Access to health services by informal sector workers in Bangladesh

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Abstract

According to the constitution of Bangladesh, health is a right and, in 2012, initial work towards universal health coverage was marked by introduction of a health-care financing strategy. However, for 2016, Bangladesh's domestic general government health expenditure was only 0.42% of gross domestic product, making it one of the lowest-spending countries in the world, with 72% of current health expenditure coming from out-of-pocket spending. One factor that is key to the challenge of providing universal health coverage in Bangladesh is the large proportion of the population who work in the informal sector – an estimated 51.7 million people or 85.1% of the labour force in 2017. Most workers engaged in the informal sector lack job security, social benefits and legal protection. The evidence base on the health needs and health-seeking behaviours of this large population is sparse. The government has recognized that increased efforts are needed to ensure that the country's notable successes in improving maternal, neonatal and child health need to be expanded to cover the full range of health services to the whole population, and specifically the more marginalized and impoverished sectors of society. In addition to the universal need to increase funding and to improve the availability and quality of primary health care, workers in the informal sector need to be targeted through an explicit mechanism, with enhanced budgetary allocation to health facilities serving these communities. Importantly, there is a clear need to build an evidence base to inform policies that seek to ensure that informal sector workers have greater access to quality health services.

Keywords: Bangladesh, health financing, informal workers, quality, universal health coverage

Background

Since independence in 1971, Bangladesh has had notable successes in health, despite significant challenges. As a "good health at low cost" exemplar, Bangladesh has used a number of innovative approaches and achieved significant improvements, notably in lowering the total fertility rate and the rates of infant and under-5 mortality.[1] However, progress has been uneven in recent years. According to the most recent analysis of progress on universal health coverage and the health-related Sustainable Development Goals[2] in the World Health Organization (WHO) South-East Asia Region, only half of its population is covered by essential health services, while the average for countries in the region is 64%.[3] This low coverage exists despite a large network of health facilities throughout the country.

Health planning in Bangladesh

Between 2016 and 2017, the government revised its essential health service package (ESP) to expand the scope of services to include noncommunicable diseases and to focus on strengthening provision at the district level. The ESP is part of the Strategic Investment Plan[4] of the Fourth Five-Year Health Sector Programme, which is being implemented between January 2017 and June 2022. The goal to roll out an expanded ESP package for all is challenging, since the *Bangladesh Demographic and Health Survey 2017–2018* showed very wide variations in coverage both by type of service – from only 2.2% coverage for female sterilization to 82.5% for BCG vaccination – and by delivery channel, with an estimated weighted average of 20.4% coverage in the public sector.[5] According to the constitution of Bangladesh, health is a right. However, public investment is yet to match the constitutional commitment: for 2016, Bangladesh's domestic general government health expenditure was only 0.42% of gross domestic product (GDP), making it one of the lowest-spending countries in the world, with 72% of current health expenditure coming from out-of-pocket spending.[6]

Informal employment and associated health costs in Bangladesh

As with all low- and middle-income countries, employment in Bangladesh is largely informal. Although definitions of informal employment differ, it is generally recognized as being an unregistered, unincorporated (i.e. not a separate legal entity from the owner) activity that involves selling at least some of the goods or services produced.[7]

The Fourth Five-Year Health Sector Programme explicitly recognizes the need to expand existing services to groups that are currently underserved;[4] however, the evidence as to who is actually covered by health services and who is left behind is sparse. The national health management information system only captures data from the public sector at an aggregated level. Therefore, the extent to which workers in the informal sector are covered with health services is largely unknown; yet this large group of 51.7 million people constitutes 85.1% of the labour force.[8] The sectoral distribution of this group is 97.9% in the agricultural sector, 90% in the industry sector and 70.6% in the service sector. Their profile is mixed, ranging from daily labourers, piece-rate workers, farmers, self-employed persons and others. Most workers engaged in the informal sector lack the benefits of secure contracts, social benefits and legal protection. This group is more likely to have a hazardous working environment; to be more exposed to exploitation and loss of income when ill; and thus to be less likely to seek formal health services and instead resort to informal health providers or self-medication through pharmacies and drug sellers.

