# Health Services in Argentina

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*The Argentine health service comprises three sub-sectors: public, social security (social work) and private (insurance pre-paid medicine), which provides the health care for much of the population. There are major inequalities in health coverage and financing of the national health system with respect to per capita, population cover and guaranteed ben-efits. It is a very fragmented system, without coordination and integration, heterogeneous in its organisation*

The coexistence of different sub-sectors and strategies used by national, provincial and municipal-governments provide the system with a mode of operation that generates implications, not only in population access to services, but also in quantity and quality of goods and services provided in different jurisdictions, which vary even within provinces. This is significant when considering regional disparities, with inequalities in funding and access to services between the different sub-sectors and within them. There is no linear relationship between employment and coverage. Money is contributed by employees (3% of total wages) and employers (6% of each employee's wage).There are also differences in indicators of health status of the population.

There is little or no integration between public and private sectors, with fragmentation within each accentuated and deepened by two factors:

1) decentralisation of public health services, involving separated health institutions from central state to provincial and municipal levels. The Federal Government provided Provincial States with health institutions and determined that they were in charge of them and, in turn, the Provincial States did the same with the municipalities. Then the national government stopped sending money to the provinces for health management.

2) the severe economic downturn of recent years generated significant social problems associated with lack of employment, marginalisation and poverty and increase in" black" labour, which does not contribute to social work system .

Health spending has three funding sources: direct household spending (including pre-paid health systems), three levels of government (national, provincial and municipal) and workers and employers, who contribute to social welfare, linked to the unions. The private sector accounts for between 40 and 50% of total health expenditure. The rest covers social work and public subsector and corresponds to 8% of GDP (Gross Domestic Product).

**Composition of Expenditures and Coverage in Health in Argentina**

*The public subsector.*

The public subsector is divided by uncoordinated jurisdictions (national, provincial and municipal). The central level (Ministry of Health) leads the whole system through policies and programmes. Provincial governments have some degree of autonomy in their health policies and are responsible for most service provision.

The public subsector is characterised by universal-ity and gratuitousness of care. In 2005, with a total of 17,485 structures in the three sectors, 44% belonged to the public subsector. Increased demand for services comes from the population without coverage, or who are underinsured. Children under 15 years have lower coverage (44%) and those over 65 have only 81.3% coverage.

The organisation is decentralised with great disparity in economic and social development by geographic region, with inequalities in public spending per capita in each of the 24 provinces. There are asymmetries between public hospitals by national, provincial or municipal membership and even within each of these levels.

The financing of the health system is performed through three forms, one for each of the three sectors that compose it. The public health sector is financed through taxes, charges and contributions. The collection for the three levels of government is basically intended to cover the needs of low-income individ-als and those who have no formal health coverage, although some beneficiaries of the Social Security receive care in public hospitals. The public subsector does not have a basket of benefits that covers all possibilities.

The State operates a national compensation fund that redistributes money between the most powerful and economically disadvantaged social work depar-ments, to ensure equitable health coverage to all workers. Currently there are complaints from this sector to the government, arguing that it is owed a large sum of money, creating a risk they may not be able to fulfil their functions. The State is responsible for the cost of decentralised organisations and programmes that provide REMEDY (free distribution of medicines), Community Health (primary care to the most needy population), Maternal and Child Plan (parturients and babies), vaccinations, etc. This compensates for differences in resources and health outcomes among the provinces, at the primary level. It constitutes 19% of national public expenditure, 30% of which is delivered to the provinces in the form of goods and services. 67% of the uncovered population live in provinces where governments are unable to provide the minimum coverage required by the Mandatory Emergency Medical Services (PMO-E). These promulgated obligations for provinces and municipalities, but without delineating economic commitment. The national government has discretion to send money to maintain centralised control over decisions of governors and mayors.

The public sector health expenditure comes to 66% of the provincial governments' and is intended for hospitals where there is the largest source of expenditure on human resources. The expense is associated with greater or lesser development of each province. Calculated on population uninsured or underinsured, spending is $40/month per capita. Provincial differences range from $ 93 to $ 637 per capita, giving an average of $154. Municipal Governments commit to 15% of public spending, particularly in primary care centres

*Social works (social security)*

Nearly 53% of Argentines have health coverage through social work units of trade unions or private insurance. The development of social work departments, related to guilds of workers from different areas, increased the degree of fragmentation of the system. Each guild seeks care for workers affiliated to it. The money is automatically deducted from the employee's salary. Social work projects are managed by the relevant union, and unions receive and manage large amounts of money from workers through their social work commitment. Unionisation, with its corresponding economic contribution by the worker to the guild is not mandatory, unlike membership in social work itself thus Guilds receive monies for social work people who are not union members - a source of acrimony. .

