



Full length article

# Health shocks and the mitigating role of microcredit— The case of rural households in Vietnam

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## ABSTRACT

This paper examines the effects of health shocks and the mitigating role of microcredit using a large household panel data set from rural Vietnam. The research findings are mixed; particularly, the economic impacts of health shocks and the role of microcredit in mitigating these effects vary greatly, depending upon the specific shocks and the outcomes in question. It is noteworthy that rural households may mobilize child or elderly labor in response to labor lost due to health shocks, and microcredit may reduce these adverse effects to some extent.

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## 1. Introduction

Major illness to household members is considered as one of the biggest shocks faced by households (Islam and Maitra, 2012). In developing countries, the social insurance system is not well-organized, which thereby impedes households from accessing formal coping strategies to insure against such shocks. Consequently, households may become destitute due to too high out-of-pocket (OOP) healthcare expenditures. Even if OOP treatment costs are avoided by not seeking care, the households in face of any health shocks may still forgo earnings since there may be labor days lost by the members with health problem or their informal caregivers (Alam and Mahal, 2014). Therefore, when households face any severe health problems, their economic condition would be adversely affected and they may go into deeper poverty.

To mitigate the consequences of health shocks, households may adopt one or more of a range of coping strategies, including: formal health insurance, borrowing, sales of assets, labor supply (hiring outside labor, mobility of children or elderly), assistance from relatives or friends, or income diversification (Alam and Mahal, 2014). If these coping mechanisms are less or ineffective, households may reduce non-medical expenditures, such as food, education, housing, recreation and/or other necessities. If such informal coping strategies as sales of productive durable assets or less human capital investments (health, education) lower potential earnings, households may become impoverished and even be pushed below poverty line in the long run.

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It is well established in the existing literature that the economic impact of health shocks is crucially contingent upon the ability of households to insure against such shocks. Better-off households or households with access to cash sources would be better insured against income shocks such as agricultural or health shocks (Townsend, 1994; Jalan and Ravallion, 1999). This implies that financial institutions could play a significant role in insuring consumption against income shocks (Islam and Maitra, 2012).

To achieve the Millennium Development Goals, the governments in developing countries have implemented many programs to support the poor households, especially those residing in the rural area. Rural credit is considered one of the most effective tools to improve their living standards. However, without collateral the poor households can face binding constraints in rural credit market (Cuong, 2008). Therefore, microfinance institutions may hold a significant promise due to their collateral-free merit. Moreover, the target clients of microcredit programs are typically the poor (Islam and Maitra, 2012). Thenceforth, the emergence of microcredit could be an effective solution to enhance access to credit of the rural poor.

Microcredit is defined as a small loan granted to the poor with the aim of enabling them to raise their income and improve living standards (Hassan and Ibrahim, 2015). Microcredit is found to improve food security, dietary diversity, income, or smooth consumption, which thereby contributes to hunger eradication and poverty reduction (Morduch, 1995; Pitt and Khandker, 1998; Amin et al., 2003; Li et al., 2011; Phan et al., 2014; Bidisha et al., 2017).

There have been a plethora of articles examining the impacts of microcredit on living standards; however, very few studies in literature investigate the role of microcredit in mitigating the adverse effects of health shocks. Gertler et al. (2009) use data from Indonesia and show that microfinance institutions play an important role in helping households self-insure against health shocks. Notably, using a large panel data set from rural Bangladesh, Islam and Maitra (2012) examine the economic impacts of health shocks and the mitigating role of microcredit. They find that households with access to microcredit do not need to sell livestock to smooth their consumption. These studies also reveal that borrowing households can insure consumption against health shocks better than those without any coping strategies.

We apply, in this paper a large household panel data from the recent national living standard surveys in Vietnam to investigate the adverse effects of health shocks on households' income, consumption and intra-household labor allocation, and then examine the role of microcredit as a coping mechanism. The main contributions of this paper are to systematically examine the economic impacts of health shocks in multi-faceted dimensions, including hospitalization and death of household member, and then the mitigating role of microcredit. The heterogeneous effects are also conducted to examine whether there are differences in the impacts between groups of households categorized by poverty status and ethnicity. It is noteworthy in developing countries that rural households with health shocks may increase out-of-working-age labor supply (children or elderly) in response to health shocks. Rural households, especially those who are credit-rationed, may mobilize out-of-working members to work in response to health shocks, but this adverse effect could be mitigated if they have access to credit sources (Jacoby and Skoufias, 1997; Beegle et al., 2003; Guarcello et al., 2010; Dillon, 2012). Therefore, we attempt to investigate the effects on labor substitution due to health shocks in association with microcredit borrowings. To our knowledge, it is among very few attempts to investigate the two mechanisms (microcredit and labor substitution) in coping with health shocks in low income countries.

## 2. Literature review

### 2.1. Impacts of health shocks

There have been a number of empirical studies on the impact of health shocks and the results vary among these studies. Asfaw and Von Braun (2004) find that when the household heads in rural Ethiopia suffer from any health shocks, there is only a reduction in non-food expenditure, but no impact on food consumption. Genoni (2012) reveals that deteriorations in physical functioning abilities would lower households' earned income, while there is no significant effect on their consumption. Vecchio et al. (2014) show evidence that mental health is negatively associated with probability of labor participation. Townsend (1994) and Kochar (1995) conclude that households can protect themselves against health shocks to some extent. Townsend (1994) finds that households' consumption is not much affected after an onset of illness. Kochar (1995) states that health shocks incurred by the male would reduce wage income and increase the use of informal credit in the peak time of agricultural cycle, but no effect in the slack time of this cycle, and finds no evidence on the adverse effects of health shocks to the female.

Regarding health shock associated with mortality of a household member, a systematic literature review by Alam and Mahal (2014) show that adult deaths lead to unobvious effects on non-medical expenditures, with some studies finding no change and the others concluding a reduction or an increase in at least one items of non-medical consumption expenditures. For instance, Khan (2010) finds that death of a household member in Bangladesh reduces food consumption per capita by 15% but increases non-food consumption per capita by 46%. Beegle et al. (2008) reveal that households in Tanzania with mortality of a prime-aged adult would have lower annual per capita consumption by 30%. Meanwhile, some empirical studies in Ethiopia and Bangladesh conclude that there is no evidence for the adverse effects of adult deaths on non-medical consumption (Dercon et al., 2005; Islam and Maitra, 2012).

The impacts of health shocks may be different, depending on households' socio-economic condition (Genoni, 2012). For instance, poor households would be more vulnerable to health shocks (Jalan and Ravallion, 1999; Kurosaki, 2006; Sparrow et al., 2014). Wagstaff (2007) find that health shock has greater impact on the urban households than the rural households in Vietnam. Okonogi et al. (2015) show that the economic impacts of health shocks are varied, depending on types of health shocks and households' poverty status.

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