

# Health Care Organization and Delivery in Argentina: A Case of Fragmentation, Inefficiency and Inequality

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## Abstract

Fragmentation is a common trait of most Latin-American systems. In Argentina the lack of integration among sub systems has a deep impact on health care access and financial sustainability, leading to exclusion, inefficiency, inequality, lack of transparency in administration and one of the highest burdens of household catastrophic out-of-pocket spending in Latin America. The national budget, although within the average of the region, is insufficient to cover the health care needs of the uninsured and to fully address the imbalances in social determinants of health. In this article, we first present the organizational and financial structure of the health care system. We then analyse the system dynamics and local health care history, and we explore a few possible lines of action and reforms for the next decade. This analysis may provide lessons for other countries in the region with analogous contexts and facing similar challenges.

## Background

According to the Pan American Health Organization (PAHO), the Argentinean health care system is heavily fragmented. Furthermore, a report from The Lancet Oncology Commission states that the 'multiple independent systems lack vertical and horizontal integration, resulting in inadequate coverage for many' (Goss, 2013, p. 396). Fragmentation, however, is a common trait of most Latin-American systems, including Argentina, which are all also experiencing epidemiological transitions, ageing populations, and increasing burdens of non-communicable diseases. In this region, government health care spending is subject to biased allocation of resources and segmented financial structures. This results in basic or minimum care, especially for the poor or unemployed. Although the Argentinean system intends to provide universal coverage, the segmentation and fragmentation, as well as the lack of integration among sub-systems, lead to inefficiencies and inequities.

This article presents the basic structure of the Argentinean health care system, its impact on health care access and financial sustainability and the role of social determinants of health in the country. It also reflects on local health care history to explore a few possible lines of action and reforms for the next decade.

## Overview of the Argentinean health system

About 36 per cent of the population in Argentina does not have any formal coverage and receives health care in the public system (Figure 1). About 16 per cent of the population have private coverage, 5 per cent by means of a monthly premium and out-of-pocket expenses and 11 per cent via a worker's union (*Obra Social*). The worker's

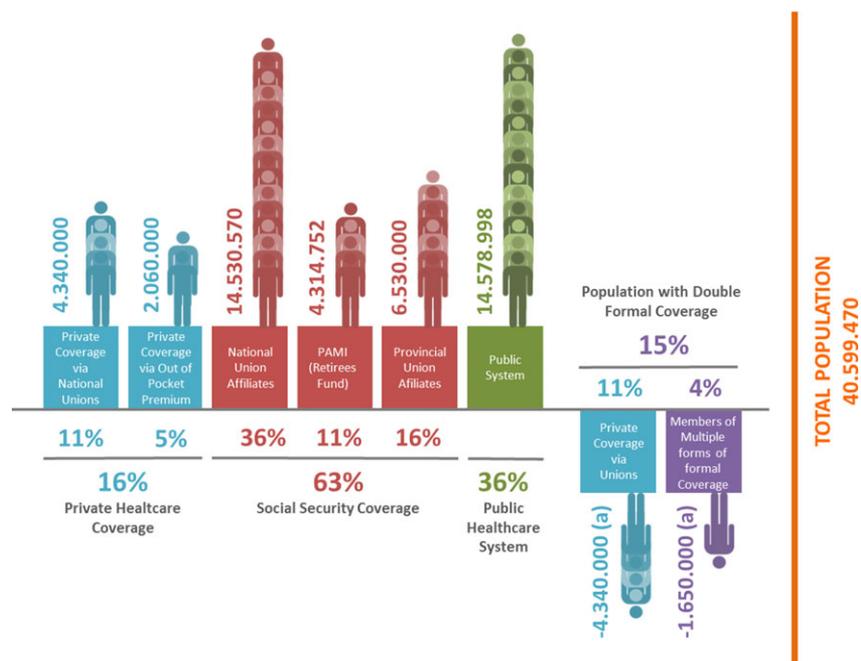
unions represent the largest part of the social health insurance sector which includes 63 per cent of the total population.

These unions consists of more than 300 national unions (*Obras Sociales Nacionales*), each of which is associated with a specific trade or industry and encompass 36 per cent of the population. The segment of social health insurance also includes 24 provincial unions (*Obras Sociales Provinciales*) – one for each province – which cover around 5 million public sector employees and their dependents (16 per cent of the population) (Figure 1). Many of the provincial unions also contribute to and are covered by a national union. Social health insurance is funded by a compulsory payroll contribution from employees (3 per cent) and employers (6 per cent). Unions can contract private companies to provide total or partial coverage for their affiliates; each year the affiliates can choose the union that best fits their service expectations and preferences. Finally, this segment includes the retirees (11 per cent of the total population) covered by a state-run pensioners' health fund (*Programa de Atención Médica Integral – PAMI*), which is financed by a portion of the payroll tax and its own revenues.

Figure 1 also depicts the percentage of the population with some form of duplicate formal health care coverage (15 per cent), including union affiliates, as well as those that receive medical care from private companies, networks and providers.

