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RESEARCH

Surgeons' and payers' perceptions of barriers to accessing bariatric and metabolic surgery in Argentina: An exploratory qualitative study

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ABSTRACT

INTRODUCTION Bariatric and metabolic surgery is a safe and effective method for treating clinically severe obesity. In Argentina, Law 26 396 and its amendments establish the regulatory framework for its coverage. However, administrative, regulatory, and financial barriers limit effective access to it, with gaps remaining in its scope and understanding. This study aimed to explore surgeons' and health insurance providers' perceptions of the implementation of bariatric and metabolic surgery in Argentina, within the framework of Law 26 396, and to identify the barriers that impede effective, timely access.

METHODS We conducted an exploratory qualitative study comprising 16 in-depth virtual interviews with eight surgeons specializing in bariatric and metabolic surgery and eight health insurance officers of the Argentine healthcare system, conducted between November and December 2024. The sampling was intentional. The interviews were recorded, transcribed, and coded. A thematic and recursive analysis was conducted, enabling us to identify emerging categories.

RESULTS We identified multiple barriers and challenges to the effective implementation of bariatric and metabolic surgery in Argentina, including geographic inequalities, heterogeneity in surgical module agreements, administrative and bureaucratic restrictions related to variability in the interpretation of the law and its requirements, high costs, and the imposition of quotas that delay timely access, among others.

CONCLUSIONS The implementation of bariatric and metabolic surgery presents structural and functional challenges that affect equitable and timely access. Although Law 26 396 and its subsequent regulations established a regulatory framework for its coverage, tensions among healthcare system actors and regional disparities have resulted in heterogeneous implementation. Administrative and financial barriers persist, affecting its effective and timely practice. We highlight the need to strengthen coordination between physicians and health insurance providers, promoting opportunities for dialogue that optimize authorization and funding processes.

KEYWORDS Morbid obesity, Argentina, Bariatric surgery, Delivery of health care, Surgeons, Health policy, Perception

INTRODUCTION

Severe obesity is a growing global public health problem, with consequences for individual health, healthcare systems, and economies [1]. According to the latest official data available, the prevalence of obesity in Argentina was estimated at 25.3% in the 4th National Risk Factor Survey, in the last quarter of 2018, reporting an increase of 21.6% compared to the previous five years [2].

Bariatric surgery has proven to be an effective intervention for the treatment of obesity and its comorbidities [3–6]. Studies conducted in Europe and Latin America have shown that it is cost-effective compared to medical therapy in patients with obesity and metabolic diseases. These cost-effectiveness and cost-utility analyses from the financier's perspective consistently report favorable results in terms of efficiency [7–15].

In Argentina, this surgery was included in the Compulsory Medical Program, that is, the set of basic services that private insurers and social security must guarantee [14] through Law 26 396 on Eating Disorders [16]. Recently, the 1420/2022 resolution updated the basic benefits of the Compulsory Medical Program, incorporating surgical techniques and aligning the regulations with available scientific evidence on the treatment of obesity [17]. The inclusion of bariatric and metabolic surgery in this program recognizes it as a necessary, evidence-based intervention that aims to ensure comprehensive coverage and availability for people with medical indications, regardless

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MAIN MESSAGES

- Severe obesity is a growing global public health problem, with consequences for individual health, healthcare systems, and economies.
- Bariatric surgery has proven to be a cost-effective intervention for the medical treatment of patients with obesity and metabolic diseases.
- This study seeks to broaden the international discussion by introducing a look at legal frameworks, administrative mismatches, and legal conflicts regarding coverage and effective access to bariatric and metabolic surgery.
- This work has limitations inherent to its exploratory qualitative design. The sample was intentional and aimed at obtaining in-depth discourse, without any claim to statistical representativeness.

of their socioeconomic status. Table 1 details the medical conditions and requirements necessary for coverage [17].

