1-1-1995

Health Concerns in Argentina

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Introduction

Argentina is a federal republic composed of 23 provinces and the federal capital. According to the constitution, these political divisions are responsible for caring for the population's health. The government that came into power in 1989 under President Carlos Menem — the second since the democratic system was restored — began many structural changes in the economy and the state, and in the state's relation with society in general. (PAHO, vol. 2, 1994, p. 16) Deregulation and privatization strategies have caused the provision of many public services (such as social services, education, and health) in which the state traditionally played a major role, to become less efficient. In the health care sector particularly, many resources are being wasted. Furthermore, the decentralization of the system has caused it to become overly bureaucratic, health education is limited, and few preventive measures are being taken to improve health risk factors.

The increasing bureaucratization of the Argentinean medical system allows physicians to hold down several jobs and creates more physician-held administrative positions. However, this same system concentrates resources for maximizing profit on quick, lucrative curative care as opposed to more cost-effective preventive medicine and health promotion. (Scarpaci, p. 364) This lack of attention to preventive care is especially problematic in a country where beef and alcohol consumption is high, cigarette smoking is widespread, and chronic illnesses are major causes of death.

New ways of structuring and operating the health care system are now being sought in order to address some of its problems. Some of the principal health reforms being pursued are a reform of the social security system (with a payroll tax used to provide health care to workers), a reorganization of public health care services, and a change in the role of the Department of Health. (PAHO, vol. 2, 1994, p. 24) The department maintains national institutes and administrative units that are designed to set policy in conjunction with the provinces and to provide support to critical elements and approaches of the health care system. The Department of Health has been transferring
health care services formerly under its control to the provinces and local governments, ending the central government’s direct responsibility.

This paper will briefly review the current Argentine health care system. It will also discuss some of the largest health concerns in Argentina today and review what quality of care the average Argentine hospital-goer can expect to receive. Finally, it will address what kind of health education Argentina offers, from the quality of teaching within the medical schools to the role which the government and other agencies may play in supplying announcements and health warnings to the public.

Health Care System Organization

Two years before Juan Domingo Perón took the office of President of Argentina in 1946, he claimed: “The medical profession in our country should begin to be transformed into an activity that is controlled by the state, so the physician can develop along the lines of excellence.” (Neri, 1983, p. 100) Although Perón was hinting at the idea of creating a socialized medical system, this did not occur. The Peronist government of the 1940s transferred power over medical care to labor unions in exchange for their electoral support. (Scarpaci, p. 367) This permitted unions to manage large funds derived from mandatory wage withholdings in order to finance medical programs for their workers. The number of these prepaid labor-based medical programs, which are run by agencies known as obras sociales, increased, as did the bureaucracy of the medical system.

Today Argentina’s health system consists of three interrelated levels and bears some resemblance to the health care system in the United States, including the deficiencies in coverage, excess medicalization and unnecessary expenses. Despite the system’s complexity, its different services are dependent upon one another, working through a form of financing called “subsidized supply.” (PAHO, vol. 2, 1994, p. 24) Subsidies are provided through social security and public funds, and payment is made according to a schedule of fees determined through negotiation between financing groups (e.g., obras sociales) and providers. About $3 billion per year, however, is lost to negotiation and contract commissions, so new ways of structuring the health care system are currently being sought. There is debate about whether the “subsidized supply” system or a “subsidized demand” system (the model being tested in many countries) would be more cost efficient.

The first level of the health care system is designed for the public (especially the poor and unemployed) and includes hospitals and community health centers. (Labonte, p. 1216) These hospitals and health centers may be managed at the level of the federal, provincial, or local governments, and provide most of the system’s beds for acute care. Currently it is the provincial and local services that serve low-income groups not covered by social security.

