BHEW

Equity Dialogue

CENTRE FOR HEALTH AND POPULATION RESEARCH

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In this issue:

KNOWLEDGE BASE

Aristotle's Duality
Horizontal equity- requires that individuals having the same need ought to be treated equally.
Vertical equity- grants individuals with greater needs a greater claim on resources.

QUOTATION

Poverty is the worst form of violence.
Mahatma Gandhi

Educating the poor in rural Bangladesh
Photograph by: Asem Ansari

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Inequalities in health: Evidence from the Bangladesh household income and expenditure survey 2000

Simeen Mahmud, Bangladesh Institute of Development Studies.

In the last decade the national averages of mortality, morbidity, nutrition and life expectancy have improved considerably in Bangladesh. However, disparities in access to health care services and health as an outcome exist among different socioeconomic groups.

The analysis presented here has used a nationally representative sample of the household income and expenditure survey (HIES) of 2000 conducted by the Bangladesh Bureau of Statistics. The analysis examines the importance of factors such as location of residence (rural/urban), gender and household socioeconomic status (indicated by head's wife's educational level) as determinants of health and health seeking behaviour. The bivariate distributions of health and health seeking behaviour, as dependent variables, were examined in relation to a few selected explanatory variables. The details of the dependent variables included are:

Indicators of health as an outcome:

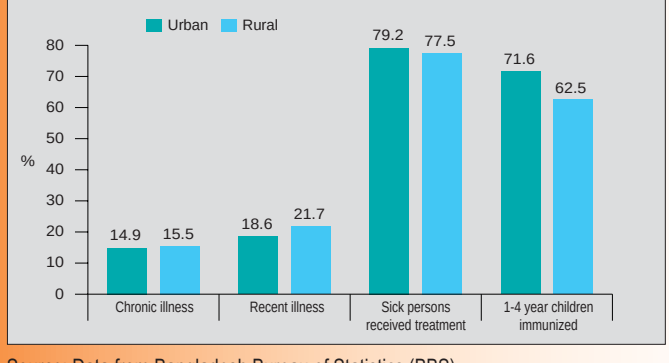
1. Percentage of households with family members sick with chronic illness.
2. Percentage of households with family members sick with a recent (in the last 30 days) illness.

Health seeking behaviour:

1. Percentage of households with sick family members who have sought treatment from any public/government or private facility.
2. Percentage of households with children 1-4 years of age who have been immunized with 8 doses.

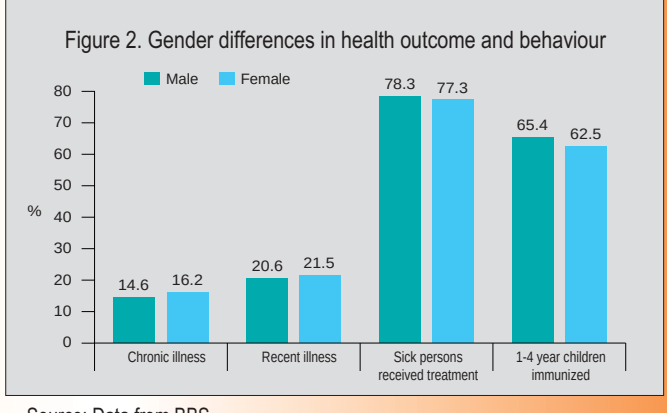
Health status of the population is poorer in rural compared to urban areas in terms of prevalence of both chronic and recent illnesses (Fig. 1). The difference is more pronounced for recent illnesses. Health seeking behaviour also varies by area of residence. Rural children are less likely to be immunized and the sick living in rural areas are less likely to receive treatment when ill. The urban rural gap is more evident for immunization. And for all indicators, both health status and health seeking behavior, there is a visible gender difference in favour of males (Fig. 2), but it is interesting to note that the gender difference in health status is less for rural than urban areas (Fig. 3). Gender difference in health seeking behaviour is more in rural areas than urban areas (Fig. 4).

