Ageing & Society (2022), **42**, 1159–1175
doi:10.1017/S0144686X20001361

ARTICLE

The relation between social pensions and health among poor older individuals in Colombia: a qualitative study

Philipp Hessel[1]*, Laura C. López[1], Ivonne Ordóñez-Monak[2,3] and Catalina González-Uribe[4]

[1]Alberto Lleras Camargo School of Government, Universidad de los Andes, Bogotá, Colombia, [2]Faculty of Economics, Universidad Santo Tomás, Bogotá, Colombia, [3]Faculty of Medicine, Universidad Nacional de Colombia, Bogotá, Colombia and [4]Faculty of Medicine, Universidad de los Andes, Bogotá, Colombia
*Corresponding author. Email: p.hessel@uniandes.edu.co

(Accepted 9 September 2020; first published online 28 October 2020)

Abstract

We assessed the relation between social pension benefits and health among poor older individuals in Colombia based on a qualitative case study (N = 51) using in-depth semi-structured interviews. Participants were beneficiaries of the Colombia Mayor social pension programme, recruited through snowball sampling in one rural and one urban area. Participants reported using cash benefits mainly for purchasing essential foods and medicines, as well as for paying for household utilities and satisfying personal needs. Beneficiaries of the programme view the latter as being positively associated with their health as it not only satisfies material needs but also increases their sense of autonomy, emotional wellbeing and also promotes a positive and cheerful attitude. Despite most beneficiaries perceiving the programme as positively associated with their health and wellbeing, results also highlight the importance of the various individual- as well as contextual-level factors in determining the relation between social pensions and health.

Keywords: social pension; ageing; health; Colombia; qualitative

Introduction

Similar to many other low- and middle-income countries (LMICs), Colombia faces an important challenge due to the increasing number of older individuals combined with high risks of old-age poverty and low social security coverage (World Bank, 2011). In Colombia, 20 per cent of individuals aged 60 years or above are classified as poor, with only 5 per cent of older individuals from the bottom two income quartiles receiving a pension (Organisation for Economic Co-operation and Development (OECD) *et al.*, 2014). This circumstance is concerning from a public health and equity point of view since a large share of older individuals lacks adequate material resources to maintain themselves, while also bearing the largest burden of disease (Ocampo-Chaparro *et al.*, 2019).

© The Author(s), 2020. Published by Cambridge University Press

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

To reduce extreme poverty and improve wellbeing among poor older individuals, most Central and South American countries – and increasingly also in Africa and Asia – have introduced so-called social or non-contributory pensions. Those programmes generally provide a modest unconditional cash benefit to older individuals after passing a means test. Existing programmes in Central and South America differ substantially with respect to population coverage, *e.g.* covering more than 40 per cent of those aged 65 years and above in Colombia but only around 12 per cent in Brazil, as well as generosity, with the cash benefit representing only around 4 per cent of average per capita incomes in Colombia but 33 per cent in Brazil, for example (OECD *et al.*, 2014).

In theory, demand-side interventions in the form of social pensions should positively affect the health of beneficiaries by improving various social determinants of health, *e.g.* better housing, nutrition and health-care access, and also by reducing labour supply and exposure to often hazardous working conditions as a result. Indeed, several studies have found that social pensions income can indeed reduce incidence of poverty (Bertranou *et al.*, 2004), the likelihood of suffering from food shortages (Huang and Zhang, 2016; Juarez and Pfutze, in press), reduce labour supply (Juárez and Pfutze, 2015; Huang and Zhang, 2016) as well as improve access and utilisation of health-care services (Riumallo-Herl and Aguila, 2019). Studies have also shown that social pensions can have positive effects on various health outcomes among older individuals, including self-rated health (Hessel *et al.*, 2018), mental health (Salinas-Rodríguez *et al.*, 2014) and frailty (Aguila *et al.*, 2018). Studies have also shown that these positive health-effects can 'trickle down' to children living in beneficiaries' households (Duflo, 2003; Ponczek, 2011).

Despite several studies finding positive effects of social pensions on health and its social determinants, however, several reasons raise doubt on whether social pensions really can lead to sizeable health improvements among beneficiaries (Lloyd-Sherlock *et al.*, 2012*b*). For example, the possibility of translating social pension income into better health is likely highly contingent on the availability and quality of health-care services in disadvantaged areas (Lloyd-Sherlock, 2006). Furthermore, additional disposable income may result in increased purchase and consumption of unhealthy substances such as alcohol and tobacco (Evans and Popova, 2017), or increased consumption of high-calorie foods, potentially increasing the risk of hypertension and being overweight (Fernald *et al.*, 2008). In addition, in many countries, the benefit amount may be simply too small to make a real difference, especially in cultural contexts with high levels of income pooling among household and family members (Lloyd-Sherlock, 2006). Evidence from South Africa found that social pensions improved the health of grandchildren in the household, but not the health of older beneficiaries (Duflo, 2000). Those factors may help to explain why the evidence on the health effects of social pensions, and unconditional cash benefits more generally (Pega *et al.*, 2017), in LMICs is far from conclusive, with studies finding that programmes only affect some but not other health outcomes (Aguila *et al.*, 2015; Cheng *et al.*, 2018; Hessel *et al.*, 2018) or only among men but not women (Hessel *et al.*, 2018).

