions of the System

Steering Role. The main role of MSAS has been intersectoral negotiation, the establishment of public policies and legal frameworks, monitoring, the dissemination of information, and other functions inherent to the central government. Following the change in government at the end of 2001, the redesign of MSAS (Decree No. 486 of February 2002) has meant an improvement in its articulation with the provinces. Of particular note is the impetus given to the Federal Health Council (COFESA), made up of the Ministers or Secretaries of Health of the Argentine Provinces and City of Buenos Aires.

As a decentralized agency of the MSAS, the Health Services Authority (SSS), created by Decree No. 1615/96 of the National Executive Branch, plays an important part in the exercise of the steering role. The SSS enjoys administrative, economic, and financing autonomy and directs its activities to: i) ensuring compliance with the Compulsory Medical Plan (PMO); ii) implementing the National Program for Quality Assurance in Medical Care (PNGCAM) in the entities that make up the social security sector; iii) supervising enforcement of the right of beneficiaries to choose their *Obras Sociales* plans freely.

MSAS engages in joint programming activities with other health authorities. These activities are geared to specific groups, health promotion, the development of healthy public policies, environmental health care, or disease prevention and control. To support its actions, MSAS has a National Epidemiological Surveillance System (SINAVE) that furnishes information for each jurisdiction obtained from monthly reports of communicable diseases. Referring almost entirely to the public sector, the SINAVE information includes data on morbidity in outpatient consultations, health protection, and hospitalization²². It is supplemented with data from the National Program of Health Statistics in the areas of vital statistics, resources, and service production, which are confined basically to public sector facilities.

Specific policies are in place for the education of health professionals. The Higher Education Law, in effect since 1995, imposes a series of requirements for State-regulated professions whose exercise could endanger the health of the population. The Law establishes accreditation procedures for these education programs, called “risk” programs, to be applied by a decentralized agency of the Ministry of Education (ME), the National Commission on University Evaluation and Accreditation (CONEAU).²³ The Law also requires that graduate programs—whether specialized, master’s, or doctoral programs—be accredited by CONEAU or entities recognized by ME. The first accreditation of medical specialties was instituted in 1998. On the other hand, MSAS, through the PNGCAM’s Control of Professional Practice component, oversees the professional performance of the entire health team, although these functions are constitutionally reserved for the provinces. This makes it

difficult to analyze the number of physicians, since professionals are registered in each of the provinces in which they practice. Standards for the organization and operation of health services are also being drafted, explicitly defining space, equipment, human resources, and procedures requirements according to risk levels.

The National Drug and Medical Technology Administration (ANMAT) acts as the state regulatory entity in drug and technology matters, working in the areas of inspection, control, and monitoring of technology.

In 2001, Argentina's health authority evaluated the 11 essential public health functions defined in the corresponding performance evaluation instrument endorsed by PAHO/WHO. These are: 1) monitoring, evaluation, and analysis of the health situation; 2) public health monitoring, research, and control of risks and threats to public health; 3) health promotion; 4) citizen participation in health; 5) development of policies and institutional capacity for planning and management in public health; 6) strengthening of the institutional capacity for regulation and control in public health; 7) evaluation and promotion of equitable access to necessary health services; 8) human resources development and training in public health; 9) guarantee and improvement of the quality of personal and population-based health services; 10) research in public health; and 11) reduction of the impact of emergencies and disasters on health.²⁴

Financing and Expenditure. Health expenditure in Argentina exhibited a cumulative net increase of 7.5% between 1995 and 1999, for an annual average of 2.15% (24) for the period. Since 1995, health expenditure's share of GDP has fallen year after year; in the last 5-year period, the decline was 7.5%. Similarly, health expenditure as a percentage of GDP fell from 9.13% in 1995 to 8.45% in 1999.

Evolution of Total Health Expenditure, 1995-2001 (in million pesos)

	1995	1996	1997	1998	1999	2000	2001
National	582	613	720	823	875	805	755
National OS	3,497	3,464	3,700	3,836	3,893	3,861	3,282
INSSJyP	2,689	2,455	2,167	2,364	2,498	2,270	2,110
Provinces	3,499	3,508	3,686	3,807	4,116	3,913	3,589
Prov. OS	1,756	1,780	1,912	1,951	2,072	2,112	2,007
Municipalities	769	687	743	848	853	842	758
Private	9,313	9,698	10,500	10,843	10,533	10,390	9,559
Total	22,105	22,205	23,428	24,472	24,840	24,193	22,060

Source: Programa de Investigación Aplicada - PIA-Isalud.

