A review of experience concerning household ability to cope with the resource demands of ill health and health care utilisation

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Executive summary

The purpose of the paper is to review the literature examining the resource consequences of ill health at the household level. Policy has been generally ineffective in reaching the poor who have substantial problems in accessing health care. Much of international health policy has focused on identification of interventions to reduce burden of ill-health in most cost-effective way, rather than on the barriers to the poor seeking and obtaining care. This paper firstly examines the link between poverty and ill health, arguing that ill health is more likely to lead to further impoverishment amongst the poor than among the wealthy. Therefore, meeting the health needs of the poor is an important means to preventing the increase in poverty. However, because often the lost income as a result of seeking care or caring for the sick can amount to approximately 70% of total costs, there is evidence that utilisation rates for the poor are lower not just because of the cost of care itself, but because of lost income. For the poor, often taking time off to be sick, to seek care, may jeopardise the future economic survival of the household, and therefore may not be an option until it becomes physically impossible to continue working. By which time treatment may be more expensive, and possibly less likely to have a positive outcome.

Secondly, the paper goes on to examine the different areas of research that have grappled with these issues Health seeking behaviour studies have tended to examine responses to one or two episodes of illness, rather than the longer term impact on poor households, looking mostly at variables such as education, income, marital status, as well as service provision variables. The coping strategy literature, although more dynamic in approach, has attempted to draw conclusions from a plethora of household responses to a variety of crises, without a particular emphasis on health. Studies examining household decision-making reveal the extent to which household relations affect health seeking behaviour. The central lesson from the literature is the importance taking a wholistic view of poor households – including social and cultural arenas as well as economic - in order to understand the responses to ill health. And therefore how to design health provision as well as financing mechanisms in order to improve access of the poor to health care.

1. Introduction

Many studies show that the poor have serious difficulties in obtaining access to health care, and that policies are ineffective in reaching them (Lucas and Bloom 1999, McIntyre et al 1995). For example, Castro-Leal et al (1999) provide evidence that the poor receive a lower level of benefit from public health sector spending than the wealthy. (The study examines data from South Africa, Cote d'Ivoire, Ghana, Guinea, Madagascar and Tanzania) Fabricant et al (1999) provide evidence from 8 countries that the poor pay proportionally more of their income on health care than do middle income or wealthier groups, making the cost of health care regressive. The effectiveness of exemption schemes in improving access of the poor has been shown to be limited. (Hotchkiss 1998, Watkins 1997, Mbuga et al 1995). Where there is a policy of providing free care, there is evidence that there are substantial costs still remain (such as travel, food expenses, unofficial medical charges, loss of income of patient and carer etc) that deter the poor from seeking care (Abel-Smith and Rawal 1992, Nahar and Costello 1998).

Much of international health policy has focussed on identification of interventions that will reduce the burden of ill-health in the most cost-effective way, with the assumption that governments are able to define and implement policies that make these interventions available to the poor. This assumption often results from cost-effectiveness studies that take into account the costs of the government of the intervention, and improvement in health should the sick receive the care intended, but not the often considerable costs at the household level. It is the inability often to meet these costs that can prevent the poor from obtaining access to care.

Recent debates about the efficiency and equity of charging user fees for health care has emphasised how little information there is on the impact of the fees on the poor. Although in theory, it is better to direct household expenditure towards the public rather than private sector, thus enabling the former to provide a better service, there is evidence to suggest that fees reduce utilisation and impact on the household budget '(pushing) those at highest risk of ill health and death, the young and the poor, further out of the system.' (Sauerborn 1996, quoted in Fabricant 1999). Gertler and van der Gaad's study (1990) show that the price elasticity for fees and transport is twice as high for the poor, suggesting that these factors do impact on utilisation of the poor considerably more that the wealthy. However, little of the evidence examining the impact of user fees is disaggregated by income level, and changes in utilisation may not simply be due to price changes but also quality, making it difficult to draw conclusions.

Within the context of the user fees debate, Gilson et al (1997) argue for the need to examine not only the impact of user fees, but also the ability of poor households to pay for health care, and their strategies to cope with the resource consequence of ill-health. Standing (1997) argues that it is important to look at how the impact of health care expenditure/fees at the household level differ according to the type of payment and the group responsible for payment (whether women and/or the poor). These calls for more detailed examination of the problems that the poor face, have relevance beyond the immediate debate about user fees – for example the policy areas mentioned above – such as the failure of exemption schemes, and the costs associated with 'free' care etc. Other authors have made similar pleas to examine the needs of the poor in much more detail. '*What is needed is a systematic approach that identifies plausible strategies for meeting the needs of the poor, based on a realistic assessment of the existing health sector, both public and private.'* (Bloom et al 2000:27) Chambers makes an impassioned plea to ask the poor again and again. (Chambers 1989)

1.1 Objectives

The *central policy question* underlying this paper is: how to make health care more accessible to the poor – how to make the provision of care and financing more suited to the needs of the poor in order to increase their level of access. To achieve this policy goal, it is necessary to understand the resource constraints that poor households face, what coping strategies that the poor use, what trade–offs they have to make, and how the poor respond to ill health. The *objective of this paper* is to review the available evidence in the literature on household ability to cope with the resource demands of ill health and health care utilisation:

- to look at the available documentation of the experience of households in coping with ill-health;
- to examine the different analytical frameworks that have been used to understand the responses of the poor, frameworks that allow us both to order the enormous range of data available on the complex situation that the poor face, and to design effective policies;
- to draw out the links between knowledge and the policy implications; and
- to identify research gaps that need to be dealt with to take the areas of concern further.

The remainder of this section, firstly, unpacks the issues surrounding household responses to ill health using a series of questions, creating a range of sub-issues, some of which the review will examine in greater detail. Secondly, this section discusses the range of areas of literature in broad terms, that are relevant to these issues, and that the review will draw upon. The main body of the paper examines sections of the literature in detail, drawing out the main themes, and then turning to the policy implications and the research gaps that emerge from the evidence. The review is not comprehensive given time constraints, and the difficult of obtaining some of the literature, but it does highlight some of the more interesting theme.[1]

In order to begin to understand the resource consequences of ill health on poor households it is useful to unpack the issue into a series of inter-related questions:

- What are the types of costs associated with ill health (both direct and indirect) and what is their relative importance for the poor?
- What are the interactions between ill health and poverty, in terms of ill health causing further impoverishment? What are the mechanisms through which this poverty 'ratchet' occurs?
- What are the distinguishing characteristics of vulnerable households? What is the different between vulnerability, poverty and deprivation?
- What are the coping strategies used by households? How do these differ according to degrees of poverty, access to social networks, degree of social capital, infrastructure, and location? If a coping strategy challenges social norms/structures, what factors are likely to determine the success of the strategy? What are the trade-offs that households have to make between, for example between current needs and future survival?
- What are the barriers to access? For example income that is lost due to the time that is spent seeking care and intra-household resource allocation that determines who has access to sufficient resources to seek care are important, as well as more obvious barriers such as cost of care and distance to facility.
- What role do household relations play? It is important to consider the norms and values that govern household relations, the internal trade-offs between different generations and genders, the effect of (economic & health) shocks on relations and how negotiations are affected by changing circumstances.