A clear limitation of existing evidence is that qualitative studies on the topic are largely missing, with only four studies, from South Africa, Chile and Brazil, including qualitative findings on the relation between social pensions and health (Clert

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

and Wodon, 2001; Lloyd-Sherlock, 2006; Lloyd-Sherlock *et al.*, 2012*a*, 2012*c*). Additional qualitative evidence has the potential for helping to explain why social pensions seem to improve the health of older individuals in some situations and for some groups, but not others, and also to shed further light into relevant mechanisms linking social pensions to health and wellbeing. Qualitative evidence on the (likely complex) relation between social pensions and health is important for better-informing policy on how to potentially reform existing programmes in a way that they respond to the health needs of disadvantaged individuals. Qualitative evidence is equally important to explore the role of contextual factors shaping the relation between social pensions and health among older individuals. This is particularly relevant in the case of Colombia, a country that is characterised by substantial differences between rural and urban areas, major geographical regions (*e.g.* differences between Caribbean, Pacific and Amazonas) and ethnic groups (*e.g.* differences between Afro-descendants and Indigenous groups). Finally, qualitative research on social pensions in LMIC's contributes to giving 'voice' to usually underrepresented indviduals.

To shed further light on the relation between social pensions and health, we conducted a qualitative case study among urban as well as rural-dwelling beneficiaries of the Colombian social pension programme (Colombia Mayor). Building on the social determinants of health framework and qualitative in-depth interviews, we assessed three interrelated questions:

(1) How do beneficiaries of the programme conceptualise 'health'?
(2) How do beneficiaries use the cash benefit?
(3) How do beneficiaries perceive the relation between the cash benefit and their health?

Social pensions and public health care in Colombia

In 2003, the Colombian government established the first comprehensive social assistance programme for older individuals without sufficient economic resources. Called the Social Protection Program for the Elderly (Programa de Protección Social al Adulto Mayor) and financed by payroll contributions to a solidarity pension fund from workers with formal jobs, the programme started to provide unconditional cash benefits to around 140,000 older individuals in extreme poverty. Eligibility for the programme was based on age as well as a proxy means test called SISBEN (Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales).

Over the years, combined with a steady increase in the number of older individuals, the programme has significantly increased its number of beneficiaries to a total of nearly two million individuals, representing approximately 40 per cent of all individuals aged 65 or above (OECD *et al.*, 2014). As of 2019, the programme – renamed Colombia Mayor in 2013 – provides a monthly payment of 85,000 Colombian pesos (COP) (US $60 in Purchasing Power Parities) to women aged at least 54 years and men aged at least 59 years passing the SISBEN means test. (At the time the fieldwork for this study was carried out, participants in both areas were receiving 75,000 COP per month). However, since available funds for

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

the programme are not sufficient to cover all individuals meeting the age as well as poverty criteria, the government *de facto* prioritises individuals with higher ages and those living alone, or those that suffer from disabilities.

The vast majority of beneficiaries of Colombia Mayor are also covered by non-contributory public health insurance in the form of the so-called Régimen Subsidiado. Complementing a contributory and mainly private health insurance scheme, the Régimen Subsidiado provides health care to individuals without the ability to pay (Giedion and Uribe, 2009). The scheme, financed by taxes and payroll contributions by workers with formal jobs, provides access to most forms of low-complexity care and catastrophic illnesses, but only limited coverage for most hospital care and no short-term disability coverage. Also, co-payments exist for certain medicines according to the ability to pay (also assessed by the SISBEN means test). To fill the gap, the Régimen Subsidiado is complemented by services provided by public hospitals.

Methods

Study design

We conducted two qualitative case studies based on semi-structured in-depth interviews with older beneficiaries of the Colombia Mayor programme, interviewed in their homes, to generate a deeper understanding of how beneficiaries use the cash benefit and how they view its relation to their health. Interviews were conducted in two different contexts of the country: the urban municipality Soacha and the rural municipality Cómbita. We selected this approach as it studies individuals and the relevant phenomena in their real-life settings and favours their interpretation in accordance with the meaning that individuals bring to them (Stake, 1995).

Study setting

The municipality of Soacha belongs to the Cundinamarca department and is in immediate proximity to the capital city of Bogotá. Soacha has a population of approximately 544,298 people, with 98.8 per cent of the municipality's residents living in an area officially classified as urban. It is one of the most populated municipalities in the country. People aged 60 years or more represent 5.6 per cent of the total population, with 15.6 per cent of the population of working age being unemployed. More than half of all workers (55.8%) are in the informal sector, meaning that they do not have a regular contract and do not receive social security contributions from their employer. More than half of all inhabitants (53.8%) of Soacha are officially classified as poor (Mayor's Office of Soacha, 2015).

The municipality of Cómbita belongs to the department of Boyacá, which is located in the centre of Colombia with a population of approximately 1.2 million people. The Cómbita municipality is home to around 12,000 people, 1,292 of whom are aged 60 years or above. Around 98 per cent of all inhabitants of the municipality live in areas classified as rural. Given the significant geographical dispersion of the municipality and low population density (98 inhabitants per square kilometre), in combination with insufficient public transport, most inhabitants have to walk long distances to access public services, such as health centres. Thirty-six

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

per cent of individuals are classified as multi-dimensionally poor and 27 per cent of households do not have access to basic public services.

