BANGLADESH NATIONAL HEALTH ACCOUNTS, 1999-2001

Indicators	1996-97	1999-00	2000-01	2001-02
Total Health Expenditure (THE) in million Taka	55,763	74,785	80,966	88,313
National Health Expenditure (NHE) in million Taka	50,750	69,877	75,158	82,881
SHA THE in million Taka	53,038	72,485	78,225	85,301
THE in million US$	1,358	1,487	1,499	1,549
NHE in million US$	1,236	1,389	1,392	1,454
SHE THE in million US$	1,291	1,441	1,449	1,497
MOHFW as % of THE	27.6	25.7	24.0	24.3
NGO as% of THE	2.9	6.8	8.8	9.2
HH as% of THE	63.1	64.6	64.4	63.8
Development partners as % of THE	10.5	12.2	12.9	13.3
SSP as % of THE	-	19.7	19.1	19.9

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Health Economics Unit (HEU)
Ministry of Health and Family Welfare
Government of the People's Republic of Bangladesh

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Preface

The report on Bangladesh's National Health Accounts, 1999-2001, has been initiated by the Health Economics Unit (HEU), Ministry of Health and Family Welfare (MOHFW) of the Government of the People's Republic of Bangladesh, implemented by a reputed Bangladeshi consulting firm, Data International Ltd. The main objective of the study is to compile, update, and present in a systematic manner national health expenditures for Bangladesh.

Applying internationally acceptable guidelines for data collection, interpretation and analysis, this endeavor aims at disaggregating health expenditures from three perspectives. First, what are the sources of health expenditure funding? Second, who are the providers of health goods and services, i.e. where the money goes to? Third, what are the types of health goods and services purchased, i.e. functions of healthcare. Total national health expenditure for 1999-2001 period have been estimated pursuing three approaches. The study has also figured out expenditure of fiscal year 1997-1998 and 1998-99 by interpolation and provides a comparison of health expenditure 1996-2001.

Using both secondary and primary data, this study analyzes health expenditure behavior of the ultimate customers – the Bangladeshi households. A detailed review and analyses of MOHFW expenditures are provided, which should serve as a building block for continued monitoring and updating the Government's expenditure in the health sector. The relative share of other key providers – private for profit institutions and NGOs – are also studied.

I believe this report as well as the databases generated will be of much use to the policy and decision makers, researchers and academicians towards a better understanding of the trends in healthcare financing, expenditures, and the target beneficiaries.

I congratulate members of the Health Economics Unit for their efforts in undertaking this activity. I am pleased to know that Dr. A.K.M. Ghulam Rabbani, a highly respective retired civil servant, played a leading role in conducting this study. I convey my sincere appreciation to the Data International research team for the excellent job done within the timeframe. Finally, I am grateful to DFID, Bangladesh for supporting the study under the Health Economics Unit Operation Plan.

April 2004

(A.F.M. Sarwar Kamal)
Secretary
Ministry of Health and Family Welfare
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This year-long study entitled data collation and collection from secondary and primary sources. Data from several Government Ministries, Institutions and Departments had to be obtained. The assistance of the Health Economics Unit (HEU), Ministry of Health and Family Welfare (MOHFW) and the cooperation, assistance and guidance of various individuals have been invaluable in completing this study. However, it is essential to make special mention of Mr. Mustak Hassan Md. Iftekhar, former Joint Chief, HEU, Dr. Shamim Ara Begum, Dr. Ahmed Mustafa, Mr. Abdul Hamid Moral and Dr. Shahjahan Ali Khandekar of HEU. HEU assistance in soliciting participation of NGOs and private sector health providers is much appreciated.

Mr. Geoff Hoare, Senior Economist, HEU provided much guidance and encouragement in this challenging effort. Ms. Diane Northway and her colleagues at the Financial Management and Audit Unit (FWAU) were most helpful in providing detailed MOHFW budget and expenditure computerized database. Funds for this study was provided by the Department for International Development's (DFID), UK, Strategic Investment in Health Economics (SIHE) component under the Health and Population Sector Programme (HPSP).

Dr. A.K.M. Ghulam Rabbani, ex-Secretary, Government of the People's Republic of Bangladesh, was the key researcher and guide to the Data International research team. His intellectual input, demonstrable high standards for quality control, and personable guidance encouraged the team members immensely to produce a good product. Dr. Ravi Rannan Eliya, short-term international consultant on this project, provided effective input through the internet as well as during his visit to Bangladesh.

K.M. Shamsuzzaman, Khairul Abrar, Mirza Sazzadul Hoque and many other members of the Data International team sincerely worked long hours in the field in data collection. Muhammad Zahirul Hoque and Mohammed Nazmul Huq, diligently studied the data, and were the lead persons in data processing and analysis process. My colleague, Azizur Rahman, Director, Data International, and I found our coordination and management role to be a pleasant and rewarding experience due to the wonderful contributions of those mentioned above and many others not singled out.

May 2004

Najmul Hossain

Najmul Hossain
Managing Director
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Acronyms

ADB	Asian Development Bank
ADP	Annual Development Program
APNHAN	Asia Pacific National Health Accounts Network
APP	Alternative Private Practitioner
ASEAN	Association of South East Asian Network
ATP	Ability to Pay
BBS	Bangladesh Bureau of Statistics
BDHS	Bangladesh Demographic and Health Survey
BGMEA	Bangladesh Garments Manufactures and Exporters Association
BHLMS	Bangladesh Health Labor Market Study
BIA	Benefit Incidence Analysis
BIRDEM	Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders
BNHA	Bangladesh National Health Accounts
BRAC	Bangladesh Rural Advancement Committee
CAO	Chief Accounts Officer
CGA	Controller General of Accounts
CIDA	Canadian International Development Agency
CT	Cerebral Topography
CTC	Close to Client
DFID	Department for International Development
DG	Director General
DGHS	Director General of Health Services
DI	Data International Ltd.
DPA	Direct Project Aid
DSK	Dhustho Shasthya Kendra
EC	European Commission
Echo/ECG	Electro Cardio Gram
ERD	Economic Relations Division
ESP	Essential Services Package
F	Functions
FA	Financing Agents
FM	Finance Ministry
FMAU	Financial Management and Audit Unit
FP	Family Planning
FS	Financing Sources
GDP	Gross Domestic Product
GK	Gonoshastha Kendra
GOB	Government of Bangladesh
GO-NGO	Government Organization-Non Government Organization

