The health system in Argentina: an unequal struggle between equity and the market

Victor B. Penchaszadeh[1], Francisco Leone[2], Mario Rovere[3]

Ministries of Health and of Science and Technology, Argentina and Mailman School of Public Health, Columbia University, USA; [2]Undersecretary of Management and Control, Ministry of Health, Province of Tierra del Fuego, Argentina; [3]Master of Public Health Program, National University of Rosario, Argentina

Correspondence to: Victor B. Penchaszadeh, República de la India 2873, 1425 Buenos Aires Argentina. Email: vbp2002@columbia.edu

Abstract

The modern health system of Argentina was developed in 1945-1955, a period of economic bonanza characterized by industrialization, rapid urbanization and activist labor organizations. During the ensuing years it evolved in three sectors: public, social security and private, with separate services, population coverage and funding. While the national Ministry of Health is nominally responsible for general health policies and regulations, overseeing the general operation of health services, designing preventive medicine programs and negotiating the coverage and fees of health insurance plans, it has in fact very low leverage to enforce decisions in the provinces, which are autonomous, as well as in the social security and private sectors, which are weakly regulated if at all. While the health workforce, medical facilities and level of spending are acceptable, the fragmentation and segmentation of the system render it highly inequitable and inefficient. During the 1980s and 1990s, the health system has experienced further transformations, as neoliberal policies took hold in the country and dictated a reduction of state involvement in social services in favor of privatization and decentralization of health care. The result has been increased fragmentation, inequity and inefficacy, as health care is increasingly prey to the economic interests of private corporations (insurance and pharmaceutical industries), trade union bureaucracies and the medical professional and technology establishments. The expectation of popular sectors of society are that progressive polices recently enacted by Congress, and being implemented in the fields of education, retirement pensions and the media, will be followed with much needed public health policies based on equity and efficiency.

Key words: Argentina, public health, health system, health services, equity

Introduction

Argentina, in the southern tip of South America, has a population of 40 million. At the beginning of the 16th century, the territory was inhabited by millions of Amerindians of at least 30 different ethnicities. During three centuries of Spanish conquest and colonization, extensive admixture occurred, and the native population was further decimated in the late 19th century by an extermination campaign waged by the government. Amerindians currently number approximately 10% of the population. West Africans brought as slaves practically disappeared through the 19th century, by admixture, attrition and migration. In the second half of the 19th century and first half of the 20th century, Argentina received a huge influx of immigration from virtually all countries of Europe, intermixing with the existing population. In recent times immigration comes primarily from neighboring countries (Paraguay and Bolivia) with strong Amerindian ancestry. Currently, about 50% trace their origin to Italian immigrants and 25-30 % to Spaniards. The official language is Spanish and the majority of the population is nominally of catholic faith.

Politics and economics

Argentina is a federal republic with a presidential system, with 24 political jurisdictions (23 provinces and the autonomous City of Buenos Aires, site of the National government). Each province has its own constitution and elects its governing officials. At the beginning of the 20th century, Argentina's economy boomed, but political and economic crises were recurrent, including a succession of military dictatorships, the last of which, between 1976 and 1983, committed egregious violations of human rights, with 30,000 persons disappearing after abduction, torture and assassination [1]. The military concentrated wealth in the hands of few, incurred in a huge foreign debt, destroyed much

of the national industry and began dismantling the welfare state, privatizing strategic state enterprises and services, including health services. Civilian governments that followed, obeying impositions of the International Monetary Fund and the World Bank, continued with privatizations, leading to an economic meltdown in 2001, with a 300% currency depreciation and default in the foreign debt repayment [2], a precipitous drop in annual per capita income and rise in unemployment and extreme poverty to over 25% [3]. The economic crisis was eventually brought under control by 2004, and economic growth resumed. However, poverty and indigence continued to be very prevalent and the distribution of income remained highly unequal: in 2003 the poorest 10% of households had an average monthly income per person of USD 16, compared with USD 590 among the wealthiest 10% of households. Further, the poorest quintile's share of national income between 1992 and 2005 decreased from 4.8% to 3.1%, while that of the wealthiest quintile increased from 50.6% to 54.7% [3]. The percentage of the population with "unsatisfied basic needs" (defined by a complex index of the Census Bureau, INDEC (available at www.indec.mecon.gov.ar) is currently 17.5% [4, 5] The policies of the last quarter of the 20th century drastically changed the landscape of the health system, which regressed from that of a publicly funded health system, to one in which the interests of private for-profit corporations became prevalent.