Figure 1. Health status and behaviour by area of residence



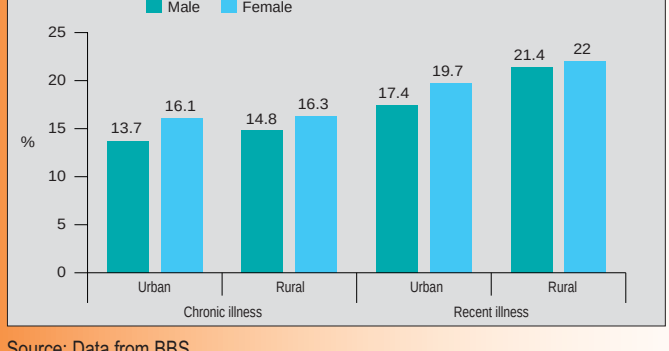
Source: Data from Bangladesh Bureau of Statistics (BBS)

Figure 2. Gender differences in health outcome and behaviour



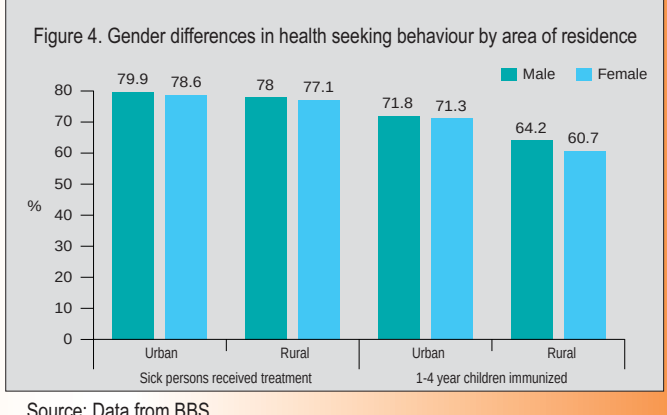
Source: Data from BBS

Figure 3. Gender differences in health status by area of residence



Source: Data from BBS

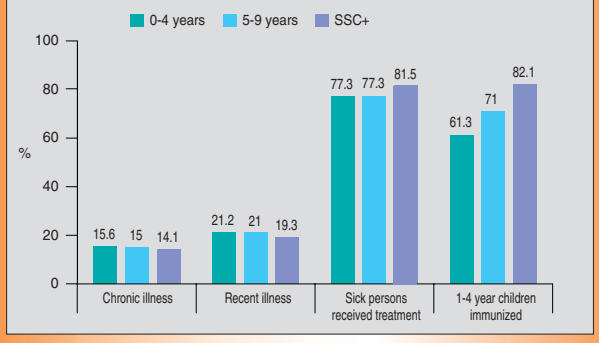
Figure 4. Gender differences in health seeking behaviour by area of residence



Source: Data from BBS

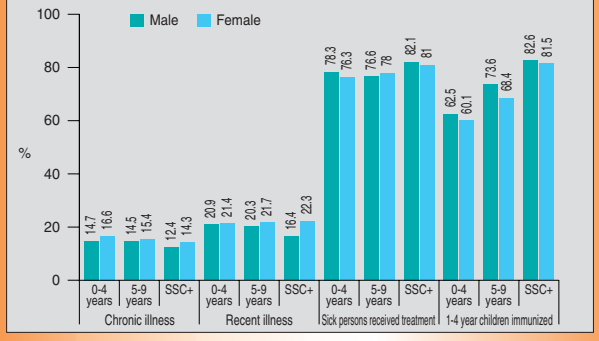
The probability of suffering a chronic or recent illness has an inverse relationship with head's wife's education (Fig. 5). Also, the probability of the sick receiving treatment when ill and children 1-4 years of age being immunized is more with the extent of head's wife's schooling level (Fig. 5). The difference, however, is visible when SSC or higher schooling level is attained.