Sampling and participants

Participants were recruited in Soacha and Cómbita using snowball sampling. Key community members were contacted to identify possible participants. The inclusion criteria for the study included women aged at least 54 years and men aged at least 59 (being the official age-threshold for receiving the programme) who were beneficiaries of Colombia Mayor for a minimum of two years. Older persons who could not provide information themselves due to factors that would preclude a meaningful interview (cognitive impairment, profound hearing loss and language barriers) were excluded.

Data collection

Semi-structured in-depth interviews were conducted during June and July 2018 in Soacha and from March to May 2019 in Cómbita. The interviews lasted 30–58 minutes and were audio-recorded in-person until the researchers felt that saturation had been achieved, and no new information could be obtained (Douglas, 2002). The interview questions covered the following topics: demographic characteristics of the study participants, basic needs of older adults, health perception, and use of the cash benefit and its possible relation to their health. In addition, participants were asked about their suggestions for possible improvements to the programme on behalf of the government (*see* the online supplementary material).

Ethical considerations

The study was reviewed and approved by the Institutional Review Board of the Universidad de los Andes. Participants were informed about the objectives, research procedures, and their right to decline or withdraw from the study at any time without any adverse consequences.

Data transcription and analysis

Interviews were transcribed verbatim from digital audio format to text and analysed. First, the researchers began to read through each transcript to find general and potential meanings in the interviews, organise and identify emergent patterns in participant's responses. Afterward, categories were created from sorting and coding of emergent themes in responses that were derived from the data through inductive content analysis. The creation of categories was built from the most specific to the most general topics (Elo and Kyngäs, 2008). Using NVivo software, researchers then compared the categories of respondents with deductive categories and sub-categories from existing theoretical frameworks, in particular the Social Determinants of Health. The result was detail-coding frames of categories grouped under higher-order headings (Burnard, 1991). The aim of grouping data was to reduce the number of categories to provide a meaningful way of describing the phenomenon (Burnard, 1991). Finally, during the last stage of our analysis, data were reduced and a framework matrix approach was developed to seek out patterns in the responses (Ritchie *et al.*, 2013). A data matrix was created with research themes that emerged in the columns and

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

main quotations by respondents in the rows. A summary of respondent data was entered into each cell. The advantage of this visual platform is that it enables systematic comparison of differences across respondents.

Results

Sample overview

The sample included 51 persons aged between 61 and 91 years, of whom 23 (45.1%) were residents in the rural area of Cómbita and 28 (54.9%) were residents of the urban area Soacha (Table 1). With respect to the gender of the interviewees, a difference in the distribution between the rural and urban areas was evident, with a greater concentration of women in the rural sample (69%) compared to the urban sample (42%). The latter may be due to the significantly lower life expectancy of men in rural areas, with 56.25 per cent of women in Cómbita stating they were widows. Additionally, some inhabitants of the municipality of Cómbita indicated that there is a tendency on the part of local authorities to prefer women receiving the subsidy. The distribution by age groups was similar for the rural and urban areas. With regard to labour force participation, 22 per cent of older individuals from Cómbita described themselves as currently working, while 50 per cent of participants in Soacha described themselves as currently working. It is important to note that none of the participants had ever had a formal job (including social security contributions by the employer) or regular income. About half of the respondents, both in the rural and the urban areas, had only completed primary education, while around one-third of respondents in both areas had not attended formal education.

Conceptualisation of health according to the participants

The most relevant and frequently mentioned dimension with regard to the participants' conceptualisation of health, in both the rural as well as the urban area and among men and women, was the *sense of autonomy* for carrying out activities of daily living. The latter is reflected in the following statements:

> To be healthy is to be able to cook, because my lady she is in bed, she cannot walk. And I have to cook for her and cook for me, in order to have health. (Rural participant, 78-year-old man, married)

> I say that health will be to feel good, that nothing hurts you. That one can eat and sleep, because sometimes it is that one can neither eat nor sleep. (Rural participant, 63-year-old woman, living with her non-married partner, lives from selling eggs and milk from her farm)

Closely related to the concept of autonomy, as important dimensions of health, was the possibility of *carrying out their own work* as reflected in the following statements:

> Well, [health] it means that one feels able to work, for one to walk and everything. (Urban participant, 68-year-old man, married, street vendor)

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

Table 1. Sample overview

	Urban (Soacha)		Rural (Cómbita)		Total	
	N	%	N	%	N	%
Gender:						
Female	12	43	16	70	28	55
Male	16	57	7	30	23	45
Age group:						
61–70	8	29	6	26	14	27
71–80	9	32	8	35	17	33
81–90	10	36	9	39	19	37
91–100	1	4	0	0	1	2
Household status:						
Partner (married or not)	5	18	7	30	12	24
Other family member	1	4	2	9	3	6
Daughter or son	9	32	6	26	15	29
Daughter or son + other family member	5	18	0	0	5	10
Niece	0	0	1	4	1	2
Alone	8	29	7	30	15	29
Labour force participation:						
No	14	50	18	78	32	63
Yes	14	50	5	22	19	37
Educational achievement:						
High school completed	4	14	0	0	4	8
Primary education completed	14	50	14	61	28	55
Without formal education	9	32	9	39	18	35
Technical degree/apprenticeship	1	4	0	0	1	2
Total	28		23		51	

