SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

Health universalism in Argentina between 2003 and 2015: assessments and challenges based in a macro-institutional approach

El universalismo en salud en Argentina entre 2003 y 2015: balances y desafíos desde una aproximación macroinstitucional

Magdalena Chiara[1], María Crojethovic[2], Ana Ariovich[3]

[1]PhD in Social Sciences. Associate Professor, Metropolitan Area of Buenos Aires Research Institute [Instituto del Conurbano - ICO], Universidad Nacional de General Sarmiento, Buenos Aires, Argentina.

[2]PhD in Social Sciences. Associate Professor, Metropolitan Area of Buenos Aires Research Institute [Instituto del Conurbano - ICO], Universidad Nacional de General Sarmiento, Buenos Aires, Argentina.

[3]Master's Degree in Economic Sociology. Principal Teaching Assistant, Metropolitan Area of Buenos Aires Research Institute [Instituto del Conurbano - ICO], Universidad Nacional de General Sarmiento, Buenos Aires, Argentina.

ABSTRACT Debates about universalism in health have been gaining ground in Latin America and have entered the policy agenda with differing results. Notwithstanding the country's federalism, the most profound changes that took place in Argentina in the last decade occurred in the arena of national politics. Based on the theoretical contributions of historical neo-institutionalism and implementation studies, this paper aims to analyze, from a macro institutional approach, the scope of the national policy regarding health universalization. This descriptive study is based on secondary sources and the review of research results on the implementation of the programs Remediar, Sumar and Plan Nacer in relation to four variables: coverage, access, sets of benefits and rights included in the policy. Given the characteristics of the Argentine institutional matrix, program implementation in subnational scenarios can be expected to confront complex and heterogeneous terrain in which the programs acquire new meanings with respect to the goal of universality that each poses.

KEY WORDS Health Plan Implementation; Universal Access to Health Care Services; State Health Care Coverage; Decentralization; Federalism; Argentina.

RESUMEN Los debates en torno al universalismo en salud fueron ganando terreno en la región e ingresando a la agenda de las políticas con resultados desiguales. Aun en el contexto del federalismo, los cambios más profundos que se sucedieron en Argentina en la última década tuvieron lugar en la arena de la política nacional. A partir de los aportes teóricos del neoinstitucionalismo histórico y de los estudios de implementación, este trabajo se propone analizar el alcance de la política nacional en torno a la universalización en salud, en un nivel macroinstitucional. Se trata de un estudio descriptivo, basado en fuentes secundarias y en la revisión de resultados de investigaciones sobre la implementación del Programa Remediar, el Plan Nacer y el Programa Sumar en relación con cuatro variables: acceso, cobertura, conjunto de beneficios y derechos que recoge la política. Dadas las características de la matriz institucional argentina, puede esperarse que la implementación en los escenarios subnacionales recorra espacios complejos y heterogéneos en los que los programas pueden adquirir nuevos significados con relación al horizonte de la universalidad que cada uno de ellos plantea.

PALABRAS CLAVES Implementación de Plan de Salud; Acceso Universal a Servicios de Salud; Cobertura de Servicios Públicos de Salud; Descentralización; Federalismo; Argentina.

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

INTRODUCTION

The question of universalism has been gaining ground in Latin America, both in the academic sphere and in health policy management. This issue entered the policy agenda at the beginning of the 21st century with the proposal for Universal Health Coverage promoted by the World Health Organization (WHO) and the Pan-American Health Organization (PAHO). Such a horizon presents unique challenges within each country as regards the best ways to promote universalism in health.

A previous study identified four broad levels which spark tension in the debate. A first level alludes to the meaning in dispute regarding the right to universal services: whether it amounts to an individual safeguard or a social right that contributes to the construction of citizenship.[1,2] A second level refers to how to define the scope of universalization, since programs with target populations or certain services recognize a social universe that may restrict the right only to socially excluded groups.[3] The third level has to do with the type of services which are given priority, and how and by whom access to these services is defined.[4] A fourth level of tension in the debate about universalism in health involves institutional capacity with respect to resources, organizational responsibility and public capacities while addressing the changes required in the financing and management of those institutions responsible for formulating and implementing such policies.[5,6]

Narrowing the issue down to the services themselves, the WHO identified three dimensions to analyze the universal health coverage: services, coverage and financing, the latter being understood as the economic protection of the population to avoid the risk of impoverishment when treating a disease.[7] By the year 2014, with the emphasis placed on expanding access to services so as to include vulnerable groups, the universal health coverage proposal was turned into the universal health access and coverage.[8]

The meaning of universality encompassed in this proposal seems to be more orientated toward offering coverage to vulnerable or at-risk populations, rather than guaranteeing social rights; this distinction is significant in that it narrows the debate to addressing populations at-risk or in situations of vulnerability.[6] In this framework, the aim of this study is to assess the scope of health universalization policies implemented in Argentina over the last decade with a special focus on two policy mechanisms in particular: the Program *Remediar* [meaning "to remedy"] and Plan *Nacer* ["to be born"], which later became the Program *Sumar* ["to add"].