The second level (social security level) superficially resembles health maintenance organizations (HMOs) in the United States. Funding is provided through a social security payroll tax which the government transfers to more than 300 independent agencies, the obras sociales. (Labonte, p. 1216-17) Many of these agencies are administered by trade unions, and their primary task is to contract private or public hospitals and health centers to provide services to agency members. While the obras sociales are the largest health care providers in Argentina, covering about 65 percent of the population, there is actually little money for this system. Poor and often corrupt administration of funds leaves workers with insufficient coverage. Consequently, many workers covered by obras sociales end up using the first level public system, overtaxing that system’s ability to care for those who have no second level coverage.

The third level, which covers the smallest percentage of the population, is the fully private system of hospitals and medical care provided on a prepaid insurance basis. (Labonte, 1217) This level is composed of two major groups: independent professionals providing services to private patients or a private prepaid health care system, and health care establishments under contract with the obras sociales. The obras sociales may hire intermediary labor contractors to purchase the hospital and medical services on their behalf. This level is economically the most profitable, with much of the profit derived from the services provided under these contracts.
In 1986, the Department of Health reported that there were approximately 6,500 physicians' offices and outpatient facilities, 3,180 hospitals, and 147,000 hospital beds in the country. (PAHO, vol. 2, 1994, p. 26) Of the beds, 44,300 are available in the metropolitan region, and two-thirds of these are for patients with acute problems. The public level has 53 percent of all of the beds available for patients with acute conditions, and 67 percent of the beds available for patients with chronic conditions. The social security level has only 9 percent of the beds for patients with acute conditions, while the private level has the rest.

**Major Causes of Death**

According to the 1991 National Census, the population of Argentina was 32.6 million. (PAHO, vol. 2, 1994, p. 17) Eighty-five percent of this population lives in urban areas, so the greater part of the country is sparsely inhabited and often lacks sufficient health resources. The decline in the infant mortality rate (from 33.2 to 25.6 per 1,000 live births) and in the general mortality rate (from 8.6 to 8.0 per 1,000 inhabitants) from 1980 to 1990 has helped to raise the life expectancy from 65.4 years for men and 72.1 years for women in 1975-1980 to 67.3 years for men and 74.0 years for women in 1985-1990. (PAHO, vol. 2, 1994, p. 17) However, there has also been an increase in the incidence of chronic diseases over these years, which remain the major causes of death in Argentina. Heart disease, malignant tumors, and diseases of the brain are the greatest concerns, as they are in the United States.

**Heart Disease**

In 1980, coronary heart disease was the primary cause of death in Argentina, being responsible for 29.9 percent of all deaths. In 1990 this figure had risen to 31.4 percent, with heart disease still the leading cause of death. (INDEC, p. 74) Hauger-Klevene and Balossi (1987, p. 133) found that over the last 15-20 years there has been a decreasing trend in mortality from coronary heart disease in some countries including the United States, but coronary heart disease mortality in Argentina is still exceptionally high and does not appear to be declining.

The international comparison of coronary heart disease mortality for 1990 published by the World Health Organization shows that men aged 35-64 in Argentina have not only the highest mortality rates in Latin America at 921.8 per 100,000, but also one of the highest mortality rates in the world. (WHO, p. D-11) In the United States, where coronary heart disease is also the leading cause of death, the rate in men aged 35-64 is only 775.7 per 100,000. Argentina is now facing the same problem as in other countries where coronary heart disease mortality rates are very high and are apparently still showing an increase. One must look at the possible determinants of heart disease in order to explain these trends.

