HEALTH-POVERTY NEXUS: PREVENTING FAMILIES FROM FALLING INTO THE POVERTY HOLE

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All governments have allocated resources directly for poverty alleviation or for development projects that, it is claimed, would contribute to reduction of poverty. During the last two decades, enormous amounts have been devoted to anti-poverty measures: preparation of the Poverty Reduction Strategy Paper, popularly known by its acronym – PRSP; setting up of multi-million rupee funded institutions with mandates to mitigate poverty, such as, the Pakistan Poverty Alleviation Fund, Khushali Bank, etc.; and so on. Donors too have poured millions of dollars each year towards the hitherto elusive goal of lowering the incidence of poverty.

Ironically, while substantial resources are allocated to try to *pull out* those who are mired in the poverty hole, little attention is paid to factors that *push in* currently non-poor families down the poverty hole. And, given that the rate at which families are being pulled out of poverty is slower than the rate at which families are being pushed into poverty, the absolute numbers of the poor keeps rising – and the battle against poverty appears to be hopelessly lost. Clearly, some effort needs to be directed to address the factors that push families below the poverty line, in addition to dealing with factors that could pull families out of poverty.

Impact of Under-nutrition:

The impact of health care burden on poverty is well documented. Among others, World Bank studies (2002, 2001) have identified health problems as the single most common trigger for descent into poverty and, in the case of India, concluded that nearly 25 percent of those hospitalized fell below the poverty line because of medical costs.

Lawrence Haddad (2002) has encapsulated the nutrition-health-productivity-wages-poverty relationship. According to Haddad: "… the ratio of the percentage improvements in adult wage over the percentage improvement in adult nutrition status is greater than one" and "losses from various components of under-nutrition can be as high as 3 percent of GDP". The linkages are explained thus: "… better nutrition improves intellectual capacity and intellectual capacity increases an adult's ability to access other types of assets that are essential for increases in labour productivity" and "An adult who is more productive has a larger set of available livelihood options, which raises lifetime private savings in a way that is robust to external shocks such as disease, unemployment or natural disasters".

SPDC (2001) has recorded the voices of poor women and which vividly portrays the relationship between poverty, hunger, nutrition and health. Information for the study was obtained in Karachi and Lahore. In each city, three focus group discussions were held with a total of 104 women, who were married for at least 5 years and had at least one child or who were divorced or widowed and had at least one child.

A sub-sample of beggars, drug-addicts and sex workers was also included.

The women in the research sample come from lower middle class families – including single parent female-headed families – with year 2001 total family income ranging from Rs. 2000 to Rs. 5000. They have few fixed assets, other their own house in some cases. Some possess a refrigerator or television, purchased during better times. Most of the women in the sample have four or more children and live in small one or two room houses. Occupationally, the families belong to the categories of low-level public sectoremployees, industrial labourers, shop assistants, skilled workers (e.g., electricians, carpenters, etc.) and those self-employed in the informal sector.

A sample of their 'voices' is presented here.

If there are no jobs, the next thing to follow is hunger.

We can't afford anything. We cannot eat properly, wear proper clothes or visit our relatives. If we have sugar, there is no tea; if we have atta, there are no vegetables.

At times, we go through a lot of suffering. Once I had nothing to cook in the house. I cooked some rice with left over roti and told the children that I was cooking haleem.

The situation was better when my husband was alive. I have growing daughters who ask for food.

I give the best portion of the food to my husband, because we are all dependent on his income. If he falls sick, we will starve.

Nowadays, our children are not fed properly even once a day. They fight over pieces of roti. Someone or the other in the family always sleeps hungry.

I sometimes cry when I see my children's pale faces and weak bodies. We just don't have the means to feed them properly. I can't do anything about it, except cry.

My husband has a back problem and cannot work any longer. In the beginning, we spent a lot of money on his treatment, but after we ran out of resources, he is just bed-ridden.

My children often suffer from common colds and coughs, but I never take them to the doctor, because I can't afford the fee or the medicines. I myself have a heart problem and have been advised rest. But how is that possible? Who will support my children if I don't work?