Wide variation is seen in the intermediate years between 1995 and 2001, with no major changes in total values at either extreme. However, the composition of the expenditure changed markedly, with

the greatest declines occurring in social security as a whole (INSSJyP, National OS, and Provincial OS).

In conclusion, the impact of the deep recession in Argentina on sanitary financing since 1998 is significant. Estimates of the expenditure for 2001 show a strong contraction, and the most likely scenario is that the trend will continue in 2002. This will be compounded by the impact of the devaluation of the peso since the end of convertibility in January 2002. This situation has caused Argentina to lose its status as the country with the highest per capita health expenditure in the Region²⁵.

Insurance. Official estimates show the formal coverage but do not always reflect the coverage for benefits such as drugs and the treatment of chronic, high-complexity, or lengthy illnesses. The National Health Services Authority (SSS) was created by Decree No. 1615/96 as a decentralized agency under the Ministry of Health following the merger of ANSSAL, the National *Obras Sociales* Board (INOS), and the National *Obras Sociales* Directorate (DINOS). The SSS is responsible for overseeing compliance with the Compulsory Medical Plan (PMO) by the insurance entities, in addition to guaranteeing the quality and coverage of the system and cost recovery by the Decentralized Hospitals. The following table shows the distribution of health care coverage by type of coverage.²⁶

Health System Coverage by Sector, 2001

Sector	Million Inhabitants	Percentage	
<i>Obras Sociales</i> Plans (Only)	18.4	50%	11.6 are National <i>Obras Sociales</i> Plans
Associations and/or Prepaid Plans (*)	2.9	8%	
<i>Obras Sociales</i> Plans and Prepaid Plans Dual Coverage	1.5	4%	
Public Sector Only	13.7	38%	
TOTAL	36.6	100	

Source: Fundación Isalud. 2001. (*) Includes half a million people with only an emergency medical plan.

The following table presents coverage in each sector by quintiles of income:

Health System Coverage by Sector, by Quintiles of Income, 1997

	First	Second	Third	Fourth	Fifth
<i>Obras Sociales</i> Plans	30.8%	54.1%	62.2%	67.9%	61.3%
Associations and/or Prepaid Plans	2.9%	5.5%	6.9%	10%	16.4%
<i>Obras Sociales</i> and Prepaid Plans (Dual Coverage)	1.4%	2.3%	4.9%	5.7%	13.3%
Emergency Only	1.3%	1.2%	1.6%	1.7%	1%
Public Sector	63.3%	36.7%	24.4%	14.6%	8%
Average Household Income	\$355.6	\$834.6	\$931.8	\$1,210.3	\$2,536.9
Average Per Capita Income	\$68.7	\$153.8	\$355.6	\$403.5	\$1,041.4

Source: SIEMPRO *Apud*. Tobar, F., 2001.

The *Obras Sociales* plans cover a population of 18.3 million, distributed among nearly 300 institutions of varying scope and size. Thus, 20 entities (around 7%) cover 7,626,534 beneficiaries (slightly more than 40% of the total) and another 43 *Obras Sociales* plans (around 15%) cover 9,446,015 beneficiaries (slightly more than 51%). The maximum values for voluntary private coverage appear in the Metropolitan Region, and almost 50% of the population in the provinces of the Northeast (NEA) is not covered by any type of insurance.

MEDICAL CARE COVERAGE BY TYPE AND GEOGRAPHICAL AREA, 2000

Type of Coverage	Metro-politan Area	North-west	Las Pampas	North-east	Cuyo	Patago-nia	Total
No Coverage	36.46 %	37.81 %	33.99 %	48.87 %	39.39 %	32.65 %	38.04 %
<i>Obras Sociales</i> Plans	47.63 %	51.89 %	52.05 %	44.98 %	51.50 %	60.82 %	51.19 %
Voluntary Subscription	10.71 %	5.68 %	8.36 %	3.13 %	4.90 %	3.07 %	6.29 %
<i>Obras Sociales</i> Plans and Voluntary Subscription	3.97 %	3.76 %	3.98 %	1.94 %	1.87 %	2.85 %	3.21 %
Emergency Coverage	1.02 %	0.74 %	1.33 %	0.68 %	1.83 %	0.53 %	1.00 %
Other Coverage	0.03 %	0.02 %	0.22 %	0.30 %	0.19 %	0.06 %	0.13 %
Ns/Nr	0.17 %	0.10 %	0.06 %	0.10 %	0.34 %	0.02 %	0.13 %

Source: Prepared by ACR y Asociados based on ENGH and INDEC data.