It is important to note that the social security system does not represent a government agency, but a pool of independent worker's organizations that at one point in time acquired the role of health care administrators and providers. Since their creation, alternate government agendas have been giving these organizations different levels of political and financial support.

Figure 1. Argentinean healthcare system: segments and population covered



Source: Adapted from Van der Kooy and Pezzella (2013).

According to the World Bank (2014a), total health expenditures as a percentage of the GDP has been around 8.5 per cent over the last decade. About one third of the total is public spending, one third is *Obras Sociales* spending, and one third is out-of-pocket spending on private premiums, co-payments, deductibles, or uncovered benefits.

About 26 per cent of total spending per person is by individuals with formal coverage (Tobar, 2011). This is one of the many forms in which public funds subsidize private coverage, unveiling in itself one of many dimension of inefficiency and inequality.

There are several key features of the Argentinean health care system: first, access to health care coverage in Argentina is a constitutional right for everyone. For example, a visitor with or without any other form of medical coverage holds equal right to access the public health care system.

Second, in 1995, a catalogue of covered benefits – the *Plan Medico Obligatorio* (PMO) – was instituted. Over time, the number and range of covered benefits has increased, and the catalogue is today one of the most inclusive of the world.

Third, the coded catalogue is greatly outdated, and there is currently no common nomenclature for diagnoses and procedures. As a result, every payer or provider of every segment has developed its own nomenclature.

Fourth, there are no formal clearing or reimbursement mechanisms for any services in any of the segments of coverage. Therefore, an individual with formal coverage can receive health care from a public facility at no cost and its insurance company may never receive a bill for it.

Fifth, provincial union beneficiaries can also be members of a national union, and PAMI beneficiaries can contract with a private insurance or pay for medical care out-of-

pocket. In other words, most sub-systems functionally overlap.

Sixth, even beneficiaries of private workers' compensation insurance companies – about 8 million people or 19 per cent of the population – can receive medical coverage by *Obras Sociales*, private health care companies, and public facilities. As in the previous case, the insurance company may never be billed for it.

Seventh, there is a weak legal framework binding all health care related activities and segments, such as that every segment has its own set of laws and regulations and is controlled by different government offices.

Finally, there is no health technology assessment agency. The state mainly considers safety issues when approving or rejecting applications for the inclusion of new technologies. The medical, social, ethical, and economic implications of new medical technologies are not evaluated. New technologies are therefore virtually unrestrictedly and uncritically incorporated into the catalogue of covered benefits.

The structural and functional elements of the Argentinean system help explain why the country performs poorly on a number of health status indicators. For example, the life expectancy at birth (LEB = 76 years) and infant mortality rate (IMR = 12 deaths per 1,000 live births) are worse than those of other countries in the region with lower health expenditure, such as Chile (LEB = 80 and IMR = 7) and Costa Rica (LEB = 80 and IMR = 9) (World Bank, 2014b).

Unless health care reforms improve efficiency in resource allocation, the national budget will be insufficient to cover the health care needs of the uninsured (36 per cent of the population), and the government will be unable to respond to the catalogue of covered benefits to which it is bound by

its own laws. Therefore, health care access in terms of quality and opportunity will remain low for those in need, especially economically vulnerable patient groups for whom the ever growing catalogue of covered benefits becomes an abstract declaration of purpose.

### Social determinants of health

Imbalances in social determinants should also be considered when analysing the health care system. There is overwhelming evidence that morbidity and mortality rise steadily with gradually decreasing social or socioeconomic status. This is known as the 'inverse social gradient.' This gradient is observed for a wide range of medical conditions, and it is now widely acknowledged that many factors other than the health system contribute to poor health. Tackling those social determinants might result in a great positive impact on population health and well-being.

Although for years many economic and social indicators provided by government agencies of Argentina have long been questioned or referred to as inconsistent, during the last decade most social determinants have experienced a certain level of improvement. However, many private and academic reports, present some troubling indicators that should set as a priority for the public agenda for the upcoming years.

For example, studies on social inclusion have found that 31.9 per cent of low-income families living in precarious settlements or housing are at risk of suffering food shortages. This figure is nine times higher than that for middle-income families. Additionally, within the same group, 30 per cent do not have running water, 90 per cent do not have gas, and 70 per cent do not have sewerage systems (Salvia, 2014). These figures are broadly comparable with those in other middle-income countries in the region, which also have social, economic or educational gaps.

### Future directions

Historical evidence and lessons should be taken into account when considering future health reforms. The first hospitals were community hospitals constructed in the early 1900s in the late Capital Federal, which is today the Autonomous City of Buenos Aires. Since then, Buenos Aires and few major cities in the provinces have enjoyed significant improvements in infrastructure, as well as professional and technological development.