GVA	Gross Value Added
HC	Health Care
HCP	Health Card Program
HDS	Health and Demographic Survey
HERTI	Health Education Research and Training Institutes
HES	Household Expenditure Survey
HEU	Health Economics Unit
HH	Households
HIES	Household Income and Expenditure Survey
HNP	Health and Nutrition Program
HPSP	Health and Population Sector Program
HRD	Human Resource Development
HRDU	Human Resource Development Unit
ICDDR,B	International Center for Diarrhoea Disease Research, Bangladesh
ICHA	International Classification for Health Accounts
ICHA-FC	International Classification of Health Accounts- Functional Category
ICPD	International Conference on Population and Development
ILO	International Labor Organization
IMS	International Marketing Service, South Asia
ISCO	International Standard Classification of Occupations
LGED	Local Government Engineering Department
LGRD	Local Government Rural Development
MAU	Management Accounting Unit
MCH	Medical College Hospital
MFI	Micro Finance Institution
MHI	Micro Health Insurance
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MRI	Magnetic Resonance Imagery
MSCS	Marie Stops Clinic Society
MSR	Medical and Surgical Requisites
MSS	Medical and Surgical Supplies
NAC	National Advisory Committee
NGO	Non Government Organization
NHA	National Health Accounts
NHA-2	National Health Accounts, Second Edition
NHE	National Health Expenditure
NIPORT	National Institute of Population Research and Training
NIPSOM	National Institute of Preventive and Social Medicine
NPI	Non Profit Institutions
NPISH	Non Profit Institutions Serving Households
OECD	Organization for Economic Cooperation and Development

OLS	Ordinary Least Squares
OOP	Out of Pocket Payment
P	Provider
PE	Public Expenditure
PI	Poverty Impact
PPP	Purchasing Power Parity
PPP$	Purchasing Power Parity Dollar
PRU	Policy Research Unit
R&D	Research and Development
RFP	Request for Proposal
ROW	Rest of the World
RPA	Reimbursable Project Aid
RTI	Reproductive Tract Infection
SAARC	South Asian Association for Regional Cooperation
SEARO	South East Asian Regional Office
SHA	System of Health Accounts
SHA THE	System of Health Accounts Total Health Expenditure
SIDA	Swedish International Development Agency
SNA	System of National Accounts
STD	Sexually Transmitted Disease
TBA	Trained Birth Attendant
TCHE	Total Current Health Expenditure
THE	Total Health Expenditure
TOR	Terms of Reference
UMIS	Unified Management Information System
UN	United Nations
UNFPA	United Nations Fund for Population Activates
UNICEF	United Nations International Children Emergency Fund
USAID	United States Agency for International Development
UTBA	Untrained Birth Attendants
VHSS	Voluntary Health Service Society
WB	World Bank
WHO	World Health Organization

Exchange rates and GDP used in NHA-2

Currency	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
1 US$ =	Taka 41.07	Taka 45.32	Taka 48.07	Taka 50.30	Taka 54.00	Taka 57.00
1 PPP$ =	Taka 12.64	Taka 12.64	Taka 12.64	Taka 12.64	Taka 12.64	Taka 12.64
GDP at current price (in billion Taka)	1,807	2,002	2,197	2,371	2,535	2,732
GDP in US$ (in billion)	44	44.17	45.7	47.12	46.94	47.92

Executive Summary

Background

1. The Bangladesh National Health Accounts, 1999-2001, termed as "NHA-2", represents the second endeavor of the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW) of the Government of the People's Republic of Bangladesh to compile and update estimates of the health expenditures of the country. The first initiative of compilation of National Health Accounts relates to 1996-97, termed as "NHA-1" in the report. NHA-2 provides updated and comprehensive estimates for three years relating to the fiscal years 1999-2000, 2000-2001 and 2001-2002 with 1999-2000 as the benchmark accounting year. NHA-2 also provides background revisions to NHA-1 estimates for 1996-97, along with interpolated figures for 1997-98 and 1998-99. Hence, NHA-2 makes an effort to provide time series estimates for the 1996-2001 period. NHA-2 studies the complex healthcare system of Bangladesh and analyses the expenditures occurring in the system from the perspective of providers, sources of financing and functions.

2. Along with other estimates and analyses, NHA-2 presents nationwide estimates of the three basic aggregates of national health accounting. These are: (1) National Health Expenditure (NHE); (2) Total Health Expenditure (THE); and (3) System of Health Accounts THE (SHA THE).

3. National Health Expenditure (NHE) represents the health expenditures of the nation during the accounting years comprising expenditures on all healthcare functions. Total Health Expenditure (THE) includes NHE plus capital formations of all healthcare providers and expenditures on education and research during the accounting period. SHA THE is defined as THE minus expenditures on education and research during the accounting period.

Major Findings

4. THE, NHE, and SHA THE Bangladesh estimates for the period 1996-97 to 2001-02 are presented in Table 1. The figures are presented both in local currency as well as in US dollars. In the most recent NHA-2 year estimate, 2001-02, THE amounted to over Taka 88.3 billion (1.54 billion); comparable NHE and SHA THE figures for 2001-2002 are Taka 82.8 billion ($1.45 billion) and Taka 85.3 billion ($1.49 billion) respectively. THE witnessed a real annual growth (adjusted for inflation) of around 6% during the 1996-97 to 2001-02 period while NHE increased at closer to 6.5% during the comparable period.

Table 1: Total Health Expenditures, 1996-97 to 2001-02

Indicators	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Total Health Expenditure (THE) in million Taka	55,763	62,022	68,281	74,785	80,966	88,313
National Health Expenditure (NHE) in million Taka	50,750	57,043	63,337	69,877	75,158	82,881
SHA THE in million Taka	53,038	59,438	65,838	72,485	78,225	85,301
THE in million US$	1,358	1,369	1,420	1,487	1,499	1,549
NHE in million US$	1,236	1,259	1,318	1,389	1,392	1,454
SHE THE in million US$	1,291	1,312	1,370	1,441	1,449	1,497
Real growth rate of THE	-	5.6	5.2	7.5	6.6	5.7
Real growth rate of NHE	-	6.8	6.1	8.3	5.9	6.9
Real growth rate of SHA THE	-	6.5	5.8	8.1	6.2	5.7
MOHFW as % of THE	27.6	28.3	27.2	25.7	24.0	24.3
NGO as % of THE	2.9	3	4.1	6.8	8.8	9.2
HH as % of THE	64.1	65.1	65.7	64.6	64.4	63.8
Development partners as % of THE	10.5	-	-	12.2	12.9	13.3
ESP as % of THE	-	-	-	19.7	19.1	19.9

Source: NHA-2

Note: HH = Household, GDP = Gross Domestic Product, OOP = Out of Pocket Payment
NGO = Non Government Organization, MOHFW = Ministry of Health and Family Welfare
NHA = National Health Accounts, THE = Total Health Expenditure
NHE = National Health Expenditure, SHA THE = THE following OECD-ICHA concept

5. Total Health Expenditure (THE) shows a steady increase in both per capita and total volume of expenditures. The annualized increase in real term between NHA-1 (1996-97) and the NHA-2 benchmark year of 1999-2000 is of the order of 4.4% in per capita term and 6.4% in volume term. The overall expenditures, measured by THE, also exhibit a modest rising trend in comparison to Gross Domestic Product (GDP) – from 3 % of GDP in 1996-97 to 3.2% in the terminal year covered under NHA-2, i.e. in 2001-2002.