THEORETICAL AND METHODOLOGICAL APPROACH

This research study utilizes contributions of the implementation perspective to discuss the trajectories of policies moving toward health universalism. According to this approach, the implementation of a policy is a complex process involving a set of actions that turn initial intentions and objectives into observable outcomes[9]; furthermore, implementation has an intrinsically political nature which entails the participation of actors having varying interests and points of view who must reach arrangements of cooperation in order to accomplish shared objectives.[10]

On the other hand, using several approaches historical neo-institutionalism has postulated that institutions have an influence over the way that policy actors form their preferences and define their interests and objectives, affecting – in turn – the outcome of such policies.[11] According to this school, the elements comprising the institutional framework range from formal and informal rules of the game that shape relationships between groups or individuals, to organizational routines put into play at the level of practices.[12,13] In line with these theoretical contributions, the studies falling within the so-called "historical neo-institutionalism" further describe institutions as relatively persistent

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

features and as core factors that push historical development through a set of "paths" that condition future policies.[14]

Bearing in mind this assumption, our analysis begins with a characterization of the paths of the institutional matrix through which Argentina's domestic policy is developed. To that end, we will describe the main features that define Argentina's political and health system.

This is a descriptive study based on a macroinstitucional approach and secondary sources, as well as on the review of findings in other research studies to detect potential challenges when implementing universality-oriented policies within the Argentine institutional matrix. An approach explaining these phenomena requires not only undertaking a broader analysis, but also delimiting the empirical object to subnational scenarios (at the provincial and/or municipal level), and formulating questions to be answered – additionally and especially – using primary sources, in order to recover the perspective of the actors at stake and their interests. This article is a partial result of the start-up phase of a research project entitled "*Cobertura universal de salud y redes de servicios: encuentros y desencuentros entre la macro y la meso gestión: Un estudio de caso en el conurbano bonaerense 2008-2015*" [Universal health coverage and service networks: agreements and disagreements between the macro and mezzo management: A case study in Metropolitan Area of Buenos Aires 2008-2015".

As the unit of analysis of health policy at the national level, oriented toward establishments reporting to state agencies, we selected two programs or policy mechanisms that include the following features:

a. They are within the national sphere (they facilitate the problematization of relations among governmental levels).
b. They lasted at least one governmental term.
c. Their institutional documentary records explicitly show an intention of universality.
d. Their positioning within the sector affords them certain visibility in the public sphere.

The orientations and progress toward universalism in mechanisms involving public health policies chosen for this research were studied by taking into account four major variables that utilize theoretical agreements put forward in the primary debates surrounding universalism, which were presented in the introductory section of this article:

- *Access* (considering the conditions facilitating such access, and free health care services).
- *Coverage* (in terms of population reached).
- *Benefits* (services offered in terms of quantity and quality).
- *Rights* (making reference to the type of right or rights addressed by the policy).

From a methodological perspective, these variables facilitate research operationalization of a complex concept like universalism within the health sphere, while making it possible to reconstruct and analyze public policy in health limited to those institutions belonging to the state-run subsector. Even with the restrictions involved, the delimitation of the subject-matter under analysis, adopted in the research study on which this paper is based, is founded in the objective postulated – at least in regulatory norms – by the institutions of the state-run subsector: guaranteeing health care to the whole population regardless of the condition of the individual who attends these establishments. Among the sources used in collecting secondary data, we can mention the following: documents of selected programs, information on their coverage and impact (progress reports and publications), national and provincial legislation, national and provincial executive orders, local ordinances, program implementation agreements, epidemiological data and management reports on the health programs under review.

Finally, it should be noted that the guidelines elaborated by international organizations to monitor the fulfillment of relevant covenants involving safeguards of the right to health[15] establish a series of optimal standards that closely link universality with the

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

right to health, making reference to interrelated dimensions, such as availability, accessibility, acceptability, and quality in order to weigh the trajectories and the performance of the health sector in different Latin American countries. However, larger research studies are necessary and should involve other types of units of analysis (such as health services) and qualitative approaches and tools in developing empirical evidence.

RESULTS

Argentina's federal system established a state-run structure that combines self-administered provinces with shared government that, in practice, requires reconciling the national State unit with the internal political autonomy prevailing in each province.[16]

The health sector in Argentina is made up of three subsectors (the state, social security, and private providers), and it has inherited two health models: the Beveridge Model, which promotes a nationalized health care system, and the Bismarck Model, which is centered on an insurance system. The health sector is founded on the notion that all inhabitants are entitled to public health regardless of the kind of social security or private insurance that they may have. The total government expenditure in health accounts for 6.21% of the gross domestic product (GDP),[17] with a per capita GDP calculated in the amount of 13,431.90 USD for the year 2015.[18]

Due to its federal nature, the state-run subsector is organized into three governmental levels (national, provincial, and municipal in some provinces), offering services to the entire population. Private workers employed within the formal market and those hired in the state public sector have additional coverage provided by social security institutions known as *obras sociales* [employment-based health insurance]; similarly, workers employed by provincial public agencies are given provincial employment-based health insurance through *obras sociales*. Figure 1 shows the percentage distribution of the population according to the type of medical-health care coverage.[19] Finally, the private sector is mainly made up of medical service providers, financing agents or medical insurance firms, laboratories of medical specialties, and companies providing medical equipment and supplies.