However, the existence of a regulatory framework does not guarantee its effective implementation. In addition, the incorporation of new technologies, such as glucagon-like peptide-1 (GLP-1) agonist drugs, is reshaping the therapeutic landscape and creating new challenges for clinical and coverage decision-making. In this qualitative study, we explore surgeons' and health insurance officers' perceptions and experiences of implementing bariatric surgery in the Argentine healthcare system. The objective of this study is to characterize the implementation of bariatric surgery in Argentina within the framework of the Eating Disorders Act by exploring the perceptions and experiences of medical specialists and health insurance officers. In addition, we seek to identify barriers to approval, financing, and effective access, and to analyze the relationship between current regulations, medical practice, and health insurance providers´ decision-making.

METHODS

For this report, the COREQ (Consolidated Criteria for Reporting Qualitative Research) criteria were used. The study design is qualitative, exploratory-descriptive, and based on individual semi-structured interviews conducted virtually between November and December 2024. The instrument was administered to 16 leaders in the field of bariatric and metabolic surgery: eight surgeons and eight health insurance officers from the private and public subsectors. The interviews, which lasted approximately one hour, were conducted after participants signed informed consent forms that guaranteed the anonymity and confidentiality of sensitive data. They were moderated and then coded by a sociologist specializing in qualitative research, with advice and review from a physician with expertise in the subject and a third-party observer. There was no prior relationship between the moderator and the interviewees.

Cases were selected through purposive sampling to identify key informants. The inclusion criteria for surgeons were: specialists in bariatric and metabolic surgery, nationally and/or internationally recognized, with more than ten years of surgical experience. Geographic diversity was prioritized. In the case of health insurance officers, the following were included: medical auditors or specialists in healthcare management, working in national and/or provincial social security and/or prepaid health plans, with active decision-making power over coverage, knowledge of the law, and at least ten years of experience in management and/or medical auditing. In both cases, we established refusal to give consent as an exclusion criterion. Compliance with these criteria was verified based on professional résumés, confirmed by telephone consultation. Information was provided on the study's characteristics, the privacy policy, and the requirement to sign the consent form. Both surgeons and officers could work at more than one institution (and table 3).

The data collection period was from November to December 2024. We used a semi-structured interview guide, designed ad hoc for each segment of interviewees. Its construction followed the expected path of access to bariatric surgery, from clinical indication to coverage and effective implementation. The questions were organized into six dimensions (professional profile, experience in bariatric and metabolic surgery, perceived barriers, relationship between law and practice, financing, and reflections) to explore the perceptions of both groups: physicians and financiers. The guides were reviewed by a medical specialist and by the study's sponsor.

The interviews were recorded and transcribed. Based on the semi-structured interview guide, we designed the coding of the information into ten areas:

1. General perceptions of surgeons and health insurance officers.
2. Experience in the interdisciplinary approach and management of obesity treatment.
3. Relationship between surgical teams, institutions, and health insurance officers.
4. Influence of geographic location on the effective implementation of bariatric and metabolic surgery.
5. Assessment of mechanical sutures for decision-making.
6. Regulatory, management, and financing aspects.
7. Influence of new drugs available for the treatment of obesity.
8. Barriers to the effective and timely implementation of bariatric and metabolic surgery.
9. Relationship between Law 26 396 and practice.
10. The future of bariatric and metabolic surgery.

Table 2. Geographic distribution of surgeons.

Provinces	Number (n)
Córdoba	1
Corrientes	1
Buenos Aires	1
Tucumán	1
Rosario	3
Ciudad Autónoma de Buenos Aires	4

Source: Prepared by the authors based on data from the study.

Table 3. Distribution of health insurance officers by subsector and scope.

Health insurance provider	Reach	Number (n)
Private	National	3
OSN	National	5
OSP	Provincial	2

OSN, National Health Insurance. OSP, Provincial Health Insurance.
Source: Prepared by the authors based on data from the study.

A recursive thematic analysis was performed at three complementary levels: individual (each participant's discourse), group (regularities and divergences within each segment), and interpretive synthesis (provisional conclusions, tensions, convergences, and emerging themes from the intersection of perspectives). Interviews were not repeated, and saturation was achieved.

RESULTS

General perceptions of surgeons and health insurance officers

Surgeons perceive limited access to surgery due to bureaucratic barriers, differing interpretations of the law, and restricted quotas (the maximum number of surgeries a surgeon can perform per month). They highlight the importance of an interdisciplinary approach and emphasize the need for greater flexibility to prioritize clinical criteria over budgetary or administrative restrictions, without regulatory constraints.