[1] I would like to acknowledge the considerable assistance of IDRC in obtaining numerous articles for review.

- What determines health-seeking behaviour? All of the above issues will be important as well as the range of health care facility options available.
- How does/has AIDS affect households ability to cope? As well as intensifying the importance of these issues, what are the issues that are particular to AIDS, given the size of the epidemic and its nature?

The review covers a range of areas of literature – each of which has attempted to deal with some element of the issues described above.

Impact studies

The main areas of concern are the short-term economic and social impacts of disease, with some studies examining the long-term interaction between poverty and ill health. The studies are often disease specific, either quantitative or qualitative in approach, with a few attempting to collect both types of data.

Health seeking behaviour literature (HSB)

This group of studies tends to look at how household characteristics are related to health-seeking behaviour associated with one or two episodes of illness. Much of the emphasis is on which type of facility do respondents choose to go to and how does this differ according to the health problem, and the socio-economic characteristics of the household. There is little examination of:

- health seeking behaviour once the respondent is inside the facility (the ability to demand/ensure adequate care or whether there is the provision of sufficient information to enable patient to interact with provider effectively); and
- how HSB might be related to livelihood coping strategies of the household and how it can be effected by the longer term poverty 'ratchet'.

Household coping strategies studies

This literature arose out of the famines in mid 1980s in Africa with intention to determine: why some households survived and others did not; whether it is possible to use the prevalence of coping strategies as an early warning system to detect possible future famines; and how to intervene in a manner that supports household strategies rather than undermining them. It is primarily concerned with food shortages, but a few studies concern how households cope with ill health. Given the limited number of studies the review will also include those looking at how households cope with economic shocks, particularly those resulting famine.

Intra-household literature

This group of studies has primarily concerned with how household relations affect the allocation of resources between members, the division of labour between men and women, the impact on the productivity, nutritional status of boys and girls, and the extent of female poverty and vulnerability. There are specific studies that examine how health is affected by the allocation of resources, but few discuss how, given a specific health event, the household relations affect the type of coping strategy chosen, and the outcome.

Poverty/Development studies literature

These studies are primarily concerned more generally with poverty alleviation, and therefore, income generating activities, their viability/productivity, their affect on the environment, and how to support these activities. This area is of obvious importance for enabling access to health care and in determining health outcomes. However, it is not generally within the remit of health specialists, even though perhaps it should be, and therefore it has been left out of this review.

AIDS
Unfortunately, due time constraints this literature was not examined in any detail. The articles that were examined tended to be mostly descriptive, quantifying or outlining the impacts, with little analysis. The AIDS epidemic has major implications for the issues discussed here – both in terms of amplifying their importance, and reducing the communities ability to act as a support structure, as a result of the size of the epidemic. Further research needs to be carried out on this topic.

2. Definitions

2.1 Defining poverty

The term poverty is often defined as a lack of access to economic assets (either income or productive assets), and low levels of consumption. However, the experience of poverty is multifaceted – vulnerability and deprivation are also important concepts. Chambers (1989) defines the dimensions of *deprivation* as physical weakness, social isolation, poverty, powerlessness as well as vulnerability, and *vulnerability* as defencelessness, insecurity, exposure to risk, shocks and stress. Vulnerability is the inability to withstand economic shocks without irreversible damage to the productive capacity of their members and to their net position (Agarwal 1991 in Moser 1998). It is the lack of the means to cope, such that a shock results in people 'becoming physically weaker, economically impoverished, socially dependent, humiliated, or psychologically harmed.' (Chambers 1989). And in turn the capacity to cope or resist impoverishment is dependent on access to resources – labour, human capital, productive assets, social capital etc.

In defining poverty, it is important to include the views of those that are poor and experience 'poverty' in its different forms. It is only through incorporating the views and experience of the poor that the academic perspective is given any reality, providing a qualitative depth that would otherwise be missing. Such an approach has been important in defining poverty more broadly than simply the lack of economic wealth. For example, Chamber quotes a study in Gujarat where despite lower incomes, households considered themselves to better off, because their independence, mobility, security and self-respect had all improved. (Chambers 1989).

2.2 Defining the household

There has been considerable literature on the problems of choosing a unit of analysis for both theoretical and fieldwork purposes. Much of the literature has berated the sometimes blind reliance on the concept of discrete households (Peters 1995, Guyer 1981, Guyers and Peters 1987, O'Laughlin 1995). Goudge (1998:41) points out that the definition of the household is an intractable theoretical problem. There are a variety of possible defining characteristics – joint residence, joint consumption, joint production – yet no one attribute fits all situations. Households may contain a variety of overlapping units and actual boundaries of the household are far from clear – or to use Peter's term, the boundaries are 'permeable' (Peters 1995). For example, a polygamous husband may have two wives who carry out agricultural production separately, yet live under the same roof. Or the two wives may live in separate houses in different villages, yet the husband has one plot of land from which he financially supports both wives. A single mother may be living on her brother's or father's compound and yet obtain financial support from a visiting lover. Imposing the notion of a coherent and discrete household has generated misleading images of domestic life, that tend to ignore the importance of inter-household linkages, and intra-household divisions in resource and labour allocation

3. Impact studies

There are various established analytical approaches used to assess the impact of ill health:

- using the *DALY* to estimate the number of 'disability adjusted life years lost' to compare the impact of different diseases, but this does not capture the implications, for the individuals, households or community, of those lost years;
- *household economics* that examines changes in household expenditure, production and allocations between individuals as a result of ill health; and
- less common is the *sociological approach*, often more participatory, assessing the various social and cultural impacts.

Approaches also differ, firstly, as to whether they examine only the short-term impact of one or possibly two episodes of illness, to those using qualitative data to examine the long term implications of a major health event. Secondly, they differ as to whether they compare the impacts on the poor with non-poor. The intention is this section is to firstly draw out the more general conclusions, and secondly to look specifically at the impact on the poor, and the nature of the linkages between poverty and ill health.

Several studies have highlighted that a substantial part of the cost of ill health at the household level is the income or production loss due to time spent sick, seeking care or caring for the sick. In a study in Nepal, Sauerborn et al (1996) estimate that the income lost amounted to 70% of total costs. In Ghana, Aseno-Okyere (1998) estimate 79% of the costs were due to time spent seeking care and caring for the sick. Pryer (1989) in a study in Bangladesh, estimated that in afflicted households the poorest income quintile lost 74% of monthly income. This concurs with the conclusion from other studies that much of the burden of ill health falls on households, particularly women in caring for the sick. Taylor et al (Uganda – 1996) documents the extent of time women spend caring for the sick, often with insufficient resources at their disposal to do so). Leslie (1992) describes how the constraints on women's time prevent use of health services. Studies examining the social impact point to the stigmatisation associated with various diseases, the effects of social exclusion, and resulting in reduced mobility and decreased availability to economic resources. (Bandybadhyay 1996, McGrath et al 1993, Leifooghe et al 1995)

In what ways do poverty and ill health interact? What are the sources of health inequities? The poor spend a higher proportion of their income on health to obtain the same level of health care. Fabricant, Kamara and Mills (1999) provide evidence from eight countries showing that lower income groups pay a significantly higher proportion. A study in Sierra Leone described in the same paper, shows while costs of care and travel are important deterrents to seeking care, expenditure is highly income inelastic suggesting that health is an essential good that has to be purchased.

