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CHARACTERISTICS OF THE ARGENTINE HEALTH CARE SYSTEM

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Executive Summary

The purpose of this report is to provide a comprehensive characterization of the health system in Argentina, considering both the types of actions implemented by the National Government on health matters (promotion, prevention, and care) and the internal organization of the different subsystems, including a multidimensional federal perspective by considering regulatory, population, administrative and budgetary issues.

As for health promotion, the process that enables persons to have better control over their health as defined by the World Health Organization (WHO), 421 budget actions have been identified in 34 agencies of the National Government that contribute to this dimension, with a budget of ARS1.425 trillion in 2021, which represents 3.3% of the estimated Gross Domestic Product (GDP) for the year. In this categorization of policies, those related to the improvement and protection of the environment, promotion of sports, community development, housing and habitat, access to information, health protection, public safety, access to public services, and accessibility and transportation stand out.

For preventive health, defined as measures aimed not only at preventing the onset of disease, but also at halting its progression and mitigating its consequences, 119 budget actions were identified in 15 government agencies, with a total of ARS180.975 billion allocated, equivalent to 0.4% of GDP. Policies that contribute to the prevention of diseases or illnesses, the protection of specific populations and the institutional and professional strengthening of health care are highlighted.

The selection of policies aimed at health promotion and preventive health at the national level is the result of a regulatory and classification analysis made by the Argentine Congressional Budget Office (OPC), based on the definitions of each type of action, since there is currently no formal and official identification procedure carried out by the Executive Branch to determine the investment and approach of either concept.

Likewise, given the extent and diversity of this type of actions, and in the absence of an information system that standardizes the data related to the implementation of policies in provinces and municipalities, only information from the National Government is included. In addition, even though the private sector carries out some actions that contribute to health promotion and prevention, these actions are implemented with the purpose of complementing and outlining its main activity, which is health care, and are therefore not included.

Special emphasis is placed on health care actions, given the complexity, diversity, and specificity of the subject. There is a significant variability among provinces in terms of both the availability of health facilities and professionals and access to equitable and quality health coverage.

Comparing the availability of health facilities and professionals in each province in relation to their populations, there are significant disparities. Thus, the province with the largest number of health facilities has 4.7 times more facilitates than the province with the fewest, with a strong State presence in most of the jurisdictions, since the private health care services are limited to the most populated areas.

Likewise, there is a significant gap between the province with the highest number of physicians per 100,000 inhabitants and the one with the lowest number, which is 7 times.

The three subsystems (public, social security and private) are analyzed in detail. Although they cover the entire population of the country, this does not imply that coverage is equitable and equal for all. The public subsystem is accessible to all persons living in Argentina, but it is mostly used by approximately 36% of the population who do not have any other type of coverage. The compulsory social security subsystem, which covers formal workers and their direct family members, covers

61.2% of the population; and the private subsystem, which covers those who contract health plans by out-of-pocket expenses or by means of the transfer of social security contributions, covers 13.6%. These percentages exceed the total population estimated by INDEC, because of the multiple coverage (provincial and national social security, or social security and private) caused by the scarce articulation between subsystems.

The specific analysis of the public subsystem shows budget allocations to 5 health facilities that have their own Financial Administrative Service (FAS) and to 6 facilities that the national government funds on its own or together with the jurisdictions where they are located. Likewise, there are budget allocations for the health facilities of the Armed Forces, Police and Security Forces, as well as for University Hospitals. Among all of them, the national government allocates 0.17% of GDP.

Additionally, in terms of the geographic distribution of the beneficiaries of the *Sumar* and *Incluir Salud* national programs (the former aimed at the population with no other type of coverage and the latter aimed at the beneficiaries of non-contributory pensions), there are significant gaps between provinces which, in general, are related to the different levels of development observed. Both programs have budget allocations that, together, are equivalent to 0.12% of GDP.

As for the social security subsystem, which primarily is under the scope of the National Government in accordance with the provisions of the National Constitution, it is observed that 3 out of every 4 persons covered by Social Security are under national jurisdiction (when adding the National Social Security Health Insurances - OSNs -, the INSSJP-PAMI and other health coverages), whereas 1 out of every 4 persons are under provincial jurisdiction, and more than half of the population covered by the Social Security subsystem is covered only by the OSNs. It should also be emphasized that the provision of services to persons receiving health care in this sector is mainly implemented through agreements with private health facilities, with the OSNs operating as risk managers.

It is observed that the correlation between access to Social Security benefits and formal employment results in difficulties for the universalization of this type of coverage. Even among those who are formally employed and consequently have Social Security coverage, there are significant asymmetries, moving even further away from the concept of equitable and egalitarian "social security". Finally, the complementary policies of free choice of OSN and transfer of contributions to the private subsector widen, in practice, the differences between the services provided by the different OSNs and affect their financing. All of this particularly affects women, who have lower rates of formal employment and lower relative wages.

For its part, the Redistribution Solidarity Fund, which is aimed at making compensations and financial assistance in favor of equity in the provision of health services among all OSNs, distributed up to the date of analysis resources for a little more than 0.12% of GDP during 2021.

Among the different types of OSNs, it can be observed that: about 75% of the entities and beneficiaries within the OSN regime are trade union-run; although the INSSJP-PAMI has an extensive coverage throughout the national territory, there are uneven levels of coverage in the different provinces; although the Provincial Social Security Insurances (OSPs) are created in the same way as the national ones, none of them are governed by Law 23,661.

Furthermore, there is a strong concentration of beneficiaries in a few large OSNs because of the flexibility provided by various regulations for the migration of contributions, which leads to strong disparities in the quality of services.

With respect to the Private Subsystem, it is observed that, as in Social Security subsystem, there is a high concentration in a few large companies that control most of the health insurance market.

Finally, the evaluation of the health system in Argentina based on different population health indicators, mainly related to birth and mortality, shows a significant variability among provinces, with

higher levels of mortality (infant and maternal) and lower life expectancy in those provinces with less availability and access to health coverage.

Introduction

Health is a collective, public, and social right rooted in the Constitution, which involves not only access to basic health services, but also their maintenance and regularity over time. The guarantee of this right is mainly the responsibility of the Government, especially in the specific cases of legal protections involving vulnerable persons such as children and adolescents, older adults, persons with disabilities, children in distress, from pregnancy until the end of elementary school, and mothers during pregnancy and breastfeeding.

The outbreak of the pandemic caused by COVID-19, whose impact in Argentina emerged in March 2020, raised the level of attention on the health system throughout the national territory, focusing on its response capacity to provide care to the entire population, promote good health practices to prevent COVID-19 from spreading and carry out preventive actions to avoid its expansion.

After going through the most critical moments of the pandemic and already with high rates of vaccination in Argentina, the attention turns to the reconsideration of the Argentine health system, making visible the need to rethink it not only in the face of specific events but also from a structural perspective based on the health needs of the population.

Therefore, it is essential to provide the National Legislative Branch with comprehensive information on the Argentine health system, addressing all its dimensions, to ensure a general knowledge of the system to understand health budget allocations and the opportunities that give rise to public health policy.

Considering the complexity of the Argentine health system, this report is intended to provide a summarized and systematized overview of its distinctive aspects, thus allowing for a general understanding without ignoring the fact that this complexity does not end with the issues addressed and that each of them can be further disaggregated and detailed with more specificity in the future.

This report analyzes exclusively the role of the National Government in health promotion, prevention, and care actions in the multiple functions it assumes in each case: planner, organizer, regulator, financier, or operator. In all cases, the regulatory and institutional framework is analyzed, as well as the approach and implementation and the target population covered.

Although data from different sources and dates are used, given that these are structural issues, it can be inferred that the information provided is a systemic example of the reality of the issue addressed in each case, using an alternative indicator (for example, percentage of GDP when budget allocations are included) in those cases in which the data may be affected by circumstantial factors.

Finally, we would like to give special thanks to the Superintendency of Health Services, which provided the necessary data for the development of the sub-sections related to the Social Security and Private Health Care subsystems included in the Section on Health Care.

The first of the dimensions analyzed is health promotion, which identifies the actions undertaken by various agencies of the National Government for the maintenance and improvement of the quality of life in the broadest sense of the term.

The second of the dimensions addressed refers to actions for preventive health, detailing the activities implemented by the National Government, either for the prevention of diseases or for the protection of specific or vulnerable population groups to avoid the deterioration of their health.

The third of the dimensions addressed is health care, in which the general policies implemented by the National Government for the coordination of health care are analyzed, followed by a detailed description of the subsystems that comprise it: public, social security and private, identifying the population covered and describing the role assumed by the National Government with respect to each one of them.

Finally, the fourth dimension is an evaluation of the various outcome indicators that reveal the effectiveness and efficiency of the health system in Argentina.

Conceptual and Regulatory Framework

Definition of Health

To analyze the functioning of the health system in Argentina, it is first necessary to define what is meant by "health" and how it is contemplated in Argentina's regulations.

The World Health Organization (WHO) considers health to be a fundamental human right, and in the Preamble of its Constitution defines it as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Within the context of health promotion, it has been considered not as an abstract state but as a means to an end, as a resource that enables persons to lead an individual, social and economically productive life. Health is a resource for daily life, not the goal of life. It is a positive concept that emphasizes social and personal resources as well as physical aptitude[1].

From these definitions health is not only medical care, but a much more comprehensive concept, including other determining factors such as access to potable water, adequate sanitary conditions, decent housing, healthy food, environmental protection, healthy working conditions, access to information, among others, and it is the responsibility of the States to ensure that this is guaranteed and complied with.

Regulatory framework

Although the Argentine Constitution does not explicitly mention the right to health that all Argentine citizens have, it does so implicitly, since Section 75, subsection 22, grants constitutional hierarchy to various international treaties that address, among other things, the right to health. Likewise, Section 41 of the National Constitution mentions that: "All inhabitants are entitled to a healthy, balanced environment, fit for human development..." and Section 42 states that: "Consumers and users of goods and services have the right to the protection of their health...". In addition, several Sections of the Constitution address human development and the protection of human rights.

Furthermore, in accordance with the legislation in force, the primary responsibility for the regulation, funding, provision, and control of health actions lies with the provincial governments, although in practice they have delegated a large part of these duties to both the National Government and the municipalities, often resulting in overlapping and redundancies in the actions undertaken.

Coordination in health matters between the National Government, the provinces, and the Autonomous City of Buenos Aires (CABA) is implemented through the Federal Health Council (COFESA), created by Law 22,373, within the framework of which federal health policies and actions are articulated.

Among the contributions of the National Government towards federal coordination, Executive Order 455/2000 by which the Executive Branch approved the "Strategic-political framework for the health of the Argentines" stands out, which understands health as a situation of relative physical, psychological and social well-being resulting from the permanent transforming interaction between the individuals, the society in which they participate and their environment, emphasizing that the achievement of comprehensive health is related to the satisfaction of the needs for food, housing, education, culture, work and clothing.

1 https://apps.who.int/iris/bitstream/handle/10665/67246/WHO_HPR_HEP_98.1_spa.pdf;jsessionid=A38529F7E37EAADC2BEB8177BD7E5698?sequence=1

Actions to guarantee Health

The actions undertaken to guarantee health, as classified in the specialized literature, are:

- Promotion: actions aimed at improving the quality of life for the maintenance and improvement of health, such as a sustainable environment, access to services, sports, infrastructure, among others.
- Prevention: actions aimed at avoiding the loss of health or the aggravation of diseases, such as medical check-ups, vaccination, asepsis, good practices, nutrition, among others.
- Care: actions aimed at recovering health in the face of illness or disease, through the practice of the medical profession in hospitals, clinics, doctor's offices, among others.

Both promotion and prevention are the most powerful tools for achieving a healthy population. Stimuli to develop these actions are highly cost-effective, since with low investment it is possible to achieve broad and extensive results in terms of population health, but in practice results are usually low and the focus is on care once the disease or illness has been confirmed, which involves more than ninety percent of the social expenditure of health services[2].

The National Government usually funds many promotion and prevention actions that are implemented jointly with provinces and municipalities, regulates, and controls the OSN regime and private prepaid health care providers, determines general regulatory criteria for all public hospitals in the country and operates about 20 national health care institutions, including hospitals and other health facilities.

Health promotion

The World Health Organization (WHO) defines health promotion as "the process of enabling individuals to increase control over their health". This means that health promotion seeks to encourage changes in the environment to help ensure a better population health status. Health promotion implies a particular way of collaborating: it is population-based, participatory, intersectoral, context-sensitive and operates at multiple levels.

Health promotion can be understood as those contextual actions that contribute to a better standard of living through healthy habits and environments, contributing to the achievement of a complete development throughout life.

Some of the targets of health promotion are to reduce health risks, to positively transform living conditions, to encourage society to make decisions about its health and to improve the general living conditions of a population.

Health promotion includes actions aimed at favoring the implementation of healthy individual and collective practices, as well as the modification of social, environmental, and economic conditions, to reduce health inequalities.

Within this framework, responsibility for health promotion falls on all levels of government (national, provincial, and municipal) and, as part of these, on various agencies, not only on ministries or health departments.

[2] https://salud.gob.ar/dels/entradas/el-modelo-de-salud-argentino-historia-caracter%C3%ADsticas-fallas

Preventive Health

The WHO definition of preventive health refers to "measures aimed not only at preventing the onset of disease, but also at halting its progression and mitigating its consequences".

Although there is no consensus in the literature on the limits between promotion and prevention, the latter can be considered as a subsequent and complementary stage to promotion, since promotion refers to contextual actions to promote a better quality of life and lifestyle, and prevention refers to specific actions to avoid, as far as possible, the onset of diseases or illnesses and to mitigate their spread.

In addition, the monitoring and support of specific population groups, such as persons with disabilities and those in vulnerable situations, who require special care because of their greater exposure to health deterioration, should also be considered in the context of prevention.

Therefore, considering these concepts as a definition of preventive health, it is also the responsibility of the different levels of government and involves various agencies, but in this case the Ministries of Health take on special relevance, with vaccination campaigns being the classic example of preventive actions.

Health care

In the Declaration of Alma-Ata, the World Health Organization (WHO) defines health care as "essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford".

The health care system in Argentina is divided into three subsystems with differentiated regulatory, organizational, provisioning and financing characteristics, with little coordination among them, resulting in many cases in multiple coverage of the population[3].

These subsystems are the public subsystem, comprising the network of public and free access hospitals and health care facilities offered by the National Government and the provincial and municipal governments; the Compulsory Social Security subsystem, comprising the various national and provincial social security health insurances (OSNs and OSPs); and the private subsystem, comprising private health insurance companies, independent health care professionals and cooperatives, mutuals, and SMEs that provide specific and limited health care services.

Responsible agencies

In this context, considering the concept and the different types of actions related to health, there are several national government agencies that have responsibility in this matter, complementing the functions and duties of the Ministries of Health (national[4] and subnational), which are: the Ministry of Public Works, the Ministry of Territorial Development and Habitat, the Ministry of Environment and Sustainable Development, the Ministry of Tourism and Sports, the Ministry of Education, the Ministry of Social Development and the National Health and Food Quality Service (SENASA), among the

[3] A person can make use of the three subsystems by having a union-run health insurance (*obra social*) for working under an employment relationship, paying for a private health insurance, and receiving care in a public hospital.
[4] In terms of financial administration, the jurisdiction of the National Ministry of Health includes the Ministry itself and the Superintendence of Health Services, the National Administration of Medicines, Food and Medical Technology (ANMAT) and the National Administration of Laboratories and Health Institutes, together with the hospitals and institutions providing health services at the national level.

most relevant. They have a fundamental role in the promotion of health since their functions are focused on improving the living conditions of the population.

At the national level, the National Ministry of Health is responsible for health prevention actions through various campaigns and activities implemented directly by the Ministry or in coordination with the provinces or other national government agencies; and for health care actions by regulating, controlling, financing, or providing health care services.

National government actions for health promotion

Thirty-four agencies of the National Government implement public policies that contribute to the promotion of health, understood as those contextual actions that contribute to a better standard of living through healthy habits and environments. Among these agencies, 421 contributing activities and works are identified, which together represent an expenditure of USD1.424,925 trillion, which represents 3.3% of the Gross Domestic Product (GDP) estimated for 2021 and 14.8% of total National Government expenditure.

There is no specific identification of the actions carried out by the National Government for the promotion of health at the national level. However, taking the definitions previously exposed and based on a general regulatory analysis of the public policies carried out by the National Government, a non-exhaustive selection of the budget actions that contribute to health promotion has been made for the purposes of this report, identifying also the financial forecasts related to these actions. These actions constitute the National Government's social investment in health promotion.

For a better understanding, we propose to group these policies in dimensions based on the health promotion issues they address, identifying nine of them:

1) Improvement and protection of the environment: it includes policies aimed at preserving and protecting natural environments, as well as reducing and treating pollution and waste.
2) Promotion of sports: it includes public policies to promote the development and practice of sports among the general population and specific populations.
3) Community development: it includes policies aimed at supporting the community and accompanying population groups in vulnerable situations, from an integrated and comprehensive perspective.
4) Housing and habitat: it includes policies aimed at guaranteeing and improving housing conditions and the community environment.
5) Access to information: it includes dissemination policies that enable citizens to make better decisions based on information.
6) Safety: it includes actions aimed at guaranteeing food and product safety, as well as the prevention of diseases in domestic and farm animals.
7) Public Security: it involves policies to guarantee safe environments as well as those aimed at preventing drug trafficking.
8) Access to public services: it includes policies aimed at providing the population with quality public services (electricity, gas, water, and sewage).
9) Accessibility and transportation: it includes policies aimed at improving population mobility.

Table 1 shows the number of actions included in the current budget and the national investment in health promotion by dimension.

Table 1. Number and budget of public policies for health promotion, by dimension

In millions of ARS and as a percentage of GDP. As of August 2021.

Dimension	Number of budget actions	Budget forecast - ARS	GDP %
Improvement and protection of the environment	134	37,158.66	0.09%
Promotion of sports	7	2,804.98	0.01%
Community development	25	36,021.20	0.08%
Housing and habitat	17	111,976.25	0.26%
Access to information	8	1,012.35	0.00%
Safety	44	7,986.37	0.02%
Public Security	28	83,922.04	0.20%
Access to public services	90	879,200.82	2.05%
Accessibility and transportation	68	264,842.62	0.62%
Total	421	1,424,925.30	3.3%

SOURCE: OPC, based on E-SIDIF

A total of 421 public policies in 34 government agencies contribute to the promotion of health, whose budget in 2021 represents 3.3% of GDP.

Under the criteria outlined in this document, 421 public policies were identified in 34 government agencies that contribute to health promotion, with a total budget of ARS1.425 trillion, which represents 3.3% of the estimated Gross Domestic Product (GDP) for 2021 and 14.8% of the total projected expenditure for the year.

The dimension that focuses on the improvement and protection of the environment is the one with the largest number of initiatives, but in budgetary terms, access to public services is the most significant, since it involves 61.7% of health promotion expenditure, mainly due to consumer subsidies.

Of the total expenditure on health promotion, only 0.6% (ARS7.988 billion) is allocated to agencies whose main function is health (the National Ministry of Health and the National Service of Agri-food Health and Quality).

Details on the actions that are included in the dimensions listed in Table 1 are presented in Annex I.

National government actions for preventive health

Preventive health includes three dimensions (disease prevention, protection of specific populations and strengthening of institutions and professionals) involving 119 activities or works, with a budget of ARS180.975 billion, which represents 0.4% of the estimated GDP for 2021 and 1.9% of total National Government expenditure. Most of this budget is allocated to food policies, which represents 63.2% of expenditure on preventive actions.

As with health promotion, there is no clear identification of policies for preventive health at the national level. However, a series of actions implemented by the National Government can be identified which, based on the definition given, can be grouped into three dimensions:

1) Prevention of diseases or illnesses: it includes public policies aimed at preventing the onset and spread of diseases or illnesses that may affect a large portion of the population, or only a small number of individuals, but because of their chronic nature or their intensity, they represent a major concern and are usually costly to treat.
2) Protection of specific populations: it includes policies aimed at preventing situations that could deteriorate the health or living conditions of population groups that are more exposed or vulnerable to the onset of diseases or illnesses.
3) Strengthening of institutions and professionals: it includes public policies implemented to improve the operational capacity to preventive health care, as well as research and development related to the prevention of diseases or illnesses.

Based on this classification by dimensions, the number of actions and the budget allocated by the National Government for preventive health during the current year are shown in Table 2.

Table 2. Number and budget of public policies for preventive health, by dimension

In millions of ARS and as a percentage of GDP. As of August 2021.

Dimension	Number of budget actions	Budget forecast - ARS	GDP %
Prevention of diseases or illnesses	56	55,968.91	0.13%
Protection of specific populations	22	114,562.13	0.27%
Strengthening of institutions and professionals	41	10,444.29	0.02%
Total	119	180,975.33	0.4%

SOURCE: OPC, based on E-SIDIF

A total of 119 public policies in 15 government agencies contribute to preventative health, whose budget in 2021 represents 0.4% of GDP.

A total of 119 actions contributing to preventive health were identified among the three dimensions in fifteen government agencies, with a total budget of ARS180.975 billion, which represents 0.4% of the estimated GDP for 2021 and 1.9% of total National Government expenditure projected for the year.

Although the prevention of diseases or illnesses is the dimension with the largest number of actions, where the provision of vaccines included in the vaccination calendar and those against COVID-19 stand out, it is the protection of specific populations that has the largest budget, since it includes food policies aimed at persons in situations of vulnerability, which are activities with a high budget forecast.

Of the total expenditure on preventive health, 35.8% (ARS64.797 billion) is allocated to agencies whose main function is health: National Ministry of Health, National Administration of Laboratories

and Institutes of Health *Dr. Carlos G. Malbrán*, National Administration of Medicines, Food and Medical Technology, National Agency for Disability, National Agency of Public Laboratories, National Network Hospital Specialized in Mental Health and Addictions *Licenciada Laura Bonaparte*, National Cancer Institute and National Institute of Ablation and Implant Coordination.

Details on the actions that are included in the dimensions listed in Table 2 are presented in Annex II.

Health Care

Health care is provided through three subsystems that cover the entire population of the country, although this does not imply that it is equitable and equal for all. These subsystems are: the public subsystem, which is accessible to all persons living in the country, but which is used by approximately 36% of the population who have no other type of coverage; the mandatory social security subsystem (*Obras Sociales*), which covers all workers under employment relationship together with their direct family members, covering 61.2% of the population; and the private subsystem, which covers those who contract health insurance plans through out-of-pocket expenses or through transfer of social security contributions, comprising 13.6% of the population. These percentages exceed the total population estimated by INDEC, because of multiple coverage (provincial and national social security, or social security and private) resulting from a scarce articulation between subsystems.

Considering the division of health care in Argentina into subsystems, the estimate of the general distribution of coverage by type of subsystem is shown in Table 3.

Table 3. Population covered by type of coverage

Number and percentage. 2021.

Type of coverage	Population covered	Share of total population
Public subsystem (1)	16,500,000	36.00%
Social Security subsystem	27,928,471	60.97%
Private subsystem	6,218,032	13.57%
Total	50,750,833	110.54%
Argentine Population	45,808,747	100.00%
Population with more than one type of coverage (2)	4,942,086	10.54%

(1) Estimate as of 2021 based on 2010 Census-INDEC, consistent with the Permanent Household Survey (EPH).

(2) Estimate based on the difference between projected population as of 2021 and total population covered.

SOURCE: OPC, based on data from the Superintendence of Health Services and INDEC.

There are organizational and operational differences between the health care subsystems, either in terms of who is responsible for them, how they are organized, how they are coordinated or how they are funded. The National Government plays different roles in each of the subsystems, through attempts at homogenization and subsidiary assistance for the Public Subsystem (since primary responsibility lies with the provinces), through general coordination, risk management, authorization, and control of the Social Security Subsystem, and through supervision and control of the Private Subsystem.