"...you have to do monthly reports and then, after twelve months, do an annual report (...) we have a quota there (...) waiting lists..." So, if you don't have a month of psychology or you don't send it, they freeze it [referring to the procedure]" (surgeon).

Health insurance officers recognize the procedure's effectiveness but argue that controls and restrictions are necessary to sustain the system.

"Without these controls, we run the risk of authorizing surgeries for patients who may not really be ready" (social security officer).

"This creates tension because we have to balance access with the sustainability of the system..." (provincial health insurance officer).

Axis of expertise in interdisciplinary approach and obesity treatment management

Both segments recognize that although the interdisciplinary approach is highly relevant to clinical outcomes, coordination across specialties is difficult due to disparities in resource availability, complex administrative procedures, and delays in funding agency authorizations. This is particularly relevant when specialists do not belong to the same center.

"The problem is that many health insurance companies do not want to cover the work of the interdisciplinary team, only the surgery. This limits comprehensive treatment" (surgeon).

Relationship between surgical teams, institutions, and health insurance officers

Analysis of the interviews revealed discrepancies in the negotiation of surgical modules (predefined payment contracts that group the most relevant costs associated with surgeries into a single total value, considering fees, supplies, hospitalization days, etc.). The inclusion or exclusion of surgical materials, such as mechanical sutures, varies according to the agreements. Surgeons perceive that rising suturing costs compensate for low professional fees. Additionally, they point to restrictions imposed by financiers that limit their autonomy: monthly surgery quotas, changes in treating professionals, limited availability of operating rooms and/or beds for the procedure, and requirements for prolonged pre-surgical preparation times, among others.

Table 1. Eligibility criteria for surgical treatment.

People who meet the following inclusion criteria will be eligible for surgical treatment:
Age 18 to 70 years.
BMI greater than 40 kg/m^2 (with or without comorbidities) or greater than 35 kg/m^2 with at least one of the following comorbidities (the BMIs considered correspond to those before the decrease in preoperative preparation): type 2 diabetes mellitus, high blood pressure, apnea or OSAHS, or joint disease with severe functional limitation.
Acceptable surgical risk, i.e., comorbidities controlled before surgery according to the ASA scale.
Having tried other non-surgical methods for obesity control under medical supervision for at least twelve months, without success or with initial success but regaining the lost weight, establishing a treatment contact at least once a month with an interdisciplinary team or individual consultations with a physician or licensed nutritionist plus psychotherapy, on an uninterrupted basis.
Informed consent: acceptance and desire for the procedure, this being an informed decision agreed upon with the treating team, with a commitment to the requirements of the multidisciplinary team, assessing expectations, and evaluating the possibilities of carrying out the correct follow-up.
Psychological stability.

BMI, body mass index. OSAHS, obstructive sleep apnea-hypopnea syndrome. ASA, American Society of Anesthesiologists Physical Status Scale.
Source: Prepared by the authors based on Resolution 1420/2022 [18].

"Even if the patient is within the norm, they reject them. Of every 10 patients they reject, they know that six will not come back. It's a modus operandi, a form of attrition" (surgeon).

"The patient needs to have all the tests done, get the team's approval... Then they submit the paperwork, and that's when the health insurance lottery begins" (surgeon).

"They told me to tell the patient that they have to wait until next year, but that's not my job, nor is it ethical" (surgeon).

"They authorize the surgery, but they tell you that you can only operate on two patients per month. That limits our capacity and creates unnecessary waiting lists" (surgeon).

Geographical areas' influence on the effective implementation of bariatric and metabolic surgery

The testimonies reflect differences between large urban centers and peripheral regions.

"In Córdoba, for example, I see that we are behind Brazil and Chile, our neighboring countries, in terms of volume, technique, and legislation. We are way behind" (surgeon).

"In some provinces, there isn't even a complete multidisciplinary team to follow up on patients" (provincial health insurance officer).

The lack of infrastructure, combined with a concentration of specialized professionals in urban areas, creates a challenge.

"Patients from suburban areas are forced to travel to the capital for surgery because there are no specialized surgeons in their provinces" (provincial health insurance officer).

