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Research Briefs

Does Money Protect Health? Evidence from South African Pensions

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A strong, positive association between health and income is well-documented across many countries at varying levels of development. Policymakers and researchers are interested in quantifying the impact of income on health and documenting how income improves health.

In a Center for Health and Wellbeing working paper, **Does Money Protect Health Status? Evidence from South African Pensions**, Anne Case assesses the link between income and health in South Africa by taking advantage of a policy change that provides all elderly adults who do not receive a private pension with sizable monthly income. To evaluate the impact of the pension on household well-being, she uses data from the Langeberg Survey, a randomized survey of 1300 individuals in 300 households on health-related issues and family income. By comparing households that receive a pension with those that do not, she finds that the added income not only improves the pensioner's health, but also that of other household members. The added income allows for improved diet, less stress, and improved living conditions.

Findings

Black South Africans reported significantly worse health than whites and colored respondents. Blacks also had significantly lower income, roughly half that of colored respondents and one-third that of white respondents. Whites had more education than either group; 12 years, on average, compared with 7 years for blacks. In addition, there is a strong association between income and health. For blacks, doubling income is equivalent to rolling back the age clock by 6 years. However, this strong association does not, by itself, demonstrate that income improves health. Causality can run in both directions, with influences from income to health and from health to income (good health may be parlayed into higher wages, for example), and with third factors potentially influencing both. To demonstrate a definitive causal link, a sharp knife is needed to cut the knot between health and income. The South African old-age pension is just such a knife.

The pension was originally intended as a safety net for a small number of whites who reached retirement without a pension. By 1993, the system had been fully extended to all racial groups. In effect, blacks who had never expected a substantial pension were now receiving more than twice the median income per capita. The pensions received by these elderly individuals have become an important source of income.

To determine the effects of income on health status, Case compares the self-reported health of adults who live with pensioners with those that do not. For children, she compares the height for age of children living in households with and without a pensioner.

Case uses two strategies to untangle the effects of the pension itself from that of having an elderly person in the household, who might, for example, be able to spend extra time caring for children. First, she compares those households that pool income with those that do not. The elderly in South Africa typically live in large, multi-generational households. Although most households pool their incomes, others (roughly 25%) do not. If incomes are pooled, the pension should protect the health of all household members. If incomes are not pooled, the effect should be limited to the elderly

recipient only. A second strategy controls for the number of elderly in the household aged 55 and older. This separates the effect of having an older person in the household who receives a pension (those aged 60 and above for women and 65 and above for men) from that of having an older person who does not (ages 55 to pension age).

Case finds that the pension income protects the health of all adult members in households that pool income, and it protects the health of only pensioners in households that do not pool income. Adding a pensioner to a household that pools income improves the health of all adults by 0.5 points, an effect equivalent to rolling back the age clock by more than 10 years. The pension does not affect the pensioner's health above and beyond that of other household members. In contrast, in nonpooling households, the pension has no effect on the health of other household members but does improve the pensioner's health. Pensioners in these households report their health to be a full point better than other members, on average, controlling for age, race, and sex. For children, having a pensioner in the home increases their height by 5 centimeters, or roughly a half-year's growth for children 0–6 years old.

Health was improved through a variety of avenues. Improved food availability figured prominently; fewer family members skipped meals in households that pooled income. Some respondents upgraded their housing, while others simply had fewer worries. The levels of stress were reduced, as were levels of depression in households. Further, Case finds that it is not the presence of older members, but the money they bring that reduces the stress for all adults in the household.

Among the elderly whose daily activities were limited by health problems, pensioners reported better health than those who did not receive a pension. The elderly with limitations who lived in larger household also reported better health. Money appears to bring help (purchased or volunteered) when respondents cannot dress or bathe themselves.

Policy Implications

This study begins to untangle the association between income and health. Income in the form of a cash pension clearly improved the health not only of the pensioner but other household members as well. Shoring up household income appears to be an alternative method that government might use to improve health status. In states that lack the capacity, organizational ability, or political will to improve health systems, providing cash payments may be a better option if the goal is to improve health. The health effects from the added cash assistance provide a benchmark against which other health-related interventions can be evaluated.

Data

The Langeberg survey interviewed a random set of 300 households, with 1300 individuals, in Western Cape, South Africa. Each adult in the household was interviewed separately because household members often have information to which others are not privy. Questions assessed the family's financial situation and whether they had skipped meals. All adults were queried on their work histories, earnings, health, mental health, and social connectedness. Weight and height were obtained for all members. Older adults were asked a battery of questions on activities of daily living and on the receipt and disposition of their pensions.