Many studies have shown that the major coronary risk factors are high blood pressure, cigarette smoking, and, especially, total serum cholesterol levels. Although there has been no national sampling of the Argentinean population, a high prevalence of coronary risk factors has been observed among civil workers in the army, including hyperlipoproteinemia (high blood cholesterol, detected in 43.9 percent of workers), smoking habits (35 percent), and psychosocial stress (49.5 percent). (Neuman et al., 1979) Studies carried out in Buenos Aires and Zarate (Hauger-Klevene and Balossi, 1984, p. 1) also demonstrate the high prevalence of hyperlipoproteinemia. The elevated total cholesterol levels may reflect the fact that the average meat consumption in the Argentinean diet is very high. The total calorie consumption per capita per day (3,070 in 1990) is also very high, similar to that observed in the United States (3,666). (PAHO, vol. 1, 1994, p. 428)

**Cancer**

As in the United States, malignant tumors (cancers) rank as the second leading cause of death in Argentina, accounting for 17.9 percent of all deaths in 1990 (INDEC, p. 74) and continuing to show an increasing trend (16.1 percent in 1980, 17.6 percent in 1985). Argentina shows a pattern of cancer mortality that is intermediate between patterns of developed and developing countries, with lung cancer noted as the greatest cause of death by cancer in men.
and breast cancer noted as the greatest cause of death by cancer in women. (Matos, Loria, and Vilensky, p. 213)

Tobacco-related Cancers

The rate for lung cancer in men is more than eight times higher than the rate in women. The incidence of other tobacco-related cancers is also dramatically higher in men, such as cancer of the larynx (15 times higher) and cancer of the bladder (6 times higher). As noted previously, tobacco smoking is very common in Argentina. As in other countries, though, trends have shown that the percentage of male smokers in Argentina is decreasing while the percentage of female smokers is increasing. (Poletto et al., p. 389) As a result, we may begin to see less of a difference between the rates of tobacco-related cancers for men and women.

Lung, bladder, and larynx cancer rates for men are also more prevalent in provinces where the population is most urbanized and where many industries are located. (Matos, Parkin, Loria, and Vilensky, p. 868) It is uncertain, however, whether this observation is primarily attributable to the high prevalence of smoking or to the environmental air pollution of such provinces. There is little data on the use of tobacco by province to show this.

Breast Cancer

Although Argentina is not as developed as the United States, the incidence of breast cancer is nearly as high. The breast cancer rate in Argentina in 1980 was 82.2 per 100,000 women, while it was 85.4 per 100,000 women in the United States. (Matos, Thomas, Sobel, and Vuoto, p. 358) Mortality rates from breast cancer are also similar in both countries. According to the World Health Organization (p. D-10), 26.2 per 100,000 women died from breast cancer in Argentina in 1990 compared to 34.0 per 100,000 women in the United States. These high rates of breast cancer in Argentina may be attributable to the unusually large quantities of meat, again mainly beef, that are eaten. This is significant because high consumption of animal products, particularly fats, has been shown to be correlated with high breast cancer levels.

Gastrointestinal Cancers

Rates of esophageal cancer in Argentina are considerably higher than those rates in Europe or the United States (2.9 times greater in men and 2.7 times greater in women). (Matos, Parkin, Loria, and Vilensky, p. 868) Mortality rates from cancer of the esophagus, though, are significantly higher in Argentine men than women. This pattern may result from the combined effects of tobacco and alcohol, considering that women still smoke and drink much less than men in Argentina. Mortality rates for colon cancer are moderately high and only slightly greater for men than women (9.6 and 8.0 per 100,000, respectively). The highest rates have been reported in the more developed central and eastern provinces, and seem to again be due to high consumption of meat and animal fats.

Palliative Care

Relieving the pain and suffering of cancer (palliative care), especially for a developing country such as Argentina, is made more difficult by resource limitations and sociocultural views of sickness. A few successful palliative care programs, however, have developed in certain cities in Argentina. (Johanson, p. 11) The first program was developed in 1987 by Dr. Robert Wenk. It is named Centro de Cuidados Paliativos de San Nicolás and was formed with the help of private donations and volunteer efforts. The national Argentine Palliative Care Program has since developed numerous small centers with many trained volunteers, including a program in La Plata which is formally attached to a cancer treatment program.