The regressive nature of health care expenditure is compounded by the fact that:

- The poor have lower health status because of their poorer living conditions (e.g. Inadequate nutritional intake, poor sanitation, water supply & refuse collection, overcrowding, pollution, etc).
- The poor are more dependent on their physical ability as a source of income. Chambers (1989:4) expresses this very well:

  > *The main asset of most poor people is their body. Terms such as labour power, labour availability, dependency ratio blunt this sharp point, and miss the stark personal reality. The good ethical and humanitarian reasons for providing health services and reducing suffering from sickness sometimes serve to divert attention from economic aspects of ill-health. These include the plain facts that the poorer people are, the more it matters to be able to work and earn, the more*

> *they depend on physical work, and the higher are the personal costs of physical disability.* (Chambers 1989: 4)

Given that the lost income due to sickness is a substantial part of the cost of ill health (approximately 70%) – the dependency of the poor on their physical ability becomes even more crucial.

Tropical conditions in Africa combine to create additional seasonal difficulties. During the rains, there is a high exposure to infection, hard work is required for cultivation, and there are often food shortages because it is some time since the last harvest. Combined with indebtedness and low access to health facilities these factors interact such that when it matters most the poor are at most risk.

Despite the greater importance of lost income, *the poor are less likely to have to access to either sickness benefit or health insurance* than wealthier groups in the formal sector.

The poor frequently have insufficient information to make the most cost-effective decisions about health care expenditure. There is little effective regulation, public health laws are often ignored, and it is difficult, if not impossible, to assess the competence of practitioners. The poor have insufficient information to weigh up the costs of the treatment against the likelihood of cure or control of symptoms, and what steps are required for self-management both of the symptoms and the drugs. Compounding this the poor often lack the power to demand this knowledge from the care provider. (Bernal and Meleis 1995, and Jayawardene 1993 provide examples of this.)

As a result the poor often receive a lower value for money from the health service. For example, travelling to a clinic that has no drugs, and having insufficient funds to travel further, or purchasing only part of a complete dose – both of which reduce the effectiveness of the expenditure (Bloom et al 2000). Or the poor may delay seeking treatment due limited funds until the condition is serious when the treatment may be more expensive, and result in a greater level of loss income. (Jayawardene 1993)

Economic and health crises (such as AIDS and structural adjustment programmes) often impact significantly on the poor. Their greater level of vulnerability makes it more difficult for the poor to withstand the negative impact of, either, reduced public expenditure on health, water, sanitation and education (that can be the result of structural adjustment programmes), or the devastating impact high levels of mortality of productive adults that results from AIDS.

What is the interaction between ill health and further impoverishment? Does a poverty ratchet exist? Chambers (1989) argues that a poverty/health ratchet exists – sickness in poor households is more likely to lead to impoverishment than in a wealthy household. The poor are vulnerable to further deprivation due to the lack of 'buffers' or extra resources that they are able to call upon when in need. He suggests that the ratchet is increasing due to AIDS, the squeeze on the public sector, and the high cost of allopathic medicine, resulting in a high and rising incidence of assets disposal and indebtedness as a consequence, where by health expenditure may be an increasingly important cause of impoverishment.

There is considerable evidence to support this thesis. Studies show the extent of loss of income due to illness (Pryer 1989, Fabricant et al 1999), and those medical expenditures impose considerable hardship. For example, Lasker et al (Ivory Coast: 1981) has data showing 10% of income is spent on medical expenditure. Abel-Smith (1986) (Tanzania) shows 60% of 'involuntary' land sales are due to high medical bills. In a study on the effect of river blindness, Evans describes an example of how illness can reduce working capacity of adults, leading to lower income, low nutritional status and health & life expectancy of others - to the extent that from a healthy six person household, two blind members are left with only

an unnourished sighted 15 year old boy. A study in India (Dogra 1988) documents how the economic and health status of respondents had been weakened by three years of successive drought, making them more susceptible to illness and malnutrition. The respondents were unable to meet extensive health care costs without considerable indebtedness, mortgaging land or animals, thereby endangering the economic viability of the households. Pryer's study in Bangladesh (1989) shows how the incapacitation of adults and the resulting loss of income can lead to the accumulation of large consumption loans, and the sale of assets in order to pay medical costs. It also provides evidence of the inter-generation linkages – where households with an incapacitated adult was three times more likely to have malnourished children, as supposed to those without.

It would appear that the interaction of physical and economic vulnerability could lead to desperate circumstances for the poor. However Corbett argues that within the poverty/health ratchet thesis is the assumption that the poor simply sell off what assets they have in order to meet the costs of ill health. There is evidence however that the poor may attempt to ignore their illness, not seek care, and try to continue working. For example, Sauerborn (1996) provides evidence that during the season of heavy agricultural work, despite greater exposure to disease, fewer illnesses were perceived, less time was spent caring for the sick, and health expenditure is reduced in comparison with other periods of the year. In Pryer's study children were often withdrawn early from a free nutritional rehabilitation centre, or not taken, because adults had insufficient time. Berman et al (West Java, 1987) provides evidence that although reporting of illness is fairly even across income groups, 45% of the poor do not seek care for mild illness (in comparison to 20% of the wealthy), and 31% of the poor do not seek care for a severe illness (in comparison with 13% of the wealthy). Several studies show that the poor are deterred from seeking care due to time and financial costs (Fabricant et al 1999, Hotchkiss et al 1998, Dor et al 1987, Gertler et al 1990). Corbett concludes:

> *Coping by not seeking treatment, even when it is fairly accessible, indicates a survival strategy which avoids indebtedness or destitution at the risk of greater risk to health - or even survival of some household members.* (Corbett: 1989)

This highlights that poor households have to make tradeoffs not only between health expenditure and other forms of expenditure, but also between current and future needs of different household members.

Jayawardene (1993: 1174) provides a good qualitative description of the panic that illness invokes in poor households:

> *If fever did not subside, stress and anxiety within the household increased with dawning of comprehension that the episode would be serious and prolonged. Household decisions had to be made about treatment, finances, and management of the duties of the sick individual. Within a span of 3-4 days there had to be a reallocation of finances, food supplies, work routines, and consultation sought, treatment bought, and labour supply ensured on the farm. The household began to function under emergency criteria. The severity of impact depended on who was afflicted and to what extent. Often, it was illness of the male and female heads of households that had most severe effect on households. Work was disrupted, the daily income was lost and there were additional expenses incurred for treatment. Absence from work heightened fear and frustration about jobs undone until eventually the households' ability to control events was stretched to a maximum.*

Given this linkage between poverty and ill-health and the problems that the poor face in terms of access to health care, how has the academic community attempted to explore these issues?