> Oh well, health is that one can work … yes. I started working since I was five years old. And everything barefoot and everything. I went to work over there in some stores. I have worked hard. I have been a hardworking man. These days I no longer have the health to continue working. (Rural participant, 78-year-old man, living with his non-married partner)

Inhabitants of the rural area stressed the role of rural work as a determinant for deterioration in their own health, as highlighted by the following quote:

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

> I have to stay permanently with oxygen, and that's why moving or going from one place is very difficult. This is because of so many days working in the sun and rain on the fields. (Rural participant, 67-year old man, widower, lives with a grandson)

A third dimension significant for the conceptualisation of health from the perspective of older adults was that of *joyfulness*, seen mainly as the maintenance of a positive and cheerful attitude despite the presence of disability and hardship. This perception was particularly widespread among women in both areas and reflected in the following quotes:

> Well … seeing a joyful person in good health … one also feels happy, to see that person, and say: we are in good health even though we do not have money, but health is worth more than everything. (Rural participant, 67-year-old woman, married, street vendor of fruits)

The inclusion of *faith* in relation to the conceptualisation of health was the fourth most relevant dimension among participants, especially in the oldest women in the sample. This dimension focused on a strong belief in God as a provider of health or as support and comfort in the midst of physical ailments, as shown in the following statements:

> Health is given to us by God, if one takes care of oneself, if one has bad habits, drinks, gets drunk, smokes, makes who knows what calamities – as one sees many people – because they are going to get sick. (Urban participant, 86-year-old man, lives with his daughter)

> The most important thing you have in life is health, the most important thing, what do I do with a lot of money if I have no health? I do not have the strength to go for a walk, thank God so far I am not with a cane dragging me, I thank God. (Urban participant, 81-year-old woman)

Use of the Colombia Mayor cash benefit by beneficiaries

Participants used the cash benefit in a wide range of ways, although the most frequently reported use was for *purchasing food*. The latter was especially important among participants who lived alone or only with their spouses, as well in the rural area. In both areas it is common to share the food purchased with the cash benefit with other household members:

> We live only from the subsidy. Because that is what serves us. With it we buy the groceries for the month. And we live from that. (Rural participant, 75-year-old married woman, lives with a spouse who is also a beneficiary)

> Most of it is spent on food. Because her [his daughter's] husband does not have a job, she [her daughter] is not working either. I have to pay the food for everyone. (Urban participant, 68-year-old man, married, street vendor)

The second most frequently mentioned use of the subsidy was that of *payment of services and taxes*. This was common to all participants, regardless of their sex, age

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

or area of residence, who stated that the payment of public services is a constant need. A frequently mentioned complaint was the high costs of some services, particularly for water and sewerage:

> I am concerned about the arrival of water, I have to pay for water, gas and cable, what I have left is to eat or to buy some medicine or for personal use. (Urban participant, 81-year-old woman)

> Well, it is difficult for me because at home they keep discriminating against me, insulting me that I do not contribute enough. But I always help them with something for services, water services. Even the little income I receive from the government is to pay the water bill, but it is not enough. (Urban participant, 77-year-old man, lives with his son's family, works as street vendor)

The third dimension in order of hierarchy for the subsidy use category was the *purchase of medicines*. This was common to all the participants, but more frequent among participants between 71 and 80 years and women, groups that also manifested greater physical ailments. With regard to the area of residence, a greater use of the subsidy in the purchase of medicines for the urban area was evident which can be partly explained by the circumstance, repeatedly stressed by rural dwellers, that the costs involved in transportation to the nearest pharmacy are sometimes greater than the cost of the drug:

> In medicines … because one goes to the health centre to buy two seals of acetaminophen [medication used to treat pain and fever] worth 2,200 pesos in the drugstore, and you have to spend one whole day to come to the doctor. (Rural participant, 66-year-old woman, married, lives with her husband)

The fourth dimension in order of hierarchy for the category use of the subsidy was to *satisfy personal needs* other than food or medicines. This was frequent in the urban area, and practically non-existent in the rural area. This may be explained by the circumstance that, in urban areas, self-employment and co-residence with a larger family of older adults between 61 and 78 years of age was very frequent, which represents a greater possibility for income generation and sharing of resources within the household.

> As I tell you … transport, toiletries or personal care, and also buying little clothes that one needs, and also to be able to even go out to the park and have something to eat, an ice cream. (Urban participant, 91-year-old woman, lives with her daughter)

> For example, if I suddenly need some interiors, then I buy them, what I told you now, for soap, for shaving cream, for razors, things like that, at all times I don't have the money to be there buying. (Urban participant, 64-year-old man, lives with his son)

In contrast, in rural areas, there existed a strong tendency for older adults to live alone or only one other person, generating the need for the entire subsidy to be used exclusively for food and medicines.