In 1940, the Ministry of Health was created and hospital capacity doubled. By the mid-1950s, when General Juan D. Perón led the government towards socially-oriented policies, union workers were empowered with the resources to establish their own medical facilities. These were to be used to address needs of their own affiliates, under the auspices of the Ministry of Social Services, rather than the Ministry of Health. This policy hiatus has contributed at least part to the fragmentation observed today.

During the short history of the Argentinean health care system, there have been three key influences that have gradually led to this fragmentation: first, medical organiza-

tions fighting very strenuously to gain and maintain a strong position in terms of political leverage, payment terms, fees and working conditions; second, unions pushing to retain and strengthen their gained incumbency on health care finance and administration; and, third, the Ministry of Health attempting to integrate the health care system into a coherent structure with varying levels of technical competency and political support. The last attempt at integration was 30 years ago, with a proposal for a National Health Insurance Scheme of the Ministry of Health and Social Services. Since then, no substantial initiatives for structural integration have been undertaken.

Structural integration remains the main challenge ahead. In the structural fragmentation lies the root of the system's inefficiencies, the lack of transparency in administration, and the resulting inequities in access.

It is true that after so many years of relative inactivity, the roles and responsibilities of different stakeholders cannot be redefined with one single action. It is equally true that all the elements for at least drawing a new roadmap in public health care policy are available as well as the technical capacity to set the change in motion. Nevertheless, political determination at the highest level of government is a prerequisite for achieving a successful health care reform. It appears, however, that such a determination is still at large.

Until this major change is set forth, a number of very specific policy areas can and must be addressed as a matter of priority in order to cover urgent needs in terms of health care system sustainability, equitable distribution of resources and social inclusion.

The first priority area is the financing of catastrophic health care. Health spending is considered catastrophic if a household's financial contribution to the health system exceeds 40 per cent of their income (Xu, 2003). A report of the United Nations found that in Argentina 6.7 per cent of households have catastrophic expenses and that the country ranks fourth in the list of 18 countries of Latin America with the highest incidence of households with catastrophic health expenses, (Economic Commission for Latin America and the Caribbean, United Nations, 2013). The 2010 National Survey on Health Spending and Utilization found that up to 61 per cent of them refer to the cost of medications (Ministerio de Salud de la Nación, 2010).

The Special Programs Administration was created in 1998 to compensate for catastrophic health expenditure on behalf of the *Obras Sociales*. However, these subsidies were not based on technical analysis or specifically defined conditions, but instead reflect cycles of cooperation and conflict between unions and the government. In an attempt to promote transparency, the Special Programs Administration was absorbed by the Superintendency of Health Services, based at the Ministry of Health. The main objective was to establish a formal body of rules for funding and enforcing a tighter monitoring of reimbursement administration.

This model of financial support, today reserved only for the *Obras Sociales*, should be available to all segments, either via the creation of National Insurance Fund to financially support the provider network for each segment, to

retain the funds to render service in public facilities or a combination of both.

The second area of priority relates to the optimization of resources available for health care and could be operationalized through the creation of a single national health technology assessment body. New technologies should be evaluated based on technical consideration of indications, cost effectiveness, and financial sustainability for each segment of payers. Only then should it be included in the benefits catalogue and be allowed to diffuse. New technology should not expose patients, families, and the health care system to financial burdens that they cannot support. Never the inclusion of new technology or drugs in the catalogue of compulsory benefits can be due to political opportunism or expediency.

The third priority area relates to the ability to addressing regional inequalities. The public sector is decentralized from the federal level to provincial or local administrations (municipalities). Therefore, the federal level of governance is accountable only for about 2 per cent of total health expenditure. Provincial health ministries are responsible for basic public health services, including prevention, health education, and health promotion. Differences in infrastructure and administration, as well as uneven and unclear distribution of their legally-assigned part of the federal budget, result in regional inequalities. For example, the 2012 neonatal mortality rates in the city of Buenos Aires and the province of Formosa were 6.0 and 11.7, respectively (PAHO, 2014). During the same year, the potential years of life lost (PYLL) – an estimate of the average years a person would have lived if he or she had not died prematurely, expressed in years of life potentially lost per 100,000 – was 495.77 and 881.05 in the city of Buenos Aires and the province of Formosa, respectively. Consequently, redressing the inequities in health care provision and the disparate results created by it is now more imperative than ever.

Finally, the fourth priority area relates to a re-balancing of the major social determinants of health. Only about 9 per cent of the total health care budget is allocated to health promotion and disease prevention. The growth of non-communicable diseases, which is largely due to lifestyle changes and social and cultural determinants of health, must be tackled through targeted programmes. Part of the remaining 91 per cent of the budget, which is currently allocated to the public provider network, should be redirected to disease prevention efforts.

## Conclusion

Argentina's health care system is young and developing. Although access to health care is a constitutional right, and the system strives to be greatly inclusive, its own complexity and fragmentation undermine those efforts. Capacity building and political determination are needed to undertake the deep health care reforms ahead. Only then can the constitutional commitments for health care be fully honored.

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