As opposed to what we may be used to in the United States, in Argentine society protecting the patient from learning of certain unfortunate treatment realities takes priority over honesty and truth-telling. (Johanson, p. 12) Therefore, discussion about cancer and limited life expectancy are often taboo. The strong influence of Catholicism has also contributed to limited conversation about death and dying. This limited conversation may sometimes lead to feelings of isolation for the patient.

A major problem for Argentine palliative
care is resources. Private and government money available to develop new programs is very limited. (Johanson, p. 12) A shortage of trained licensed nurses and poor access to nursing training programs are also great impediments. The number of professional nurses per 100,000 people is only 56 in Argentina compared to 829 in the United States. (WHO, p. C-14) Access to greater resources and an increase in the number of trained nurses would help to bring higher quality care to a growing number of patients.

Diseases of the Brain

Diseases of the brain rank as the third leading cause of death in Argentina, accounting for 10.1 percent of all deaths in 1990. This is only a slight increase over the percentage in 1980 (9.3 percent). (INDEC, p. 74) The rates of brain diseases in Argentina for 1990, however, were significantly greater than the rates within the United States. Among men, 81.3 per 100,000 died of brain diseases in Argentina, while in the United States, the rate was only 46.8 per 100,000. Brain diseases were responsible for 78.3 deaths per 100,000 women in Argentina, compared to 68.6 per 100,000 in the United States. (WHO, p. D-12)

The high mortality rates from brain diseases in Argentina may be due to many of the same factors that cause high mortality rates from heart disease, including high meat intake, high levels of cigarette smoking, and psychosocial stress. In women, diseases of the brain have significantly increased over the past 15-20 years in the age group 35-44. (Hauger-Klevene and Balossi, 1987, p. 138) For these women, an increasing trend in cigarette smoking, as well as oral contraceptive use, may be responsible for the increase in brain diseases. The possible role of oral contraceptive use in the increased mortality of younger women is speculative, but oral contraceptives have long been suspected to be related to cerebrovascular accidents. (Hauger-Klevene and Balossi, 1987, p. 138) The presence of both these risk factors in women raises the mortality risk more than 20 times.

Other Health Concerns

AIDS

The number of individuals in Argentina with AIDS is growing rapidly. During 1989, 281 new cases were reported, representing a 70 percent increase over previous years. By 1993 the number of new cases reported each year had nearly quadrupled, and the cumulative total number of cases had reached 3,762. (PAHO, vol. 1, 1994, p. 186) Argentina's epidemiological trend seems to resemble those of countries where the epidemic started earlier, such as the United States and France. (Raggi and Blanco, p. 226) One major factor in the spread of AIDS within Argentina lies in those cases reported in which the HIV virus was acquired abroad. There was a significant number of infected individuals who returned from abroad during the late 'seventies, a time in which tourism outside of the country increased significantly. Prior to this time, the existence of the epidemic was not yet known. Such imported cases represented nearly 50 percent of the total number of cases reported by the National Program of Sexually Transmitted Diseases and AIDS, Ministry of Public Health (NPA), up to December 1989. Regardless of how the epidemic started, though, the rate of infection is now controlled by internal factors, while the imported contribution is fading rapidly.

The population of homosexual and bisexual men had been infected earlier by the spread of HIV than any other group. (Raggi and Blanco, p. 227-29) This seems important to the onset of the epidemic because many of these same individuals were those infected abroad during 1978 to 1983. Through April 1990, a total of 167 AIDS cases had been reported in male homosexuals or bisexuals. Estimates based upon trends within other countries indicated that 1,432 new AIDS cases would be diagnosed by the end of 1992, representing a 757 percent increase over the previous number.

The first AIDS case reported in an intravenous drug user (IVDU) took place in 1986. Since that time, a total of 152 cases had been reported to the NPA through the beginning of
1990. Predictions indicated that by the end of 1992 the cumulative number of AIDS cases reported in this group would be 1,483. (Raggi and Blanco, p. 229) Although the infection among IVDU individuals started somewhat later than in other risk groups, the rate of spread among this group is of a particular concern because it is currently the fastest-growing of any group defined.