Programs *Remediar*, Plan *Nacer* and *Sumar*

The decade following the crisis in Argentina at the beginning of the century saw important changes in the ideas surrounding the role of the State with respect to social issues; different measures evidence the decision to intervene in the conditions under which the life of the population is reproduced. In a silent and less visible way, "health" was the target scenario for changes; different studies describe

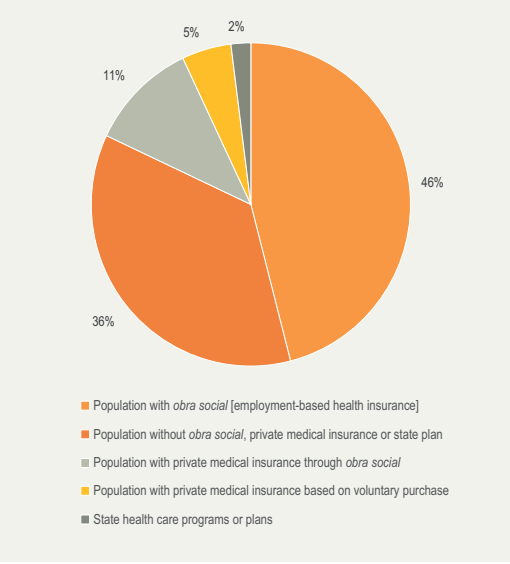

Figure 1. Percentage distribution of population (N=40,117,096), by medical-health care coverage. Argentina, 2010.

Source: Own elaboration based on the latest data available on population and health care coverage for the year 2010 according to Argentina's National Institute of Statistics and Censuses (INDEC) [*Instituto Nacional de Estadística y Censos*].[19]

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

the emergence of new initiatives and the reinforcement of preexisting ones.[20,21,22,23,24]

National policy was the most sensitive to these processes. The most important difference with respect to neoliberal reforms, which characterized the decade prior, lies in the purposes that guided the proposals and the return of the National Ministry of Health as an actor in the service arena, almost in its entirety under the purview of the State at the provincial and municipal level.

Although it was not an overall reform of the sector, the prioritization of the first health care level based on a strategy involving primary health care as the organizer of the state-run subsector was originally proposed by the Federal Health Plan 2004-2007, and included different programs that had primary health care centers as a privileged site of activity.

Among the most important initiatives, we should highlight: Program *Remediar* (in its two versions); Program Community Doctors (with variations over time); Program for Sexual Health and Responsible Reproduction; National Program for Tuberculosis and Leprosy Control 2014 (formerly called National Program for TB Control); Plan for the Reduction of Maternal and Infant Mortality, and in Mortality in Adult and Adolescent Women; the National Program of Congenital Heart Diseases; and Plan *Nacer* and Program *Sumar*.[20,25,26]

Out of this set of national initiatives, for the purposes of this research we selected only two policy mechanisms that meet the characteristics described above for the units of analysis: Program *Remediar* and Plan *Nacer* which later became Program *Sumar* (Table 1).

Program *Remediar*

Within a broader framework of medicine policy (which required prescriptions using generic drug names), Program *Remediar* included the free provision and distribution of essential outpatient medications at primary health care centers. Although it was intended for the population with public health coverage exclusively, the routines and procedures do not appear to have prevented such medicines from being provided to the population with a different coverage who went to these primary health care centers to receive medical attention.[26]

Even though this program underwent several changes, it was in force throughout the study period as the Program for the Reform of Primary Health Care II (PROAPS) [*Programa de Reforma de la Atención Primaria de la Salud*]. In 2008, in the context of the Program for Strengthening the Primary Health Care Strategy (FEAPS) [*Fortalecimiento de la Estrategia de Atención Primaria de la Salud*], the most significant change in Program *Remediar* was the integration of a component aimed at

Table 1. Program *Remediar*, Plan *Nacer* and Program *Sumar*, according to their basic characteristics. Argentina, 2015.

Program / Plan	Year beginning	Jurisdiction	Organization	Covered population	Financing		Providers	
					Source	Amount (in USD)	Type	Quantity
Program *Remediar*	2002	National	National Ministry of Health	16,086,023	Inter-American Development Bank	139,726,9622	Primary Health Care Centers	7,823
Plan *Nacer* and Program *Sumar*	2003	National	National Ministry of Health	12,787,232	Inter-American Bank for Reconstruction and Development (IBRD), and provincial and national budget	234,880,546	Hospitals and Primary Health Care Centers	7,515

Sources: Own elaboration based on Ballesteros[33] and data about Program *Remediar* and Program *Sumar* supplied by Argentina's National Ministry of Health.[34,35]

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

the creation of health services networks oriented toward early detection and follow-up of non-communicable chronic pathologies (hypertension and diabetes). Apart from the national level, throughout almost all its duration the program received financing from the Inter-American Development Bank (IDB), which amounted to 230 million USD.[27]

Focusing its efforts on the primary health care centers, the program sought to reinforce the capacity for resolution of health problems at the first level of care, to promote the primary health care strategy and to train the different actors of the primary care system in rational therapeutics, care of medications and the medication management cycle.

Toward the end of the period, the so-called "first-aid kits" were made up of 74 medications that covered 7,823 establishments in charge of providing medical attention to 16 million identified users.[28]

The logistics of the distribution centered around a "centralized federal supply system" of medications and supplies that allowed the other programs under the National Ministry of Health to reach the primary health care centers all across Argentina. In spite of its centralization, the management involved, in different ways, both the provinces and municipalities, especially when the latter were in charge of first level care services.

The program had strict and systematic auditing, monitoring and assessment mechanisms. The *free consultation* was one of the requirements that the program established in order for a provider to remain in the program. The auditing mechanisms played a crucial role, since based on auditing reports, commitments aimed at correcting detected problems could be made among the national, the provincial and municipal governments.

