

Protecting the poor against health shocks

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Health shocks

It is widely recognised that ill-health is one of the most serious challenges that many households have to face. Apart from the pain and distress suffered by the affected person and those who care for them, sickness can have a wide range of deleterious impacts. In particular, major illness is generally accepted to be a common cause of household impoverishment. Anecdotal evidence (Narayan et al., 2000) suggests that health shocks are seen by the poor themselves as one of their greatest concerns. However, relatively little is known about how different types of households cope with a variety of health-related challenges.

This is in part because of the multiple pathways by which health shocks can impact on the well-being of poor households and individuals. There are many different kinds of illness and their impact will depend greatly on the characteristics not only of the individual falling ill but the household of which they are a member and the community in which that household is located. Whether impoverishment results will depend to a considerable extent both on the effectiveness of formal or informal mechanisms intended to assist distressed households and on local opportunities for income generation. The functioning of the health system and, in particular, the availability of safe, effective, low cost and trusted care may also play a major role in determining outcomes.

For example, when a key worker is incapacitated, labour supply is reduced and demand increased, as care of the sick individual places additional burdens on other household members. Any consequent reduction in household income may be exacerbated by the need for expenditure on health care, if such care is available and accessible. This typically entails reduced household food consumption (World Bank, 2001), possibly impacting on labour productivity. Over time it may lead to a run down of savings; forced borrowing at high rates of interest; and/or sale of physical assets, possibly further reducing income flows if this includes land, livestock or production tools and equipment.

The complex nature of health shocks and the limited current understanding of their impact mechanisms is clearly a considerable frustration for those attempting to design effective interventions. However, disregard of that complexity carries high risks. In particular, it is argued here that the insufficiently considered use of such terms as catastrophic illness and iatrogenic poverty has encouraged the implementation of somewhat simplistic strategies which fail to address the needs of large numbers of the poor and especially the very poor.

Catastrophic illness

It has become commonplace to use the term 'catastrophic illness' as if it is a well defined single event for which one can design an effective intervention. In fact, nothing is further from the truth. At an elementary level, use of the concept certainly varies substantially between the medical community, which would probably base its judgement on the nature of the diagnosis¹, the required intervention and the characteristics of the patient, health insurers, who would be primarily concerned with the cost of treatment, and health economists, who focus on conditions requiring health care expenditures which "can lead to individuals having to pay catastrophic *proportions* of their available income and push many households into poverty." (Xu, 2003).

In practice, household studies show a variety of patterns through which health shocks and poverty interact. Major, unexpected events may require costly hospital care. However, chronic illnesses and even recurrent acute health problems can create a major financial drain on household resources. Chronic illnesses that completely or partially disable the sufferer and follow a gradual course of increasing dependency are especially burdensome.

¹ Some medical conditions are so identified in the International Classification of Diseases.

Heart disease, HIV/AIDS and some cancers are examples of this kind of challenge. Injuries resulting in the loss of sight or limbs may entail limited health expenditures but have serious consequences in terms of paid employment or the viability of household enterprises. A variety of conditions may initially not impact on income or expenditure but have extremely serious social implications in terms of loss of status, isolation, rejection, persecution. These different types of shock call for very different responses.

A focus on expenditure also crucially ignores the fact that many of the poor and probably most of the poorest may have low health expenditures because they are unable or choose not to access health care. As a recent study in Chad highlights, “households ignore health problems – absorbing them into the experience of everyday life – When illnesses appear as crises it is often because ... easily treatable problems spiral out of control.” (Leonard, 2005). Of course, immiserating expenditure on health care is an important issue but it should not preclude a focus on the potential immiserating effects of not accessing health care when needed, especially as it is the poorest households who are more likely to experience the latter.

Health perceptions, attitudes and beliefs

Interventions intended to address health shocks have to address two other complicating factors which relate to the wide range of perceptions, attitudes and beliefs which different populations attach to health issues. First, much expenditure on health care, perhaps especially by the poor, is wasted, at least in clinical terms, on inappropriate, ineffective, unnecessary or even dangerous treatments. Assisting households in their purchase would generally be seen as counterproductive, though given the power of the placebo effect and the natural desire for rapid and cheap cures, the general population and the medical profession may well disagree as to which treatments should be so regarded.

Second, and more contentiously, it is possible to argue that interventions which tend to make treatment attainable but only at substantial cost need very careful consideration. For example, many of the serious funding problems currently confronting health care systems in developed and transition countries relate to the availability of very expensive, and often only moderately effective, treatments which can prolong the life of the elderly population. In countries where health care costs are primarily met from current income or limited savings, should interventions be introduced which make it possible for the poor to gain health care for aged relatives with serious illness but only if they – and their children – make major, and possibly permanently damaging, sacrifices? Similar, and in many respects even more difficult, issues arise in relation to the treatment of AIDS. How can households or extended families refuse their members long term treatment with ARVs, even if the possibly heavily subsidised cost remains high enough to gradually drive them into destitution? A very heavy ‘burden of choice’ may be placed on households already living under constant stress by such well-intentioned initiatives.

