Coping with the costs of illness in slum households in Bangladesh. An empirical analysis of the relationship between income distribution and household behaviour
Desmet, M.

Citation for published version (APA):

General rights
It is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), other than for strictly personal, individual use, unless the work is under an open content license (like Creative Commons).

Disclaimer/Complaints regulations
If you believe that digital publication of certain material infringes any of your rights or (privacy) interests, please let the Library know, stating your reasons. In case of a legitimate complaint, the Library will make the material inaccessible and/or remove it from the website. Please Ask the Library: http://uba.uva.nl/en/contact, or a letter to: Library of the University of Amsterdam, Secretariat, Singel 425, 1012 WP Amsterdam, The Netherlands. You will be contacted as soon as possible.
PART I

RATIONALE AND METHODOLOGICAL ISSUES
INTRODUCTION.
RATIONALE FOR THE CHOICE OF THE SUBJECT

1.1 A focus on the linkage between poverty, health and health systems development

1.1.1 A focus on the poor and poverty reduction

"Poverty is a moral and an ethical issue. Giving poverty priority is a recognition of, and a response to, the immense suffering and injustice which ... we know could be avoided. It is recognition of the importance of reducing differences ... between people in a way that enables all people to develop and realize their full potential and to participate, and to contribute towards society" (Sköld, 1999).

Reducing poverty is a moral obligation for all those who believe that the world should be governed by social justice and policies addressing the needs of populations. Although often identified as a state of low income, poverty is multi-dimensional and can be defined in a comprehensive way as "a lack of access to and control over the social, economic and political resources to meet basic human needs with dignity, such as food, clothing, shelter, education and health care (the so-called material dimensions), and lack of opportunity or of choice, powerlessness and fear of oppression (the so-called non-material dimensions)" (ACTIONAID, 1994). Thus poverty encompasses various forms of deprivation which usually co-exist with and reinforce each other, although each form may act as an independent determinant of poverty.

Considering the situation of the urban slum population as a group corresponds to an intermediate level analysis of poverty. It emphasizes that, from a national perspective, poverty can be recognized in some sub-groups in the community that share common economic, geographic, environmental and socio-cultural characteristics. At the same time such intermediate level analysis assists in differentiating between levels of poverty within these poor communities. This is poverty conceived in absolute terms. However, these sub-groups do not live in isolation from others. Consequently, their poverty, here conceived in relative terms, may be the result of their lack of benefiting, in the same way as others, from existing social services and economic opportunities (Gunatilleke G., 1995). This observation also points to poverty as a result of macro-level policies and processes. There is the growing impact of international events, such as the debt burden and structural adjustment. More recently, globalizing trends of national economies have resulted in growing disparities among and within countries and, have created instability and socio-economic fragmentation in already fragile economic, environmental and socio-cultural entities (Oyen E. et al.). There is growing evidence that the highest burden resulting from these policies is borne by the most vulnerable in society: the poor, women and children (Harrison K., 1997; OXFAM, 1995). In this respect, special attention needs to be paid to the poorest of the poor, the so-called hard-core poor. Proper identification is required before specific programmes can address the problems of these extremely vulnerable sections of society. In conclusion, not only absolute poverty matters (a reference to an absolute standard of minimum requirements), but also relative poverty which means a “falling behind most others in the society” (UNDP, 1997). It has been noted that a lack of self-esteem is among the core characteristics of how poor people view themselves, even more than a lack of food per se (Beck T., 1989).
In order to be effective, policies and strategies aiming at reducing poverty will thus have to be alert to tackling all levels of poverty-inducing determinants. They range from (1) micro- and intermediate-level strategies, such as the establishment of credit and savings schemes, and participatory approaches to involve the poor themselves in causal analyses of their situation and in finding appropriate solutions to the problems identified, to (2) national programmes specifically targeting the poor and promoting primary education and education of women (WHO, 1995).

1.1.2 How poverty and health interrelate

A study of the 40 poorest countries in the world demonstrates how health indicators improved with reductions of poverty across different groups of countries. They moved together with other socio-economic and demographic output indicators, such as life expectancy, fertility, enrolment in primary schooling, daily calorie intake, and income (Gunatilleke, 1994). Because of these relations, it is now widely accepted that health and development are intricately related. Poverty can lead to poor health and conversely the absence of health is a major obstacle to attaining an acceptable level of well-being (which is the mirror image of poverty as we defined in the previous section). However, health may improve without significant increases in Gross Domestic Product (GDP) or per capita income, if the distribution of GDP and national wealth is more equal across the population and consistent policies ensure access over a long period of time to basic amenities, such as education and soundly organised health services. In a number of countries in the South, strategies were implemented that aimed at encouraging households and communities to participate in the management of their own uplift. Such policies not only resulted in a more equitable provision of social services, but at the same time in higher quality human capital and household capacities to deal with developmental problems. The latter included appropriate treatment and prevention of illnesses thereby reducing direct and indirect health care costs.