General national framework for health care

To set common and general standards for the different subsystems, the Executive Branch created the "National Health Care Quality Assurance Program", originally approved in 1992 and whose last update was made through Executive Order 178/2017. This regulation is of mandatory application in all national health facilities, in the National Health Insurance System and OSNs, in the National Institute of Social Services for Retirees and Pensioners (INSSJP), in the facilities included in the National Registry of Public Hospitals of Decentralized Management, as well as in the facilities

dependent on the different provincial and municipal jurisdictions and of the Autonomous City of Buenos Aires and the entities of the Health Sector that join the Program.

The purpose of the program is the assurance of the quality of services and benefits provided to the population and, to this end, the Resolution of the National Ministry of Health 856/2017 establishes the organizational structure in which the conceptual aspects of the Program are regulated: authorization of facilities, certification of specialties, the development of standards for the organization and operation of health services, the design of service quality indicators, technical cooperation between jurisdictions and patient safety, among other aspects.

Federal Registry of Health Facilities

The National Ministry of Health, in agreement with the Federal Health Council (COFESA), created the Federal Registry of Health Facilities (REFES) through Resolution 1070/2009, an instrument for the identification of all health facilities (inpatient and outpatient), both public and private (except for individual offices), which are functioning in each of the provincial jurisdictions in accordance with the regulations in force in each of them.

This Registry also includes the categorization of facilities based on ten typologies that allow differentiating the type of service they provide, based on whether they are inpatient (six typologies) or outpatient (four typologies)[5].

As of January 2021, this Registry included 32,857 registered facilities throughout the country, distributed according to management sector, origin of funds and general classification by type of service (Table 4).

[5] Annex III provides a description of the typologies considered, as well as information on the distribution of REFES-registered facilities in the different provincial jurisdictions by typologies and funding sector (government, non-government and mixed).

Table 4. Health facilities registered with the REFES by sector, origin of funds and type of service

As of January 2021

Sector	Origin of funds	Inpatient	Outpatient	Total
Government	National	25	137	162
	Provincial	1,166	5,785	6,951
	Municipal	580	3,868	4,448
	Armed /Security Forces	27	181	208
	Federal Penitentiary Service	4	26	30
	Provincial Penitentiary Service	4	66	70
	Public universities	9	34	43
	Subtotal	*1,815*	*10,097*	*11,912*
Non-government	Private	4,558	15,812	20,370
	Obras sociales	30	280	310
	Mutual	10	83	93
	Private universities	1	4	5
	Others	40	94	134
	Subtotal	*4,639*	*16,273*	*20,912*
Mixed		7	26	33
Total		6,461	26,396	32,857

SOURCE: OPC, based on National Ministry of Health - REFES.

Of the registered facilities, 63.6% belong to the non-government sector, 97% of which are private. The remaining 36.4% belong to the government sector, 95.7% of which are provincial or municipal.

Of the facilities registered with the REFES, 63.6% belong to the non-government sector, 97% of which are private, with only marginal participation of other types, which can be considered as an indicator that the provision of health care services in this sector is mainly implemented through agreements with private health facilities.

As for the government sector (36.4% of the facilities registered with the REFES), the distribution is predominantly at the subnational levels, with 58.4% under provincial jurisdiction and 37.3% under municipal jurisdiction, which together account for 95.7% of the government-run facilities. This scenario highlights the subsidiary role of the National Government in health care, a situation that is sustained even if the facilities belonging to the Armed Forces, Security Forces, Federal Penitentiary Service and National Universities, all of which are national institutions, are included.

If the distribution of facilities by province is analyzed, it can be observed that those with the largest population are those with the largest number of facilities. However, the distribution of facilities by sector, as well as the number of facilities available per 10,000 inhabitants, is heterogeneous, as shown in Table 5.

Table 5. Health facilities registered with the REFES by province, sector, and number per 10,000 inhabitants

Number of facilities per 10,000 inhabitants and percentages. As of January 2021.

Province	Number of facilities	Sector		Facilities per 10,000 inhabitants		
		Government	Non-government	Total	Government	Non-government
Buenos Aires	8,331	38.0%	62.0%	4.7	1.8	2.9
Autonomous City of Buenos Aires (CABA)	1,715	13.3%	86.6%	5.6	0.7	4.8
Catamarca	526	71.1%	28.7%	12.6	8.9	3.6
Chaco	961	49.2%	50.7%	7.9	3.9	4.0
Chubut	692	29.0%	71.0%	11.0	3.2	7.8
Córdoba	3,353	28.5%	71.5%	8.8	2.5	6.3
Corrientes	684	59.9%	39.9%	6.1	3.6	2.4
Entre Ríos	1,081	41.8%	58.1%	7.7	3.2	4.5
Formosa	460	72.2%	27.8%	7.5	5.4	2.1
Jujuy	641	59.8%	40.2%	8.2	4.9	3.3
La Pampa	750	18.0%	82.0%	20.8	3.7	17.0
La Rioja	385	73.8%	26.2%	9.7	7.1	2.5
Mendoza	2,192	22.9%	77.1%	10.9	2.5	8.4
Misiones	927	58.1%	41.0%	7.3	4.2	3.0
Neuquén	1,272	21.0%	78.9%	18.9	4.0	14.9
Río Negro	584	39.9%	60.1%	7.7	3.1	4.6
Salta	1,071	53.8%	46.0%	7.4	4.0	3.4
San Juan	852	22.5%	77.5%	10.8	2.4	8.4
San Luis	545	32.3%	67.7%	10.6	3.4	7.2
Santa Cruz	350	30.0%	70.0%	9.3	2.8	6.5
Santa Fe	2,351	35.2%	64.7%	6.6	2.3	4.3
Santiago del Estero	840	76.9%	23.0%	8.5	6.5	2.0
Tierra del Fuego	388	13.4%	86.3%	21.8	2.9	18.9
Tucumán	1,906	21.1%	78.5%	11.1	2.3	8.7
Total	32,857	36.3%	63.6%	7.2	2.6	4.6
Max. / Min.	23.8			4.6	12.1	9.7
2nd Highest / 2nd Lowest	8.7			3.7	4.0	8.1

SOURCE: OPC, based on National Ministry of Health - REFES.

The Northwest and Northeast regions have a higher number of government facilities compared to non-government facilities.

The northwestern (NOA) and northeastern (NEA) provinces of Argentina, except for Tucumán and Chaco, have a greater number of government facilities compared to non-government facilities.

In terms of the number of facilities per 10,000 inhabitants, the provinces of Tierra del Fuego and La Pampa are the ones with the highest number, both with more than twenty facilities per 10,000 inhabitants, because of the large presence of private facilities in both provinces. At the other extreme, the province of Buenos Aires is the one with the lowest number of facilities per 10,000 inhabitants, with around five, and Formosa is the one with the lowest number of non-government facilities, with just over two facilities per 10,000 inhabitants.

The territorial differences can be evaluated by comparing the extreme cases (maximum over minimum) and the second extreme values (to reduce the bias produced by limit situations).

There is a wide disparity among provinces in terms of the availability of facilities per 10,000 inhabitants, with the one with the most facilities having 4.7 times more than the one with the fewest.

In terms of the total number of facilities, these values are 4.6 and 3.7, respectively; a situation that highlights the wide disparity in the number of facilities per 10,000 inhabitants among provinces. Thus, the provinces with the highest number of facilities have approximately four times as many as those with the lowest number.

If only the government sector is considered, the province with the highest number of facilities has 12 times more facilities per 10,000 inhabitants than the province with the lowest number of facilities, a gap that is reduced to 4 when the limit values are discarded. For the non-government sector, the disparities remain high, even when the extremes are discarded.

Unified Registry of Health Professionals

Law No. 17,132, as amended and derived, establishes the conditions for "the professional practice of medicine, dentistry and their collaborative activities" at the national level. In 2008, within the framework of the regulatory adjustments made for the homogenization of the Mercosur member countries and with the prior agreement of COFESA, Resolution 404/2008 of the National Ministry of Health established the common federal standards for the registration of health professionals with the Unified Registry of Health Professionals (*Registro Único de Profesionales de la Salud* - RUP).

To ensure a homogeneous registry, a Single Health Professional File was created, which contains information on each of the health professionals with respect to their personal identification, training and professional license records, specialties, and residencies[6].

The registry includes not only physicians, but also dentists, psychiatrists, psychopedagogues, kinesiologists, phonoaudiologists, therapists, biochemists, nurses, and other health-related professionals, totaling 225,811 registered throughout the country, of which 92,700 are physicians and 133,111 are other health professionals.

The distribution by province and the number of professionals per 100,000 inhabitants in each one is shown in Table 6.

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Table 6. Physicians registered with the RUP by province and number per 100,000 inhabitants

Number of professionals per 10,000 inhabitants and percentages. As of January 2021.

Province	Physician	Others	Total	Number per 100,000 inhabitants	
				Physician	Total
Buenos Aires	31,480	48,138	79,618	180	454
CABA	18,989	19,059	38,048	607	1.216
Catamarca	662	906	1,568	159	377
Chaco	1,454	1,851	3,305	121	275
Chubut	1,007	1,590	2,597	165	426
Córdoba	8,238	15,630	23,868	219	635
Corrientes	1,792	2,326	4,118	160	367
Entre Ríos	2,021	3,316	5,337	146	385
Formosa	532	797	1,329	88	219
Jujuy	912	1,362	2,274	119	296
La Pampa	436	1,262	1,698	121	473
La Rioja	715	766	1,481	183	379
Mendoza	3,600	4,721	8,321	181	419
Misiones	1,352	1,879	3,231	108	257
Neuquén	1,353	2,046	3,399	205	515
Rio Negro	1,241	1,855	3,096	167	417
Salta	2,060	2,578	4,638	145	328
San Juan	1,352	2,142	3,494	173	448
San Luis	688	1,493	2,181	136	432
Santa Cruz	411	729	1,140	116	322
Santa Fe	7,547	12,765	20,312	213	572
Santiago Del Estero	1,242	1,299	2,541	127	260
Tierra Del Fuego	292	508	800	174	476
Tucumán	3,150	3,955	7,105	187	421
N/D	174	138	312	-	-
Total	92,700	133,111	225,811	204	498
Max/Min				6,9	5,6
2nd Highest / 2nd Lowest				2,0	2,5

SOURCE: OPC, based on Superintendence of Health Services - RUP.

The gap between the province with the highest number of physicians per 100,000 inhabitants and the one with the lowest number of physicians per 100,000 inhabitants is approximately seven times. If the extremes are discarded from the analysis and the second province with the highest number is compared to the second province with the lowest number, this gap is reduced to twice the number.

A similar situation is observed when comparing the total number of professionals (physicians and others), where the difference between extremes is six times, and between the second highest and the second lowest is two and a half times, showing the territorial disparity in the distribution of human resources.

Public health subsystem

The public subsystem includes care in public hospitals and health care facilities at the national, provincial, or municipal level. Any person who is in the Argentine territory can access health care in the public subsystem free of charge. Public hospitals are funded through the public budgets of the jurisdictions to which they belong and may receive other additional income as compensation for services provided to users of other health subsystems, with INSSJP-PAMI being the main contractor of public hospitals for the provision of services.

There is not a defined and homogeneous benefit plan for the different public hospitals and health facilities, so that the health care services offered depend on the availability of health care personnel (and their specialties), equipment, supplies and care capacity (e.g., available beds, appointment availability, etc.) at the time the population demands them. When demand exceeds availability, access to health services is restricted. These restrictions are mainly manifested in delays in the scheduling of appointments or unavailability of specialties in some facilities.

The funds received by this type of entities work as a subsidy to the supply, which, in turn, are organized based on that funding, determining the extent to which the population's demand is to be satisfied. The lack of a systematic planning of the services to be provided (or of their funding) results in asymmetries among the different provinces. Since the services to be provided are not determined based on needs and requirements defined according to reliable information, the offer may be very disparate and not consistent with the demand.

Although the primary responsibility for health care lies with the provincial governments, the National Government has assumed a prominent role

Although the primary responsibility for health care lies with the provincial governments and the Autonomous City of Buenos Aires, in practice the National Government has assumed an organizing role in the provision of services and the administration of public health care, through attempts at federal organization of health care and by providing services with its own large-scale facilities in some jurisdictions.

Public hospitals

Executive Order 939/2000 created the Regime for Decentralized Management Public Hospitals (*Régimen de Hospitales Públicos de Gestión Descentralizada*)[7], whose purpose is to:

- Promote actions aimed at increasing hospital budgets through the income obtained from the payment of services rendered to beneficiaries of other health subsystems.
- Promote efficient and rational management of health care.
- Improve the accessibility for the population without coverage.
- Preserve the regional and local distinctive features of the facilities by supporting and consolidating a federal conception of health care.
- Increase the commitment of the personnel with the facility through the distribution of a percentage of the income obtained from billing and collection.

This regulation also created the National Registry of Decentralized Management Public Hospitals (RNHPGD), administered by the National Ministry of Health, in which all public hospitals and health care facilities (national, provincial, and municipal) have the option of registering. Every hospital or facility that registers must comply with the stipulated requirements and may receive resources generated by the system. The number of hospitals and facilities registered as of August 2021, by province, is shown in Table 7.

[7] Replacing the "Self-managed Public Hospital Regime" approved by Executive Order No. 578/93.

Table 7. Health facilities registered with the RNHPGD by province

Number of facilities. As of August 2021.

Province	Number of facilities registered
Buenos Aires	870
CABA	44
Catamarca	51
Chaco	48
Chubut	111
Córdoba	512
Corrientes	52
Entre Ríos	183
Formosa	37
Jujuy	27
La Pampa	67
La Rioja	59
Mendoza	55
Misiones	46
Neuquén	0
Río Negro	37
Salta	21
San Juan	16
San Luis	73
Santa Cruz	4
Santa Fe	189
Santiago del Estero	104
Tucumán	339
Tierra del Fuego	0
Total	2,948

SOURCE: OPC, based on RNHPGD.

These facilities registered with the RNHPGD represent 9% of the total number of facilities included in the REFES, and 24.7% if only those in the public sector are considered.

Hospitals managed exclusively by the National Government are considered as part of the jurisdiction where they are located. The provinces of Neuquén and Tierra del Fuego had no hospitals or facilities registered with the RNHPGD as of the date of analysis.

The regulations establish the minimum standards that public hospitals must comply with, including regulatory requirements (jurisdictional authorizations, preparation of internal regulations and procedure manuals), operational requirements (creation of administrative and human resources offices, compliance with requirements and service schedules) and administrative requirements (preparation and submission of operational and financial programs).

Public Hospitals under this regime may enter into agreements with social security entities included in Law No. 23,660, as amended, with respect to the benefits that these entities are obliged to provide to their beneficiaries. Likewise, public hospitals may charge third parties for the services provided to members of OSNs, mutual insurances, private health insurance companies, accident insurance companies, occupational health insurance companies or other similar entities, within the limits of the coverage duly contracted by the member in accordance with the regulations in force.

Furthermore, they can complement the services they provide to the population through the integration of health service networks with other public or private health care facilities, duly authorized by the competent authority.

There are five health care facilities at the national level that have their own administrative-financial service, to which, the National Government budget in force as of August 2021 allocated ARS17.988 billion distributed as shown in Table 8.

Table 8. Health facilities with own administrative-financial service

In millions of ARS. Budget in force as of August 2021.

Facility	Budget in force 2021 - ARS	GDP %
National Network Hospital Specialized in Mental Health and Addictions "Licenciada Laura Bonaparte"	863.70	0.002%
Dr. Baldomero Sommer National Hospital	2,479.10	0.006%
Professor Alejandro Posadas National Hospital	11,871.44	0.028%
Dr. Manuel A. Montes de Oca National Colony	1,907.31	0.004%
National Institute of Psychophysical Rehabilitation of the South “Dr. Juan Otimio Tesone”	866.96	0.002%
Total	17,988.50	0.042%

SOURCE: OPC, based on E-SIDIF.

Additionally, as per the programmatic structure in force, the National Government funds, either fully or jointly with the respective provincial government, the functioning of six additional hospitals located in the Autonomous City of Buenos Aires (1), Province of Buenos Aires (4) and Province of Santa Cruz (1) with a budget appropriation of ARS23.538 billion as of August 2021, distributed as shown in Table 9.

Table 9. Jurisdictional hospitals funded by the National Government

In millions of ARS. Budget in force as of August 2021.

Facility	Province	Budget 2021 - ARS	GDP %
Garrahan Hospital	CABA	11,767.13	0.027%
El Cruce Hospital in Florencio Varela	Province of Buenos Aires	6,026.44	0.014%
Cuenca Alta Néstor Kirchner Hospital	Province of Buenos Aires	1,739.44	0.004%
Dr. René Favaloro Hospital	Province of Buenos Aires	1,018.29	0.002%
High Complexity Hospital of the Bicentenary in Esteban Echeverría	Province of Buenos Aires	1,192.64	0.003%
SAMIC "El Calafate" High Complexity Hospital	Province of Santa Cruz	1,794.56	0.004%
Total		23,538.50	0.055%

SOURCE: OPC, based on E-SIDIF.

Likewise, health care for the Armed Forces, National Security and Police Forces, as well as financial assistance to university hospitals also fall within the scope of the National Government, whose budget appropriation, under the budget in force as of August 2021, are shown in Table 10.

Table 10. Health care of Armed Forces, National Security and Police Forces, and financial assistance to University Hospitals

In millions of ARS. Budget in force as of August 2021.

Institution	Budget 2021 - ARS	GDP %
Argentine Federal Police	3,645.03	0.008%
National Gendarmerie	3,934.02	0.009%
Argentine Naval Prefecture	1,233.71	0.003%
Argentine Army	9,230.00	0.021%
Argentine Navy	4,066.56	0.009%
Argentine Air Force	4,702.30	0.011%
University Hospitals	6,028.32	0.014%
Total	32,839.94	0.076%

SOURCE: OPC, based on E-SIDIF.

In sum, the National Government allocates ARS74.367 billion to the functioning of Hospitals and to the health care of its own institutions, which represents 0.17% of the projected GDP to 2021.

Health care in public hospitals

The number of individuals without social security or private health insurance coverage among provinces ranges between 20% and 60%, reflecting a great disparity at the federal level

Although there is no unified and individualized record of health care in public hospitals and facilities, the population potentially covered by this subsystem is usually estimated based on the population census conducted by the INDEC or the Permanent Household Survey (EPH) of the same agency, on those persons who declared not having any type of health care coverage, whether social security or private.

Both sources estimate that an average of 36% of the population does not have health coverage, so that, in case of need, they receive public health care. Considering the projected population for 2021, it is estimated that throughout the country more than 16 million people do not have coverage and demand health services in public hospitals or facilities.

When the distribution of persons without social security coverage or private health insurance among provinces is analyzed, a wide variability is observed: in some provinces the population without coverage does not exceed 20%, whereas in others it is close to 60%. These differences remain even if extreme values are discarded.

Thus, if we consider the ratio between the second province with the highest level of coverage and the second with the lowest level of coverage, the difference continues to be significant, about three times, so that these disparities result in differences in the potential demand on the public health care system.

The use of the public health care system can be estimated by the number of outpatient medical consultations (AMC) provided in public health care facilities. The latest data on the number of AMCs published by the National Ministry of Health was for 2018, totaling more than 140 million consultations nationwide.

Table 11 combines the distribution of the estimated population without health care coverage by province with the number of AMCs per inhabitant as an approximation of the use of public health care facilities.

Table 11. Population without health care coverage, potential patients in the public subsystem and estimated number of medical consultations per person

Percentage and rates.

Province	Population without health care coverage	Number of medical consultations per person	
		Over total population	Over population without coverage
Buenos Aires	35%	4.6	13.1
CABA	18%	2.9	16.0
Catamarca	39%	1.5	3.8
Chaco	58%	2.2	3.8
Chubut	27%	1.7	6.2
Córdoba	33%	1.0	2.9
Corrientes	48%	1.8	3.7
Entre Ríos	36%	2.5	7.0
Formosa	57%	2.0	3.6
Jujuy	45%	3.3	7.3
La Pampa	32%	4.3	13.3
La Rioja	38%	3.7	9.8
Mendoza	37%	2.0	5.5
Misiones	44%	1.8	4.1
Neuquén	35%	2.1	6.0
Río Negro	34%	2.2	6.5
Salta	48%	2.7	5.5
San Juan	44%	4.7	10.8
San Luis	40%	4.0	10.1
Santa Cruz	17%	1.4	8.1
Santa Fe	32%	1.8	5.7
Santiago del Estero	56%	1.3	2.4
Tierra del Fuego	21%	2.6	12.4
Tucumán	36%	2.7	7.5
Total	36%	3.2	8.8
Max. / Min.	3.4	4.7	6.7
2nd Highest / 2nd Lowest	3.2	3.5	4.6

SOURCE: OPC, based on INDEC 2010 Population Census.

The annual average number of consultations per inhabitant in each province ranges between 1 and 4.7. Under the assumption that only those without coverage use the public health system, the annual average rises to a maximum of 16 consultations.

Although the values shown are general estimates that only allow visualizing the possible range of use of the public system for extreme cases (all inhabitants use the public system or only inhabitants without coverage use it), they are useful for analyzing the differences across the different provinces. Thus, if all the inhabitants of the country make exclusive use of the public health system, the inhabitants of the provinces that use the public system the most make between 3.5 and 5 times more consultations than the inhabitants of the provinces that use it the least. These values increase if we consider that only the population without coverage is the one that uses the public health system (between 4.6 and 6.7 times).

However, it should be noted that this record is not standardized, but counts the total number of consultations, so it is not possible to determine whether a person uses the system more than once or if those who use it belong to the province where the facility is located or come from a different one.

SUMAR Program

The National Government, through Resolution 1195/2012 of the Ministry of Health (amended by Resolution 1460/2012) created the *Sumar* Program[8], which is based on the *Nacer* Plan originally intended to provide health coverage to the maternal and child population without health insurance and extends the target population to other subgroups in the same situation, completing the coverage for all age groups and sexes by 2020.

This program provides for the care and follow-up of the population by the health system, making explicit the services that constitute their right to health, giving it precise content and scope. Thus, for each person under the Program and for each consultation and follow-up carried out, the hospital or health facility receives resources to strengthen the staff and to improve the services provided to the whole community, which would contribute to improve the planning of the public health services.

The program provides two types of coverage: first, for general services and care priorities identified in the Health Services Plan (PSS) (under the program), the Provincial Public Health Insurances (SPS) are offered. These are co-funded by the National Government and the provincial governments, with the National Government transferring funds of equal individual value to all provinces and the financing of technical assistance for the development of insurances and the equipment of health facilities. As for the provision of services, the provinces must prioritize the use of the public network of health facilities, with the possibility of resorting to the private sector in case of need. The relationship between the National Government and the provincial governments is established through the signing of Framework Agreements and Annual Management Commitments, which define the strategies and goals to be achieved.

Secondly, for high-cost and low-incidence pathologies, the National Public Health Insurances (SNS) are offered, which are entirely funded by the National Government through transfers to the provinces based on a series of performance indicators defined in the regulations for the monitoring of these pathologies.

As of June 2020 (latest available data), the Program had 17,636,541 beneficiaries, distributed by province as shown in Table 12.

[8] Also called National Public Health Insurance Development Program.

Table 12. Beneficiaries of the SUMAR Program by province

Number of beneficiaries and as a percentage of the population. As of June 2020.