Plan *Nacer and* Program *Sumar*

Plan *Nacer*, later called Program *Sumar*, was a policy mechanism oriented toward the creation of public provincial health insurance aimed at guaranteeing a set of services to the population with no explicit health coverage. It received financing from the Inter-American Bank for Reconstruction and Development (IBRD), and it accumulated, starting in the year 2005 (when the first fund transfers were made to the provinces), the sum of 234 million USD (in transfers to primary health care centers, hospitals and, although very marginally, to other private providers). These contributions accounted for 1% of the resources that were invested in health by the provinces and municipalities,[29] though with the operational capacity of being allocated directly to establishments so that their teams could make decisions on how to use them.

At the very beginning, Plan *Nacer* aimed to reverse the increase in maternal and infant morbidity and mortality rates and to provide explicit safeguards for the vulnerable population, targeting pregnant women and children under the age of five years.

Originally oriented toward the maternal and infant group, in the year 2003 it progressed from including only the provinces of the northern part of Argentina to achieving national coverage in the year 2007. In 2011, its name changed to Program *Sumar*, progressively expanding coverage to other population groups: children aged 6 to 9 years, adolescents aged 10 to 19 years, and women and men up to 64 years of age.

At the end of the period under analysis, Program *Sumar* aimed to accomplish the following objectives: to continue lowering maternal and infant death rates; to reinforce health care of children throughout their school years and during adolescence; to improve comprehensive health care in both women and men by promoting preventive exams and seeking to reduce death rates due to uterine and breast cancer and colorectal cancer; and to create and develop provincial health insurance targeted at the most vulnerable population.[30]

This system was a money-based incentive plan associated with outcomes. Different tools linked money transfers (to provincial insurance and, later, to providers) to the accomplishment of certain population coverage outcomes, services to be covered and public health goals. The auditing, monitoring and assessment mechanisms played

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

a substantial role in linking said transfers to public health outcomes. In the framework of these commitments, each provider received financial resources that they could assign to the construction and improvement of buildings, the purchase and maintenance of equipment, the hiring and training of human resources or the purchase of supplies not provided by other plans.[31]

Public health goals known as "tracing" goals were a set of indicators aimed to measure different aspects of the health care process which should explicitly guarantee services existing in the official nomenclature index for the entire population, regardless of jurisdiction or accountability of the provider in charge.[32]

Implementation challenges in subnational scenarios

Returning to the historical neo-institutionalism approach, two attributes help characterize the Argentine institutional matrix in which universality-orientated policies occur: federalism and decentralization.[26]

Federalism defines the scope and limitations of the powers within each jurisdiction, since it means that there is more than one government regulating the same territory. Although the provinces in Argentina did not delegate health issues to the federal government, the National Constitution as amended in the year 1994 establishes the safeguard concerning the right to health and, in turn, sets forth that the right should be exercised under the jurisdiction of the provinces, which are still responsible for defining the scope of the right and organizing the methods for providing services.

Subject to these constitutional conditions, *decentralization* processes also converged in shaping the network of hospitals and health centers. Certain studies on decentralization processes have shown that they were motivated more by the mandate of solving the financial conflict between the national and the provincial states than by an interest in bringing the services closer to the population's preferences. This peculiar aspect explains the fact that transfers were made without considering the articulation or needs of the organization of health services, and also helps to understand its consequences: the emergence of provincial governments with limited capacity for action and serious financing problems.[36]

Confronted with these limitations, the provincial states (and, later on, municipalities as well) progressively started to assume health service provision as part of their governmental agenda: they created establishments, broadened services, made innovations in the organization, and took on the management of hospitals and health centers. These challenges were contemporary with the progressive and radical regression of the national State with respect to the development of the offer of public health. During this process, service profiles, access methods and articulation mechanisms with social security began to be defined, which varied among provinces and even among municipalities.

These processes resulted in extremely heterogeneous, and very unequal, provincial as well as municipal scenarios, in terms of their capacity for financial response. Such conditions were of key importance to the development of the provincial configurations in which the efforts of the national programs oriented toward universality in health take place.

At the beginning of Program *Remediar* and the then Plan *Nacer*, the provinces were responsible for 68% of health care centers (first level) and 73% of the hospitals (second level), while almost all of the remaining establishments were under municipal jurisdiction (30% of health centers and 24% of hospitals), and only a few remained under national jurisdiction. This jurisdictional division of providers was also reflected in the distribution of state health investment that, without including the different types of social security contributions, accounted for the following percentages: 0.33% of the gross domestic product (GDP) reflected the investment made by the national State, while the investment coming from the provinces amounted to 1.26%, and that of the municipalities 0.26%.[37]

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

The distribution of responsibilities inherited from decentralization also marked the borders of action in each governmental level at the beginning of the decade: while the National Ministry of Health (with very few establishments under its control) managed to lead an intergovernmental agenda focused on primary health care service strategies, provincial as well as municipal decisions were subject to the mandate to guarantee the provision of health services at hospitals and health centers falling within their responsibility.

Therefore, the "return" of the National Ministry of Health to the arena of health services represented by Program *Remediar*, Plan *Nacer* and Program *Sumar* found 24 extremely heterogeneous provincial settings, both in the way the duties were distributed with respect to the provision of services, and in the orientations behind the policies that (not always in a progressive way) affected the conditions in which health universality was promoted.

The prioritization of the first health care level in national policy confronted the National Ministry of Health with two different types of actors that varied in their responsibilities regarding the provision of services: the provincial states and the municipalities. National initiatives showed the capability of determining a clearer (though not always uniform) role for the provinces and a less explicit place for the municipalities, whose participation in the provision of state-run services varied among provinces.

