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Roberto Ariel Abeldaño

The Health Care System in Argentina



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THE HEALTH CARE SYSTEM IN ARGENTINA

Roberto Ariel Abeldaño*

Content

1. COUNTRY OVERVIEW	3
2. SELECTED HEALTH INDICATORS	3
3. LEGAL BEGINNING OF THE SYSTEM	4
4. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION	4
a. Organisational structure	4
b. Provision	5
c. Financing	5
d. Regulation	5
d. Benefit package	5
5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE	5
a. Major reform I	5
b. Major reform II	6
6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM	6
a. Organisational structure	6
b. Provision	7
c. Financing (as percentage of current GDP)	7
d. Regulation of dominant system	7
e. Benefit package	8
7. CO-EXISTING SYSTEMS	8
8. ROLE OF GLOBAL ACTORS	8
REFERENCES	8

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1. COUNTRY OVERVIEW



Source: <https://ontheworldmap.com/argentina/> (Accessed: June 9, 2022)

- » Sub-Region: South America
- » Capital: Buenos Aires
- » Official Language: Spanish
- » Population size: 45,196,000 in 2020
- » Share of rural population: 8% (2019)
- » GDP per capita: 8,579 USD in 2020
- » Income group: Upper Middle Income
- » Gini Index: 41.4 in 2018
- » Independence: The independence period was between 1810-1820. The Declaration of Independence (from Spain) was in 1816

Source: World Bank (2021); Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2021)

2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy (2020-2025 projection) ^a	73.82	70.81
Female life expectancy (2020-2025 projection) ^a	80.42	75.59
Under-5 mortality rate (2020-2025 projection) ^a	10 per 100,000 live births	36 per 100,000 live births
Maternal mortality rate (2020) ^b	39 per 100,000 live births	211 per 100,000 live births
HIV prevalence (2020) ^c	0.4% (15-49 age range)	0.7% (15-49 age range)
Tuberculosis prevalence (2020) ^b	31 per 100,000 people	127 per 100,000 people

Source: a) Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2021); b) World Bank (2021); c) UNAIDS (2021)

3. LEGAL BEGINNING OF THE SYSTEM

Name and type of legal act	Law 12912 "Creation of The National Direction of Public Health and Social Assistance"
Date the law was passed	October 21, 1943
Date of <i>de jure</i> implementation	November 30, 1944
Brief summary of content	The major policy goal was to promote and to preserve the health of the country's inhabitants, ensuring medical-social assistance and treatment of diseases. In terms of extent of coverage, the creation of The National Direction of Public Health and Social Assistance sought the expansion of social rights in general, the multiplication of the universal and free public offer of health services, and the expansion of social security, but institutionally it was reflected in the development of a fragmented system with three subsectors that serve three categories of users: a) low-income social groups, who do not have social security; b) salaried workers and retirees, and c) the population with the ability to pay, who buys private insurance or pays out-of-pocket when receiving care (Tobar 2012; Belló and Becerril-Montekio 2011; Congreso de la Nación Argentina 1943).
Socio-political context of introduction	In 1943, Argentina took the first step towards the recognition of public health as a problem of specific interest to the State. The creation of the National Direction of Public Health and Social Assistance was followed in 1946 by the transformation into a Ministry of Health. The socio-political context of the decade was the "responsible-guarantor" State. The main driver of the policy was to guarantee the right to health protection of the workers that later gave rise to the health system (Belló and Becerril-Montekio 2011).

4. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION

a. Organisational structure

The HCS was mainly regulated by the state. From 1946 to 1978 the HCS in Argentina was totally centralized. The degree of centralization was manifested in the lack of allocation of HCS responsibilities to other municipalities (Bisang and Cetrángolo 1997).

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The entitlement criteria were occupational status and economic status (Bisang and Cetrángolo 1997).

» Coverage (principal health insurance)

At the introduction of the HCS in Argentina the covered groups were the formal workers and their families (Bisang and Cetrángolo 1997). Provision

b. Provision

Indicator	Value
Number/density of physicians (per 1,000 people) in 1960	1.351
Number/density of nurses/midwives (per 1,000 people) in 1992	2.0
Number or density of beds in public hospitals in 1960	6.3

Source: World Bank (2021)

c. Financing

The expenditure in health was about 8.47 % of GDP in 2000 (World Bank 2021). From 1946 to 1978, the state was the main responsible actor for financing the HCS.