Figure 5. Health status and behaviour by head's wife's education



Source: Data from BBS

Figure 6. Gender differences in health status and behaviour by head's wife's of schooling level



Source: Data from BBS

As before, the gender difference remains irrespective of head's wife's schooling level (Fig. 6). The only exception was in the group of 5-9 years of schooling where the females were more likely to receive treatment than their male counterparts. An interesting finding is that the gender gap increased and females suffered more with higher levels of education for recent illnesses. In households where the wife's schooling was for 5-9 years, fewer males received treatment for illnesses compared to the group where the wife's schooling was for 0-4 years. ■

Evaluating the poverty impact of economic policies: Some analytical challenges

F. Bourguignon, L. Pereira da Silva and N. Stern
2002, Washington DC, World Bank

Abstract:
Where redistribution and anti poverty policies consist of cash transfers allocated according to some pre-specified rules, evaluating their impact on the distribution of living standards and poverty might seem straightforward. It seems sufficient to apply the transfer rules to some representative sample of households. This is the essence of 'incidence analysis' and micro-simulation techniques used in many countries. In practice, however, things are not so easy. There are various reasons for this: a) cash transfers are likely to modify behaviour, which in turn can generate economy wide changes through general equilibrium effects; b) in most developing countries, transfers are made only indirectly, through public spending or indirect taxation, with allocation rules which are often far from transparent and may themselves depend on behaviour; and c) implementation may be partial or distorted. More fundamentally, poverty reduction policies often go through both macro-economic and structural instruments aimed at enhancing economic activity and growth. The actual change in individuals' standard of living generated by these instruments is not easy to work out because of the fundamental difficulty of establishing satisfactory linkages between micro and macro analysis, whether the latter refers to aggregate demand, medium-run growth or general equilibrium in a somewhat disaggregated framework. This paper reviews the various tools presently available to evaluate the impact of economic policies in general on poverty reduction, or on the distribution of living standards, and explores directions of improvement. It is organized around the common thread of 'incidence analysis'. But this basic micro-economic evaluation tool is used in different contexts and in different ways so as to accommodate a wide range of policies with some potential impact on poverty. ■

Bangladesh Health Economics Conference

Bangladesh Health Economics Conference was held on 3-4 December 2003 at BIAM Auditorium, Dhaka. The conference was hosted by the Institute of Health Economics, University of Dhaka and sponsored by the British Government's Department for International Development (DfID). A large number of distinguished personalities, experts, academicians, scholars and managers participated in the conference.

The conference comprised of four themed sessions including an overview session. The main issues discussed were concepts and methods, performance at the health system level and performance at the service level. The theme of the conference was very appropriate and highlights the fact that, at present, the main task of the health sector is to improve performance. The health sector in Bangladesh has achieved commendable progress and has entered into the second phase of development, where the main focus is to improve performance and increase coverage of hard to reach segments of the population. The discussants emphasized important issues of improving economic efficiency, enhancing equity and reducing poverty through improved health. The financing gap was identified as a major obstacle and the recommendation was to develop non-traditional methods of financing. It was suggested that the financial burden of health care expenditure should be equitably distributed and fairness of public health measures should be ensured. In the overview session, areas in which considerable improvements were achieved and also, areas that require significant improvements in performance have been identified. Measures to be adopted for improvement of the sector have also been suggested. ■

A case history

This issue and subsequent issues present narratives of people who have experienced poverty and are deprived of basic human needs. These stories are reflections of tragic consequences or maybe encouraging accounts of poverty. The purpose behind the stories is to promote a better perception of the many dimensions of poverty and the problems associated with it. We hope that these stories may provide insights into the different problems of impoverishment, which may help to highlight relevant practices and policies that might help the poor.

Poverty and ill health

Poverty is a major barrier in reducing maternal mortality. The following is a story of one of the 16 maternal deaths that occurred in Chakaria, a field site of ICDDR,B, in 2002-04. The name of the woman was changed to maintain anonymity.

