Ensuring Health Services for the Ultra Poor in Bangladesh: BRAC Experience

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Health services for the poorest have remained grossly inadequate.

Bangladesh is a poor country with nearly half (48%) of the population living on the wrong side of the poverty line. The health status of the population has remained poor. The socioeconomic inequality in health has been increasing. Recent evidence shows that Bangladesh has achieved very little in reducing mortality. Only a very small proportion of poor women have access to antenatal services. The point prevalence of sickness is 7% among the working adults. Child mortality is 7.6 per 1,000 population. Nearly 95% of children suffer from malnutrition.

In addition, poor are unable to pay the costs for their health care. Less than 40% of the population has access to basic health services. The poorest and women suffer a greater burden of ill health than do the rest of the population. They are less likely to report sickness than the rich. Use of private sector services is roughly four times greater than the use of government services. Private sector usage appears to be on the increase. Overall utilisation of services by the poor remains weak.

The government policy change has promoted inequity in health.

The multilateral aid agencies such as USAID, World Bank, DFID, etc. have considerable influence in shaping national health policy in Bangladesh in terms of defining priorities and provisioning of health care. There has been a major strategic shift in the government health policy during the last decade. Such policy change has not been based on the assessment of health needs of the population. For instance, health services, previously offered at the household level, were decided to deliver at the community clinics. User fees have been introduced at government facilities. Introduction of user fees has marginalized access for the poorer sections. Health services have been integrated at the community level without considering institutional constraints. Although this has been an attractive proposition, deep-rooted differences between different cadres of personnel have posed serious constraints to adequately provide services. These policy changes have considerable negative effects on health particularly among the ultra poor.

Problems of governance in health sector have marginalized the ultra poor.

The national health system has not been transparent, accountable, sustainable and efficient to meet the needs of the population. The Ministry of Health was unable to co-ordinate all components of the project. No systematic monitoring or follow-up of the performance of projects was designed and implemented. Poor regulatory mechanisms, absence of quality assurance, weak participation of primary stakeholders, non-recognition of clients' rights and responsibilities have been identified as key challenges. Provision of free services caused considerable wastage of limited public resources. The poor paid more than others for services at public facilities.

As a result, the government services were poorly utilized. The health outlay was 4.48% of the total in 1973-78 which declined to 3.72% in 1980-85 to 3.05% in 1990-95 and 3.17% in 1997-2002. The government spending on health care constitutes only 34% of total expenditure on health at present. Private expenditure accounts for 64% and the remaining 1% is coming from NGOs.

The government health sector has huge resource gap (availability of US$ 5 against the need of $35). About 80% of the *out of pocket* expenditures are on drugs due to over the counter practices. As a result, unregulated profit driven private medicine market has been growing fast. In addition, the relations between the government and the advocacy-oriented NGOs deteriorated during recent years and the sufferings of the beneficiaries have increased accordingly.

BRAC has attempted to improve health of the ultra poor by challenging the frontiers of poverty reduction.

Ultra poor households are the most deprived segment of the population who lack even the most basic necessities, often have very little to eat, no adequate shelter, suffer from extreme malnutrition and are very prone to all forms of diseases. The conventional micro-finance and other development programs have failed to reach them because they were unable to repay their debt, often trapped in chronic food insecurity and have no asset base to protect themselves from the web of shocks.

BRAC recognizes the need of a more innovative and tailored approach to effectively reach these ultra poor households. The new program seeks to 'push down' the reach of development programs through targeting the ultra poor who are excluded from the conventional micro-finance and other development interventions. Also the program seeks to 'push out' the domain within which the existing systems and constraints operate.

The 'pushing down' strategy includes a special investment program in the form of a grant of productive assets and stipend, skill development training to use the assets and the provision of essential health care. On the other hand, the 'pushing out' strategy focuses on the policies, structures and institutions reproducing and sustaining poverty and vulnerability.

'Pushing down' strategy to make the health services available for the ultra poor

Given that the poor are not a homogenous group and that the different sub-groups have different health needs, a new delivery strategy has been developed to i) ensure that the ultra poor know about basic health care, ii) provide access to information about the services and iii) facilitate their access to these health resources. In other words, unlike a uniform health package, the services have been tailored to address the specific health needs identified by the poor. These include antenatal care, immunization, nutrition education, safe water supply, sanitary toilets, family planning, TB control and basic curative services. The services are provided by specially trained health providers. Availability of essential drugs, equipment and supplies has been ensured.

'Pushing out' approach to create enable environment to seek health care by the ultra poor

This strategy attempts to uphold the basic rights to health care of the poor by expanding the services provisions and coverage. The health programs are expanded to outreach to bring services closer to the disadvantaged such as the poor and women. Since women do not gather in particular locations regularly and their mobility is severely restricted, home-based care and mobile services have been promoted. An essential element of this strategy has been the sensitization of the community about the need of health services of the poorest in terms of raising access to basic health resources, ensuring security of their newly gained assets and helping them during emergencies.

Another dimension of pushing out strategy has been to build partnership and referral linkages with the government and other health facilities to expand the existing services. The purpose has been to ensure that the ultra poor know about the essential health care, get access to and the adequate use of health services and

ensure that they receive free or subsidized health services. Since cost is one of the main barriers to the use of health services, a mechanism to provide financial assistance in cases of medical emergencies is established.

In conclusion

Bangladesh will continue to face a formidable challenge in improving health of the poor. It is, therefore, important to recognize the varied health need of the poor, and tailor both the health and social development interventions to match the specific livelihood strategies of different households. Experience suggests that the health needs as well as the health outcomes vary even among the ultra poor population. The current approach also needs to be flexible enough to adopt in changing context. Such specially targeted health interventions for the poor are likely to significantly improve the health status of the poor in Bangladesh.