Epidemiologic profile

Table 1 shows some key demographic, economic and health indicators of Argentina. Life expectancy is 75.24 years and crude mortality 8/10,000, of which 35% is due to cancer, 20 % to cardiovascular diseases and 10% to infections. Diseases of poverty (infections and malnutrition) are still a major problem [4, 5]. Maternal mortality is unacceptably high (44 per 100,000), one-third of which is due to complications arising from illegal voluntary abortion. Infant mortality is 13.3 per 1,000), and its main causes are peri-natal conditions (52%) and congenital anomalies (27%) [4, 5].

Health System in Argentina

In contrast to the relative homogeneity and rather unified health systems prevalent in Western Europe, Latin America is characterized by the world's highest degree of inequality in income distribution, with coexistence of groups that are part of modern dynamic areas of the economy, with those with aged-old patterns of life, still relatively untouched by modern industry and commerce, and with the disenfranchised who live on the limits of survival. The significant economic setbacks of the 1990s increased concentration of wealth in fewer hands, affected employment and quality of life, and rendered health systems less able to provide equitable services to most people. [2, 6, 7].

Like most countries in Latin America, Argentina has developed a mixed health system with a combination of: (a) remnants of an old welfare state with an extensive network of public hospitals and health centers, (b) a social health insurance system for formally employed workers, and (c) a concentrated for-profit private health insurance sector ('prepaid medicine'), providing services to middle-upper and upper classes.

The three major health sectors that exist today in Argentina (public, social security and private) evolved in a somewhat sequential manner, following political and economic circumstances. The first stages of a *public sector* originated in religious and public charity hospitals of the 19th century, and it eventually developed into an extensive and centralized public system, through the building of many hospitals during the economic bonanza of post world-wars periods (1918-1929 and 1946-1954). During the economic crises of the 1980s and 1990s, the International Monetary Fund and the World Bank imposed privatizations that weakened the public system by successive fragmentations, decentralizations, and dilution of responsibilities, while the social security and private systems hybridized and increased their complexity, to the benefit of the profit-seeking sector [2, 7-9].

The *social security* system began to evolve during the mid 20th century as heir to the trade unionism of European immigrants. Designed by the state, it was inspired in Bismarkian and Franquist philosophies of "social peace", to prevent the radicalization of the working class. To accomodate the interests of organized labor, the delivery of medical care to people formally employed was put under the responsibility of the trade unions themselves, with funds contributed by employers and employees, and with some regulation from the state (these entities are called *obras sociales*) [9, 11, 12].

Up to the 1970's, the *private sector* was relatively small, consisting of community hospitals for former immigrants (Spanish, Italian, British, German, French, Jewish hospitals) and numerous private offices and hospitals. This sector grew significantly in the 1980s as it was contracted by the obras sociales to provide medical care to their beneficiaries. In the 1990s, as neoliberal policies pushed privatizations further, the private sector took on an additional financial role, expanding

Table 1. Argentina. Basic demographic, socioeconomic and health indicators [5].