Programmes aiming at improving access to health care should thus be embedded in a government-led consistent and comprehensive policy of poverty reduction. Gunatilleke (Gunatilleke, 1994) notes that programmes appearing to be most successful in reducing deprivation, are those able to deal simultaneously with all the major conditions of deprivation - low income, poor health, high fertility and overall and female illiteracy, but that the path to poverty alleviation and higher well-being varies significantly among countries dependent upon their characteristics in the key development areas indicated above. He also stresses that ill-health becomes a problem of survival in households in extreme poverty. Therefore, for the hard-core poor, special attention will have to be focussed on issues of access to, use and financing of health care services in particular.

1.1.3 The role of health systems development.

The functioning of health care systems in developing countries that suffered from the severe economic crisis during the past decades, has been severely affected by reductions in government spending. Concurrently, the deteriorating public health services were paralleled by, and their few remaining resources re-channelled to, selected so-called cost-effective and therefore priority health interventions. This interference disregarded the holistic approach to health and health care organisation as social goods in the Primary Health Care (PHC) promoted by WHO and UNICEF since the 1978 Alma Ata Declaration.

Another response to shrinking budgets for the public health sector was to make populations more financially responsible for health care use. However, it has been shown that the introduction of user fees, especially of flat fees-for-service, had adverse effects on demand by the poorer sections of the population unless they were protected by exemption mechanisms (McPake B., 1993). Such exemption mechanisms simultaneously result in excluding the poor from participating in the management of health services by the people, thus reinforcing their feeling of being excluded and not respected. The adverse effects of fees
on the demand for services may nonetheless be mitigated, if revenue from fees is used to improve the quality of service delivery (Litvack J., Bodard C., 1993), or if fees are lower than what people would otherwise pay in the private sectors. One should also consider that the poor are already paying ‘unofficial fees’ to government services, or were spending money on traditional medicine, direct purchase of medicine, etc. (Abel-Smith B., Rawal P., 1992).

A greater emphasis on the own responsibility of populations for their own health and health care was a cornerstone of the Alma Ata Conference and situated within a framework of decentralised decision-making to improve on equity, accountability, and responsiveness to local needs. In many developing countries, decentralisation remains a largely political issue pressurised by lobbies with conflicting interests (Collins C., Green A., 1994). Decentralisation may exacerbate existing inequalities if the central government is unable to ensure equitable distribution of human and other resources.

The challenge for health decision-makers and health professionals in poverty eradication through health systems development is fourfold. Firstly, to actively participate in the creation of an informed, supportive and enabling environment for the pursuit of health for all. Secondly, to ensure that people are empowered to manage together their health care facilities at the community-level, irrespective of poverty/wealth status. Thirdly, to develop health systems that ensure access for all to health care through functional community-based health facilities that are linked up with referral facilities. Fourthly, to create a permanent special focus on opportunities to improve the health status of the poorest and most vulnerable groups of populations in general and to improve their access to and use of health services in particular. ‘Solidarity’ among sub-groups in society is at the root of health systems that are capable of catering equally for the needs of all, including the vulnerable, such as the poor, children and women. Fifthly, lasting health status improvements in those groups could be supported if other development sectors put poverty reduction high on their policy agendas and if a multi-disciplinary and inter-sectoral approach to poverty reduction is promoted. In conclusion, health systems development as specified here, is intended to succeed where previous efforts failed.

1.2 Growing international interest in cities and the urban poor in developing countries in general and Bangladesh in particular

In developing countries in general, and in Bangladesh in particular, attention is increasingly drawn to the problems of the urban poor. Although the development of the cities are contributing to substantial increases in economic output, there are many problems caused by the demographic explosion of the cities. These include overcrowding, with consequent extremely poor living conditions for the lowest socio-economic sections of the urban population clustered in settlements known as ‘slums’ (Urban Health Extension Project, 1993). Additionally, there is the emergence of violence, and problems faced by governments and other bodies in attempting to meet growing demands of urban dwellers for social services, such as health care. Consequently, the sustainability of urban health services is at stake. Crucial elements of sustainability concern the sources and mechanisms of financing. Of equal concern is the effect of financing on equity, which can be broadly defined as equal utilisation and access for equal need (that means, horizontal equity in utilisation), coupled with payment according to ability to pay (which is vertical equity in payment) (Gilson L., 1988; Carrin G. et al., 1993; Van Doorslaer E. et al., 1993; Gilson L., Mills A., 1995). Moreover, government revenues are more and more under strain (Abel-Smith B., 1986) and new ways for cost recovery, including user fees have been explored (World Bank, 1987; Mapeke B., 1993). The public debate in Bangladesh on a comprehensive health policy framework for urban areas, including financing sources and mechanisms, has gained momentum in the past few years. Before such policies can be developed, it is necessary to assess first the current pattern of use of and payment for health care (Gilson L., 1988; Akin et al., 1986). Research findings in many developing
countries suggest that people spend money almost exclusively on curative care. Because of the existence of externalities and the acceptance that it is better to prevent than to cure, preventive health services are delivered free of charge (leaving only transport and time cost to its users). Illness may not only result in considerable treatment costs, but also in substantial loss of household income as a consequence of the income earner's illness, expressed in travel and waiting time and days of disability or incapacity.