Those in the health arena have tended to ask: 'What determines health seeking behaviour? Why do some seek care and others not? What are the barriers to access, and what are the household characteristics associated with seeking care? Where do people seek care and why?' This has led to a rather static approach, where few studies go beyond looking at the short-term effect of one or two episodes of illness, without attempting to understand the long-term processes at work, and how households cope with the linkage between physical and economic vulnerability. Academics, working in development studies, have examined issues such as how do poor households survive a crisis, particularly food shortage or famine? What are the characteristics of a viable livelihood? What coping strategies are used? What factors enable/disable those strategies? What interventions support those strategies rather that perpetuate dependency? These studies, though the conclusions are often relevant to health, are rarely conducted with health as the key area of interest. The following two sections of this paper will look at these two areas of work: health-seeking behaviour, and household coping strategies, drawing out the main themes and conclusions.

4. Health seeking behaviour

In an annotated review of the health seeking behaviour, Tipping and Segall distinguish between two broad types of studies: a) those that examine the end point of the decision making process – utilisation – normally recorded by attendance at the health facility; b) those that attempt to 'root the seeker of health care in the social context in which decisions are made and actions taken' (Tipping and Segall 1995). The latter group, of more interest here, examines not only the type of service available, but 'how much time and money the household can afford to spend on treatment, perceptions of service quality, treatment effectiveness, cultural and religious propriety etc'. The methodology used in such studies are household surveys, with varying combinations of qualitative and quantitative techniques, that have highlighted the following factors as being important in determining health seeking behaviour.

4.1 Cost and type of service available

Relationship between **costs of health services** and utilisation of services has been extensively evaluated in relation to the introduction of user fees (Gilson 1988, Creese 1990), as impacting on vulnerable groups (lower income, elderly, young etc). Results have been equivocal in part due to methodological issues (study design, dependent variables, type of analysis, sample size etc).

Distance and physical access *are important barriers to seeking care. Relevant factors are physical access, availability of transport, travelling time and opportunity cost of time (Becker et al 1993, Bichmann et al 1991, and Nougtara et al. 1989: Burkina Faso). Physical access is particularly a problem in regions where seasonal flooding occurs.*

Perceived poor quality is seen as a barrier to seeking care (Becker et al 1993, Waddington and Enimayew 1990, Litvack and Bodart 1993). Various indicators of poor quality have been used: *Inadequacies in drug provision* (Khan 1985: Bangladesh, Waddington and Enimayew 1990: Ghana, Stock 1983: Nigeria); *Convenience* in relation to opening hours, provision of home visits, organisation of health services (Key 1987: India, Becker et al 1993: Philippines, Tipping et al. 1994: Viet Nam); *Staff attitudes and interpersonal relations* (Becker et al 1993: Philippines, Waddington and Enimayew 1990: Ghana, Nougtara *et al*. 1989: Burkina Faso, Bichmann *et al* 1991: Benin).

Primary versus hospital services. *Hospitals are generally perceived to have a better quality of services than primary level (Holdsworth et al.1993: Lesotho). Poor tend to use mission hospitals when available, and wealthier groups tend to opt for private facilities (Abel-Smith and Rawal 1992: Tanzania).*

4.2 Type and Severity of Illness

The **nature and severity of the illness** influence patterns of utilisation (Kloos 1990: Ethiopia, Stocks 1983: Nigeria) in relation what is considered to be the appropriate choice of treatment and provider (e.g. informal home care, traditional healers, versus modern medicine).

4.3 Socio-economic variables

Educational levels*:* The focus has been on educational levels of mothers, where more highly educated women and mothers tend to use health services more often (Becker *et al* 1993, Bichmann *et al* 1991).

Maternal occupation*:* Health service utilisation is higher amongst women who were employed (Becker et al 1993). Utilisation is also dependent on type of occupation, in relation to opportunity cost of time (Bichmann *et al* 1991).

Marital status*:* It was found in Mali that single headed households are likely to make greater use of health services than households with several female relatives (Castle 1993).

Economic status*:* Utilisation of health services is higher amongst well-resourced households (Fosu 1994: Sub-Saharan Africa, Berman *et al*. 1987: Indonesia, Bichmann *et al* 1991: Benin, Nougtara *et al*. 1989: Burkina Faso), with a higher percentage of poor than non-poor households experiencing difficulty in paying the costs of health care, more especially hospital costs (Tipping *et al* 1994: Viet Nam), and the poor having the lowest expenditure per contact/episode/person (Duggal and Amin 1989: India).

Social status of women *has been evaluated in relation to cultural norms and values as a determinant of the social position of women within a family as a determinant of their access to resources and therefore health care (Castles 1993: Mali, Stocks 1983: Nigeria), and their freedom of movement outside of the household (Key 1987: India), as directed to by cultural and religious conventions.*

4.4 Age and sex

Age*:* Younger women tend to use services more often than older women do (Bichmann *et al* 1991: Benin, Sauerborn *et al* 1994: Burkina Faso). Might be on account of better educational opportunities for younger women.

There is evidence in some countries of a **gender** bias against women and children in the allocation of household resources (Goudge 1997), with women spending less time tending to illness despite higher rates of morbidity (Duggal and Amin 1989: India), and men more often making use of expensive, modern health care services whilst women use local and less expensive services (Heinonen 1994: Philippines). Also evidence of a gender bias in seeking care for children (Hunte and Sultana 1987: Pakistan, Paul 1991: Bangladesh, Stock 1993: Nigeria), with care being sought more often and immediately for sick boys than girls.

Despite the separation of variables such as income, education and marital status of women, these variables obviously interact with one another, and with a woman's social status and her linkage to social networks. The role of variables such as gender and age emphasise how entitlement to resources can be determined by hierarchies based on these factors. In essence these variables are the more measurable counterparts of social norms, social relations and structures that shape entitlements and access to resources, including health care. Some research has attempted to examine social relations and its affect on health seeking behaviour. For example, Wallman and Baker (1996) look at elements of household

livelihood that are relevant to women's capacity to obtain and pay for treatment. They identify the following factors:

- actual income
- potential income (on the basis of which it may be possible borrow)
- social status (which determines access to resources)
- social life (which provides access to people for exchange)
- networks (which provide access to knowledge through people)
- autonomy (enabling responsibility, decision-making and control over resources)
- liability (as a result of recent crises that have reduced resources and energy).

Whyte and Kariuki (1991) argue that women are enmeshed in social relationships that affect their ability to care for their children. They examine how household relations affect the health seeking behaviour, identifying the 'therapy managing group' or 'therapeutic support structure' as the group of people who support and mobilise a sick person in seeking care, or a mother to take her sick child for care. They provide evidence of the importance of often both the husband, mother, and/or mother in law in deciding whether to take a child to the clinic, to a nutritional rehabilitation centre, or to the mother's place of work. Part of the joint decision process will concern access and entitlement to resources, and conflicting needs of other members of the household. These trade-offs between different household members, the importance of social status and supportive social networks are factors that emerge in the coping strategy literature.