6. Total Health Expenditure (THE) by providers for 1996-97 to 2001-02 after adjusting for inflation grew between 5.6% (1996-97 to 1997-98) and 6.6% (1999-2000 to 2000-01). While THE annual growth kept pace with GDP growth, real public expenditure consistently fell below THE as well as GDP growth rates.

7. NHA-2 captures changes occurring in the financing pattern of Bangladesh's national health expenditure. Share of the public sector in the overall financing of the national expenditure, which is dominated by MOHFW expenditures, is declining. On the other hand, shares of NGO and household OOP health expenditure have been on the rise. Compared to around 33% in 1996-97, as measured by NHA-1, the share of public sources in THE declined to 26% in 2001-2002. The share of NGO expenditures increased from

3% to 9% while household OOP health expenditure share has remained around 64% of THE during the five year period studied.

8. Overall development partners funding increased from 10.5% of THE in 1996-1997 to 13.3% in 2001-2002. Along with the overall increase, the share of development partners support to MOHFW and NGO expenditures also increased significantly in the same period both in relative and absolute terms. However, the pattern of development partners funding appears to be shifting. MOHFW is collaborating relatively more with multilateral development partners than with bilateral development partners. The reverse is the scenario in the case of NGOs.

9. The MOHFW expenditure pattern is exhibiting structural shifts. It is in conformity with the major reforms in public health policy and the impetus of Health and Population Sector Program (HPSP). Essential Services Package (ESP) has emerged as the dominant mode of MOHFW healthcare provision during 1999-2000 to 2001-02. ESP expenditures are estimated to account for around 54% of MOHFW current expenditure excluding proportionate allocation of expenditure on health administration (alternatively termed as "super overhead expenditure").

10. The emergence of Essential Services Package (ESP) as the dominant service mode of the MOHFW providers has resulted in a major shift of focus of MOHFW expenditure from the tertiary and secondary level providers to the primary providers represented by the Upazila– the third administrative tier of the government – and below level Close to Client (CTC) facilities. The shift was precipitated by a shift of development partner funding to Upazila and other CTC facilities at the grass root level, and to the provision of ESP related health goods.

11. High Out of Pocket (OOP) expenditure on purchase of pharmaceuticals continued to be the most distinctive feature of household healthcare expenditures in the years covered by NHA-2 as in the earlier year of 1996-97 covered by NHA-1. Between NHA-1 and NHA-2 pharmaceutical purchases by households remained almost unchanged at around 70% of household OOP. Total household OOP expenditure makes up for 45% of THE.

12. Per capita household OOP expenditure on healthcare for 1999-2000 is estimated around Taka 398 and $31.5 in Purchasing Power Parity (PPP) dollar. Per capita household OOP increased in real terms in the years covered by NHA-2 and rose to 3.2% per annum. The pattern of variation in per capita household OOP was analyzed by working out its decile distribution (by consumption deciles) and several other discriminatory variables such as urban and rural and administrative divisions, age, and gender.

13. Household survey database was available only for 1999-2000, and therefore the analysis was carried out for that year only. Results of the analysis suggest that of the total National

Health Expenditure (NHE) in 1999-2000, which ultimately benefited the households, 24.6% was provided by public providers, 6.7% by NGO providers, 66.9% by private for-profit providers and 1.8% by foreign providers.

Conclusion

14. NHA compilation needs to be a regular undertaking. Its institutionalization within the MOHFW is a challenging but desirable objective. The NHA-2 experience suggests a few strategies that are essential to achieve such goals.

15. First, enhanced intra and inter ministerial cooperation is essential. Departments and bodies within the MOHFW should be discouraged from lumping up various expenditures into broad categories. A disaggregated breakdown of sources of funding, functions, etc. are desirable not only for better NHA estimates but would also lead to improved accountability and transparency in the system.

16. Second, the Bangladesh Bureau of Statistics (BBS) is the premier institution of Bangladesh in conducting large-scale surveys, including on health. Greater collaboration between BBS and MOHFW in sharing of existing databases as well as initiating new surveys would be desirable and cost effective towards implementing future NHA efforts.

17. Third, the MOHFW is well-positioned to seek greater cooperation of the non-government providers – NGOs, private clinics and diagnostic centers – to provide data. Reluctance of information sharing by large sized NGOs and private sector facilities is a major data collection challenge.

18. Finally, the responsibility of effective use at the policy level of NHA findings lies primarily with the MOHFW. The role of researchers is limited to collating and collection of data and in preparing NHA-related statistical tables.

Bangladesh National Health Accounts, 1999-2001

I. Introduction

1.1 Embodying interrelated accounts, the National Health Accounts (NHA) provide a systematic compilation and analysis of the health expenditure of a country. NHA is a part of the country's national accounts. NHA traces how much is being spent on healthcare in the course of the accounting year, in what areas of healthcare it is being spent, what is being spent on and for whom. It can be used to demonstrate how the healthcare spending has changed over time, and allows inter-country comparisons of health related expenditures.

1.2 NHA-2 studies the complex healthcare system of the country and analyses expenditures occurring in the system from the perspective of providers, sources of financing and functions. In addition to portraying a picture of the financial state of the country's health system, it offers relevant information towards designing better health system policies by providing answers to the following key questions:

- How are resources mobilized and managed for the health system?
- Who pays and how much is paid for healthcare?
- Who provides goods and services and what resources do they use?
- How are healthcare funds distributed across the different services, interventions and activities that the health system produces?
- Who benefits from healthcare expenditure of goods and services transacted within the health accounts boundaries?

1.3 The National Health Accounts conceptual framework includes the definition of:

- What constitutes health expenditures?
- Components to be included in national health expenditure of a country;
- The institutional entities involved.

1.4 The Bangladesh National Health Accounts, 1999-2001, termed as "NHA-2", represents the second endeavor of the Health Economics Unit (HEU) of the Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh and compiles and updates estimates of the health expenditures of Bangladesh. The first initiative of compilation of National Health Accounts relates to 1996-97, termed as "NHA-1" in the report. NHA-2 provides updated and comprehensive estimates for three years relating to the fiscal years 1999-2000, 2000-01 and 2001-02 with 1999-2000 as the benchmark accounting year. NHA-2 also provides background revisions to NHA-1 estimates for 1996-97, along with interpolated figures for 1997-98 and 1998-99.