Geographical factors not only limit access to bariatric and metabolic surgery but also contribute to inequalities in the availability of centers and professionals, given the disparities in infrastructure and specialized human resources.

Assessment criteria for mechanical sutures for decision-making

Surgeons emphasize the importance of choosing mechanical sutures but note that this decision is not always within their control. In many cases, funding institutions determine purchases through competitive bidding.

"At the hospital, I have no say in what materials are used (...) I have to operate with whatever is available, let's say, it's not up to me" (surgeon).

The interviews reveal divergent opinions on mechanical sutures. However, there is a shared perception of overbilling for supplies, either by surgeons or suppliers, which contributes significantly to increased costs.

"The material passes from hand to hand, and each intermediary increases the price. The material should not be a source of profit for either the surgeon or the clinic, beyond a minimal administrative profit" (surgeon).

"The challenge is to find a balance between the quality of supplies and financial sustainability" (social security officer).

Regulatory, management, and financing issues

Surgeons perceive that differences in how health insurance officers interpret the law affect surgical planning, increase the paperwork burden, and lead to preoperative requirements that are not based on clinical criteria but rather on bureaucratic procedures that hinder patient care. The imposition of unjustified quotas limits the availability of care and prolongs waiting times, affecting adherence.

"The biggest obstacle is not the surgery itself, but the entire bureaucratic process that the patient has to go through to get authorization from the health insurance company" (surgeon).

"...We have a quota, a monthly quota, and (in) that health insurance company, we have a waiting list because it has become so full that we have 400 or 500 patients waiting" (surgeon).

Although health insurance officers recognize the rights established by law, they warn that these rights are not accompanied by financing mechanisms that ensure their sustainability. The phenomenon of quotas is therefore interpreted as part of a web of challenges related to the sustainability of the healthcare system. They assert that the lack of uniform criteria for interpreting the law creates inequalities. This contributes to some patients resorting to legal action. Additionally, they note that authorization times depend on factors such as the availability of surgical appointments and the centers' operational capacity.

"The law says they have to cover it, but each health insurance officer interprets it in their own way. Some put up more obstacles than others" (social security officer).

Influence of new drugs available for obesity treatment

The discourse highlights the complementarity of drug and surgical approaches to optimize outcomes.

"We believe that drugs and surgery are an excellent combination. It is not competition for surgery" (surgeon).

This approach extends to both preoperative preparation and the management of postoperative weight gain:

"We use them as enhancers of surgery" (surgeon).

However, they also express doubts about the long-term side effects. Both segments agree that price and lack of coverage limit access to drugs.

Some funders believe that out-of-pocket payments or co-payments will be required to favor treatment adherence.

"Part of the effort has to involve co-payment by the patient. That even helps to value the treatment" (social security officer).

We identified a shift in discourse from the focus on "obesity" to "metabolic disease," reflecting an argumentative strategy used by surgeons to legitimize surgery as an intervention that goes beyond weight loss.

"When we talk about these drugs, we always come back to the idea that surgery is not just for obesity, it is metabolic surgery that impacts diabetes, hypertension..." (surgeon).

Barriers to the effective and timely implementation of bariatric and metabolic surgery

The interviewees agree that bureaucratic barriers are among the main obstacles to the effective implementation of bariatric and metabolic surgery.

"Each health insurance officer has their own requirements. What is approved quickly in one place can take months in another" (surgeon).

Financial factors condition access to bariatric and metabolic surgery, and funders' cost-containment strategies (quotas). Table 4 summarizes the main barriers.

Relationship between law 26 396 and clinical practice

The main difference in interpretation between physicians and health insurance officers regarding the relationship between the law and practice lies in how preoperative requirements are perceived and applied. Surgeons believe that the requirement for prolonged pre-surgical treatments (Table 1) bureaucratizes the process and does not contribute to improving clinical outcomes, generating a negative impact on mental and emotional health. In contrast, officers defend these requirements as necessary mechanisms to ensure that only patients who "really" need surgery have access to it. From their perspective, these measures act as filters to ensure adherence to treatment and the responsible use of resources, and they warn of insufficient financial resources to guarantee their effective implementation (Table 5).

