

running of healthcare systems". (7) This consideration is valid for normal situations, and even more so in a pandemic, which requires greater effort, dedication and commitment.

The functioning of the whole healthcare system is supported by HR in any instance of care and prevention: "Beyond the growing incorporation of new technologies, medical knowledge and the doctor-patient relationship are pillars of any successful healthcare strategy". (9) We can therefore declare that the working conditions for doctors, nurses and other healthcare professions have a key value and can condition its results.

Today, a staff physician working a 36-hour shift in CABA receives around 50,000 Argentine pesos in the lowest category (USD 700 at the official exchange rate), and nurses around USD 500, values that are lower than for other unions. The term "health is priceless" could mean that health is valuable or expensive, or that professionals should work "for free". This marks a paradigm shift in the valuation of the profession, showing also new trends such as a higher proportion of women in medical careers in Argentina, all of which illustrates a difficult framework to stand by.

The COVID-19 pandemic confronts us with our own realities and weaknesses, making structural problems visible in our country (and in the world). It is announced that "everything will be different" in health. This requires a deep analysis and discussion of today's rules. It is necessary to clearly put the issue "on the public agenda", and *create a new agenda*. The State has the ultimate authority and the non-delegable function of stewardship.

We deserve to think about a single health system – a truly supportive system – with coordination between its public and private sectors, taking advantage of resources, providing equal opportunities to access healthcare, not depending on income and employment status, and with a fully functioning high-level public hospital. It is our unpaid *domestic debt*. The 1853 Constitution mentioned the right to health ("...general welfare..."); the 1994 reform confirms this right. It is written.

The pandemic has displayed health on the "front page". The crisis (re)updates the structural problems. Prioritizing this issue is first and foremost a political decision, which will encounter conflicting interests from various actors involved in the health field. (5) It means recognizing the real situation, the multi-segmentation at all levels, the failures in coordination, the inefficient use of resources and, mainly, the inequity of the system with enormous differences in access to health and quality of care according to the place of residence, income level, and other socioeconomic variables. *This is our chance to change*.

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REFERENCES

- Cetrángolo O. y Goldschmit A. (2018) "Organización y financiamiento de la provisión pública de salud en un país federal. El caso argentino", Serie Documentos de Trabajo del IIEP 24, IIEP UBA CONICET, Buenos Aires, marzo 2018. ISSN 2451-5728. <http://iiep-baires.econ.uba.ar/uploads/publicaciones/447/archivos/1.pdf>
- Tobar F. El modelo de salud argentino: Historia, características, fallas, F Recursos Humanos en Salud en Argentina/2001. Observatorio de Recursos Humanos en Salud, Representación OPS/OMS en Argentina, 2001
- Macchia A, Mariani J, Nul D, Grancelli H, Doval HC. Inequidad social, lugar de residencia y muerte prematura por cualquier causa en la Argentina. *Rev Argent Cardiol* 2016;84:114-9. <http://dx.doi.org/10.7775/rac.v84.i2.8267>.
- PNUD, CEPAL y OPS. Aportes para el desarrollo humano en Argentina 2011: El sistema de salud argentino y su trayectoria de largo plazo: logros alcanzados y desafíos futuros. Capítulos I, III, IV, V y VI, Buenos Aires, 2011.
- Chiara M, Di Virgilio MM, Tobar E, Catenazzi A, Moro J, Airovich A. Conceptualizando la gestión social. Gestión de la Política Social: conceptos y herramientas, UNGS/Prometeo. 1a. ed. Los Polvorines: Universidad Nacional de General Sarmiento, 2015. ISBN 978-987-630-198-5. E-Book
- Análisis de situación de salud República Argentina. Edición 2018. Ministerio de Salud y Desarrollo Social. ISBN 978-950-38-0271-7.
- Borracci RA, Calderón JG, Sokn F, Ángel A, Lerman J, Darú V et al. Relación entre el nivel de ingresos y la calidad de vida profesional de los cardiólogos en la Argentina. *Rev Argent Cardiol* 2008;76: 352-8.
- Salazar AI, Boissonnet CP, Sosa Liprandi MI, Boscaró M, Francesia AN, Besmalinovich et al. Expectativas acerca del futuro en una población de cardiólogos argentinos. *Rev Argent Cardiol* 2015; 83:549-55. <http://dx.doi.org/10.7775/rac.es.v83.i6.7298>
- Maceira D, Palacios A, Urrutia M, Espinola N, Nieves M. Descentralización y estructura de las remuneraciones médicas en Argentina: Un análisis comparado en cinco jurisdicciones. *Rev Argent Salud Publ* 2017;8:26-32.