Province	Beneficiaries	% of population
Buenos Aires	6,523,094	37.2%
CABA	849,392	27.1%
Catamarca	159,719	38.4%
Chaco	612,900	50.9%
Chubut	167,506	27.4%
Córdoba	1,478,007	39.3%
Corrientes	502,552	44.8%
Entre Ríos	412,833	29.8%
Formosa	349,638	57.6%
Jujuy	345,261	44.9%
La Pampa	133,449	37.1%
La Rioja	151,911	38.9%
Mendoza	708,664	35.6%
Misiones	699,783	55.6%
Neuquén	273,380	41.4%
Río Negro	169,645	22.8%
Salta	688,450	48.6%
San Juan	333,110	42.7%
San Luis	185,247	36.7%
Santa Cruz	96,496	27.2%
Santa Fe	1,492,508	42.0%
Santiago del Estero	536,488	54.9%
Tierra del Fuego	45,847	27.3%
Tucumán	720,661	42.7%
Total	17,636,541	38.9%
Max. / Mín.		2.5
2nd Highest / 2nd Lowest		2.1

SOURCE: OPC, based on National Ministry of Health

The number of beneficiaries of the SUMAR Program represents 38.9% of the Argentine population, slightly higher than the national estimates of people without social security or private coverage.

The number of beneficiaries represented 38.9% of the Argentine population as of June 2020, a value slightly higher than the estimates of the population without social security or private coverage from the 2010 Census and the Permanent Household Survey (PHS).

However, when analyzing the data by province, there are significant differences in some specific cases between the estimated population without coverage and the number of beneficiaries of the SUMAR program: the Autonomous City of Buenos Aires, Misiones, Santa Cruz, and Santa Fe have approximately 10% more of their population enrolled in the program compared to the estimated population without coverage. At the other extreme, Río Negro and Chaco has 11% and 7% fewer, respectively.

The services provided under the SUMAR Program during the first half of 2020 totaled 34,703,133, representing an average of almost two services provided per beneficiary.

For the year 2021, this Program forecasts a current budget as of August of ARS12.949 billion (which in terms of GDP represents 0.03%), within which 91.4% (ARS11.820 billion) are transfers to the provinces to finance the SPS and SNS, and 3.8% (ARS498 million) are for the procurement of health and computer equipment. The average annual expenditure per person enrolled in the program amounts to ARS734.23.

INCLUIR SALUD Program

With the purpose of guaranteeing access to health care for the beneficiaries of non-contributory pensions (PNC)[9], Resolution 1862/2011 of the Ministry of Health created the INCLUIR SALUD Program, replacing the Federal Health Program in force until that date. The program covers individuals who do not have other health care coverage, such as OSNs or private health insurance, and who voluntarily enroll in the program.

In 2018, by means of several administrative decisions, different competences that were under the scope of the Ministry of Health were transferred to the National Agency for Disability (ANDIS), including the INCLUIR SALUD Program. This transfer was originally intended to be temporary, but after successive extensions, by Resolution 1079/2021 of the ANDIS, the program was permanently established within its scope, although by including health care for all types of pensions and not only disability pensions, exceeds the Agency's core functions.

The program is implemented by contracting services through direct agreements with providers and through agreements with all provinces. As of August 2021, the Program had 980,458 beneficiaries, which represents approximately 75% of the total number of PNC beneficiaries.

The distribution by type of pension is shown in Table 13.

Table 13. Beneficiaries of the INCLUIR SALUD Program by type of pension

Number of beneficiaries and as a percentage. As of August 2021.

Type of pension	Beneficiaries	
	Number	Percentage
Disability	774,578	79.00%
Mother of 7 or more children	180,019	18.36%
Ex gratia (granted by Congress)	23,837	2.43%
Old-age pensions	1,743	0.18%
Relatives of the disappeared	182	0.02%
Others	99	0.01%
Total	980,458	100.00%

SOURCE: OPC, based on National Agency for Disability (ANDIS).

[9] It includes holders of assistential pensions (mothers with seven or more children, persons with occupational disability and persons over 70 years of age living in poverty); beneficiaries of pensions under special laws (former combatants of Malvinas, relatives of the disappeared, precursors of the Argentine Antarctic, Nobel or Olympic Prize winners, prelates, etc.) and beneficiaries of ex gratia pensions (granted by legislators of the National Congress).

The distribution of beneficiaries by province is shown in Table 14.

Table 14. Beneficiaries of the INCLUIR SALUD Program by province

Number of beneficiaries and as a percentage of the population. 2021.

Province	Beneficiaries	% of population
Buenos Aires	233,766	1.3%
CABA	19,502	0.6%
Catamarca	13,798	3.3%
Chaco	77,379	6.4%
Chubut	7,626	1.2%
Córdoba	65,206	1.7%
Corrientes	59,841	5.3%
Entre Ríos	31,943	2.3%
Formosa	38,360	6.3%
Jujuy	21,751	2.8%
La Pampa	9,011	2.5%
La Rioja	12,255	3.1%
Mendoza	33,661	1.7%
Misiones	62,854	5.0%
Neuquén	9,720	1.5%
Río Negro	11,724	1.6%
Salta	50,059	3.5%
San Juan	22,128	2.8%
San Luis	17,366	3.4%
Santa Cruz	3,286	0.9%
Santa Fe	41,062	1.2%
Santiago del Estero	79,299	8.1%
Tierra del Fuego	1,251	0.7%
Tucumán	57,610	3.4%
Total	980,458	2.2%
Max. / Min.		13.0
2nd. Highest/ 2nd. Lowest		8.6

SOURCE: OPC, based on National Agency for Disability (ANDIS).

There is a significant variability between provinces in terms of program coverage. There are provinces with more than 7% of their population enrolled in the program and others with less than 1%, a situation that highlights the differentiated needs that must be considered to strengthen health care for persons with disabilities in the different provinces of the country.

For the year 2021, the INCLUIR SALUD Program has a current budget (data as of August) of ARS39.220 billion, which represents 0.09% of GDP. The average annual expenditure per person in the program amounts to ARS37,204.1.

In conclusion, although public health care, whether provided to the population in general (public hospitals and health facilities) or to specific populations (SUMAR and INCLUIR SALUD programs), can guarantee basic levels of coverage to those who for various reasons do not have access to the other subsystems, it is subject to limitations because of the lack of a general and long-term planning of the necessary services to be provided to the population.

This translates into supply limitations reflected in the lack of specialties or treatments for some demands or in waiting lists and delayed appointments in the absence of a rapid response capacity due to a shortage of medical personnel or resources, with a greater number of inequities and differences depending on the region of the country analyzed.

The total National Government expenditure on public health care (national hospitals and care, the SUMAR program and the INCLUIR SALUD program) represents 0.29% of GDP.

Social Security subsystem

Social security can be understood as the "protection that society provides to its members through a series of public measures against economic and social deprivations that would otherwise result in the disappearance or a sharp reduction of their income as a consequence of illness, maternity, work accidents or occupational disease, unemployment, disability, old age and death"[10].

The National Constitution, in its Section 14bis, assigns the responsibility for granting Social Security benefits to the National Government, and it is incumbent upon the National Congress to legislate on Social Security matters (Section 75, subsection 12). However, Section 125 empowers the provincial governments to retain their social security agencies for government employees and professionals in their respective territories.

Under this framework, the National Government has the primary responsibility for Social Security, as opposed to public health, which is the responsibility of the provincial governments.

Social Security in the field of health care is implemented through *Obras Sociales*, institutions that operate under the concept of social insurance covering the risk of illness or loss of health. In other words, they provide coverage to their beneficiary population for a predefined selection of benefits, financing them on a contributory basis by charging contributions that do not arise from the actuarial calculation of the coverage to be provided, but represent a proportion of their gross income (contributions).

The target population of *Obras Sociales* are active formal workers (either under employment relationship or self-employed) and retirees, both with their respective family groups, whose participation in this subsystem is compulsory as long as they maintain their status.

Considering the above, health coverage within the framework of Social Security is divided into four large groups depending on the field of work and the regulations applicable to that field.

The distribution of beneficiaries among these groups is shown in Table 15.

[10] https://salud.gob.ar/dels/entradas/obras-sociales

Table 15. Population covered by Social Security by type of *obra social*

Number of beneficiaries and as a percentage

Type of *Obra Social*	Population covered	Share of total
National *Obras Sociales* (OSNs) (1)	14,967,855	53.6%
INSSJP-PAMI (1)	5,064,946	18.1%
Provincial *Obras Sociales** (OSPs) (2)	7,095,670	25.4%
Other *Obras Sociales*** (3)	800,000	2.9%
Total	27,928,471	100.0%

* As of 2014 (last available data)

** Includes Armed and Security Forces, Federal Police, Judicial Branch, Legislative Branch and Universities. Estimate is approximate because of lack of information.

SOURCE: OPC, based on: (1) data from the Superintendence of Health Services, (2) Provincial Social Security Observatory and (3) IOSFA, Federal Police and estimate based on various bibliographic sources for missing data.

The distribution observed shows that 3 out of every 4 persons covered by Social Security belong to national jurisdiction (when adding OSNs, INSSJP-PAMI and other *Obras Sociales*), whereas 1 out of every 4 is covered by provincial entities. Within this context, more than half of the population covered by the Social Security subsystem belongs to OSNs.

Contextual situation of OSNs

Before addressing the regulatory, qualitative and coverage aspects of the different types of *Obras Sociales* that comprise the social security subsystem, we should mention some characteristics of their design which should not be overlooked in the analysis.

The high levels of labor informality make the extension of social security coverage (which requires formal employment) not universal

First, considering the problem that Argentina faces in terms of registered work, where informal work has for decades represented approximately one out of every three jobs, the direct link between the benefits derived from this type of coverage and the holding of a formal job makes coverage to most of the population difficult (or impossible), thus affecting one of the basic principles of Social Security, which is to provide equitable benefits for all citizens.

In addition, recurrent macroeconomic crises generate falls in formal employment and in the income of the employed population, which in turn result in the defunding of the Social Security system, while placing greater demands on the government to cover those who leave the system and to assist OSNs in crisis due to a reduction in their revenues. These emergency situations have led to the adoption of measures which, rather than providing definitive solutions, have caused greater asymmetries and increased public spending.

The quality of the coverage received by each worker varies depending on wage levels and the number of contributors of the industry to which each worker belongs

Likewise, even among persons who do have a formal job and consequently Social Security coverage, there are significant asymmetries: as a general rule, each worker is entitled to an OSN according to the activity or industry in which he or she works, with different wage levels and number of contributors in such activity or industry, so that the coverage received by each worker varies depending on the limitations derived from both variables, thus further distancing the concept of equitable and egalitarian "social security".

This fragmentation, as well as the territorial disparities shown, affect women to a greater extent, since they have greater difficulties in entering the labor market; and when they do so, it is mostly in the informal sector or with lower relative wages and, in the event of an economic crisis, they are usually the first to lose their jobs.

Finally, the complementary policies of free choice of OSN and transfer of contributions to the private health subsystem further aggravate in practice the differences between the services provided by the different OSNs.

Social Security in the field of health is regulated by Laws No 23,660 and 23,661, from which many regulations are derived that together govern and frame the OSNs.

National Health Insurance System

The National Health Insurance System was created by Law No. 23,661, for the purpose of ensuring the full enjoyment of the right to health for all the inhabitants of the country without social, economic, cultural, or geographic discrimination.

This insurance is intended to grant equal, comprehensive, and humanized health benefits, aimed at the promotion, protection, recovery, and rehabilitation of health, meeting the best available quality, and guaranteeing the beneficiaries the same type and level of benefits, eliminating all forms of discrimination based on a criterion of distributive justice.

Law No. 23,661 also created the controlling body of the System, currently known as the Superintendence of Health Services[11], an autarchic agency under the Ministry of Health, whose purpose is to register, supervise and control the Insurance agents, as well as to regulate the system.

Under this Law, the Insurance agents are all the OSNs, both national and provincial, if the latter adhere to the system. These agents are responsible for administering the Insurance for their beneficiaries, receiving the contributions, and granting the required health benefits, either through their own providers (in a few cases) or through contracted providers (in most cases).

Public Hospitals may be Social Security providers if they are registered with the National Registry.

For a provider to render services within the framework of the System, it must be registered with the National Registry of Providers, which includes both health professionals and associations, and independent facilities or those belonging to an OSN.

In addition, public hospitals and health facilities may join the System as providers, being able to bill for the services provided to the beneficiaries of OSNs, if they are registered with the RNHPGD. On the other hand, if public hospitals and health facilities are not registered with the RNHPGD, they cannot be included in the list of providers of OSNs or bill them for the services rendered to their beneficiaries.

Finally, Law 23,661 also created the Redistribution Solidarity Fund, administered by the Superintendence of Health Services, which is funded with percentages of the contributions paid by the beneficiaries of the OSNs and subsidiarily with fines collected, investments, contributions from the Treasury and grants, among others. This fund functions as a kind of reinsurance for the agents. Law 23,661 specifies the following purposes:

- To cover the operating expenses of the Superintendency of Health Services.
- To subsidize benefits for lower income beneficiaries.
- To provide coverage for high complexity or high-cost health care services.

[11] Originally known as the National Health Insurance Administration (ANSSAL).

– To cover financial imbalances of the agents for delayed payment of beneficiaries' contributions.

The Redistribution Solidarity Fund functions as a reinsurance for the OSNs and aims to promote equity among them, although in practice various aspects prevent this principle from being fully complied with.

With these purposes, the aim is to reinforce the solidarity and equity inherent to Social Security, by providing for the equalization of health services regardless of the beneficiaries' wages through subsidies, by covering with the Fund the most complex situations (called "catastrophic" in insurance terminology), and by providing for those OSNs that do not receive the expected contributions because of employers' non-compliance.

However, as the automatic distribution of funds is only for a percentage of the amounts, the solidarity of the system, a fundamental pillar of any Social Security system, is affected (as indicated by the OSNs), by delays in transfers, discretionary decisions, and bureaucratic aspects.

The Superintendency of Health Services has different transfer lines within the framework of the Redistribution Solidarity Fund depending on the type and purpose of the contingencies to be covered:

- Single Reimbursement System (SUR): financial support to Health Insurance Agents for medical services of low incidence, high financial impact and prolonged treatment.
- Automatic Nominative Subsidy of OSNs (SANO): subsidy to OSNs beneficiaries whose contributions do not cover the minimum amount provided for in the regulations, which is distributed automatically according to the records of the Federal Administration of Public Revenues (AFIP).
- Integration: funding of the services provided for in the Nomenclature of Basic Benefits for Persons with Disabilities (Resolution 428/1999 of the Ministry of Health, as amended and derived).
- Subsidy for the Mitigation of Asymmetries (SUMA): automatic distribution of 6% of the monthly amounts paid into the Solidarity Redistribution Fund weighted by the number of beneficiaries of each OSN.
- Subsidy for the Mitigation of Asymmetries for the Special Work Regime (SUMARTE): automatic distribution of 1.5% of the monthly amounts paid into the Redistribution Solidarity Fund to supplement the contributions made by domestic workers and workers included in the Simplified Regime for Small Taxpayers (*Monotributo, Monotributo Social and Monotributo Agropecuario*), weighted by the number of this type of workers of each OSN.
- Subsidy for the Mitigation of Asymmetries for Persons Over 65 Years of Age (SUMA 65): automatic distribution of 1.2% of the monthly amounts paid into the Redistribution Solidarity Fund to complement the funding of OSNs with beneficiaries 65 years of age or older, weighted by the number of beneficiaries in such age group of each OSN.

In addition, the Superintendence of Health Services supervises the payment to Public Hospitals of Decentralized Management when they provide services to beneficiaries of OSNs, making the automatic debit of the authorized amounts from the collection account of the OSNs through the AFIP in case of non-compliance with the payments for the services provided.

Finally, the Superintendency of Health Services administers and manages circumstantial transfers and payments, such as compensation for a drop in revenues, distribution of modules for the COVID-19 pandemic, and payments for precautionary measures or court orders.

The amounts transferred for each of the items listed are shown in Table 16.

Table 16. Transfers and compensations made by the Superintendence of Health Services

In millions of ARS. As of August 2021.

Item	2021
SUR	10,229.13
SANO	2,014.76
SUMA	11,175.51
SUMARTE	5,121.04
SUMA 65	4,089.46
Integration	18,738.75
Compensation for a drop in revenues	227.71
Precautionary measures/Court orders	84.24
Modules COVID	282.93
Others	204.57
Total	52,168.09

SOURCE: OPC, based on Superintendence of Health Services.

These expenditures as of August 2021 represent 0.12% of the projected GDP for the year 2021.

Compulsory Medical Program

All beneficiaries of the National Health Insurance System are entitled to receive, at least, a set of benefits provided for in the "Compulsory Medical Program" (PMO). The PMO was originally created by Resolution 492/95 of the Ministry of Health, which was amended and supplemented by various regulations over the years, broadening its scope and content.

The provision of the benefits included in the PMO is mandatory for the insurance agents, therefore, if one of them is not able to provide the PMO to all its beneficiaries, it is required to merge with another agent to comply with the PMO. In addition, it is established that all insurance agents must allocate at least 80% of their resources to the PMO.

The PMO seeks to clearly define the mandatory coverage to be granted, providing a wide range of benefits regardless of the OSN to which the beneficiary belongs, to guarantee equity and equality for all.

The PMO provides a wide variety of benefits, including the following:

- Maternal and Infant Plan (PMI): coverage of tests, hospitalization, medications, vaccines, and milk during pregnancy and during the first years of the child's life.
- Dentistry: coverage for emergencies, diagnosis, and preventive dental care.
- Mental health: coverage of up to 30 consultations per year and 30-day hospitalization for acute conditions.
- Sexual and reproductive health: coverage for certain contraceptive methods.
- Medications: 40% coverage for general medications and 100% coverage in specific situations (HIV, cancer, hospitalization, and cystic fibrosis).

Although the existence of a PMO is based on granting equal coverage for all beneficiaries regardless of the OSN to which they belong, in practice, differences have been observed among OSNs in matters such as the administrative procedures, the availability of appointments, the number of

professionals and the proximity of the beneficiaries to the health care facilities, which leads to the existence of different categories of OSNs.

OSNs capacity to cover the PMO

There is no actuarial calculation or official estimate of the PMO's unit cost. Estimates made by independent agencies[12] indicated that, as of July 2020, the monthly cost per person of this basic benefit coverage was around ARS2,870.

Considering that OSNs framed under Law 23.660 fall within the national scope and that, therefore, with some exceptions, their beneficiaries pay their contributions to the Argentine Integrated Pension System (SIPA), the Average Taxable Remuneration of Stable Workers (RIPTE) is a reliable indicator of the average wages of the beneficiaries of OSNs, especially considering that the Redistribution Solidarity Fund works as a compensator between those who pay higher contribution and those who pay lower contributions.

At the date of the PMO estimate (July 2020), the RIPTE had a value of ARS60,440.53. Considering the percentages established by the regulations for the financing of OSNs, the contribution to Social Security for health coverage of the average wage would be around ARS5,440, which is close to double the estimate made.

However, it is important to consider that OSNs also include self-employed workers under the Simplified Tax Regime (*monotributistas*), whose contribution to the system for health coverage as of the date of analysis was ARS1,408.87 for all categories, a figure far below the amount needed to cover the PMO.

This group represents approximately 25% of the contributors to the National Social Security subsystem, so that the average contribution per person is ARS4,432, which, although to a lesser extent, is still higher than the PMO estimate.

These estimates are average values, so that in practice it can be observed that, depending on the income and labor status of their beneficiaries, some OSNs receive contributions that are sufficient to cover the PMO, while others have insufficient contributions to guarantee the PMO and the Solidarity Redistribution Fund may not operate with the necessary efficiency in such cases to make the pertinent compensations.

In addition, court rulings which in many cases oblige OSNs to provide coverage for benefits not included in the PMO may unbalance and jeopardize the solvency of these institutions, especially the smaller ones.

[12] Such as the one prepared by ISALUD University, an educational and research institution, aimed at the development of scientific and technological knowledge.

Regime for OSNs

Law 23,660 created a general and comprehensive regime for the different types of OSNs within the national scope. This regime does not include provincial *Obras Sociales* (OSPs), the National Public Sector (Legislative and Judicial Branches, Universities, Armed Forces and Security Forces) or the National Institute of Social Services for Retirees and Pensioners (INSSJP-PAMI), since they have their own regulations.

The OSNs included in the referred Law are heterogeneous in terms of their organizational and administrative characteristics and the income of their beneficiaries, thus the regulation is broad in its contents, establishing general requirements such as compliance with the PMO, the requirement of being registered with the Registry of Agents of the National Health Insurance System, the management of funds to guarantee coverage to beneficiaries residing in different regions of the country, the requirements to become and remain a beneficiary and the contributions to be paid by the beneficiaries.

Although enrollment in an OSN is compulsory and it depends on the trade union the worker belongs to and his or her labor status, Executive Order 9/93 established the free choice of OSN, allowing any beneficiary of an OSN contemplated in Law 23,660 to choose another one within the same regulatory framework.

This provision further contributed to the inequalities between OSNs, favoring the larger ones (with a larger number of members or with a high volume of contributions) and harming the smaller ones (with a smaller number of members or with a low volume of contributions), deteriorating the possibility of access to benefits for those beneficiaries who remain in the latter, thus departing from the concept of equitable "social security".

Executive Order 9/93 was recently amended by Executive Order 438/21, which establishes that workers in an employment relationship must remain for one year in the OSN applicable to their activity or industry before being able to exercise the option to change. Such situation generates a temporary incentive for smaller OSNs, but it does not improve inequalities in the medium and long term and, it does not improve the situation of workers who, depending on their activity, are covered by possibly limited or scarce health services, forcing them to maintain such coverage for the established term.

Additionally, Executive Order 292/95 sought, among other purposes, to eliminate the double enrollment generated because of multi-employment or because of being a family member of a worker in an employment relationship, allowing the unification of contributions either of the individual worker or of the latter together with his or her family group to a single OSN.

Based on the data submitted by the Superintendence of Health Services, as of June 2021, there were 290 OSNs within the framework of Law 23,660 (adding the different schemes) and they had 14,967,855 beneficiaries, distributed as shown in Table 17.

Table 17. Entities and beneficiaries of OSNs by type

Number of entities and percentage. As of July 2021

Type	Entities		Beneficiaries			
	Number	% of population	Holders	Dependents	Total	% of population
Trade union-run	212	*73.1%*	6,705,995	4,607,417	11,313,412	*75.6%*
Management and professional associations	26	*9.0%*	897,914	666,644	1,564,558	*10.5%*
By agreement with public or private entities	12	*4.1%*	26,381	25,854	52,235	*0.3%*
Others	40	*13.8%*	1,232,700	804,950	2,037,650	*13.6%*
Total	290	100.0%	8,862,990	6,104,865	14,967,855	100.0%

SOURCE: OPC, based on Superintendence of Health Services.

There is a significant prevalence of trade union-run OSN among those included in Law 23,660, with three out of every four entities and three out of every four beneficiaries belonging to this classification. Those OSN related to management personnel and employers, the second most represented, have only one out of every ten beneficiaries (with a similar distribution in terms of entities). Other schemes included in Law 23,660 have a low representation.

Nearly 75% of the entities and beneficiaries within the framework of the OSNs are of the trade union type.

If the distribution of beneficiaries OSNs under Law 23,660 by province and by their representation with respect to the population of each province is analyzed, a wide variability with respect to the national average of coverage can be observed. (Table 18)

Table 18. Beneficiaries of OSNs by province and percentage of the population covered

Number of beneficiaries and as a percentage. As of July 2021.