"The lack of dialogue between doctors and auditors is a problem. Often, weeks are wasted in back-and-forth exchanges that could be resolved with a phone call" (social security officer).

"Today, there is no dialogue between officers and the healthcare professionals, and if we had dialogue, we could establish criteria for prioritizing patients" (surgeon).

Future focus of bariatric and metabolic surgery

Surgeons and funders agree that bariatric and metabolic surgery will continue to play a central role in the management of obesity. However, they express concerns about the system's structural challenges. They emphasize the need for more specialized interdisciplinary teams and for integrating this procedure into a strategy for improving comorbidities.

"Surgery should be a subcomponent of a diabetes and obesity program that can capture the complexity of the health, cultural, and economic problem" (national health insurance and social security officer).

DISCUSSION

This study, conducted in Argentina, provides a contextually grounded perspective on barriers to accessing bariatric and metabolic surgery and highlights the intersection between administrative, regulatory, budgetary, and symbolic dimensions. Drawing on the analysis of interviews with surgeons and healthcare payers, it reconstructs a scenario in which the day-to-day conflicts in the implementation of Law 26 396 are shaped by structural conditions of the health system, such as institutional fragmentation, misalignments between actors, and the absence of uniform criteria.

Several international studies have identified similar obstacles, but in contexts of greater institutional integration. Hlavin et al. (2023) [19] points out how logistical, economic, and informational factors affect access to bariatric and metabolic surgery among marginalized populations in the United States, despite their having health insurance coverage. In Argentina, similar complexities arise from the coexistence of multiple coverage subsystems, each with its own interpretation of regulations and authorization procedures. This heterogeneity creates space for discretion, with consequences for access.

The findings of Majstorovic et al. [20,21] reveal tensions between medical and administrative logics. The Argentine inquiry shows how bureaucratic requirements, differences in authorization pathways, and difficulties in the coverage of specific supplies and devices affect the continuity of the surgical process. In this country, these tensions are heightened by the lack of transparency in the negotiation of payment modules and the limited regulation of which supplies are included.

This study allows observation of the adaptive strategies developed by medical teams to address these obstacles. One approach, less developed in the international literature, is to seek alternative resources when faced with delays or denials of authorization. Judicial recourse emerges as an option in some instances (as documented for other health interventions in Argentina), although its use is not specific to access to bariatric and metabolic surgery. Instead, it is symptomatic of the mismatch between formally recognized rights and barriers to access.

A relevant finding of the Argentine study, not reported in the international articles reviewed, is the identification of a discursive shift from obesity to metabolic disease as a legitimizing framework. This shift, which redefines medical language and the argumentative strategies used with payers, enables new forms of legal and clinical framing of bariatric and metabolic surgery. In a context in which the recognition of obesity as a disease is not always sufficient to guarantee access, the category of "metabolic disease" acts as a symbolic facilitator. This finding invites reflection on how diagnostic categories not only structure medical practice but also facilitate access or exclusion in segmented systems.

Funk et al. (2022) [22] and Rubin et al. (2016) [23] underscore the need to integrate care teams better and reduce preoperative requirements that ultimately discourage patients. In Argentina, the burden of these requirements is substantial and adds to budgetary constraints that affect both patients and professionals.

This study contributes to broadening the international debate by focusing on legal frameworks, administrative misalignments, and disputes over the law. System fragmentation appears as a structuring condition of barriers to access. At the same time, the findings show that the right to bariatric and metabolic

Table 4. Main barriers to effective access to bariatric and metabolic surgery.

Barriers	Description
Legal and regulatory	Variable interpretation of Law 26 396 among health insurance providers. Inequalities in the application of the law vary by region. Frequent need for patients to take their cases to court to access coverage.
Administrative and bureaucratic	Delays in the approval of authorizations by social security and prepaid health plans. Excessive paperwork for clinical teams and a lack of unified administrative criteria. Lack of communication and coordination between physicians, auditors, and administrative areas. Complexity in the internal management of health centers.
Geographical	Inequality in the availability of specialized centers varies by region. Approval of surgical centers is conditioned by insufficient infrastructure in some provinces. Lack of auditors and periodic controls in regions with less access. Logistical difficulties and transportation costs for patients from the interior of the country. Limitations in health insurance coverage for transportation and accommodation of patients requiring surgery.
Financial	Creation of quotas and limitations on the number of surgeries authorized annually without a legal basis. Impact of the cost of supplies, such as mechanical sutures, on the procedure's coverage.