Public hospitals provide coverage to the population on demand and, in fact, act as reinsurance for the other sectors, since they maintain a flow of free care even for the insured population, notwithstanding Decree 939/2000.²⁷

Prepaid health care plans still lack an adequate regulatory framework despite the existence of numerous pieces of draft legislation and the intense debate surrounding the issue. The remaining insurance institutions cover occupational hazards, grouped under the Occupational Hazards Authority, as well as the Associations of Retirement and Pension Funds (AFJP), which cover retirees, including those who retire for reasons of disability.

2.4. Service Delivery²⁸

Public Health Services: MSAS, the provinces, and certain large municipalities provide public health services through programs in the areas of: maternal and child care, women’s health, mass communication, education for health, reorientation of medical practice in the health services networks; promotion and protection of air quality, workers’ health; communicable disease prevention and control (for example, the National Expanded Program on Immunization, and programs to combat cholera, neonatal tetanus, leprosy, diphtheria, human rabies, measles, Chagas’

disease, and HIV/AIDS²⁹, and the polio eradication program, the system for monitoring emerging or reemerging pathologies, and the *Escuelas Rancho* Eradication Program).

Vaccination programs are coordinated with the various jurisdictions. In 1996, according to data supplied by the Ministry of Health, the percentages of vaccination coverage in children under 1 year of age were DPT, 82.8%; polio, 89.7; BCG, 123.6%, and measles, 102.9%. Environmental health and health education are examples of areas with population-based interventions whose execution is coordinated with the jurisdictions.

Personal Health Services: Most personal health services are procured in the private sector, from which the *Obras Sociales* plans purchase services. MSAS has transferred the vast majority of its services to local jurisdictions, but maintains programs for the training of personnel, technical support, the preparation of standards, and the direct delivery of some services. In 1999, the public sector recorded 81,973,049 medical consultations and 2,173,140 hospital discharges. According to MSAS data, in 1997, the number of patient/days in public health care facilities was 18,173,057, and the average number of available bed/days was 77,005. In 1996, 97% of births were attended in health care facilities (ranging from 99.8% in San Luis to 83.0% in Formosa).

Quality: There is no systematic evaluation of the quality of services. It should be emphasized that both the National Government, through the National Program for Quality Assurance in Medical Care, and private organizations (such as ITAES, Sociedad Argentina de Auditoría Médica, Programas de Calidad por Educación a Distancia, the Fundación Donabedian, and Medicina y Sociedad) devote resources to the improvement of medical care. The available results, in terms of the cost-benefit ratio, indicate the need to heighten the impact of these efforts. MSAS Resolution 857/93 provided for the creation of medical ethics committees within the framework of PNGCAM. These committees must be set up in every Hospital with Decentralized Management (HGD) that becomes part of the system, as well as all national health facilities.

3. MONITORING AND EVALUATION OF SECTORAL REFORM

3.1 Monitoring of the Process

Monitoring of the Dynamic: In recent decades, from different perspectives and through different strategies, public policies have been proposed to correct the heavy fragmentation of the system and reorganize resources to improve coverage and access by the population to health. Among these are the Integrated National Health System (SNIS) in the 1970s, the decisions of the National Equity Commission (Law 19,710), and National Health Insurance in the 1980s. In 1993, with the support of international credit institutions and PAHO/WHO, the different governments initiated health sector reform. The central tenets of the reform were: to guarantee a basic package health services to

the entire population; to promote more efficient use of the available resources; to introduce market principles and competition among insurance providers and policies; to encourage demand-based financing; and to improve the quality of health services.

The first stage saw the beginning of the changes in the *Obras Sociales* plans (OS), particularly the union OS, to enable beneficiaries to transfer from the entity corresponding to their line of work to another OS. This has reduced the total number of OS and facilitated their association with private health insurance companies (Prepaid Plans). This also involved the preparation of a standardized basket of benefits known as the Compulsory Medical Plan (PMO).