The first perinatally transmitted AIDS case was also first reported in 1986. Through the beginning of 1990, only 13 such cases had been reported; but by the end of 1992, a total of 153 cases are thought to have occurred perinatally.

Thirty-six AIDS cases have been reported in people with hemophilia or other blood coagulation disorders who need blood product transfusions. (Raggi and Blanco, p. 229) Unlike in other risk groups, though, this number appears to be fairly constant. The use of heat-treated hemoderivatives (blood factor concentrates) has contributed to a sharp reduction in HIV infection from receipt of blood products.

Until April 1990, a total of only 48 AIDS cases had been reported in heterosexual adults (with heterosexual contact thought to be the mode of transmission for 45 of them). Estimates indicated that by the end of 1992, however, a total of 449 AIDS cases would have been diagnosed among heterosexuals. (Raggi and Blanco, p. 231) Heterosexuals represented approximately 9 percent of the total HIV infected individuals in 1990, estimated at 4088. By the end of 1992, it was predicted that they would contribute well above 20 percent of the total number of infected people, at about 15,600. At this stage, it seems that the spread of HIV into the heterosexual population in Argentina is dominated mainly by the rate of HIV transfer from IVDU individuals. The future course of the AIDS epidemic in Argentina, though, will depend on the propagation of HIV among heterosexuals. Because of this threat, public health policy related to AIDS should currently be focused on prevention among sexual partners.

**Cholera**

During the 19th century, world cholera epidemics hit Latin America hard, with thousands of deaths affecting all countries of the region. By the end of the century, though, cholera disappeared from Latin America due to the installation of basic sewage disposal and water supply systems in large cities. (PAHO, vol. 1, 1994, p. 163) By 1991 and through 1993, however, cholera alarmingly once again appeared in Latin America. In January of 1992, the first case of cholera in Argentina in about 100 years was reported in the area of Pilcomayo in the province of Salta, along the Bolivian border. (PAHO, vol. 2, 1994, p. 22) Hitting mainly in Salta and Jujuy, the epidemic produced 553 cases with 15 deaths in 1992, which was one of the highest mortality rates in Latin America according to the World Health Organization. (Kowalski, p. 35) Local officials in these areas were criticized for not taking seriously government warnings about the cholera threat and for not providing clean living facilities for their 15,000-20,000 migrant workers, who were most affected.

In Argentina, as elsewhere, cholera is predominantly a disease of the poor. Drinking unboiled common water or heavily contaminated water is a major risk factor, as is eating food that is contaminated because it was improperly prepared, handled, or stored. Throughout much of Argentina, sewage is also usually discharged without treatment into rivers and other waters, which may then be diverted for irrigating crops. (PAHO, vol. 1, 1994, p. 166) Before this latest outbreak, many health and environmental services, including water and sanitation, deteriorated due to lack of maintenance or investment to meet increasing needs. The highest incidences of cholera had been reported in the northern and northeastern provinces where water supply and excreta disposal are especially serious problems.

By 1993, 2,623 cases of cholera in Argentina had been reported. Argentina, like other Latin American countries, approached the epidemic as an emergency and again recognized the need to put effort into improving public health. (PAHO, vol. 1, 1994, p. 166) Laboratory diagnostic confirmation of cases, testing for antibodies, and identification of organisms contaminating food and water were strengthened. Methods for disinfecting water, disposing of human wastes, and handling foods to prevent contamination were also implemented. These health and environmental prevention efforts will need to be contin-
ued and expanded so that Argentina is no longer susceptible to epidemic cholera.

