ARGENTINA

SELECTED BASIC INDICATORS

1990–2015

	1990 value	Value and year	Change (%)
Gross national income by purchasing power parity (PPP, US$ per capita)	...	22,049 (2014)	...
Human development index	0.705	0.836 (2013)	18.5
Mean years of schooling	7.9	9.8 (2014)	23.9
Improved drinking-water source coverage (%)	94.0	99.0 (2015)	5.3
Improved sanitation coverage (%)	87.0	96.0 (2015)	10.3
Life expectancy at birth (years)	71.6	76.6 (2013)	7.0
Infant mortality (per 1,000 live births)	24.4	10.6 (2013)	-56.6
Maternal mortality (per 100,000 live births)	...	37.3 (2013)	...
TB incidence (per 100,000 population)	59.0	21.4 (2013)	-63.7
TB mortality (per 100,000 population)	4.2	1.4 (2013)	-66.7
Measles immunization coverage (%)	93.0	89.0 (2015)	-4.3
Births attended by trained personnel (%)	...	99.6 (2015)	...

1990 population (millions)	32.7
2014 population (millions)	42.7
Change (%)	30.5

Argentina is located in the far southeast of South America. It covers an area of 3,761,274 km^2 and borders Bolivia, Paraguay, Brazil, Uruguay, Chile, and the Atlantic Ocean. It has a representative, republican, and federal form of government. Politically, the country is organized into the Autonomous City of Buenos Aires (CABA) and 23 provinces, which form a federation, distributed into five geographical regions.

Between 1990 and 2014, the population grew by some 30.5%, reaching around 42.7 million in 2014. The population has aged, and its structure has become stationary.

Life expectancy at birth in 2015 was 76.6 years (80.4 in women and 72.8 in men).

A full 91% of the population lives in urban areas, and 2.4% of the population is indigenous, with 31 indigenous groups across the country.

SOCIAL DETERMINANTS OF HEALTH

In 2014, the average educational attainment was 9.8 years of schooling; in 2015, the literacy rate in the population aged 15-24 was 99.3% (99.5% of women and 99.1% of men).

In 2016, drinking water coverage from the public water supply was 84.4%, while 58.4% of the public had access to the sewerage system.

Of the total population, 75.7% is nonmigrant, a proportion that has been similar in the last three censuses. Immigrants come largely from bordering countries; Peruvians account for 3.5% and people from other countries, 0.9%.

In 2015, the maternal mortality rate was 3.9 deaths per 10,000 live births, ranging from 8.1 (Salta) to 1.9 (CABA, Santa Fe, and La Pampa), revealing profound inequalities among the different provinces for the same causes of death.

Chagas disease is considered to be closely linked with poverty and a priority problem that must be solved.

Recent years have witnessed a gradual increase in private funding for science, although public-sector funding still predominates.

Because of its geographic location and productive structure, Argentina is one of the countries most affected by global warming. Over the span of the past 50 years, average temperatures in the country overall have increased by half a degree, and in the case of Patagonia, by 1 degree. If the current trend continues, forecasts for the 2080s project potential increases of up to 4°C in the north of the country and 2°C in the south, bringing higher levels of hydric stress, drought, and increased desertification.

HEALTH SITUATION AND THE HEALTH SYSTEM

In 2015, maternal mortality was 3.9 per 10,000 live births. The leading causes of death were hemorrhage, hypertension, infections, and miscarriage. Major inequalities in maternal mortality were recorded across provinces. Direct obstetric causes were responsible for more than 50% of all maternal deaths in the period 2010-2014.

Infant mortality trended downward in the period 2010-2014, from 12.0 to 10.6 per 1,000 live births, respectively.

In 2014, 325,539 deaths were recorded, for an overall mortality rate of 7.6 deaths per 1,000 population. Geographically, mortality ranges from 10.7 deaths per 1,000 population in the city of Buenos Aires to 3.7 per 1,000 population in Tierra del Fuego.

In 2014, diseases of the circulatory system were responsible for 28% of deaths, and neoplasms, 20%; these 2 groups of causes combined accounted for almost half of all deaths.