Population (millions)	39,356,383
Gross National Product per capita (in current US dollars)	9,126
Urban population	89.5
Percentage of population under poverty (defined by a complex index of the Census Bureau to denote "unsatisfied basic needs")*	17.5
Literacy (percentage of population of 10 years of age or older who know how to read and write)	97.2
Population with drinking water (%)	77.0
Population with sewage drain (%)	42.5
Crude birth rate (per 1000 population)	17.5
Approximate annual number of live births	700,000
Annual population growth (per 1000)	10.1
Fertility rate	2.3
Life expectancy at birth	75.24
Crude general mortality rate (per 1,000)**	8
Maternal mortality rate (per 100,000 live births)^	44
Infant mortality rate (per 1000 live births)^^	13.3
Under-5 mortality rate (per 1000 live births)	15.6
Public expenditure in health, total (% of Gross National Product)	5.07
Expenditure in medical care in the public system (% of Gross National Product)	2.09
Expenditure in health care in the Obras Sociales (% of Gross National Product)	2.28
Expenditure in health care of retired citizens (% of Gross National Product)	0.70
Total number of hospital beds	53,065
Physicians (per 10,000 population)	32.1
Nurses (per 10,000 population)	3.8

*www.indec.mecon.gov.ar
**cancer: 35%; cardiovascular conditions: 20%; infections: 10%
^31% due to complications of voluntary abortion
^^70% of infant mortality rate occurs in the neonatal period; 60% is preventable;
perinatal conditions: 52%, congenital anomalies: 27%, respiratory conditions: 7%, infections: 4%

even more, with two strategies: (a) setting up for-profit health insurance plans that catered to the upper classes, with differential coverage according to one's ability to pay; and (b) becoming the contractor for health services to the beneficiaries of the obras sociales, channeling funds from social security to the private sector [4, 11].

According to the constitution, all 23 provinces and the Autonomous City of Buenos Aires are autonomous in deciding and implementing the public policies not delegated to the federal government, as is the case with health care. There is no common framework for the respective responsibilities and functions in health care of the national government and of the provinces [12]. This fact, plus the lack of political will throughout the 20th century, allowed the primacy of the vested interests of private sectors and trade union bureaucracy to impede the development of a unified public national health system. During the economic crisis of the 1980s and 1990s, the public system was further reduced and health services further privatized and transferred to the provinces, increasing their fragmentation, segmentation and inequity [2, 13]. Reliance on the public sector is higher as income declines, and inversely for the private sector (Table 2) [14].

While the Argentine Constitution does not explicitly include the right to health as such, it defines the right to medical care from the viewpoint of the consumer and it ratifies, at a constitutional level, international treaties such as the Universal Declaration of Human Rights, the Covenant on Economic Social and Cultural Rights and the Convention on the Rights of Children, which explicitly mention the right to health and the responsibility of the state to implement and safeguard it [15].

Health governance

Although weakened by successive transfers of facilities and services to the provinces, the national Ministry of Health, as the highest health authority in the country, is enticed with the following functions:

1. Global health system planning and preventive medicine programs in coordination with health authorities of the provinces and municipalities, and the social security and private sectors.
2. Regulation of the practice of medicine,

dentistry and allied health professions, and guidelines of medical care quality.
3. Oversight of the medical care provided by social security and the private sector.
4. Oversight of production, distribution and commercialization of medicines, drugs and medical equipment.

To accomplish these tasks, the Consejo Federal de Salud (COFESA, Federal Health Council) was created in 1981 within the National Ministry of Health, headed by the minister and constituted by the ministers of health of the provinces and the Autonomous City of Buenos Aires. However, because of differences in resources and political views among the provinces, COFESA has not been fully able to fully implement public health policies at the national level [10, 12].

The *Superintendencia de Servicios de Salud* (SSS, Superintendency of Health Services) is an autonomous agency within the national Ministry of Health, in charge of supervision, oversight and control of the health insurance system, which comprises the social security services managed and/or provided by the *obras sociales*, and the services provided by the private for-profit insurance system (*pre-paid medicine*). In the 1990s the SSS defined a *Programa Médico Obligatorio* (PMO, Mandatory Medical Program), which establishes the minimum package of services that all insurance plans (social security and private) must provide to their members. Despite SSS's legal authority, the private sector is largely unregulated and SSS only intervenes in cases of overt irregularities. The SSS has no jurisdiction in the public sector, except to monitor the payments that the *obras sociales* make to public hospitals for services rendered to their members [10, 11, 16].