**Risk Factors**

While it is important to understand what some of the most threatening health problems are within a society, it is of far greater importance to know what factors may be causing these conditions. This is the nature of preventive medicine. Rather than attempting to simply treat sicknesses once they appear, we should concentrate our efforts on eliminating the cause of the sickness. In the Argentine society, health risk factors are prominent in a number of aspects including diet, smoking, and sanitation deficiencies.

It is apparent that parts of the Argentine diet may be related to numerous health problems. Beef, once called the “Argentine bread,” elevates blood cholesterol levels more than most other foods because it is relatively fatty and 48 percent of its fat is saturated. In 1993 the annual beef consumption in Argentina was 67.0 kilograms per capita, compared to 43.2 kilograms per capita in the United States. (GATT, pp. 27-37) Such high quantities of consumed meat have consistently been correlated with heart disease, diseases of the brain, and certain cancers.

Smoking is a very prevalent habit in Argentina and is also related to many health concerns. According to the Pan American Health Organization (1993, p. 165), the prevalence of smoking in 1988 in Argentina was 43.0 percent for men and 27.0 percent for women. In the United States the prevalence of smoking in 1987 was 31.7 percent for men and 26.8 percent for women. In a study based in Rosario (one of the larger urban centers in Argentina, with a population of approximately one million), it was noted that as the level of education of the population increased, the percentage of smokers decreased. (Poletto et al., p. 390-92) This is noteworthy because the prevalence of smoking among 18 year olds in Argentina (33 percent) is high compared to countries that administer more elaborate anti-smoking programs within schools and the community. Many Argentine students indicated that they felt a need for more programs in order to help them quit smoking.

A housing shortage has become an important health risk factor, caused primarily by a large population shift from rural to suburban and urban areas. According to the Department of Housing and Environmental Quality, nearly 13 million people (34.7 percent of the population) live in substandard housing, which has begun to give rise to slums. (PAHO, vol. 2, 1994, p. 17) The most recent information indicates that in the late 1980s Argentina also had serious problems with sanitation services, which seems to still be true today. (PAHO, vol. 2, 1994, p. 23) Only 67 percent of the urban population and 43 percent of the rural population had access to drinking water through public systems. On average, the sewage system covered just 39 percent of the urban population. Although methods to improve water and sewage deficiencies have been implemented since the cholera epidemic of 1991-93, the quality of water sources continues to deteriorate. The National Institute of Water Science and Technology has found that industrial wastes and sewer discharges are the main water contamination factors. It is estimated that 65 percent of wastewater is discharged in surface waterways without any treatment. This becomes apparent to any observer travelling along the Parana River Delta in Tigre. The brown colored water, foul odor, and sewage lines extending from the river bank are obvious signs of Argentina’s sewage disposal problems.

Although an air quality monitoring system has yet to be set up, by analyzing particulate matter it is known that risks from air and atmospheric pollution have increased in recent years. (PAHO, vol. 2, 1994, p. 23-24) This pollution is most notable in major urban and suburban areas, where an estimated 70 percent of all the pollutants are produced by mobile sources. These pollutants are thought to have their greatest health effects on rates of lung, bladder, and larynx cancers.

**Quality of Care**

**Physicians**

Physicians play an important role in Argentine society. Not only do they form part
of the social and professional elite, but physicians' influence has also carried over into political and economic life as well. (Scarpaci, p. 365) Latin American physicians seem to command a higher social status and are less frequently challenged on their clinical expertise than in more advanced industrial nations. This may be due to the fact that, in general, there are fewer total professionals in Latin America, but it is also attributable to the fact that there are fewer well-informed health care consumers. In Argentina, for example, fewer than five medical malpractice suits were filed between 1983 and 1989. (Scarpaci, p. 365) Recently, an increase in the number of lawsuits has occurred, which is a surprising challenge to physician authority.