The biggest worry for us is our daughters' marriages. But should we eat or save for their marriage? I just hope that some decent family which does not want a dowry will agree to marry my daughters.

What can I do? Sometimes, I just beat my children and cry. Sometimes, I pray that my children should just die, because I can't even feed them properly.

SPDC (2001), pp. 56-57 and 62

Impact of Shocks:

While the process from poor nutrition to poverty is incremental, shocks can cause discreet impacts on the economic status of affected families. One factor that plays a key role in pushing families into the poverty hole is unanticipated emergency expenditures, forcing indebtedness or distress sale of assets or temporary or permanent loss of income, or all of them. A medical emergency is one such prime example. Medical emergencies force families to seek medical care, irrespective of whether they can afford it or not. In economics language, it is said that the demand for emergency medical care is highly inelastic. In fact, the need for emergency medical care acquires such a position of priority that other routine or planned expenditures are postponed or forgone altogether in order to divert resources to attending to the emergency.

A medical emergency could be an accident – burn, fracture, etc. – or a serious life-threatening disease – cancer, kidney failure, etc. – or an ailment requirement long-term or life-long treatment or medication – hypertension, heart disease, etc. Any of these require large outlays of funds, either at once or over a length of time. Financing treatment and associated costs, like special dietary requirements and transportation to and from medical centres, impose costs on affected families. Patients from rural or remote areas are usually accompanied by more than one attendant, who have to bear the cost of their own accommodation and meals while the patient is hospitalized.

Routine expenditures that are postponed or foregone may include food items or school/college fees, usually for girls. Planned expenditures that are postponed or foregone may include home repairs or purchase of an asset like a house or a car. There are opportunity costs as well; i.e., loss of income of the patient and of those attending to the patient. These foregone income losses add to financial pressures.

Research into the modes of coping financially with the crisis shows a systematic and definite pattern. One study documented 30 cases – 15 relating to cancer patients and 15 relating to patients requiring dialysis – over a period of one year to systematically record the financial coping patterns of these families and, in particular, the process of asset depletion. The sample selection was highly purposive, targeting lower middle income families with the onset of disease of the patient in its initial stage. The sample was selected from one oncology unit of a hospital and one dialysis centre, both in Karachi.

It is shown that the first recourse is usually to tap into family savings. Liquid savings, e.g., cash, savings certificates, etc., are drawn on first. The second stage involves a mix of borrowing and asset sales. Where employment benefits are available, loans against provident fund is obtained. Borrowing from relatives, employers, friends and even acquaintances follows. Assets – jewelry, motor-bike/scooter, car, cattle, standing crops, land, house, flat, etc. – are pawned next, generally in this order. Land or house/flat is usually among the last of the assets that are placed on the block. Surveys have brought forth cases where affected families have resorted to selling their house or flat to raise funds for medical expenditures and moving into smaller rented premises. Given that the sale of assets is carried out under pressure of time, they are forced to accept lower than market prices: thus the term ‘distress sale of assets’.

The primary financial casualty of a serious medical emergency is savings, given that borrowings and asset sales are forms of savings. Borrowed amounts are savings against future income, given that the amounts have to be repaid; thus, the term negative savings. Assets are physical manifestation of past savings, held in an illiquid form; as such, asset sale is tantamount to liquidation of past savings. As such, families that are constrained to consume present, past and future savings are rendered into poverty, from which it finds it no longer has any means to escape from.

Meeting Medical Expenses By Source				
Quarter	Income	Savings	Borrowings	Asset Sales
1	20.8	74.1	5.1	0
2	19.4	40.5	25.1	15.0
3	14.6	19.0	41.1	25.3
4	9.7	4.2	19.9	66.2

The above table, based on data collected from 30 households over a period of one year, clearly highlights the 'descent into poverty' phenomenon, as their present, past and future savings evaporate. The principal source of financing medical costs in the first and second quarters is current savings, although the share of current savings in the second quarter declines by nearly half and the share of borrowings (i.e., future savings) rises five fold. In the third quarter, borrowings emerges as the main source of financing medical costs, but declines by half as sources from where funds can be borrowed are gradually exhausted. In the fourth quarter, sale of assets – past savings, which was zero in the first quarter – emerges as the major source of financing medical costs.

