

ARGENTINA

Health Insurance for Poor People in the Province Of Santa Fe, Argentina: The Power of the Clear Model for All

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SUMMARY

In Argentina, the system is characterized by the existence of a large (more than 40% after 2002 economic crisis) poor uninsured population.

Whitin Argentina the poor die earlier than they should and there is evidence that the quality of care also varies with income.

Available health sector resources are more than adequate for providing a comprehensive package of public health and personal health services for the entire population.

A recent pilot experience in Santa Fe show that if the poor's oriented Insurance programs has clear model and monetary incentives to Primary Health Care Teams it could reach good advances in critical indicators as Infant Mortality Rate.

ARGENTINA: HEALTH SECTOR STRUCTURE

In Argentina, health care delivery responsibilities are broadly shared by public providers, private providers and semi public entities.

The majority of doctors have either full time private practices or combine employment in public hospitals with part-time private practice. With regard to facilities, about 50 percent (67,000 beds) are in private hospitals, 39 percent (47,000 beds) in public institutions, and the remaining 11 percent (8,000 beds) are operated directly by the semi-public Obras Sociales.

Within the public sector, the federal Ministry of Health and Social Action retains important policymaking, norm-setting and regulatory functions, but has few health care facilities of its own. Most responsibility for service provision lies with the Provincial Health Ministries and, in some cases, their municipal counterparts. The scope, quality and size of public delivery systems vary significantly according to the economic and political strength of the individual provinces and the extent of local insurance coverage.

Service delivery capacity in the public sector, predominantly hospital-based, has been seriously eroded as a result of both inadequate financing and management weakness. Most hospitals are old and inadequately maintained, have obsolete equipment, and are poorly managed.

Internal inefficiencies are further magnified by the lack of accountability of hospital directors. As decision-making is highly centralized at the level of the Provincial Health Ministries, hospitals have limited authority to achieve improvements in efficiency.

The large and influential private sector provides care to Argentines affiliated with a commercial health plan paid “out of pocket”, or with access to the semi-public Obras Sociales, which contract the great part of services with private providers. The vast majority of Argentine physicians, who are organized in provincial and national professional associations, are engaged in private practice at least on a part time basis.

HEALTH CARE EXPENDITURE AND FINANCING.

Argentina’s total expenditure on health (more than 7% percent of GDP in 1993 and 11,4% of GDP in 2000) is high for an upper-middle income developing country, more closely approximating OECD expenditure patterns.

Sectoral expenditures are financed by federal and provincial taxes and other government revenues (about 20 percent of total expenditures), social insurance taxes (34.13 percent) and household payments, either direct (e.g. drug purchase) or through private health insurance (45.05 percent). (See table 1).

Health care delivered in public facilities is financed from general tax revenues, with 75 percent of funding from provincial government, 16 percent from municipalities and 9 percent from federal government.

In addition to “out of pocket” expenditures for drugs and services, private financing is represented by financial intermediation of commercial insurers or similar financial groups, who cover on prepaid basis services provided by private clinics or HMOs.

Around 200 private insurance plans cover an estimated three million individuals. In addition, there are about 1000 non profit mutual insurance funds, which offer health care plans funded by individuals contributions.

Table 1. Argentina’s Health Expenditure.

Year: 2000

		% of total Health Spending
PUBLIC SECTOR	Federal, Provincial, and Municipal Gov. Subtotal	20,81
OBRAS SOCIALES. (HIF)	National and Provincial HIF Subtotal	34.13
PRIVATE SECTOR	Indirect (private plans) Direct (medications, out of pocket). Subtotal	45.05
TOTAL		100

Source: Secretaría de Promoción Económica.
Cuentas Nacionales. Ministerio de Economía de la Nación.

HEALTH STATUS AND POVERTY

Argentina is a relatively rich country, with an annual per capita income officially calculated at \$8970 per person (1998, World Bank Atlas). Yet, despite this relative wealth it is a country with a surprisingly high degree of poverty

The overall health indicators of Argentina are good when compared with those of other countries in the Region.

However, these rates are worse than those of other middle income countries, and lower than one would expect from the economic and education indicators. For example neighboring Chile, with a lower income than Argentina, had in 2000 an infant mortality rate of 10 per 1,000 live births compared to 17.6 per 1,000 live births in Argentina.(table 1).

Table 2: Argentina's Indicators in context.