5. Coping strategy literature

Much of the coping strategy literature arose in response to the famines in Africa in mid and late 1980s, and as a result has particular concerns. The central theme is food shortage (which affects the household as a whole rather than ill health, which afflicts an individual but has ramifications for other household members). The emphasis is often on agricultural and therefore rural communities, because famine is often associated with crop failure and drought. (Food shortage obviously occurs in urban areas, but because of the greater diversity of income generating activities, it is not as likely to be as wide spread at a particular time.) The debate raised the important issue of 'entitlements' – the right to access resources (Sen 1981) – due to the realisation that famine can occur when food is available, but that certain groups do not have access to it. This issue is important to health debates in the sense that the problem of access is not simply the availability of health care but also the affordability of seeking care. The coping strategy literature is primarily concerned with whether it is possible to use the prevalence of coping strategies as an early warning indicator system to identify households at risk, and to determine whether it is possible to intervene in a way that supports local coping strategies, rather than undermining them (for example, does providing food aid lock people into a vicious cycle of subsistence and coping, or can it prevent the poor from having to sell their assets for the purposes of consumption). Again, the issues of how to intervene effectively at the household level is important within the health sector.

Within the literature a range of analytical approaches are used in an attempt to order a plethora of complex qualitative and quantitative data, and to draw out some lessons and generalisations. These approaches have different emphases, and depict different aspects of a complex situation. For example, data is organised in various ways – according to types of strategies, sequencing of strategies, enabling factors, and types of trade-offs. Few have attempted to map out a complete framework. This section of the paper will look at some of these approaches, some of the problems of the coping strategy approach, concluding with a discussion of Bebbington's attempt at a comprehensive framework.

5.1 Types of strategies

In one of the few studies that specifically examines household coping strategies in response to illness, Sauerborn et al (1996) divides the strategies according to whether they are intended to cope with financial or time costs. These are listed in Table 1 with other strategies discussed in Chambers (1989). Longhurst (1986) uses a categorisation based on the productive, social and biological spheres of life (Table 2).

Table 1: Categorisation of coping strategies according to constraint

Strategies to cope with financial costs	Strategies to cope with time costs
• Using cash and mobilising savings • Deferring expenditure (e.g. education) • Sale of assets • Loans • Income diversification • Wage labour • Free care • Gifts/ Mutual support • Eating less in terms of quantity and nutritional value • Prostitution • Begging • Theft	• Intra-household labour substitution • Changing the capital-labour mix of production • Hiring labour • Free community labour

Source: Sauerborn et al (1996) and Chambers (1989).

Table 2: Categorisation of coping strategies according to whether production, social or biologically based.

Production related adjustments	Social adjustments	Biological 'strategies/body adaptations
(These examples are relevant to agricultural production, other types of production would require other types of strategies) • Diversification • Root crops • Exploitation of vertisols that retain water • Sale of livestock • Bush and wild food collection	• Reciprocal economic exchange (Labour or goods) • Change in allocation of tasks (particularly age and gender based allocations) • Changes in household composition (Increases in labour, or reduction in dependency)	• Adapting patterns of energy expenditure • Drawing on body fat stores (Evidence from Ghana and Gambia that adults lose about 5-7% of body weight during the wet season (Longhurst and Payne 1981) • Changing the composition of diet

Source: Longhurst (1986).

5.2 Sequencing of strategies

Various authors attempt to set a typical sequence of events, with the aim of perhaps being able to devise a blue print that could be used to monitor communities at risk, and to enable preventative policy intervention (Table 3).

Table 3: Typical sequences of coping strategies

Production related adjustments Jodha 1975/Watts 1983, quoted in Longhurst 1986	Social adjustments Dirks 1980, quoted in Longhurst 1986	Expenditure adjustments Moser 1998
• Diversification of income • Domestic mutual support • Minimisation of current commitments to others • Disposal of inventories (stored for specific occasions) • Sale or mortgage of assets (with a sequence based on liquidity and productivity of assets with a preference towards mortgage rather than sale.) • Short-term migration, possibly taking animals • Famine relief or patron assistance • Possible return and replanting	• *Alarm, followed by activity*: even hyper activity such as hoarding, movements of people, general irritability, hostility and political unrest • *Resistance*: energy conserving strategies, sustained undernutrition, erosion of social ties, and reduction of social interaction. • *Exhaustion*: collapse of family unit, elderly are pushed out first, children may forage in gangs, and adjustment is not possible without external relief	• Cut total spending • Change dietary habits • Cut back on purchase of non-essential goods • Protecting assets that generate non-monetary income.

Source: Longhurst 1986, Moser 1998

The language used to describe famine or food shortage can reveal poor people's experience and coping strategies available. In Bangladesh, there are three words for famine: *akal* – scarcity (when times are bad)*, durvichkha* – famine (when alms are scarce), *mananthar* – nationwide famine (when the epoch changes) (Longhurst 1986: 31). It would appear that there are three stages. Firstly, when there is a shortage of food either within the household or the community. Secondly, when the shortage is severe such that the normally wealthy are unable/unwilling to give food to the poorer members of the community. Thirdly, when the structure of society changes as a result of migration, an increase in death rates, or major loss of productive assets that will be difficult to regain. (Apparently in northern Nigeria there are a dozen terms for different degrees of famine.)

5.3 Factors that enabling effective 'coping'

Moser organises the evidence from a four-country study into categories of assets that appear to be particularly important in enabling/facilitating coping strategies of the poor (Table 4). These enabling factors allow a more general discussion, which analyses that look at specific coping strategies, that are inevitably related to a specific type of livelihood, do not.

Table 4: Moser's assets that enable coping strategies

Enabling assets	Discussion
Labour	A frequent response to a crisis is to mobilise extra labour, often women and children from inside and outside the home. Child employment is sometimes 'hidden' either intentionally or because they are working in household enterprises. The poorest households send children out to work and tend to be more dependent on women's income. Working does not necessarily result in children dropping out school. Moser describes ingenious efforts at keeping children at school.