1.5 Periodic updates of national health accounts can be of much benefit to policy makers. They are better informed of the trend in healthcare spending by various government machineries,

the relative public-private share, and who the recipients of the interventions are. Armed with an array of national level health data and analysis, policy makers are well-positioned in implementing government health policies and objectives. More specifically, policy makers can pursue allocative as well as structural changes of the government health providers, the funding intermediaries, and in soliciting assistance and collaboration of the private sector, NGOs, and the development partners in achieving its policy goals.

1.6 Following a brief introduction, the conceptual framework of National Health Accounts is presented in Section II. The theoretical exposition includes discussion on various one-way and two-way classifications applied in computing and analyzing health expenditure data. This section also highlights the International Classification of Health Accounts (ICHA) and other international standards and guidelines that NHA-2 attempted to adhere to. Section III presents the major findings of NHA-2. It presents overall health expenditure estimates as well as expenditures by various providers, sources of funding, and types of services based on Bangladesh National Health Accounts (BNHA) classification. In addition, two-way classifications – function by provider, provider by source of funding; and function by source of funding also based on BNHA – have been developed. Detailed discussion of key institutional providers – various government ministries and departments, private clinics, diagnostic centers, NGOs, and insurance companies – appears in Chapter IV. Under the theme "Issues of Special Focus", Chapter V includes analyses on an array of health accounts related topics. More specifically, five independent notes have been prepared. These are: (1) Household Out Of Pocket (OOP) Health Expenditure; (2) Benefit Incidence Analysis; (3) Health Expenditure by Essential Services Package (ESP); (4) Health Professionals and Workers in Healthcare Industries; and (5) Health Expenditures by Development Partners. Finally, Chapter VI provides a brief conclusion.

1.7 There are seven annexes in this report. Annex 1 discusses data sources and methodology. Detailed International Classified Health Accounts (ICHA) categorization appears in Annex 2. Annex 3 to Annex 7 presents detailed statistical tables.

II. National Health Accounts Conceptual Framework

2.1 The National Health Accounts provide nationwide estimates of the two basic aggregates of national health accounting: (a) National Health Expenditure (NHE), representing the health expenditures of Bangladesh during the accounting years comprising expenditures on all healthcare functions, and (b) Total Health Expenditure (THE) which include NHE plus capital formations of all healthcare providers during the accounting period. For international comparison, a third estimate is in vogue globally, called the System of Health Accounts Total Health Expenditure (SHA THE). SHA THE includes THE minus health education expenditures.

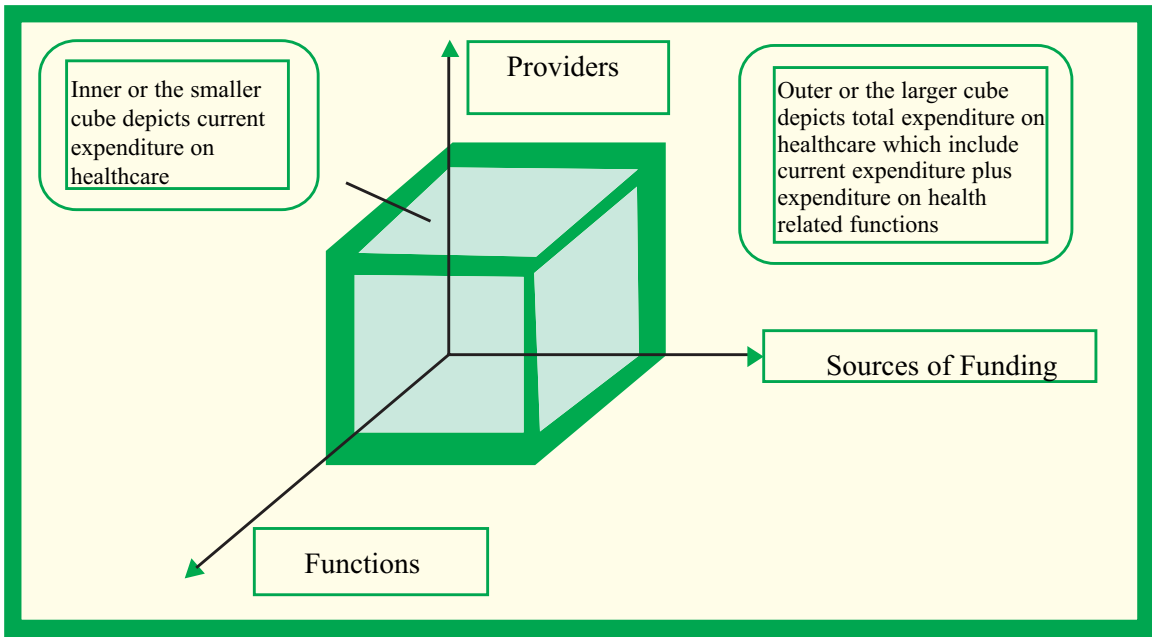
2.2 In deriving the conceptual framework of Bangladesh National Health Accounts, 1999-2001, technical guidelines provided by Organization for Economic Cooperation and Development System of Health Accounts 2000 (SHA) manual has been adhered to. The compilation process of NHA-2 is based on an integrated road map, which follows a step-by-step building block approach advocated by the World Health Organization-World Bank-United States Agency for International Development (WHO-WB-USAID) publication entitled "Guide to Produce National Health Accounts"; for brevity termed as the "Guide" in this report.

2.3 The core objective of NHA-2 is to provide nationwide estimates on the three basic goals of national health accounting for the country:

- Sources of funding of healthcare expenditures – where does the money for health expenditures come from?
- Providers of healthcare services and goods – where does the money go?
- Functions of healthcare – what types of goods and services are purchased in the country?

2.4 For conceptualizing National Health Accounts (NHA) in an accounting framework, SHA recommends interlinking the three basic goals of healthcare in a three-dimensional or a tri-axial system of healthcare expenditures as defined by: (F) Functions of health care; (P) Providers of health care; and (FA) Funding (or financing agents) of healthcare (Figure 2.1).

Figure 2.1: SHA Tri-axial System of Recording National Healthcare Expenditures



National Health Expenditure Cube

Total healthcare expenditure of the nation can be viewed in a three dimensional space which helps in bringing out the linkages among the three vectors or one-way classifications of health expenditures. These are: providers, functions and sources of funding. Since the total health expenditures measured by each of the three vectors must be equal, a cube with equal sides represents total national health expenditure. As any two opposite sides of the cube are equal, only three adjacent sides of the cube are relevant for analysis. They can be visualized to represent the size of expenditure classified by (a) providers by functions; (b) providers by sources of funding; and (c) functions by sources of funding.