The *Administración Nacional de Medicamentos, Alimentos y Tecnología* (ANMAT, National Administration for Drugs, Food and Technology), under the National Ministry of Health, has as its main functions: I. control of safety, quality and efficacy of all drugs, chemicals, reagents, pharmaceuticals, medicines, diagnostic products, biomedical and biotechnology products, and any other product used in human medicine; II. registry and accreditation of all individuals or companies involved in supplying, producing, fractioning, import/export, deposit and marketing of products described above; III. market regulation (price control). ANMAT's budget is insufficient to enforce its regulations, and often obtains funds from the pharmaceutical and food industries, that is, the very players that it is charged with regulating and controlling [17].

Structure of the Health System in Argentina

The health workforce

The latest survey of health professionals was conducted in 2004 from national census data of 2001 [18]. There were about 300,000 health professionals with university degrees in 11 different professions, of which 121,076 were physicians (32.1 per 10,000 at the time of the survey) and only 12,614 were certified nurses. This strikingly inadequate 10/1 ratio improved to 1/1 when all categories of nurses were considered, which is still woefully inadequate [18]. While the number of physicians was high, its geographic distribution was markedly inequitable, ranging from 11.1/1000 in Buenos Aires to 1.5/1000 in the province of Santiago del Estero [18].

Most physicians work part-time in the public sector and in their own private practices, with a dual allegiance that leads to a lack of commitment towards the public system and the patients' interests, including the unethical practice of siphoning patients, able to pay with their own funds, away from public hospitals to their private practices. While organized medicine has consistently opposed full-time employment in public hospitals, many young physicians are joining the growing movement for a national unified health system.

Table 2. Percentages of types of health care coverage by income quintiles, 2005. (Quintile I is the poorest, quintile V is the wealthiest) [14].

Health care coverage	I	II	III	IV	V	Total Population
Obra social	34.6	49.0	60.4	67.8	64.5	56.0
Private	3.5	4.7	6.9	10.5	23.1	10.1
Public	61.4	45.8	32.2	21.6	12.1	33.5
Unknown	0.5	0.5	0.5	0.1	0.3	0.4
Total	100.0	100.0	100.0	100.0	100.0	100.0

Hospital network

Of a total of 153,065 hospital beds, about 50% belong to the public sector (76,885 beds in 1,319 hospitals). About a thousand public hospitals are run by the provinces, while the remainder are run by municipalities. The national ministry of health administers only four national hospitals. Forty seven percent of hospital beds are in the private sector, while the remaining 3% belong to obras sociales.

The public hospital network is open to anyone and nominally free of charge, covering 47% of the population. However, for the past several decades little has been done to strengthen the public system, which is clearly underfinanced and deteriorated, with numerous access barriers and low quality of care. Still, there are some niches of excellence in specific specialties, which are sought even by middle and upper classes. In fact, one-third of the patients that receive care in the public sector have some type of social security coverage, and 5.2% are covered by private health insurance [19].

Primary health care

In the early eighties Argentina developed a primary health care (PHC) strategy for its public sector to provide care to the poor and the uninsured, structured around 6,290 PHC centers throughout the country, funded by provinces or municipalities. Centers in rural areas follow a geographic and demographic perspective and are staffed by community health workers (non physicians). Those in slums and poor neighborhoods of large cities count with physicians and follow a model of care based on demand and supply, with little idea about their population and its epidemiology. PHC centers provide ambulatory care and refer patients to secondary and tertiary levels of care according to need, without much regionalization nor coordination, and with the shortcomings characteristic of a fragmented system. Recently there has been a revival of the PHC strategy at the national Ministry of Health, which funded a program which trained several thousand physicians in community health, with the goal of staffing existing centers [18]. Primary care has been strengthened recently by the national Ministry of Health's *Remediar* program, which supplies medicines for free to all 6,290 centers of the country.