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

As previously mentioned in the analysis of the contribution category of the subsidy, the use as working capital was an expense of the inhabitants of the urban area, due to their participation in independent work activities:

> First, to buy me a small showcase to put the dolls, heads and stuffing to sell to see if something is done … and paid for the repair of the charterer's machine. (Urban participant, 61-year-old woman maid-tailor, lives with her son and grandson)

> Well what, to buy the products, and keep the business … Yes, for example, the mango, the sauces, and thus, the work items. (Urban participant, 77-year-old man, lives with his son's family, works as street vendor)

Relation between Colombia Mayor benefit and health according to participants

From the perspective of the beneficiaries of the Colombia Mayor programme and taking into account their own understanding of health, it can be affirmed that the subsidy generates a positive contribution in this regard, particularly as it grants them independence and autonomy and is related to feelings such as hope and joy, and even motivations to continue living. Participants report that the subsidy generates a sense of wellbeing, since it allows them to undertake specific activities that are relevant for the maintenance of good health, such as buying medicines or food. With regard to older adults who work as independents in urban areas, who were concentrated in the younger age ranges, the subsidy was considered to be a benefit that brings them *health as they can invest capital in their jobs and fulfil their social responsibilities*, such as providing money for their families. This dynamic was not the same in the rural area, since those who had work activities did not express the need to invest capital in their jobs (since the sales input comes directly from products of their gardens or farms), and also mostly live alone or with only one other family member. For the beneficiaries of the rural area, on the other hand, the greatest contribution of the subsidy to health, safety and wellbeing was concentrated in the guarantee of *access to food and nutrition*, which was also one of the most frequent uses reported by this group:

> Oh yes, so to support me, to buy the potato, buy what is needed at home. Yes, because that money is good for health. It serves to buy a paste, for whatever it takes. And in food. (Rural participant, 87-year-old woman, married, lives with spouse and grandson)

> I use it for my market … only for my food. For my fruits and vegetables … I like to eat fruit and I live very grateful to the mayor for that … because I only use it for the fruit market. Of course, my health would be worse, because if I didn't eat fruit … the fruit is very healthy and helps me for my mobility. (Rural participant, 82-year-old woman, single, lives alone)

Participants also related the programme's cash benefit to affecting their health positively by generating *positive feelings of joy, happiness and satisfaction*. These feelings were more frequent in women than in men, in the highest age groups, and in the

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

rural area compared to the urban area. In general, these attitudes were the result of the *possibility of satisfying needs*:

> [With the subsidy] one has hope and hope is what feeds one's life, like when one is in love … because at least one has an incentive to live. And without the subsidy it would be a life without any incentive, one that can no longer work, that is an aid that encourages one to live longer. (Urban participant, 91-year-old woman, lives with daughter)

> Because it is a help [subsidy] and a joy that gives one, to have at least that little help. Yes, it is good, and if I have the subsidy there, it helps me to help myself, to buy the medicines. (Urban participant, 69-year-old man, shoe polisher)

Another important dimension related to the participants' own view regarding the relation between the benefit and their health was that of *recognition*; referring to the fact of being taken into account by government entities and society, and to be respected for being older adults. The recognition was not such an obvious dimension in the inhabitants of the urban area, while it was very significant for the inhabitants of the rural area, who stated that they felt recognised, being beneficiaries of a government initiative such as the subsidy, accessing programmes and additional services led by the mayor's office, and enjoying recreational activities designed especially for them, generated a sense of wellbeing and satisfaction:

> I think that it [answering the question, how would your health be without the subsidy] would be rather bad. Before they [the government] offered nothing. There was no subsidy neither for children, nor for adults, nor for anything. That's when one was alone. (Rural participant, 63-year-old woman, free union, lives with spouse)

> I feel satisfied, calm, I feel that someone loves me, that the government has thought of us. (Rural participant, 82-year-old woman, single, lives alone)

The third most frequent dimension that, according to the participants, explains why the benefit would be positively related to their health was that of *material circumstances*. For the older adults of the study, in general, it focuses on the positive impact that the subsidy has on their health and wellbeing by favouring their permanence in a decent place to live, access to services such as transportation and the possibility of working through investment capital. Within the material circumstances, access to health services and direct health benefits, older adults associate the benefit of the subsidy with the *purchase of medicines*:

> Health is a question of having access to drugs...because I actually need a drug that, however, I have not been able to buy because it is very expensive and that is not covered by SISBEN . (Urban participant, 61-year-old man, bag seller of garbage)

On the other hand, it is worth mentioning that there was a particular group that *did not perceive the subsidy as a health benefit*: older adults who are heads or heads of household in urban areas, since they respond financially for the needs of the house

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

and their families, and the focus of attention and care is on those people, or on outstanding debts, and not so much on themselves:

> For health [the benefit] is not enough. Sometimes for buying some silly things, although I will always defend it. This money [of the benefit] for health? No, that is not enough. Everything is no expensive, no, no, no, that is not enough. (Urban participant, 83-year-old man, takes care of his wife with a physical disability condition)

> [The subsidy is good for health] yes, but a very minimal thing, because sometimes the children tell me 'what did he do about the subsidy? What did he invest in? Did he give it to his son?' That is tenacious. Well, now, let's say, with the debt, who would pay me the debt? Instead of helping me, they will empty me. (Urban participant, 63-year old woman, lives with her son and grandson)

Discussion

Drawing on qualitative in-depth interviews, this study assessed how older beneficiaries of the Colombian social pension programme perceive the relation of the programme with their health. The majority of participants, recruited from a rural and an urban area of the country, clearly view the programme as positively affecting their health and wellbeing. This can be explained, one the one hand, by the circumstance that participants mainly use the cash benefit to purchase essential foods and medicines, or for paying for household utilities and satisfying personal needs. Besides pathways between social pensions and health operating directly through these social determinants of health, participants also see the benefit to be associated positively with their sense of autonomy and emotional wellbeing as it promotes a positive and cheerful attitude, despite the exposure of material hardship. However, the interviews also highlight that the potential of social pensions for improving the health of poor older individuals in Colombia is not only dependent on various individual as well as contextual factors, but is also limited by the comparatively small benefit amount.