MSAS negotiated loans and technical cooperation with the multilateral credit institutions to finance the reform programs. In order to gain access to these funds, the OS had to present proposals for institutional modernization, updating of the membership registry, the introduction of modern management methods, and guaranteeing the PMO. Mixed private consultancy groups (international groups lined with national groups) drew up these plans with World Bank financing^{30 31}. The Prepaid Health Care Companies were also affected in matters relating to standards, regulations, compulsory benefits, safeguards, and others. The public hospitals were also involved; the new regulations fostered their functional decentralization, increased their capacity for institutional self-management, and boosted their efficiency and effectiveness.

In 2000, the sectoral reform was in the phase of implementing the planned regulatory and control mechanisms, such as the Health Authority, the PNGCAM, and the Compulsory Medical Plan (PMO). Ministry of Health Resolution 939/00 modified the PMO, defined by Decree 492/95 and approved in its design by Resolution No. 247/96 of the Ministry of Health. The latter explicitly detailed the coverage to be offered by insurance providers; it emphasized health promotion and disease prevention, giving primacy to primary care. Additional regulations made all insurance providers responsible for the care of AIDS patients, the disabled, and people with addictions. Self-managing Hospitals were renamed Decentralized Hospitals (HGD).

The deregulation of the OS also continued its main thrust: a) transformation of the *Obras Sociales* plans through the World Bank-funded Program for Transformation of the Health Services System; b) promotion of efficient, rational expenditures by these entities, increasing their possibilities of success in an open competitive market, which has reduced their numbers from 312 in 1994 to 275 in 1999; c) guarantee of beneficiaries' freedom to choose their OS, which has not produced heavy waves of beneficiary transfers since it is limited to the union OS (the direction of the transfers is from the largest OS with the lowest per capita income to the smallest OS with the highest per capita income); d) competition on a totally open plane with the private prepaid health care companies, which has occurred in the form of private agreements between the managers of OS and Prepaid

Health Care Companies, so that transfers occur by groups of beneficiaries rather than by free personal choice.

The National OS regulatory framework established in Decree 446/2000 was suspended by Decree 377/2001, owing to the fact that numerous institutions were successful in barring its implementation with lawsuits, especially the clauses referring to the freedom to choose between the OS and the Prepaid Health Care Companies.

Within the framework of the National Board for the Coordination of Social Policies and the implementation of social policy to deal with the social emergency, the current goal is to provide universal access to drugs, strengthen the primary health care strategy, and guarantee the continuity of supplies to public hospitals.³² The PMO has also had to be reformulated.

Monitoring of the Contents:

Legal Framework: A Constitutional Convention was called in 1993 to reform the National Constitution, which was amended to establish the right of the people to health protection and the enjoyment of a healthy environment, and the duty of the authorities to safeguard these rights and ensure quality control and efficiency in public services. There was also recognition of the international treaties that establish the right to the preservation of health.

The sectoral reform process has led to the creation of numerous standards but limited execution and leadership in dealing with the actors in the sector. Thus, the standards pose problems such as the absence of regulation, scattered enforcement structures, shared responsibility with other jurisdictions where coordination efforts are just beginning, and the basically indicative nature of many standards and procedures, since their execution requires the collaboration of the provinces within the federalist structure of the State.

The institutional changes that began in 2002 have resulted in a restructuring of MSAS, aimed essentially at eliminating service administration functions and focusing on the work of planning and coordinating the provincial agencies.

Right to Health Care and Insurance: The national policies address the need to improve the accessibility, efficiency, and quality of medical care through the effective expansion of coverage to the entire population through the highest possible quality of action at the lowest economic and social cost.

The PMO became part of the health insurance system as stipulated in Decree No. 492/95. An intersectoral commission was charged with developing the program, whose compulsory implementation was set for six months from the date of its approval. Decree No. 247/96 approved the basic package of benefits guaranteed under the Compulsory Medical Plan (PMO); an insurer that did not offer coverage for all these services would have to merge with one or more other

entities. The PMO guarantees coverage in the areas of preventive care, diagnosis, medical treatment, dental care, and drugs. It does not allow for periods without coverage or modification of the coinsurance payments stipulated in it. Benefits not included may be provided through a waiver mechanism. The agency responsible for overseeing compliance with the PMO and the National Program for Quality Assurance in Medical Care is the Health Services Authority. At present, considering the health emergency that was declared through aforementioned Decree No. 486/02, a guaranteed package of essential health benefits that can be underwritten with the available resources is being formulated.³³ Decree No. 446/2000 mandates consideration of an insurance system for high-cost, low incidence pathologies that would replace the Special Benefits Administration (APE).