Province	Holders	Dependents	Total	% of population
Buenos Aires	3,487,731	2,313,857	5,801,588	33.1%
CABA	1,377,457	603,579	1,981,036	63.3%
Catamarca	56,435	43,007	99,442	23.9%
Chaco	107,271	78,908	186,179	15.5%
Chubut	122,106	102,769	224,875	36.9%
Córdoba	681,436	489,912	1,171,348	31.2%
Corrientes	129,123	118,201	247,324	22.0%
Entre Ríos	238,209	191,126	429,335	30.9%
Formosa	45,297	35,018	80,315	13.2%
Jujuy	88,064	70,504	158,568	20.6%
La Pampa	62,467	38,910	101,377	28.2%
La Rioja	46,144	41,112	87,256	22.3%
Mendoza	311,687	239,158	550,845	27.7%
Misiones	146,052	136,811	282,863	22.5%
Neuquén	107,860	77,253	185,113	28.1%
Río Negro	147,264	101,371	248,635	33.5%
Salta	171,922	144,445	316,367	22.3%
San Juan	100.,729	91,586	192,315	24.7%
San Luis	77,023	69,439	146,462	29.0%
Santa Cruz	57,904	53,567	111,471	31.4%
Santa Fe	670,048	474,378	1,144,426	32.2%
Santiago del Estero	93,349	78,486	171,835	17.6%
Tierra del Fuego	40,387	25,838	66,225	39.4%
Tucumán	229,696	201,081	430,777	25.5%
N/D	267,329	284,549	551,878	-
Total	8,862,990	6,104,865	14,967,855	33.0%
Max. / Min.				4.8
2nd Highest / 2nd Lowest				2.5

N/D: No jurisdiction data

SOURCE: OPC, based on Superintendence of Health Services.

With a federal average of 33% of the population covered by the OSNs under Law 23,660, the comparison between maximum and minimum shows a difference of almost 5 times, which is reduced to half (2.5 times) if the extreme cases are ignored, evidencing with both indicators a significant asymmetry in the formal registered work among provinces (except for provincial government employment) that give rise to these Social Security benefits.

There is a significant asymmetry among provinces with respect to national Social Security coverage.

In addition to the classification by geographical area, the population covered by OSNs can be analyzed by age range, where the average age of beneficiaries is around 35 years old; by modality of enrollment, where 54% have made use of their free choice of OSN while the remaining 46% have kept their original OSN; and by type of beneficiary, where almost 80% are workers in an employment relationship and almost 400,000 beneficiaries are retirees who chose to continue with their OSN

instead of switching to the INSSJP-PAMI. Annex IV includes several tables showing the distribution according to these classifications.

The following is an analysis of each type of OSN according to its characteristics and internal distribution of beneficiaries:

Trade Union-run OSNs

These are those entities that belong to workers' associations with union status recognized by the Ministry of Labor, Employment and Social Security and an approved collective bargaining agreement.

These OSNs are the property of the workers of the respective unions and are managed by the unions themselves. As for the legal framework, they are non-government legal entities of public law, which are private entities, but with a semi-public legal nature.

The target population of these OSNs are most private sector workers in an employment relationship and workers of the national public sector, together with their direct family members, provided that the latter are not registered in another OSN under Law No. 23,660, and their children not older than 21 years of age, extending this age up to 25 years of age if they are studying but not working. There is no age limit for coverage of disabled children.

There were two hundred and twelve (212) OSNs in Argentina as of June 2021, with 11,313,412 beneficiaries, distributed by status and sex as shown in Table 19.

Table 19. Beneficiaries of trade union-run OSNs by status and sex

Number of beneficiaries. As of 2021.

Sex	Status		Total
	Holders	Dependents	
Female	2,525,638	2,764,474	5,290,112
Male	4,180,357	1,842,943	6,023,300
Total	6,705,995	4,607,417	11,313,412

SOURCE: OPC, based on Superintendence of Health Services.

Of the union-run OSNs policyholders, 62.3% were male and 37.7% were female. Among the dependents, which include policyholders' direct family members, 60% were females and 40% were male.

The concentration of beneficiaries among the different OSNs is notably uneven: while some union-run OSNs have more than 500,000 beneficiaries (the extreme case being the Commerce Workers' OSN with 1,692,600 beneficiaries), others have fewer than 500, with the 20 largest OSNs accounting for almost two thirds of all beneficiaries, the other third being distributed among the remaining 192 OSNs.

OSNs for Management Personnel and Professional Associations

These OSNs provide benefits to hierarchical personnel with decision-making capacity and power of command in companies and organizations, are administrated by Chambers of Commerce and managed by collegiate bodies composed of representatives selected from among the beneficiaries.

As of June 2021, there were twenty-six (26) OSNs for Management Personnel and Professional Associations in Argentina with 1,564,558 beneficiaries, distributed by status and sex as shown in Table 20.

Table 20. Beneficiaries of Management Personnel and Professional Associations OSNs by status and sex

Number of beneficiaries. As of 2021.

Sex	Status		Total
	Holders	Dependents	
Female	368,853	387,393	756,246
Male	529,061	279,251	808,312
Total	897,914	666,644	1,564,558

SOURCE: OPC, based on Superintendence of Health Services.

Of the OSNs for management personnel and professional associations policyholders, 58.9% were male and 41.1% were female. Among the dependents, which include policyholders' direct family members, 58.1% were female, and 41.9% were male.

As with the union-run OSNs, the concentration of beneficiaries is high: 50% belong to a single institution, the OSN for Executive and Management Personnel (OSDE), with 783,359 beneficiaries[13], and only two others have more than 100,000 beneficiaries, accounting for 80% of the total. The remaining 20% is distributed among the other 23 OSNs.

OSNs by agreement with private or public entities

This classification groups the OSNs that were created by the companies themselves to provide social security services to their employees by signing an agreement with the competent authority for their approval and recognition as OSNs. Both the administration and the management of these OSNs vary from agreement to agreement, so there are no uniform criteria.

As of June 2021, there were twelve (12) OSNs by agreement with private or public companies with 52,235 beneficiaries, distributed by status and sex as shown in Table 21.

[13]These figures only refer to coverage under the OSN scheme and do not include members of the Prepaid health insurance also offered by the entity.

Table 21. Beneficiaries of OSNs under agreements with private or public entities by status and sex

Number of beneficiaries. As of July 2021.

Sex	Status		Total
	Holders	Dependents	
Female	7,441	16,904	24,345
Male	18,940	8,950	27,890
Total	26,381	25,854	52,235

SOURCE: OPC, based on Superintendence of Health Services.

Of the OSNs by agreement with private or public entities' policyholders, 71.8% were male and 37.7% were female. Among the dependents, which include policyholders' direct family members, 65.4% were female and 34.6% were male.

In this group, there is also a concentration in terms of number of beneficiaries, although less pronounced than in the previous categories: two OSNs have more than 10,000 beneficiaries and between them they account for more than 60% of the beneficiaries, the remaining 40% being distributed among the other ten.

Other OSNs with special characteristics

Law 23,660 includes other types of OSNs which, because of their characteristics, do not respond to the union, the management or by agreement classification. They are institutions created by special national laws or specific OSNs created within the scope of the Central Administration (that adhere to the System), autarchic agencies, OSNs of government-owned companies, and any other type of OSN that does not fall within these classifications.

The regulation of Law 23,660 establishes that it is necessary the adjustment of this type of OSNs to comply with the requirements of Laws 23,660 and 23,661.

As of June 2021, there were forty (40) OSNs of other types with 2,037,650 beneficiaries, distributed by status and sex as shown in Table 22.

Table 22. Beneficiaries of OSNs of other types by status and sex

Number of beneficiaries. As of July 2021.

Sex	Status		Total
	Holders	Dependents	
Female	543,078	460,384	1,003,462
Male	689,622	344,566	1,034,188
Total	1,232,700	804,950	2,037,650

SOURCE: OPC, based on Superintendence of Health Services.

Of this group of OSNs policyholders, 55.9% were male and 44.1% were female. Among the dependents, which include policyholders' direct family members, 57.2% were female and 42.8% were male.

In terms of dispersion, this category is the one with the lowest concentration. However, there are differences in the number of beneficiaries, since only eight OSNs of this category have more than 100,000 beneficiaries and they account for 50% of all beneficiaries, with the remaining 50% distributed among the other 32 OSNs.

There is a significant concentration of beneficiaries in a few large OSNs against many others of smaller size, thus contributing to the imbalance in the provision of equitable services

Considering the different types of OSNs, the concentration of beneficiaries in a few institutions, which to a greater or lesser extent is observed in each of the different categories of OSNs, evidences the distances and asymmetries between the health services received by the beneficiaries, since the smaller OSNs, by having a small number of beneficiaries, receive low revenues (except for those covering high-income activities or sectors). This situation affects the smaller OSNs capacity of negotiating and contracting providers, putting them at a disadvantage with respect to the quantity and quality of the services that the beneficiaries of the larger OSNs can receive, which unbalances the main purpose of Social Security, which is to provide equitable services among all its beneficiaries.

National Institute of Social Services for Retirees and Pensioners (INSSJP-PAMI)

Decree-Law 19,032 created the INSSJP-PAMI with the purpose of providing the beneficiaries of the National Social Security System and their primary family group with medical assistance services aimed at the promotion, protection, and recovery of health. The INSSJP-PAMI is the largest *Obra Social* in Argentina, with branches in all sub-national jurisdictions.

The target population of the INSSJP-PAMI are retirees who during their working life were beneficiaries of union-run or management personnel OSNs. It also provides coverage to those who retired as independent workers and to veterans of the Malvinas War.

The Institute operates as a decentralized agency of the Ministry of Health and it is a non-government legal entity of public law, with financial and administrative autonomy. The INSSJP-PAMI is managed by a collegiate body with representatives of the Government, the retirees, and the active workers.

It should be noted that, although the Institute is independent from the Central Administration in accordance with the regulations, since its Board of Directors should be composed of different representatives from different sectors, the successive interventions, as well as the regular financial support from the National Treasury make its independence not to be always verified.

The acronym "PAMI", by which the Institute is known, stands for "*Programa de Atención Médica Integral*" (Comprehensive Medical Care Program), which is the benefit plan that this *Obra Social* provides and is obliged to offer to its beneficiaries, since PAMI is not included in Law 23,660 and is not obliged to offer the PMO (Mandatory Medical Program).

As for the modality by which it provides benefits, the Institute operates as a financing entity, contracting services from the private sector and public hospitals, with only six health care facilities of its own[14]. The Institute uses the figure of the "family doctor" to follow up each beneficiary, who, in general, coordinates the health care they receive.

The INSSJP-PAMI is funded by contributions from active workers and retirees and pensioners through the withholding of a percentage of their paychecks. In addition, the Institute collects fees for services rendered, receive grants, interest generated by investments, and contributions from the National Treasury provided for in the annual budgets.

The INSSJP-PAMI target population may choose another OSN if they do not wish to join or remain in it. Beneficiaries can only choose for those OSNs registered with the Registry of Agents of the

[14] Houssay Hospital (Mar del Plata, Province of Buenos Aires); Dr. César Milstein Health Care Unit (CABA); PAMI I and II Polyclinics (Rosario, Province of Santa Fe); Esteban Echeverría Hospital of the Bicentenary (Monte Grande, Province of Buenos Aires); Ituzaingó Hospital of the Bicentenary (Ituzaingó, Province of Buenos Aires).

National Health Insurance System as recipients of retirees and pensioners (85 OSNs as of August 2021), which once registered cannot condition their enrollment for any reason.

As of June 2021, the INSSJP-PAMI had 5,064,946 beneficiaries, representing 11.2% of the estimated Argentine population in 2021 and, if only the estimated population over 60 years of age is considered, it represents nearly 70%[15].

The distribution of beneficiaries by sex and status is shown in Table 23.

Table 23. Beneficiaries of INSSJP-PAMI by status and sex

Number of beneficiaries. As of July 2021.

Sex	Status		Total
	Holders	Dependents	
Female	3,122,641	49,538	3,172,179
Male	1,872,662	20,105	1,892,767
Total	4,995,303	69,643	5,064,946

SOURCE: OPC, based on Superintendence of Health Services.

Of the INSSJP-PAMI policyholders, 62.5% were women and 37.5% were men. Among dependents, the majority were also female, 71.1%, and 28.9% were male.

Table 24 shows the INSSJP-PAMI coverage by province.

[15] The value shown represents an approximation, given that not all INSSJP-PAMI beneficiaries are over 60 years of age.

Table 24. Beneficiaries of INSSJP-PAMI by province and percentage of the population covered

Number of beneficiaries and as a percentage. As of July 2021.

Province	Holders	Dependents	Total	% of population
Buenos Aires	2,002,298	21,410	2,023,708	11.5%
CABA	508,043	1,701	509,744	16.3%
Catamarca	29,307	849	30,156	7.2%
Chaco	95,876	2,410	98,286	8.2%
Chubut	56,669	1,657	58,326	9.6%
Córdoba	462,592	8,006	470,598	12.5%
Corrientes	104,550	2,220	106,770	9.5%
Entre Ríos	152,316	4,223	156,539	11.3%
Formosa	45,292	583	45,875	7.6%
Jujuy	69,273	2,017	71,290	9.3%
La Pampa	44,578	961	45,539	12.7%
La Rioja	22,489	397	22,886	5.9%
Mendoza	245,450	2,870	248,320	12.5%
Misiones	101,763	3,563	105,326	8.4%
Neuquén	55,249	675	55,924	8.5%
Río Negro	76,904	1,018	77,922	10.5%
Salta	101,082	852	101,934	7.2%
San Juan	74,512	846	75,358	9.7%
San Luis	46,459	415	46,874	9.3%
Santa Cruz	25,774	895	26,669	7.5%
Santa Fe	413,683	8,650	422,333	11.9%
Santiago del Estero	81,888	1,224	83,112	8.5%
Tierra del Fuego	10,165	363	10,528	6.3%
Tucumán	154,339	1,826	156,165	9.3%
N/D	14,752	12	14,764	
Total	4,995,303	69,643	5,064,946	11.2%
Max. / Min.				2.8
2nd Highest/ 2nd Lowest				2.0

N/D: No jurisdiction data.

SOURCE: OPC, based on Superintendence of Health Services.

The variability observed for the INSSJP-PAMI is not as significant as for OSNs for the active population. However, the difference between extremes is 2.8 times, and between the second highest and the second lowest is 2 times.

Although there are different levels of coverage among provinces, INSSJP-PAMI has a wide coverage throughout the country.

These differences may be explained by demographic aspects, since some regions have a larger number of older adults than others (main beneficiaries of the INSSJP-PAMI), which means that a larger portion of the population in those regions is covered.

However, at the federal level there is a wide extension of semi-contributory or non-contributory pensions and retirement benefits among the older adults[16] covered by the INSSJP-PAMI, which explains part of the differences observed.

For the year 2021, the INSSJP-PAMI budget includes resources for ARS456.4 billion, based on different items (Table 25).

Table 25. INSSJP-PAMI budget

In millions of ARS. 2021.

Item	Amount - ARS
Tax Revenues	94,136.52
Non-Tax Revenues	295.55
Social Security Contributions	250,727.81
Current Transfers	108,547.69
Other Current Revenues	2,692.67
Total	456,400.24

SOURCE: OPC, based on INSSJP-PAMI.

The PAMI budget, adding all its items, represents 1.1% of GDP in 2021.

Obras Sociales of the National Public Sector

These *Obras Sociales* (OS) group workers of certain agencies or entities of the National Government. Included in this group are the OSs of the Judiciary, the Directorate of Social Assistance for the Personnel of the Congress of the Nation, the OSs of Universities, the OS of the Armed Forces (IOSFA)[17] and the Superintendence of Welfare of the Federal Police.

These entities are not subject to a regulatory framework or a common control entity. They are government public entities.

During the year 2021, requests for information were sent to the above-mentioned agencies, receiving a response only from the IOSFA and the Superintendence of Welfare of the Federal Police.

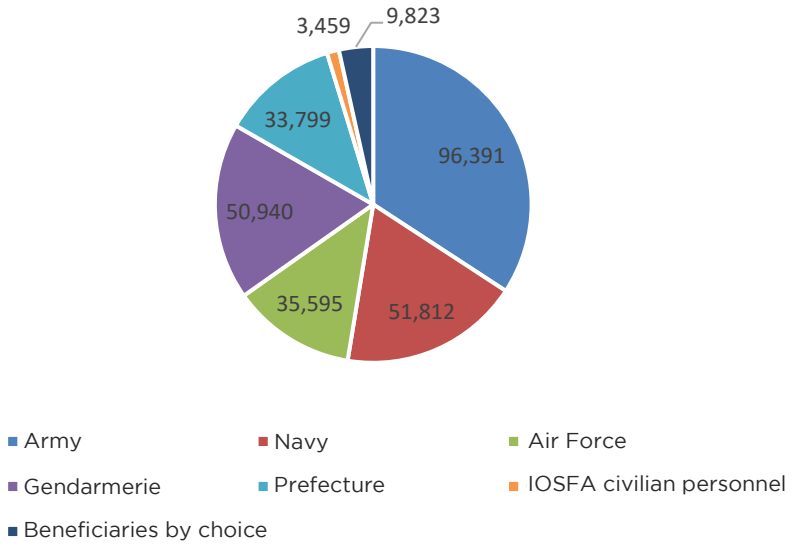
The IOSFA had 281,819 beneficiaries as of May 2021, distributed by Force (or other origin) as shown in Figure 1.

[16] The Argentine Integrated Pension System (SIPA), through moratoriums, allows the retirement of workers who have not reached the required number of years of formal contributions, that is, those who in their working life were not formally employed and therefore were nor covered by a OSN. Additionally, for those who cannot join the pension system because they do not meet the general requirements or those of the moratoriums, there is the Universal Pension for Older Adults (PUAM). With both types of benefits, the coverage of older adults exceeds 90% of this population group throughout the country.

[17] *Obra Social* for military personnel of the three Armed Forces and for Gendarmerie and Prefecture personnel.

Figure 1. Distribution of IOSFA beneficiaries by origin

Number of beneficiaries. 2021.



SOURCE: OPC, based on IOSFA.

On its part, the Superintendence of Welfare of the Federal Police reported that as of June 2021 it had 172,302 beneficiaries, of which 85,617 were holders and 86,685 dependents.

As for the OS of the Judiciary, the information provided by the Judicial Information Center (CIJ) indicated that, as of October 2021, this institution had 99,759 beneficiaries, of which 47,923 were holders and 51,835 were dependents.

As no data is available for the remaining entities, it is estimated that there are approximately 250,000 beneficiaries distributed among them, so that the total estimated for this group is 800,000 beneficiaries.

Provincial *Obras Sociales* (OSP)

The twenty-four subnational jurisdictions have their own *Obras Sociales* whose target population is the government employees of their respective territories[18]. OSPs are public entities, which are part of the central administrations of the provincial governments.

These institutions are grouped in the Council of *Obras Sociales* and Social Services of the Argentine Republic (COSSPRA), which is a non-profit organization.

OSPs have the common characteristic of being systems created on the same basis as OSNs through solidarity health systems, where each beneficiary contributes proportionally to his or her income and receives the benefits he or she needs, with the aim of guaranteeing equal access to health care for all beneficiaries.

Although OSPs are created on the same basis as OSNs, none of them has adhered to Law 23,661, evidencing another instance of disparity in the coverage provided by Obras Sociales in Argentina

However, none of the OSPs are part of Law 23,660 and have not adhered to Law 23,661, so they are not part of the National Health Insurance System and are not supervised by the Superintendence of Health Services. In addition, they are not

[18] The independent professionals registered in each of the sub-national jurisdictions also have their own Obras Sociales, which fall under the scope of their jurisdictions.

obliged to comply with the PMO, which implies that in each jurisdiction the services to be provided may be different and depend on the capacity and availability of facilities and professionals in the territory, again generating differences in terms of access to health care.

There is no updated database available on the population coverage of OSPs. The latest available data are from 2014 and were published by the Provincial Social Security Observatory of the COSSPRA (Table 26)[19].

Table 26. Beneficiaries of OSPs and percentage of the population covered

Number of beneficiaries and percentage. As of 2014.

Province	OSPs beneficiaries	% of population*
Buenos Aires	1,934,467	11.7%
CABA	260,000	8.5%
Catamarca	163,104	41.5%
Chaco	242,518	21.5%
Chubut	123,487	22.2%
Córdoba	550,572	15.6%
Corrientes	132,871	12.5%
Entre Ríos	266,331	20.4%
Formosa	110,761	19.3%
Jujuy	172,390	24.0%
La Pampa	84,057	24.7%
La Rioja	125,700	34.7%
Mendoza	770,048	41.3%
Misiones	177,851	15.1%
Neuquén	201,500	33.0%
Rio Negro	127,814	18.6%
Salta	260,615	19.8%
San Juan	134,326	18.4%
San Luis	79,840	17.0%
Santa Cruz	115,000	36.9%
Santa Fe	536,061	15.9%
Santiago del Estero	166,144	18.1%
Tierra del Fuego	49,412	33.4%
Tucumán	310,801	19.8%
Total	7,095,670	16.6%
Max/Min		4.9
2nd highest / 2nd lowest		3.5

* Percentages are based on the estimated population in 2014 according to projections from the 2010 Census-INDEC.

SOURCE: OPC, based on Provincial Social Security Observatory of the COSSPRA.

There is a significant variability among provinces, with a difference of almost five times between the province with the highest number of the population covered by its OSP and the lowest, being 3.5 times if the extreme cases are discarded and the second highest and lowest are considered. This situation is a strong indicator of the prominence of provincial government employment in overall provincial employment.

[19] The data are presented in an aggregated manner not being possible its disaggregation between holders and dependents.

The OSPs are funded by the government employees' own contributions and by provincial budgets. They do not receive direct funding from the National Government.

Private subsystem

The third modality of health care in Argentina is the private subsystem which is regulated by Law 26,682. The entities offering health services within the framework of this subsystem are all those individuals or legal entities whose total or partial purpose is to provide prevention, protection, treatment, and rehabilitation of human health to their members, through voluntary pre-paid health insurance plans.

Under these terms, this subsystem operates in the form of an insurance by option (unlike the Social Security subsystem, which is compulsory) through which coverage is provided for a series of contingencies predefined by contract for which a premium is charged that varies according to the actuarial calculation of the risk (unlike Social Security, where the premium is the result of a percentage of the worker's wages or income paid as contributions and, in the event of possible insufficiencies of premiums, the Solidarity Redistribution Fund intervenes).

The regulation establishes that all the entities included under this framework are obliged to provide, as a minimum, the health services provided for in the Mandatory Medical Program (PMO) and in the Basic Benefits System for Persons with Disabilities, except for those entities that have less than 5,000 members and operate in only one district[20]. The rendering of services by these entities may be carried out by means of their own providers or through third parties linked or contracted for such purpose.

The controlling body of private health entities is the National Ministry of Health, through the Superintendence of Health Services, which oversees compliance with the regulatory provisions, grants operating licenses, manages the National Registry of Private Health Insurance Companies (RNEMP) with which all licensed entities must be registered, determines the technical-actuarial conditions and the values of the fees for the services to be provided in order to guarantee free competition, determines the standard contracts between entities and members and entities and providers, and receives and manages members' claims in the event of possible contractual breaches.

Since the services provided are derived from the relationship between private parties through voluntary enrollment, the regulation does not determine a target population and any person with the capacity to contract may opt for enrollment, with acceptance or rejection being at the discretion of the entity. However, the regulation establishes some specific cases and situations that prevent these entities from refusing enrollment:

[20] These entities are exempted because it is considered that, since they carry out activities in only one district, i.e., in a limited geographical area, the capacity to obtain and manage the equipment, supplies and professionals needed to provide mandatory comprehensive coverage is difficult (if not impossible) to comply with. In addition, as they have few members, their revenue is low, so that the possibility of acquiring such services is even more limited.

- Age: the age of the person cannot be a criterion for rejection[21].
- Pre-existing conditions: if a person has a pre-existing condition at the time of contracting, he or she cannot be rejected, but the entity may charge a differential authorized by the controlling body for coverage[22].
- Acute conditions: if a person is suffering from a non-chronic condition at the time of contracting, he or she cannot be rejected, but the entity may charge a differential for such condition, which must be temporary, and the term of duration must be informed.

These entities may establish waiting periods (i.e., pre-established minimum periods that must elapse prior to the provision of a given service) for any benefit that is not included in the PMO or in the mandatory coverages. Any waiting period must be explicitly stipulated in the contracts and may not be longer than 12 months from the date of contract execution.

