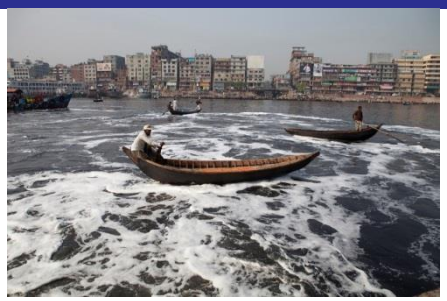
ESTIMATING BANGLADESH URBAN HEALTHCARE EXPENDITURE UNDER THE SYSTEM OF HEALTH ACCOUNTS (SHA) 2011 FRAMEWORK



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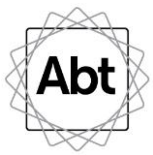
Top Right: Rokeya Begum (32) runs a small grocery shop in Bangladesh to contribute income to her family alongside her rickshaw puller husband.

Bottom Right: Men pilot boats on the polluted Buriganga River in Dhaka, Bangladesh.



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We would like to thank all members Bangladesh National Health Accounts (BNHA) Cell, specifically Mr. Ashadul Islam, Director General (Additional Secretary) of the Health Economics Unit and Team Leader BNHA Cell and Tahmina Begum, World Bank consultant, who provided critical contributions to this analysis. As well, we thank Mursaleena Islam, Yann Derriennic, and Tesfaye Ashagari of HFG for their technical inputs. Aasit Nanavati of HFG provided production support.

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1. BACKGROUND AND METHODOLOGY

1.1 Background

Bangladesh is a densely populated country with 23 % people residing in urban areas[1] and with a 3.5% annual growth of urban population[2]. Bangladesh Bureau of Statistics divided into seven administrative divisions: Barisal, Chittagong, Dhaka, Khulna, Rajshahi, Rangpur, and Sylhet. Each division is divided into zilas, and each zila into upazilas. Each urban area in an upazila is divided into wards, which are further subdivided into mohallas. A rural area in an upazila is divided into union parishads (UPs) and, within UPs, into mouzas. The people who are living in wards were considered as urban population and the Ups' population was considered as rural.[3] However, the division between urban and rural health care is not so distinct and it is difficult to create an urban and rural demarcation of health expenditure. According to BDHS 2014, the urban population has more access to facility delivery, qualified doctors and less unmet need for contraception. This raises the question whether there is more health expenditure by urban population than the rural.

This study aims to estimate the health expenditures of the urban population in terms of provider, financing agents and functions by analyzing the data of National health account[4], which will eventually give a specific direction to identify the gaps and way of addressing those issues.

1.2 National Health Accounts (NHA)

National Health Accounts (NHA) presents the expenditure flows – both public and private – within the health sector of a country. They describe, in an integrated way, the sources, uses and channels for all funds utilized in the whole health system. NHA shows the amount of funds provided by major financing agents (e.g. government, firms, households), and how these funds are used in the provision of final services, organized according to the institutional entities providing the services (e.g. hospitals, outpatient clinics, pharmacies, traditional medicine providers) and types of service (e.g. inpatient and outpatient care, dental services, medical research, etc.).

Bangladesh National Health Accounts (BNHA) tracks the total health expenditure in Bangladesh between the fiscal years 1997 to 2012, cross-stratified and categorized by financing, provision and consumption on an annual basis. Adoption of SHA 2011 introduces two new classifications in the financing dimension that provide more specific answers to the questions: "what instruments are used for fund raising?" and "how the health resources are managed?" This new classification offers better interpretation of public and private funding in the health care sector.

A useful application of NHA methodology and data sets is to investigate health expenditure patterns for different target groups (e.g. child accounts) or by location (e.g. administrative division). This study is aimed at tracking urban health expenditure for Bangladesh. The urban population is growing at a higher pace than the national average, and many non-urban (rural) patients are seeking healthcare (particularly tertiary care) services from urban facilities. An overall assessment of urban health outlay based on NHA-defined dimensions can be of significance in urban health sector planning and policy formulation. A relative comparison with rural health outlays also has strong policy implications.

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[1] According to the Bangladesh Bureau of Statistics, Population & Housing Census-2011 (National Volume 3), urban population is estimated around 23% (Table 2.1). Share of urban population increases to around 28% if the population of Statistical Metropolitan Area (SMA) are considered as urban population.

[2] World Bank Data Bank, 2015

[3] Bangladesh Demographic and Health Survey, 2014

[4] Ministry of Health and Family Welfare. Bangladesh National Health Accounts 1997-2012. Research Paper no.42a, Dhaka: Health Economics Unit, Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh, March 2015

1.3 BNHA Framework

The Bangladesh National Health Accounts (BNHA) framework has been built following Organization of Economic Co-operation and Development (OECD) A System of Health Accounts 2011 (SHA 2011) and World Health Organization (WHO) led work on a National Health Accounts Producer Guide. Definitions and classification used under BNHA are identical that of SHA 2011. However, to accommodate the national institutional structure and for policy relevance, sub-groups within a broader group of NHA have been created under BNHA. For example, "General Hospital" under SHA 2011 provider classification is sub-grouped into "Medical College Hospital", District Hospital" and "Upazila Hospital". The analysis used the Total Health Expenditure[5] as a basis for the report. However, the tables in the annex provide the "current health expenditure" and "capital health expenditure" separately and provide the aggregates accordingly- in line with the SHA 2011 framework.

1.4 BNHA Analysis

Under the fourth round of Bangladesh National Health Accounts (BNHA) effort, health expenditure estimates by Provider, Function and Financing classification were completed (Bangladesh National Health Accounts Report, 1997-2012) by the BNHA cell of the Health Economics Unit (HEU) under the Ministry of Health and Family Welfare (MOHFW). The System of Health Accounts (SHA) 2011 served as the key technical guideline for production of BNHA and extensively used for analysis of public and private sector expenditures. For analysis of the public sector expenditure data, the BNHA cell relied on the audited government data provided by the Controller General of Accounts (CGA). Private healthcare expenditure was estimated using various national level estimates following OECD private expenditure guidelines and Annex D of the WHO NHA Producers Guide. The latter document is designed to address special applications for low-income and middle-income countries.

As a first step of the analysis, the BNHA cell identified all the providers. Once the provider identity was established, functions of the providers was determined and classified accordingly. In cases where providers (e.g. hospitals) are engaged in multiple functions, secondary data on the provider is used in reallocating expenditure by functions. For example, breakdown of hospital expenditure by functions is calculated using ratios generated from an Asian Development Bank (ADB) funded "Bangladesh Facility Efficiency Survey 2011". The facility efficiency study was specifically designed to capture expenditure by inpatient, outpatient and other activities. In summary, the BNHA estimates have been derived based on the guidelines and data sets cited, and the experience of the preceding rounds of Bangladesh National Health Accounts.

1.5 Urban Health Expenditure

The urban analysis of BNHA data has created an additional dimension 'location/residence' based on beneficiary characteristics. Accordingly, expenditures are allocated per these characteristics within established BNHA categories of function, provider or financing. In summary, the scope of urban healthcare analysis is limited to tracking of urban health expenditure within the classification[6] established under the Bangladesh National Health Accounts, 1997 -2012.

Urban health expenditure is defined as the expenditure of the urban population on health and not by the healthcare services provided from an urban location. For example, expenditure reported by Dhaka Medical Collage Hospital (DMCH) is treated as health expenditure reported from a hospital where a mix of urban and rural population is treated. For allocating expenditure of DMCH by urban and rural, expenditure reported by the urban and rural households on hospital services is calculated using secondary data explained in the following section. The urban health expenditure has been estimated within the context of BNHA framework.

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[5] Current expenditure on healthcare measures "final consumption expenditure of resident units on health care goods and services." Gross Capital formation – "measuring assets that providers of health services have acquired during the accounting period (less the value of the disposals of assets of the same type) and that are used repeatedly or for more than one year in the provision of health services". Research and development as well as education and training are tracked under capital account as related items.

[6] One can argue this as a limitation as the SHA 2011 guideline recommends the use of minimum classification but duel coding system used in the BNHA allowed preserving additional detailed information on provider and function.

1.6 Tracking Urban Expenditures

An overwhelming majority of health facilities, especially those offering inpatient and specialized care are geographically located in urban areas. Rural area health facilities are dominated by public upazila health complexes and union health centers. Outpatient service providers include formally and informally trained allopathic and non-allopathic (e.g. homeopathic, ayurvedic) private health practitioners, retail drug outlets (pharmacies), medical and diagnostic laboratories. Such types of services are available in both urban and rural setting. The actual or perceived quality and range of services offered and their respective relative prices can be significantly different between cities, towns and upazilas. Health awareness programs offered by the government and NGOs are implemented in both urban and rural locations.

To reach a consensus on boundaries for urban health accounts two factors should be considered: (i) Boundaries should be relevant from policy perspective; and (ii) it adheres to National Health Accounts (NHA) framework.

1.7 Limitation of the Study

The current analysis made the permanent residency of beneficiaries as the basis of delineating whether the associated expenditure is urban or rural. More specifically, expenditures incurred or revenues generated from serving the urban and vis-à-vis rural population are not systematically recorded and therefore could not be estimated from facility or provider level data sets.