There has been very little PHC development in the private and the social security sectors.

Medical care to senior citizens

The *Programa de Asistencia Médica Integral* (PAMI, Comprehensive Medical Care Program) was created in 1971 to concentrate health services to retired citizens under a single, universal and mandatory coverage. It currently provides health insurance to about 4 million people, including about 91% of the population older than 65 years, the disabled, the beneficiaries of pensions, and the war veterans. The PAMI is financed by general taxation to salaries of employees and to incomes of retired citizens, as well as subsidies from the government. Primary care services, specialty care and hospital admissions are provided by private physicians and hospitals under contract with the PAMI administration by the system of capitation. In addition, there are separate contracts for other types of services, such as drug benefits, dentistry and mental health [11].

Obras Sociales

The social security system finances healthcare to formally employed people and was consolidated in 1970. The law made it mandatory for governmental and private workers and employees to become members of *obras sociales*, new autonomous entities which would administer funds contributed by employers and employees and provide health care to their members and their direct families. The obras sociales are organized by occupation or trade (i.e. government employees, construction workers, bank employees, transportation workers, etc) and are administered by the corresponding trade unions. Currently, there are approximately 300 national *obras sociales* with about 10 million beneficiaries. The size of these entities varies, with the largest 17 obras sociales having 50% of the total beneficiaries. While obras sociales provide some direct services in their own facilities, most services are contracted outside and within the private sector [11, 12]. To reduce the inequity resulting from the existence of "wealthy" and "poor" *obras sociales*, the *Fondo Solidario de Redistribución* (Redistribution Solidarity Fund) was created with 10% of contributions to obras sociales and administered by the Superintendent of Health Services (SSS), for use for expensive medical treatments and surgical procedures.

Each province counts with *obras sociales* of their own, for governmental provincial employees, active and retired, with funds contributed by their members and the provincial government. They are autonomous and administered by provincial trade unions, and they vary widely in their financial status, in the services provided, the population covered and its legal framework. In 2001, the last year

a special survey was conducted, 15.2% of the population of the 23 provinces was member of a provincial obra social [12].

The private sector

The private health sector has experienced a huge transformation in the second half of the 20th century. As provider of services, it is constituted by private offices of physicians in solo practice and for-profit private hospitals with both salaried physicians and private stakeholders with privileges. Private hospitals have grown at a fast rate as the public sector was being dismantled by the neoliberal privatizing policies of the 1980s and 1990s. Currently approximately 50% of the total number of hospital beds of the country are private-own. The main source of patients and revenues is the provision of health services to members of obras sociales, under contracts negotiated by the *Confederación de Clínicas y Sanatorios* (CONFECLISA, national association of private hospitals), the corporation that represents the interests of the owners of for-profit private hospitals.

In addition, the private sector has recently developed a role in financing health insurance in the form of "prepaid medicine" for-profit companies, which offer health services to individuals or families that voluntarily become members and pay a monthly fee, similar to the private insurance plans in the USA [2]. These companies either have their own facilities with salaried physicians, or contract services with private hospitals and physicians in private practice. These companies are not meaningfully regulated by the state and the level of services and fees vary with the monthly payments by the members, although all plans must provide the minimum services mandated by the PMO. There are about 200 prepaid medicine for-profit companies, with a market constituted by about 8% of the population (mostly the wealthy) [11].

Interaction between the private sector and the social security system

The majority of Obras Sociales do not have their own health services and contract with the private sector for the health care of their beneficiaries. In this way, funds that are largely public, because they are collected by law from employers and employees, are channeled to the private for-profit sector. The private sector has special categories of services for the different types of beneficiaries, depending on contracts established with the *Obras Sociales*.