Steering Role: The agency responsible for designing the sectoral reform is MSAS. The results of the performance evaluation of the essential public health functions (FESP) in Argentina that was conducted using the evaluation instrument endorsed by PAHO/WHO in 2001 showed the highest ratings for the functions *monitoring, evaluation and analysis of the health situation of the population, and reduction of the impact of emergencies and disasters on health*. The lowest performance ratings corresponded to the functions *guarantee and improvement of the quality of personal and population-based health services and citizen participation in health*.³⁴

Separation of Functions: Since the last changeover of national government, under strong pressure from the provinces, the roles of the national, provincial, and local authorities in the management of health services are being reviewed. MSAS would assume responsibility for devising policies, overseeing the system as a whole, standardizing procedures, and performing the epidemiological function, with a view to eliminating its role as a health services provider.

Decentralization Modalities: With regard to its restructuring of the sector in the direction of federalization and decentralization, MSAS intends to transfer the health services still under its jurisdiction to the provinces and municipalities.

Social Participation and Control: COFESA is a national body made up of national and subnational health authorities, in addition to various nongovernmental entities that participate in the sector. Some jurisdictions have Local Health Boards (CLS) and Area Health Boards (CZS). The former play a decisive role in formulating and implementing local policies to complement those in force at the area and provincial levels. They function as a political body, and their actions address the general health problems of each level, maintaining an ongoing and coordinated relationship with the other jurisdictional levels. In addition to technical personnel, they include community representatives and health workers. The CZS are also political entities responsible for the relationship between the communities and hospitals of the area and the higher jurisdictional level.

They provide a forum for the discussion of area health problems and are made up of technical personnel and CLS and health worker representatives.

Although not widely implemented in reality, the regulations governing Self-Managing Public Hospitals state that the managers of medium- and high-complexity facilities are to be supported by a Technical Advisory Council and an Administrative Council with social participation, whose constitution, functions, obligations and membership are defined, in each case, by the jurisdictional health authority³⁵. Several provinces have instituted hospital reforms aimed at introducing Administrative Councils in which professional and nonprofessional hospital workers and community representatives participate.³⁶

Financing and Expenditure: The externally-financed institutional strengthening programs of the MSAS have an important component aimed at improving expenditure and financing information systems, especially through procedures to upgrade the national accounts system. A significant step was the transfer of responsibility for the collection of OS premiums in 1991 to the Ministry of Finance's National Tax Directorate (DGI).

The Common Redistribution Fund, created in the 1970s with the requirement that all OS contribute 10% of their income to it, was also reorganized. The Fund was intended to compensate low-income OS, but the redistributions were left to the discretion of Fund managers until the changes introduced by Decree No. 292/1995 made them automatic. Decree No. 492/95 then guaranteed every OS a predetermined minimum income of \$40 per subscriber, and Decree 1400/2001 subsequently changed the guaranteed amount to \$20 per capita for the subscriber and \$12 for each dependent. Another aspect was the incorporation of a cash flow to offset the public sector's indirect subsidy of the *Obras Sociales* plans. Health services have traditionally been free and universal in Argentina. The beneficiaries of OS or prepaid plans occasionally visited public hospitals, where they were treated at no cost to the insurance companies; thus, the State was subsidizing the *Obras Sociales* plans and Prepaid Health Care Companies. Decree No. 578/93 established the Self-Managing Public Hospital (HPA) Registry, which included an automatic payment system for the benefits owed to the HPA by the Health Insurance Entities.³⁷

Service Delivery: Nearly all the benefits supplied by the OS are through private providers. As a reflection of individual initiatives, a diversification of the supply of new health care modalities has been observed in recent years in the various sectors and jurisdictions in the form of shorter hospital stays, the creation of day hospitals, and others.³⁸ At the same time, reorganization of the services in the direction of cost reduction can be observed in the OS and the private sector, which has led--more in rhetoric than in reality--to the primacy of general practitioners and family doctors. In addition, maternal and child programs are being conducted, focusing on groups with unmet basic

needs (NBI), and nutritional recovery and food supplements for pregnant women and children under 6 are being promoted.