Provinces were a veto point for the development of the national policy, not only due to the characteristics of the federal Argentine system, but because the public health authority was and is still based in the provinces, out of which duties are derived in relation to the institutional interaction with the setting, the management of resources and the enactment of standards oriented toward health care processes. During the period under review, the "adherence to laws" and the execution of "contracts of adhesion" institutionalized the approval of national policies on the part of the provincial states, and established commitments to be accomplished by each party.

Progress toward universality

The mechanisms of the policies being analyzed – Program *Remediar*, Plan *Nacer* and Program *Sumar* – show different attempts at change in the variables under review: access, coverage, benefits, and rights.

Access

The effort of the national public policy to strengthen the first level of health care was a strategy existing in the policy mechanisms analyzed during the whole period, which sought to facilitate the provision of public health care to the population of greater vulnerability. According to a characterization of demand carried out by Program *Remediar*, 82% of the individuals using the primary health care centers were concentrated in income quintiles 1 and 2, while 7 out of 10 received coverage exclusively from state subsector.[28]

This strategy encountered a vast and heterogeneous array of provincial and municipal health centers and posts demonstrating different forms of *commodification in the access to services*, among which the collection of a "bonus" was the most widespread. In this context, Program *Remediar* fought to remove economic barriers in health *access* by formally establishing free health care at each primary health care center as a requirement to continue to implement the program, a mechanism reinforced by auditing procedures and the discussion of relevant reports in meetings involving representatives from the national, provincial and municipal levels. A study involving 18,317 auditing procedures detected the existence of bonus payments for health care services (professional consultations or medical practices), in which compulsory payment for consultations occurred at the expense of optional consultation payments, with very important differences between provinces and – within them – among municipalities. Although this study shows the trajectory to be erratic in the period under review, the Survey of Use and Expenditure in Health Services reveals some achievements reflected in a reduced proportion of the population that faced

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

financial obstacles in consultations within the state-run subsector services, from 13% in 2003 to 5% in 2010.[33]

The defense of the free status of services was also a requirement to remain a "supplier" within Plan *Nacer*, later called Program *Sumar*, although in this case the application of financial incentives to promote timely access to certain services should be highlighted (well child visits and pregnancy visits per trimester, among others).

Coverage

With respect to the second variable in our analysis, guaranteeing *coverage of services* to the population was another concern of the national policy, especially, in a context with difficulties in reducing the percentage of the population not covered by social security or private insurance (31% in the year 2011).[38]

Within that framework, both Program *Remediar* and Plan *Nacer*/Program *Sumar* nominalized the population to concentrate the efforts on those to whom the state-run health services were the only alternative. With Plan *Sumar*, strict mechanisms linked payment tools to the fulfillment of the focalization requirement (population not covered by employment-based or private insurance). As a result, in the year 2015, 100% of the 12,787,232 million people covered by the program[35] did not have any coverage other than that provided by the State.

Despite sharing identical formal criteria when defining the target population, for only 66% of the individuals resorting to Program *Remediar* the State was the only health care provider in the year 2013, and 82% of the total belonged to the two lowest income quintiles.[39]

The Universal Allowance per Child (AUH) [*Asignación Universal por Hijo*], a type of social security which integrated children, adolescents and young people up to the age of 18 into the Family Allowance System regardless of their parents' condition in the labor market, had the requirement of carrying out health check-ups to receive a percentage of the allowance, with differential impacts depending on the programs under analysis. With Plan *Nacer,* the registration of children increased by 50% and the number of children with complete controls grew by 12%. However, the reverse also took place: 230,000 children accessed the AUH because they were enrolled in Plan *Nacer*.[40] As for Program *Remediar,* the results in terms of integration seem to have been lower: out of 5,096,267 children aged 0 to 18 years who were Program *Remediar* beneficiaries, only 19% (991,745) received the AUH, while 44% received benefits from Program *Sumar*. This percentage reaches 80% when children under 6 years of age are considered.[28]

Benefits

Heterogeneous responses by the State both at a provincial and municipal level led national policy to also consider the need to explicitly guarantee *a homogeneous set of benefits in terms of quantity, quality and opportunity for the entire population*. The training of health care teams, the regulation of prescriptions and the provision of essential medications at the first level (accomplished through Program *Remediar*), as well as the adoption of a "nomenclature index of services" and "tracing" goals associated with payment mechanisms for Plan *Nacer* and Program *Sumar* providers, are the tools used by the policy mechanisms under analysis to accomplish homogeneous standards in services, regardless of the jurisdiction where the health care facilities and hospitals were located.

The medications supplied by Program *Remediar* accounted for 85% of the medications delivered free of charge by first health care level providers. A quantitative study about the impact on equity conducted in the year 2013 showed that the transfer of Program *Remediar* reduced the total expenditure in medications for the people in the lowest income quintiles.[28]

By expanding the target population, Plan *Nacer* and Program *Sumar* integrated new services. In 2005 they began with a basic benefit plan orientated toward the maternal and infant population – mostly preventive

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

and health promotional benefits – provided by establishments with low complexity of care. The program's scope increased gradually and, starting in 2010, included the care of other age groups and broadened the comprehensive care of people with congenital heart diseases as well as high-risk pregnancy and neonatology services (including treatment, diagnosis and required medications). Starting in the year 2015, the program included secondary prevention of non-communicable chronic illnesses in men aged 20 to 64 years.