The return to democratic rule has allowed Argentine medical schools to relax admissions criteria, creating an oversupply of physicians. (Scarpaci, p. 371) According to the Pan American Health Organization (vol. 1, 1994, p. 435), there were 26.8 physicians per 10,000 people in Argentina as of 1990, representing the third greatest density of physicians in the Americas. This compares to a ratio of 24.5 physicians per 10,000 people in the United States. This high number of physicians has caused public medical facilities to pay relatively low salaries to physicians. Many physicians, therefore, are often forced to hold other jobs in addition to their public hospital assignments. Mornings are usually spent at the public hospitals or clinics, or at public research institutions. Afternoons, however, are almost exclusively devoted to private practice. (Scarpaci, p. 373) Much part-time work in different settings has led to a problem in trying to maintain continuity of health care delivery, and also suggests poor quality of care. High levels of multiple employment, unfortunately, stress the curative rather than the preventive nature of the medical system because physicians are concentrating on quick and profitable health care delivery. Because there is less full-time work, Argentine physicians also have a more difficult time keeping up to date on new technology, further hindering the quality of care. (Neri, 1994)

There is also an uneven distribution of physicians in Argentina, with fewer medical personnel practicing in the less populated interior regions of the country. (Scarpaci, p. 364) Physicians working in small towns in these regions, though, have greater control over their practices because of the absence of much of the administrative bureaucracy found in larger cities. Between 10 and 25 percent of Argentine physicians still own their means of production through private clinics or diagnostic equipment, but this is more common outside of the capital city.

The different fields in which physicians choose to practice intensify the curative nature of health care in Argentina. Studies have found that 50 to 60 percent of all doctors specialize, which almost ensures the use of curative medicine. There is a strong pressure to specialize, which starts during medical training and is reinforced by market conditions and the increasing use of complex technology. (PAHO, vol. 2, 1994, p. 26) As more women enter medical schools, though, they opt for more general practices (e.g., pediatrics and internal medicine) than for specialty training.

Health Care Spending

The proportion of the GNP devoted to health care is approximately 10 percent in Argentina. (Scarpaci, p. 365) While not as high as the 15 percent in the United States, this figure is comparable to that of other industrialized countries. Since Argentina returned to a democratic government in 1983, public funding of health care has declined, while employer-sponsored medical care has been promoted.

In the late 'eighties when the annual inflation rate in Argentina was extremely high, problems of the larger national economy led to even more severe problems in the medical care industry. Domestic capital has been depleted by imported imaging and diagnostic equipment. (Scarpaci, p. 370-73) For example, purchases of CT (computer axial topographer) and MRI (magnetic resonance imagery) machines were estimated to have risen by 400 percent in Argentina between 1985 and 1989. The aging urban population also has one the highest life expectancies in Latin America. The previously noted problems of chronic diseases and the high costs of elderly care have had dramatic effects on the economy.

Although Argentina has had a long tradi-
tion of health research, a recent study shows that the research tradition appears to be deteriorating. (Novick, Sonino, and Bianchi, 1993) According to a national survey of scientific and technical resources, between 1969 and 1988 both the number of people in health research and the number of research projects have declined. Health research still accounts for 30 percent of all scientific research, though, with most of the research supported by the state. (PAHO, vol. 2, 1994, p. 29) Of this research, 70 percent is in the field of biomedicine and 10 percent is in chemistry. Between 25 and 30 percent of all studies have to do with diseases, 25 percent with cellular and molecular biology, 18 percent with technical issues, and 11 percent with public health.