Year: 2000

	Argentina	Chile	Mexico	Uruguay	Brasil
Infant Mortality Rate	17.6	10.1	14.5	14.1	33.1
Under 5 Mortality Rate	24.5	14.5	36.4	18.1	45.9
Annual National Health Expenditure as a Proportion of GDP	11.4	7	5.3	10.3	8.4
Physicians per 10.000 Inhabitants Ratio	26.8	13	15.6	37	14.4
Life Expectancy at Birth	73.6	75.5	72.8	74.7	67.7
GNP per Capita	11.940	8410	8070	8750	6840

Source: PAHO.

The relatively good national health indicators also hide significant variations between different income groups, the poor having a much worse health status than the rich and having a different pattern of death, disease and disability.

Objectively, when one looks at the burden of disease in terms of years of life lost due to premature death, evidence shows a quite different picture: the poor die earlier than they should, and are disproportionately stricken by largely preventable Group A diseases, i.e. communicable, maternal, perinatal and nutritional conditions. In fact there is a strong negative association between per capita household income and the years of life lost per 100,000 population due to syphilis, diarrhea, tetanus, abortion, protein-energy malnutrition, and with infant, neonatal and maternal mortality (see Table 3).

Table 3. Association between Average Per Capita Household Income and Years of Life Lost per 1,000 Population

Disease which affect disproportionately the poor	Linear Correlation
Infant mortality ratio	-0.62
Neonatal mortality rate	-0.56
Maternal mortality rate	-0.48
Proportion of low birth weight babies (<2,500 g)	-0.58
Diarrhea	-0.455
Tetanus	-0.455
Protein-energy malnutrition	-0.450
Abortion	-0.435

Source: World Bank (2000), Argentina: Poor People in a Rich Country

HEALTH CARE COVERAGE AND UTILIZATION

In Argentina, the system is characterized by the existence of a large (more than 40% after the 2002 economic crisis) poor uninsured population.

For this population the coverage from essential public health programs is high. If we take prenatal care as an example, only about three percent of women do not benefit from some form of prenatal care. However, the poor are less likely to benefit from such essential public health programs, and when they do the quality of service is lower.

If we use prenatal care as a tracer for the quality of essential public health programs, we find a direct negative association between per capita income of the household and the probability of having had less than five prenatal exams (see Fig. 3). Most of the poor have access to public hospitals, but the care they receive differs significantly from that received by higher income groups. As show in table 3 over 25 percent of pregnant women coming from the lowest income quintile are delivered by non doctors, compared to one tenth of one percent of women from the highest income quintile.

Table 4: Quality of Maternal Care by Household Income per Capita.

	Per Capita Household income Quintiles				
	1	2	3	4	5
Prenatal Care Delivered by non-doctor	8.3	3.3	2.1	0.4	0.1
Delivery by non doctor	28.5	17.9	10.2	8.2	0.1
Cesarean Section	21.8	33.7	37.7	41.5	42.1
Non post partum follow up	31.6	17.2	6.5	2.5	2.3

Source: Social Development Household Survey

THE MODEL OF SANTA FE'S HEALTH INSURANCE PROGRAM (SSP)

In the province of Santa Fe 47% of the population does not have explicit health insurance coverage. This population goes to public health services. Most of the province's resources are allocated to level two health establishments, which absorb 84% of the resources and deal with 64% of the consultations. Most doctors in the system are not Primary Health Care Specialists, and just 6% of the resources are allocated to so-called level one outpatient services.

The health Insurance Scheme is a model of care whose objective is to provide a package of Primary Health Care to uninsured, poor people within the province of Santa Fe.

The model of The insurance of health is supported by three pillars: The Census Population, The Local Participative Program (LPP) and interdisciplinary work.

The SSP Primary Health Care (PHC) teams are comprised of General Practitioners or Family Physician, Nurses and health visitors. If required a psychologist will be added.

Being part of the SSP PHC team is voluntary and selection is according to the ranking of characteristics, the most important being experience of working in Primary Health Care and living in the community.

Private suppliers and members of the community were included in the SSP model, which is based on a Local Participative Program (LPP). In a few words this means that the way the PHC team will implement the activity in the community must be discussed with the community and written clearly in an annual plan.

These teams are responsible for registering the population in the geographical area in

their care. During the census the teams will learn the main needs of this community in order to conform to its LPP along with the main institutions of that community.

As a result of the LPP the activity and the training requirements will be established.

The universal and basic package of the SSP includes: (filmina 4)

- Curative and Preventive ambulatory Medical care.
- Nursing care
- Home Visits from health visitors
- Lab Tests
- Rx tests
- Pharmacies
- Dental care

The basic package is universal for all uninsured people.