Plan *Nacer* and Program *Sumar* defined an essential set of prioritized medical services considered crucial for good health care which were included in the nomenclature index and for which each Provincial Health Insurance could be billed. Included were 400 primary prevention medical and health promotion services, and treatment and secondary prevention activities organized in 47 health care areas that formed a single and homogeneous nomenclature index for the whole country aimed at specifically establishing attributes of quality required for each of them.[29]

Rights

Despite the relevance that they had for the sector and challenges they faced in a very fragmented institutional matrix, the policy mechanisms under review were not accompanied by institutional arrangements that, at a national level, would demand any requirement linked to *the expansion of rights*.

Program *Remediar* sought to merge into the organizational structure of the Ministry of Health, while Plan *Nacer* and Program *Sumar* were managed from a separate administrative unit. However, the creation of "provincial health insurance" and their accompanying budgetary commitments amount to advances whose effectiveness, in terms of universality, will have to be evaluated in the future.

Coverage subject to the absence of employment-based health insurance and the payment mechanisms used by Plan *Nacer* and Program *Sumar* reveal not only a concern to guarantee coverage to the entire population, but also an interest in promoting the *separation of duties between financing agents and providers* to coordinate the financing among governmental levels. With respect to this latter orientation, along the paths toward universality that were proposed by national policy until 2015, two public health models coexisted: one oriented to the construction of a public insurance (represented by Plan *Nacer* and Program *Sumar*), and another one oriented to reinforcing the public service supply (Program *Remediar*). Although all based on a common origin (the Federal Health Plan 2004-2007), these programs reveal discrepancies within the National Ministry of Health regarding the methods of conceiving the recovery of leadership capacity over a network of state-run establishments that, several decades ago, were the concern of other governmental jurisdictions.

FINDINGS

Generally speaking, national policy actions were concentrated on the relationships between the population and the providers, seeking to regulate and reinforce crucial aspects of medical and institutional practice at the level of services. To this end, different monetary and nonmonetary incentives (medications, medical and non-medical equipment, production incentives, among others) were encouraged that were directly focused on the primary health care centers and, with lesser intensity, on state-run hospitals in provinces and municipalities. In turn, the strategies adopted by almost all of the mechanisms were oriented toward the training of health care teams and the creation of care provision standards.

While being implemented – and fulfilling the requirements imposed by federalism in health for the implementation of national programs – each policy device under analysis gave to the provincial State a different place and varied margins of autonomy regarding the way of allocating resources. Although Program *Remediar*, Plan *Nacer* and Program *Sumar* shared the idea of forging a

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

direct relationship with the primary health care centers, Program *Remediar* achieved this by seeking to reinforce the offering of state-run services, while Plan *Nacer* tried to establish a division of tasks between financing and provision.

The implied "change models" in the policy mechanisms under review meant different hierarchy given to the provincial level: in Program *Remediar*, provinces were responsible for the primary health care centers; in Plan *Nacer* and Program *Sumar*, the provincial level was the space for the creation of provincial public health insurance, as buyers of services from providers (both public and private). In those scenarios where the provision of services was (in whole or in part) under the charge of the municipalities, differences also appeared in relation to the place assigned to this governmental level: while Program *Remediar* gave municipalities the role of entities "responsible for the provision of services" and emphasized this role through organizational routines, Plan *Nacer* and Program *Sumar* gave municipalities the role of "manager of third-party funds" of the primary health care centers (defined as "public-private suppliers"), and insisted on the sovereignty of these centers in the allocation of resources derived from the billing of services.[24]

The national initiatives under review (with their rules and routines) established a new actor, the primary health care teams, with different autonomy margins in each policy device according to the aspect of the medical practice and/or organizational routine that it sought to regulate.

At the same time, both policy mechanisms helped reinforce the leadership capacity of the National Ministry of Health, though from different perspectives. Program *Remediar* had a founding role since it was a centralized policy of medication distribution with strong auditing, monitoring and assessment mechanisms, although the management also included the provinces and municipalities with first level establishments under their jurisdiction. On the other hand, Plan *Nacer* and Program *Sumar* was aimed at maintaining leadership capacity with respect to coverage issues and guaranteeing a set of services in quantitative and qualitative terms, leaving different degrees of autonomy open for provincial decision-making.

During the universalization process, the goal of national policy was the reinforcement of the first level of health care to promote access, a strategy that was present in the policy mechanisms being analyzed, by facilitating free health care to population groups with no coverage other than that provided by the State. Hence, Program *Remediar* aimed to remove economic barriers as a prerequisite to deliver "first-aid kits" of medications to primary health care centers, and Plan *Nacer* and Program *Sumar* protected the free status of services by imposing this as a requirement to continue as a provider in the program.

The coverage of services provided to the population was another concern, especially in a context that revealed difficulties in reducing the percentage of population that could not obtain coverage through social security or through private insurance. Both Program *Remediar* and Plan *Nacer*/Program *Sumar* nominalized the population, and concentrated their efforts on those that received state-run health services as the only alternative.

With respect to the benefits, heterogeneous responses by the State at a provincial and municipal level also led to the consideration of the need to explicitly guarantee a homogeneous set of services in terms of quantity, quality and opportunity for the entire population. The training of health care teams, the regulation of prescriptions and the provision of essential medications in the primary level accomplished through Program *Remediar*, as well as the adoption of a "nomenclature index of services" and "tracing" goals associated with mechanisms of payment in favor of Plan *Nacer* and Program *Sumar* providers, were the tools used to achieve homogeneous standards in the services, regardless of the jurisdiction where the health care facilities and hospitals were located.

