HEALTH FINANCING PROFILE - ARGENTINA

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Argentina has one of the highest levels of GDP per capita in Latin America and has historically spent a considerable portion of GDP on health. It has, however, lagged far behind other upper-middle income nations on several health measures such as life expectancy, infant mortality, maternal mortality and under-5 mortality (table 2).[1]

Approximately 40% of Argentina's population remains uninsured and the government has a constitutional responsibility to finance and provide health services to this population. The poor northern provinces have a higher percentage of uninsured (approximately 60%) and public facilities in these regions are more poorly provisioned and staffed. This disparity in coverage and quality of care between poor provinces and rich ones is echoed in health outcomes between these same provinces. Outcomes in poor provinces are often several orders of magnitude worse than in rich ones.[1]

At the federal level, the government has initiated several programs with national coverage to address these provincial inequalities. Several results-based financing mechanisms have been implemented to offer incentives to provinces and health providers for improved health outcomes. Plan Nacer – now succeeded by Programa SUMAR – is the most ambitious of these programs and has reached over 90% coverage of the target population.[2]

Health Finance Snapshot

Argentina has consistently spent a relatively high percentage of GDP (8 to 9%) on **Total Health Expenditures (THE)**.

General Government Expenditure on Health (GGHE) fluctuates, generally remaining close to 60% of THE while private insurance remains a smaller but important portion of health spending.

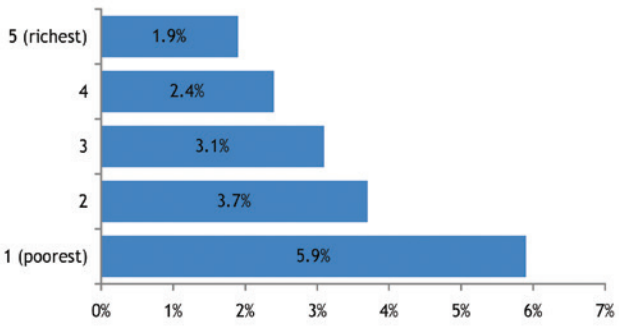
Table 1. Health Finance Indicators: Argentina

	1995	2000	2002	2003	2005	2007	2009	2012
Population (thousands)	34,855	36,931	37,657	38,001	38,681	39,368	40,062	40,765
Total health expenditure (**THE**, in million current US$)	21,450	26,196	8,484	10,648	15,260	21,553	29,047	40,889
THE as % of GDP	8	9	8	8	8	8	9	8
THE per capita at exchange rate	615	709	225	280	394	547	725	892
General government expenditure on health (GGHE) as % of THE	59.8	53.9	53.6	51.7	53.5	58.2	66.0	69
Out of pocket spending as % of THE	28.0	29.0	29.8	31.1	29.9	25.7	20.1	20
Private insurance as % of THE	11.0	14.0	13.0	14.0	13.0	13.0	11.0	8.0

Source: WHO, Global Health Expenditure Database; National Health Accounts, Argentina

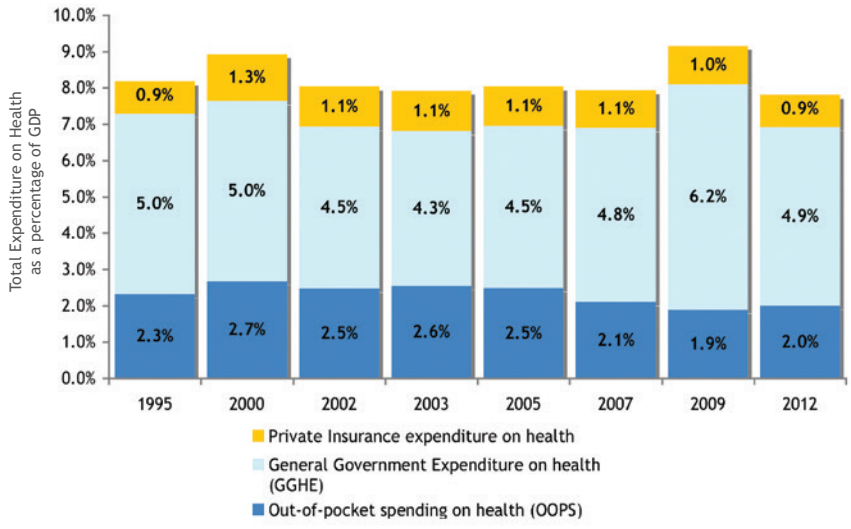
- **Out of pocket spending (OOPS)** in Argentina remains lower than in many other Latin American countries as a portion of THE (Figure 1).
- **OOPS are, however, regressive in their incidence** with households in the lowest income quintiles paying a higher percentage of their income in OOPS than households in the highest quintiles (Figure 2).