The coverage may be extended, by means of the payment of the applicable supplements, to the member's family group. For these purposes, the following are considered as members of the family group: the spouse, unmarried children up to 21 years of age (or up to 25 years of age if they are students), and disabled children, regardless of their age.

Transfer of Social Security contributions to the Private Subsystem

Several OSNs offer their beneficiaries the so-called "supplementary plans", which consist of providing not only the PMO, but also additional benefits not contemplated therein. In addition, some OSNs, although they do not offer a supplementary plan on their own, sign agreements with private health insurance companies or with other OSNs to offer additional coverage to their beneficiaries.

This type of "supplementary" coverage falls within the private sector, so that those who offer it (either through supplementary plans or through a private health insurance company) are entities framed within Law 26,682.

Beneficiaries of OSNs may choose to transfer their contributions to the Private Subsystem, which may affect the financing and equity of Social Security.

Beneficiaries who choose this type of coverage transfer their Social Security contributions to the private entity offering the supplementary plan, having to pay the difference between the amount contributed and the technical-actuarial value of the premium for the chosen plan. These options affect the financing and equity of the Social Security subsystem, having a strong impact on its equity objective, especially considering that, in general, those who choose this option are those who have a greater volume of contributions, a situation known as "skimming".

However, given that in these cases the private health insurance companies assume the role of coverage of mandatory health care benefits under the Social Security framework, and that the choice of a supplementary plan can only be made once a year (which implies the obligation to maintain the same coverage for at least one full year), the choice of a supplementary plan does not contemplate waiting periods for the additional services offered, unlike the voluntary enrollment in a private health insurance company, since this type of arrangement is a hybrid between Social Security and voluntary enrollment in private health insurance.

[21] Those who intend to contract services and are 65 years of age or older, where the risk and demand for services increases, must be accepted, but the entity may charge a higher premium (up to 3 times the value of the premium of a younger person), the amount of which must be authorized and validated by the controlling body. If a person reaches the age of 65 and has been a member of the entity for more than 10 years, the premium cannot be increased for age-related reasons.
[22] Considering that the person who intends to contract services with these entities must sign an affidavit in which they inform, among other things, the existence of pre-existing conditions, if such information is misrepresented, the contract may be cancelled.

The offering of supplementary plans or the enrollment in private health insurance companies is beneficial both for the Health Insurance Agents and for the entities of the Private Subsystem. In the case of the former, they receive a percentage of the beneficiary's contributions and transfer all or most of the risk to the latter since they transfer the responsibility of offering services by outsourcing it; in the case of the latter, they increase the volume of members and can request, through the OSN linked or agreed with, resources from the Redistribution Solidarity Fund since the member receives services within the framework of the Social Security system.

Finally, it is also important to point out that the possibility of contribution transfers, combined with the mentioned Executive Order 9/93 on the free choice of OSN and Executive Order 292/95 on the unification of contributions, has contributed to the increase in the mobility of beneficiaries among OSNs, since many beneficiaries choose supplementary plans in specific entities of their preference, which further concentrates the health care service in a few entities.

Classification of private health care entities

Section 1 of Law 26,682 specifies which are the private health care entities, collectively called Prepaid Medicine Enterprises (EMP), regulated by this regime, recognizing six types: Health Insurance Companies, OSNs with supplementary plans, Cooperatives, Mutuals, Partnerships, and Foundations. The Superintendence of Health Services added as "others" those entities that are included in this regulation, but do not comply with the mentioned corporate types.

Based on the data provided by the Superintendence of Health Services, as of May 2021, there were a total of 159 entities (including all types), with a total of 6,218,032 members. Table 27 shows the disaggregation of the entities and members by type of entity.

Table 27. Private health care entities and members

Number of members and percentages. As of May 2021.

Type	Entity		Members			
	Number	% of population	Holders	Dependents	Total	% of population
Health Insurance Companies	55	*34.6%*	1,317,807	1,126,134	2,443,941	*39.3%*
OSNs with supplementary plans	30	*18.9%*	1,139,818	1,112,076	2,251,894	*36.2%*
Cooperatives	2	*1.3%*	93,986	77,029	171,015	*2.8%*
Mutuals	51	*32.1%*	437,181	285,859	723,040	*11.6%*
Partnerships	17	*10.7%*	332,955	262,116	595,071	*9.6%*
Foundations	3	*1.9%*	10,303	6,653	16,956	*0.3%*
Other types	1	*0.6%*	8,347	7,768	16,115	*0.3%*
Total	159	100.0%	3,340,397	2,877,635	6,218,032	100.0%

SOURCE: OPC, based on Superintendence of Health Services.

Health Insurance Companies and OSNs with supplementary plans are those that account for the largest share of the private health insurance market

Health Insurance Companies and OSNs with supplementary plans are those that account for the largest share of the private health insurance market, each one having a little more than a third of all members. Among the other types, mutuals have the largest share.

These distributions do not correlate with the number of entities, since mutuals account for almost the same number of members as health insurance companies, each one representing more than 30% of the entities.

An analysis of the distribution of members of EMPs by province and their representation with respect to the population of each province shows the greatest variability in population coverage among all the systems analyzed (Table 28).

Table 28. Members of EMPs by province and percentage of the population covered

Number of members and percentages. As of July 2021.

Province	Holders	Dependents	Total	% of population
Buenos Aires	1,387,567	1,256,794	2,644,361	15.1%
CABA	837,410	584,613	1,422,023	45.4%
Catamarca	18,237	15,214	33,451	8.0%
Chaco	18,624	14,651	33,275	2.8%
Chubut	38,755	42,122	80,877	13.3%
Córdoba	271,534	243,782	515,316	13.7%
Corrientes	21,785	20,809	42,594	3.8%
Entre Ríos	56,665	49,000	105,665	7.6%
Formosa	7,156	5,867	13,023	2.1%
Jujuy	12,525	14,509	27,034	3.5%
La Pampa	19,890	16,580	36,470	10.1%
La Rioja	7,047	7,607	14,654	3.7%
Mendoza	80,046	81,261	161,307	8.1%
Misiones	25,124	19,919	45,043	3.6%
Neuquén	42,612	43,659	86,271	13.1%
Río Negro	36,481	35,072	71,553	9.6%
Salta	29,237	31,736	60,973	4.3%
San Juan	18,463	22,967	41,430	5.3%
San Luis	16,235	18,405	34,640	6.9%
Santa Cruz	21,180	26,501	47,681	13.5%
Santa Fe	237,095	201,420	438,515	12.4%
Santiago del Estero	12,078	9,879	21,957	2.2%
Tierra del Fuego	14,696	13,815	28,511	16.9%
Tucumán	35,099	33,021	68,120	4.0%
N/D	74,856	68,432	143,288	
Total	3,340,397	2,877,635	6,218,032	13.7%
Max. / Min.				21.2
2nd Highest / 2nd Lowest				7.5

SOURCE: OPC, based on Superintendence of Health Services.

The difference in coverage of the private subsystem is the most significant: between the province with the highest and lowest coverage (with respect to its total population) there is a difference of 21.2 times.

Comparing the province with the highest number of members and the one with the lowest (in relation to its population), there is a difference of 21.2 times. If the extreme cases are not considered and the second with the highest private coverage is compared to the second with the lowest coverage, the difference is still significant, at 7.5 times.

This situation can be explained by the lower private coverage offer in some provinces, since many EMPs only operate in

selected areas where there is a high concentration of population with medium and high-income levels.

In addition, the characterization of members of EMPs can be made by age range, which shows an average age of 38 years old, and by relationship or kinship with the holder (Annex V).

Each type of entity is analyzed below by general characteristics and internal distribution of members:

Health Insurance Companies

Health insurance companies are for-profit entities, but their purpose is not merely commercial in nature, since, by providing health services, they also have a social purpose, so they must comply with all the health standards determined by the authority and the amounts to be charged as premiums must be authorized and validated by the latter.

The relationship between the company and the member is established through an adhesion contract, by means of which the parties are mutually obliged: one to provide health services to the member and the other, to pay a premium.

Three types of contracts with a private health insurance company are available:

- Individual: individuals contract voluntarily for themselves or for themselves and their family group the services offered by the Health Insurance Company, paying periodically the premium for the plan chosen among those offered.
- Corporate Business: a company contracts with a Health Insurance Company to provide health coverage to all or part of its employees (for example, only for management personnel), with the contracting company being responsible for the payment of the premiums. This contract does not replace the obligation to pay contributions to the Social Security but complements it.
- Transfer from Social Security: a person may choose to transfer his Social Security contributions to a Health Insurance Company under the terms previously mentioned, through a OSN with which the Health Insurance Company has an agreement.

As of May 2021, there were fifty-five Private Health Insurance Companies in Argentina with 2,443,941 members, distributed by status and sex as shown in Table 29.

Table 29. Members of Private Health Insurance Companies by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	583,875	657,442	1,241,317
Male	733,932	468,692	1,202,624
Total	1,317,807	1,126,134	2,443,941

SOURCE: OPC, based on Superintendence of Health Services.

Of Health Insurance Companies policyholders, 55.7% were male and 44.3% were female. Among the dependents, which include policyholders' direct family members, 58.4% were female and 41.6% were male.

The company with the largest number of members (Swiss Medical) had more than 800,000 members as of May 2021, and the second largest (Galeno) had more than 500,000 members. Both companies account for 60% of members. Only five companies have more than 100,000 members (Swiss Medical, Galeno, Omint, Medicus and Paramedic), concentrating 80% of the total. This situation shows a strong concentration of members in a few companies, a characteristic that is accentuated if we consider that approximately 23% of the private health insurance companies have less than 1,000 members per company.

Supplementary plans of voluntary enrollment

OSNs within the framework of Laws 23,660 and 23,661 may offer supplementary plans for more services. These plans are of voluntary enrollment and are managed in the private sector, and therefore regulated by Law 26,682.

The relationship between the OSNs and the member who chooses a supplementary plan is implemented under the same conditions as between a Private Health Insurance Company and its members: they sign a contract which can be individual, corporate or by transfer of contributions, and pay a premium.

The main difference between Private Health Insurance Companies and OSNs with supplementary plans is of a legal nature since they have a different regulatory framework. The former are governed by private law, while the latter are non-government entities of public law.

As of May 2021, there were 30 OSNs in Argentina with supplementary plans with a total of 2,251,894 members, distributed by status and sex as shown in Table 30.

Table 30. Members of OSNs with supplementary plans by status and sex

Number on members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	522,046	652,488	1,174,534
Male	617,772	459,588	1,077,360
Total	1,139,818	1,112,076	2,251,894

SOURCE: OPC, based on Superintendence of Health Services.

Of the OSNs with supplementary plans policyholders, 54.2% were male and 45.8% were female. Among the dependents, 58.7% were female and 41.3% were male.

Of those members, 86% belonged to one OSN with supplementary plans (OSDE), and if the two with the largest number of members (OSDE and ACCORD) are counted together, they have 96.5% of the members, the remaining 3.5% being distributed among the other 28 OSNs with supplementary plans, with an average of 2,800 members each, which makes this subgroup the most concentrated one in the private health care subsystem.

Cooperatives

Cooperatives were originally excluded from Law 26,682, but by means of Necessity and Urgency Decree (DNU) 1991/2011 they were included within the framework of that Law, on the grounds that the inclusion was made to avoid distortions and to harmonize the private health system. Therefore, the provision of services and the relationship with their members is similar to those previously analyzed and, again, the difference is of a legal nature. Under Law 20,337 on the cooperative system, cooperatives are defined as "entities created through their own efforts and mutual aid to organize and provide services", and are not for profit, with solidarity as their essential value. For tax and regulatory purposes, they are framed within the different existing regulations for this type of entities.

As of May 2021, there were two Cooperatives in Argentina with the purpose of providing health benefits either totally or partially, with 171,015 members, distributed by status and sex as shown in Table 31.

Table 31. Members of health care cooperatives by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	41,753	45,249	87,002
Male	52,233	31,780	84,013
Total	93,986	77,029	171,015

SOURCE: OPC, based on Superintendence of Health Services.

Of the health cooperatives plans policyholders, 55.6%, were male and 44.4% were female, but among dependents 58.7% were female and 41.3% were male.

Ninety-six percent of the members of this category belonged to one cooperative (ACA Salud), with the remaining 4% belonging to the other.

Mutuals

As with Cooperatives, they were included within the framework of Law 26,682 by means of DNU 1991/2011 and only have legal differences with respect to other entities. In accordance with Law 20,321 on Mutual Associations, mutual associations are " the associations freely formed for non-profit purposes by persons inspired by solidarity, with the purpose of providing mutual assistance to each other in case of contingencies or to contribute to their material and spiritual wellbeing, by means of a periodic contribution".

In most cases, they are associations that were originally created to provide various services (health, tourism, financing, etc.) to workers in a company or industry.

Within the private entities offering health services, mutual associations are the second largest in number after the Private Health Insurance Companies, totaling 51 as of May 2021, which together comprise 723,040 members, distributed by status and sex as shown in Table 32.

Table 32. Members of mutual health organizations by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	210,335	168,998	379,333
Male	226,846	116,861	343,707
Total	437,181	285,859	723,040

SOURCE: OPC, based on Superintendence of Health Services.

Of the mutual health organizations plans policyholders, 51.9% were male and 48.1% were female. Among dependents, 59.1% were female and 40.9% were male.

One of the mutuals (SANCOR Salud) has more than 50% of the members of this type of health coverage, with only two having more than 100,000 members (SANCOR Salud and FEDERADA Salud).

Partnerships (Asociaciones civiles)

As Cooperatives and Mutual Associations, Partnerships were included within the framework of Law 26,682 through DNU1991/2011, under the same terms as the former. In accordance with Section 168 of the Civil and Commercial Code, "The partnership (*asociación civil*) shall have an object that is not contrary to the general interest or to the common good. The general interest is interpreted as the respect for different identities, beliefs, and traditions, whether cultural, religious, artistic, literary, social, political, or ethnic, which do not infringe constitutional values". They are also not-for-profit organizations, and in most cases, this is the corporate type adopted by major Hospitals and Medical Associations for the health care plans they offer.

As of May 2021, there were 17 Partnerships in Argentina totally or partially aimed at providing health care services, with 595,071 members, distributed by status and sex as shown in Table 33.

Table 33. Members of Health Care Partnerships by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	168,005	152,510	320,515
Male	164,950	109,606	274,556
Total	332,955	262,116	595,071

SOURCE: OPC, based on Superintendence of Health Services.

Of the Health Care Partnerships plans policyholders, 50.5% were female, and 49.5% were male. Among dependents, 58.2% were female and 41.8% were male.

Only two Partnerships have more than 100,000 members (Medifé and Hospital Italiano), which together account for 66.5% of the members in this category.

Foundations

The last typology included within the framework of Law 26,682 by means of DNU 1991/2011 and in the same terms as the previous ones are the Foundations, which are defined in Section 193 of the Civil and Commercial Code as "non-for-profit legal entities created for the common good through the contribution of one or more persons, with the purpose of achieving their goals".

Only three Foundations, whose total or partial purpose is to provide health services, operated in Argentina as of May 2021, with 16,956 members, distributed by status and sex as shown in Table 34.

Table 34. Members of Health Care Foundations by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	5,349	3,621	8,970
Male	4,954	3,032	7,986
Total	10,303	6,653	16,956

SOURCE: OPC, based on Superintendence of Health Services.

Of the Health Care Foundations plans policyholders, 51.9% were female and 48.1% were male. Among dependents, 54.4% were female and 45.6% were male.

One of the three foundations (Fundación Médica Mar Del Plata) accounted for 80% of all members, with the other two accounting for the remaining 20%.

Other schemes

The Superintendence of Health Services also includes the health service provided by the Professional Council of Economic Sciences of the Autonomous City of Buenos Aires, called "*Consejo Salud*", within the framework of Law 26,682. Although it does not adopt one of the schemes mentioned, since it is a non-profit organization, it is included in DNU1991/2011. Since 2018, *Consejo Salud* channels its benefit through a single provider, the Private Health Insurance Company Swiss Medical, maintaining the relationship with the members.

As of March 2021, "*Consejo Salud*" had 16,115 members, distributed by status and sex as shown in Table 35.

Table 35. Members of *Consejo Salud* by status and sex

Number of members. As of May 2021.

Sex	Status		Total
	Holders	Dependents	
Female	3,556	4,665	8,221
Male	4,791	3,103	7,894
Total	8,347	7,768	16,115

SOURCE: OPC, based on Superintendence of Health Services.

Of the "*Consejo Salud*" policyholders, 57.4% were male and 42.6% were female. Among dependents, 60.1% were female and while 39.9% were male.

In conclusion to this section, it can be observed that the number of policyholders is greater than the number of dependents in all cases. The proportions between the two are relatively similar within each group, where the most even situation is observed in the supplementary plans offered by the OSNs, where 50.6% are holders and 49.4% are dependents, and the most uneven is observed in the Foundations, where 60.8% are holders and 39.2% are dependents.

In most cases, the number of male holders is higher than the number of female holders, mirroring the situation observed in the labor market

A comparative analysis of the distribution by sex in the different groups shows that only Foundations and Partnerships have a higher number of female holders than male, and in all cases the number of female dependents is always higher, a situation that mirrors the reality of the labor market, where most formal jobs are held by men.

Evaluation of the Health System

The ultimate purpose of organizing a health system is to achieve the highest standards of health for the population, understood as the reduction of mortality and morbidity from preventable causes, as well as the extension of life expectancy.

Therefore, to evaluate the performance of a health system in global terms, population, and aggregate indicators (as opposed to individual indicators) are analyzed to understand the dynamics of the overall health and well-being of a specific population group and its disaggregation by region, sex, and age, thus observing possible differences or heterogeneities in this disaggregation.

Within this framework, the literature specialized in the evaluation of health systems places special emphasis on the measurement of infant mortality as the main global indicator of countries' health performance, since it is highly related to the socioeconomic conditions of the population, as well as to the accessibility and quality of health systems.

Consequently, various general population health indicators and particularly maternal and child health indicators are analyzed in this section, both at the national level and by province, sex, or age group, which allows us to evaluate in general terms the performance of the Argentine health system through the health status of its population.

The data refers to the year 2019, last published by the National Ministry of Health, which allows understanding and knowing the population health without considering the effect caused by the COVID-19 pandemic, obtaining a structural vision instead of a circumstantial one, without ignoring that the pandemic has originated changes that may affect the structure of the health system whose impact may be clearly evaluated in the following years.

General population health indicators

First, the general birth and mortality indicators are presented, which show the number of births and deaths, respectively, per 1,000 inhabitants (and per 1,000 live births for infant mortality), for each province (Table 36).

Table 36. Birth and mortality rates (general and infant) by province

As a percentage. 2019.

Province	Birth rate	Mortality rate	
		General	Infant
Buenos Aires	13.1%	7.9%	9.1%
CABA	11.1%	10.1%	7.3%
Catamarca	13.9%	6.1%	10.5%
Córdoba	13.7%	8.1%	7.5%
Corrientes	16.3%	6.7%	12.0%
Chaco	18.6%	6.9%	12.4%
Chubut	12.9%	5.5%	7.8%
Entre Ríos	14.0%	7.7%	9.8%
Formosa	17.1%	6.4%	13.6%
Jujuy	13.6%	5.9%	9.9%
La Pampa	12.1%	6.9%	9.1%
La Rioja	13.7%	5.9%	10.3%
Mendoza	13.9%	7.3%	8.3%
Misiones	18.4%	5.8%	9.6%
Neuquén	14.4%	5.4%	5.4%
Río Negro	13.3%	6.3%	7.8%
Salta	16.3%	5.7%	10.6%
San Juan	16.2%	6.7%	9.3%
San Luis	13.2%	6.7%	8.6%
Santa Cruz	13.3%	4.5%	7.4%
Santa Fe	13.4%	8.5%	8.2%
Santiago del Estero	17.5%	6.6%	6.6%
Tucumán	15.0%	6.8%	13.3%
Tierra del Fuego	14.2%	3.4%	7.1%
Total	13.9%	7.6%	9.2%
Max. / Min.	1.7	3.0	2.5
2nd Highest/ 2nd Lowest	1.5	1.9	2.0

SOURCE: OPC, based on DEIS, Ministry of Health.

The highest birth rates occurred mainly in the northern provinces

The highest birth rates occurred mainly in the provinces of northern Argentina, with Chaco and Misiones having the highest number of births per 1,000 inhabitants. At the other extreme, the Autonomous City of Buenos Aires had the lowest birth rate.

Provinces with the highest number of older adults are those with the highest population mortality rates

In terms of general population mortality, the Autonomous City of Buenos Aires was the only one to show double digits in the indicator, with a little more than 10 deaths per 1,000 inhabitants. This jurisdiction is followed by Santa Fe and Córdoba in number of deaths. This situation is mainly explained by the demographic distribution of these provinces, since they have the highest proportion of older adults, with ages at which the probability of death is high.

In general terms, infant mortality is higher in the provinces of northern Argentina than in the rest of the country

Infant mortality showed a high variability among provinces, and it was generally observed that in the northern provinces it is much higher than in the south, where the rates are lower. The exception to this trend is Santiago del Estero, which has one of the lowest infant mortality rates in the country, according to official data.

Birth rates are relatively stable throughout the country since the comparison between extreme cases shows a difference of 1.7 times and of 1.5 times if the second highest and second lowest values are considered.

As for general population mortality, the gaps are larger, where the province with the highest mortality rate is 3 times higher than the province with the lowest rate. If the extreme cases are discarded and the second highest is compared with the second lowest, the gap is reduced to almost half.

Finally, the gap between extremes in infant mortality is 2.5 times and is reduced to 2 times when the highest and lowest values are excluded.

The results observed for annual mortality by age group in each province are shown in Table 37.

Table 37. Distribution of annual mortality rate by province

As a percentage. 2019.

Province	Under 1 y/o	1-9	10-19	20-34	35-49	50-64	65-79	80 and older	Not specified
Buenos Aires	1.5%	0.5%	0.7%	2.7%	5.1%	14.8%	33.0%	40.5%	1.2%
CABA	0.8%	0.2%	0.2%	1.4%	3.4%	10.8%	28.5%	54.7%	0.1%
Catamarca	2.4%	0.6%	1.3%	4.1%	6.1%	16.7%	33.6%	35.2%	0.0%
Córdoba	1.3%	0.5%	0.7%	2.5%	4.4%	13.0%	33.9%	43.9%	0.0%
Corrientes	2.9%	1.0%	1.2%	4.6%	6.3%	18.9%	34.2%	31.0%	0.0%
Chaco	3.4%	0.7%	1.7%	4.4%	6.4%	20.2%	34.2%	29.0%	0.0%
Chubut	1.8%	0.5%	1.0%	4.4%	6.6%	16.8%	32.6%	36.4%	0.0%
Entre Ríos	1.8%	0.4%	0.9%	2.5%	5.4%	15.2%	34.4%	39.4%	0.0%
Formosa	3.6%	1.1%	1.8%	5.0%	8.0%	20.4%	31.9%	28.2%	0.0%
Jujuy	2.2%	0.7%	1.7%	4.9%	7.8%	16.5%	33.6%	32.7%	0.0%
La Pampa	1.6%	0.4%	0.5%	3.1%	4.0%	13.4%	34.8%	42.1%	0.1%
La Rioja	2.4%	0.6%	1.4%	4.6%	6.7%	17.8%	35.0%	31.3%	0.1%
Mendoza	1.6%	0.6%	0.8%	2.7%	4.8%	12.7%	35.5%	41.3%	0.0%
Misiones	3.0%	1.1%	1.7%	4.7%	6.8%	19.0%	34.3%	29.3%	0.0%
Neuquén	1.4%	0.6%	1.1%	3.8%	8.0%	17.5%	33.2%	34.4%	0.0%
Río Negro	1.7%	0.5%	0.8%	3.7%	6.2%	15.9%	33.1%	38.0%	0.2%
Salta	3.0%	1.0%	1.6%	5.1%	7.3%	16.1%	33.1%	32.8%	0.0%
San Juan	2.3%	0.6%	1.0%	2.8%	4.8%	14.4%	38.0%	36.1%	0.0%
San Luis	1.7%	0.5%	1.3%	3.3%	5.6%	14.8%	35.8%	37.0%	0.0%
Santa Cruz	2.2%	0.5%	1.0%	4.5%	9.3%	22.0%	32.7%	27.8%	0.1%
Santa Fe	1.3%	0.4%	0.9%	2.8%	4.5%	13.5%	32.9%	43.7%	0.0%
Santiago del Estero	1.8%	0.8%	1.6%	4.9%	7.4%	17.9%	34.3%	31.4%	0.0%
Tucumán	2.9%	0.5%	1.4%	4.5%	6.5%	15.5%	34.9%	33.8%	0.0%
Tierra del Fuego	2.9%	0.7%	1.7%	4.5%	8.3%	25.5%	33.0%	23.4%	0.0%
Total	1.7%	0.5%	0.9%	3.0%	5.2%	14.8%	33.1%	40.3%	0.6%

SOURCE: OPC, based on DEIS, Ministry of Health.