Source: Prepared by the authors based on data from the study.

Table 5. Perceptions of surgeons and health insurance officers regarding Law 26 396 and its practical application.

Criteria	Surgeons	Health insurance officers
Overall assessment	The law represents a step forward in formalizing access.	The law acts as a regulatory framework.
Limiting factors Deadlines imposed on the requirements	Legal requirements are out of step with medical practice. It bureaucratizes the process without improving results.	They experience economic pressure due to mandatory coverage. Administrative complexity in meeting requirements.
Pre-surgical requirements	They have a negative impact on patients' mental health, motivation, quality of life, and health.	They are necessary to demonstrate adherence and to link lifestyle changes to the long-term success of the surgery.
Overall assessment	Unnecessary and perceived as a barrier to access.	Necessary for the proper selection of candidates.

Source: Prepared by the authors based on data from the study.

surgery, though formally guaranteed, is mediated by variable interpretations, asymmetries between payers, and diverse forms of institutional and professional negotiation.

The study contributes elements that enrich the international debate from a situated perspective: it shows that access problems do not only stem from individual or clinical limitations but also emerge from the local configurations of the health system. Its main contribution lies in making visible the concrete effects of this configuration on the implementation of a health policy that, although legally recognized, faces obstacles in its application.

This study presents limitations inherent to its exploratory qualitative design. The sample was purposive and aimed at obtaining in-depth accounts, without any claim to statistical representativeness. Both surgeons and payers are institutional actors whose positions are shaped by regulatory frameworks, organizational criteria, and legal obligations that condition their accounts. In a context in which bariatric surgery is legally mandated to be covered when correctly indicated, narratives about restrictions or denials may be presented with strategic biases. To counter these limitations, the analysis relied on systematic comparisons across segments, and a future line of research is to broaden triangulation of perspectives by studying patients' experiences and perceptions.

CONCLUSIONS

The implementation of bariatric and metabolic surgery in Argentina is limited by structural, administrative, regulatory, and financial barriers that affect equity and timely access.

Discursive patterns allowed us to identify some of these barriers and the discrepancies between surgeons and health insurers in a context of limited health resources. The reports reveal a heterogeneous and discretionary application of the law, with inequalities in effective and timely access.

In light of these findings, strategies are needed to reduce accessibility gaps. Similarly, opportunities for dialogue among health system actors must be created to optimize authorization processes and ensure sustainable, strategic financing.