These costs have long-term impacts. Future income is rendered mortgaged to repayment of borrowed amounts, forcing families to forgo consumption. Sale of assets that are providing a flow of income, like cultivable land, cattle, rented out house, etc., deprive the family of the stream of income even after the demise of the patient. In one case, a school transport operator had to sell his van to support treatment for his daughter, losing income during the period of the treatment and after her demise as well.

Patients and/or their attendants lose their jobs on account of frequent absenteeism on account of their own illness, during visits to the medical centre or during hospitalization. Attendant(s) who have to care for the patient or escort the patient to the clinics, or stay with the patient during hospitalization face similar hazards. In most cases, the surviving attendants fail to reclaim their old jobs or easily find a new one.

There are inter-generational impacts as well. Children, especially girls, miss classes often enough to be disallowed or unable to sit for exams and, as a result, fall behind. Many are withdrawn altogether, either because of the need to attend to the patient or because of declining affordability. These children suffer from weak income earning capacity when in their adulthood.

Mohammed Khan* is a resident of Khuzdar in Balochistan. He could be classified as a medium sized farmer of reasonable means – indicated by the fact that he owned a Pajero, carried an expensive cell phone and was always dressed in starched white shalwar kameez. Also, he was usually in an expansive mood. His wife had developed kidney problems and required regular dialysis, for which he would bring her to Karachi. Having been selected among the 15 cases for analysis, the research team met him and his wife at least once a month for a period of one year.

The dialysis clinic offered two tracts: one for paying patients and the other for non-paying patients, supported from zakat funds. Mohammed Khan's wife was a paying patient and he made it a point to remind the research team on almost every occasion of that fact. That was for the first 8-9 months.

Towards the 9th or 10th month, the research team began to discern a change. He was generally quieter. That was understandable, as his wife was not responding too well to the dialysis. But there were other signs of change too. For example, he was no longer in his usual starched white attire. In the 12th month, the clinic authorities disclosed to the research team that Mohammed Khan's wife had now transferred from the 'paying patient' category to the 'zakat-supported' category. Subsequently, the research team noted that Mohammed Khan and his wife had arrived at the clinic in a ramshackle Toyota car. During the interview – the last scheduled one – he disclosed that he had had to sell his Pajero and that the car was a taxi hired from Khuzdar.

* Name changed to protect identity

Case for Policy Action:

The prevailing situation is largely a product of lack of attention to human development needs in macroeconomic policymaking and policy inaction with respect to the structure of fiscal allocations. SPDC (2001-2005) has produced a number of studies that point to the absence of pro-poor bias in macroeconomic policies. According to Dara Carr (2004), health care financing systems in developing countries disadvantage the poor, with low government spending in health forcing medical care seekers to bear up to 80 percent of medical costs through out-of-pocket payments.

In Pakistan, a shocking less than one percent of GDP is devoted health. By contrast, up to 5 percent of GDP is consumed by defence related expenditures. Given that defence allocations are utilized to acquire arms and ammunition – instruments of taking life – and health allocations are employed to acquire instruments of saving lives, and there is a 5 to 1 ratio between the two, questions arise as to the nature of the collective values of the people, the country and the nation.

Remedial measures, it would appear, are urgently called for. On the nutrition front, macroeconomic measures need to be taken to raise the incomes of the poor, so as to enable them to afford basic food items.

At the same time, or alternatively, more direct measures can be taken to provide essential food items to the poor at affordable prices. With respect to protecting the poor from medical shocks, allocations for health need to be raised substantially, with a careful appraisal as to how the additional allocations are to be utilized. One possible measure to protect the poor from the impact of medical shocks is to institute a nation-wide health insurance scheme that would cover up to 90 percent of expenditures for treatment of serious accidental injuries and selected chronic diseases. The scheme could be posited on a triangular relationship: government, insurance companies and hospitals/medical centres; with the government responsible for premium payments, insurance companies responsible for coverage and hospitals/medical centres responsible for treatment.

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