Interpretation of findings

Overall, the findings of this study are in line with existing studies suggesting that social pensions can not only affect positively the health and wellbeing of poor older beneficiaries in Central and South America (Lloyd-Sherlock *et al.*, 2012*a*; Aguila *et al.*, 2015; Hessel *et al.*, 2018), at least partly through the positive effects on various social determinants of health, including improved access to nutrition, medicines and other basic necessities. At the same time, however, the present study also highlights that the relation between social pensions and health is arguably complex and depends not only on the specific living arrangements and individual resources of beneficiaries, but equally on the wider socio-economic context in which they live (Lloyd-Sherlock *et al.*, 2012*a*).

A key pathway through which social pensions are thought to improve health and wellbeing is by improving *access to health care and medicines*. The findings from

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

this study generally support this view in line with evidence for other LMICs (Lloyd-Sherlock, 2006; Aguila *et al.*, 2015; Riumallo-Herl and Aguila, 2019). However, the findings of this study also highlight several important barriers that older people, especially in rural areas, face in accessing health-care services and in covering co-payments for essential medicines. In the context of Colombia, in contrast to many LMICs without similar provision and coverage of public health care, the Colombia Mayor benefit does not necessarily improve access to health care as the majority of beneficiaries are already covered by the publicly subsidised health insurance system Régimen Subsidiado. However, as the qualitative interviews clearly highlight, one of the most frequently reported uses of the cash benefit is for (co-)payments for specific medicines that are not fully reimbursed by the Régimen Subsidiado. A recurrent topic raised by participants in the rural area of Cómbita was the large amount of time and money necessary to visit the closest health-care centre in the nearby city, usually requiring a full day of travel and waiting, as well as the payment of an overland coach. Especially for individuals with pre-existing health conditions and those of older ages, this not only represents a clear burden and barrier in accessing health-care services but also disproportionate financial costs. (For example, for rural participants, the average cost for a return bus ticket to the nearest town with a health centre was 18,000 COP, thus approximately 24 per cent of the monthly cash benefit of the programme at the time.) Problems and barriers in accessing health-care facilities by older people, and specifically also among recipients of social pensions, have also been highlighted in several other studies from LMICs (Cloos *et al.*, 2010; National Gender and Equality Commission of Kenya, 2014; Galvani *et al.*, 2017).

Another potential mechanism through which social pensions may positively affect health is by *reducing labour force participation* and exposure to stressful and hazardous working conditions in later life. Indeed, studies from LMICs have found that social pensions reduced the probability of beneficiaries being economically active (Juárez and Pfutze, 2015). In contrast, the results of this study do not generally support this finding. Among rural-dwelling participants in our sample, there existed no apparent relation between social pensions and economic activity. Given the lack of other economic opportunities, those individuals physically able to do so did work on their small farms and sold the products for a small income. Also, no participant in the urban sample reported having reduced economic activity as a result of receiving Colombia Mayor. In contrast, many participants reported explicitly using the additional cash benefit as an input or investment into their small business. The latter is in line with a quantitative study showing that, overall, the programme increases labour force participation, particularly among recipients of the programme undertaking economic activities that may require an up-front investment, such as street vendors (Pfutze and Rodríguez-Castelán, 2019). A possible explanation for this finding is that Colombia's social pension has one of the lowest age thresholds compared to other LMICs, which usually is 60 years or above. Furthermore, the benefit amount in Colombia is also comparatively small and likely insufficient to substitute income from economic activity sufficiently.

The results of this study emphasise clear differences in the use of the Colombia Mayor cash benefit as well as the perception by older beneficiaries about its potential relation with their health. Participants from the rural area reported using the

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

cash benefit almost exclusively to purchase food and essential medicines. On the one hand, this can, at least partly, be explained by the circumstance that the majority of rural participants, mostly women, either were living alone or with only one other family member, therefore limiting the possibility of sharing resources among a wider household unit. On the other hand, in the rural area, opportunities for additional income generation – other than from selling products from their small farms – are largely absent, so that the cash benefit has to be spent on the essential necessities. In contrast, participants from the urban area are much more likely to be part of a larger household and have more opportunities for being economically active than their rural counterparts. As a result, individuals from the urban area are more likely to spend part of the Colombia Mayor benefit on items for personal care or clothes as well as impulse convenience goods such as ice cream. In line with related studies (Lloyd-Sherlock *et al.*, 2012*a*), practically all participants living with other household members reported spending a significant share of the cash benefit on household utilities and needs.