Health-related interventions

In the design of interventions intended to counter health-related shocks, it is important to recognise the variety of existing social mechanisms established to cope with health challenges. These may be organised by households, extended families and other community and social arrangements. Novel interventions need to complement and support these existing strategies. However, in many countries there are no systematic studies of these arrangements.

Table 1 (Bloom, 2005) provides a useful initial framework for thinking about the diverse range of health-related shocks and the variety of interventions intended to achieve one or more of the following objectives:

1. reduce the likelihood that the event will take place;
2. mitigate the deleterious impact on individuals and households; and
3. help households cope.

One point to note is that an appropriate strategy to meet the health-related needs of poor households may well combine supply and demand-side interventions.

Table 1: Types of response to health challenges and supporting interventions

Type of protection	Type of intervention
Reduced risk	
Reduce the risk of major shocks	<ul style="list-style-type: none"> - early warning and capacity for rapid response - rules for open information enforced - legal rights to compensation for adverse impacts on the poor
Reduce the risk of adverse health consequences of major shocks	<ul style="list-style-type: none"> - investment in competent and accountable international, government or other crisis management systems - relief programmes with a strong health component
Reduce the risk of health-related shocks	<ul style="list-style-type: none"> - legal right to a minimum standard of essential public health measures - effective preventive programmes
Mitigation	
mitigate impact of small health-related shocks	<ul style="list-style-type: none"> - subsidise government health services or provided targeted benefits to the poor - improve quality of organised services for the poor - community health insurance (with government or donor subsidies) - reduce useless and dangerous medical practices (regulation, training and provision of information on drugs)
mitigate the high cost of hospitalisation	<ul style="list-style-type: none"> - subsidise public hospitals - hospital insurance - health safety net for the poor - increase availability of credit - control quality and cost of hospital services
Coping	
cope with the high cost of chronic disease	<ul style="list-style-type: none"> - improve capacity to treat these diseases - entitlements to specific treatments at subsidised cost - financial transfers to specific groups such as elderly, disabled (cash or vouchers)
cope with the cost of caring for a severely ill or disabled family member	<ul style="list-style-type: none"> - community support or nursing homes (with government subsidy) - cash transfers to specific groups
cope with the impact of a major illness event	<ul style="list-style-type: none"> - special support for survivors - assistance in reconstruction of livelihoods

Source: adapted from Bloom 2005

One important characteristic of an intervention is whether it is based on rules-based entitlements or on discretion. Almost every society combines the two. The advantage of rules-based entitlements is that they constitute a right against which eligible people can make a claim. Individuals will be less dependent on the good will of the powerful. These entitlements should be quite reliable and they provide predictable protection against shocks. However, it can be very costly to finance rules-based entitlements to cope with all health-related shocks. For example, a commitment to provide all possible treatments for HIV/AIDS

or a serious cancer can be a very large, almost open-ended claim for resources. The advanced market economies have found it very difficult to draft rules to define the limits of these claims. Even in these countries, a variety of faith-based groups and charitable organisations have emerged to support people with particular needs. The challenge is much greater in low and middle income countries.

Table 2 provides a summary of the different types of rules-based and discretionary benefits, organising them in terms of the type of benefit, institutions that organise the benefit and the criteria for identifying the beneficiary.

Table 2: Rules-based and discretionary benefits

	Rules-based	Discretionary
Type of benefit	<ul style="list-style-type: none"> • insurance • insurance plus top-up • vouchers or exemptions • health safety net 	<ul style="list-style-type: none"> • response to special need • community support
Institutions	<ul style="list-style-type: none"> • insurance schemes • public hospitals • public finance • special purpose community organisations 	<ul style="list-style-type: none"> • community organisations • faith-based organisations • charity
Criteria for benefit	<ul style="list-style-type: none"> • household characteristics (e.g. income, disability, age) • type of health problem 	<ul style="list-style-type: none"> • “deserving” • specific communities • specific household characteristics

Rules-based benefits are characteristically organised by government or by highly regulated private entities such as insurance companies. Some community organisations also function on the basis of clearly defined rules. Examples of these benefits include:

- health insurance (perhaps with subsidies to incorporate the poor)
- vouchers or exemptions for defined beneficiaries
- subsidised care for those suffering from particular health problems (universal or for defined beneficiaries)
- cash transfers to defined beneficiaries

Beneficiaries are usually identified in terms of a measurable characteristic such as household income or wealth, age, particular diagnosis or ethnicity. Societies may invest heavily in systems to limit benefits to the eligible. The legitimacy of rules-based systems depends on the perceived fairness of the rules and the degree to which they are adhered to in practice.