Figure 2. OOPS as % of Income by Income Quintile, 2010



Source: Ministry of Health, Argentina. "Encuesta de Utilizacion y Gasto en Servicios de Salud Argentina - Year 2010" (2012)

Figure 1. Total Expenditures on Health by type, Argentina



Source: WHO, Global Health Expenditure Database; National Health Accounts, Argentina

Health Status and the Demographic Transition

Argentina has undergone the demographic and epidemiological transitions so that it finds itself with an aging population suffering increasingly from chronic non-communicable disease and less from communicable (infectious) disease. However, on several important measures such as maternal and infant mortality, outcomes are stratified. For example, the poor provinces of Formosa and Jujuy had a maternal mortality rate over 100 (per 1,000 live births) in 2008 while the city of Buenos Aires had a rate of just 9.[3]

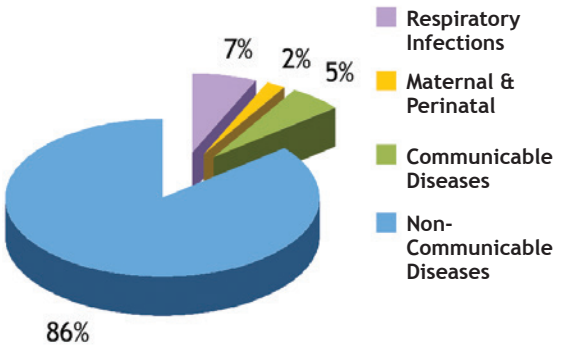
Demographic Transition

- Birth and mortality rates are declining (figure 2).
- The total fertility rate (TFR) has fallen from 3 in 1990 to 2.3 in 2012.
- The 'bulge' in the population pyramid is moving upward (figure 4).

Epidemiological transition

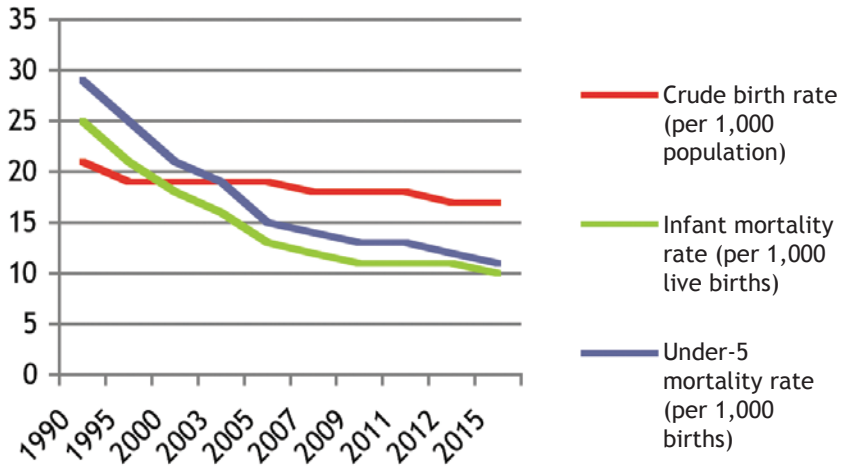
- Mortality from non-communicable (chronic) illnesses has far surpassed infectious disease mortality (Figures 5 and 6).

Figure 5. Mortality by Cause, 2008, Argentina



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 3. Demographic Indicators, Argentina



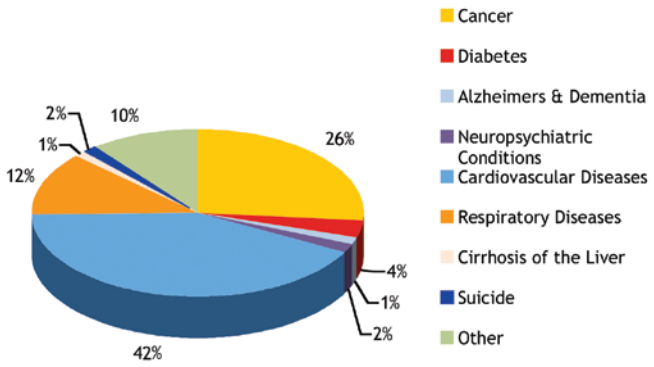
Source: United Nations Statistics Division and the Instituto Nacional de Estadistica y Censos, Argentina.