1.8 Ways to Overcome the Limitations

To address the issue of tracking healthcare expenditure of urban and non-urban population, several assumptions were applied to the data sets used in producing the Bangladesh National Health Accounts (BNHA) estimates. Expenditure reported in the BNHA data set can be classified into three categories based on the target group of population it is catering to: (i) exclusively urban population; (ii) exclusively rural population; and (iii) a mix of urban and rural population. The following steps were followed in tracking and categorizing expenditure by urban and rural:

i. If a healthcare service or facility is identified as serving exclusively or predominantly urban population then expenditure of such service by facility is booked as urban expenditure

   a. Health care expenditure of the government as well as the private sector designed specifically to serve the needs of the urban population area being treated as urban health expenditure. For example, government or NGO programs on urban primary health care are classified as a health outlay exclusively used by the urban population.

   b. Health care services provided to the readymade garments workers in Dhaka, Chittagong and Khulna city by the Bangladesh Garments Manufacturers Exporter Associations (BGMEA) is identified and categorized as an urban health care expenditure. Concurrently, all expenditures relating to government healthcare facilities situated at the Upazila level or below are treated as rural health care expenditures.

ii. If a healthcare service or facility is identified as serving exclusively or predominantly rural population then that expenditure is booked as rural expenditure.

   a. A functional definition of rural public or private facility is defined as "healthcare service or facility at the Upazila and below[7]." Under the urban health expenditure tracking, use of this definition is limited to public health facilities. Due to data limitations, this definition could not be applied to the analysis of private sector data, and therefore has been included under the third category.

[7] Upazila is a sub-district and below means facilities at the union level. Union is the lowest administrative tier in Bangladesh.

iii. Expenditure that cannot be classified exclusively as urban or rural, then such expenditure is categorized as mix of urban and rural. For example, beneficiary of a tertiary level hospital[8] can either be an urban resident or a rural household.

   a. Knowledge on utilization rate by the urban and rural population will be required for estimating their respective shares. The only data set under BNHA that can serve as a proxy for urban-rural utilization of selected health services is the Bangladesh Bureau of Statistics' (BBS) Household Income Expenditure Survey (HIES), 2010. HIES 2010 is a nationally representative household survey which includes a health segment or module. This module allows estimating household out-of-pocket (OOP) expenditure on health by urban and rural population. Information on morbidity, factors affecting their selection of health service provider by location, and their expenditure on health were posited.

   b. For redistributing health expenditure by urban and rural of those which could not be identified as either predominantly urban or rural, ratio of expenditure by health providers were calculated[9] using HIES 2010. Dissimilarity in expenditure due to location (division) is also considered in calculating the ratios. According to BNHA, four types of provider: (i) Hospitals (30%); (ii) Ambulatory health care by doctors (15%); (iii) Ancillary services by diagnostic facilities (5%); (iv) Retailers of medical goods (41%) accounts for 91% of Total Health Expenditure (THE). In this context, expenditure ratio by urban and rural for the four major providers was calculated by division from the HIES 2010 data. These ratios are subsequently used as distribution keys for allocating expenditure by urban and rural categories.

   c. Outlays not covered by the four groups are lumped as residual expenditure. For example, general administrative cost of the health ministry's secretariat. For reallocating of the expenditure of the residual category by urban and rural, overall expenditure ratio calculated from HIES 2010 is used as the distribution key.

A distribution key for allocating BNHA expenditure by urban and rural population is presented in Table 1. For estimating healthcare expenditure by the urban population, percentage share reported by location and type of services is multiplied with total expenditure reported by that particular type of service. For example, according to Table 1 the share of urban population pharmaceutical expenditure is 19% of total pharmaceuticals outlay for that division. Accordingly, to derive the urban pharmaceuticals outlay, the total expenditure is multiplied by the coefficient or weight of 0.19 (19%).

Table 1: Distribution Key for Allocating BNHA Expenditure by Urban and Rural Population

Function	Operation	Office	Legal	Operation description	Urban	Rural
Government programs targeting urban population						
2701	7150	01	5	Blank OR (Better Sexual and Reproductive Health for Young People for Urban and Peri-urban Areas of Bangladesh	100%	
2701	7151	01	5	Better Sexual and Reproductive Health for Young People for Urban and Peri-urban Areas of Bangladesh (01/04/2003-31/03/2006) Approved	100%	
2703	8005	22	5	Urban Health Services	100%	
2776	0000	01	3	Urban Dispensary (34)	100%	
2776	0000	21	3	Urban Dispensary (34)	100%	

[8] The data sets used under BNHA for estimating expenditure from the provider perspective (e.g. hospitals, diagnostic facilities) or by type of service or function (e.g. inpatient curative care, pharmaceuticals) does not include urban-rural breakdown.

[9] Annual health expenditure captured in HIES 2010 questionnaire on health, Section 9, variable 390 to 423 are considered for estimating health expenditure.

Function	Operation	Office	Legal	Operation description	Urban	Rural
2776	0000	22	3	Urban Dispensary (34)	100%	
3701	5040	21	5	Strengthening Reproductive Health Services for the Urban Poor (01/07/03-31/12/05) Approved	100%	
3701	5470	01	5	Urban primary health care	100%	
3701	6010	01	5	Second Urban Primary Health cate Project (Phase II)	100%	
3701	6010	22	5	Second Urban Primary Health cate Project (Phase II)	100%	
3701	6040	01	5	Preparing the Urban Health Care Sector Development Programs (01/03/2008-31/12/2008)	100%	
3701	7479	01	5	Urban Public Environment Health Development Programs	100%	
3705	5470	01	5	Urban primary health care	100%	
2705	3580	21	3	Center for Integrated Rural Development		100%
2901	5140	01	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2901	5140	02	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2901	5140	21	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2901	5140	22	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2931	5140	01	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2931	5140	02	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2931	5140	21	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
2931	5140	22	5	Strengthening population activities through rural mother care centers (Phase-5)		100%
3741	5930	01	5	Rural health development project (Phase-3)		100%
3741	5930	02	5	Rural health development project (Phase-3)		100%
3741	5930	21	5	Rural health development project (Phase-3)		100%
3741	5930	22	5	Rural health development project (Phase-3)		100%
3805	5730	01	5	Family welfare education and motivation through rural Co-operatives and family planning services project (Phase-3)		100%
3805	8095	01	5	Advocacy on Reproductive Health and Gender Issues Through Rural Co-Operatives (01/01/2003-31/12/2005)		100%
Healthcare services provided at the upazila and below by the government facility						100%

Health expenditure reported by the following are also treated as expenditure made for the urban population:		
	Urban	Rural
Autonomous bodies healthcare services	100%	
Bangladesh Garments Manufacturers Exporter Association health expenditure	100%	
Healthcare services provided by City Corporation and Municipalities	100%	
Healthcare services provided by Business Enterprise	100%	
Health insurance services availed from the private insurance company	100%	
Providers serving both urban and rural:		
Retailers of medical goods in Barisal Division	19%	81%
Retailers of medical goods in Chittagong Division	25%	75%
Retailers of medical goods in Dhaka Division	56%	44%
Retailers of medical goods in Khulna Division	28%	72%
Retailers of medical goods in Rajshahi Division	18%	82%
Retailers of medical goods in Rangpur Division	19%	81%
Retailers of medical goods in Sylhet Division	17%	83%
Hospitals in Barisal Division	28%	72%
Hospitals in Chittagong Division	32%	68%
Hospitals in Dhaka Division	44%	56%
Hospitals in Khulna Division	18%	82%
Hospitals in Rajshahi Division	16%	84%
Hospitals in Rangpur Division	49%	51%
Hospitals in Sylhet Division	9%	91%
Ambulatory health care by doctors in Barisal Division	19%	81%
Ambulatory health care by doctors in Chittagong Division	36%	64%
Ambulatory health care by doctors in Dhaka Division	43%	57%
Ambulatory health care by doctors in Khulna Division	27%	73%
Ambulatory health care by doctors in Rajshahi Division	15%	85%
Ambulatory health care by doctors in Rangpur Division	27%	73%
Ambulatory health care by doctors in Sylhet Division	21%	79%
Ancillary services by diagnostic facilities in Barisal Division	24%	76%
Ancillary services by diagnostic facilities in Chittagong Division	20%	80%
Ancillary services by diagnostic facilities in Dhaka Division	31%	69%
Ancillary services by diagnostic facilities in Khulna Division	28%	72%
Ancillary services by diagnostic facilities in Rajshahi Division	29%	71%
Ancillary services by diagnostic facilities in Rangpur Division	19%	81%
Ancillary services by diagnostic facilities in Sylhet Division	18%	82%
Residual expenditure in Barisal Division	19%	81%
Residual expenditure in Chittagong Division	26%	74%
Residual expenditure in Dhaka Division	52%	48%
Residual expenditure in Khulna Division	27%	73%
Residual expenditure in Rajshahi Division	18%	82%
Residual expenditure in Rangpur Division	22%	78%
Residual expenditure in Sylhet Division	16%	84%

2. RESULTS BANGLADESH URBAN HEALTH EXPENDITURES

Under the Bangladesh National Health Accounts (BNHA), in 2012, the Total Health Expenditure (THE) in Bangladesh was Taka 325 billion. As part of the secondary analysis of BNHA data, urban health expenditure has been estimated at Taka 106 billion for 2012 which constitute 33% of THE. The urban health outlay primarily targets the 23% of Bangladesh's total population who reside in urban areas.