**Public Health and Health Education**

Medical education in Argentina concentrates on training physicians to work in urban-based settings endowed with teaching hospitals and modern diagnostic equipment. (Scarpaci, p. 371) Because only the provincial capitals have these, the current medical education in Argentina is adding to the unevenly distributed system of health care. Training is also based on curricula that focus on curative aspects of medical practice and emphasize the biological components of health and disease processes, without considering the social factors associated with those processes. (PAHO, vol. 2, 1994, p. 27) It is difficult to expect the public to be conscious of preventive health measures when physicians are not trained in preventive care themselves. The scarcity of full-time positions for physicians is also a concern, especially considering their continued need for clinical education. Therefore, in response to requests from doctors working in isolated rural settings, the Secretary of University Affairs of the Physicians' Medical Federation in Cordoba has initiated a series of refresher courses for doctors who have graduated more than five years previously. (Wyse, p. 589)

Public health training in Argentina is oriented towards hospital administrative positions and towards research evaluating the quality of care, rather than towards actual preventive programs. (Scarpaci, p. 372) Argentine physicians seem to be aware of the problems surrounding medical education and training, but so far have not addressed them. Alternatives to existing entrance criteria into medical schools have not been proposed, and the nature of medical education has not been altered. These professional behaviors are ensuring the dominance of curative care.

Neither the state nor the private sector devotes many resources to preventive care in Argentina. (Scarpaci, p. 372) This is quite a concern considering the high beef and alcohol consumption and prevalence of cigarette smoking. A country in which chronic diseases are the cause of such a large percentage of mortalities is in great need of preventive medicine and health education. Health promotions, however, are very rare in the press or in other media; and physicians concerned with public health have difficulty among colleagues who view public health as a lesser form of medicine.

As a consequence of the decentralization of the central government, though, provincial units responsible for health programs under the Department of Health have recently acquired a greater importance. (PAHO, vol. 2, 1994, p. 28) One of the main federal programs is a maternal and child health and nutrition program. The program's strategy initially involves focusing on socioeconomic risk groups; this effort is expected to cover about 25 percent of the provincial jurisdictions. An immunization program has reached high levels of coverage, with a national campaign to eliminate measles.

Cholera and AIDS control programs are also noteworthy. After the cholera epidemic of 1991-1993, programs were established for public information, health education, and investment in basic sanitation in the infected areas. (PAHO, vol. 2, 1994, p. 28) Almost all of the provinces are taking part in a national AIDS control program. The program is aimed at improving diagnostic laboratories, medical care for AIDS patients, and information and educational programs for the general public, and is specifically aimed at the various high risk groups. Nongovernment organizations and interest groups have also begun to take an active involvement in education and support programs.
Conclusion

While there are problems within Argentine health practice and health organizations, many of these same problems can be observed in other societies. The United States is more developed than Argentina, but still suffers from the same leading causes of death, probably as a result of similar risk factors within the two countries. Nonetheless, these are problems which require attention and reform. If the risk factors can be reduced, so can the mortalities that result from them.

Responsibility first falls upon the government and the health system itself, because improvements in health within Argentina must begin with education. Argentina's tradition of health research must be continued, with a greater emphasis placed upon the social factors associated with the processes of sickness and disease. Public and private institutions, as well as the mass media, are needed to present research findings to the general public and to educate the public about health risks and health promotion. It is then society's responsibility to act with this knowledge to address such concerns as diet, smoking, air and water quality, and sewage disposal. This attention given to the risk factors will then cause prevention to be a greater part of health care. The spread of AIDS will present a test for Argentina. The virus is currently spreading as it has in other countries during the early stages of the epidemic, with numbers of infected individuals continuing to increase exponentially. AIDS, however, is easily controlled through proper education and preventive measures, although few societies have been able to demonstrate this.

It will be difficult, though, for medical care in Argentina to change significantly because the sociocultural ideals of the people must change first. Argentines have come to think of health only in terms of doctors and hospitals; they do not think of prevention or self-care. It will also be difficult to change the views of the caregivers. Current medical education does not focus strongly enough on the social components related to sickness, so physicians are predominantly trained in curative medicine. Because of strong competition among physicians in excess supply, it is also not economically feasible for physicians to practice preventive medicine and support public health. Reform in health care in Argentina will therefore be difficult; but if more attention is given to the root problems — especially medical education, health research, and health promotion — improvements in the population's health and in health services will soon follow.
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