

Editorial: Iatrogenic poverty

Bruno Meessen¹, Zhang Zhenzhong², Wim Van Damme¹, Narayanan Devadasan¹, Bart Criel¹ and Gerald Bloom³

¹ *Institute of Tropical Medicine, Antwerp, Belgium*

² *Chinese Health Economics Institute, Beijing, China*

³ *Institute of Development Studies, Brighton, UK*

keywords poverty, iatrogenesis, catastrophic health care expenditure, health insurance, social assistance, Asia, transition

Poverty and illness are intertwined. It is a well-documented fact that poverty leads to ill-health. In every society, morbidity and mortality are higher among the poor (Wagstaff 2002). Determinants of lower health status include nutrition, environment, education, lifestyle and access to health care. Less is known about how illness itself can lead to poverty in developing countries. There are two major pathways. The first is through the death or disability of a household income earner. This reduces future income generation and may jeopardize household consumption. After a household has depleted its wealth it may have less capacity to invest in the education of their children. This transmits poverty to the next generation.

The second is through the treatment itself, or more exactly its cost. The chain of events is as follows: when someone falls ill, the household faces several different costs (opportunity cost of care giving, transportation, treatment), and to cope with them, it follows diverse strategies. Sometimes the costs are limited, and the household is able to buffer them by making a short-term adjustment (such as consuming precautionary saving, calling on assistance from informal support networks, temporarily reducing its consumption of other goods). Yet, sometimes, the costs are at, or increase to, a level where these coping mechanisms are not sufficient anymore. The household then adopts the riskier strategies of selling or mortgaging its productive assets (Ensor & Bich San 1996; Bloom & Lucas 2000; Meessen & Criel 2003). Some households recover from the financial shock, but others do not (Wilkes *et al.* 1997). The next time when they have to deal with an illness, a crop failure or another problem, they may be tipped into poverty. Chambers (1983) has called this process a poverty ratchet.

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Poor people are well aware of that cycle. Surveys have found that they identify sickness as one of their greatest

worries (Milimo *et al.* 2002). Economists and experts in poverty analysis have raised the issue. The WHO, the World Bank and the ILO are trying to put it higher on the agenda by referring to it as *catastrophic health care expenditure*. But the issue is still little recognized by the political, scientific and, most of all, the medical communities. Doctors are trained to assess the outcome of their interventions in terms of health status, it is high time to consider them in terms of welfare.

Let us have a look at the world outside the health sector. What has been the major change for humanity these last two decades? The average reader of this journal might identify globalization. But for 1.7 billion people, the major change has another name: transition. The transition from a planned economy to a market economy has concerned China, most of South East Asia, Eastern Europe and the Republics of the former Soviet Union. What has this transition meant for the citizens of these countries? Economic growth in some countries, but also a reshaping of the pattern of entitlements (Sen 1981). While education, jobs, income and welfare services used to be taken for granted, today they are determined by a combination of market forces and political commitment to provide benefits. One can find a job and earn an income according to one's skills and the demand in the labour market. Access to education and health care are no longer universal, but are influenced by the ability to pay.

Most governments fail to fund their health sector adequately because of limited budgets, excessive faith in market forces or other priorities. Consequently, many public health care facilities are run down or they generate revenue by charging patients. At the same time, rural households in many countries have a new opportunity to mortgage or sell their land and other productive assets. 'Marketization' is indeed ubiquitous. Today, more than ever, the Cambodian or Chinese farmer is able to match his ability to pay for health care with his willingness to pay. Credit and land markets, i.e. usurious

moneylenders and resourceful neighbouring farmers, are there to 'help'.

Is this problem limited to transitional countries? Certainly not. The problem is also important in Asian countries with less dramatic changes, such as India or Indonesia (Gertler & Gruber 2002). Many years ago Chambers (1983) suggested that the development of modern hospitals was a major source of difficulties for the rural poor, who have been made to choose between letting a sick parent die without care on the one hand and impoverishment because of high health care costs on the other (G. Bloom personal communication). The AIDS epidemic has made these choices even more agonizing.

The whole problem cannot be explained by the rising liquidity of household assets alone. Willingness to pay is also increasing. Because of economic growth, epidemiological transition, the ageing of the population and access to information, there is an emerging demand in low- and middle-income countries for treatments similar to those delivered in rich countries. Many are ready to try out anything for their loved ones.

The supply side follows demand: medical progress – mainly drugs and imaging technology – penetrates liberalizing markets easily. In a country like China, the health staff are understandably eager to increase their income and keep themselves in line with the other dynamic sectors of the economy. They face few regulatory constraints. This unique convergence of factors is creating a real business in health care. Health is one of the fast growing sectors in transition economies. For example, since 1996, the annual growth rate of health expenditure in China has been more than 13%, significantly exceeding the already fast-growing economic growth rate (Zhao 2002).

Is this impressive growth justified by needs? Only partly. A major feature of the health care market is asymmetry of information: as far as diagnosis and treatments are concerned, the patient is at the mercy of his agent, the health worker. Many health workers get their knowledge from the people who sell them drugs. To control the risk of provider-induced consumption, a full toolbox of institutions has been developed over the ages, ranging from market regulation to what we can club together under the term 'professionalism'. Many Asian countries in transition lack these set of mechanisms. Traditionally, providers were only accountable to the state which had a ubiquitous presence (as an owner, supplier, employer, manager and payer). With transition, the grip of these mechanisms is loosening. Unprotected by checks and balances, the patients are today at the mercy of health workers who, for historical reasons, often have very limited medical knowledge. This fuels a vicious circle: distress caused by disease, the quest for treatment – often through a succession of

ineffective therapies, consumption of savings, indebtedness, sale of productive assets and eventually poverty. The disease does not have to be a complex one; dengue in Cambodia can be enough (Van Leemput & Van Damme 2002). There, health care costs are reported today as the single most important reason for households to fall into poverty (Kassie 2000). China's policy-makers also acknowledge that illness of a family member has become one of the most important causes of household poverty (Zhang 2002). Poverty induced by medicine – 'iatrogenic poverty'!