Per-capita health expenditure for Bangladesh is estimated at Taka 2,167. This study estimated the urban per capita expenditure at Taka 3,083 and Taka 1,894 for rural individuals. It is important to note that although two-third (67%) of the Bangladesh population live in rural areas, many avail of healthcare services from urban facilities. Expenditure incurred by such rural households is treated as rural healthcare expenditure under this study. It is estimated that in 2012, Taka 218.7 billion was spent by the rural population on health (Table 2).

Table 2: Total Health Expenditure and Urban Health Expenditure, 2012

Indicator	Urban	Rural	National
THE (million Taka)	106,368	218,726	325,094
Population (million)	34.5	115.5	150
Urban Population as % of Total Population	23%	77%	100%
Urban Expenditure as % of THE	33%	67%	100%
Per Capita THE	3,083	1,894	2,167

2.1 Urban Health Expenditure: Providers

There exist a wide range and type of health care providers in Bangladesh. They range from large size public and private hospitals to trained and untrained medical practitioners. As showed in Table 3, the biggest health related expenditure at the urban level was incurred at pharmacies/retail drug outlets -- Taka 48 billion in 2012. A comparison of expenditure on medicine between urban and rural population shows that urban population spend 45% of their THE on medicine while it is 39% for the rural population.

The second largest outlay in urban area is general hospitals, including teaching hospitals, and it accounts for about Taka 29 billion in 2012. The use of hospitals as service provider is found low in urban areas (28%) compared to 31% in rural areas. Ambulatory healthcare providers are primarily involved in providing services directly to outpatients who do not require inpatient care. It includes outpatient services offered by physicians, family planning centres and community clinics. In 2012, urban population spent Taka 13 billion on ambulatory services while the rural population incurred Taka 35 billion for such services. Ambulatory services at the rural level are largely provided through government facilities and satellite clinics.

The Ministry of Health and Family Welfare (MOHFW) is the lead institution in conducting public health programs in Bangladesh. The share of expenditure targeted through public health programs of MOHFW and that of other government ministries and NGOs have been estimated at 2% of THE for both urban and rural locations. In 2012, Taka 2.2 billion was spent on urban public health programs, and Taka 7.4 billion in rural areas. In addition to the regular provider of healthcare services, there are facilities providing healthcare services as their secondary activity. Such providers are identified as Rest of the Economy. Healthcare services provided by the Rest of the Economy is Taka 4 billion for urban and Taka 6.7 billion for rural population.

Table 3: Healthcare Expenditure by Provider Classification, 2012

Provider	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Hospitals	29,423	28%	68,402	31%	97,825	30%
Row %	30%		70%		100%	
Residential long-term care facilities	18	0%	84	0%	102	0%
Row %	18%		82%		100%	
Providers of ambulatory health care	13,483	13%	35,483	16%	48,966	15%
Row %	28%		72%		100%	
Providers of ancillary services	5,340	5%	12,465	6%	17,805	5%
Row %	30%		70%		100%	
Retailers and other providers of medical goods	48,129	45%	85,868	39%	133,997	41%
Row %	36%		64%		100%	
Public health programs	2,296	2%	5,084	2%	7,380	2%
Row %	31%		69%		100%	
Providers of health care system administration and financing	3,625	3%	8,742	4%	12,367	4%
Row %	29%		71%		100%	
Rest of Economy	4,054	4%	2,597	1%	6,651	2%
Row %	61%		39%		100%	
Total Health Expenditure	106,368	100%	218,726	100%	325,094	100%
Row %	33%		67%		100%	

2.2 Urban Health Expenditure: Function

Services and activities that are delivered on health related issues are called functions. Examples include curative and preventive care, management of programs, capital formation, research and development relating to the health sector. Disaggregation of expenditures by functional category shows that medicine and medical goods are the largest component of urban THE. In 2012, Taka 48 billion was spent on medical goods by the urban population, which comprises 45% of total urban health outlay (Table 4). Share of expenditure on medicine and medical goods by the rural population is around 39% of rural THE.

Curative care primarily comprising of inpatient and outpatient care accounts for 25% of urban THE (Taka 27 billion) in 2012. Share of curative care in rural THE is also similar to urban (26%) outlay. It is important to note that urban facilities used by rural population are accounted as rural expenditure. If only rural health facilities are considered for rural expenditure estimates this share would be considerably lower as there are not many rural facilities in Bangladesh that provides inpatient curative care. Expenditure on ancillary services like pathological tests or imaging services are found to be between 5% (urban) and 6% (rural) of their respective THE.

Around 10% of urban THE (Taka 10 billion) is spent on preventive care, with family planning and awareness creation as major components. The share of preventive care in rural THE is around 15%. NHA classifies use of alternative and traditional medicine as Reporting Items. Use of such function amongst the urban population is found to be higher as a share of their THE. In 2012, urban population spent Taka 2.9 billion on Reporting Items. Total amount spent by the rural population on Reporting Items was around Taka 5.1 billion which is 2% of rural THE.

Table 4: Healthcare Expenditure by Function Classification, 2012

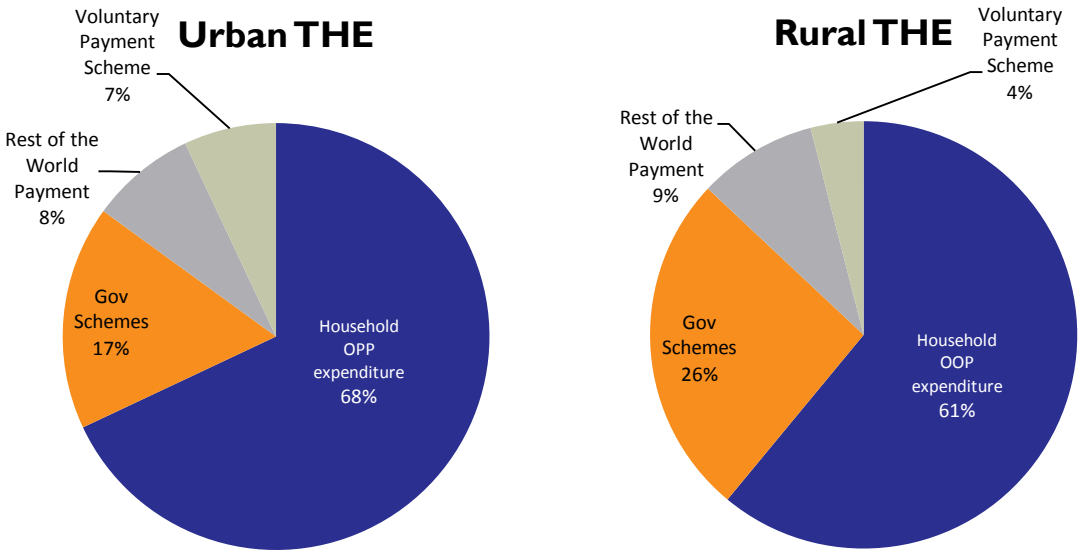
Function	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Services of curative care	26,939	25%	56,556	26%	83,495	26%
Row %	32%		68%		100%	
Rehabilitative care	28	0%	85	0%	113	0%
Row %	25%		75%		100%	
Long term care (health)	75	0%	226	0%	300	0%
Row %	25%		75%		100%	
Ancillary services (non-specialized function)	5,345	5%	12,465	6%	17,810	5%
Row %	30%		70%		100%	
Medical goods (non-specialized function)	48,141	45%	85,868	39%	134,009	41%
Row %	36%		64%		100%	
Preventive care	10,115	10%	33,556	15%	43,671	13%
Row %	23%		77%		100%	
Governance, health system and financing administration	4,981	5%	11,853	5%	16,835	5%
Row %	30%		70%		100%	
Reporting Items	2,885	3%	5,135	2%	8,020	2%
Row %	36%		64%		100%	
Gross capital formation	6,572	6%	9,690	4%	16,262	5%
Row %	40%		60%		100%	
Research and development in health	1,287	1%	3,293	2%	4,580	1%
Row %	28%		72%		100%	
Total Health Expenditure	106,368	100%	218,727	100%	325,094	100%
Row %	33%		67%		100%	

2.3 Urban Health Expenditure: Financing Schemes

Health care financing schemes encompass major types of financing arrangements through which health services are paid for and obtained by households. These include direct payments by households as well as third-party financing arrangements, such as social health insurance and voluntary insurance. Revenues of Financing Schemes capture the revenue sources of individual financing schemes.