Despite the overall positive view of the Colombia Mayor programme and its relation to health and wellbeing by participants of this study, substantial diversity of living conditions of poor older individuals in Colombia in combination with barriers in accessing health-care services in rural areas, widespread income pooling among household members and a comparatively small cash benefit also underscore that social pensions alone should not be seen as the sole or primary determinant of a poor older individual's health and wellbeing in LMICs (Lloyd-Sherlock *et al.*, 2012*a*). In fact, a quasi-experimental evaluation of the Colombia Mayor programme found that the programme only had a small positive effect on (self-rated) health and risk of hospitalisation among men, without having an effect on women (Hessel *et al.*, 2018). Different to the results of the latter quantitative study, the present qualitative study did not reveal any substantial differences in the relation between Colombia Mayor and health according to either male or female participants. The only notable difference was that many female participants did associate the benefit with feelings of cheerfulness, which was not the case among men, as well as the circumstance that men in the rural area commonly referred to the hazardous health effects of rural work.

Limitations

Although this study included men and women living in a rural as well an urban area, given the non-representative sample of this study, the results cannot be generalised to represent the situation of beneficiaries of Colombia Mayor in Colombia. The latter is particularly the case as the relation between the programme's cash benefit and beneficiaries' health depends not only on the individual and household characteristics but also on several contextual factors, including the accessibility of transport and health-care facilities. As the results of this study underscore, the experiences and living conditions of poor older individuals in Colombia are highly diverse, even within the same country and context. A second limitation of this study is that the results, suggesting that overall respondents use the cash benefit for satisfying personal needs, may be biased as a result of social desirability. The latter may occur as respondents may tend not to mention that

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

they spend the cash benefit on 'unhealthy' things like alcohol or cigarettes. Although this potential bias cannot be ruled out entirely, the circumstance that no respondent of this study mentioned spending the cash benefit on alcohol or cigarettes is in line with results from a nationally representative survey of older individuals carried out in 2015 (Estudio Nacional de Salud, Bienestar y Envejecimiento), according to which only 8 per cent of recipients of Colombia Mayor consume any alcohol and only 11 per cent smoke (Ministerio de Salud y Protección Social de Colombia, 2015).

Conclusions

The results of this study suggest that the Colombian social pension programme is generally perceived by beneficiaries to be positively associated with their health and wellbeing. Despite the widespread importance of the programme for beneficiaries, especially for feelings of hope and autonomy, the present study suggests that there exist several reasons limiting the potential for the programme to have a significant effect on beneficiaries' health. Although the policy of the Colombian government remains of giving a comparatively small cash benefit to a relatively large share of older individuals, policy makers should consider how to maximise the positive effects of the programme on the health and wellbeing of beneficiaries. One viable strategy may be better integration of social pensions with the public health-care system, *e.g.* by combining the payment of social pensions with health check-ups and preventive strategies.

Supplementary material. The supplementary material for this article can be found at https://doi.org/10.1017/S0144686X20001361

Acknowledgements. Our gratitude to all the individuals who took part in this study.

Author contribution. All authors meet the criteria to be listed as full authors in agreement with this journal's guidelines as well as those outlined by the International Committee of Medical Journal Editors.

Financial support. This research received no specific grant from any funding agency, commercial or not-for-profit sectors.

Conflict of interest. The authors declare no conflicts of interest.

Ethical standards. Ethical approval was received from the Universidad de los Andes Ethics Committee.

References

Aguila E, Kapteyn A and Smith JP (2015) Effects of income supplementation on health of the poor elderly: the case of Mexico. *Proceedings of the National Academy of Sciences* **112**, 70–75.

Aguila E, Lopez-Ortega M and Robledo LMG (2018) Non-contributory pension programs and frailty of older adults: evidence from Mexico. *PLOS ONE* **13**, e0206792.

Bertranou FM, Van Ginneken W and Solorio C (2004) The impact of tax-financed pensions on poverty reduction in Latin America: evidence from Argentina, Brazil, Chile, Costa Rica and Uruguay. *International Social Security Review* **57**, 3–18.

Burnard P (1991) A method of analysing interview transcripts in qualitative research. *Nurse Education Today* **11**, 461–466.

Cheng L, Liu H, Zhang Y and Zhao Z (2018) The health implications of social pensions: evidence from China's new rural pension scheme. *Journal of Comparative Economics* **46**, 53–77.

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

Clert C and Wodon Q. (2001) The targeting of government programs in Chile: a quantitative and qualitative assessment. In The World Bank (ed). *Chile's High Growth Economy: Poverty and Income Distribution*. Washington, DC: World Bank, pp. 143-166.

Cloos P, Allen CF, Alvarado BE, Zunzunegui MV, Simeon DT and Eldemire-Shearer D (2010) 'Active ageing': a qualitative study in six Caribbean countries. *Ageing & Society* **30**, 79–101.

Douglas E (2002) *Qualitative Analysis: Practice and Innovation*. London: Taylor and Francis.

Duflo E (2000) Child health and household resources in South Africa: evidence from the old age pension program. *American Economic Review* **90**, 393–398.

Duflo E (2003) Grandmothers and granddaughters: old-age pensions and intrahousehold allocation in South Africa. *The World Bank Economic Review* **17**, 1–25.

Elo S and Kyngäs H (2008) The qualitative content analysis process. *Journal of Advanced Nursing* **62**, 107–115.