In the diagram (Figure 2.1), two cubes are presented. The smaller cube depicts current expenditures on healthcare and the larger or the outer cube depicts total expenditures on healthcare, which include current expenditures plus expenditures on health relaed functions.

2.5 Following the SHA guidelines, NHA-2 comprises three two–dimensional tables or matrices providing: (a) Current healthcare expenditures cross-classified by Providers and Sources of funding; (b) Current health expenditures cross-classified by Providers and Functions; and (c) Current expenditures cross-classified by Sources and Functions. Since capital formation by healthcare providers is a key policy variable, NHA-2 also provides a matrix (two-way table) on THE – current healthcare expenditure plus capital – cross-classifying with healthcare functions and providers.

2.6 The boundary of NHA-2 was determined by including all healthcare expenditures related to International Classification of Health Accounts (ICHA) healthcare functions. ICHA healthcare functions define the boundary of the healthcare system for Bangladesh and thereby delimit the subject area of NHA. Operationally this implies that NHA-2 aimed at capturing all healthcare expenditures by resident Bangladeshis both at home and abroad that fell within ICHA functional categories during the NHA-2 accounting periods. For lack of data and system of estimation, healthcare expenditures of non-residents within the territory of Bangladesh (which are technically "export" of healthcare) are not identified separately and remain embedded within the total national expenditures. Following the Guide, NHA-2 also includes goods and services provided by traditional (practicing non-allopathic or non-western), informal and nonlicensed (possibly illegal) providers.

2.7 For compiling NHA-2, the broad ICHA Functional Classifications (ICHA FC) that were adapted are presented in Table 2.1. ICHA classification system categorizes healthcare both by the basic functions of care (curative, rehabilitative and long-term nursing care) and by mode of production (in-patient, day care, out-patient and home care). It defines the components of personal or individual healthcare as well as collective healthcare.

2.8 As evidenced in Table 2.1, HC1 to HC5 ICHA codes represent personal healthcare functions and includes services and goods that can be directly allocated to individuals. Collective care or services provided to society at large are included under prevention and Public Health Services (HC6), and Health Administration and Health Insurance under HC7.

Table 2.1: ICHA 3-digit Classification of Healthcare Functions

ICHA code	Functions of Healthcare
HC1	Services of curative care
HC2	Services of rehabilitative care
HC3	Services of long term nursing care
HC4	Ancillary services to healthcare
HC5	Medical goods dispensed to out-patients
HC6	Prevention and public health services
HC7	Health administration and health insurance
ICHA code	**Health-related Functions**
HCR.1	Capital formation of healthcare provider institutions
HCR.2	Education and training of health personnel
HCR.3	Research and development in health
HCR.4	Food, hygiene and drinking water control
HCR.5	Environmental health

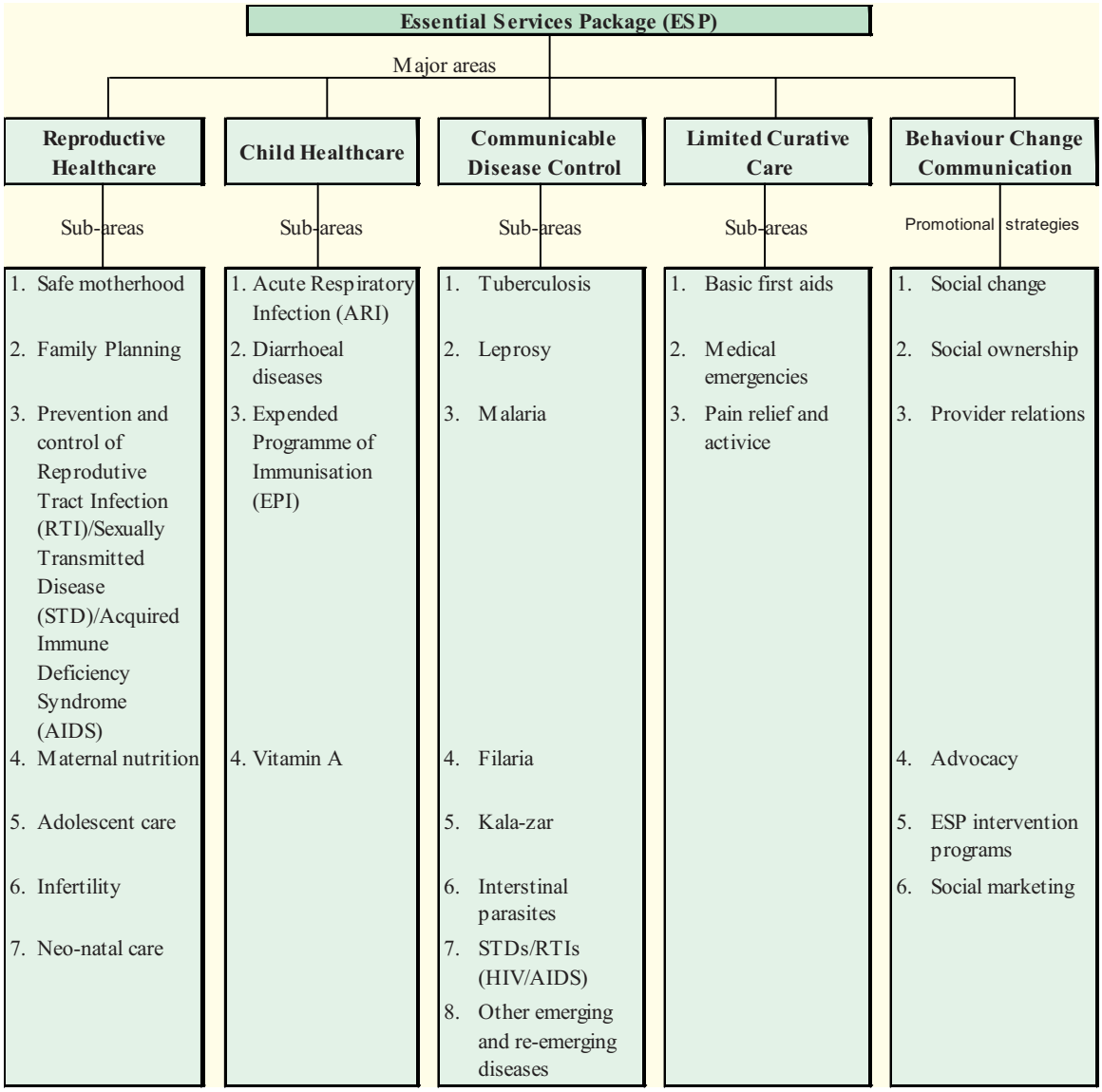
2.9 Three aggregate measures of health spending are obtained from the ICHA Functional Classification (FC):

- Total expenditure on personal healthcare: sum of expenditures under categories HC1 through HC5;
- Total Current Expenditure on Health (TCHE): sum of expenditures classified under categories HC1 through HC7; and
- Total Expenditure on Health (THE): sum of TCHE plus capital formation by health provider institutions.