Households serve as the biggest financing scheme for Bangladesh health care system. In 2012, the share of urban households' out-of-pocket expenses excluding cost sharing was Taka 72.6 billion which comprise 68% of urban THE (Table 8, figure 1). Household as a financing scheme in rural THE is also dominant. The total amount financed by the rural household in 2012 was Taka 133 billion which comprise 61% of rural THE. A distant second are government schemes that benefit the urban population – Taka 18.1 billion in 2012. The share of government healthcare spending in rural area is relatively higher (26%) compared to 17% for urban of their respective THE. All upazila (sub-district) level government facilities and below are treated as facilities catering services to the rural population. Higher share of government financing is primarily due to large numbers of government outpatient centers operating in rural areas. NGO financing schemes are relatively modest. In 2012, Taka 1.7 billion were spent through NGOs own funding. The relative share of urban to rural population suggests 35.3% of OOP is incurred by urban households and the remaining 64.7% by the rural population. Voluntary Health Insurance schemes are primarily in the form of spending to provide or reimburse medical care for employees of business entities. As a financing scheme, such schemes exclusively reach to the urban population, as such programs are offered by large formal urban sector business entities.

Figure 1: Urban vs Rural THE by financing Scheme



Under the System of Health Accounts (SHA) 2011, revenue of various financing schemes are tracked and classified as Financing Source. When classified by financing source, urban households are identified as the key finance source, contributing Taka 72.6 billion in 2012. Their relative share of total urban health outlay is 68%. Internal transfer and grants is the second largest financing source – Taka 18.1 billion (17%) in 2012. According to SHA 2011, "revenues allocated to government schemes, which may be an internal transfer within the same level of government or a transfer between central and local governments. Includes: the budget of national health services; funds allocated to central government health programs in countries with social insurance; etc." is defined as Internal transfer and grants.

Table 5: Healthcare Expenditure by Urban/Rural and Financing Scheme Classification, 2012

Financing Schemes	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Government schemes and compulsory health care financing schemes	18,101	17%	56,970	26%	75,071	23%
Row %	24%		76%		100%	
Voluntary health care payment schemes	7,545	7%	9,514	4%	17,059	5%
Row %	44%		56%		100%	
Households out-of-pocket payment	72,607	68%	133,213	61%	205,820	63%
Row %	35%		65%		100%	
Rest of the world health financing schemes (non-resident)	8,115	8%	19,029	9%	27,144	8%
Row %	30%		70%		100%	
Total Health Expenditure	106,368	100%	218,726	100%	325,094	100%
Row %	33%		67%		100%	

Table 6: Healthcare Expenditure by Financing Source Classification, 2012

Funding Source	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Transfers from government domestic revenue	18,101	17%	56,970	26%	75,071	23%
Row %	24%		76%		100%	
Voluntary prepayment	221	0%	0	0%	221	0%
Row %	100%		0%		100%	
Other domestic revenues n.e.c.	79,931	75%	142,726	65%	222,657	68%
Row %	36%		64%		100%	
Direct foreign transfers	8,115	8%	19,029	9%	27,144	8%
Row %	30%		70%		100%	
Total Health Expenditure	106,368	100%	218,726	100%	325,094	100%
Row %	33%		67%		100%	

Table 7: Urban Healthcare Expenditure by Financing Agent Classification, 2012

Financing Agent	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
General government	18,202	17%	56,970	26%	75,172	23%
Row %	24%		76%		100%	
Insurance corporations	221	0%	0	0%	221	0.1%
Row %	100%		0%		100%	
Corporations (other than insurance corporations)	5,532	5%	5,549	3%	11,081	3%
Row %	50%		50%		100%	
Non-profit institutions serving households (NPISH)	1,691	2%	3,965	2%	5,656	2%
Row %	30%		70%		100%	
Households	72,607	68%	133,213	61%	205,820	63%
Row %	35%		65%		100%	
Rest of the world	8,115	8%	19,029	9%	27,144	8%
Row %	30%		70%		100%	
Total Health Expenditure	106,368	100%	218,726	100%	325,094	100%
Row %	33%		67%		100%	

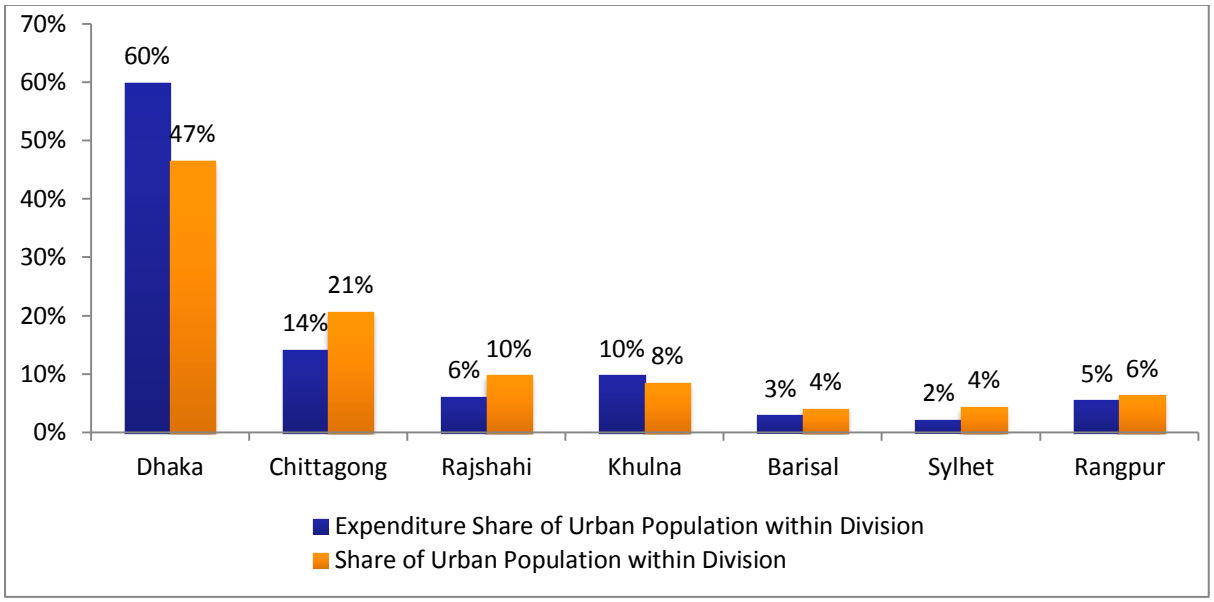
2.4 Urban Health Expenditure: Geographical Classification

Of the seven administrative divisions of Bangladesh, urban health expenditure is the significantly higher in Dhaka than the others. In 2012, Taka 63.6 billion was spent on health in Dhaka division, which constitutes 60% of total urban health outlay (Figure 1). The lowest level of urban expenditure is in Sylhet (Taka 2.3 billion) and Barisal (Taka 3 billion) in 2012. An urban-rural comparison suggests, in Dhaka division, 47.5% is incurred by urban households and 52.5% by the rural population.

Table 8: Bangladesh urban healthcare expenditure by Functions and Division, 2012

Functional Classification	Dhaka	Chittagong	Rajshahi	Khulna	Barisal	Sylhet	Rangpur	National
	Million Taka							
Services of curative care	15,069	4,869	1,742	2,385	898	637	1,339	26,939
Rehabilitative care	5	2	1	1	1	0	17	28
Long term care (health)	21	10	24	10	3	2	5	75
Ancillary services (non-specialized function)	4,833	200	65	137	51	10	48	5,345
Medical goods (non-specialized function)	30,015	6,367	2,655	4,879	1,019	912	2,294	48,141
Preventive care	4,543	1,575	863	1,339	494	352	949	10,115
Governance, health system and financing administration	2,143	752	424	679	233	171	579	4,981
Reporting Items	1,677	428	193	307	65	54	163	2,885
Gross capital formation	4,811	520	270	411	216	114	230	6,572
Research and development in health	507	216	131	157	71	52	153	1,287
Total Urban Health Expenditure	63,624	14,940	6,367	10,305	3,051	2,304	5,777	106,368