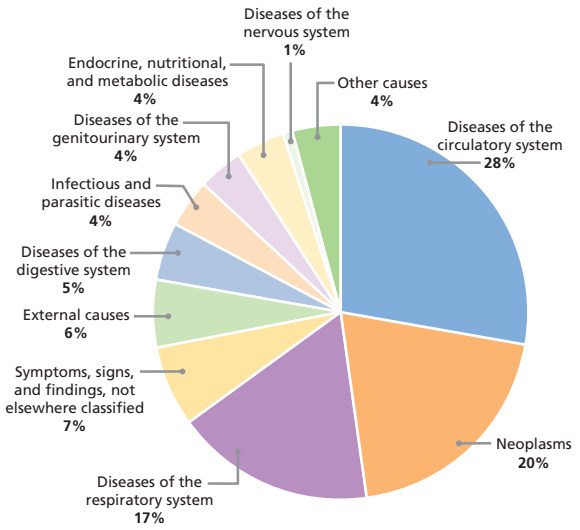
Between 2010 and 2014, mortality from cardiovascular diseases and neoplasms declined by 13% and 2.5%, respectively, while mortality from infectious diseases and external causes increased by 5.5% and 3.4%, respectively.

In 2013, the HIV incidence rate was 13.5 cases per 100,000 population, and HIV/AIDS-related mortality, 3.4 per 100,000 population. In 2015, the estimated TB infection rate was 22.6 cases per 100,000 population, and in 2014, the mortality rate was 1.6 per 100,000 population.

The dengue situation is characterized by major outbreaks such as those of 2009 and 2013. In 2016, the first autochthonous cases of chikungunya were recorded, which were confined

Distribution of the population by age and sex, Argentina, 1990 and 2015

Proportional mortality (% of all deaths, all ages, both sexes), 2014



to Salta and Jujuy provinces. Autochthonous vector-borne transmission of the Zika virus was also recorded, as was sexual transmission.

Tackling Chagas disease by interrupting vector-borne and congenital transmission has been designated a priority. In 2014, the seroprevalence of *Trypanosoma cruzi* infection in pregnant women was 2.5%, and 5.7% in children through congenital transmission.

Malaria is considered a controlled problem, given the absence of reported cases since 2010. Visceral leishmaniasis is a new phenomenon in the northeast region of the country, with 11 cases recorded in the 2010-2015 period.

In 2013, the prevalence of diabetes mellitus in the population aged 18 and over was 9.8%, reaching 20.3% among the elderly (aged 65 and over).

Poliomyelitis, measles, rubella, and congenital rubella syndrome are all considered eliminated in the country.

The incorporation of the *Haemophilus influenzae* type b (Hib) vaccine into the National Vaccination Schedule in 1997 has changed the epidemiological situation of Hib infection: a sustained nationwide rate of <0.1 cases per 100,000 population has been achieved.

In 2015, there were 975 confirmed cases of whooping cough, 77.7% of them in children under 1.

Since 2015, vaccination against chickenpox has been made compulsory and universal for all children aged 15 months, using a single-dose scheme. The rotavirus vaccine has also been included in the schedule.

The last case of rabies was recorded in 2008. The average annual incidence of echinococcosis in the period 2010-2014 was 1.5 cases per 100,000 population.

The health system is organized in line with the country's federal structure. It consists of three sectors: public, social security, and private. Each province has autonomy over governance, financing, and service delivery. Thus, the health system has a fragmented and segmented structure.

The public sector is composed of the national and provincial ministries and the network of public hospitals and health centers. All of these facilities provide free care on demand; they essentially serve people in the lowest income quintile without social security, who are unable to pay out of pocket. Public sector funding accounts for nearly 2.2% of the gross domestic product (GDP).

The compulsory social security sector is organized around national and provincial *obras sociales* (entities charged with overseeing medical care for Argentine workers). At the national level, there are more than 200 of these entities, representing expenditures equivalent to 1.59% of the GDP, while expenditures of the 23 provincial *obras sociales*, which cover civil servants in their respective jurisdictions, represent 0.74% of GDP.

The National Institute of Social Services for Retirees and Pensioners provides coverage for retirees in the national pension system and their families; it covers 20% of the population and represents expenditures equivalent to 0.75% of GDP.

The private sector is composed of health professionals and facilities that serve individuals who pay out of pocket, beneficiaries of the *obras sociales*, and people with private insurance coverage.