Management Model: Around 1998, the discussion of management contracts or commitments began at the various levels of the public health sector. The legal framework for the purchase and sale of third party services lies in the regulations of the Decentralized Hospitals (HGD, formerly HPA), permitting them to enter into agreements with social security facilities or other entities, collect fees for services from people with the ability to pay or from third-party payers, and set up service networks. In order to facilitate billing in public hospitals, modular fees were introduced (Ministry of Health Resolution No. 282/93 and its amendments). The decentralization of hospital management has given hospital managers administrative flexibility, making it possible for local authorities to privatize some services (food, janitorial services, etc.).

Human Resources: The HGD can designate, promote, and relocate personnel within the approved structures, apply sanctions under the prevailing standards in each jurisdiction, and accept dismissals for any reason. In addition, the Decree establishing the HGD provides for the creation of a monthly fund for redistribution among the entire hospital staff, pursuant to the guidelines set by the local authority, based on the facility's productivity and efficiency.

Quality and Health Technology Assessment: PNGCAM outlines new procedures for the authorization, accreditation, and classification of health care facilities, professional certification and recertification, sanitary control and supervision, and evaluation of the quality of medical care and the health services. Whether these procedures have been complied with is arguable, since these functions belong to the provinces. In 1993, a Steering Committee was set up to lay down the general guidelines and basic requirements of PNGCAM. Under its regulations, the HPA must comply with the basic requirements established in PNGCAM. Decree No. 1,424/97 also stipulates that the standards of care approved in PNGCAM must be observed by the OS belonging to ANSSAL and the HGD in jurisdictions and entities affiliated with PNGCAM. Private sector regulations stipulate that prepaid health care companies must provide the same “compulsory benefits” in their medical plans that are provided in OS, and that they will be subject to identical controls. The function of ANMAT is to control or oversee all aspects in the areas of diagnosis, supplies, and biomedical technologies, in addition to any other product utilized and applied in human medicine, as well as to manage the supply, production, fractionation, import, export, and marketing of products and materials utilized in medicine, food, and human cosmetics. The medical technology surveillance system is currently being improved.

3.2 Evaluation of Results

No systematic information is available to evaluate the results of the reform processes themselves.³⁹ It is believed that progress in sectoral reform has been limited by several factors: a) the cutbacks in resources before the deregulation was consolidated; b) the power plays among the different actors, as well as the advances and setbacks that fueled uncertainty rather than establishing a clear, objective image of the post-reform scenario; c) insufficient strategic planning for the reform: on one hand, the relevant economic and financial scenarios and the sustainability levels of the different measures were not evaluated; on the other, users were practically left out of the reform process. There was no overarching proposal that would integrate the three sectors and all the provinces; there was not even the necessary debate for this purpose. The fragmentation of the system and the federal nature of Argentina (characterized by the protection and care of health as a government function at the national, provincial, and municipal levels) lead to the fragmentation and overlapping of efforts, with low levels of coordination. The greatest progress lies in introducing competition among the national OS and establishing a Basic Program to be guaranteed by all of them. The complaints still voiced today about the reform or deregulation of the OS are valid proof that none of the strategies has been completely successful in meeting its objective. Nevertheless, the social and economic framework in which the strategies were proposed should be considered.

Equity

The study conducted on equity in health in the Argentine Republic exposes the inequitable conditions of the health system in general terms.⁴⁰ The results indicators and their relationship to income level signal major disparities in access to the system and, particularly, in the levels of expenditure and results. On the other hand, it is well known that sectoral inequity is related not only to poverty, but fundamentally to access differentials. The concentration of wealth and its increase at the highest income levels and the growing pauperization of the middle and lower classes gives an extrasectoral framework to equity in health. The hasty introduction of market principles and competition unaccompanied by effective controls has broken the bonds of structural and personal solidarity within the sector. The data on the distribution of financial resources in the sector and the out-of-pocket expenditure of the population provide figures on the subject.

Nevertheless, the search for equity in the health system is a State policy, expressly supported by the system's leading actors, including various scientific societies. The steady increase in drug prices and the high cost of drugs are an objective element in the potential for equitable access to the system.

