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Equity during an economic crisis: Financing of the Argentine health system

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ABSTRACT

This article analyses the redistributive effect caused by health financing and the distribution of healthcare utilization in Argentina before and during the severe 2001/2002 economic crisis. Both dramatically changed during this period: the redistributive effect became much more positive and utilization shifted from pro-poor to pro-rich. This clearly demonstrates that when utilization is contingent on financing, changes can occur rapidly; and that an integrated approach is required when monitoring equity. From a policy perspective, the Argentine health system appears vulnerable to economic downturns mainly due to high reliance on out-of-pocket payments and the strong link between health insurance and employment.

1. Introduction

The way in which health systems are financed as well as the consequences of this financing is a highly debated policy issue. The study of equity in health financing is important because fairness is one of the fundamental objectives of the health system (Wagstaff and van Doorslaer, 2000; WHO, 2000). Indeed, inequity in health financing is likely to adversely affect not only income distribution but also access to health services, which can in turn lead to greater inequality in health status in the long run. Many policy-makers consider that health system payments should be set according to household ability-to-pay (see for instance Wagstaff and van Doorslaer, 2000; Xu et al., 2003). From this point of view, health financing should not be linked to utilization, and the distribution of household contributions has to be seen as an independent policy choice whose consequences should be examined separately. The idea is not only to promote access to healthcare, with payments disconnected from utilization, but also income protection. Furthermore, this implies that people with higher incomes should pay more (vertical equity) and those deemed equal should be treated equally (horizontal equality). This also implies that payments should not change the individual's ranking in terms of income distribution nor worsen income inequality. The purpose of health financing is not to redistribute income, but its impact on the distribution of income is of obvious interest to policy-makers.

This article looks at the redistributive effect caused by healthcare financing and the distribution of healthcare utilization in Argentina in the years 1997 and 2002. The study of Argentina during this period is noteworthy since this was a time of remarkable change in its distributional, social and labour conditions. Between the years 1996 and 1998 the economy experienced a period of economic expansion and per capita income grew by 10 percent (Gasparini, 2007). However, the recession started soon afterwards, culminating in a severe economic crisis at the end of 2001. This economic downturn resulted in an 18 percent reduction in per capita GDP. Unemployment and poverty reached levels without precedent (Fiszbein et al., 2002) and three quarters of households experienced a reduction in real income of 20 percent or more

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(McKenzie, 2004). Gasparini (2007) demonstrated that, over the period 1992–2006, Argentina showed one of the most disappointing examples of economic performance in the region. All measures of inequality increased during this period. For instance, the Gini coefficient rose from 0.45 in 1992 to 0.528 in May 2003, with a peak at 0.533 in 2002. In addition, this crisis has undoubtedly caused other problems of equity, such as those affecting the financing of the health system, as it is likely to have simultaneously affected the distribution of healthcare payments, private and social health insurance contributions, and taxes paid.

Wagstaff and van Doorslaer (1997) were the first to apply the Aronson et al. (1994) (hereafter AJL) decomposition to the analysis of the redistributive effect caused by health system financing. This method makes it possible to decompose the redistributive effect caused by financing into a vertical, horizontal and reranking effect. However, it has the limitation of requiring the grouping of close pre-financing equals in order to measure horizontal inequality. This has been shown to be an important drawback even with large samples. It is for this reason that we use the Duclos et al. (2003) (hereafter DJA) method, which presents a new way of carrying out the decomposition analysis by means of a continuous method involving a nonparametric estimation. This method has been recently applied to the health context by Bilger (2008), who discusses in detail its advantages over earlier decompositions. These include better statistical efficiency, suitability for the analysis of different health financing sources and adaptability to a wider set of social preferences. Moreover, this method makes it possible both to determine to what extent a given financing source deviates from proportionality and to measure separately horizontal inequality and reranking in a more precise way. In this paper, the DJA decomposition is used to analyse the relationship between each health system financing source and household ability-to-pay (measured by its monthly total expenditure) before and during the Argentine economic crisis.