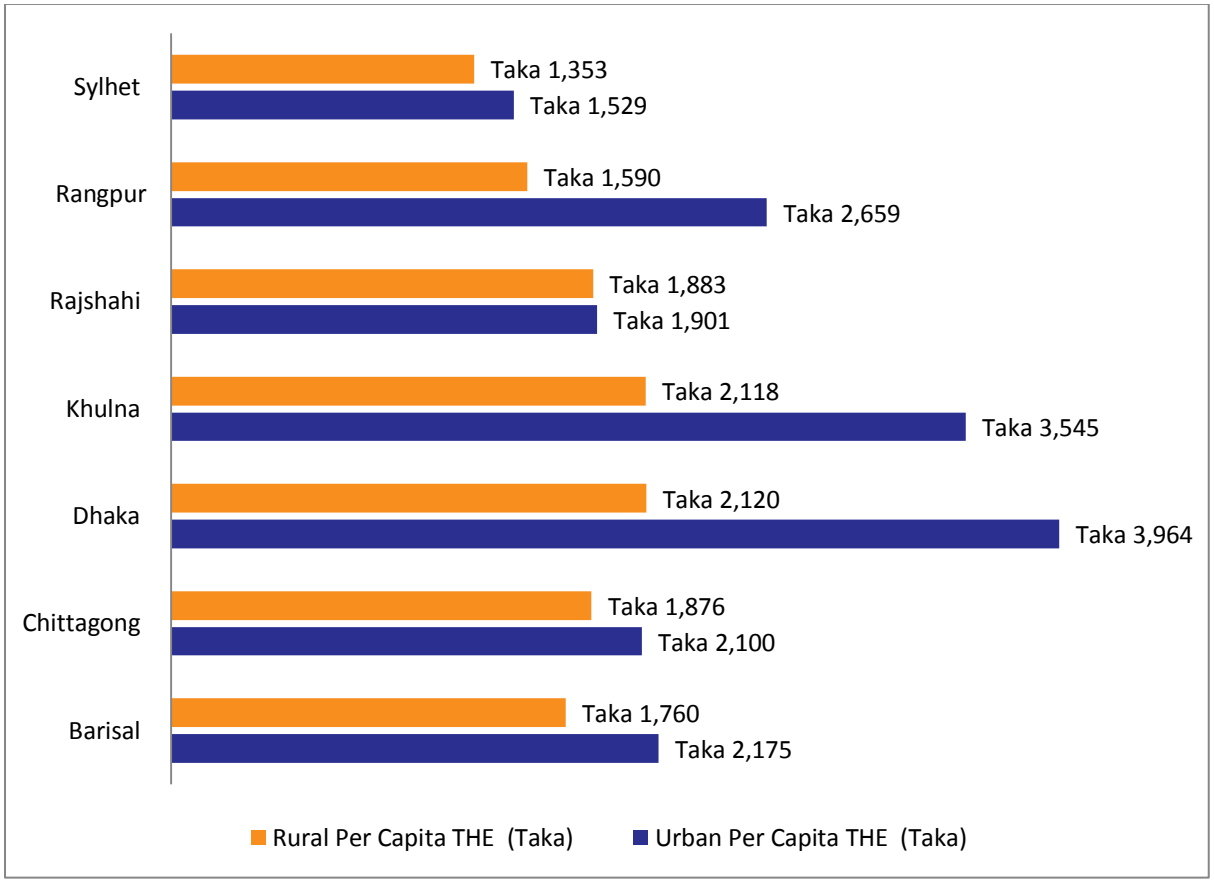
Figure 2: Urban Total Health Expenditure by Division, 2012[10]



Per-capita urban and rural expenditure on health has been estimated for 2012 for each of the seven administrative divisions of Bangladesh (Figure 2). Total health expenditure of each division by location (urban/rural) has been divided by their respective population to compute the per capita outlay. Urban Bangladeshis spend considerably more (Taka 3,083) than their rural cohort (Taka 1,893). A divisional comparison suggest per capita urban health expenditure is the highest in Dhaka division (Taka 3,964), followed by Khulna (Taka 3,545). The lowest per capita expenditure of Taka 1,529 per year is that of Sylhet division. The gap between rural and urban per capita THE is highest in Dhaka division and lowest in Rajshahi division. Per capita rural THE for Dhaka division is Taka 2,118 while it is almost double for urban areas (Taka 3,964). Rajshahi division has the lowest gap in per capita spending between urban and rural --Taka 1,883 and Taka 1,901 respectively.

[10] Note: Dhaka division's expenditure share is proportionately higher than its population share. One major reason: most tertiary care health facilities are in Dhaka city.

Figure 3: Per Capita Urban and Rural Healthcare Expenditure by Division, 2012



2.5 Urban Health Expenditure: Cross Classification

The National Health Accounts (NHA) framework allows expenditures occurring from the perspective of providers, sources of financing and functions. Further disaggregation of data through cross-classification between providers, sources of financing and function allows in-depth analysis of expenditure patterns.

Table 9 presents urban health expenditure cross classified between functions and provider for 2012. Of the total Taka 106.4 billion urban health expenditure, the three major functional outlays are on: (i) medical goods (Taka 48.1 billion); (ii) curative care (Taka 26.9 billion); and (iii) preventive care (Taka 10.1 billion). Their relative share to total urban expenditure is 45.3%, 25.3% and 9.5% respectively. Medical goods are almost entirely by retail drug outlets (Taka 48.1 billion); curative care expenditure is primarily incurred in hospitals (Taka 17.3 billion) and through providers of ambulatory care (Taka 6.9 billion).

Table 9: Bangladesh Urban Healthcare Expenditure by Functions and Provider, 2012

	Provider Classification (Million Taka)								
Functional Classification	**Hospitals**	**Residential long-term care facilities**	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and other providers of medical goods**	**Public health programs**	**Providers of health care system administration and financing**	**Rest of Economy**	**Total Health Expenditure**
Services of curative care	17,637		6,881			46		2,375	26,939
Rehabilitative care	28								28
Long term care (health)	17	18	39						75
Ancillary services (non-specialized function)				5,340				5	5,345
Medical goods (non-specialized function)					48,129			12	48,141
Preventive care	5,019		2,680			1,901		514	10,115
Governance, health system and financing administration	1,947		181			174	2,680		4,981
Reporting Items			2,718					168	2,885
Gross capital formation	4,763	0	985			175	614	35	6,572
Research and development in health	12						330	945	1,287
Total Urban Health Expenditure	29,423	18	13,483	5,340	48,129	2,296	3,625	4,054	106,368

Table 10 includes urban health expenditure cross classified between functions and financing schemes for 2012. Almost all medical goods purchase is financed through household out-of-pocket (OOP). It should be noted that expenditure on drugs in hospitals is not included under the medical goods category, but embedded in inpatient and outpatient care outlay. Services of curative care is financed by households (Taka 16 billion), government schemes and compulsory health financing schemes (Taka 6.1 billion), rest of the world health financing scheme (Taka 2.5 billion) and voluntary health care payment schemes (Taka 2.3 billion) –Table 10. Governance, health system and financing administration is supported by government and non-government financing schemes.

Table 10: Bangladesh Urban Healthcare Expenditure by Functions and Financing Schemes, 2012

	Financing Schemes (Million Taka)				
Functional Classification	**Government schemes and compulsory health care financing schemes**	**Voluntary health care payment schemes**	**Households out-of-pocket payment**	**Rest of the world health financing schemes (non-resident)**	**Total Health Expenditure**
Services of curative care	6,101	2,309	15,980	2,548	26,939
Rehabilitative care	28				28
Long term care (health)	75				75
Ancillary services (non-specialized function)	4	5	5,335		5,345
Medical goods (non-specialized function)		12	48,129		48,141
Preventive care	5,049	954		4,111	10,115
Governance, health system and financing administration	2,818	263	445	1,455	4,981
Reporting Items	168		2,718		2,885
Gross capital formation	2,571	4,001			6,572
Research and development in health	1,287				1,287
Total Urban Health Expenditure	18,101	7,545	72,607	8,115	106,368

Table 11 presents urban health expenditure by providers and financing schemes for 2012. Pharmacies/retail drug outlets are the major providers in terms of expenditure receiving financing from household out-of-pocket payment (Taka 48.1 billion). Hospitals as providers receive payments from households (Taka 10.7 billion; 36.4% of total urban THE); rest of the world health financing schemes (Taka 7.9 billion; 26.8% of total urban THE); voluntary healthcare payment financing schemes (Taka 5.7 billion; 19.4% of total urban THE); and government schemes and compulsory healthcare financing schemes (Taka 5.1 billion; 17.4% of total urban THE). Providers of public health programs, healthcare system administration and financing and the rest of the economy are largely dependent on government schemes and compulsory healthcare financing schemes. Facilities that provide healthcare services as a secondary activity is categorized as rest of the economy, e.g., healthcare services provided by the private companies.

Table 11: Bangladesh Urban Healthcare Expenditure by Providers and Financing Schemes, 2012

	Financing Schemes (Million Taka)				
Provider Classification	**Government schemes and compulsory health care financing schemes**	**Voluntary health care payment schemes**	**Households out-of-pocket payment**	**Rest of the world health financing schemes (non-resident)**	**Total Health Expenditure**
Hospitals	5,126	5,703	10,715	7,879	29,423
Residential long-term care facilities	18				18
Providers of ambulatory health care	4,987	12	8,428	56	13,483
Providers of ancillary services	4		5,335		5,340
Retailers and other providers of medical goods			48,129		48,129
Public health programs	1,918	199		180	2,296
Providers of health care system administration and financing	3,625				3,625
Rest of Economy	2,422	1,632			4,054
Total Urban Health Expenditure	18,101	7,545	72,607	8,115	106,368

2.6 Household Out-of-Pocket Expenditure

In 2012, the out-of-pocket (OOP) expenditure on healthcare by households was Taka 205.8 billion (Table 12). Of the total national household OOP outlay, urban residents spent Taka 72.6 billion which constitute 35.3% of total household healthcare expenditure. The rural populace OOP expenditure is Taka 133.2 billion – 64.7% of total household expenditure on healthcare. The major component of household OOP expenditure is on medical goods both for urban (66% of total OOP outlay) and rural (64% of total OOP outlay) families.