The financing of public insurance comes from the payment of 8% of the salary of active workers. That 8% is divided into 3% contributed by the worker, and 5% contributed by the employer.

The financing of private insurance is through out-of-pocket payment.

d. Regulation

The National Direction of Public Health and Social Assistance was the only public organisation responsible for the regulation of HCS. This body was in charge of the functions of standardization, regulation, planning and evaluation of the health care actions carried out in the national territory.

In order for providers to be able to serve the beneficiaries, the law required licensing for facilities, and professional licensing for physicians.

e. Benefit package

The Basic Medical Program includes a very broad set of benefits and the respective medicines. This program covers 95% of the causes of outpatient consultation, surgical and hospital care, dental care, mental health, rehabilitation and palliative care (Tobar 2012; Belló and Becerril-Montekio 2011).

5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE

a. Major reform I

Name and type of legal act	Presidential Decree Nº 14,807
Date the law was passed	May 23, 1946
Date of <i>de jure</i> implementation	May 29, 1946
Brief summary of content	There was a paradigm shift that transformed the Argentine health system from the curative-care model focused on the disease to one based on preventive and social medicine that understands man as a bio-psycho-spiritual and social whole that falls ill and cures according to the relationship with the environment in which it develops. In 1949, during the first presidential term of Juan Domingo Perón, the National Hygiene Directorate, the Health Secretariat and the National Ministry of Public Health were created. Dr Carrillo was appointed as the first Minister of Health in Argentina (Ministerio de Salud 2021).
Socio-political context of introduction	In 1949, during the first presidential term of Juan Domingo Perón, the National Hygiene Directorate, the Health Secretariat and the National Ministry of Public Health were created. Dr Carrillo was appointed as the first Minister of Health in Argentina (Ministerio de Salud 2021).

b. Major reform II

Name and type of legal act	National Law N° 21,883
Date the law was passed	October 5, 1978
Date of <i>de jure</i> implementation	No data
Brief summary of content	The agreements signed between the Ministry of Social Welfare of the Nation, the provinces of Buenos Aires, Catamarca, Cordoba, Entre Rios, Salta, Santa Fe, Santiago del Estero and Tucuman, approved the transfer of health facilities to those jurisdictions (Ministerio de Salud 2021).
Socio-political context of introduction	The second half of the 1970s decade marked the beginning of a process of fiscal decentralization of various health services that depended on the federal level towards the provinces. National Law 21883 agreements were approved between the Ministry of Health of the Nation with 9 provinces for the transfer of the management of 65 hospitals (Bisang and Cetrángolo 1997).

6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM

a. Organisational structure

The process of decentralization of health care services in Argentina took place mainly during the 1980 and 1990 decades. These reform and decentralization policies had as main axes the level, structure, financing and form of execution of the national budget, and it materialized in a bid between the national management and that of the provinces in relation to the distribution of the proceeds and the execution of public spending on healthcare.

This is how the national administration has transferred an important part of the health services to the provinces. In this process of more than a decade, the national administration has decentralized almost all the health services to the provinces and a small portion to some municipalities.

Thus, each province or municipality established its own policies for the management and coordination of its health services. This has implied greater autonomy and self-management for local hospitals in terms of purchases, hiring of human capital, attracting additional resources, etc (Bisang and Cetrángolo 1997).

Health management is regulated by the National Health Ministry, which in turn regulates the provincial health ministries. These two levels of management regulate a network for the provision of healthcare services that are divided into two sub-sectors: public and private. The private sub-sector depends on private companies for its management; while the public sub-sector integrates a network of first, second, third and fourth level services (from less to greater complexity), which are provincial-dependents or national-dependents, as the case may be. Only in the richest and most populated provinces are there (smaller) care networks dependent from the municipal level.

» Eligibility and entitlement

The eligibility criteria are linked to the occupational status of the individuals and their families. The low-income population that does not have social security benefits is covered by the network of hospitals and public health centres in which free care is provided to anyone who requires it (from low to high levels of complexity). Active workers (from the public and private sector) and retired workers, and their families, have social security administered by the Health Insurance (locally known as "Obras Sociales") (national and provincial), which are not-for-profit, and which are organized from the various branches of economic activity (education, transport, gastronomic, and other sectors). These entities subcontract the services of the private sector (private hospitals) for the health attention of their beneficiaries (Tobar 2012; Belló and Becerril-Montekio 2011).

