Health and poverty in Bangladesh

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Sociology of health care

A number of key health indicators in Bangladesh reflect improvement during recent years. Infant and child mortality rates have declined in rural as well as urban areas, and there has been a dramatic reduction in the infant mortality rate from 116 per 1000 births in 1988 to 75 in 1995. This has been accompanied by an increase in life expectancy at birth – from 55 to 59 years in the same period. Much of the progress at the aggregate level was propelled by the rapid growth of the immunization programme, which covered less than 3% of all children in the late 1970s and over 80% in the mid-1990s. Access to safe drinking-water is another indicator which registered considerable progress in the 1980s; even in rural areas the access rate is currently estimated at 78% compared with only 50% in the early 1980s. The progress on the health front was, however, mainly restricted to the sphere of preventive health care, with little sign of improvement in the area of essential curative health.

Of course, there are still significant deficiencies in the field of preventive and primary health care. In particular, mothers' health is still a neglected area as evidenced by the high maternal mortality rate; communicable diseases that are mostly preventable account for the major portion of morbidity and mortality; and access to sanitary toilets is limited to only 15% of rural households. The poor quality of health services and overall health and hygiene conditions, including the quality of drinking-water, are persistent concerns. Furthermore, progress at the aggregate level masks serious disparities between population groups. Thus, the infant mortality rate is more than twice as high for the households of landless people (90 to 95 per 1000 births) as it is for those of landowners (40 per 1000 births). The disparity between slum-dwellers and other communities within the urban area is similar (129 per 1000 compared to 63 per 1000), while the overall rural–urban disparity is also revealing (103 per 1000 compared to 81 per 1000). Gender differences are prominent in the case of most of the health indicators for

Preventive care in an outreach community. There is a definite cause-and-effect link between economic conditions and health status. Photo Still Pictures/M. Edwards ©

which data are available. Child death rates are higher for girls in the age group of 1–4 years, and women have a lower life expectancy than men.

Curative health care for mothers, particularly essential obstetric care, and services for injuries and accidents for the poor in both rural and urban areas, remain inadequate. This is an issue not only of quality but quantity. In urban areas there is no public health infrastructure and in rural areas it is shrinking. In 1984, only about 20% of the treatment in rural areas for acute illness was carried out in the public sector and in 1994 the proportion had fallen to 12%.

A numerous underclass

There are controversies over how to measure poverty, but three main findings of poverty analyses are inescapable. First, the poor are not homogeneous: sharp differences exist within their ranks in terms of income, calorie intake or standard of living indicators. By the conventional criterion of income about 52% of the rural population lived in absolute poverty in 1994, and they could be divided into two distinct groups: moderately poor (29%) and extremely poor (23%). The existence of a very numerous underclass of extremely poor people is something which national policies must come to terms with, whether they are designed to improve health or reduce poverty, or both.

Second, the incidence of poverty varies significantly according to individual, household and community circumstances. Poverty is usually higher among those who possess little land and is endemic among those who earn their livelihood mainly through agricultural labour. It is concentrated in areas with underdeveloped transport and electricity services. Again, gender differences in poverty are notable. For instance, the incidence of rural poverty is about 12% higher in female-headed households than in male-headed households.

Third, there has been a decline in long-term poverty (however it is defined and measured) over the last 25 years, but the rate at which it has declined has slowed down considerably since the mid-1980s. A large contingent of the extremely poor have remained outside the trickle-down process, and economic improvements such as the expansion of roads, electricity, irrigation or new technology in agriculture, have not helped them. Even micro-credit programmes which target landless and land-poor groups have largely bypassed the extremely poor. The search for other ways of promoting growth and reducing poverty has become a policy imperative.

How poverty and health affect each other

It is hardly surprising that poverty increases the likelihood of getting sick, but this is only one (and perhaps not the most important) aspect of the connection between health and poverty. For instance, the very lack of adequate health care places the rural households at even greater risk of slipping into the downward spiral of poverty. The extremely poor households in Bangladesh currently spend between 7% and 10% of their income on health, which is a sizeable burden by any reckoning. Easing it through public health care would be a substantial step towards alleviating poverty.

Poor households are acutely vulnerable to unexpected health-related setbacks, often leading to loss of income and employment. Data from the Bangladesh Institute of Development Studies show that health-related setbacks account on average for 16 % of the causes of deterioration experienced by households during the 1990–94 period. To a large extent, health hazard-related risks explain the vulnerability of *tomorrow's* poor. While poverty alleviation programmes, usually run by NGOs, provide access to credit or training and thus help the poor to generate additional income, the net impact of such policies is often greatly reduced by the lack of an adequate insurance mechanism against health-related risks.

In order to forge a closer link between health and anti-poverty programmes what is needed is an effective combination of health action and micro-credit schemes (along with education) specifically for the extremely poor. Meanwhile institutional arrangements for the public health services leave much to be desired; for instance, there is an endemic problem of absenteeism among the doctors at rural health centres. The situation has been made worse by the poor quality of services, shortages of drugs and supplies, and poor maintenance of the facilities. Solutions that are currently on offer envisage a much greater role for NGOs and local government, with less emphasis on a bureaucratic, centrally managed public health system. ■

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Access to safe water has considerably improved in recent years in underserved areas of Bangladesh. Photo Still Pictures/J. Schytte ©