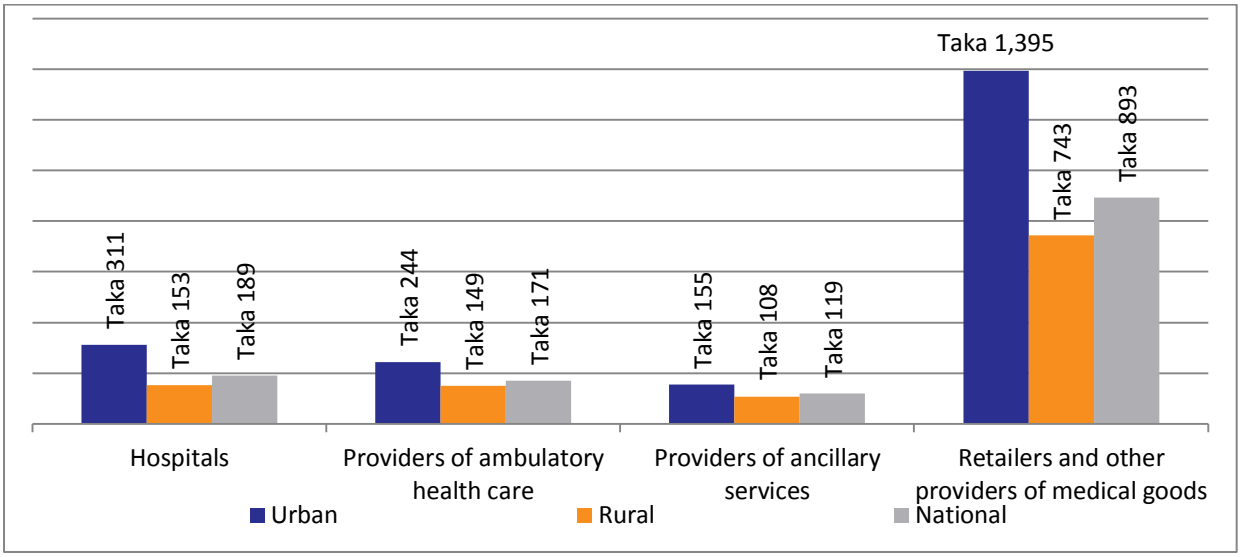
Expenditures made in hospitals is the second major expenditure for both urban (Taka 10.7 billion; 15% of urban household OOP expenditure on healthcare) and rural populace (Taka 17.6 billion; 13% of rural household OOP expenditure on healthcare). Ambulatory healthcare outlay through household OOP was Taka 8.4 billion and Taka 25.6 billion for urban and rural population respectively.

Table 12: Household Out of Pocket Healthcare Expenditure by Providers, 2012

Provider	**Urban**		**Rural**		**National**	
	(Million Taka)	**Col. %**	**(Million Taka)**	**Col. %**	**(Million Taka)**	**Col.%**
Hospitals	10,715	15%	17,661	13%	28,376	14%
Providers of ambulatory health care	8,428	12%	17,229	13%	25,658	12%
Providers of ancillary services	5,335	7%	12,455	9%	17,790	9%
Retailers and other providers of medicine and medical goods	48,129	66%	85,868	64%	133,997	65%
Total Out-of-Pocket Health Expenditure	72,607	100%	133,213	100%	205,820	100%
Population (Million)	34.5	23%	115.5	77%	150	100%
Per-Capita (Taka)	2,105		1,153		1,372	

Per capita household OOP expenditure by Bangladeshis on healthcare was Taka 1,372 in 2012 (Table 12). The per capita household OOP expenditure by urban households on healthcare was Taka 2,105 and Taka 1,153 for the rural population (Table 12). A breakdown by key expenditure components per capita for urban and rural household is presented in Figure 3. On an average an urban resident spent Taka 1,395 on medical goods annually while their rural cohorts spent Taka 743. The per capita OOP outlay in hospitals is Taka 311 and Taka 153 respectively for urban and rural population. Each urban resident spend on an average Taka 244 per year on ambulatory care and Taka 155 on ancillary services.

Figure 4: Per-Capita Household Out-of-Pocket Healthcare Expenditure



Urban household OOP health expenditure when analyzed by function indicates that 66% (Taka 48.1 billion) of their total expenses are on medical goods and 22% (Taka 15.98 billion) on curative care (Table 13). The comparable figures for rural household are: 64% (Taka 85.9 billion) on medical goods and 22% (Taka 28.8 billion) on curative care.

Table 13: Household Out of Pocket Healthcare Expenditure by Functions, 2012

Function	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Services of curative care	15,980	22%	28,835	22%	44,814	22%
Ancillary services (non-specialized function)	5,335	7%	12,455	9%	17,790	9%
Medical goods (non-specialized function)	48,129	66%	85,868	64%	133,997	65%
Governance, health system and financing administration	445	1%	921	1%	1,367	1%
Reporting Items (Traditional, complementary and alternative medicine)	2,718	4%	5,135	4%	7,852	4%
THE	72,607	100%	133,213	100%	205,820	100%

Based on their consumption expenditure estimates from Household Income Expenditure Survey, 2011 data, households have been classified into five quintiles. The poorest quintile is termed as quintile 1 and the richest quintile 5. According to Table 14, urban households' out-of-pocket (OOP) healthcare expenditure for 2012 is Taka 72.6 billion where 56% (Figure 4) of that are made by the richest quintile of the population (quintile 5). Similar scenario is also observed among the rural households. Around 46% of total rural OOP expenditure on healthcare is by the richest quintile (quintile 5). Households belonging to the poorest quintile (quintile 1) spend around Taka 4.1 billion in urban area and Taka 9.3 billion in rural area, which is approximately 6% and 7% of respective total OOP for the year 2012.

A comparison of household OOP healthcare expenditure as percentage of total consumption expenditure shows that the richest populace (quintile 5) of urban as well as rural allocates a higher percent (5.5%) of their

total consumption expenditure on healthcare compared to the relatively less poor quintile groups (Table 14). In urban areas, the first three quintiles – quintile 1 to quintile 3 – incur a similar proportion (3.1%) of their total household OOP expenditure on healthcare. Quintile 4 in the urban area spends 3.7% of the total household OOP outlay, while the same quintile rural population spends 4.8% of their total consumption expenditure.

Figure 5: Share of Total Household OOP Expenditures on Health by Income Quintile

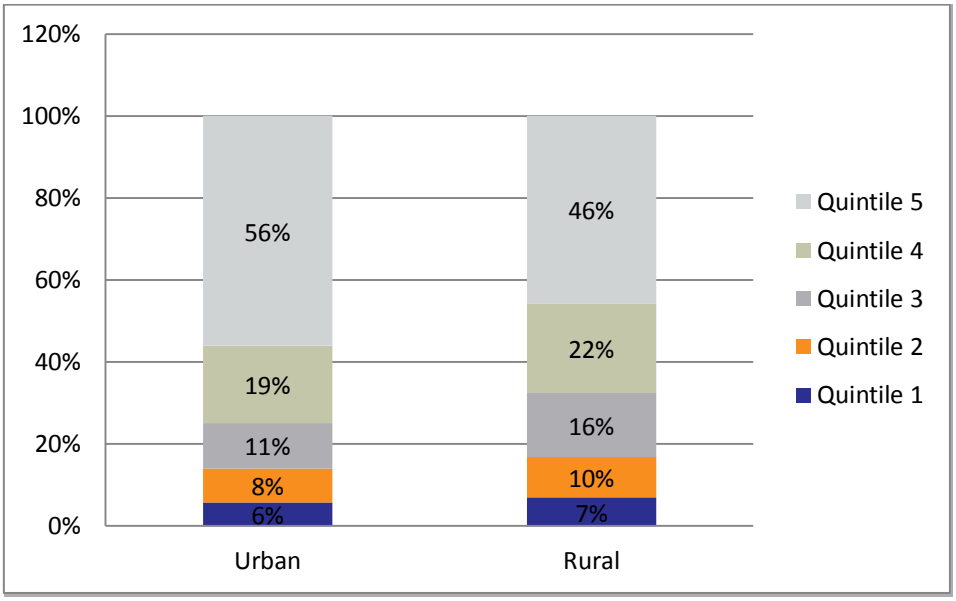


Table 14: Household Consumption and Out of Pocket Healthcare Expenditure by Quintiles, 2012

Consumption	Urban			Rural		
	Annual Per-Capita Household Consumption Expenditure (Taka)	Annual Household Per-Capita OOP Health Expenditure (Taka)	OOP as % of Consumption	Annual Per-Capita Household Consumption Expenditure (Taka)	Annual Household Per-Capita OOP Health Expenditure (Taka)	OOP as % of Consumption
Quintile 1 (Poorest)	19,098	599	3.14%	11,793	401	3.4%
Quintile 2	28,665	880	3.07%	16,304	571	3.5%
Quintile 3	37,882	1,159	3.06%	20,447	896	4.4%
Quintile 4	53,428	1,982	3.71%	26,324	1,262	4.8%
Quintile 5 (Richest)	107,124	5,901	5.51%	46,801	2,636	5.6%
Average	49,240	2,104	4.3%	24,334	1,153	4.7%