Although the informal sector contributes the most to the economy of Bangladesh, the workers in this sector have hardly any financial protection. A study among three occupational groups of informal workers – rickshaw pullers, shopkeepers and restaurant workers – revealed that 57% had experienced an episode of illness in the previous 6 months that led to considerable direct and indirect costs.[9] The average health expenditure incurred for their treatment accounted for 8.9% of their annual income, while income loss for the periods of absence from work due to illness during the study period accounted for 28.5% of their overall income – i.e. a total loss of 37.4% of their overall income.

In a community-based cross-sectional study of rural households in Bangladesh, there was some evidence to suggest that patients engaged in agricultural or daily labour occupations were more likely to seek treatment from informal providers or paramedics (e.g. village doctors, medical assistants and community health workers), while patients engaged in the service sector were more likely to seek treatment from qualified health professionals.[10]

With respect to urban informal sector workers, a study on the health-care-seeking behaviour of street dwellers in Dhaka city showed only 11% used government health facilities, with pharmacies and drug sellers being the preferred point of contact for those seeking health care.[11] The female street dwellers were mainly domestic helpers, pickers and sellers, day labourers and sex workers, with 48% unemployed. The male street dwellers were day labourers and rickshaw/van pullers. Among the reasons for not seeking care, street dwellers of both sexes cited lack of money as the main reason, while men also considered that treatment was not necessary. Other reasons included lack of knowledge about the location of health facilities and neglect of service providers.[10]

A household survey demonstrated a similar pattern among 3000 slum dwellers in Dhaka City, who were mainly employed in the informal sector. Almost 70% used pharmacies or drug stores as their main source of health care. About 33% had used allopathic health facilities, of which only 14% were government services.[12] This is in line with the high share of spending on medicines and medical goods (through pharmacies) in the country, which accounts for almost half of the total (public and private) health spending, at 43.3%.[13]

The way forward

As Bangladesh seeks to contribute to the global commitment of “health for all”, and improve the health of its population, more inclusive policies are needed to ensure workers in the informal sector are not left behind. To this end, there is need to:

- Target informal sector workers through an explicit mechanism that ensures they benefit from the ESP as a set of priority interventions. Geographical targeting could be introduced, seeking to reach informal workers in the poorest areas, through enhanced budgetary allocation to health facilities in those areas. Moreover, demand-side financing is another option to incentivize the uptake of services by this population group.
- Improve the evidence base to inform policies that seek to ensure workers in the informal sector have greater access to quality health services. This should be achieved by supporting enhancements of the routine information and population-based systems to better capture data from both the public and private sectors, which are disaggregated by income, gender, geography, etc., while assisting capacity-development to analyse, interpret and disseminate evidence generated through these systems. At the same time, it is important to ensure regular mechanisms to review the evidence base and monitor courses of action and policies, for instance, through a sector-wide approach.
- In view of rapid urbanization, strengthen the primary health-care delivery system for populations in urban and slum areas, to address the health problems of this vulnerable and marginalized group.

Targeting of the informal workforce in Bangladesh needs to be done in concert with overall strengthening of health-care delivery to the whole population. To that end, there is a clear need to increase the government budget allocation to the health sector. As noted previously, with less than 1% of GDP spent on health by the government, Bangladesh is among the countries that spend least on health. Whether this will be pursued through an increased tax base or through a larger share of the budget for health, the bottom line is that health needs more public investment. In addition, there is a recognized need to increase the number of qualified health-care providers posted to lower-level health facilities, prioritizing quality in front-line services. More mid-level cadres such as nurses should be trained (with improved quality standards for their education as well) and posts created to absorb them at union and community levels.

Finally, as noted explicitly in the Fourth Five-Year Health Sector Programme,[4] there is a need to enhance the quality of services provided. This should include the quality of clinical services, which needs to closely adhere to evidence-based practices, with supervision and monitoring systems introduced, particularly for front-line services. It is important to ensure regular supplies of medicines in public facilities and to improve rational prescribing and use, which would contribute to both quality objectives and reducing out-of-pocket spending. In parallel, improved responsiveness of health workers and facilities in line with a people-centred approach to services is needed.

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