Life expectancy in the provinces of northern Argentina, as well as in San Juan and Tierra del Fuego, is lower than in the rest of the country.

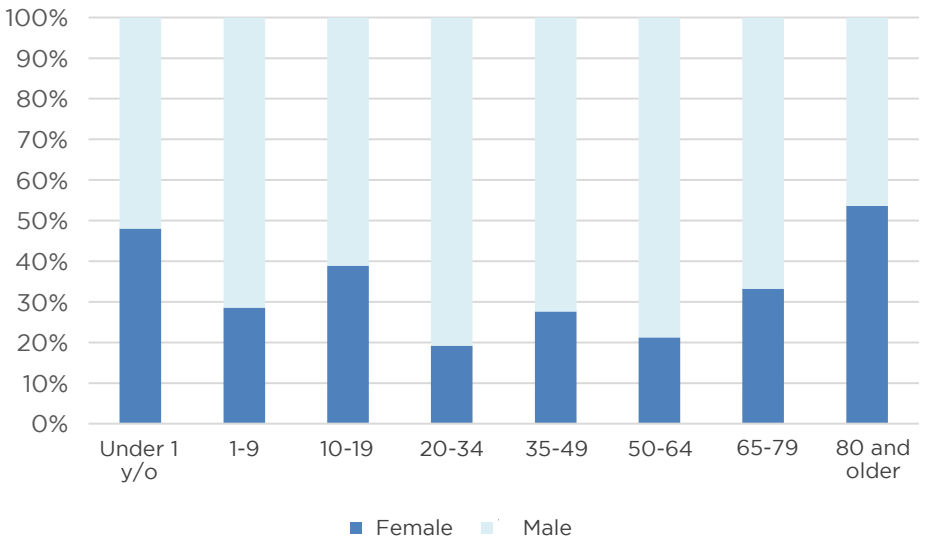
In all cases, the highest number of deaths occurred in the higher age groups, i.e., those aged 65 years and older. However, in the provinces of northern Argentina, as well as in San Juan and Tierra del Fuego, the age group between 65 and 79 years of age has a higher mortality rate than that of 80 years and older (the highest for the other provinces), which implies that, in approximate terms, life expectancy in these provinces is lower than in the other provinces.

In addition, these same provinces are the ones with the highest mortality in children under 1 year of ages, some of them accounting for more than 3% of deaths in this age group.

At the national level, mortality by age group divided by sex shows a higher probability of death for men than for women in most cases, except for the extremes where the values are similar for both sexes. Within each jurisdiction, this distribution is relatively stable and similar to the national average (Figure 2).

Figure 2. Distribution of deaths by age group and sex

As a percentage. 2019.



SOURCE: OPC, based on DEIS, Ministry of Health.

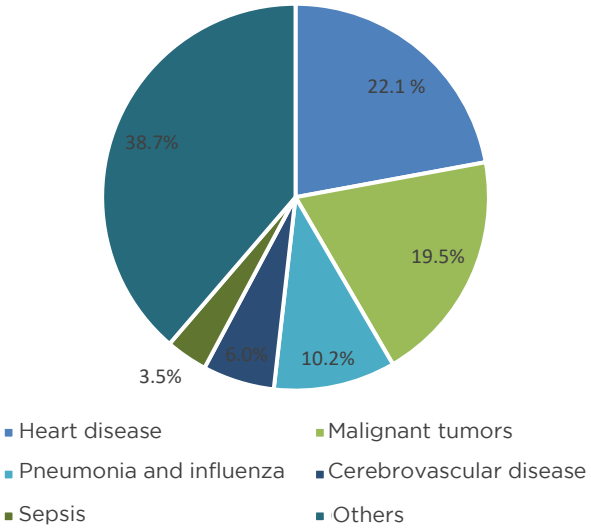
Figure 2 shows that mortality in children under 1 year of age is not particularly related to biological sex since it is associated with specific pathologies of this stage of life and with medical conditions at the time of birth. On the other hand, considering that women have a longer life expectancy than men, the increase in the "80 and older" age group is explained by the fact that more women survive to reach the last age group.

Causes of death indicators

As for the main causes of death, five causes can be identified that together explain practically 2 out of every 3 deaths, whose proportional distribution is shown in Figure 3.

Figure 3. Leading causes of deaths in Argentina

As a percentage. 2019.



SOURCE: OPC, based on DEIS, Ministry of Health.

Heart disease is the leading cause of death in the country for all age groups

Heart disease is the leading cause of death in the country for all ages, accounting for 22.1% of duly registered deaths, followed by malignant tumors, which accounted for 19.5% of deaths.

However, for each age group the leading causes of death vary, as the risks are different:

- In children from 0 to 4 years of age: perinatal conditions, and congenital malformations.
- In children and adolescents between 5 and 14 years of age: accidents, and malignant tumors.
- In adolescents and young adults between 15 and 24 years of age: accidents, self-inflicted injuries, and assaults.
- In adults between 25 and 34 years of age: accidents, malignant tumors, and self-inflicted injuries.
- After the age of 34: although in different proportions, the leading causes of death for all age groups were heart disease and malignant tumors.

In terms of maternal mortality, the average mortality ratio at the national level was 3 maternal deaths per 10,000 births in the year under analysis, although the analysis by province shows different values. Additionally, the causes of death also show a wide variability (Table 38).

Table 38. Maternal mortality by province and cause

Number of deaths and percentages. 2019.

Province	Number of deaths	Cause of death				Maternal mortality ratio per 10,000 births
		Abortion	Direct	Indirect	Late	
Buenos Aires	72	13.9%	47.2%	23.6%	15.3%	2.7
CABA	10	30.0%	40.0%	20.0%	10.0%	2.6
Catamarca	4	50.0%	50.0%	0.0%	0.0%	7.0
Córdoba	10	0.0%	70.0%	30.0%	0.0%	2.0
Corrientes	10	0.0%	70.0%	30.0%	0.0%	5.5
Chaco	17	0.0%	70.6%	17.6%	11.8%	6.8
Chubut	1	0.0%	100.0%	0.0%	0.0%	1.3
Entre Ríos	6	0.0%	33.3%	16.7%	50.0%	1.6
Formosa	7	0.0%	71.4%	14.3%	14.3%	5.9
Jujuy	2	0.0%	50.0%	50.0%	0.0%	1.9
La Pampa	3	0.0%	100.0%	0.0%	0.0%	7.0
La Rioja	2	50.0%	0.0%	50.0%	0.0%	3.8
Mendoza	15	0.0%	33.3%	6.7%	60.0%	2.2
Misiones	16	0.0%	25.0%	18.8%	56.3%	3.0
Neuquén	1	0.0%	0.0%	0.0%	100.0%	-
Río Negro	2	50.0%	50.0%	0.0%	0.0%	2.0
Salta	13	15.4%	46.2%	23.1%	15.4%	4.8
San Juan	2	0.0%	0.0%	50.0%	50.0%	0.8
San Luis	2	0.0%	0.0%	50.0%	50.0%	1.5
Santa Cruz	2	50.0%	0.0%	50.0%	0.0%	4.2
Santa Fe	12	0.0%	58.3%	25.0%	16.7%	2.1
Santiago del Estero	7	28.6%	57.1%	14.3%	0.0%	4.1
Tierra del Fuego	0	-	-	-	-	-
Tucumán	15	20.0%	66.7%	13.3%	0.0%	6.0
Total	231	10.8%	49.8%	20.8%	18.6%	3.0
Max. / Min.						8.8
2nd Highest / 2nd Lowest						5.4

SOURCE: OPC, based on DEIS, Ministry of Health.

Ten provinces show a maternal mortality ratio above the average, with four of them with a value more than twice the national average.

In terms of causes, mortality due to direct obstetric causes is the most prevalent in 22 of the 24 provinces, with late death (42 days after delivery) linked to childbirth being the most prevalent cause in the two remaining provinces.

In conclusion, it can be inferred that the variability observed between provinces in terms of both the availability of health facilities and professionals and access to health coverage is generally reflected in the different rates and indicators shown, with higher levels of mortality (infant and maternal) and lower life expectancy in those jurisdictions with less availability and access to health coverage.

ANNEX I – Health promotion policies

Table 39. Description of activities and works for health promotion by government agency and dimension

In millions of ARS. As of August 2021.

Agency	Budget action	Current budget	Dimension
National Atomic Energy Commission	Environmental Management and Nuclear Safety	253.34	Environment
	Radioactive Waste Management	119.19	Environment
	Uranium Mining Environmental Restitution (IBRD 7583-AR PPF 352-PRAMU)	94.74	Environment
	Low Activity Radioactive Waste Treatment (PPF 352)	61.81	Environment
National Parks Administration	Fire Management	45.88	Environment
	Conservation Policy Planning and Formulation	182.79	Environment
	Natural Protected Areas Operational Management	89.93	Environment
National Road Safety Agency	Road Safety Awareness	59.37	Security
	Coordination of Road Control and Inspection, Interjurisdictional and Standardization of Regulations	539.26	Security
General Secretariat of the Presidency of the Nation	Support to Railroad Safety in the Metropolitan Area of Buenos Aires (FONPLATA ARG-38/2018)	28.51	Transportation
	Regional Transportation Infrastructure (IDB 4841/OC -AR)	4,061.92	Transportation
Secretariat of Comprehensive Policies on Drugs (SEDRONAR)	Strengthening of Scientific Knowledge	56.39	Community development
Office of the Chief of Cabinet of Ministers	Management and Administration of the Argentina 2030 Program	15.86	Community development
	Generation of Discussion Spaces in the Argentina 2030 Program.	6.86	Community development
Ministry of Health	Social - Health - Environmental Strengthening for the Matanza-Riachuelo Basin Community	2.10	Environment
	Promotion of Actions aimed at Preserving Environmental Health.	5.00	Environmental Health
	Promotion and Control of Responsible Dog and Cat Ownership and Health	73.46	Environmental Health
Ministry of Social Development	Strengthening of Early Childhood Spaces and Home Interventions (IDN No. 4229/OC-AR) (NNA)	376.60	Community development
	Actions linked to the Socio-Urban Integration Program in Low-income Neighborhoods (IDB No. 4804/OC-AR-OC)	1,437.10	Community development
	Comprehensive Approach to Low-income Neighborhoods	1,540.57	Community development
	Comprehensive Community Development	219.64	Community development
	Support to Socially Vulnerable Households	601.52	Community development
	Comprehensive Support to "*El Estado En Tu Barrio*" Program	45.00	Community development
	Community Strengthening for Human Development	12.50	Community development
Ministry of Environment and Sustainable Development	Multiple Environmental Actions for the Promotion of Sustainable Development Goals in Argentina (CAF 770/17)	4.38	Environment
	Sustainable Land Management in the Cuyo and NOA Regions (UNDP ARG/14/G55)	35.00	Environment
	Integration of Biodiversity Conservation and Sustainable Land Management in Development Planning (UNDP ARG 19/G24)	150.00	Environment
	Environmental Management of Water and Aquatic Ecosystems (UNDP ARG 19/G24)	35.02	Environment
	Implementation of the Guarani Aquifer Strategic Action Program - GEFSEC ID 10139	2.20	Environment
	Strengthening Management and Protection of Coastal Marine Biodiversity and Implementation of the Ecosystem Approach in Fisheries (GEF 5112-BD-GCP/ARG/025/GFF)	82.00	Environment
	Integration of the Sustainable Use of Biodiversity in the Practices of Small Producers (UNDP ARG/15/G53)	84.23	Environment
	Biodiversity Protection Through the Formulation and Implementation of the National Strategy on Invasive Alien Species (GCP/ARG/023/GFF)	30.00	Environment
	Implementation of the Nagoya Protocol (GEF Project 5820-UNDP ARG 16/G54)	20.00	Environment

Agency	Budget action	Current budget	Dimension
	Conservation in Sectoral and Intersectoral Public Policies and in Programs to Safeguard Threatened Wildlife (PNUD ARG19/G28)	70,91	Environment
	National Program for the Protection of Native Forests	25,00	Environment
	National Fund for the Enrichment and Conservation of Native Forests and Community (IBRD No. 8493)	1,212.42	Environment
	Support for the Implementation of the National Strategic Plan for the Sustainable Management of Palo Santo-Bulnesia Sarmientoi (UNDP ARG 19/004)	98.83	Environment
	Cooperative Fund for Forest Carbon (IBRD TF019086)	17.80	Environment
	Ozone Layer Protection, Institutional Strengthening (UNDP ARG 14/G61)	110.00	Environment
	Adaptation to Climate Change in Cities and Vulnerable Coastal Ecosystems of the Uruguay River (Argentina-Uruguay Regional Project) (AF/AU/RIOU/G1)	13.70	Environment
	Initiative for Transparency in Climate Action Argentina (ICAT)	56.14	Environment
	Strengthening of Capacities for Climate Transparency Argentina (CBIT - GEF 9955)	5.33	Environment
	Standardization and Implementation of Environmental Impact Assessment (EIA) and Strategic Environmental Assessment (SEA)	37.46	Environment
	Development and Implementation of Sustainable Production, Consumption and Construction Programs.	6.41	Environment
	Design and Implementation of a Multi-Media Platform on Climate Change Mitigation and Adaptation	0.01	Environment
	Conservation in Sectoral and Intersectoral Public Policies and in Programs to Safeguard Threatened Wildlife (PNUD ARG19/G28)	13.23	Information
	Design and Implementation of a National GHG Inventory and CC Mitigation Measures Monitoring System.	3.02	Environment
	Positioning Argentina as a Proactive Country in Climate Matters in Multilateral Forums.	0.05	Environment
	Implementation of the National Program of Entrepreneurs for Sustainable Development.	0.05	Environment
	Environmental Risk Analysis	10.74	Environment
	Support for the Implementation of National Contributions (PNUD ARG 19/007)	49.51	Environment
	Implementation of Law on Minimum Budgets for Adaptation and Mitigation of Global Climate Change (Law 27520).	0.41	Environment
	Support for the Design of the National Adaptation Plan (UNDP ARG/19/003)	77.85	Environment
	Strengthening the Identification of Regulatory Frameworks for Climate Finance Research (ECF G-2011-03977)	1.80	Environment
	Construction in Public Domain Assets within the Framework of the Argentina-Uruguay Regional Project - Adaptation Fund (AF/AU/RIOU/G1)	19.12	Environment
	Development of Social and Territorial Policies	153.54	Community development
	Comprehensive Management of Urban Solid Waste - (IDB No. 3249/OC-AR)	280.84	Environment
	Promotion of Biogas Generation from Urban Solid Waste (GEF-UNDP ARG 16/G23)	88.21	Environment
	Environmental Quality	0.70	Environment
	Contaminated Sites Program (PROSICO)	2.43	Environment
	Environmentally Sound Management of POPs, Mercury, and other Hazardous Chemical Substances in Argentina (UNDP ARG 20/G27)	122.67	Environment
	Creation of the Environmental Monitoring Network	7.26	Environment
	Creation of the Federal Network for Environmental Control and Oversight.	99.83	Environment
	Control of Vehicle Emissions for Homologation	468.88	Environment
	Design of Universal Generation Special Waste Collection Programs	2.81	Environment
	Strengthening of National Capacities for Chemical and Waste Management (UNDP ARG 17/010)	1.30	Environment
	National Fire Management Service	85.35	Environment

Agency	Budget action	Current budget	Dimension
	Institutional, Technical and Scientific Cooperation for the Contribution of Environmental Public Policies / Argentina - Portugal (MOU).	10.00	Environment
	Sanitary Landfill in the Metropolitan Area of Mendoza (IDB No. 3249/OC-AR)	2.00	Environment
	Construction of a Sanitary Landfill and a Materials Recovery Plant in the City of Concordia (IDB No. 3249/OC-AR).	75.00	Environment
	Construction of a Sanitary Landfill and a Materials Recovery Plant in the Metropolitan Area of Formosa (IDB No.3249)	55.65	Environment
	Construction of a Sanitary Landfill and a Materials Recovery Plant in the Alto Valle de Río Negro (IDB No. 3249/OC-AR)	2.00	Environment
	Recovery of Contaminated Sites in Barrio Pampa, Lanus (IDB No. 3249/OC-AR)	9.05	Environment
	Recovery of Contaminated Sites - Emporio Tanque, Quilmes	80.00	Environment
	Recovery of Contaminated Sites at Piazza Tannery	100.00	Environment
	Construction of a Sanitary Landfill for the City of Paraná and Neighboring Municipalities (IDB No.3249)	22.16	Environment
	Construction of the Environmental Center of Colón, Entre Ríos (IDB No.3249)	2.00	Environment
	Construction of CNG Biogas System Rafaela (GEF-UNDP ARG 16/G23)	2.00	Environment
	Construction of the Tapalqué Biodigester (GEF-UNDP ARG 16/G23).	7.80	Environment
	Construction of Transfer Plants and Equipment for Sanitary Landfill in the Tupungato Region, Mendoza (IDB No.3249)	12.47	Environment
	Construction of a Sanitary Landfill and a Materials Recovery Plant in Corrientes (IDB No.3249).	2.00	Environment
	Biogas Generation Facility in Gualeguaychú, Province of Entre Ríos, based on the use of methane collection in the city's landfill (GEF-UNDP ARG 16/G23).	22.80	Environment
	Installation for Biogas Generation through Methane Capture in a Sewage Water Stabilization Lagoon (GEF-UNDP ARG 16/G23).	10.80	Environment
	Construction and Installation of a Biodigester in the Central Market of the Municipality of Escobar (GEF-UNDP ARG 16/G23).	7.80	Environment
	Biogas Generation from MSW in a Landfill according to INTI Report (GEF-UNDP ARG 16/G23).	21.90	Environment
	Provision and Installation of Biodigesters in 5 Technical and Agricultural Schools in the Province of Buenos Aires (GEF-UNDP ARG 16/G23).	0.82	Environment
	Construction of a Comprehensive Solid Waste Center in Luján (IDB No. 3249)	26.35	Environment
	Construction of a Comprehensive Solid Waste Center in Chascomús, Dolores, Ranchos, and surrounding areas (IDB No. 3249)	2.00	Environment
	Construction of a Comprehensive Solid Waste Center in Partido de la Costa (IDB No. 3249)	1.80	Environment
	Construction of a Comprehensive Solid Waste Center in Miramar (IDB No. 3249)	1.80	Environment
	Construction of a Comprehensive Solid Waste Center in the City of Córdoba (IDB No. 3249)	73.00	Environment
	Construction of a Comprehensive MSW Center: Córdoba, Small Municipalities Consortium: Consortium 1 (IDB No. 3249)	2.57	Environment
	Construction of a Comprehensive MSW Center: Córdoba, Small Municipalities Consortium: Consortium 2 (IDB No. 3249)	2.57	Environment
	Construction of a Comprehensive MSW Center: Córdoba, Small Municipalities Consortium: Consortium 3 (IDB No. 3249)	2.57	Environment
	Construction of a Comprehensive Solid Waste Center in Reconquista, Avellaneda, Guadalupe Norte and Nicanor Molinas (IDB No. 3249)	2.30	Environment
	Construction of Comprehensive Solid Waste Center in Microregion 2 of La Pampa (IDB No. 3249)	2.40	Environment
	Construction of a Comprehensive Solid Waste Center in Micro-region 7 of La Pampa - Santa Rosa (IDB No. 3249)	2.50	Environment

Agency	Budget action	Current budget	Dimension
	Construction of a Comprehensive Solid Waste Center in La Banda (IDB No. 3249)	2.00	Environment
	Construction of a Comprehensive Solid Waste Center in Chaco (IDB No. 3249)	6.50	Environment
	Construction of a Comprehensive Solid Waste Center in Salta (IDB No. 3249)	0.00	Environment
	Construction of a Comprehensive Solid Waste Center in La Rioja (IDB No. 3249)	0.00	Environment
	Construction of Socio-Environmental Center Ecoparque Quilmes (IDB No. 3249)	75.05	Environment
	Construction of Strengthening Center in Avellaneda - Containers in Public Schools (IDB No. 3249)	27.16	Environment
	Construction of a Strengthening Center in Avellaneda - Containers in Gerli (IDB No. 3249)	70.41	Environment
	Construction of a Strengthening Center in Avellaneda - Recovery of Used Vegetable Oil (IDB No. 3249)	4.00	Environment
	Construction of a Strengthening Center in Avellaneda - Tire Retreading (IDB No. 3249)	0.00	Environment
	Construction of a Strengthening Center in Moreno (IDB No. 3249)	74.70	Environment
	Construction of a Strengthening Center in Almirante Brown (IDB No. 3249)	0.00	Environment
	Construction of a Comprehensive MSW Center in Villarino - Province of Buenos Aires (IDB No. 3249)	2.00	Environment
	Construction of Comprehensive MSW and Strengthening Centers - Buenos Aires Project: ACUMAR (IDB No. 3249)	2.00	Environment
	Construction of Separation Plant - Santo Tomé Corrientes (IDB No. 3249)	0.00	Environment
	Construction of MSW Center - Gualeguaychú (IDB No. 3249)	2.65	Environment
	Construction of MSW Center Florencio Varela (IDB No. 3249)	0.00	Environment
	Construction of USW Center Rosario - Santa Fe (IDB No. 3249)	0.00	Environment
	Construction of RSU Center Baradero - San Pedro (IDB No. 3249)	0.00	Environment
	Construction of San Juan USW Center (IDB No. 3249)	0.00	Environment
	Construction of MSW Center Chivilcoy - Buenos Aires (IDB No. 3249)	0.00	Environment
	Construction of Works to Address Social Situations in Argentina (IDB No. 3249)	2.28	Community development
	Construction of a Biogas Generation System for Fishing Waste, in the Virch Valdes Area, Province of Chubut (GEF-UNDP ARG 16/G23)	12.00	Environment
	Development and Implementation of Production and Sustainable Consumption Programs.	1.06	Environment
	Promotion of Sustainable Cities	588.63	Environment
	Energy Efficiency and Renewable Energies in Argentine Social Housing (GEF ARG 1002 IDB AR 15083)	19.97	Environment
	Integrated Low-Carbon Investments and Conservation in Argentine Cities Project - GEF 7	23.50	Environment
	Program for the Consolidation of Entrepreneurs and Sustainable Projects (GEF 7)	5.60	Environment
Ministry of Tourism and Sports	Sports Infrastructure and National Sports Centers	455.92	Sports
	National Competitions	210.23	Sports
	Neighborhood and Village Sports Clubs	1,091.72	Sports
	Federated and National Representation Sports	887.61	Sports
	Sports Initiation Schools	143.50	Sports
Ministry of Internal Affairs	Assistance to Municipalities for Social Infrastructure	3,000.00	Community development
	Development of Metropolitan Areas outside the Greater Buenos Aires - DAMI II (IDB No. 3780/OC-AR)	546.98	Community development
Argentine Federal Police	Deployment of regions outside the Greater Buenos Aires	14,149.67	Security
	Prevention and Fight against Drug Trafficking	2,251.78	Security
	Transportation Safety	1,303.31	Transportation
	Public Order Maintenance	2,018.11	Security