2.10 Several of the ICHA functions, such as Social Security (HC.7.1.2) and Private Social Insurance (HC.7.2.2) are yet to develop in Bangladesh. Furthermore, data on long term Home Nursing Care Expenditures (HC.3.3) are difficult to generate. As a result NHA-2 is unable to provide data on these healthcare functions.

2.11 Provision of the Essential Service Package (ESP) is of key policy relevance in Bangladesh. ESP can be functionally identified as a sub-set of prevention and public health services including a limited level of curative care. Current national level expenditures on ESP estimated under NHA-2 are provided. The estimates comprise: Maternal and Child Health, Family Planning and Counseling (HC 6.1); School Health Service (HC 6.2); Prevention of Communicable Diseases (HC 6.3); Public Health Services of Health Education, Disease Prevention and Promotion of Healthy Living Conditions and Lifestyle (HC 6.4); Miscellaneous Public Health Services like public health surveillance and public information on environmental conditions (HC 6.9); and a very limited component of Curative Care (HC 1). Economy wide ESP estimates by providers as well as resource costs for providing it have been attempted. A schematic presentation of Bangladesh's ESP, identifying the major as well as sub-areas appear in Figure 2.2.

Figure 2.2: Structure of Essential Services Package



Source : MOHFW, International Conference on Population and Development (ICPD) Bangladesh Country Report 1999

2.12 The ICHA classification of primary care is relatively capital intensive and implies advanced technology. Hence no attempt was made to accommodate ESP activities under ICHA classification in NHA-2.

Classification of Healthcare Providers

2.13 There are a wide range and types of healthcare providers in Bangladesh and their proper identification and classification was important for developing NHA-2. The three broad categories of providers are: (a) public providers, (b) private providers, and (c) Non-Profit Institutions Serving Households (NPISH) commonly known as Non Governmen Organization (NGO) providers.

2.14 Public providers include General Government (Central and Local Governments), Public Corporations and Government owned Non-Profit Institutions (NPI) healthcare institutions. Private healthcare providers include healthcare enterprises, including private clinics and hospitals, diagnostic and imaging centers, private modern ambulatory practitioners as well as a large number of traditional healthcare providers operating as unincorporated enterprises. NGO providers operate largely at grass root levels and are dependent on government and development partner transfers. All three categories of providers also perform health related functions of capital formation, education and training of varying degrees.

2.15 The Government and NGO providers are non-market providers in that the services they provide are generally not offered in the market. Private providers including traditional providers are all market operators. Therefore, for NHA-2 data collection and analysis, Public-NGO-Private categorization of providers is essential. A broad categorization of health providers for Bangladesh is presented in Table 2.2.

Table 2.2: Categorization of Healthcare Providers for Bangladesh

BNHA Code	Category
1	General government of Bangladesh healthcare providers:
1.1.1	Ministry of Health and Family Welfare (MOHFW)
1.1.1.1	MOHFW secretariat
1.2	Local government facilities
1.3	Facilities of central government owned corporations and autonomous bodies
1.4	Facilities of the central government NPIs (mainly public universities)
1.5	Health Education, Research and Training Institutions (HERTI)
2	Nonprofit Institutions Serving Households (NPISH)/NGOs
3	Private corporations/enterprise owned health services providing occupational healthcare
4	Private for profit providers
5	Foreign providers

2.16 NHA-2 adapted the ICHA classification of healthcare providers in the context of Bangladesh for international comparison and standardization of compilation. ICHA provider classification is by functional categories, while the convenient means of identification of Bangladesh providers is to follow through their institutional affiliations, i.e. whether they belong to the public, private or NGO categories.

Sources of Healthcare Funding

2.17 ICHA financing classification provides a breakdown of health expenditures into public and private institutional units incurring expenditures on healthcare and is harmonized with the System of National Accounts (SNA-93) central framework of institutional sectors.

SHA classification is designed to provide estimates of total resource costs of each of the funding units net of the flow of funds, such as current transfers or capital grants. The classification therefore provides non-overlapping actual costs incurred by the financing entities in funding health expenditures of the country. Table 2.3 presents the ICHA classification of sources of healthcare funding or financing agents.

Table 2.3: ICHA Classification of Sources of Healthcare Funding or Financing Agents

ICHA- HF Classification of Sources of Funding	
ICHA Code	**Source of Funding**
HF.1	General government
HF.2	Private sector
HF. 2.2	Private insurance other than social insurance
HF. 2.3	Private households
HF. 2.4	Non-profit institutions serving households (other than social insurance)
HF. 2.5	Corporations (other than social insurance)
HF. 3	Rest of the world

2.18 From an operational viewpoint, in Bangladesh, financing sources do not provide funds directly to the providers except to private households. In most cases, the financing sources provide funds to financial intermediaries or financing agents (as defined in the Guide), who in turn provide funds to the providers. Healthcare financial intermediaries therefore can be defined as entities that pass funds from financing sources to other financial intermediaries or providers in order to pay for the provision of healthcare.

Categorization of Healthcare Financial Intermediaries

2.19 The Bangladesh healthcare financial intermediaries or financing agents are classified under the following categories:

- Government of Bangladesh (GOB) Ministries and Departments;
- Ministry of Health and Family Welfare (MOHFW) Revenue and Development Budgets as separate funding channels;
- NGOs acting as intermediaries;
- NGO health insurance/community insurance schemes;
- Commercial health insurance schemes.