Source: Secondary analysis of HIES 2010

Figure 6: Per capita annual household health expenditures by quintiles

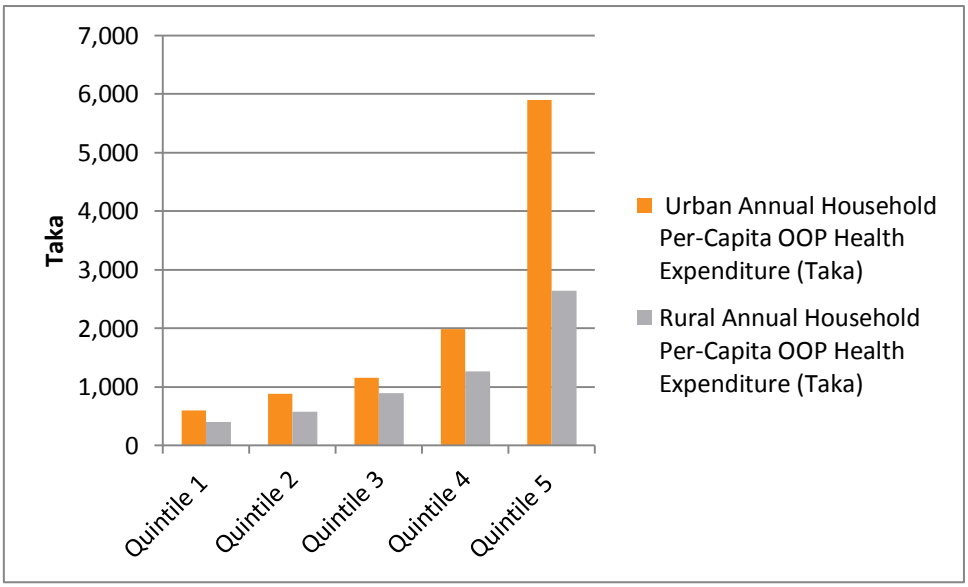
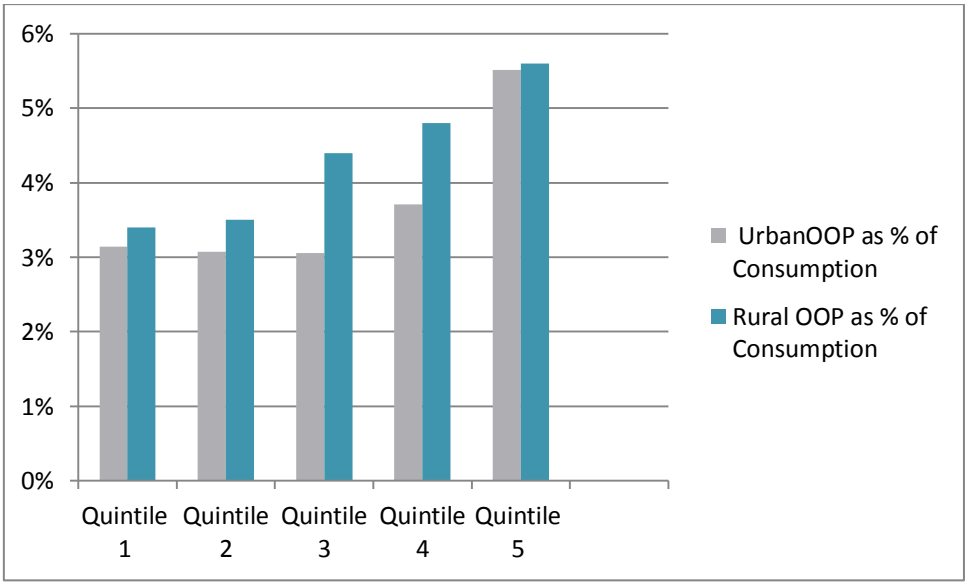


Figure 7: OOP for health as a percentage of consumption by quintiles



3. DISCUSSION

According to HEIS 2010, urban income and expenditure is higher than the rural, it is expected that urban population can spend more on health than the rural. Fig 5 above illustrates this with the richest quintile, quintile 5, spending the most out of pocket for health care. As well, per capita OOP health expenditure is higher in urban areas than the rural. The richest quintiles, both urban and rural, spend the most out of pocket for health care in per capita term: 5,901 and 2,636 verses 599 and 401BDT for the poorest urban and rural quintiles; the urban poor spend 50% more per capita than the rural poor do. However, as a proportion of consumption, the richest, quintiles, spend the most out of pocket for health care: 5.51% and 5.6%, against 3.14% and 3.4% respectively for urban and rural quintiles (table 14).

It is possible that increase health expenditure in urban areas is driven by a broader choice of providers. These health expenditure estimates are consistent with findings on healthcare utilization. The Demographic and Health Survey (DHS) 2014 show stark differences between some urban and rural indicators: 56.8% of deliveries were in facility for the urban population and 35.6% were done by caesarian section while only 30.6% delivery was in facilities in rural areas and 17% were done by caesarian section. In urban areas, out of 56.8% of facilities deliveries, private sector contributed 35.6%, public sector 15.8% and NGOs 5.4%. The urban population also has a rate 74% antenatal visits with qualified doctors and it is only 52% in case for the rural population. The access and utilization of private sector and NGOs providers is almost double of public sector providers in urban areas. Having better private sector utilization data would have been an added a value on this topic.

The major financing source for both urban and rural population is the household out of pocket expenditure. In case of household expenditures, the greater part (65% at national level) is spend on the retailers and other providers of medicine and medical goods which is 68% in urban and 64% in rural (Fig 3). The expenditure on retailers and other medical goods accounts for 45% of THE in urban while it is 39% in rural. Again, only 23% of the total population is spending 48,129 million BDT on medical goods that is almost 15% of the total health expenditure (THE). Private sector pharmacy plays a major role in providing health services, for example, they are the highest supplier of the modern contraceptive methods, and 48% of contraceptive pill is distributed through private sector pharmacy and 5% through non-formal private sector.

There are also variations between urban and rural health expenditure across the eight divisions of the country. In Dhaka, health expenditure is more in urban than the rural, which can be reasoned by having a greater urban population in Dhaka division than the other divisions (Fig 2).

4. WAY FORWARD

Bangladesh is a geographically small country and with communication and technological advancement, it is going through rapid urbanization process. Also there is a constant seasonal migration that make more difficult to categorize urban and rural population. As mentioned administrative demarcation is being used to track data of these two different groups, but it doesn't help to track the health expenditure as rural population often comes to urban areas for seeking health services. The majority of secondary and tertiary health facilities are located in the urban areas providing services to both urban and rural population. These facts and the lack of data to quantify them, has limited the usefulness of the current estimates. The analysis would have been more informative if the urban and rural health expenditure could have tracked from the origin of the population. This can only be done if the providers keep records of the origin of the patients.

As discussed a major group of population seek health care services from private sectors, data from a survey on private health sector could have added more value in this analysis. Information on where the urban and rural population seeks care, whether they self-medicate or consult service providers, and what kind of medication they have, would also have contribute to make further analysis and recommendations.

ANNEX A: TABLES: URBAN HEALTHCARE EXPENDITURE BY SHA 2011 CLASSIFICATION

Table A1: Total Health Expenditure and Urban Health Expenditure, 2012 by SHA 2011 Classification

Indicator	Urban	Rural	National
Current Health Expenditure (CHE) million Taka	95,623	200,609	296,232
Population (million)	34.5	115.5	150
Urban Population as % of Total Population	23%	77%	100%
Urban Expenditure as % of THE	32%	68%	100%
Per Capita CHE	2,772	1,737	1,975

Table A1: Healthcare Expenditure by Provider Classification, 2012 by SHA 2011 Classification

Provider	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Hospitals	24,648	26%	60,898	30%	85,546	29%
Row %	29%		71%		100%	
Residential long-term care facilities	18.27234	0%	83	0%	101.513	0%
Row %	18%		82%		100%	
Providers of ambulatory health care	9,780	10%	29,827	15%	39,608	13%
Row %	25%		75%		100%	
Providers of ancillary services	5,340	6%	12,465	6%	17,805	6%
Row %	30%		70%		100%	
Retailers and other providers of medical goods	48,129	50%	85,868	43%	133,997	45%
Row %	36%		64%		100%	
Public health programmes	2,121	2%	4,910	2%	7,031	2%
Row %	30%		70%		100%	
Providers of health care system administration and financing	2,680	3%	6,484	3%	9,165	3%
Row %	29%		71%		100%	
Rest of Economy	2,906	3%	73	0%	2,979	1%
Row %	98%		2%		100%	
Current Health Expenditure	95,623	100%	200,609	100%	296,232	100%
Row %	32%		68%		100%	

Table A2: Healthcare Expenditure by Function Classification, 2012 by SHA 2011 Classification, by SHA 2011 Classification

Function	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Services of curative care	26,939	28%	56,556	28%	83,495	28%
Row %	32%		68%		100%	
Rehabilitative care	28	0%	85	0%	113	0%
Row %	25%		75%		100%	
Long term care (health)	75	0%	226	0%	300	0%
Row %	25%		75%		100%	
Ancillary services (non-specialized function)	5,345	6%	12,465	6%	17,810	6%
Row %	30%		70%		100%	
Medical goods (non-specialized function)	48,141	50%	85,868	43%	134,009	45%
Row %	36%		64%		100%	
Preventive care	10,115	11%	33,556	17%	43,671	15%
Row %	23%		77%		100%	
Governance, health system and financing administration	4,981	5%	11,853	6%	16,835	6%
Row %	30%		70%		100%	
Current Health Expenditure	95,623	100%	200,609	100%	296,232	100%
Row %	32%		68%		100%	