	Often in responding to ill health, the extra labour can be deployed to replace the sick member of the household. However, this is dependent on the substitutability of labour – most family members can contribute to a family agricultural enterprise, but not replace a miner or taxi driver. Migration can be both a strategy to obtain income to send home, or simply a strategy to reduce the number of mouths to feed.
Social and economic infrastructure	Household coping is made considerably easier where infrastructure (such as water, transport and electricity) and social services (health and education) are provided and maintained – the latter enabling the building of human capital, and the former for the skills to be used productively. As public investment in many African contexts has declined, access to services is often dependent on the ability to pay. For example, with declining water supply, households either purchase drinking water from vendors or install water pumps to cope with the low pressure. Those unable to pay have to put up with the poor service, often spending 2 hours per day collecting water. Cuts in public spending reduce the earning capacity of the poor. Women (& children) must spend more time meeting daily needs, and unaffordable health care and poor sanitation has implications for health and physical abilities to earn. Not attending school affects children's future earning capacity.
Housing	Housing is an important resource whose productive value is often not recognised. If the poor have security of tenure, a house can provide the location for enterprise, it can be rented, or part of it sold, it can be used to extend personal relationships and to generate social capital. Its productive value is greatly enhanced with the availability of productive services – electricity, water, skills, and credit.
Household relations	Households form an 'important adaptive institutions for the poor, providing mechanisms for pooling income and other resources and for sharing consumption. In times of economic difficulty, households act as safety nets, and can be shock absorbers reducing the vulnerability of those who join them.' (p.8) Moser argues that the poorest are not necessarily female-headed households – but often the most extended households, with high dependency ratios and low per capita income. Single women with children, unable to set up an independent household move in with relatives – both young women in their twenties as well as middle-aged women whose children may be nearly adults. Households are important mechanism for providing security, redistributing income and other resources, but are also sources of inequality. Entitlement to household resources depends on gender, age, earning capacity as well as the details of the particular context. The ability of the household to cope is dependant on its flexibility – both in switching resources from one activity to another (associated with different individuals), task allocation, and responsibility for expenditure. This is discussed in greater detail below. Moser provides evidence of a direct link between declining male income and increasing domestic violence, suggesting that household relations can constraint coping strategies, and produce additional problems.
Social capital	Social capital is an important asset that can reduce vulnerability and increase opportunities. It can however be both weakened and strengthened by economic crisis.

Source: Moser (1998).

5.4 Trade-offs between different needs

Lucas and Bloom (1999) recognise that each coping strategy, or decision taken in relation to a crisis, is to some extent a trade-off between current or future needs, between different individuals (often on the basis of age or gender), or between the sick and healthy. This is particularly true when resources are limited due to poverty. Lucas and Bloom identify three general adaptations (or trade-offs) that poor households make when one member is sick:

Primary adaptation

Where resources are re-allocated and reserves depleted without substantially affecting future productivity, for example using savings or selling an unproductive asset such as jewellery.

Secondary adaptation

Choosing between neglecting a sick person and compromising the household's ability to withstand future shocks. For example, foregoing funds for food, education, borrowing from a commercial lender, or selling productive assets in order to find the funds for treatment. Chambers (1989) recounts an incident of a woman mixing millet seed with sand to prevent her hungry children from eating it. There is considerable evidence of the poor, despite higher rates of sickness, not seeking available care or taking time off work, due to the loss of productivity and income that will result, suggesting that productive activity has a higher priority than attending to health needs. (Corbett 1989, Hotchkiss et al 1998, Berman et al 1987 and Sauerborn et. al 1996). In addition to the emotional implications of neglecting a sick person, the trade-off is not as simple as Lucas and Bloom make it appear. If such a decision were purely economic, the 'cut-off' point would be very difficult, if not impossible, to determine – i.e. the point at which treatment will not result in cure and therefore continued expenditure on treatment will result in greater expenses as well as the loss of an individual.

Tertiary adaptation

Here coping requires either migration in order to find food or work, or reconstituting the household, for example a wife and children going to live with her natal family. Evan's account of the effect of river blindness on a particular household describes a young son realising that if he stays to care for his blind sister and father he will not earn enough funds for bride wealth and be unable to get married. Gray (1993) reports an account a wife, whose husband had migrated to find work, not expecting him to send her funds, and expressing the view that it was better that he left, because if he stayed in the village he would simply be another mouth to feed.

Lucas and Bloom's formulation, while making an important point recognising the complex and difficult trade-offs that the poor are forced to make, places much emphasis on the economic trade-offs without acknowledging those that occur within the socio-cultural and political arenas. Bebbington's classification of the different types of capital and a framework of requirements for a viable livelihood, discussed below, enables a balance to be struck between the different types of resources, and different levels of interaction – whether it be within the household, at the community level, or with government.

Davies (1993) distinguishes between 'coping' strategies – that enable a household to maintain the same level of resources, and 'adaptive' strategies where the household is moving towards a new equilibrium – trading off future security for current consumption. Mackenzie (1992) identifies 'strategic' strategies that not only meet practical needs, but also challenge social norms or social relations. Such strategies may face considerable opposition because they challenge current social relations, and therefore fail as a result.

The problems with the 'coping strategy' approach from the policy perspective

Davies (1993) questions the usefulness of the 'coping strategy' approach. Her concern is that coping strategies, by definition are about success rather than failure – it defines actions that enable survival, and as a result may blind policy makers into the belief that households are 'coping'. It is as important to define what constitutes failure to cope, and situations in which intervention is necessary, preferably before households fail to cope or collapse. Davies also makes the point that it is difficult but important to distinguish between coping strategies and normal behaviour – that one household's coping strategy may in fact be another's normal behaviour.

5.5 Implications of the coping strategy literature

Coping strategies are the actions that result from poor households trying to manage a complex but limited portfolio of (both economic and social) resources. The coping strategy approach is difficult to use as a guide to intervention – because strategies differ according to context, sequencing differs, and policy decision made in response to strategies that are a desperate attempt to survive, the chances are that the intervention may be too late. The approach is perhaps more useful as a means of documenting the complexity of the trade-offs, and the interlinkages between the different facets of the lives of the poor, and how, and why, they poor respond in particular ways to health crises.

6. Household relations

6.1 Are household relations important? Do they impact on the allocation of resources?

Over the last decade there has been a substantial challenge to the unitary household economic model, which presumes that the household is a single unit with the main area of concern being the interaction between that household and its broader context. Authors such as Folbre (1988), Guyer (1988), and Whitehead (1990, 1981) have argued that relations within the household are crucial for determining allocations within the household, and have considerable impact on the interactions of the household with its context. The key argument is that the household can not presumed to be an altruistic unit, and as a result the situation of individual members can differ considerably, affecting their interaction with actors outside the household:

- Allocation of tasks can differ according to gender and age, and not result in equitable distribution (there is evidence from a number of countries that women on average work longer hours than men).
- Individuals do not often pool their income or resources (Goudge 1998, Young et al 1981, Dwyer et al 1988).
- As a result members have access to different levels of income, and have different levels of responsibility for expenditure – without necessarily income and responsibility being proportionate (Goudge 1998).
- Members can have varying levels of entitlements to resources (in addition to income, such as natural, productive, social, human and cultural capital), often determined by social norms.
- Members have access to different types of income activities, and therefore have different coping strategies.

Whitehead (1990:451, cited in Gray, 1993:91) wrote:

> *The altruistic household presents a significant lack of fit between the model of social relations of the sub-Saharan family farm enterprise enshrined in development projects, and the complex and particular form these social relations actually take.*

Both Jiggins (1986) and Whitehead (1981) examine the implications of the 'non-altruistic' household on household welfare:

> *Men and women may have different ideas of what constitutes welfare of the family. Because they have different obligations and options for spending income, increased individual household income does not necessarily result in higher levels of nutrition or well-being for the entire households* (Jiggins 1986: 91).

> *Men have access to much more substantial alternative forms of income, but they are not, in the last analysis, responsible for the sustenance of their children.* (Whitehead, 1981:102, cited in Gray, 1993:90).