In this context of the Argentine institutional matrix, these programmatic orientations fought their battles within spheres of implementation with diverse configurations

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

(in terms of service provision profiles, access methods and articulation mechanisms with social security), posing different research questions about the paths toward universality to be answered at a subnational level and through studies limited to specific territorial and institutional contexts.

ACKNOWLEDGMENTS

This paper is the result of a research work entitled *"Cobertura universal de salud y redes de servicios: encuentros y desencuentros entre la macro y la meso gestión: Un estudio de caso en el conurbano bonaerense 2008-2015"* [Universal health coverage and service networks: agreements and disagreements between the macro and mezzo management: A case study in Metropolitan Area of Buenos Aires 2008-2015"], conducted with the support of the Scientific and Technological Research Funds [Fondo para la Investigación Científica y Tecnológica - FONCyT], Research Scientific and Technological Project (2014) PICT 0693, developed at the Metropolitan Area of Buenos Aires Research Institute at Universidad Nacional de General Sarmiento, Buenos Aires, Argentina.

REFERENCES

1. Bergallo P. Argentina: los tribunales y el derecho a la salud. In: Yamin AE, Gloppen S. La lucha por los derechos de la salud: ¿Puede la justicia ser una herramienta de cambio? Buenos Aires: Siglo XXI Editores; 2013.

2. Laurell AC. Contradicciones en salud: sobre acumulación y legitimidad en los gobiernos neoliberales y sociales de derecho en América Latina. Saúde em Debate. 2014;38(103):853-871.

3. Abramovich V, Pautassi L. Dilemas actuales en la resolución de la pobreza: El aporte del enfoque de derechos. Seminario "Los Derechos Humanos y las Políticas Públicas para Enfrentar la Pobreza y la Desigualdad"; Universidad Nacional Tres de Febrero, Buenos Aires. Buenos Aires: UNESCO, Secretaría de Derechos Humanos; 2006.

4. Cetrángolo O. Aportes para el desarrollo humano en Argentina 2011. Buenos Aires: PNUD, OPS, CEPAL; 2011.

5. Cunill Grau N. Las políticas con enfoque de derechos y su incidencia en la institucionalidad pública. Revista del CLAD Reforma y Democracia. 2010;46:41-72.

6. Crojethovic M. Universalismo en salud: La reconstrucción de un debate sobre los derechos. Revista Vía Iuris. 2016;21:13-23.

7. Organización Mundial de la Salud. Hacia la cobertura sanitaria universal: conceptos, enseñanzas extraídas y desafíos para las políticas públicas. Revista Española de Salud Pública. 2013;8 (1):3-9.

8. Organización Mundial de la Salud. Estrategia para el acceso universal a la salud y la cobertura universal de salud [Internet]. Washington DC: OMS; 2014 [cited 25 Jan 2017]. Available from: https://goo.gl/qMW7At.

9. Pressman J, Wildavsky A. Prefacio a la primera edición. In: Implementación: Cómo grandes expectativas concebidas en Washington se frustran en Oakland. México: Fondo de Cultura Económica; 1998.

10. Aguilar Villanueva LF. Estudio introductorio. In: La implementación de las políticas públicas. México: Miguel Ángel Porrúa; 1996.

11. Belmartino S. Desarrollo metodológico para una historia comparada de la profesión médica (Documento de Trabajo Nº 80). Buenos Aires: Centro Interdisciplinario para el estudio de las políticas públicas; 2011.

12. March JG, Olsen JP. Las reglas y la institucionalización de la acción. In: El redescubrimiento de las instituciones: La base organizativa de la política. México: Fondo de Cultura Económica; 1997.

13. Pierson P, Skocpol T. El institucionalismo histórico en la ciencia política contemporánea. Revista Uruguaya de Ciencia Política. 2008;17(1):7-38.

14. Hall P, Taylor R. Political science and the three new institutionalisms. Political Studies. 1996;XLIV:936-957.

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

15. Naciones Unidas para los Derechos Humanos. Estándares internacionales sobre el derecho a la salud en el sistema de Naciones Unidas. Colombia: Oficina del Alto Comisionado de las Naciones Unidas para los Derechos Humanos; 2015.

16. De Riz L. Argentina, una vez más en la encrucijada. Temas y Debates. 2008;(16):9-27.

17. Ministerio de Salud de la Nación, Organización Mundial de la Salud, Organización Panamericana de la Salud. Indicadores Básicos Argentina 2015 [Internet]. Argentina: Ministerio de Salud de la Nación, OMS, OPS; 2015 [cited 25 Jan 2017]. Available from: https://tinyurl.com/yaj45m74.

18. Banco Mundial. Indicadores del desarrollo mundial: PBI per cápita año 2015 (a precios actuales) [Internet]. Banco Mundial [cited 25 Jan 2017]. Available from: https://tinyurl.com/yd4hbu9j.

19. Instituto Nacional de Estadística y Censos. Censo Nacional de Población, Hogares y Viviendas 2010: Cuestionario Ampliado [Internet]. INDEC [cited 25 Jan 2017]. Available from: https://tinyurl.com/ybc5ndvg.

20. Maceira D, Apella I, Barbieri E. Necesidades de la demanda y subsidios de medicamentos: La experiencia del Programa Remediar en Argentina. Buenos Aires: CEDES; 2005.