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Vaccination in Patients with Heart Failure in Argentina: Results from the ARGENT-IC. Real Data, far from Clinical Practice Guidelines

The Argentine Registry of Acute Heart Failure (ARGENT-IC) is a prospective, multicenter, national study carried out in 50 institutions, which included patients diagnosed with acute heart failure from August 2018 to March 2019, with a 12-month follow-up.

We have recently published data of 909 patients provided by 74 researchers from 18 Argentinian provinces. (1) Patients aged 72.2 years (SD: 14), 60.5% male, 33% with a history of diabetes, and 26% with ischemic-necrotic etiology, were enrolled in the study. In 77.6% of cases, patients were admitted to the Critical Care Unit, with an overall median hospital stay of 8 days and 7.9% overall mortality rate.

We noticed the low percentage of patients who had received the influenza and pneumococcal vaccines, despite many of them had indication due to their health history or risk factors. Only 33.3 % of the population had received the influenza vaccine, 24.6 % the pneumococcal vaccine and 3% both vaccines prior to hospitalization. Within the group of patients with a history of heart failure, only 43% had been vaccinated.

Currently, the National Ministry of Health (<https://www.argentina.gob.ar/salud/vacunas>) recommends who should be vaccinated to prevent diseases which have been associated with the risk of poor prognosis in patients with heart failure. (2) The Argentine Society of Cardiology Consensus on chronic heart failure makes a strong recommendation in favor of influenza and pneumococcal vaccines in patients with this condition. (3) People aged > 65 years and those with chronic obstructive pulmonary disease (COPD) are a vulnerable population and require both vaccines. The table below shows the low percentage of patients admitted with heart failure who had received both vaccines despite their comorbidities.

The relationship between the level of vaccination and health coverage was also analyzed. No statistically significant difference in the vaccination rate according to health coverage was observed. In contrast, educational level seems to have some relationship with vaccination.

Current available data seem to demonstrate that influenza vaccination could reduce cardiovascular mortality. Vaccination can reduce the incidence and/or severity of respiratory infections, and consequently decrease exacerbations, hospitalizations, increased costs and morbidity and mortality. (4, 5)

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Comorbidities for which vaccination is indicated	Percentage of ARGEN_IC patients who had received the influenza vaccine	Percentage of ARGEN_IC patients who had received the pneumococcal vaccine
Age > 65 years	36.7	35.6
Diabetes (33%)	37%	
Obesity (15%)	28%	
AMI (17%)	36%	
Previous HF (37%)	37%	
Previous CABG/PCI (20%)	34%	
Ischemic stroke (8%)	33%	
COPD (14.6%)	43%	34%
CRF (18.5%)	50%	

AMI: Acute myocardial infarction. HF: Heart failure. CABG/PCI: Coronary artery bypass grafting/Percutaneous coronary intervention, COPD: Chronic obstructive pulmonary disease. CRF: Chronic renal failure.

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REFERENCES

- Lescano A, Sorasio G, Soricetti G, Arakaki D, Coronel L, Caceres L, et al. Argentine Registry of Acute Heart Failure (ARGEN-IC). Evaluation of a partial cohort at 30 days. *Rev Argent Cardiol* 2020;88:118-24. <http://dx.doi.org/10.7775/rac.v88.i2.17201>
- Johnstone J, Loeb M, Teo KK. Influenza vaccination and major adverse vascular events in high-risk patients. *Circulation* 2012;126:278-86. <http://dx.doi.org/10.1016/j.ahj.2019.02.009>
- Sociedad Argentina de Cardiología. Área de Consensos y Normas, Consenso de Insuficiencia Cardiaca Crónica. *Rev Argent Cardiol* 2016;84(Supl. 3):1-50
- Bhatt AS, DeVore AD, Hernandez AF, Mentzel RJ. Can Vaccinations Improve Heart Failure Outcomes? *JACC Heart Fail* 2017;5:194-203. <http://dx.doi.org/10.1016/j.jchf.2016.12.007>
- Clar C, Oseni Z, Flowers N, Keshtkar-Jahromi M, K. Influenza vaccines for preventing cardiovascular disease. *Cochrane Database Syst Rev* 2015;CD005050. <http://dx.doi.org/10.1002/14651858.CD005050.pub3>

Rev Argent Cardiol 2020;88:370-371. <http://dx.doi.org/10.7775/rac.v88.i4.18663>