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REFERENCES

1. Ng M, Gakidou E, Lo J, Abate YH, Abbafati C, Abbas N, et al. Global, regional, and national prevalence of adult overweight and obesity, 1990–2021, with forecasts to 2050: a forecasting study for the Global Burden of Disease Study 2021. The Lancet. 2025;405: 813–838. https://doi.org/10.1016/S0140-6736(25)00355-1
2. Instituto Nacional de Estadística y Censos (INDEC); Secretaría de Gobierno de Salud de la Nación. 4° Encuesta Nacional de Factores de Riesgo Resultados def initivos. Ciudad Autónoma de Buenos Aires. 2019. https://www.indec.gob.ar/ftp/cuadros/publicaciones/enfr_2018_resultados_definitivos.pdf
3. Rubino F, Nathan DM, Eckel RH, Schauer PR, Alberti KGMM, Zimmet PZ, et al. Metabolic Surgery in the Treatment Algorithm for Type 2 Diabetes: A Joint Statement by International Diabetes Organizations. Diabetes Care. 2016;39: 861–77. https://doi.org/10.2337/dc16-0236
4. Schauer PR, Bhatt DL, Kirwan JP, Wolski K, Aminian A, Brethauer SA, et al. Bariatric Surgery versus Intensive Medical Therapy for Diabetes - 5-Year Outcomes. N Engl J Med. 2017;376: 641–651. https://doi.org/10.1056/NEJMoa1600869
5. ChangSH, StollCR, SongJ, VarelaJE, EagonCJ, ColditzGA. The effectiveness and risks of bariatric surgery: an updated systematic review and meta-analysis, 2003–2012. JAMA Surg. 2014;149: 275–87. https://doi.org/10.1001/jamasurg.2013.3654
6. Harraca JL, Grigaites AL, Martínez Duartez P, Aguirre Ackermann M, Quevedo P, Musso C. Consenso Argentino Intersociedades de Cirugía Bariátrica y Metabólica. Rev Argent Cir. 2025. https://revista.aac.org.ar/index.php/RevArgentCirug/article/view/179
7. Ackroyd R, Mouiel J, Chevallier JM, Daoud F. Cost-effectiveness and budget impact of obesity surgery in patients with type-2 diabetes in three European countries. Obes Surg. 2006;16: 1488–503. https://doi.org/10.1381/096089206778870067
8. Anselmino M, Bammer T, Fernández Cebrián JM, Daoud F, Romagnoli G, Torres A. Cost-effectiveness and budget impact of obesity surgery in patients with type 2 diabetes in three European countries(II). Obes Surg. 2009;19: 1542–9. https://doi.org/10.1007/s11695-009-9946-z
9. Mäklin S, Malmivaara A, Linna M, Victorzon M, Koivukangas V, Sintonen H. Cost-utility of bariatric surgery for morbid obesity in Finland. Br J Surg. 2011;98: 1422–9. https://doi.org/10.1002/bjs.7640
10. Faria GR, Preto JR, Costa-Maia J. Gastric bypass is a cost-saving procedure: results from a comprehensive Markov model. Obes Surg. 2013;23: 460–6. https://doi.org/10.1007/s11695-012-0816-8
11. Borisenko O, Mann O, Duprée A. Cost-utility analysis of bariatric surgery compared with conventional medical management in Germany: a decision analytic modeling. BMC Surg. 2017;17. https://doi.org/10.1186/s12893-017-0284-0
12. Gil-Rojas Y, Garzón A, Lasalvia P, Hernández F, Castañeda-Cardona C, Rosselli D. Cost-Effectiveness of Bariatric Surgery Compared With Nonsurgical Treatment in People With Obesity and Comorbidity in Colombia. Value Health Reg Issues. 2019;20: 79–85. https://doi.org/10.1016/j.vhri.2019.01.010
13. Klebanoff MJ, Corey KE, Samur S, Choi JG, Kaplan LM, Chhatwal J, et al. Cost-effectiveness Analysis of Bariatric Surgery for Patients With Nonalcoholic Steatohepatitis Cirrhosis. JAMA Netw Open. 2019;2. https://doi.org/10.1001/jamanetworkopen.2019.0047
14. Pollock RF, Muduma G, Valentine WJ. Evaluating the cost-effectiveness of laparoscopic adjustable gastric banding versus standard medical management in obese patients with type 2 diabetes in the UK. Diabetes Obesity Metabolism. 2013;15: 121–129. https://dom-pubs.onlinelibrary.wiley.com/toc/14631326/15/2 https://doi.org/10.1111/j.1463-1326.2012.01692.x
15. Elliot L, Frew E, Mollan SP, Mitchell JL, Yiangou A, Alimajstorovic Z, et al. Cost-effectiveness of bariatric surgery versus community weight management to treat obesity-related idiopathic intracranial hypertension: evidence from a single-payer healthcare system. Surg Obes Relat Dis. 2021;17: 1310–1316. https://www.sciencedirect.com/science/article/pii/S155072892100155 https://doi.org/10.1016/j.soard.2021.03.020
16. Ley 26.396. Declárase de interés nacional la prevención y control de los trastornos alimentarios [Internet]. Buenos Aires: Boletín Oficial. 2025. https://www.argentina.gob.ar/normativa/nacional/ley-26396-144033/texto
17. Ministerio de Salud. Resolución 201/2002 Aprueba el Programa Médico Obligatorio de Emergencia (PMOE). 2022. https://www.argentina.gob.ar/normativa/nacional/resoluci%C3%B3n-201-2002-73649
18. Buenos Aires: Boletín Oficial de la República Argentina. Resolución 1420/2022Apruébanse los lineamientos estratégicos para el abordaje integral de la obesidad en el primer nivel de atención. 2025;2022. https://www.boletinoficial.gob.ar/#!DetalleNorma/267139/20220722
19. Hlavin C, Sebastiani RS, Scherer RJ, Kenkre T, Bernardi K, Reed DA, et al. Barriers to Bariatric Surgery: a Mixed Methods Study Investigating Obstacles Between Clinic Contact and Surgery. Obes Surg. 2023;33: 2874–2883. https://doi.org/10.1007/s11695-023-06761-6