Each PHC team will define special programs to be developed for their population according to the main problems detected during LPP. Eg: Community programs against addictions, educative programs to reduce adolescent pregnancy, etc.

Public-Private Mix to Improve access.

Because the current public network is insufficient in the SSP model it is permitted to contract private suppliers to complement the public network (physician, biochemistry, pharmacist, etc) they will play a very important role in guaranteeing that uninsured people get better access to health care.

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Management Contract

The SSP and PHC team sign a yearly management contract which stipulates the activities of the team and the goals which should be attained.

This management contract, defines clearly the conditions of collection of the financial incentives.

In all the Management Contract it is obligatory to cover the basic package, to be qualified and to deliver the statistics reports monthly.

Forms of Payment.

Incentive Scholarship

The majority of the professionals in the PHC Teams are hired for the province, municipality or the nation.

The SSP pays a semiannual incentive according to the results of the work measured by indicators previously agreed in the management contract.

The scholarship incentive is related to the quantity of people that the teams have in their register.

The PHC Team which has full capitation (2000 uninsured people) and reaches the indicators of the LPP will receive an incentive payment of two salaries per year.

Zone III Pilot Experience

Two years ago a Provincial Health Insurance pilot experience was started.

It was decided to begin a pilot experience in the two poorest departments of the province.

With these objectives:

1. - To reduce the global burden disease, mainly diseases linked to poverty.
2. - To strengthen the PHC model.
3. - To provide explicit care to uninsured people
4. - To improve the equity, accessibility and efficiency of the public service.
5. - To implement a new mechanism of payment based on productivity, capitation and incentives.
6. - To establish the public-Private network
7. - To develop an Efficient mechanism to allow community participation.

32 PHC teams were established and the same number of management contract arrangement were signed between PHC teams and SSP authorities.

The preliminary Results

15 months after the Santa Fe Province Health Insurance pilot experience was implemented, the following indicators of improvement in the area's services can be observed:

Women's Health

- An increase of more than double in the amount of pap tests.
- An increase from 46% to 81% of pregnancy check up before week 20.
- 40% of total of Deliveries having more than 5 antenatal check ups .
- All women in the SSP having access to contraceptive methods.

Children's health

- 98% of babies born in public hospitals having Neonatal Screening Test (Fenilcetonuria, hipotiroidismo, FQ).
- 84% of children under 5 are in the Growth and Development program.
- All children with a diagnosis of undernourishment are in treatment. (9,2% of the total child population 80% of whom are in grade I)
- For the first time, the area in which the health insurance experience took place managed to reduces infant mortality to a level lower than the provincial average.

Access.

- There was a 120% increase in scheduled consultations in clinics and doctors'

surgeries, 30% of these were in private clinics.

- An increase of 86% in the amount of visits made by community agents to beneficiary families was achieved.
- The beneficiaries can receive prescribed drugs from all the area's private pharmacies, which guarantees 24-hour access to drugs.

For the health system.

1. - The compilation of a register of uninsured people.
2. - The Implementation of an LPP.
3. - The Improvement in training of the PHC team. (the previous year's hours of educational activities was tripled).
4. - The Organization of Referral methods (For the first time, the 10 main reasons for frequent consultations are known for each professional in the insurance system).
5. - The Improvement of access to pharmaceutical services due to the inclusion of private pharmacies in the public network.
6. - The modification of a payment system.
7. - Vademecum, Family Records, Codification etc.

The Cost Evaluation

The budget of the Zone III Pilot Experience was US\$ 150.000 per year.

The total amount is destined to pay monetary incentives to PHC teams and the rest of the professionals.

This means that for a population of 28.000 uninsured people we have invested US\$ 5.37 per head per year.

If we can extend this Insurance frame for all uninsured people in the Santa Fe province (almost 1.500.000 people) we need to invest US\$ 8.055.000.

The Health Ministry budget for the year 2002 was US\$ 220.000.000.

Therefore, to cover the total population we need to increase by 3.63% the Health budget. This would seem to be a very acceptable budget increase for the province.

Conclusion

Santa Fe's health Insurance program has imposed to clear a model of health care for both beneficiaries and Primary health care suppliers.

Total public health expenditures are sufficient to finance a very generous package of public health and personal health benefits for the entire population.

Since the implementation of the care model, the greatest strengths are the ability to motivate PHC teams to achieve desired indicators, a distribution of care according to the concept of the population to be covered by health staff, a guarantee of free access to citizens with a very low payment capacity (extremely poor), and a implementation of a model of Local Participation as a guide to the model of care whose financing is distributed in accordance with poverty rates.