Drug benefits

In the public sector, medicines are free to patients admitted in hospitals, although the prescribed medications are often not available and the patient has to buy them in the private market. Until recently, there were no free medications in public sector ambulatory centers. To correct this, the National Ministry of Health recently created the program *Remediar,* by which a standard package of common medications are delivered periodically and free of charge to the 6,290 ambulatory health centers throughout the country [20]. This program became very popular and, at the same time, it gave the National Ministry of Health political and economic leverage towards the provinces. Criticisms included the fact that the program was funded with international loans instead of being part of the national budget, and that the homogeneity of the medication package often conspired with local needs. Medications for PAMI beneficiaries are either free or greatly discounted. Similarly, the obras sociales and private insurances entitle their members to discounted drugs.

Preventive medicine

As one of its main functions, the national Ministry of Health is responsible for preventive medicine programs nationwide that are negotiated at COFESA for their implementation in the provinces. These programs include prevention of maternal and infant mortality, of cervical cancer, of aids and sexually transmitted diseases, of addictions, of epidemic or endemic infections such as tuberculosis, dengue and Chagas disease, and many others. The Ministry of Health is also responsible for the national immunization program.

Functioning of the health system from the point of view of the population

Patients access the health system according to their social situation. If they belong to the 47% of the population that is uninsured, their medical care is provided by the network of primary, secondary and tertiary care centers of the public health system, mostly provincial and municipal. If they belong to the 45% of the population covered by social insurance (*obras sociales*), their medical care is provided by designated centers, mostly in the private sector, according to the terms of each contract between the obra social and the particular private provider. Patients who have private insurance (about 8% of the population) receive their medical care at designated private medical centers according to each prepaid medicine plan.

Still, as mentioned above, a significant proportion of patients who receive care in the public sector have some type of social security coverage (33%) or private insurance (5.2%) [19].

Health expenditures, fragmentation and inequity

Figures about health expenditures are estimates, as there are many sources of funds from numerous agencies, not all of them under governmental control. In particular, the finances of the private sector are very difficult to audit and not known in detail. Figures of health expenditures vary according to the source and the method of estimation. Furthermore, they fluctuate significantly from year to year. According to official figures from 2007 shown in Table 1, the total public health expenditures were 5.7% of the Gross National Product (2.09% in the public sector, 2.28% in the obras sociales, and 0.70% in the retired citizens program). There is no official estimation of expenditures in the private sector. On the other hand, a private consulting firm published figures coming from various sources, estimating a total health expenditure in 2010 of USD 25 billion (about USD 625 per capita), or 9.6% of the Gross National Product [21]. According to these estimations 28% of these funds were collected through taxes by governments (national, provincial and local) and were used to run the public health sector, which provides medical care to the 47% of the population not covered by insurance. About 38% of health expenditure was financed by employer and employee contributions and spent by the social security sector (national and provincial *obras sociales* and retired citizens' medical care program) to provide services to their members (about 45% of the population), largely by contracting with the private sector. The expenditures of the private sector (which provides services to about 8% of the population) is assumed to account for the remainder 34% of expenditures. In addition to insurance premiums, it collects co-payments and pocket expenses for medicines, consultations and medical devices. The discrepancies of different estimations of health expenditures are due in part to the fact that they relate to different years (in a rapidly changing reality), and in part to the use of different sources of data and analytical methodologies.

Furthermore, there are indicators of geographical inequities. For example, the *per capita* income in Buenos Aires is double that of one of the poorest provinces (USD 10,000 versus 5,000), while the health expenditure in the former is 23% of the budget, while it is only 10% in the latter [14]. Moreover, pocket expenses in 2005 were almost double in the first (poorest) income quintile than in the fifth (wealthiest) income quintile (10.5% versus 5.5%) [14].