Begum was an eighteen year old who lived in a village in Chakaria. Her father, a day labourer without any cultivable land of his own, could hardly support his family of six. Begum's father agreed to the marriage of his daughter to a rickshaw puller aged 35 years, who had come to settle in their village about a year and a half ago. If Begum were to marry a local villager her father would have had to pay a heavy dowry. Under these circumstances he agreed to give his daughter's hand to a person he hardly knew.

Four months into her marriage, Begum became pregnant, but in two months she lost the baby. She became pregnant again in two months time. During her pregnancy she had problems eating because of excessive vomiting. Her husband brought her medicine from a pharmacy in a nearby town. Begum developed edema in the fifth month of her pregnancy. Her husband consulted the village doctor again and brought medicine for her. Subsequently, her husband left her without informing anybody. Without her husband's support she struggled through economic hardship and had great difficulty obtaining adequate food. Her health deteriorated and her edema became severe. Her parents took her to the traditional healer who treated her with amulets, spiritual water and oil. For this they spent about 210 Taka (around USD 4). As her condition failed to improve, she was treated with homeopath medicine. Still her health kept on deteriorating and a month before her delivery she had serious problems urinating. Her mother consulted the village doctor whose treatment did not help her. In due time she went into labour and suffered for a whole day to deliver a stillborn baby boy with the assistance of a traditional birth attendant. Her placenta was manually extracted, the delivery was complicated by severe bleeding and subsequent fever. The day after her delivery the village doctor

to deliver a stillborn baby boy with the assistance of a traditional birth attendant. Her placenta was manually extracted, the delivery was complicated by severe bleeding and subsequent fever. The day after her delivery the village doctor prescribed some medicine as she was severely anaemic and advised a blood transfusion. Over the next two days her condition worsened and the village doctor gave her two injections on the second day. She felt a bit better but only for a short while. Late in the evening she started to have breathing problems. Her mother gave her the medicine that the doctor had prescribed. Finally, that night she passed away.

The reasons for Begum's untimely death as identified by her mother and neighbours: As Begum's parents were unable to pay for her dowry she was married to a virtual stranger. Her husband abandoned her when she was in need. As she did not get any proper treatment because of poverty and lack of knowledge, her life came to a tragic end. ■

Child health on a dollar a day: Some tentative cross-country comparisons

Wagstaff A

Soc Sci Med 2003, 57: 1529-1538

Abstract:

Children living on a dollar a day- the international extreme poverty line appear to have radically different chances of dying in childhood and being malnourished, depending on the country in which they live. In Kazakhstan, a child living on a dollar a day, has only a 10% risk of being underweight, while the risk facing a child living on a dollar a day in India is nearly 60%. The Kazakh child has a risk of less than 40 per 1000 of dying before his first birthday, while a child living on a dollar a day in Niger faces a risk of nearly 160 per 1000. Countries where mortality and malnutrition risks at a dollar a day are high are not typically those where there are large gaps in child survival and malnutrition between the poor and the better-off. The two concepts of inequality and health risks at the poverty line are not only conceptually distinct- they are empirically distinct too. The large differences between countries in the risks of mortality and malnutrition in childhood beg the obvious question- what accounts for these differences? Some regression results presented in the paper suggest that these differences may be due to differences across countries in levels of per capita public spending on the health sector. Regressions find that higher levels of per capita public spending on the health sector are associated with significantly lower levels of mortality and malnutrition amongst children living on a dollar a day. ■

The Equity Dialogue is a joint initiative of the Bangladesh Health Equity Watch and the Poverty and Health Programme of ICDDR,B. Bangladesh Health Equity Watch is a collaborative initiative of four organizations that share a common concern for equitable health and development in Bangladesh. The organizations are the Bangladesh Bureau of Statistics (BBS), Bangladesh Institute of Development Studies (BIDS), BRAC and ICDDR,B. The Rockefeller Foundation currently funds the project. The goal of the Poverty and Health Programme of ICDDR,B is to generate relevant knowledge to improve the health of the poor to reduce poverty. The project is presently being funded by the Department for International Development (DfID).

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