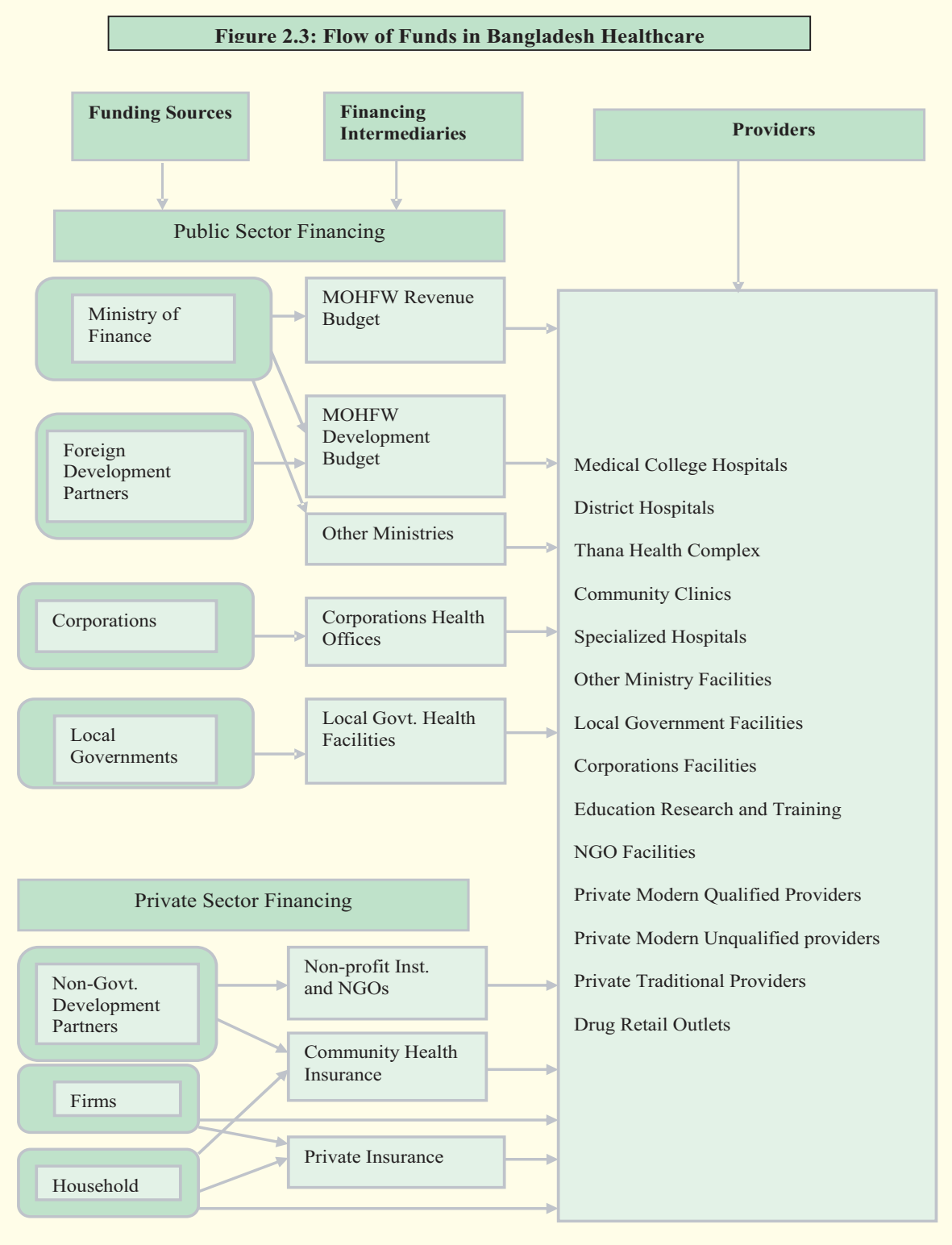
Following the above categorization, NHA-2 specifically identifies a number of entities as financing intermediaries (Table 2.4).

Table 2.4: Healthcare Financing Intermediaries

General Government of Bangladesh Intermediaries	
1.	Central Government
1.1	MOHFW
1.1.1	Revenue budget
1.1.2	Development budget
1.2	Ministry of Defense
1.3	Ministry of Home Affairs
1.4	Ministry of Establishment
1.5	Other ministries and divisions
1.6	GOB owned public corporations
2.	Local Governments
NGO Intermediaries	
1.	NGOs that contract with other NGOs
2.	NGO health insurance/financing schemes

2.20 Bridging of the financial intermediaries and the funding sources can be visualized from the flow of funds among them. Figure 2.3 traces the flow of funds among the intermediaries and the ultimate funding sources.

Figure 2.3: Flow of Funds in Bangladesh Healthcare



2.21 Financial intermediaries are thus the operational channels through which healthcare funding flows from the funding sources to the providers. Accordingly, their identification in the Bangladesh healthcare financing process and inclusion of these in selected classifications are useful for policy purposes. The intermediaries help in tracing the flows of financing from the funding sources and in avoiding duplication of expenditures.

2.22 In addition to the core classifications described above, NHA-2 also classified the beneficiary population by selected policy relevant categories such as gender and age groups, by residence categories such as urban rural and the six administrative divisions. Classification was also made by broad disease categories such as acute and chronic diseases. These classifications are in line with the Organization for Economic Cooperation and Development – System of Health Accounts, 2000 (OECD-SHA) manual and the Guide to Produce National Health Accounts, 2003 (Guide). Along with estimates of healthcare providing institutions and enterprises, an estimate of the healthcare providing human resources of the country is also provided following modification of the OECD manual recommendations.

Expected Outputs of NHA-2

2.23 The NHA-2 objectives are extended to develop outputs, which require production of economy wide information on health care expenditures on various entities. The ICHA healthcare vectors or the basic one-way classifications of ICHA include:

- Providers (P): entities that deliver healthcare services within the health accounts boundary in exchange of or in anticipation of receiving money;
- Financing Sources (FS): institutions or entities that provide funds used in the system by financing agents or financing intermediaries;
- Financing Agents (FA) or Financing Intermediaries: institutions or entities that channel funds provided by financing sources and use those funds to pay for, and or purchase of services within the health accounts boundary;
- Functions (F): the type of goods and services provided and activities performed within the health accounts boundary.

The three two-way cross-classifications are:

- FA x P
- P x F
- FA x F

These matrices cross–tabulate health expenditures by type of: (a) financing agents and providers; (b) healthcare expenditure and functions; and (c) providers and functions. The matrices form the core tables of NHA-2.

2.24 The table exhibiting health expenditures by type of financing and producers (FA x P) demonstrate the flows of financing to different providers from various financing agents. It answers the question of "who finances whom" in the country's health system. It is an important tool for estimating total health spending and constituted an early focus of NHA initiative in Bangladesh under NHA-1.

2.25 The table cross-classifying health expenditure by type of provider and by function (P x F) demonstrate how expenditures on different health functions are channeled through various providers and analyses "who does what". It provides a perspective on the contribution of different types of providers to the total spending on specific types of healthcare. Essential for delineating healthcare boundary, the table also attempts disaggregating NHE from THE and other health related spending.

2.26 The table cross-classifying health expenditures by financing agent and by function (FA x F) exhibit who finances what types of services in the country's health system and highlights key policy issues of resource allocation. This table is derived from the two tables described earlier. The table cross-classifying health expenditures by type of financing source and financing agents (FS x FA) highlights resource mobilization patterns in the country's health system and addresses the question of "where does the money come from" by showing the contribution of the financing sources to each financing agent. In NHA-2 this table is the designated flow of funds for healthcare expenditures.

