
Payments for healthcare: Do they aggravate poverty?

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SUMMARY

The authors assessed the impoverishing effect of healthcare expenditure in 11 low-to-medium income countries of Asia. In almost all countries of the world, conventional estimates of poverty (or the definition of poverty line) do not explicitly include out-of-pocket payments to finance healthcare. In developing countries, a large share of expenditure on health comes directly from people's pockets. Sometimes, unexpected illness can have a catastrophic effect on the family of the ill person. One of the reasons for not including medical expenditure in the definition of poverty line is the uncertainty and variability of illness.

Data from nationally representative surveys of household expenditure or socioeconomic status that recorded both out-of-pocket payments for healthcare and total household consumption in detail were used for the analysis. Out-of-pocket payments for healthcare included medical fees, user charges for public care, purchase of medicines, insurance payments, and payments for appliances, diagnostic tests, etc. The authors estimated the additional number of individuals who would lie below the international poverty thresholds if medical expenditures were subtracted from their total household resources. They also estimated the poverty gap, which is the amount by which the resources would fall short of poverty thresholds.

The authors' estimate of the overall prevalence of absolute poverty in these countries was 14% higher than conventional estimates that do not take account of out-of-pocket payments for healthcare. An additional 2.7% of the population under study (78 million people) ended up with less than US\$ 1 per day after they had paid for healthcare. In Bangladesh, China, India, Nepal and Viet Nam, where households pay more than 60% of healthcare costs out-of-pocket, the estimates of poverty were much higher than conventional figures, ranging from an additional 1.2% of the population in Viet Nam to 3.8% in Bangladesh. In India, it was 3.7%. Increase in poverty was highest in countries with the highest reliance on out-of-pocket health financing. There was substantial cross-country variation in the magnitude of out-of-pocket health payments, and the extent to which people at risk of poverty are protected from such costs by fee waivers. At the higher poverty line of US\$ 2.15 per day, the adjustment for healthcare payments caused the poverty rate across all countries to rise from 58.8% to 60.8%. The aggregate percentage point increase in the population-weighted average poverty gap was 0.75 at US\$ 1 per day and 1.5 at US\$ 2 per day. Changes in the poverty gap after accounting for out-of-pocket payments were larger than adjustments to the poverty head count. The increase in the poverty gap was not only due to more individuals falling below the poverty line, but also due to poor individuals sinking even further below the poverty line once healthcare payments were subtracted from their resources.

The authors suggest that effective exemption schemes for the poor and curbing of user charges for public sector healthcare should be considered when policies are formulated to reduce poverty.

COMMENT

The poverty line is calculated from estimates of the cost of nutritional requirements for a country and an allowance for non-food basic needs. Although non-food basic needs might be expected to include healthcare payments, they are never explicitly included. The World Bank has developed two international absolute poverty lines of US\$ 1.08 and US\$ 2.15 per head per day (adjusted to represent purchasing power parity in relation to the 1993 consumer prices of each country).^{1,2} The lower line is the median of the 10 lowest poverty lines used in a sample of low income countries. It represents a very low living standard or extreme poverty.³ US\$ 2.15 corresponds to the low standard of living at which someone would experience poverty in a middle income country. The World Bank calculated this line by doubling the lower one. There is growing evidence globally that healthcare costs can plunge households into poverty.⁴ This may happen particularly during catastrophic illnesses. However, even routine ambulatory care with so-called nominal fees can worsen the situation of extremely poor households. This is also known as the 'medical poverty trap'. When people have to pay fees or co-payments for healthcare, the amount can be so high in relation to income that it results in 'financial catastrophe' for the individual or the household.⁵ People have to cut down on necessities such as food, clothing or children's education. The WHO has proposed that health expenditure be viewed as catastrophic whenever it is $\geq 40\%$ of a household's non-subsistence income, i.e. income available after basic needs have been met.⁶ Every year, globally approximately 44 million households, or more than 150 million individuals, face catastrophic health expenditure and about 25 million households or more than 100 million individuals are pushed into poverty by the need to pay for healthcare services.⁷

An out-of-pocket payment for healthcare is considered to be the most inefficient and inequitable means of financing a health system and one of the most regressive forms of healthcare financing.^{8,9} There is little room for risk pooling, competition among providers is reduced and patients pay more than they would with a prepayment scheme.¹⁰ The impact goes beyond catastrophic spending alone. Many people may decide not to use services. Poor households are likely to sink even further into poverty because of the adverse effects of illness on their earnings and general welfare.

In India, the percentage of the population below the poverty line is decreasing over the years.¹¹ The latest data from the National Sample Survey Organization (NSSO) 61st Round shows that 22.2% of Indians were living below the poverty line during 2004–05.¹² According to the NSSO data 55th Round, households spend about 5%–6% of their total consumption expenditure on health, which is 11% of all non-food consumption expenditure.¹³ In India, around 70% of the healthcare expenditure is borne by households.¹⁴ Direct out-of-pocket payments could push 2.2% of all healthcare users and one-fourth of all hospitalized patients, into poverty in a year. Although these percentages may seem small, they translate into substantial numbers considering our huge population. Besides, these estimates do not take into account sick persons who do not seek treatment.¹⁵ Peters *et al.*¹⁶ estimated that out-of-pocket spending on hospital care might have raised the proportion of the population in poverty by 2%.

The authors acknowledge that the finding of a difference in the poverty estimates (before and after deducting out-of-pocket payments for healthcare) can be interpreted as a rough approximation of the impoverishing effect of such out-of-pocket payments. So, under what circumstances would this difference

between the two poverty estimates correspond to poverty due to health payments? There should be two necessary conditions: A fixed overall household budget, and households having no choice about the size of out-of-pocket health expenditures. Only then would the difference between the two estimates correspond to poverty due to health payments. In any society neither of these two conditions hold perfectly. Citing the example of Sri Lanka, the authors have emphasized that by sufficient revenue from taxation, public spending priorities, accessibility of public health services and good governance, the economic burden due to healthcare expenditure can be reduced.

The authors used household expenditure surveys for estimating poverty adjustment due to healthcare costs. These are cross-sectional surveys and do not assess the effects of healthcare expenditure on chronic poverty. Short duration dips in spending below the poverty line should be weighted against the longer term effects. By these surveys, one does not know what happens to household expenditures during long enough periods after an adverse health event. Moreover, since health expenditure varies over time, by analysing these data one cannot comment on the difference in poverty gap across time.

Consumption expenditures are sometimes underreported. In India, such underreporting resulted in a mismatch of poverty estimates based on national accounts data and household survey data.¹⁷ Correction of non-health expenditures for underreporting will raise the overall number of non-poor and subsequently reduce the poverty-adjustment estimate due to healthcare expenditure. The effect of informal insurance also needs to be considered. Payments made with support from the extended family and relatives are common in many developing countries, especially in India. Some insurance providers require advance payments that are then reimbursed, often with substantial delays. Inadequate consideration of these factors would lead to overestimation of the impoverishing effects of health spending. Estimation of poverty by measurement of spending after deducting out-of-pocket health expenditures insufficiently captures economic implications for households who forego urgent healthcare. Further, definition of a threshold spending level for health is not easy, because treatment of an adverse health event could simultaneously constitute a basic need and be extremely expensive.

Payments for medicines are another factor that can contribute to the possible impoverishing effect of out-of-pocket payments for healthcare. In many countries, exemptions from public sector charges do not include prescribed medicines. This issue merits careful consideration, as does reduction in the user charges for public sector healthcare, and exemption schemes for the poor, at the time of policy planning and formulation of relevant strategies for alleviation of poverty in India.

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