Table 2. International Comparisons: Health Indicators

	Argentina	Upper Middle Income Country Average	% Difference
GNI per capita (year 2000 US$)	5,170.0	3,420.8	33.8
Prenatal service coverage	99.2	93.8	5.4
Contraceptive coverage	78.3	80.5	-2.8
Skilled birth coverage	94.9	98.0	-3.3
Sanitation	90	73	18.9
TB Success	48	86	-79.2
Infant Mortality Rate	12.6	16.5	-31.0
<5 Mortality Rate	14.1	19.6	-39.0
Maternal Mortality Rate	44	53.2	-20.9
Life expectancy	75.8	72.8	4.0
THE % of GDP	8.0	6.1	23.8
GGHE as % of THE	60.6	54.3	10.4
Physician Density	3.2	1.7	46.9
Hospital Bed Density	4.5	3.7	17.8

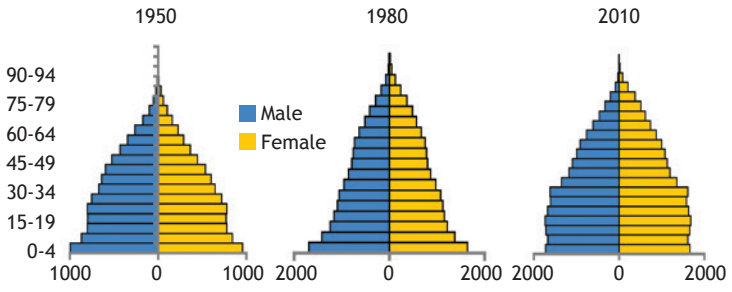
Source: World Bank, DataBank. Health, Nutrition and Population Statistics.

Figure 6. Non-Communicable Disease Mortality, 2008, Argentina



Source: WHO, Global Burden of Disease Death Estimates (2011)

Figure 4. Population Pyramids of Argentina

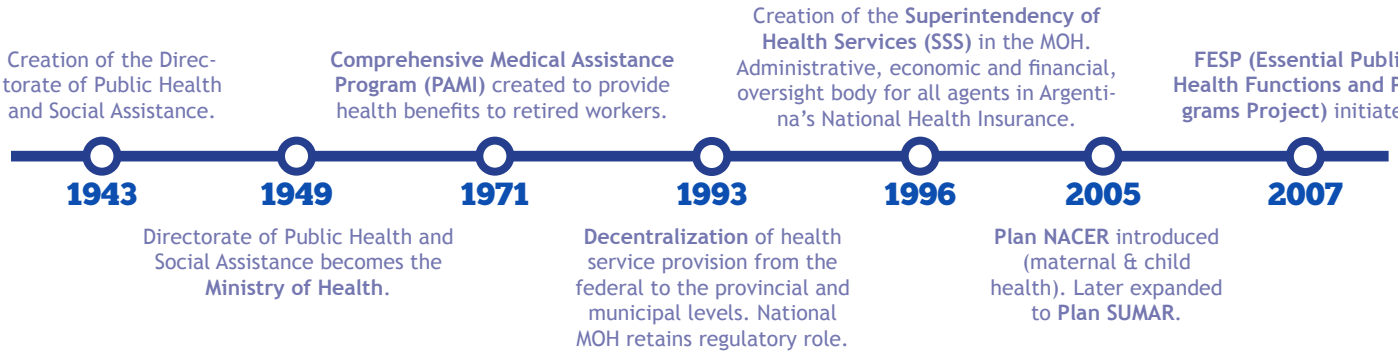


Source: Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, World Population Prospects: The 2010 Revision.

Health System Financing and Coverage

Argentina's health system has historically been split into three distinct regimes: the public system which is free for all, the *Obras Sociales* (OS) which provide coverage in a mandatory contributory social health insurance scheme, and a supplementary private insurance system. Numerous providers exist in both the OS and private systems, both at the national and provincial levels. The public system has been decentralized since 1993. These three regimes are fragmented but Argentines under each regime utilize a mix of public, private and OS facilities and services leading to a complex web of OOPS and cross-subsidization between systems.

Figure 7. Timeline of Argentina's Health System



Argentina's health system has several broad coverage regimes which are not only separate from one another, with fragmented risk and financial pools, but are also internally fragmented as well.