20. Majstorovic M, Chur-Hansen A, Andrews J, Burke ALJ. On the Barriers and Enablers to Bariatric Surgery: A Qualitative Study with Bariatric Surgeons. Obes Facts. 2025; 1–11. https://doi.org/10.1159/000547169
21. Majstorovic M, Chur-Hansen A, Andrews JM, Burke ALJ. Bariatric surgeons' views on pre-operative factors associated with improved health-related quality of life following surgery. Clin Obes. 2024;14. https://doi.org/10.1111/cob.12668
22. Funk LM, Alagoz E, Jolles SA, Shea GE, Gunter RL, Raffa SD, et al. A Qualitative Study of the System-level Barriers to Bariatric Surgery Within the Veterans Health Administration. Ann Surg. 2022;275: e181–e188. https://doi.org/10.1097/SLA.0000000000003982 https://doi.org/10.1097/SLA.0000000000003982
23. Rubin JK, Hinrichs-Krapels S, Hesketh R, Martin A, Herman WH, Rubino F. Identifying Barriers to Appropriate Use of Metabolic/Bariatric Surgery for Type 2 Diabetes Treatment: Policy Lab Results. Diabetes Care. 2016;39: 954–63. https://doi.org/10.2337/dc15-2781

Percepciones de cirujanos y financiadores sobre barreras de acceso a la cirugía bariátrica y metabólica en Argentina: estudio cualitativo exploratorio

RESUMEN

INTRODUCCIÓN La cirugía bariátrica y metabólica es un método seguro y eficaz para tratar la obesidad clínicamente grave. En Argentina, la Ley 26 396 y sus modificatorias establecen el marco normativo para su cobertura. Sin embargo, barreras administrativas, regulatorias y financieras limitan su acceso efectivo, persistiendo vacancias en su alcance y comprensión. El objetivo del documento es explorar percepciones de cirujanos y financiadores respecto a la implementación de la cirugía bariátrica y metabólica en Argentina, en el marco de la referida ley identificando barreras que influyen en el acceso efectivo y oportuno.

MÉTODOS Estudio cualitativo exploratorio basado en 16 entrevistas en profundidad, virtuales, a ocho médicos cirujanos especialistas en cirugía bariátrica y metabólica y a ocho financiadores del sistema de salud argentino entre noviembre y diciembre de 2024. El muestreo fue intencional. Las entrevistas fueron grabadas, transcritas y codificadas. Se realizó un análisis temático y recursivo que permitió abordar categorías emergentes.

RESULTADOS Identificamos múltiples barreras y desafíos en la implementación efectiva de la cirugía bariátrica y metabólica en Argentina. Entre ellos destacan desigualdades geográficas, heterogeneidad en los acuerdos de los módulos quirúrgicos, restricciones administrativas y burocráticas relacionadas con la variabilidad en la interpretación de la ley y sus requisitos, altos costos e imposición de cupos que retrasan el acceso oportuno, entre otros.

CONCLUSIONES La implementación de la cirugía bariátrica y metabólica presenta desafíos estructurales y funcionales, que afectan el acceso equitativo y oportuno. Si bien la Ley 26 396 y sus reglamentaciones posteriores establecieron un marco normativo para su cobertura, las tensiones entre actores del sistema de salud y características geográficas han generado una aplicación heterogénea de la normativa. Dicha aplicación enfrenta barreras administrativas y financieras que impactan en su práctica efectiva y oportuna. Destacamos la necesidad de fortalecer la articulación entre médicos y financiadores, promoviendo instancias de diálogo que permitan optimizar los procesos de autorización y financiamiento.