21. Cetrángolo O, Lima Quintana L, San Martín M. Situación del sector salud en Argentina: Análisis en el contexto de un sistema descentralizado. Buenos Aires: Banco Interamericano de Desarrollo; 2007.

22. Findling L, Champalbert L. La política de salud en Argentina: Avances y cuestiones pendientes. Ciencias Sociales, Revista de la Facultad de Ciencias Sociales. 2007;(69):30-31.

23. Arce H. El sistema de salud: De dónde viene y hacia dónde va. Buenos Aires: Prometeo; 2010.

24. Chiara M. Políticas e instituciones en salud: el desafío de construir nuevos escenarios. Debate Público, Reflexión de Trabajo Social. 2013;3(6):31-42.

25. Potenza dal Masetto F. La implementación del Plan Nacer en ámbitos subnacionales (Documento de Trabajo No. 82). Buenos Aires: CIPPEC, Programa de Protección Social, Área de Desarrollo Social; 2012.

26. Chiara M. Política de atención de la salud y relaciones intergubernamentales (RIG): continuidades e inflexiones en los patrones de interacción en el Gran Buenos Aires, Argentina (2001-2011). [Tesis de doctorado]. Buenos Aires: Facultad de Ciencias Sociales, Universidad de Buenos Aires; 2013.

27. Banco Interamericano de Desarrollo. Programa de Fortalecimiento de la Estrategia de Atención Primaria de la Salud [Internet]. 2006 [cited 25 Jan 2017]. Available from: https://tinyurl.com/y7bz8wm5.

28. Ministerio de Salud de la Nación, Programa Remediar. Acceso a medicamentos esenciales e impacto redistributivo. Buenos Aires: Ministerio de Salud de la Nación, Programa Remediar; 2015.

29. Sabignoso M, Silva H, Curcio J. Argentina: el Plan Nacer. In: Giedion U, Bitrán R, Tristao I. Planes de beneficios en salud de América Latina: una comparación regional. Buenos Aires: Banco Interamericano de Desarrollo, División de Protección Social y Salud; 2014.

30. Ministerio de Salud de la Nación. Programa Sumar: Plan de servicios de salud. Buenos Aires: Ministerio de Salud de la Nación; 2015.

31. Ministerio de Salud de la Nación. Plan Nacer: Manual Operativo. Buenos Aires: Ministerio de Salud de la Nación; 2008.

32. Giedion U, Bitrán R, Tristao I. Explicitar lo implícito: Análisis de siete planes de beneficios en salud de América. In: Giedion U, Bitrán R, Tristao I. Planes de beneficios en salud de América Latina: una comparación regional. Buenos Aires: Banco Interamericano de Desarrollo, División de Protección Social y Salud; 2014.

33. Ballesteros M. Evolución y localización geográfica de barreras financieras para el acceso a servicios de salud en el primer nivel de atención del sector público. Buenos Aires: Ministerio de Salud de la Nación; 2015.

34. Ministerio de Salud de la Nación. ¿Quiénes consultan en los centros de salud, por qué motivos y qué se les prescribe? Un análisis de las recetas Remediar [Internet]. Buenos Aires: Ministerio de Salud de la Nación; 2015 [cited 25 Jan 2017]. Available from: https://tinyurl.com/yd2zycz7.

35. Ministerio de Salud de la Nación. Reporte de gestión Sumar [Internet]. Buenos Aires: Ministerio de Salud de la Nación; 2015 [cited 25 Jan 2017]. Available from: https://tinyurl.com/yasdlzdx.

36. Centrángolo O, Jiménez JP. Las relaciones entre niveles de gobierno en Argentina: Raíces históricas, instituciones y conflictos persistentes. Santiago de Chile: ILPES, CEPAL; 2004. (Serie Gestión Pública No. 47).

SALUD COLECTIVA. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

37. Dirección de Análisis de Gasto Público y Programas Sociales, Secretaría de Política Económica, Ministerio de Economía de la Nación. Serie Gasto público nacional, provincial y municipal consolidado [Internet]. Buenos Aires: Ministerio de Economía de la Nación [cited 25 Jan 2017]. Available from: https://tinyurl.com/yd4dg8mr.

38. Instituto Nacional de Estadísticas y Censos. Encuesta Permanente de Hogares. Buenos Aires: INDEC; 2011.

39. Ministerio de Salud de la Nación. Evaluación y monitoreo 2013: Acceso a medicamentos, diversas miradas, un mismo derecho [Internet]. Buenos Aires: Ministerio de Salud de la Nación; 2013 [cited 25 Jan 2017]. Available from: https://tinyurl.com/yazxkq6n.

40. Ministerio de Salud de la Nación. Programa Sumar, la ampliación del Plan Nacer [Internet]. Buenos Aires: Ministerio de Salud de la Nación; 2011 [cited 25 Jan 2017]. Available from: https://tinyurl.com/ybuumjj4.

CITATION
Chiara M, Crojethovic M, Ariovich A. Health universalism in Argentina between 2003 and 2015: assessments and challenges based in a macro-institutional approach. Salud Colectiva. 2017;13(4):663-676. doi: 10.18294/sc.2017.1312

Received: 2 February 2017 | Modified: 5 May 2017 | Accepted: 30 May 2017

http://dx.doi.org/10.18294/sc.2017.1312

This article was translated by Mariela Santoro, and reviewed by Vanessa Di Cecco.