The degree of fragmentation of the health system is highlighted by the number of different budgetary and administrative health units, largely independent of each other. The public system is divided in 24 provinces and more than 100 cities, each providing health services of widely different qualities and coverage. In turn, the social security sector is fragmented in over 350 *obras sociales* organized by trade or territory, while the private sector includes hundreds of institutions, either delivering or financing services or both. Although there are no available data on the administrative costs of more than one thousand institutions, there is no doubt that this fragmentation and segmentation adds substantially to the inefficiency of the health system. While there are no formal studies on efficiency, many experts are convinced that with a total per capita expenditure of over USD 600, the Argentine population should be experiencing a much better level of health than evidenced by the health indices. In spite of these negative features, an extensive network of public hospitals that provide medical care largely free of charge and with universal access is still maintained. This is to a large extent a tribute to the activism of social movements that defend the right to health whom over the past decades have defended the public system [2].

Discussion

The Argentine health system has a long history of development and accomplishments and counts on good human and structural resources, including an overall good level of spending, compared with other countries of the region. Furthermore, Argentina has a tradition of excellence in academic medicine and biomedical research. However, there is a high degree of fragmentation of the health system, with poor coordination between subsystems and lack of stewardship at the national level. (Table 3). The distribution of health expenditure is highly inequitable, with per capita spending in the public sector much lower than in the social security system, and both much lower than in the private sector. The latter serves the upper-middle and upper classes, who enjoy a level of medical care similar to that found for the wealthy in developed countries. The *obras sociales* run by trade unions imply too much economic and political power to labor bureaucrats frequently engaged in corrupt practices. The equity of the

Table 3. Characteristics of the health system of Argentina.

• Fragmentation and multiple decision-making bodies • Relative excess of highly skilled physicians, hospital beds and medical technology in big cities. • Deficiency of primary care professionals and nurses and other allied health personnel • Lack or deficient regulation of private for-profit sector (private hospitals and "prepaid medicine"). • Concentration of economic and political power in the trade unions as administrators of the *obras sociales* with little or no oversight and margin for corruption. • Inequity between the private, social security and public sectors • Demographic growth with increasing loss of coverage • Under-financing and lack of improvement in the public sector, particularly of hospitals • The three health sectors are increasingly overlapping, with potential conflict of interests of health professionals

system is further eroded as the funds of the *obras sociales* are essentially siphoned towards the for-profit private sector. During the 1980s and 1990s, under prescriptions of the IMF and World Bank, Argentina further reduced the public sector and increased privatization of health services, exacerbating inequities. The latter, in turn, are part of larger social inequalities prevalent in the country, and are reflected in worsening health indices as one goes down in the socioeconomic scale and from wealthier to poorer provinces.

The segmentation and fragmentation of the health system of Argentina are the main factors behind its low efficiency and its inequities in access and in quality of care. At the same time, it would seem that segmentation and fragmentation has been the environment that the different players (organized medicine, owners of private hospitals, *obras sociales*, private health insurers, pharmaceutical and medical technology industries and others) have found and thrived on, maintaining the *status quo* and preventing the development of a unified national health system. The iterative tensions among these players may be more apparent than real as they all have gained strength as the health sector of the economy continues to grow, albeit at the expense of equity and efficiency and the deterioration of the public system. The current government has demonstrated political will in getting progressive laws enacted in the areas of education, retirement pensions and the media. It is hoped that it will show the same will to move the country from an ailing, inefficient and inequitable health system to a unified national health system. This is what most of the population expects and what socially conscious health professionals and activists are willing to work for.