Table A3: Urban Healthcare Expenditure by Financing Scheme Classification, 2012 by SHA 2011 Classification

Financing Schemes	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Government schemes and compulsory health care financing schemes	14,075	15%	49,536	25%	63,611	21%
Row %	22%		78%		100%	
Voluntary health care payment schemes	3,544	4%	3,965	2%	7,509	3%
Row %	47%		53%		100%	
Households out-of-pocket payment	69,889	73%	128,079	64%	197,968	67%
Row %	35%		65%		100%	
Rest of the world health financing schemes (non-resident)	8,115	8%	19,030	9%	27,144	9%
Row %	30%		70%		100%	
Current Health Expenditure	95,623	100%	200,609	100%	296,232	100%
Row %	32%		68%		100%	

Table A4: Healthcare Expenditure by Financing Source Classification, 2012 by SHA 2011 Classification

Financing Schemes	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Government schemes and compulsory health care financing schemes	14,075	15%	49,536	25%	63,611	21%
Row %	22%		78%		100%	
Voluntary health care payment schemes	221	0%	0	0%	221	0%
Row %	100%		0%		100%	
Households out-of-pocket payment	73,212	77%	132,044	66%	205,256	69%
Row %	36%		64%		100%	
Rest of the world health financing schemes (non-resident)	8,115	8%	19,030	9%	27,144	9%
Row %	30%		70%		100%	
Current Health Expenditure	95,623	100%	200,609	100%	296,232	100%
Row %	32%		68%		100%	

Table A5: Urban Healthcare Expenditure by Financing Agent Classification, 2012, by SHA 2011 Classification

	Urban		Rural		National	
Financing Agent	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
General government	14,176	15%	49,536	25%	63,712	22%
Row %	22%		78%		100%	
Insurance corporations	221.17	0%	0	0%	221.17	0%
Row %	100%		0%		100%	
Corporations (other than insurance corporations)	1,531	2%	0	0%	1,531	1%
Row %	100%		0%		100%	
Non-profit institutions serving households (NPISH)	1,691	2%	3,965	2%	5,656	2%
Row %	30%		70%		100%	
Households	69,889	73%	128,079	64%	197,968	67%
Row %	35%		65%		100%	
Rest of the world	8,115	8%	19,030	9%	27,144	9%
Row %	30%		70%		100%	
Current Health Expenditure	95,623	100%	200,609	100%	296,232	100%
Row %	32%		68%		100%	

Table A6: Bangladesh Urban Healthcare Expenditure by Functions and Division, 2012 by SHA 2011 Classification

Functional Classification	Dhaka	Chitta-gong	Rajshahi	Khulna	Barisal	Sylhet	Rangpur	National
	Million Taka							
Services of curative care	15,069	4,869	1,742	2,385	898	637	1,339	26,939
Rehabilitative care	5	2	1	1	1	0	17	28
Long term care (health)	21	10	24	10	3	2	5	75
Ancillary services (non-specialized function)	4,833	200	65	137	51	10	48	5,345
Medical goods (non-specialized function)	30,015	6,367	2,655	4,879	1,019	912	2,294	48,141
Preventive care	4,543	1,575	863	1,339	494	352	949	10,115
Governance, health system and financing administration	2,143	752	424	679	233	171	579	4,981
Current Urban Health Expenditure	56,629	13,776	5,773	9,430	2,700	2,084	5,231	95,623

Table A7: Bangladesh Urban Healthcare Expenditure by Functions and Provider, 2012, by SHA 2011 Classification

	Provider Classification (Million Taka)								
Functional Classification	Hospitals	Residential long-term care facilities	Providers of ambulatory health care	Providers of ancillary services	Retailers and other providers of medical goods	Public health programmes	Providers of health care system administration and financing	Rest of Economy	Current Health Expenditure
Services of curative care	17,637	0	6,881	0	0	46	0	2,375	26,939
Rehabilitative care	28	0	0	0	0	0	0	0	28
Long term care (health)	17	18	39	0	0	0	0	0	75
Ancillary services (non-specialized function)	0	0	0	5,340	0	0	0	5	5,345

	Provider Classification (Million Taka)								
Functional Classification	**Hospitals**	**Residential long-term care facilities**	**Providers of ambulatory health care**	**Providers of ancillary services**	**Retailers and other providers of medical goods**	**Public health programmes**	**Providers of health care system administration and financing**	**Rest of Economy**	**Current Health Expenditure**
Medical goods (non-specialized function)	0	0	0	0	48,129	0	0	12	48,141
Preventive care	5,019	0	2,680	0	0	1,901	0	514	10,115
Governance, health system and financing administration	1,947	0	181	0	0	174	2,680	0	4,981
Current Urban Health Expenditure	24,648	18	9,780	5,340	48,129	2,121	2,680	2,906	95,623

Table A8: Bangladesh Urban Healthcare Expenditure by Functions and Financing Schemes, 2012, by SHA 2011 Classification

	Financing Schemes (Million Taka)				
Functional Classification	**Government schemes and compulsory health care financing schemes**	**Voluntary health care payment schemes**	**Households out-of-pocket payment**	**Rest of the world health financing schemes (non-resident)**	**Current Health Expenditure**
Services of curative care	6,101	2,309	15,980	2,548	26,939
Rehabilitative care	28	0	0	0	28
Long term care (health)	75	0	0	0	75
Ancillary services (non-specialized function)	4	5	5,335	0	5,345
Medical goods (non-specialized function)	0	12	48,129	0	48,141
Preventive care	5,049	954	0	4,111	10,115
Governance, health system and financing administration	2,818	263	445	1,455	4,981
Current Urban Health Expenditure	14,075	3,544	69,889	8,115	95,623

Table A9: Bangladesh Urban Healthcare Expenditure by Providers and Financing Schemes, 2012, by SHA 2011 Classification

	Financing Schemes (Million Taka)				
Provider Classification	**Government schemes and compulsory health care financing schemes**	**Voluntary health care payment schemes**	**Households out-of-pocket payment**	**Rest of the world health financing schemes (non-resident)**	**Current Health Expenditure**
Hospitals	4,353	1,702	10,715	7,879	24,648
Residential long-term care facilities	18	0	0	0	18
Providers of ambulatory health care	4,002	12	5,711	56	9,780
Providers of ancillary services	4	0	5,335	0	5,340
Retailers and other providers of medical goods	0	0	48,129	0	48,129
Public health programmes	1,743	199	0	180	2,121
Providers of health care system administration and financing	2,680	0	0	0	2,680
Rest of Economy	1,274	1,632	0	0	2,906
Current Urban Health Expenditure	14,075	3,544	69,889	8,115	95,623

Table A10: Household Out of Pocket Healthcare Expenditure by Providers, 2012, by SHA 2011 Classification

Provider	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Hospitals	10,715	15%	17,661	14%	28,376	14%
Providers of ambulatory health care	5,711	8%	12,095	9%	17,805	9%
Providers of ancillary services	5,335	8%	12,455	10%	17,790	9%
Retailers and other providers of medicine and medical goods	48,129	69%	85,868	67%	133,997	68%
Current Out-of-Pocket Health Expenditure	69,889	100%	128,079	100%	197,968	100%

Table A11: Household Out of Pocket Healthcare Expenditure by Functions, 2012, by SHA 2011 Classification

Function	Urban		Rural		National	
	(Million Taka)	Col.%	(Million Taka)	Col.%	(Million Taka)	Col.%
Services of curative care	15,980	23%	28,835	23%	44,814	23%
Ancillary services (non-specialized function)	5,335	8%	12,455	10%	17,790	9%
Medical goods (non-specialized function)	48,129	69%	85,868	67%	133,997	68%
Governance, health system and financing administration	445	1%	921	1%	1,367	1%
CHE	69,889	100%	128,079	100%	197,968	100%

Table A12: Household Consumption and Out of Pocket Healthcare Expenditure by Quintiles, 2012, by SHA 2011 Classification

Consumption	Urban			Rural		
Expenditure	Annual Per-Capita Household Consumption Expenditure (Taka)	Annual Household Per-Capita OOP Health Expenditure (Taka)	OOP as % of Consumption	Annual Per-Capita Household Consumption Expenditure (Taka)	Annual Household Per-Capita OOP Health Expenditure (Taka)	OOP as % of Consumption
Quintile 1	19,098	577	3.02%	11,793	401	3.40%
Quintile 2	28,665	848	2.96%	16,304	571	3.50%
Quintile 3	37,882	1,116	2.94%	20,447	896	4.38%
Quintile 4	53,428	1,908	3.57%	26,324	1,262	4.79%
Quintile 5	107,124	5,680	5.30%	46,801	2,636	5.63%
Current	49,240	2,026	4.11%	24,334	1,153	4.74%

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