The country has 3.6 physicians and 3.2 hospital beds per 1,000 population. These rates are highest in the Autonomous City of Buenos Aires (10.2 physicians and 7.3 beds per 1,000 population) and lowest in the province of Misiones, with only 1.2 physicians and 1.1 beds per 1,000 population.

The Health Services Authority regulates all *obras sociales* nationwide. The National Administration of Drugs, Foods, and Medical Devices plays a key role in regulatory matters.

The Directorate of Health Statistics and Information is responsible for coordinating and regulating the collection of specific statistical data on health programs, and since 1996 has participated in the PAHO and WHO initiative on basic health indicators; thus, Argentina is included in a common database for the Region of the Americas.

ACHIEVEMENTS, CHALLENGES, AND OUTLOOK

In 2014, health service expenditure represented 8.5% of GDP. Although the population as a whole has access to the services

provided by the public sector, achievements in health appear underwhelming in relation to the resources allocated, due to inequities in distribution.

Fragmentation exists in three areas: (i) coverage, since access to similar health benefits and services does not extend to the entire population; (ii) regulatory functions, since leadership and regulatory authority are distributed throughout the 24 jurisdictions and in various subsectors; and (iii) territorial disparities, given the pronounced differences in economic development from one region to another.

System fragmentation hinders equity in access to services, regulation, and control of the different levels and sectors, and prevents achievement of greater equity among territories. This fragmentation is closely related to the autonomy of the provinces, which poses a challenge when seeking functional integration.

A series of priorities have been set to obtain universal health coverage, develop an agency for health technology assessment, and establish a quality accreditation system.

Implementing these proposals will require not only financial resources, but also the ability to reach consensuses among various stakeholders that would make it possible to achieve equitable access to similar services in terms of financial protection, timeliness, and quality, regardless of employment status, place of residence, income level, or any other social determinant.

The country is facing a dual scenario in which infectious diseases coexist with a steady increase in the prevalence of noncommunicable diseases and their risk factors. Overweight and obesity are considered a challenge requiring the development and implementation of public policies, such as the regulation of food advertising, fiscal policies, and front-of-package labeling.

A major challenge is still the creation of strategies to combat HIV/AIDS and tuberculosis.

Interruption of vector-borne transmission of Chagas disease has already been accomplished in 8 of the 19 endemic provinces: Entre Ríos, Jujuy, La Pampa, Misiones, Neuquén, Río Negro, San Luis, and Santa Fe.

A human development agenda must be established to overcome the social determinants associated with poverty and achieve better results in the implementation of health programs.

"Toward Universal Health in the South American Chaco Population 2016-2019," an initiative of Argentina, Bolivia, Brazil, and Paraguay, is noteworthy in this regard.

Better prevention and control of chronic noncommunicable diseases require improvements in existing prevention programs that focus on controlling risk factors.

The Compulsory Medical Program (*Programa Médico Obligatorio*, PMO) should be updated on the basis of current evidence of impact and effectiveness.

ADDITIONAL POINTS

Argentina has an extensive history of social policies, along with great capacity and human talent, robust institutions, and health expenditure levels that exceed the regional average.

Despite these real strengths, the country has obstacles to overcome. Argentina has perhaps the most segmented and fragmented health system in the Americas. Thus, enormous governance efforts and strong sector leadership are needed to bring together a wide range of stakeholders in pursuit of shared health objectives.

The current administration has focused on advancing toward universal coverage, in terms of effective access to quality services, regardless of employment status or any other condition.

The Compulsory Medical Program is an organizational strategy for the health services that has proven very useful, despite the impact of the economic crises that the country has experienced and the need to update it.

Programs covered by the PMO include a maternal and child plan, a neonatal care plan, programs for the prevention of some types of cancer, dental programs, and the Sexual Health Program.

In terms of services, the Compulsory Medical Program covers outpatient visits, diagnostic testing, rehabilitation, hemodialysis, palliative care, prosthetics and orthotics, inpatient care, mental health care, interfacility transfers, an extensive drug formulary, and high-cost care services, among other things.

These services have also been embraced by the private health providers, with an effect on the system that has tended to guarantee a basic level of access to services and benefits. This element provides a measure of equity, universality, and solidarity for users of the health system.