In the 1990s, a reform reducing the large number of existing social works by ***merging or affiliation was*** tried. It also allowed social work projects to be sub-contracted to private companies' health insurance (pre-paid) with special plans and to those who had double coverage. Some social work projects acquired private health effectors to provide services directly to members.

By National Law there are 290 social work projects throughout the country. The system consists of:

1) - National Social Service (National Social Work, OSN)

It includes: the National Institute of Social Services for Pensioners (INSSJyP) covering retirees across the country, their children and many handicapped; the social work union and social work staff bringing health coverage to about 11,000,000 people

2) - Provincial Community Projects (OSP).

One per province, 24 in total include the Provincial Institutes of Forecast and provide health care and retirement.

3) - Social Work with special regulations provides for members of the armed forces, staff of national universities and legislative and judicial powers.

4) - Primary Health Care (PHC), funded by the Federal Government (for the uninsured) and by the Social Services and the Provincial States.

Since 1999 certain benefits are guaranteed by both the national social work (OSN) and INSSJyP (PAMI), for companies pre-paid medicine (PPMS, private) which are required to provide a Basic Package Mandatory Medical Services (PMO), defined by the health authority. The INSSJyP (PAMI) should work as a comparison level of benefits for its breadth, diversity and coverage throughout the country.

Social Security is funded through personal contributions of formal workers and their employers, is transferred to social works (national, provincial, municipal) and funds finance care for the population incorporated into the formal labour market.

Social work receive 80 to 90% of the share contributed ($5,700 million per year in 2007). The provincial health care plans (OSP) are funded from the contribution of the provincial public sector workers, volunteer members and treasury income of each province. OSP resources come from the provincial government and are dependent upon input from employers, with the same provincial statute. The difference in coverage between the different provinces ranges from 30 to 70% of the population.

The INSSJyP (PAMI) receives resources from active workers, retirees and the State Treasury. Spending in 2007 was estimated at $2,482 million annually. The INSSJyP (PAMI) has the highest per capita spending because it caters mostly (70% performance) to individuals over 65 years of age.

There is a free choice in health coverage to beneficiaries of National social work and INSSJyP (PAMI), but not to members of other social works (provincial armed forces). This choice causes breakdown of populace solidarity, for those who acquire more social work services are usually richer, and earn more money. Their contribution is larger than the average contribution of social work source. Thus, poorer social works are getting poorer and the richest even richer. The offering of additional plans ensures coverage is not equal in all social works. This *adverse selection mechanism*, by which OS are affiliated with some increased risk in relation to their proportionate economic contribution, is not commensurate with the benefits required by the PMO.

There is a Solidarity Redistribution Fund receiving between 10 and 20% of the remaining money of each payment received by social work (depending on the amount of income of workers and their trade union membership in social work). This Fund redistributes resources to finance the Special Programs Administration and the Nominating Automatic Grant.

The latter complements the quota of each family to reach a minimum value of $22 - monthly per group. Since the financial crisis of 2001-2002, affecting OSNs, the INSSJyP (PAMI) and PFMT a Compulsory Medical Emergency Program (PMO-E), with various forms of rationing of resources is in place to meet minimum service and essentials requirements of the widest possible population. In the case of PAMI, whose population is over 65 years old and, therefore, their
average costs are double the average population, the cost of PMO-E is around $ 100 per month per capita, with a tendency to spend more than it collects, requiring contributions from the national govern-ment, or failure to provide services to members.

Both OSN, OSP and INSSJyP (PAMI) contract private providers. Due to increases in the cost of care without a price increase of compensatory services, the deficit fall on these private providers and not the funders (OSN, OSP and INSSJyP - PAMI). This has led to private providers not being able to pay taxes, to make a technology advances and renovations and in debt with staff and suppliers.

*Private sector*

The private sector is resourced through direct house-hold spending and payment of insurance premiums. Companies who do not have private medical and compensatory mechanisms are financed by fees paid by the beneficiaries of the various schemes, covering
at least the PMO-E.

In early 2007, with the stated purpose of control-ling the rising cost of health coverage for members to pre-payments (private) services were offered two possibilities: 1) increasing the share of about 20% , adding new services (eg, discounts in gyms, optical and cosmetic) or 2) a much smaller increase (5%) and the addition of additional affiliate payments in each service. Most members chose the first option.

**Summary**

The Argentine Health service is served by many organisations both public and private. It is fragment-ed and uncoordinated, with many inequalities in financing, administration, health provision and care.

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