Agency	Budget action	Current budget	Dimension
	Federal Aeronautical Cooperation, Search and Rescue	377.81	Security
	Provision of Additional Police Service	1,744.04	Security
Ministry of Transportation	Support to the Equity and Effectiveness of the Social Protection System in Argentina (IDB No.4648-AR)	171.00	Community development
	Procurement of Rolling Stock - Roca Railroad	16,565.31	Transportation
	Procurement of Rolling Stock - Belgrano Sur Railroad	3,610.93	Transportation
	Transportation Infrastructure	21,750.83	Transportation
	Comprehensive Renovation of the Belgrano Sur Railroad M Branch Line - Tapiales - Marinos del Crucero General Belgrano Section (CAF 11175)	2,665.36	Transportation
	Undergrounding of the Sarmiento Railroad	2,872.03	Transportation
	Comprehensive Improvement of the General Roca Railroad - Constitución - La Plata Branch (IDB No.2982/OC-AR)	7,120.29	Transportation
	Adaptation of Stations and Rolling Stock (IDB No. 2982/OC-AR-OC)	297.60	Transportation
	Underpasses (IDB No. 2982/OC-AR-AR)	9.50	Transportation
	Renovation and Upgrading of Track and Track Equipment (IDB No. 2982/OC-AR-OC)	2,510.52	Transportation
	Perimeter Fences (IDB No. 2982/OC-AR-IDB)	310.84	Transportation
	Electrification of San Martín Railroad (IDB No. 4265/OC-AR)	6,154.35	Transportation
	Project Management - San Martín Railroad	108.00	Transportation
	Viaduct Elevation, Extension of Railway Laying and Construction of New Terminal Station Constitución - Belgrano Sur Railroad (CAF No. 10180/FONPLATA No. 23/2015)	2,830.79	Transportation
	Track and Corridor Renewal of the General Belgrano Cargas Railway (CDB S/N)	12,516.72	Transportation
	Rehabilitation of the Belgrano Cargas Railroad (CDB S/N)	100.00	Transportation
	Air Transportation Infrastructure	435.65	Transportation
	Airport Infrastructure Improvement (CAF S/N)	77.61	Transportation
	Support to the Single Electronic Ticketing System	16.25	Transportation
	Support to the infrastructure of the Single Electronic Ticketing System	1,703.58	Transportation
	Mass Transportation Management	489.18	Transportation
	Expansion and Improvement of Urban Bus Stops	2,258.13	Transportation
	Comprehensive Renovation of Long and Medium Distance Bus Terminals	4,578.87	Transportation
	Implementation of an Integrated Federal Non-Motorized Mobility System	1,440.28	Transportation
	Development of Equitable Public Transportation in Urban Centers	2,682.14	Transportation
	Development and implementation of Comprehensive Sustainable Mobility	1,743.64	Transportation
	Dredging and maintenance of the Barranqueras Stream	25.01	Environment
	Reconversion of TVF (Border Town Transportation) Misiones	5.00	Transportation
	Reconversion of TVF Docks (Border Town Transportation) Formosa	5.00	Transportation
Secretariat of Energy	Energy, Gas and Petroleum Infrastructure Works in Santa Cruz	3,500.00	Services
	Construction of Gas Pipeline Center II	0.00	Services
	Construction of Gas Pipeline Center II	0.00	Services
	Expansion of de la Costa and Tandil - Mar del Plata Gas Pipeline System	0.00	Services
	Expansion of de la Costa and Tandil - Mar del Plata Gas Pipeline System	0.00	Services
	Expansion of the Cordillerano - Patagónico Gas Transportation System	0.00	Services
	Expansion of the Cordillerano - Patagónico Gas Transportation System	0.00	Services
	Natural Gas Supply Subsidies	113,702.37	Services
	Stimulus to the Production of Natural Gas (Gas Plan II - Resolution CPyCE of the PNIH No. 60/2013).	0.00	Services

Agency	Budget action	Current budget	Dimension
	Stimulus to the Production of Natural Gas (Gas Plan III - Resolution CPyCE of the PNIH No. 74/2016).	0.00	Services
	Implementation of the Unconventional Gas Plan MINEM Resolution No. 46/2017.	58,056.91	Services
	Stimulus to the Production of Natural Gas (New Scheme 2020 - 2024)	55,645.46	Services
	Natural Gas and LPG Demand Subsidies	34,544.67	Services
	Hogares con Garrafas Program (Law No. 26,020)	13,882.25	Services
	Compensation for Tariff Bonus for Residential Users of Natural Gas and Propane Undiluted through Networks (Resolution No. 148/19).	0.00	Services
	Percentage Deferral in the Payment of Residential Users (Resolution No. 336/2019).	1,345.44	Services
	Nuclear Energy Policy Actions	48.40	Services
	Actions to Support the Increase of Efficiency of the Salto Grande Hydroelectric Complex (IDB 4694/OC-RG)	812.56	Services
	Evaluation and Promotion of Electric Infrastructure	3,464.94	Services
	Sustainability of the Electricity Market	441,749.97	Services
	Renewable Energies in Rural Markets Project (IBRD No. 8484)	2,127.61	Services
	Promotion of Distributed Generation	14.42	Services
	Rational and Efficient Use of Energy Actions	17.00	Services
	Actions for Energy Efficiency in Public Lighting-PLAE	100.00	Services
	Actions and Policies in the Productive, Residential and Transportation Sectors	12.05	Services
	High Voltage Line Rincón Santa María - Resistencia (CAF No. 8517)	539.00	Services
	Support for the Construction of Hydroelectric Developments in Santa Cruz River, Condor Cliff - La Barrancosa (CDB No. 201401)	14,781.94	Services
Ministry of Education	Connectivity and Infrastructure	1,238.33	Community development
Ministry of Culture	Inter-ministerial Social Support	3.48	Community development
	Grants, Awards and Federal Aids	2.81	Community development
	Incentive to Virtual Platforms	3.15	Information
Ministry of Security	Federal Security Programming and Cooperation with the Legislative Branch	34.38	Security
	Financial Assistance to Jurisdictions to Develop Operational Capacities	2.79	Security
	Actions for Civil Protection, Prevention and Disaster Risk Reduction	4,085.25	Security
	Actions for the National System for the Comprehensive Management of Risks (SINAGIR)	2.82	Security
	Actions of the National Fire Management Service	282.88	Security
	Actions to Control and Fight against Drug Trafficking	68.93	Security
	Federal Intervention Actions	51.97	Security
	Border Coordination, Design, Monitoring, Control and Surveillance Actions	26.47	Security
	Control, Planning and Operational Intervention for the Prevention of Crime	11.46	Security
	Barrios Seguros Program	20.17	Security
National Council for the Coordination of Social Policies	Articulation of Sustainable Development Goals	68.19	Community development
	National System of Information and Evaluation of Social Policies and Programs (IDB No. 4648/OC)	90.95	Information
Obligations of the Treasury	Financial Assistance to Potable Water Sector Companies for Actions in the Matanza - Riachuelo Basin	16.85	Services
	Financial Assistance to Potable Water Sector Companies	75,516.88	Services
	Financial Assistance to Transportation Sector Companies	2,996.20	Transportation
	Financial Assistance to Companies in the Potable Water Sector for Actions in the Matanza - Riachuelo Basin	1,883.13	Services
	Financial Assistance for Actions in the Matanza - Riachuelo Basin	3,853.00	Environment
	Financial Assistance to Public Enterprises and Other Ministry of Transportation Entities	138,913.11	Transportation

Agency	Budget action	Current budget	Dimension
	Financial Assistance for the Passenger Transportation Infrastructure Plan	14,034.85	Transportation
	Financial Assistance for Passenger and Freight Railroad Works	530.00	Transportation
	Social Promotion and Assistance	24,304.95	Community development
	Ecology and Environment	4,132.00	Environment
Ministry of Productive Development	Mining Environmental Management (IDB No. 1865/OC-AR)	1.38	Environment
	Sustainable Mining Development	24.34	Environment
	Environmental Management	0.38	Environment
Ministry y Public Works	Sanitation Actions (IBRD No. 7706-AC)	50.00	Services
	Industrial Pollution Reduction and Environmental Management (IBRD No. 7706-AC)	13.55	Environment
	Sanitation Actions (IBRD No. 9008-AC)	500.00	Environment
	Industrial Pollution Abatement and Environmental Management (IBRD No. 9008-AC)	97.40	Environment
	Construction of Industrial Liquid Effluent Treatment Plant PIC Lanús (IBRD No. 7706-AC)	1,697.90	Environment
	Water Sanitation and Sewerage - Tres Rosas, San Blas (Villa 21/24) (IBRD No. 7706-AC)	315.00	Environment
	Sewage Disposal-Las Heras-Cañuelas-Pte. Peron (IBRD No. 7706-AC)	2.10	Environment
	Execution of Underpass Works	2,557.30	Transportation
	Execution of Urban and Rural Connectivity Surfacing Works	2,035.00	Transportation
	Execution of Interjurisdictional Surfacing Works	2,357.70	Transportation
	Development of Potable Water and Sanitation Infrastructure - Argentina Hace Plan	392.28	Services
	Execution of Social Care Infrastructure Works and Urban Recreational Equipment	1,022.00	Community development
	Enhancement and Re-functionalization of the Mitre Railroad Station	17.36	Transportation
	Construction of Hurlingham Sports Center	15.00	Sports
	Construction of Environmental Interpretation Centers - ACUMAR	2.50	Environment
	Development of Urban Spaces for Sports and Recreation	1.00	Sports
	Development of Environmental Infrastructure	2,543.16	Environment
	Restoration of the National Parks Building	13.38	Environment
	Construction of Metropolitan Public Parks	1,264.89	Environment
	Construction of Local Urban Public Parks	1,264.89	Environment
	Water Resources Policy and Coordination	82.42	Environment
	Water Resources Development	12.75	Environment
	Works for Adaptation to Water Excesses and Droughts	3,907.83	Environment
	Execution of Water Infrastructure Works in the Norte Grande (BIRF No. 7992)	310.21	Environment
	Development of Water Infrastructure Works - (IBRD No. 8032)	475.54	Environment
	Water and Sanitation Services Development Program - Plan Belgrano (IDB No. 4312/ OC-AR)	2,040.69	Services
	Water Infrastructure of the Norte Grande (IDB No. 2776 OC/AR)	4,923.95	Environment
	Execution of Water Infrastructure Works (CAF No. 8028)	199.14	Environment
	Execution of Sanitation Infrastructure Works Norte Grande Stage II (CAF No. 8640)	2.19	Environment
	Program for the Development of Potable Water and Sanitation Services - Belgrano Plan. Bilateral - French Development Agency (AFD)	169.05	Services
	Development of the Bermejo River Basin (FONPLATA ARG 24/2015)	284.59	Environment
	Financial Assistance for Social and Economic Infrastructure Works	1,152.11	Community development
	Support for the Execution of Basic Potable Water Works Stage II (CAF No. 8591)	2,922.23	Services
	Execution of Basic Potable Water Works, Second Stage, Phase II (CAF No. 9301)	3,345.10	Services

Agency	Budget action	Current budget	Dimension
	Execution of Potable Water and Sanitation Works in Greater Buenos Aires -3rd Tranche (IDB 3733/OC-AR)	5,836.93	Services
	Execution of Potable Water and Sanitation Works for the AMBA and Districts of the I, II, III Belt of the Greater Buenos Aires Area-1st Tranche-Berazategui Outfall (IDB No. 4268)	3,538.95	Services
	Financial Assistance for Actions in Río Subterráneo Sur Section II (Bilateral Loan Exim Bank)	1,959.76	Environment
	Financial Assistance for the Execution of the *Agua + Trabajo / Cloaca + Trabajo* Program (FONPLATA)	786,00	Services
	Support for the Development of Works in the Riachuelo System, Lot 2	3,070,31	Environment
	Support for the Execution of Basic Potable Water Works - New Intake, 2nd Stage Lifting Station and Impulsions (CAF Loan)	3,045.75	Services
Ministry of Territorial Development and Habitat	Support to the Execution of PRO.CRE.AR	61,800.92	Habitat
	Financial Support to PRO.CRE.AR. Sustainable Improvements.	1,768.11	Habitat
	Development of Metropolitan Areas other than Greater Buenos Aires - DAMI II (IDB No. 3780/OC-AR)	1,271.26	Habitat
	Development of Metropolitan Areas other than Greater Buenos Aires - DAMI III (IDB S/N)	186.51	Habitat
	Institutional Strengthening of Territorial Planning - Stage II (FONPLATA ARG-25/2016)	462.96	Habitat
	Actions to Guarantee Access to Habitat through the Provision of Basic Infrastructure and Urban and Community Equipment in Urban and Suburban Edges.	106.33	Habitat
	Actions for the Planning, Development, Management and Monitoring of Comprehensive Habitat Projects.	17,380.63	Habitat
	Actions for the Improvement, Refurbishment and Expansion of Housing and Urban Infrastructure.	5,228.52	Habitat
	Support for the Execution of the Social Housing Trust Fund.	14,258.49	Habitat
	Development and Execution of Measures for the Regularization of Ownership and Tenure of the Habitat	177.28	Habitat
	Neighborhood Improvement Actions (IDB No. 3458/OC-AR)	3,758.35	Habitat
	Comprehensive Habitat Improvement (IBRD No. 8712-AR)	1,170.41	Habitat
	Actions for the Comprehensive Improvement of Border Settlements (FONPLATA ARG-29)	204.10	Habitat
	Neighborhood Improvement - PROMEBA V (IDB S/N)	336.97	Habitat
	Energy Efficiency and Renewable Energy in Argentine Social Housing (GEF No. GRT/FM-15083-AR and IDB ATN/OC-14155-AR)	588.24	Services
	Articulation for Research and Development	30.00	Community development
	Actions for Housing and Infrastructure Development in the Matanza-Riachuelo Basin	303.78	Habitat
	Actions for the Integration of Low-income Neighborhoods (Development Bank of Latin America - CAF S/N)	1,080.26	Habitat
	Actions for the Comprehensive Development of the Habitat (Development Bank of Latin America - CAF No.10099)	2,481.37	Habitat
Secretariat of Public Innovation	Modernization and Innovation of Public Services (IBRD No. 8710-AR)	18.80	Services
	Infrastructure and General Services	229.10	Services
	Strengthening of the My Argentina Platform and Digital Services to the Population and SMEs	127.50	Information
	Open Government - Open Innovation Platforms and Services	27.00	Information
	Implementation of the Digital Points Program	483.52	Information
	Connectivity and Digital Inclusion for the Community	5.00	Information
	Development of Open Digital Television	262.00	Information
National Gendarmerie	Border Control	16,058.94	Security
	Road Safety Actions	1,919.10	Security
	Aviation Support Services	493.78	Security

Agency	Budget action	Current budget	Dimension
	Special Security Operations	13,981.75	Security
	Investigation Services and Anti-Drug Operations	474.05	Security
Argentine Naval Prefecture	Rescue and Disaster Operations	592.90	Security
	Police Service on Permanent Deployment	17,912.23	Security
	Support Services	1,483.53	Security
	Actions for Border Crossing Services	2.00	Security
Airport Security Police	Preventive Airport Security Service	4,928.85	Security
	Complex Airport Security Service	347.76	Security
Ministry of Women, Genders, and Diversity	Strengthening of Community Schools on Gender Issues (PPG)	9.20	Community development
National Directorate of Roads	Safety Works in Buenos Aires District	233.55	Transportation
	Safety Works in Córdoba District	21.38	Transportation
	Safety Works in Tucumán District	51.55	Transportation
	Safety Works in Tucumán District	17.12	Transportation
	High Level Construction in Access to Trancas - National Route 9 - Section: Int. Provincial Route 347 (El Cadillal) - Tucumán / Salta Border, Section I: Km. 1365.36	24.82	Transportation
	Access to León Rouges, National Route 0038, Section: León Rouges Km.753, Section: León Rouges Km.753, Province of Tucumán.	9.61	Transportation
	Safety Works in Mendoza District	17.12	Transportation
	Safety Work in Salta District	26.14	Transportation
	Safety Work in Jujuy District	17.12	Transportation
	Safety Work in Santa Fe District	17.12	Transportation
	Safety Work in La Rioja District	17.12	Transportation
	Hillside protections Cuesta de Miranda	11.74	Transportation
	Safety Works in San Juan District	17.12	Transportation
	Safety Works in Corrientes District	17.12	Transportation
	Safety Works in Catamarca District	17.12	Transportation
	Safety Works in Neuquén District	17.12	Transportation
	Safety Works in Chubut District	71.83	Transportation
	Safety Works in San Luis District	17.12	Transportation
	Safety Works in Misiones District	31.57	Transportation
	Safety Works in Santiago del Estero District	17.12	Transportation
	Safety Works in Entre Ríos District	17.12	Transportation
	Safety Works in Chaco District	64.34	Transportation
	Safety Works in Bahía Blanca District	17.12	Transportation
	Safety Works in Río Negro District	17.12	Transportation
	National Route 0022, Barrio Las Bardas de Choele Choel Access Roundabout and Urban Crossing.	250.00	Transportation
	Safety Works in La Pampa District	53.69	Transportation
	Safety Works in Formosa District	17.12	Transportation
	Safety Works in Santa Cruz District	17.12	Transportation
	Safety Works in Tierra del Fuego District	17.12	Transportation
	Hillside protections in Paso Garibaldi District	7.70	Transportation
National Institute of Industrial Technology	Actions for the Development and Protection of Natural Resources and the Environment	426.32	Environment
National Entity of Water and Sanitation Works	Potable Water and Sanitation for Small Urban Areas - PROAS (IDB No. 1895)	3,434.85	Services
	Potable Water and Sanitation for Large Urban Areas - PAYS (IDB No. 2343)	5.17	Services
	Potable Water and Drainage Infrastructure Works in Urban Areas	1,884.94	Services
	Execution of Water Supply Projects	3,271.67	Services
	Potable Water and Sanitation Infrastructure Development - *Argentina Hace* Plan	1,224.65	Services
	Support to the Development of Potable Water and Sanitation Works - PROFESA	11,291.81	Services
	Construction of Sarmiento - Comodoro Rivadavia (Musters Lake) Aqueduct - Chubut	200.30	Services

Agency	Budget action	Current budget	Dimension
	Construction of Potable Water System in the Municipality of Concordia - Entre Ríos (IDB No. 3451 OC-AR)	145.50	Services
	Construction of West Aqueduct System - Mar del Plata - Province of Buenos Aires (IDB No. 3451 OC-AR)	13.34	Services
	Expansion of the Drinking Water System of the Municipality of Diamante - Entre Ríos (IDB AR-L1031)	68.18	Services
	Construction of the Second Stage of the Water Potabilization Plant - La Paz - Entre Ríos.	157.74	Services
	Optimization of the Raw Water Collection System – Re-functionalization and Production Increase at Ramirez Plant and New Networks and Links from Ejercito Distribution Center - Paraná - Entre Ríos	143.59	Services
	Optimization of the Drinking Water Systems - Concordia - Entre Ríos	56.80	Services
	New Drilling for Water Supply in San Miguel de Tucumán - Tucumán	94.78	Services
	Expansion of the Sewage Collector System of Gran Mendoza - Boedo-Ponce Collector (IDB No. 3451 OC-AR)	415.77	Services
	Expansion of El Paramillo Wastewater Treatment Plant, Mendoza (IDB No. 3451 OC-AR)	1,368.51	Services
	San Carlos de Bariloche Coastal Collector (IDB No. 2343 OC-AR)	317.12	Services
	Construction of Sewage Drainage System - Saladillo - Province of Buenos Aires	158.40	Services
	Expansion of Water Treatment Plant and Networks - Viedma - Río Negro	155.28	Services
	Construction of the Northern Potable Water Distribution Trunk Line - Oberá - Misiones	612.11	Services
	Expansion of the Drinking Water System - Second Stage - Jardín América - Misiones	382.32	Services
	Expansion of the Sewage Drainage System for Villaguay - Entre Ríos (IDR AR-L1031).	363.27	Services
	Construction of Collector Networks - Alderetes - Banda del Río Salí - Province of Tucumán (PAYS II - IDB 3451)	897.03	Services
	Expansion of Wastewater Treatment Plant - Alderetes and Banda de Rio Sali - Tucumán (PAYS II -BID 3451)	469.13	Services
	Construction of Sewage Drainage Network and Treatment Plant - Guatraché - La Pampa	75.30	Services
	Construction of Sewage Drainage Network and Construction of Treatment Plant - Rancul - La Pampa	75.30	Services
	Expansion of Liquid Sewage Treatment Plant - Rafaela - Santa Fe	169.22	Services
	Construction of New Sewage Treatment Plant, Collector and Spillway - Reconquista - Santa Fe	142.73	Services
	Optimization of Sewage Drainage Systems - Concordia - Entre Rios	56.80	Services
	Expansion and Optimization of Rawson Sewage Subsystem and Sewage Liquid Treatment Plant - Cerrillo Barboza - San Juan - Argentina	1,009.62	Services
	Expansion of Wastewater Treatment Plant and 3rd Stage of Network Expansion - Jáchal - San Juan	180.75	Services
	Improvements in the Treatment Capacity and Re-functionalization of San Felipe Plant - San Miguel de Tucumán - Tucumán	106.97	Services
	Construction of Sewage System and Wastewater Treatment Plant in the City of Pirané - Formosa	421.49	Services
	Construction of Sewage System and Treatment Plant for the town of Riacho He-He - Formosa	0.00	Services
	Construction of Sewage Treatment Plant for the town of San Antonio de Areco - Province of Buenos Aires	394.67	Services
	Construction of Sewage Drainage System for the town of Catriel - Río Negro	193.21	Services
	Construction of Sewage Drainage System for the town of Dina Huapi, Río Negro	138.59	Services
	Rehabilitación y Ampliación de la Planta de Tratamiento de Líquidos Cloacales para la Localidad de Rada Tilly - Chubut	142.63	Services
	Expansion of the Wastewater Treatment System - Loncopue - Neuquén	107.85	Services

Agency	Budget action	Current budget	Dimension
	Expansion of the Wastewater Treatment System - Zapala - Neuquén	178.28	Services
	Expansion of the Wastewater Treatment Plant, Expansion of Networks and Renovation of Existing Sewage Networks - General Roca - Río Negro	596.72	Services
	Construction of Tajamar Sewage Collector - La Rioja - Argentina	137.35	Services
	Expansion of Wastewater Treatment Plant - 7 Modules - Capital City - La Rioja	281.91	Services
	Construction of Potable Water System for the town of Dina Huapi, Río Negro	46.30	Services
	Construction of Potable Water System for the City of Junín de los Andes, Neuquén	88.67	Services
National Service of Agri-food Health and Quality	Comprehensive Actions for the Operation and Administration of SENASA.	1,711.10	Environmental Health
	Actions for Border Control, Ports and Sanitary Barriers	526.46	Environmental Health
	Animal Health Coordination Actions	345.83	Environmental Health
	Management Control and Special Programs Actions	228.20	Environmental Health
	Actions for the Control and Eradication of Foot-and-Mouth Disease	369.60	Environmental Health
	Actions for the Control and Eradication of Bovine Brucellosis	69.33	Environmental Health
	Actions for the Control and Eradication of Bovine Tuberculosis	57.14	Environmental Health
	Actions for Control and Surveillance of Bovine Spongiform Encephalopathy (BSE)	51.10	Environmental Health
	Control Actions on Avian Health	47.06	Environmental Health
	Control Actions on Equine Diseases	47.87	Environmental Health
	Control Actions on Swine Health	42.26	Environmental Health
	Control Actions on Diseases Affecting Beekeeping	32.34	Environmental Health
	Control Actions on Zoonotic Diseases	33.91	Environmental Health
	Control Actions on Diseases Affecting Aquatic Animals	21.29	Environmental Health
	Control Actions on Diseases Affecting Small Ruminants	52.89	Environmental Health
	Actions for Analytical Response on Animal Health	186.41	Environmental Health
	Actions for the Approval of Veterinary Products	42.13	Environmental Health
	Control Actions on Parasitic Rabies	31.53	Environmental Health
	Control Actions on Ectoparasite-borne Diseases	78.95	Environmental Health
	Actions for Phytosanitary Coordination	311.01	Environmental Health
	Control Actions on the Health of Wooden Packages	73.73	Environmental Health
	Actions on Agro-environmental Biosecurity	42.38	Environmental Health
	Actions of Strategic Phytosanitary Information	138.58	Environmental Health
	Control Actions on the Mexican Cotton Weevil Plague	60.55	Environmental Health
	Control Actions on the Carpocapsa Pest	21.54	Environmental Health
	Control Actions on the Fruit Fly Pest	42.57	Environmental Health
	Control Actions on Forest Pest	37.60	Environmental Health
	Control Actions on Locust and Tucura Pests	39.37	Environmental Health
	Control Actions on Propagation Material	63.22	Environmental Health
	Control Actions on Lobesia Botrana Plague	95.70	Environmental Health
	Control Actions on Huanglongbing	57.05	Environmental Health
	Permanent Control Actions on Treatment Centers	48.81	Environmental Health
	Actions for Phytosanitary Analytical Response	100.36	Environmental Health
	Actions for the Approval of Agrochemical and Fertilizer Products	154.76	Environmental Health
	Coordination Actions on Agri-Food Safety and Quality	709.52	Environmental Health
	Residue and Contaminant Surveillance and Alert Actions	146.82	Environmental Health
	Analytical Response Actions on Food	187.22	Environmental Health
	Control Actions on the Safety and Quality of Products and By-Products of Terrestrial Animal Origin	988.03	Environmental Health

Agency	Budget action	Current budget	Dimension
	Control Actions on the Safety and Quality of Products and By-products of Fishery and Aquaculture Origin	115.39	Environmental Health
	Control Actions on the Safety and Quality of Fruits, Vegetables and Aromatics	57.34	Environmental Health
	Feed and Grain Control Actions	203.73	Environmental Health
	Actions for Strategy and Risk Analysis on Agri-Food Safety and Quality	237.26	Environmental Health
National Gas Regulatory Entity	Regulation of Gas Transportation and Distribution	2,041.20	Services
National Electricity Regulatory Entity	Regulation and Control of the Electricity Market	758.08	Services
National Social Security Administration	Social Protection Coverage of Vulnerable Populations in Areas of Indigenous Influence (UNICEF Agreement)	4.30	Community development

SOURCE: OPC, based on E-SIDIF.