Evans DK and Popova A (2017) Cash transfers and temptation goods. *Economic Development and Cultural Change* **65**, 189–221.

Fernald LC, Gertler PJ and Hou X (2008) Cash component of conditional cash transfer program is associated with higher body mass index and blood pressure in adults. *Journal of Nutrition* **138**, 2250–2257.

Galvani F, Stefanoni S and Williamson C (2017) *Cash Transfers and Older People's Access to Healthcare: A Multi-country Study in Ethiopia, Mozambique, Tanzania and Zimbabwe*. HelpAge International. Available at http://www.helpage.org/download/5927922f5dc28.

Giedion U and Uribe MV (2009) Colombia's universal health insurance system. *Health Affairs* **28**, 853–863.

Hessel P, Avendano M, Rodríguez-Castelán C and Pfutze T (2018) Social pension income associated with small improvements in self-reported health of poor older men in Colombia. *Health Affairs* **37**, 456–463.

Huang W and Zhang C (2016) The power of social pensions. Institute of Labor Economics, Bonn, Germany, IZA Discussion Paper 10425.

Juárez L and Pfutze T (2015) The effects of a noncontributory pension program on labor force participation: the case of 70 y Más in Mexico. *Economic Development and Cultural Change* **63**, 685–713.

Juarez L and Pfutze T (2020) Can non-contributory pensions decrease food vulnerability? The case of Mexico. *Empirical Economics* **95**, 1865–1882.

Lloyd-Sherlock P (2006) Simple transfers, complex outcomes: the impacts of pensions on poor households in Brazil. *Development and Change* **37**, 969–995.

Lloyd-Sherlock P, Barrientos A, Moller V and Saboia J (2012*a*) Pensions, poverty and wellbeing in later life: comparative research from South Africa and Brazil. *Journal of Aging Studies* **26**, 243–252.

Lloyd-Sherlock P, Minicuci N, Beard J and Chatterji S (2012*b*) Social protection and preventing illness in developing countries: establishing the health effects of pensions and health insurance. *International Social Security Review* **65**, 51–68.

Lloyd-Sherlock P, Saboia J and Ramírez-Rodríguez B (2012*c*) Cash transfers and the well-being of older people in Brazil. *Development and Change* **43**, 1049–1072.

Mayor's Office of Soacha (2015) *Bienestar para todos y todas, plan de desarrollo*. Available at http://www.alcaldiasoacha.gov.co/phocadownloadpap/Normatividad/Proyecto_de_normas_municipales/Proyecto_de_Decreto_Municipal/Plan_Desarrollo_2012_2015.pdf.

Ministerio de Salud y Protección Social de Colombia (2015) *SABE Colombia 2015: Estudio Nacional de Salud, Bienestar y Envejecimiento*. Available at https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/VS/ED/GCFI/Resumen-Ejecutivo-Encuesta-SABE.pdf.

National Gender and Equality Commission of Kenya (2014) *Participation of Vulnerable Populations in Their Own Programmes: The Cash Transfers in Kenya*. Available at https://www.ngeckenya.org/Downloads/cash-transfer-programme-vulnerable-groups-kenya.pdf.

Ocampo-Chaparro JM, Reyes-Ortiz CA, Castro-Flórez X and Montes JFG (2019) Frailty in older adults and their association with social determinants of health. The SABE Colombia study. *Colombia Médica* **50**, 89–101.

Organisation for Economic Co-operation and Development (OECD), Inter-American Development Bank (IDB) and the World Bank (2014) *Pensions at a Glance: Latin America and the Caribbean*. Paris: OECD Publishing.

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press

Pega F, Walter S, Liu SY, Pabayo R, Lhachimi SK and Saith R (2017) Unconditional cash transfers for reducing poverty and vulnerabilities: effect on use of health services and health outcomes in low- and middle-income countries. *Cochrane Database of Systematic Reviews* **11**, Art. No.: CD011135.

Pfutze T and Rodríguez-Castelán C (2019) Can a small social pension promote labor force participation? Evidence from the Colombia Mayor program. *Economía* **20**, 111–154.

Ponczek V (2011) Income and bargaining effects on education and health in Brazil. *Journal of Development Economics* **94**, 242–253.

Ritchie J, Lewis J, Nicholls CM and Ormston R (2013) *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage.

Riumallo-Herl C and Aguila E (2019) The effect of old-age pensions on health care utilization patterns and insurance uptake in Mexico. *BMJ Global Health* **4**, e001771.

Salinas-Rodríguez A, Torres-Pereda DP, Manrique-Espinoza B, Moreno-Tamayo K and Solís MMT-R (2014) Impact of the non-contributory social pension program 70 y más on older adults' mental well-being. *PLOS ONE* **9**, e113085.

Stake RE (1995) *The Art of Case Study Research*. Thousand Oaks, CA: Sage.

World Bank (2011) *Population Aging: Is Latin America Ready?* (Directions in Development). Washington, DC: World Bank.

Cite this article: Hessel P, López LC, Ordóñez-Monak I, González-Uribe C (2022). The relation between social pensions and health among poor older individuals in Colombia: a qualitative study. *Ageing & Society* **42**, 1159–1175. https://doi.org/10.1017/S0144686X20001361

https://doi.org/10.1017/S0144686X20001361 Published online by Cambridge University Press