Discretionary benefits tend to be organised by a variety of community organisations, charities and faith-based organisations. They are not provided as a right but as a response to needs. They do not constitute an open-ended commitment. Often support is reserved for those most “deserving” and others may be denied support. Examples of discretionary benefits include:

- voluntary support by communities or social network organisations
- charitable support
- support by faith-based organisations

The advantage of discretionary benefits is that they can be targeted on those who need them the most, in a context of limited resources. However, the disadvantage is that recipients may be stigmatised as dependent or destitute and they are reliant on the good will and good practices of the managers of these funds. The legitimacy of discretionary funds depends on the degree to which they are perceived to provide relief to those most in need.

Special arrangements that target sub-populations on the basis of extreme poverty or other characteristics of severe vulnerability often share characteristics of rules-based and discretionary benefits. There may be rules to identify beneficiaries, but implementers often have a lot of discretion. For example, people perceived as undeserving may be less likely to become beneficiaries. The same may apply to sub-populations or localities that benefit from special programmes. The level of benefit may also vary considerably. Programmes are often budget-limited and the number of beneficiaries and level of benefits per person may vary with the size of the annual budget. This makes the "entitlements" contingent on changing resource availabilities and political trends. Targeted programmes tend to be successful at allocating resources to those who need them the most, but at the cost of stigmatising the recipients.

Most societies utilise a combination of universal entitlement programmes, targeted benefits and discretionary arrangements to help households cope with major illness, complementing a variety of "informal" community and family-based arrangements. It is dangerous to generalise, but the richer the society, the smaller its structural inequalities and the more sophisticated and stable its institutional arrangements the more likely are universal entitlements to play a significant role.

Research on health shocks

There are major methodological challenges to be overcome in understanding health shocks. Research in this area entails the development of a range of innovative methodologies, combining quantitative and qualitative data. Previous studies on the response of poor households to sickness have predominantly relied on the short-term (two weeks to one month) recall of illness episodes. They have typically focused on healthcare seeking behaviour, how much the poor spend on health care, the implications of user fees and failures of the public delivery system. (e.g. Berman, 1998; Rohde and Vishwanathan, 1995; De Zoysa, 1998; Reddy and Vandermoortele, 1996; Segall, Tipping and Lucas 2000). They mostly indicate that poor households take on large out-of-pocket expenditure relative to their income, rely heavily on primary level services and often resort to informal sector providers. They also demonstrate that the poor face serious financial, cognitive, class and gender barriers to receiving effective care (Sauerborn *et al.* 1996; Vlassoff, 1996; Dercon and Krishnan, 2000).

However, because of the short time horizon adopted, such studies have not addressed the main issue of concern here: the medium or long term impacts of health shocks and the impact of illness on sustaining normal household functioning. Cross-sectional surveys could be extremely useful in terms of assessing perceptions of risk and vulnerability. They can identify the primary concerns of different types of communities and assess their attitudes, expectations and desires. This is one key aspect of work on shocks. However, such surveys can provide limited guidance in identifying points of policy intervention that can reduce the impact of illness on poor households and halt the decline into chronic poverty or destitution. It is particularly difficult to assess the impact of a major illness, with long-term consequences from a single interview and therefore important to explore options for longitudinal studies of impact, or at least to access and reanalyse existing longitudinal data sources. The establishment of demographic surveillance sites provides an important opportunity.

While income poverty – ‘iatrogenic poverty’ – should clearly be a major concern, exploration of the impact of illness on other dimensions of poverty (e.g. World Bank, 2001) may be of equal if not greater importance. For instance, vulnerability to one aspect of poverty may not mean vulnerability to another aspect. For example, vulnerability to lack of access to education may not mean vulnerability to malnutrition. This means that measurements of vulnerability are complex and context specific. The ‘Livelihood Assets’ approach has proved a useful framework to address similar issues (Siegel, 2005).

Again, while the primary focus should be on the household, as the primary producing and consuming unit, the research will need to address the intra-household welfare implications of illness and the role of individual households and household members within the wider community. There will need to be a particular focus on gender issues. It is frequently overlooked that the great majority of health care is provided within the household and by women. Failure to consider the effect of illness on ‘reproductive burdens’² may seriously underestimate their full impact.

The design of appropriate support mechanisms – for example whether these should be government or community based and the balance between discretion and entitlement – will almost certainly depend to a considerable extent on the existing situation in any given country. It is important for research to explore a wide range of national and local circumstances in order to assess the potential and limitations of different approaches.

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² The term “reproductive burdens” derives from the literature on social reproduction and refers to the functions of households in the following areas: 1. capacity to produce and rear children, 2. day-to-day maintenance of households through food processing and cooking, care of children and other dependents, cleaning etc., 3. maintenance of household viability inter-generationally through securing necessary economic inputs and social relations (adapted from Young 1981).

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