ANNEX II – Preventive Health policies

Table 40. Description of activities and works for preventive health by government agency and dimension

In millions of ARS. As of August 2021.

Agency	Budget actions	Current Budget as of August 2021	Dimension
National Atomic Energy Commission	Application in Nuclear Medicine	17.63	Strengthening
	Operation and Maintenance of Nuclear Medicine Centers	24.07	Strengthening
Secretariat of Comprehensive Policies on Drugs (SEDRONAR)	Prevention in the Educational Environment	2.55	Prevention
	Addiction Prevention	6.97	Prevention
Ministry of Health	Coordination and Monitoring of Health Quality Activities	17.79	Strengthening
	Coordination and Monitoring of Service Management Activities	28.16	Strengthening
	Coordination and Monitoring of Quality, Regulation and Oversight Activities	27.50	Strengthening
	Coordination and Monitoring of Health Equity Activities	43.48	Strengthening
	Coordination and Monitoring of Federal Articulation Activities	45.51	Strengthening
	Coordination and Monitoring of System Integration Activities	61.56	Strengthening
	Support to Medically Assisted Reproduction (PPG)* (NNA)**	6.62	Prevention
	Coordination and Monitoring of Interventions in Perinatal Health, Childhood and Adolescence (PPG) (NNA)	168.67	Prevention
	Nutrition Actions (NNA)	4,809.61	Prevention
	Perinatology Actions (PPG) (NNA)	2,020.55	Prevention
	Child Health (NNA)	71.62	Prevention
	Comprehensive Adolescent Health (PPG) (NNA)	3.46	Prevention
	Health Actions for Inclusion and Equity (UNICEF) (NNA)	0.02	Prevention
	National School Health Program (NNA)	11.68	Prevention
	Early Detection and Care of Rare Diseases and Congenital Anomalies (NNA)	57.74	Prevention
	National Nursing Development (PPG)	2.50	Strengthening
	Workers' Health	0.15	Prevention
	Coordination of Appropriate Use of Antimicrobials	2.00	Prevention
	Standardization, Provision and Supervision of Vaccinations (NNA)	32,218.93	Prevention
	Control of Immuno-preventable Diseases (NNA)	3.86	Prevention
	Epidemiological Prevention and Control of Acute Diseases (ANC)	371.19	Prevention
	Sanitary Control of Facilities and the Professional Practice	127.99	Strengthening
	Sanitary Control of Borders and Transportation Terminals	218.70	Strengthening
	Health Care Quality Assurance	14.14	Strengthening
	Health Regulation Coordination	18.30	Strengthening
	National Blood Program	11.00	Prevention
	Development of Studies and Research on the Medicinal Use of Cannabis Plant, its Derivatives and Non-Conventional Treatments	0.27	Strengthening
	Promote health studies and research in the areas defined by the Program	9.54	Strengthening
	Assistance, Prevention, Surveillance and Research in HIV and Sexually Transmitted Infections.	5,124.28	Strengthening
	Prevention and Control of Sexually Transmitted Diseases (NNA)	0.30	Prevention
	Prevention and Control of Viral Hepatitis	359.88	Prevention
	Prevention and Control of Tuberculosis	105.28	Prevention

Agency	Budget actions	Current Budget as of August 2021	Dimension
	Prevention and Control of Tobacco Use	35.98	Prevention
	Coordination, Prevention and Control of Non-Communicable Diseases	37.90	Prevention
	Comprehensive Health of Older Adults	2.56	Prevention
	Promotion of Healthy Eating, Prevention of Obesity and Fight Against Sedentary Lifestyles	5.13	Prevention
	Prevention of Adolescent Pregnancy (PPG) (NNA)	800.53	Prevention
	Development of Sexual Health and Responsible Procreation (PPG) (NNA)	1,824.05	Prevention
	Actions linked to Health Technology Assessment Processes	3.30	Strengthening
	Surveillance, Prevention and Control of Zoonotic Diseases	17.87	Prevention
	Control of Vector-borne Transmissible Diseases and Zoonosis in general.	714.14	Prevention
	Prevention and Comprehensive Care of Chagas Disease	69.56	Prevention
	Strengthening the Interruption of Chagas Vector-Borne Transmission (FONPLATA Loan ARG-19/2013)	944.17	Prevention
	Technical Assistance to the Member Municipalities of the Argentine Network of Healthy Municipalities and Communities.	24.66	Strengthening
	Promotion of Healthy Behavior - *Cuidarse en Salud*	4.14	Prevention
	Promoting Health Care in the Community through Campaigns	0.15	Prevention
	Eye Health and Blindness Prevention	5.38	Prevention
	Prevention and Control of Chronic Respiratory Diseases	9.00	Prevention
	Prevention and Control of Persons with Diabetes Mellitus	5.73	Prevention
	Detection and Control of Celiac Disease	3.76	Prevention
	Protection of Vulnerable Populations against Chronic Non-Communicable Diseases - PROTEGER (IBRD No. 8508-AR)	4,382.60	Prevention
	Management of Chronic Non-Communicable Diseases - REDES (IDB 3772/OC-AR - IDB 5032/OC-AR)	5,305.01	Prevention
	Health Economics Analysis to Support Federal Health Policy and Management	3.40	Strengthening
	Health Statistics	1.28	Strengthening
	Promotion of Health Studies and Research	136.36	Strengthening
	Actions Linked to Epidemiological Information for Decision Making	100.23	Strengthening
	National Academy of Medicine	189.40	Strengthening
Ministry of Social Development	*Alimentar* Food Cards (PPG) (NNA) (DIS)***	93,847.74	Protection
	Food Supplement (NNA)	6,000.00	Protection
	Assistance to *Prohuerta* and Special Projects (NNA)	400.00	Protection
	School Canteens (NNA)	7,842.23	Protection
	Community Kitchens and Lunchrooms	6,000.00	Protection
	Actions Focused on Celiac Persons	160.00	Prevention
	Targeted Projects - Social Vulnerability Situation	0.00	Protection
	Support to *Argentina Contra el Hambre* National Plan in the Social-Sanitary Emergency COVID-19 (CAF No. 11367)	32.50	Protection
National Secretariat of Childhood, Adolescence and Family	Strengthening of Inclusion and Development Spaces for Civil Society Organizations	33.29	Protection
	Accompanying Families in Raising Children - *Primeros Años* Program (PPG)	169.00	Protection
	Federal Policies for the Development of Institutional Spaces	15.00	Protection
	Federal Policies for Strengthening Families and Communities (PPG)	37.75	Protection
	Federal Policies for the Strengthening of the Protection System	37.50	Protection

Agency	Budget actions	Current Budget as of August 2021	Dimension
	Federal Policies for the Strengthening of the Right to Play-JUGar	18.35	Protection
	Federal Policies for the Strengthening of the Participation of Children and Adolescents	10.00	Protection
	Policies to Strengthen Listening Channels for Children and Adolescents - Hotline 102	40.00	Protection
	Federal Actions for the Protection of Older Adults	9.76	Protection
	Residential Assistance for Older Adults	13.28	Protection
	Training to Provide Home Care and Promote Quality of Life	46.09	Strengthening
	Activities to Promote the Rights of Older Adults	30.18	Strengthening
	Strengthening of Centers for the Prevention and Recovery of Child Malnutrition	15.06	Protection
	Training and Assistance in Early Childhood Spaces	11.17	Strengthening
	Federal Actions for Early Childhood Development	686.83	Strengthening
Secretariat of Public Innovation	Implementation of Artificial Intelligence for Persons with Different Abilities (DIS)	4.00	Protection
General Staff of the Army	Actions for the Prevention of Diseases and Health Promotion	106.81	Prevention
	Operational Readiness of Sanitary Means	1.00	Strengthening
General Staff of the Navy	Actions for Disease Prevention and Health Promotion	34.80	Prevention
General Staff of the Air Force	Actions for Disease Prevention and Health Promotion	283.79	Prevention
National Network Hospital Specialized in Mental Health and Addictions *"Licenciada Laura Bonaparte"*	Prevention and Social Reinsertion (DIS)	10.10	Protection
	Social Research and Training (DIS)	7.84	Protection
National Administration of Medicines, Food and Medical Technology	Registry and Authorization of Commercialization	16.59	Prevention
	Supervision and Control	40.89	Prevention
	Health Surveillance	1.97	Prevention
	Clinical Evaluation of Medicines	9.96	Prevention
	Release of Batches of Biologicals	1.78	Prevention
	Registration and Control	14.30	Prevention
	Control	36.79	Prevention
	Health Surveillance	13.12	Prevention
	Control and Inspection of Medical Products	2.71	Prevention
	Control of Cosmetics and Products for Domestic Use and Market Control of Medicines and Medical Products	4.77	Prevention
National Cancer Institute (INC)	Management and Administration	187.81	Prevention
	Research, Prevention, Early Detection and Treatment of Cancer	52.98	Prevention
National Institute for the Coordination of Ablation and Implants	Management and Teaching	1,833.55	Strengthening
National Administration of Laboratories and Institutes of Health *Dr. Carlos G. Malbrán*	Biologics Development and Production	212.21	Prevention
	Research, Teaching and Service in Bacterial, Mycotic, Parasitic and Viral Infections	471.68	Strengthening
	Research and Training with Foreign Entities	48.78	Strengthening
	Research, Development and Service in Parasitic Diseases	120.28	Strengthening
	Research and Training	120.28	Strengthening
	Research, Development and Service in Human Viruses. Production of Vaccines against Argentine Hemorrhagic Fever - AHF	217.48	Strengthening
	Quality Control of Biologicals	55.46	Prevention
	Control of Tuberculosis and other respiratory diseases	85.89	Prevention
	Training and Management of Genetic Risk Factors	76.79	Strengthening

Agency	Budget actions	Current Budget as of August 2021	Dimension
	Epidemiological and Hospital Infections Training and Services	132.72	Strengthening
	Research and Diagnosis of Nutritional Risk Factors	48.99	Strengthening
	Research, Development and Services in Endemics - Epidemics	18.36	Strengthening
	Coordination and Support to the Laboratory Network	9.66	Strengthening
	Research, Training and Control of Tropical and Subtropical Diseases	63.08	Strengthening
National Agency of Disability	Promotion of Research and Production of Public Production Laboratories of Medicines, Vaccines and Medical Products	267.33	Strengthening
National Agency of Public Laboratories (ANLAP)	Protection of Rights and Inclusion of Persons with Disabilities	18.73	Protection
	Prevention and Control of Disabilities	246.52	Prevention

* PPG – Gender-Responsive Budgeting

** NNA – Policies for Children and Adolescents

*** DIS – Policies for Persons with disabilities

SOURCE: OPC, based on E-SIDIF.

ANNEX III – Typologies of the REFES

The categorization of facilities included in the Federal Registry of Health Facilities (REFES) is disaggregated into ten typologies, approved by Resolution 267/2003 of the National Ministry of Health. Six of them relate to inpatient facilities and the remaining four to outpatient facilities.

The categories are:

Inpatient facilities:

- General inpatient health facility (ESCIG): intended to provide inpatient care to the general demand of the population.
- Inpatient pediatric health facility (ESCIEP): intended to provide inpatient health care to meet the specific demand of the pediatric population.
- Inpatient Maternity/Maternal and Child Health Facility (ESCIEM): intended to provide inpatient health care to meet the demand for pregnancy, childbirth, puerperium, and newborn care or specifically to meet the demand for maternity and pediatric care.
- Specialized Inpatient Mental Health Care Facility (ESCIESM): intended to provide inpatient health care specifically for neuropsychiatric conditions or addictions.
- Inpatient health facility specializing in other specialties (ESCIE): intended to provide inpatient health care aimed at meeting the demand in a single specialty, such as physical rehabilitation, burns, ophthalmology, gastroenterology, emergencies, and others. The grouping of these facilities into a single category is due to the small number of such facilities in the country.
- Inpatient health care facility specializing in older adults (ESCIETE): intended to provide inpatient health care to meet the needs of older adults in the form of a geriatric residence. It includes geriatrics, nursing homes and any other denomination of institutions that contemplate the lodging of older adults who do not require specific medical treatment.

Outpatient facilities:

- Outpatient health care facility for diagnosis and treatment (ESSIDT): intended to provide health care on an exclusively outpatient basis that performs diagnostic and treatment actions. It includes CAPS - CICS in the public sector, and medical centers, outpatient surgery, etc. in the private sector. It does not include individual offices.
- Outpatient diagnostic health facility (ESSID): intended to conduct diagnostic actions only. Includes, for example, diagnostic imaging centers and clinical analysis laboratories.
- Outpatient treatment facility (ESSIT): intended to conduct treatment actions only. It includes, for example, dialysis centers.
- Complementary health facility (ESCL): intended to provide health care to the population in support of the actions carried out by other types of facilities (emergency systems, vaccination centers, etc.).

Based on this classification, Table 41 shows the distribution of facilities by type and province, as of January 2021.

Table 41. Health Facilities registered with the REFES by province and category

Number of facilities. As of January 2021.

Province	ESCIE	ESCIEM	ESCIEP	ESCIESM	ESCIETE	ESCIG	ESCL	ESSID	ESSIDT	ESSIT	Total
Buenos Aires	355	23	11	228	1,115	589	926	689	3,393	1,002	8,331
CABA	51	3	5	37	493	90	119	167	676	74	1,715
Catamarca	5	3	1	2	12	60	36	16	352	39	526
Chaco	7	0	3	5	8	100	44	99	621	74	961
Chubut	2	2	0	8	37	47	29	97	361	109	692
Córdoba	18	4	4	14	481	257	266	565	1,601	143	3,353
Corrientes	4	3	2	4	13	81	24	19	496	38	684
Entre Ríos	30	1	3	13	32	95	178	211	474	44	1,081
Formosa	4	4	1	1	3	64	27	22	314	20	460
Jujuy	9	2	0	2	8	45	13	124	405	33	641
La Pampa	4	0	0	1	67	42	68	84	437	47	750
La Rioja	4	2	0	5	3	48	19	19	254	31	385
Mendoza	30	3	4	24	147	59	118	331	1,260	216	2,192
Misiones	3	1	1	6	34	159	105	157	433	28	927
Neuquén	4	3	0	4	49	44	101	49	902	116	1,272
Río Negro	1	1	0	1	30	56	17	76	327	75	584
Salta	2	2	0	10	11	85	158	108	581	114	1,071
San Juan	26	0	1	8	32	38	78	66	519	84	852
San Luis	7	2	0	1	10	30	87	36	333	39	545
Santa Cruz	0	0	0	1	12	25	38	46	149	79	350
Santa Fe	34	4	6	32	271	243	99	694	911	57	2,351
Santiago del Estero	14	1	1	3	0	72	22	93	606	28	840
Tierra del Fuego	2	0	0	1	1	8	44	16	228	88	388
Tucumán	14	2	4	12	21	68	340	276	1,089	80	1,906
Total	630	66	47	423	2,890	2,405	2,956	4,060	16,722	2,658	32,857

SOURCE: OPC, based on Ministry of Health of the Nation – REFES.

Table 42 shows the distribution of health care facilitates by sector and type for each province.

Table 42. Health Facilities registered with the REFES by jurisdiction, financing sector and type of service

Number of facilities. As January 2021.

Province	Government		Non-government		Mixed		Total
	Inpatient	Outpatient	Inpatient	Outpatient	Inpatient	Outpatient	
Buenos Aires	483	2,685	1,837	3,325	1	0	8,331
CABA	55	173	624	861	0	2	1,715
Catamarca	51	323	31	120	1	0	526
Chaco	61	412	62	425	0	1	961
Chubut	37	164	59	432	0	0	692
Córdoba	186	770	592	1,805	0	0	3,353
Corrientes	56	354	50	223	1	0	684
Entre Ríos	71	381	103	525	0	1	1,081
Formosa	41	291	36	92	0	0	460
Jujuy	35	348	31	227	0	0	641
La Pampa	35	100	79	536	0	0	750
La Rioja	41	243	21	80	0	0	385
Mendoza	59	442	208	1,481	0	2	2,192
Misiones	115	424	87	293	2	6	927
Neuquén	33	234	71	933	0	1	1,272
Río Negro	37	196	52	299	0	0	584
Salta	65	511	45	448	0	2	1,071
San Juan	19	173	86	574	0	0	852
San Luis	31	145	19	350	0	0	545
Santa Cruz	35	70	3	242	0	0	350
Santa Fe	161	666	429	1,091	0	4	2,351
Santiago del Estero	57	589	34	159	0	1	840
Tierra del Fuego	6	46	5	330	1	0	388
Tucumán	45	357	75	1,422	1	6	1,906
Total	1,815	10,097	4,639	16,273	7	26	32,857

SOURCE: OPC, based on Ministry of Health of the Nation – REFES.

ANNEX IV – Additional Characteristics of OSNs

Table 43. Beneficiaries of OSNs by type and status

Number of beneficiaries. As of July 2021.

Type of beneficiary	Holders	Dependents	Total
Employment relationship	6,581,662	5,215,015	11,796,677
Self-employed (*monotributistas*)	1,068,094	341,282	1,409,376
Unemployed	127,662	203,439	331,101
Social effectors	279,026	181,438	460,464
Retirees	349,589	46,030	395,619
Others	456,957	117,661	574,618
Total	8,862,990	6,104,865	14,967,855

SOURCE: OPC, based on Superintendence of Health Services.

Table 44. Beneficiaries of OSNs by type of enrollment and status

Number of beneficiaries. As July 2021.

Enrollment	Holders	Dependents	Total
Direct	3,928,551	2,987,039	6,915,590
By option	4,934,439	3,117,826	8,052,265
Total	8,862,990	6,104,865	14,967,855

SOURCE: OPC, based on Superintendence of Health Services.

Table 45. Beneficiaries of OSNs by age range, status, and sex

Number of beneficiaries. As of July 2021.

Age range	Holders		Dependents		Total
	Female	Male	Female	Male	
18 or older	5,650	12,763	1,881,086	1,958,877	3,858,376
19-25	243,317	519,361	381,244	287,088	1,431,010
26-35	944,445	1,532,006	374,254	35,478	2,886,183
36-50	1,361,431	2,097,951	674,031	104,414	4,237,827
51-65	665,437	1,068,633	297,441	81,047	2,112,558
Over 65	224,730	187,266	21,099	8,806	441,901
Total	3,445,010	5,417,980	3,629,155	2,475,710	14,967,855

SOURCE: OPC, based on Superintendence of Health Services.

ANNEX V – Additional Characteristics of EMPs

Table 46. Members of EMPs by age range, status, and sex

Number of members. As of July 2021.

Age range	Holders		Dependents		Total
	Female	Male	Female	Male	
18 or older	8,369	9,752	684,612	713,452	1,416,185
19-25	80,061	82,122	179,527	168,018	509,728
26-35	420,900	455,929	153,786	60,596	1,091,211
36-50	503,950	653,307	331,593	124,374	1,613,224
51-65	283,312	377,597	213,362	84,476	958,747
Over 65	238,327	226,771	122,093	41,746	628,937
Total	1,534,919	1,805,478	1,684,973	1,192,662	6,218,032

SOURCE: OPC, based on Superintendence of Health Services.

Table 47. Members of EMPs by status and age range

Number of beneficiaries. As of July 2021.

Relationship	Age range									
	0-3	4-10	11-17	18-25	26-35	36-50	51-65	+65	N/D	TOTAL
Cohabitant	0	0	0	5,618	54,921	91,759	31,803	9,469	284	193,854
Spouse	0	0	0	4,599	80,939	339,335	253,633	136,407	425	815,338
Other Dependent family member	4,402	17,581	15,384	31,346	64,530	23,543	12,195	17,805		186,786
Cohabitant's child between 21 to 25 years of age and unmarried in regular schooling	0	0	0	1,169	53	0	0	0	0	1,222
Cohabitant's child under 21 years of age and unmarried	743	2,050	2,798	1,184	0	0	0	0	0	6,775
Unmarried child between 21 and 25 years of age in regular schooling	0	0	0	158,611	8,987	0	0	4	17	167,619
Unmarried child under 21 years of age	196,384	567,557	520,341	213,070	2,486			36	0	1,499,874
Disabled child over 25 years of age	0	0	0	0	2,465	1,330	207	118	6	4,126
Child under guardianship	146	665	852	377	1	0	0	0	0	2,041
Policyholder	0	0	0	164,073	876,829	1,157,257	660,909	465,098	16,231	3,340,397
Total	201,675	587,853	539,375	580,047	1,091,211	1,613,224	958,747	628,937	16,963	6,218,032

SOURCE: OPC, based on Superintendence of Health Services.

OPC Publications
The Argentine Congressional Budget Office was created by Law 27,343 to provide support to the Legislative Branch and deepen the understanding of issues involving public resources, democratizing knowledge and decision making. It is a technical office of fiscal analysis that produces reports open to the public.
This report does not contain binding recommendations.

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