The search for solutions

The main recommendation for protecting people against the high cost of illness is social insurance (Kawabata *et al.* 2002). Disease is a lottery and households can insure their welfare by pooling their risks and resources. Everyone shares the cost of the unlucky ones who fall ill. The benefits are obvious: people can insure against health care expenditure (social health insurance) and also the loss of income because of death or invalidity (widow, orphan and disablement benefits). Several generations of citizens of the advanced market economies have enjoyed the blessings of social security. In some low- and middle-income countries, statutory social health insurance exists but often only for a minority of the population: those working in the formal sector. Hence, there is a growing interest in voluntary health insurance schemes targeting households that live on agriculture or make a living in the informal sector (Criel & Kegels 1997; Bennett *et al.* 1998; Carrin 2002; Ranson 2002).

Yet, we must not be lured into complacency. It will probably take years, if not decades, for these voluntary health insurance schemes to consolidate and go to scale (Meessen *et al.* 2002a). Moreover, if they are not well-designed, for instance in terms of provider payment modalities, they will contribute to rapid cost escalation. Other strategies are needed to keep costs under control. A lot can be done with some basic measures to eliminate the worst prescription practices. Some forms of rationing by defining of packages of basic services is also unavoidable. A full array of measures exists to change the behaviour of providers. It has to do with empowering actors (e.g. patients, through health care education, formulation of patient rights and the emergence of family medicine), with new institutional arrangements (e.g. registration, accreditation, professional bodies, and enforcement of rules against inappropriate behaviour), and also with the internalization of new norms by practitioners (medical ethics). Once we recognize the harm that bad medical practice does, the need for health sector reforms becomes apparent.

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Is the combination of ambitious social health insurance programmes and reforms of health care provision sufficient to address the problems of health care-induced poverty? We do not think so. Health insurance is an option for those able to pay the insurance premiums, but what about the poor?

There is a need for a straightforward transfer of resources to the poor. European history has shown that even the affluent can gain from such income redistribution (de Swaan 1988). If social security is the option for the majority, the poor need a targeted transfer – *social assistance* (Norton *et al.* 2001). The creation of effective safety nets is not simple in terms of institutional arrangements. It entails addressing the following challenges: funding the transfer of resources, identifying the eligible beneficiaries and delivering services that answer the specific needs (Devereux 2002).

Recently, several countries have launched innovative safety net strategies that do not rely on fee waivers for the poor. Although many countries have introduced such waivers, these have not worked very well in most cases (Willis & Leighton 1995; Ensor *et al.* 1996; Stierle *et al.* 1999). This is not surprising, as health facilities have little incentive to treat poor patients free of charge. By doing so, they would indeed jeopardize their own financial health viability. If one really wants to give the poor access to expensive health care and protect them from falling deeper into destitution, funds must be earmarked for such purposes. Innovative safety nets such as those currently being developed in Cambodia and China provide a promising alternative (Meessen *et al.* 2002b; Zhang 2002). In Cambodia, Health Equity Funds for purchasing hospital care for the poor are entrusted to a local social welfare NGO. China has assigned responsibility for its Medical Assistance Schemes to the Ministry of Civil Affairs. These are new initiatives and they have many problems to solve. But they deserve attention from the scientific and donor community.

Fighting iatrogenic poverty calls for more than just establishing some kind of social health insurance. It should be strongly emphasized that the solution lies to a large extent within the health sector; however, a wide coalition is necessary to tackle the issue. Other government departments, such as Ministries of Social Affairs, must be involved. Civil societies have a role to play. Programmes of social assistance will require a massive support by the donors and the national governments. Eventually, the scientific community has to urgently provide other actors with a better understanding of the exact relationship between illness and poverty in a given situation.

The Millennium Development Goals are ambitious. Because of the growing 'marketization' of national economies and of the health sector in particular, it is

increasingly important that the poverty dimension is integrated into health policies and in the medical practice. In 1975, Ivan Illich put iatrogenic disease on the profession's agenda (Wright 2003). Now shortly after his death, it is time to recognize a new form of iatrogenic suffering: poverty induced by doctors. This is not only a matter of human rights, but also of public health. When someone falls ill it may bankrupt an entire household and expose its members to an increased risk of further ill-health. Poor medical practice and the lack of financial protection increases the negative impact of ill-health. This is a real vicious circle. We need to do something about it.

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Authors

Bruno Meessen, Dr Wim Van Damme, Dr Narayanan Devadasan and Dr Bart Criel, Institute of Tropical Medicine, Nationalestraat 155, 2000 Antwerp, Belgium. E-mail bmeessen@itg.be

Zhang Zhenzhong, Chinese Health Economics Institute, Peking University Medical Science Center, P.O. Box 218, 38 Xueyuan Road, Haidian District, 100083, Beijing, China. E-mail zhangzcc@public3.bta.net.in

Gerald Bloom, Institute of Development Studies, University of Sussex, Brighton BN1 9RE, UK. E-mail G.Bloom@ids.ac.uk