From a national perspective, governments allocate, particularly in urban areas, large proportions of the national health budget to curative care delivery in big (teaching) hospitals (Barnum H., Kutzin J., 1993). In Bangladesh, it is not known to what extent resources are used in a rational and equitable way. In this context, Akin et al. (Akin J. et al., 1986) state that in order to assess the demand for health care, and before establishing a programme of community-financing, one needs a clear understanding of such questions on health care seeking, as ‘who uses which type of health care, and where’.

Since the independence of Bangladesh in 1971, its rural population has received much more attention from policy makers and donors than its urban counterpart. A variety of facts and beliefs account for this situation. For instance, there is the fact that the majority of the population continues to live in rural areas (although with the recent reclassification of rural and urban areas, the urban portion has dramatically increased to about 20 to 25% of the total population (Islam N., 1995). Secondly, it is recognised that rural people have a much lower overall socio-economic and health status, and finally, it was believed that while developing the rural areas, rural-urban migration would be discouraged. Therefore, in the past 25 years, many government and non-government initiatives have been developed in all possible development domains in an attempt to uplift the lot of rural communities. In the health domain, these include the establishment of a public health infrastructure up to the first referral level (higher levels were already existing), and some initiatives to involve people in health care organisation and management, such as health insurance schemes and income generating projects to address poverty alleviation. Unfortunately, these projects and initiatives could not eradicate rural poverty, nor reverse the long existing relationships between a handful of powerful families and the majority of people living in almost total dependency on the former. In fact, over the years, the situation has worsened with more and more families becoming functionally landless and thus poorer. This prompted them to leave rural life in an attempt to find a better social and economic living in urban areas with their ever growing job opportunities. Consequently, particularly during the past decade, the cities in Bangladesh, and more specifically its capital Dhaka, have experienced an unprecedented population growth. In the future, this process is likely to continue and intensify (Mouchiraud A., 1996). Dhaka - believed to be one of the fastest growing cities in the world, with an annual crude growth rate of about 5% (Islam N., 1995) (of which about 40% is due to in-migration) -, is well underway to become by 2015 the ninth biggest city in the world with almost 20 million inhabitants (UNFPA, 1996).

For the past few years, policy-makers and concerned citizens of the country have started to pay more attention to the cities in an attempt to cope with the growth of the urban populations for which the provision of social services has difficulty keeping pace. For instance, since 1995, regular Round Tables and discussion meetings are organised by leading newspapers, non-government organisations, and teaching institutions on the management of Dhaka-City, with opinion leaders from civil society, government, and in international institutions, such as the World Bank and the Asian Development Bank. Despite this increased awareness about the situation of the cities, there is - compared to the rural areas - only scant data available on how urban dwellers cope with day-to-day problems, such as illness, and how it affects individuals, families and the (urban) society at large.

As mentioned above, in-migration - while accounting for an important portion of the urban population growth - is in the vast majority, characterised by the influx of poor peasants looking for opportunities for improvement of livelihood or survival in the cities. They settle almost invariably in areas with very poor living conditions. It is now recognized that the urban poor are among the country's worst-off in terms of health and access to basic amenities, such as health care. At the same time, there is growing concern about a possible spill-over of the effects of low health and sanitary situations in the poor
areas of the city into the city population at large. Previously considered by their better-off fellow-citizens as a nuisance for the smooth functioning of the city, the urban poor are currently increasingly considered as indispensable contributors to city-life in the informal economy (e.g. as domestic personnel) or as workers in growing industrial and commercial activities, such as the garment industry. Solving the problems of the urban poor has been recognized by the vast majority of participants to the Round Tables and meetings as one of the prime issues, if there is to be development for all in Dhaka-City, or indeed in other mega-cities in the developing world. This increasing awareness of the role of poor city dwellers in the socio-economic performance of the city coupled with the need to address the problems confronting this section of the population is by no means particular to Bangladesh. More and more national and international bodies emphasize that attention should be paid to this issue. In the words of UNFPA Executive Director Dr. Nafis Sadik: “The cities remain the centres for economic and social development. But it is also true that in developing countries some 600 million of today’s 1.7 billion urban residents do not have the means to meet their basic needs for shelter, water and health. Poverty is a direct and growing threat to the urban future” (Sadik N., 1996).

The study reported here, not only aims at providing a better insight into who uses which type of health care and where in the slum population, but also into the reasons why one type of health care is preferred above another, and into the costs of illness and how slum people cope with such costs.

It is expected that the findings of this study will feed into the current public debate on the development of a comprehensive urban health policy. It intends to shed light on health care user expenditure and health seeking behaviour in the case of illness of the largest socio-economically vulnerable sub-group in the city, namely the slum residents. Curative care responds to the direct suffering of people. This is a basis for close interaction between the sick person, his/her family and the health care provider: if carried out in an empathic, holistic and rational way, it represents a strong basis for the building of a relationship of trust between the provider and the patient and her/his family, or broader between the community and the health care system. Such a relationship would enable the health care system to (1) increase community awareness for preventive measures against future suffering, (2) effectively implement such measures, and (3) establish a system of care in which responsibilities for the patient are optimized.