» Coverage

Percentage of population covered by government schemes	9 %
Percentage of population covered by social insurance schemes	48.6 %

Percentage of population covered by private schemes	6.8 %
Percentage of population with no social insurance, but covered by the public network of health care	35.5 %

Source: Roberto Ariel Abeldaño and González (2016); Abeldaño (2016)

b. Provision

Indicator	Value (2019)	Source
Physician density (per 1,000 inhabitants)	3.99	World Bank 2021
Nurse and midwife density (per 1,000 inhabitants)	2.6	World Bank 2021
Public hospital beds density (per 1,000 inhabitants)	4.9	World Bank 2021

Importance of inpatient and outpatient sectors: In 2000 Argentina had 17,845 healthcare facilities in the public sector; 3,311 were hospitals, which gives a ratio of nine hospitals for every 100,000 inhabitants. About 60 % of the hospitals were private, 38 % public, and the rest belonged to social security. Almost 95 % of the public hospitals were provincial and only 5 % were national and municipal.

The hospitals had 153,065 beds, of which 53 % belonged to the public sector, 44 % to the private sector and the remaining 3 % to the social security sector. Regarding outpatient care units, in the country where there are 14,534 units, 44.4 % belong to the public sector (Belló and Becerril-Montekio 2011).

c. Financing

- » The total expenditure for health was 9.85% of the GDP in 2018. In 2018, there was a 18.1% out-of-pocket expenditure (% of current health expenditure). In our study, with data available from the 2012 National Expenditure Survey, 2.3% of households were identified as having health spending higher than 30% of total household expenditure (Abeldaño 2016).
- » The public sector is financed with fiscal resources. The central administration and decentralized provincial agencies are financed with resources from the national budget.
- » Retiree coverage is financed by contributions from salaried workers and with central fiscal resources. The financing of social security comes from the contribution of 8% of the salary of active workers (3% contributed by the worker and 5 % by the employer) (Belló and Becerril-Montekio 2011).

d. Regulation of dominant system

- » At the national level, the main agency for the regulation and organization of the HCS in Argentina is the National Ministry of Health. At the provincial level, the provincial Ministries of Health are the responsible for the organization at the local level.
- » The Superintendence of Health Services (SSS), created in 1996 as a decentralized agency of the Ministry of Health, plays a relevant role. It has administrative, economic and financial autonomy. It is an entity for the supervision, inspection and control of the agents that make up the National Health Insurance System so that they comply with the provisions of health policies. The Superintendency of Health Services also regulates and controls health care facilities with providing approvals and licensing (Ministerio de Salud 2021).
- » The license, authorization and approval of the healthcare facilities is regulated by the National Ministry of Health. The national and provincial ministries of health approve the license for healthcare professionals at the national and provincial level.
- » Regulations related to medicines, food and new medical technology are centralized in the National Administration of Medicines, Food and Medical Technology (ANMAT).
- » Quality control of health services is regulated by the Superintendency of Health Services, which depends on the Ministry of National Health (Ministerio de Salud 2021).

e. Benefit package

The Mandatory Medical Program (locally known as Programa Médico Obligatorio) establishes the essential basic benefits that social security providers in health must guarantee to the entire beneficiary population.

There is a catalogue with some categories:

- » Coverage: This category determines the basic coverage in: Primary Health Care; Secondary Care; Internment (Inpatient services); Mental health; Rehabilitation; Odontology; Medicines.
- » Features: This category includes a list of benefits that social security is obliged to provide according to established conditions.
- » Medicines and reference prices: these categories include lists of mandatory basic drugs that must be provided by health services. There is also a catalogue with reference prices (Ministerio de Salud 2021).

7. CO-EXISTING SYSTEMS

The entire system is divided in three sub-sectors. The public sector is the dominant, followed by the Health Insurance (locally known as “Obras Sociales”), and lastly the private sector (Tobar 2012; Belló and Becerril-Montekio 2011).

8. ROLE OF GLOBAL ACTORS

Global actors do not play a significant role in service provision, financing or regulation of the healthcare system.

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