1. **Public sector:** Non-contributory. Covers the uninsured but Argentines with contributory insurance also utilize public facilities at times. Services are provided for free at public facilities which have fixed budgets (i.e. unrelated to outputs/results) and are run by decentralized provincial and municipal governments with financing mainly from the federal budget. Explicit enrollment is not necessary. A number of supplementary programs based on Results-Based Financing (RBF) principles exist (table 4).
2. **Contributory Social Insurance (*Obras Sociales*)**, other than PAMI (see below): Run by trade unions and professional organizations. Over 250 in existence although a small percentage dominate the market share. Workers and their employers make mandatory payroll contributions. Beneficiaries primarily utilize private facilities. There exists a redistributory mechanism between different OS to offset the cost of high-cost and low-prevalence illnesses for smaller OS with fewer financial resources.
3. **Private Health Insurance (EMP):** Voluntary prepaid contributory regime. Has close to 200 insurers nationwide, both non-profit and for-profit although market share is dominated by just a few for-profit insurers. Premiums are set by each insurer and vary across individuals. Insurers contract with private facilities as well as with independent health providers to pay for services for private beneficiaries.
4. **Comprehensive Medical Assistance Program (PAMI):** Later called National Institute for Retirees and Pensioners (INSSJyP). PAMI comprises contributory health coverage for retirees and pensioners and their families affiliated with the Obras Sociales. Services are provided free of charge at public facilities and some private facilities.

Table 3. Types of Health Coverage — Argentina

	Beneficiaries	Source of Financing	Service Provision	Benefits
Public	Indigent, informal workers, unemployed.	General taxation (mainly federal budget).	Public facilities.	Regulated at the provincial and municipal levels which provide their own outline of mandatory services covered.
Mandatory Contributory Social Security (*Obras Sociales*), other than PAMI	Workers in the formal sector and independent workers who pay contributions through the AFIP (*'monotributistas'*).	-Mandatory employee (5% of wages) and employer (3%) contributions. -Fixed voluntary monthly payment for independent workers- varies based on income.	Mainly Private facilities and Decentralized Public Hospitals.	-National OS subject to the MOH-supervised Mandatory Health Program (PMO). Mandated coverage of 95% of the causes of outpatient, surgical and hospital care, dental care, mental health, rehabilitation and palliative care. - Provincial OS are not required to adhere to PMO coverage rules but have their own lists - benefits vary.
Prepay Private Insurance (EMP)	Those who are able to prepay or whose employers provide optional supplemental coverage.	Prepaid premiums of beneficiaries and/or their employers.	Mainly Private facilities.	Subject to the MOH-supervised Mandatory Health Program (PMO). Mandated coverage of 95% of the causes of outpatient, surgical and hospital care, dental care, mental health, rehabilitation and palliative care.
Comprehensive Medical Assistance Program (PAMI)	Contributory Retirees and Pensioners (and dependents).	Employee and Employer contributions.	Private facilities and Decentralized Public Hospitals.	Coverage mandated as with the other OS (see above).

Source: Ministry of Health, SSS, Argentina.

Table 4. Selected Supplementary Public Health Programs Based on Results-Based Financing (RBF) Principles

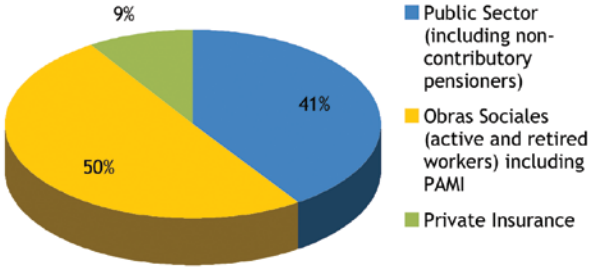
	Goals	Eligible/Target Population	Financing	Benefits & Service Priorities
Essential Public Health Functions and Programs Project (FESP I and II)	**Essential Public Health Actions** - Improve the stewardship role and appropriate regulatory environment of the nation's public health system.	Varying target populations for the various programs.	Provinces and municipalities receive performance payments based on number of Public Health Actions achieved (from an agreed list of Actions).	• Vaccine-preventable diseases; • Tuberculosis; • HIV/AIDS; • Vector-borne diseases; • Non-communicable diseases; • Safe blood.
	"Incluir Salud" Program - Public health insurance program for extremely vulnerable and uninsured people.	Women with seven or more children, severely disabled people and population over 70 receiving non-contributory pensions.	- Capitation payments to provinces based on enrollment of qualified beneficiaries (the size of the payment given per beneficiary depends in part on provincial achievement regarding a set of performance indicators). - The financing received by the provinces is used to make fee-for- service payments to public health facilities treating beneficiaries.	Range of preventative and curative services covering diseases like kidney failure; hemophilia; Gaucher's disease; HIV, Fabry's disease; multiple sclerosis, amyotrophic lateral sclerosis, cystic fibrosis and hepatitis C.
Plan NACER/SUMAR	- Decrease infant and maternal mortality rates. - Increase utilization and quality of key health services for the target population. - Improve institutional management by strengthening the incentives for results.	Women (aged 20-64) and children (< 20) not enrolled in any contributory health insurance scheme.	- Similar financing mechanism as in the case of "Incluir Salud" (see above). - The provincial performance indicators here are measures of coverage/attainment among the target population (e.g.: pre-natal care coverage, cancer screening, etc.).	Basic package of free services for: • Maternal and child basic care; • Preventive health care; • Certain types of complex care (congenital heart disease surgery, inpatient neonatal care, others).