Household relations have an impact not only through income, but also through networks and alliances, that may provide or reduce access to resources. For example, Lockwood (1997:96) discusses how strategic management of relationships by parents, relatives and children can lead to changes in the flows of resources:

> *Social marginalisation is an outcome of poverty, but it also helps to reinforce poverty, making it difficult for the poor to make claims on kinship ties.*

For example the poor may fail to hold on to their children if rich relatives court them. A poor man may fail to hold on to his wife, who may then deny her husband's paternity. Lockwood (1997) concludes that poverty can make the marriages and households of the poor more unstable than those of the rich.

Ill health, and its consequences, does not affect household members equitably. Consequences of diverting household resources for the purposes of health will have differential affects on members – the social relations and norms within the household will affect resource decisions, health-seeking behaviour and coping strategies that occur in response to ill health. Given that this is case, the crucial question becomes how do household relations affect the ability of households to cope with the resource consequences of ill health.

6.2 How do household relations affect the ability to cope with the resource constraints of ill health?

It is possible to make some generalisations about the way that conflictual household relations can impede the ability of households to cope with the resource consequences of ill health. Firstly, flexibility is important in facilitating coping strategies. A crisis may require shifting resources from one activity to another – from one members control to another in order to complement their activities – and without the trust, flexibility, and social norms that allow this, an opportunity may be lost. Similarly, with allocation of labour. Often tasks and areas of responsibility are ascribed by gender – if they are too rigid – it is more difficult to adapt to new stresses. For example:

> *Water is a big problem for women. We can sit here all day waiting for food because there are no women at home* (Wiley 1981:58, cited in Jiggins 1986:10).

It is obviously unacceptable for men in this situation to assist women in their tasks.

> *You can ask your husband to go and cut up a fallen tree for you, but even though it is some distance, he will not carry the wood home* (Goudge 1998).

Again social norms predetermine task allocation. Flexibility itself can be constrained by poverty. For example, the requirement of high input–low return activities, such as collecting water from some distance, may absorb resources, leaving no room for manoeuvre, or flexibility. The issue is not that some social norms are 'wrong' or that the poor are in anyway to 'blame' – but social norms determine activities, decisions and outcomes in a very real sense. In order to ensure better, more equitable access to health care, policy makers/ implementers not only have to confront household poverty level issues, but also relations

internal to the household (this issue is made very explicit when considering the problems of AIDS). This is also true beyond the level of the household. Policy interacts with social structures and social relations at a broader level, and its 'success' will be dependent on the outcome of that interaction, and therefore to understand those relations and norms is crucial.

Gray (1993) in a discussion of the effect of drought and economic decline on rural women in western Sudan shows how men and women face different social and economic constraints that affect their ability to earn income. For example, women's time is constrained because the household plot controlled by the head of household is given priority, and as a result the women's plots have lower yields. Women prefer cash crops, rather than food crops that will become absorbed into general household production. As a result, rotations are often inadequate, and yields are lower due to poorer access to chemical inputs. During an economic crisis, it was those households where women had been able to engage in non-agricultural activities, such as running a 'tea shop', that were able to cope better, despite the community's view that such an activity is rather disreputable. This is an example of a 'strategic' coping strategy – where the practical needs of survival lead individuals to redefine their rights and obligations - the social norms and relations – between one another (Guyer 1988). Nkoma-wamunza (1992) describes how a women's beer brewing co-operative in Tanzania was taken over by the men in the local community on the grounds that millet should not be used to brew beer when there is a shortage of food. In this example, a coping strategy failed because it challenged the norms surrounding male control. Developments projects aimed at assisting women often fail because of a lack of understanding of gender relations, creating male opposition to female participation in a project.

Secondly, who is ill can affect the coping strategies available. Because men and women make separate and complementary contributions, it is not just the resource requirements of the ill health, but also whose labour and contribution is reduced that is important. For example, the death of children from measles can allow parents to seek uncertain employment in casual labour market that is perhaps at some distance. The death of a husband may result in the wife becoming an unpaid labourer in the household of her brother-in-law, but the death of a wife might offer a husband the opportunity for re-capitalisation through a second marriage and dowry (Jiggins 1986).

A household's response to a health crisis is not only shaped by who is sick, but by household relations, what resources and coping strategies are available to the different members. Any attempt to understand the barriers to the poor accessing health care must examine the relations within as well as those outside household.

7. Bebbington's framework

Bebbington's work is not concerned directly with resource implications of ill health, but constructing a framework that allows analyses of household livelihoods and their coping strategies (Bebbington 1999). He describes his work as having its roots in various approaches - the 'access to resources' approach (Berry 1989, Blaikie 1989), asset vulnerability approach (Moser 1998), entitlement theory (Sen 1981) and sustainable rural livelihoods (Chambers, 1989, Moser 1998, Leach, Mearns and Scoones 1998). It also has been influenced substantially by the recent debates about social capital.

He suggests that a viable livelihood is characterised by access to:

- different resources;
- 'opportunities to turn resources into sources of livelihood, income, dignity, power and sustainability' (for example, access to labour and product markets, consumption to reduce poverty and improve living conditions, human and social capabilities to use and defend

assets more effectively, and the opportunities to create an asset base that will enable the continuation of the same sorts of transformations);
- 'the means of enhancing the existing ways in which resources contribute to household livelihood' (for example, improving the terms of exchange or transaction, through renegotiations of power relations); and
- other actors, such as kin, ethnic networks, social organisation, intermediate state, NGOs, and intermediary markets – that determine/facilitate access to both resources and opportunities for transformation of those resources.

He describes 'resources' as five different types of capital – produced, human, natural, social and cultural. These types of capital are both **inputs** that make 'livelihood strategies possible, assets that give people capability, and the **outputs** that make livelihoods meaningful and viable' (p2029).

Table 6: Different forms of capital as described by Bebbington

Types of capital	Description
Productive	Equipment, machinery, livestock etc.
Natural	Soil, water, fuel, clean air etc.
Human	Health, education, capabilities.
Social	'The norms and networks facilitating collective action for mutual benefit' (Woolcock 1998, cited in Bebbington 1999).
Cultural	Interaction/activities that provide meaning and identity, that can be empowering and a 'source of power to question, challenge, propose and ultimately usher in a new way of doing things'.

Source: Bebbington 1999, Harris and de Renzio 1997.

This framework makes it clear that decisions both at the household and the policy level are often trade-offs between investment in different forms of capital. Coping strategies are 'attempts at a continuous management and modification of substitutions, trade-offs, and draw downs of different types of capital assets'. Current preferences can depend on the life cycle of the household, and should be assessed not only in the extent to which assets are transformed into income or consumption, but their impact people's sense of wellbeing, and quality of life. For example, poor households may be forced to choose between investing in education of their children, and the health of a productive adult. Or between living in an urban area of pollution, violence or anomie, in order to make a living, rather than live in a safer rural environment. These trade-offs have implications for policy. Investing in agricultural projects in a poor rural area does not make sense if most of the inhabitants gain most of their income from remittances. Investment that facilitates the transfer of resources from urban to rural areas, and improves the human capital of the next generation of migrant workers enabling them to obtain better, safer jobs in the urban area is more likely to yield greater benefits (Bebbington 1999). Understanding how individuals use and transform the different forms of capital is crucial to enabling useful investment.