Effectiveness and Quality. No systematic information is available on changes in the effectiveness and quality of the system as a consequence of the reform process. It is appropriate here to reiterate

what has already been mentioned about the lack of effectiveness of sectoral resources in terms of their results indicators and the activities and programs implemented in support of these objectives. The systematic efforts made to ensure the quality of human resources and facilities in the sector should be emphasized. The classification of facilities and professional certification are two realities that impact on the sector through entities such as the National Academy of Medicine, the Argentine Medical Association, the different specialized professional centers, and the professional schools working in the area. The National Program for Quality provides governmental coverage for these efforts.

Efficiency. One of the most salient characteristics of the Argentine health system has been its low efficiency in relation to available resources. A positive element is the general awareness of the situation and systematic investment in the public and private sectors throughout the country to train human resources in health management and administration.

Sustainability. The reform process as such is a State policy that is cause for optimism in terms of its sustainability, which is contingent on its adapting to the needs and potential of the population and institutions. The apparent breakdown in the chain of payments to service providers within the social security system is troubling, as is the new phenomenon of putting union OS, sanatoriums, and other sectoral institutions up for bidding by creditors or filing for bankruptcy. The lack of effective oversight facilitates the persistence of high levels of quasi-structural corruption, where phantom managers and broken contracts are growing in regularity. The new scenario in which the social and economic reality of the country is debated seems to indicate that the reform measures should focus on three principal areas: improving resource management; ensuring the quality of the services; and upholding ethical values in the planning and development of the system. This involves greater transparency in resource allocation and utilization; reorientation of the system toward primary health care; and an emphasis on promotion and prevention.

Social Participation and Control. Various forms of participation have been included in the reform process. With regard to the deregulation of the *Obras Sociales* plans, their management is systematically consulted on modifications to the system, and the negotiations on the subject have been numerous. With regard to quality, the participation of institutions such as the Argentine Medical Association, the Academy of Medicine, the Professional Schools, and other academic and professional institutions is ongoing. Regulation of the private prepaid health care companies, still pending, was discussed in open meetings of the National Senate. The Decentralized Hospitals offer avenues of participation for their personnel and the community.

Recently, in the context of the health emergency, greater opportunities for social participation have arisen, stemming from the MSAS call to a meeting on an "Agreement for Health." This meeting

was conducted within the context of the so-called "Argentine Roundtable", a forum for public debate in which the various sectors of society were represented – the National Government, provincial governments, unions and *Obras Sociales* plans, the Church, the Academy of Medicine, entities comprised of groups of physicians, pharmacists, and biochemists, and scientific societies, private insurers' associations, and clinics. This resulted in the formation of "Sectoral Roundtables"—on Service Providers and Financiers; on Drugs; on Financing and Expenditure; and on Human Resources in Health – devoted to the discussion of specific problems in the field of health and their possible solutions.

* The second edition of the profile was prepared by a group of 30 independent professionals affiliated with the National Academy of Medicine and the Maimónides and Torcuato Di Tella Universities. Technical coordination of the national group was the responsibility of the PAHO/WHO Representative Office in Argentina. The document was reviewed by members of the Cabinet of the Argentine Minister of Health and Social Welfare. Final review, editing, and translation are the responsibility of the Program on Organization and Management of Health Systems and Services of the PAHO/WHO Division of Health Systems and Services Development.

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- ³⁶ The Law of Hospital Decentralization of the Provinces of Santa Fe and Buenos Aires includes these figures. In the first case, it provides for the incorporation of a community representative, even as a paid position. In the latter case, Law 11,072 of Hospital Decentralization of the Province of Buenos Aires proposes the development of Advisory Commissions made up of community representatives that advise the Administrative Council.
- ³⁷ Payment of the amount billed by the HPA must be made within 30 consecutive days of receipt of the monthly statement, and between the 1st and 15th of the following month (Decree No. 578/93). Once this period has expired, the outstanding balance is automatically debited from the National Health System account corresponding to the entity, and the payment is made within 15 business days.
- ³⁸ ISALUD. "El mercado de medicamentos en Argentina". Estudios de la Economía Real N° 13. Buenos Aires. 1999.
- ³⁹ Various international studies (Mills and Vaughan, 1989) demonstrated that reforms based on decentralizing strategies took more than 10 years to show a significant impact on the health system.
- ⁴⁰ Bortman Marcelo; Verdejo Guadalupe; Juan Manuel Sotelo. 1999. Situación de la Equidad en Salud. OPS/OMS, Buenos Aires.