In the context of low/middle-income countries where a large proportion of health expenditure is financed through out-of-pocket payments, progressivity is not necessarily a sign of an equitable health system. Utilization of health services may depend on direct payments, which can prevent individuals from accessing those health services. Therefore, assessing equity in healthcare financing also requires an analysis of healthcare utilization (Culyer et al., 1981; O'Donnell et al., 2008a). It is for this reason that we complement the interpretation of the redistributive effect of healthcare payments with an analysis of the distribution of healthcare utilization. The recent corrected concentration index (Erreygers, 2009) is applied to the utilization of outpatient care, medicines and lab tests. Utilization of different types of provider is also examined. Finally, inpatient use and longer-term health indicators, such as the presence of chronic conditions and disabilities are also analysed whenever available.

This article investigates important questions such as who pays for healthcare, how health financing has been altered during this period of dramatic changes and what the response was in the use of health services. Although some papers discuss the Argentine health sector in the context of the crisis (Cavagnero, 2008; Uribe and Schwab, 2002), there is no systematic study of the changes in income distribution due to healthcare payments during the economic crisis. Moreover, equity in health financing has never been analysed using a decomposition method, either in Argentina or in any other Latin American country. Our study thus complements those of Asian and OECD countries performed by Wagstaff et al. (1999), van Doorslaer et al. (1999), and O'Donnell et al. (2008a). Finally, lessons from this study have important policy implications, not only for Argentina but for all countries facing an economic crisis.

2. Argentina's healthcare financing mix

Even though the proportion of GDP allocated to healthcare in Argentina remained rather stable (at around 8–9 percent) during the period analysed, in international terms, total health expenditure per capita decreased from US$669 in 1997 to US$242 in 2002.

The Argentine health financing consists of three main subsystems, namely, the publicly funded sector, the private sector, and the social health insurance (SHI) funds. An important part of total health expenditure (30 and 34 percent in 1997 and 2002, respectively) is channeled through the SHI funds, which were established to cover specific groups of formal workers. SHI is a highly fragmented subsystem, with more than 300 sickness funds.[1] Although SHI expenditure as a share of total health expenditure remained broadly stable, 9 percent of the population lost its SHI coverage between 1997 and 2002 (Cavagnero, 2008).[2] One-third of those (mainly management-level employees) changed to private health insurance (PHI) during that period, since the health reforms implemented during the 1990s allowed some employees to do so. However, the remaining two-thirds switched from SHI to public coverage as a consequence of unemployment or informal occupation.

Government expenditure as a proportion of total health expenditure remained at around 22 percent. Although insured people use public hospitals, these are mostly used by the uninsured. As a reaction to the crisis, the Government implemented the *Remediar* program. This program, which provides free basic medicines to the estimated 15 million Argentines using public sector facilities, was gradually implemented starting in October 2002. *Remediar* has been deemed to be successful in providing basic drugs to the most vulnerable. However, there has been concern regarding its long-term sustainability, since it is mostly financed with loans from the Inter-American Development Bank (Homedes and Ugalde, 2006).

Private sector expenditure increased from 44 to 48 percent of total health expenditure during the period analysed. For both the years under study, around two-thirds came from out-of-pocket payments, which in turn accounted for 29 and 32 percent in 1997 and 2002 respectively. The remaining part, around 15 percent of total health expenditure, came from the PHI sector, which consists of non-profit and for-profit organizations, known as mutuales and prepagas, respectively. Both are composed of voluntary affiliates who pay monthly premiums. Benefit packages depend on affiliate contributions and can vary considerably across institutions. Finally, it is worth mentioning that, despite many attempts, the PHI sector remains mostly unregulated.

3. Measurement of the redistributional consequences of financing

A popular measure of the redistributive consequences of a given financing source is the redistributive effect, which is the difference between the gross and net income inequality indices (Reynolds and Smolensky, 1977). A positive redistributive effect thus reveals a decrease in income inequality, while a negative value indicates an increase. In order to gain further insight, AJL proposed a decomposition method of the redistributive effect by showing the following relationship:

$$RE = V - H - R, \tag{1}$$

[1] These include sickness funds at the national and provincial level.

[2] Gasparini (2007) also found a remarkable increase in informal work of 8 points in the period 1992–2003.