At the broader policy level there are also trade-offs between 'economic growth, human development, social integration and environmental integrity'. Investments in a particular type of capital have negative implications for other forms of capital. For example, policies to attempting ensure economic growth may result in poor human development or reduced levels of social integration.

Bebbington proposes as a methodology that maps out the different assets that people draw on. He cautions against a static approach, as livelihoods shift, loosing or gaining access to other resources. It is not only an assessment of the poor that is needed, but to relate changing livelihoods of the poor to changing assets and activities of other actors. A mapping

exercise could show how the interaction between different actors could affect the poor's ability to defend and control their assets.

Perhaps what is missing from Bebbington's approach is the analytical framework to examine fully the interactive nature of the different components of a viable livelihood. Individuals/ households have a range of different types of resources, they interact with others (individuals /households /communities /institutions etc) to transform resources into a livelihood, constantly attempting to enhance the transformation process. However, the relationships with others are important in their own right. A different approach may be to focus not only on resources and actors, but also on structures (social norms as well as households, institutions, communities etc) and social relations (the continuing interaction between actors). The interactions (or social relations) can either (or both) generate forces that challenge current structures (such as the women brewers co-operative who challenged social norms around gendered -control over resources), or support current structures (the men's response in taking over the women's assets in the co-operative). Such an approach emphases that the interaction between actors, its history and nature, and how it alters social structures, is as important as the transformation of resources that it allows.

Bebbington's framework encompasses the full range of resources, the trade-offs, and the broader context. It appears to be a good starting point in attempting to understand poor household's responses to ill health. The challenge is to devise qualitative (and potentially, if rather problematically quantitative) methods to map out the substitutions, trade-offs, and interactions with other actors; to understand the role played by local community initiatives and how to ensure that interventions support and build on the local social capital.

8. Conclusion

Just as with famine, access to food or health care is not simply a supply side issue. It is important to address the demand side obstacles – both the affordability of seeking care, and entitlement issues ('the right to access') before it is possible to reach the poorest of the poor. Barriers preventing access to health care are not just the cost of care itself, but the cost of seeking care and whether it is affordable, and the presence of social structures and relations in which the individuals have the right to demand care, and the power to obtain it. It is only poor communities that we are concerned with but the poorest within those communities – and therefore issues of equity are about a lack of resources and their control in poor areas, but also how processes internal to the community create barriers for the poorest.

8.1 Implications for designing effective and equitable policies

It is important to understand the complex and changing portfolio of assets, trade-offs, coping strategies, and the social structures and relations that govern the activities of poor households in order to intervene effectively. Effective policy design requires the acknowledgement that policy makers have to, and do, interact with social structures and relations in the course of their interventions. Having an understanding of the structures and relations that are likely to affect household response to a particular policy is therefore important. Given that social isolation is a characteristic of both the rural and urban poor, interventions that are designed through dialogue and participation with specific communities may be much more likely to achieve success. Developing ways of ensuring sustainable participation not only by communities in the process of resource allocation but also of the poor within those communities

8.2 Implications for health sector policy

When determining the viability of an intervention it is crucial to examine the costs to the recipient population as well as providing the service. The indirect cost may be substantially more than the direct costs, and prevent the poor from using the service.

Cost recovery and the collection of user fees is probably an inefficient use of public resources, given that it is likely to lead to further impoverishment, which will be more expensive to reverse than forgoing the user fee revenues.

Despite problems of exemption schemes, relieving the poor of some of the financial burden of ill health is important in increasing access and reducing further impoverishment. Therefore continuing to attempt to design and monitor more effective exemption schemes is important. The international emphasis on child health may not be warranted given that child health status is so dependent on health of income generating adults.
Providing information about health issues and treatment is a crucial means to empower the poor to make cost-effective decisions about household health care expenditure, and to enable them to obtain value for money from the health service.

8.3 Multi-sectoral policy implications.

Sickness benefit would considerably reduce the cost of ill health to the poor by about 70%, by compensating them for some of the lost income due to ill health and caring for the sick. The substantial challenge would be to design an effective targeting mechanism such that a scheme remained affordable, and included the poorest who are often not in formal sector employment. Providing a formal sector sickness benefit scheme would still be of substantial benefit to poor household dependent on one formal sector employee.

Social and economic infrastructure (such as health, water, housing etc) is important for improving health as well as for preventing the poverty/ill-health ratchet. Governments have placed much emphasis on the supporting production, market exchange, but little on the social reproduction of communities and households. Policies that strengthen social capital, and the ability of communities to engage in mutually beneficially action are important in maintaining the viability of households. Such policies can range from can range from supporting home based care, provision of child care to fostering a culture of human rights between individuals and communities.

8.4 Research gaps

The few studies that document coping strategies in response to ill health, or health seeking behaviour studies looking at one or two episodes of illness, are not sufficient to allow the development of a coherent policy framework. This paper has reviewed some of the analytical approaches that may enable the development of such policies. Bebbington's framework encompasses a more complete range of resources that are important in the lives of poor households – productive, human, natural, social and cultural capitals – as well as an analysis of how interaction with other actors allows the transformation of these capitals into a 'livelihood'. It is this process that forms the central element to household activity. This transformation process, and the resources available, household relations, resulting substitutions, and trade-offs will determine the response to a particular crisis. The health seeking behaviour (HSB) literature examined the relationship between measurable household characteristics and HSB, without a qualitative analysis of the transformation process, and the decisions that result in response to ill health. The coping strategy literature, again placed emphasis on the outward, and changing manifestations of poor households struggle at survival, without sufficient emphasis on the full range of 'capitals', and the

transformations process. The intra-household literature makes explicit the importance of social structures and relations, in determining household outcomes. With equal emphasis on social and cultural sphere, in addition to productive and human capitals, Bebbington's framework will hopefully enable a more complete analysis of health seeking behaviour, and response to crises at the household level.

Given these general points on potential future areas of research, what are the specific research gaps that have been highlighted by this review? There is a need for:

- Poverty research
  - Identifying and mapping, using qualitative techniques, the different 'capitals' available to the poor.
  - Greater understanding of the transformation process by which these 'capitals' are converted into livelihoods.
  - Greater exploration of the social structures and relations, and interactions with other actors that (dis)enable the transformation process. For example, how are relations within household renegotiated after a crisis? Do/how social networks undergo change at times of crisis? What are the institutional rules/social norms and values that govern ability to cope? How are the trade-offs that individuals face changing?
  - In what ways, and how should, policy interact this transformation process, and the social structures and relations that govern it? Or more simply, can coping strategies (or social capital) be supported by external agents, and if so, how?
- Health research
  - More longitudinal studies that enable examination of the cumulative effect of health (and other) crisis, and how poor households respond.
  - Analysis of the relative importance of different health problems in causing impoverishment.
  - Using the poverty research suggested above to improve understanding of the barriers to health care for the poor, and to enable design of policies to reduce these barriers.
  - How does AIDS affect both social and cultural capitals, as well as productive and human capitals?

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Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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