References

1) Comisión Nacional sobre la Desaparición de Personas. Nunca Más [Never Again]: Report by Argentina's National Commission on Disappeared People. London: Faber, 1986.
2) Iriart C, Waitzkin H. Argentina: No lesson learned. Intern J Health Services 2006;36 (1):177–96.
3) World Bank. Available from: http://devdata.wordlbank.org. [Accessed on october 2010].
4) Pan American Health Organization. Health in the Americas. Argentina. Washington, DC: PAHO, 2007: 27-48.
5) Ministerio de Salud, Pan American Health Organization, Argentina 2009, Basic Indicators. 2010. Available from: www.msal.gov [Accessed on october 2010].
6) Almeida C. Health systems reform and equity in Latin America and the Caribbean: lessons from the 1980s and 1990s. Cad. Saúde Pública, Rio de Janeiro 2002;18(4): 905-25.
7) Laurell AC. An Overview of Latin American Health Policies and Debates. Soc Med J 2010;5 (1): 50-7. Available from:www.socialmedicinejournal.org. [Accessed on october 2010].
8) Belmartino S. Equity issues in health care reform in Argentina. Cad Saúde Pública, Rio de Janeiro 2002;18(4):1067-76.
9) Stocker K, Waitzkin H, Iriart C. The exportation of managed care to Latin America. New Engl J Med 1999;340(14):1131–6.
10) Rodrigáñez-Riccheri P, Tobar F. El Consejo Federal de Salud Argentino (COFESA.) Actor clave en la construcción de un federalismo sanitario efectivo. [The Argentine Federal Health Council, COFESA. Key actor in the construction of an effective health federalism]. Ministerio de Salud, Argentina, 2003.
11) Mera JA, Bello J. Organización y financiamiento de los servicios de salud en Argentina: una introducción. [Organization and financing of health services in Argentina: an introduction]. Buenos Aires: Pan American Health Organization, 2003.
12) Abuelafia E, Berlinski S, Chudnovsky M et al. El funcionamiento del sistema de salud argentino en un contexto federal. [The functioning of the Argentine health system in a federal context]. Centro de Estudios para el Desarrollo Institucional. 2002, Documento 77; Argentina.
13) Moyano G, Escudero JC. La Salud en Argentina: ¿en manos de quién? Informe sobre la situación de la salud en Argentina. [Health in Argentina: who owns it? Report of the situation of health in Argentina]. Available from: www.emancipacion.org. [Accessed on october 2010].
14) Maceira D. Inequidad en el acceso a la salud en la Argentina. [Inequity in the access to the health system in Argentina]. CIPPEC, Documento de Políticas Públicas/Análisis, 2009, n° 52. Available from: http://www.cippec.org/SALUD. [Accessed on october 2010].

15) Universal Declaration of Human Rights. Available from: http://www.un.org/en/documents/udhr/; UN Covenant on Economic, Social and Cultural Rights. Available from: http://www2.ohchr.org/english/law/cescr.htm; Conventiopn of the Rights of Children. Available from: http://www2.ohchr.org/english/law/crc.htm [Accessed on october 2010].

16) López S. El sistema de salud argentino: Caracterización y conformación del sistema de salud. [The health system in Argentina: Characterization and conformation]. Department of Social Medicine, School of Social Work, National University of La Plata, Argentina, 2006. Available from: www.trabajosocial.unlp.edu.ar/articulo/2008/12/4/documentos_medicina. [Accessed on october 2010].

17) ANMAT. Available from: www.anmat.gov.ar. [Accessed on october 2010].

18) Abramzon M. Argentina: Recursos Humanos en Salud. La Distribución Geográfica [Argentina: Human health resources. Geographical distribution]. Buenos Aires: Pan American Health Organization, 2006.

19) Dossier Nacional de Atención Primaria en Salud. Fortalecimiento de la Integración de la Atención Primaria con Otros Niveles de Atención. [National Document of Primary Health Care. Strenghtening Integration of Primary Care with Other Levels of Care]. Ministry of Health of Argentina, Intercambio III.2-1-2007. Available from: www.msal.gov.ar. [Accessed on october 2010].

20) Maceira D, Apella I, Barbieri E. Análisis del Programa REMEDIAR. Notas sobre Evaluación y Seguimiento. Nota Técnica. [Analysis of the program REMEDIAR. Notes on Evaluation and Followup. Technical Report]. Office of Supervision and Evaluation. Washington, D.C.: Interamerican Development Bank, 2005. Available from: www.idb.org [Accessed on october 2010] or by request to the authors.

21) Key Market. La salud en el país: cuánto se gasta y quién la paga.Clarin, 23 May 2010. Available from: http://www.ieco.clarin.com/economia/salud-pais-gasta-paga_0_133500002.html. [Accessed on october 2010].