Source: Ministry of Health, Argentina and The World Bank: Projects and Operations, Argentina.

Access to and utilization of medical consultations and medications in Argentina is high, even among the lowest income groups[4] (figure 9).

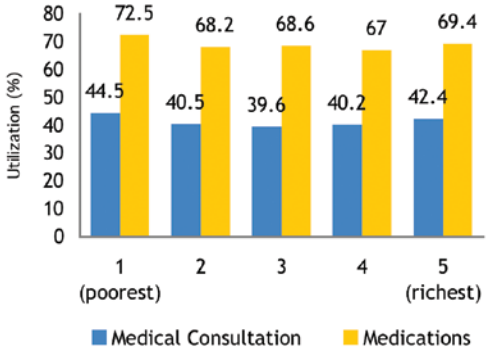
In 2010, 34.7% of all medical consultations took place in public facilities, 20.1% in OS facilities and 45.2% in private facilities[4].

Figure 8. Health Beneficiaries by Type of Coverage



Source: Belló and Becerril-Montekio. "Sistema de salud de Argentina", 2011.

Figure 9. Service Utilization by Income Quintile, 2010.



Source: Ministry of Health, Argentina. "Encuesta de Utilizacion y Gasto en Servicios de Salud Argentina - Year 2010" (2012)

Challenges and Future Agenda

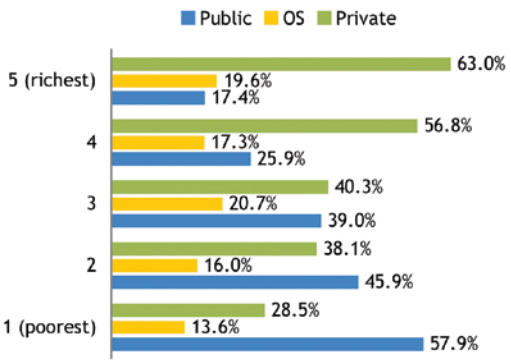
- While the richest income quintiles mainly utilize private facilities, a full 17.4% of the richest quintile and 25.9% of the second-richest utilize public facilities (figure 10). This has led to cross-subsidization of the private sector by the public sector as public facilities are rarely reimbursed by private insurers or OS.
- The fragmentation of the Argentine system is an ongoing issue. Risk and financial pools are fragmented between the public sector, the *Obras Sociales* and the private insurance regime. However, internal fragmentation within each regime has also been blamed for inefficiencies and also for heterogeneous quality of services among different regions, provinces and facilities.[5]

References

1 World Health Organization. Global Health Observatory, Interagency estimates.
2 Cortez, Rafael and Daniela Romero. "Argentina: Increasing Utilization of Health Care Services among the Uninsured Population: The Plan Nacer Program", The World Bank UNICO Studies Series, No 12, 2013.
3 Belló, Mariana and Victor M. Becerril-Montekio. "Sistema de Salud de Argentina", Salud Pública México, vol.53 suppl.2, 2011.
4 Ministry of Health, Argentina. "Encuesta de Utilizacion y Gasto en Servicios de Salud Argentina - Year 2010" (2012)
5 Cavagnero, Eleonora and Marcel Bilger. "Equity during an economic crisis: financing of the Argentine health system", World Health Organization, discussion paper, No. 3, 2009.

This profile was prepared by Dr. Deena Class, A. Sunil Rajkumar and Eleonora Cavagnero with inputs from Michele Gragnolati.

Figure 10. Type of Facility Utilized by Income Quintile, 2010.



Source: Ministry of Health, Argentina. "Encuesta de Utilizacion y Gasto en Servicios de Salud Argentina - Year 2010" (2012)