Distribution of Health Expenditure

2.27 Distributional analysis or the Benefit Incidence Analysis (BIA) of the beneficiary population forms an extension of NHA-2 compilation and analysis. Several tables showing the distribution of Household (HH) expenditures on healthcare by key distributional categories such as demographic, socio-economic status, broad disease classes and geographic areas have been produced. These tables supplement core tables of NHA-2, they focus on the financial and the organizational mechanics of providing healthcare services within the country's healthcare boundary and the scope of the NHA-2 analysis.

Benefit Incidence Analysis (BIA) Coverage

- Demographic variables groupings by broad age groups, sex, and by urban and rural residence;
- Socio-economic status by deciles and by poor (lowest decile) and rich (highest decile) comparison;
- Broad disease status grouping by broad disease category, namely acute and chronic diseases; and
- Geographical distribution of household expenditures by the six administrative divisions of the country and by rural urban disaggregation.

Accrual Accounting of NHA

2.28 NHA-2 is based on accrual accounting of the relevant expenditure flows, which requires expenditures to relate to the time period of occurrence of the healthcare event and not to the period during which actual cash disbursement took place. This obliges the period of actual expenditure and occurrence to strictly coincide. The Public and NGO providers are non-market providers and their expenditures are on cash basis and generally relate to the time period during which actual cash disbursement take place. NHA-2 minimized this problem of mismatch by working with the actual expenditures that were booked against the time period of occurrence and not with disbursements. Accounts of the private institutional providers are on an accrual basis. Household expenditures relate to the actual expenditures occurring during the survey designated reference periods and satisfy accrual criteria. Expenditures on services provided by traditional and modern ambulatory providers are such where payments and occurrences all coincide and thereby conform to the accrual criteria.

NHA Accounting Year

2.29 The System of National Accounts (SNA-93) recommends compilation of all accounts relating to national accounting to be on a calendar year basis to ensure proper international comparison. However, all government accounts and the Public Budget in Bangladesh are based on fiscal or split year of July through June basis. National accounts of Bangladesh are compiled on fiscal year basis as well. Following the lead of NHA-1, which was on fiscal year basis, NHA-2 is compiled on split or fiscal year basis. All data for NHA-2 compilation, including public sector and survey data, were available or collected on split year basis. This deviation from international practice needs to be kept in view particularly in international comparisons.

2.30 The time boundary of NHA-2 comprises the fiscal year 1999-2000 as the base year with extension to the subsequent two fiscal years 2000-01 and 2001-02. NHA-2 also provides background revisions to NHA-1 estimates for 1996-97, along with interpolated figures for 1997-98 and 1998-99. The extension was conducted primarily to establish the

time trend in national health expenditures and to test the feasibility of compiling NHA annually. The fiscal year relates to the split year of July through June and the choice was dictated by the availability of government and other public accounts, Non Government Organization (NGO) accounts and the various household surveys of the Bangladesh Bureau of Statistics (BBS), which are conducted on a fiscal year basis.

Mapping Bangladeshi Providers with ICHA

2.31 Restricting NHA-2 detailed two-way estimation to the ICHA classifications would preclude identification of specific local institutions, organizations, or activities that warrant a closer look. Accordingly, Bangladesh National Health Accounts (BNHA) codes have been created. Tables 2.5, 2.6, and 2.7 provide mapping of providers, healthcare functions and financing sources developed respectively by BNHA with those of ICHA.

Table 2.5: Health Providers Classification (with corresponding ICHA codes)

BNHA Code	BNHA Description	ICHA Code
1.	**General Government of Bangladesh**	
1.1	Central Government	
1.1.1	Ministry of Health and Family Welfare	
1.1.1.1	MOHFW secretariat	HP 6.1
1.1.1.2	University medical college hospitals	HP 1.1
1.1.1.3	Medical college hospitals	HP 1.1
1.1.1.4	District hospitals	HP 1.1
1.1.1.5	Thana and lower level facilities	HP 1.1
1.1.1.6	Specialized hospitals	HP 1.3
1.1.1.7	Other facilities	HP 1
1.1.1.7.1	Other out-patient facilities	HP 1
1.1.1.7.2	Other maternity facilities	HP 3.4.1
1.2	Other Ministries	
1.2.1	Other ministry hospitals	HP 1.1
1.2.2	Other ministry clinics	HP 3.4.5
1.3	Local government facilities	HP 1.1
1.4	Facilities of central government owned corporations and autonomous bodies	HP1.1
1.5	Health education, research and training institutions	NEC
2.	**Non-profit Institutions Serving Households (NPISH)/NGOs**	
2.1	NGO hospitals	HP 1.1
2.2	NGO clinics	HP 3.4.1

Table 2.5: Health Providers Classification (with corresponding ICHA codes) (Continued)

BNHA Code	BNHA Description	ICHA Code
2.3	Other NGO facilities (except clinics and hospitals)	HP 3.4.9
2.1	Blood bank	HP 3.9.2
2.4	Eye bank	HP 3.9.2
2.5	Other organ banks	HP 3.9.2
3.	**Private Corporations/ Enterprise Owned Health Services**	
3.1	Private corporations owned hospitals	HP 1.1
3.2	Private corporations owned clinics	HP 7.1
4.	**Private for Profit Providers**	
4.1	Private modern qualified medical providers	
4.1.1	Private clinics and hospitals	HP 1.1
4.1.2	Out-patient medical providers	HP 3.3
4.1.3	Private dental providers	HP 3.2
4.1.4	Other for profit medical providers	HP 3
4.2	Private alternative/unqualified medical providers	
4.2.1	Private alternative/unqualified medical providers	HP 3.9.9
4.2.1.1	Western	HP 3.9.9
4.2.1.2	Ayurvedic	HP 3.9.9
4.2.1.3	Homeopathic	HP 3.9.9
4.2.1.4	Uninani	HP 3.9.9
4.2.1.5	Other traditional providers (except Homeopathic, Ayurvedic and Uninani)	HP 3.9.9
4.3	Diagnostic/ imaging services providers	
4.5.1	Diagnostic and imaging services	HP 3.5
4.6	Drug and medical goods retail outlets	
4.6.1	Pharmacies	HP 4.1
4.6.2	Orthopedic appliances shop	HP 4.4
4.6.3	Glasses and vision product shops	HP 4.2
4.6.4	Hearing goods shops	HP 4.3
4.6.5	Private blood donors	HP 3.9.2
4.6.6	Private organ donors	HP 3.9.2
4.8	Health insurance administration/ companies	
4.8.1	Private insurance administration	HP 6.4
4.8.2	Community health insurance	HP 6.3
5	**Foreign Providers**	HP 9

Table 2.6: Functional Classification of Healthcare (with related ICHA codes)

BNHA Code	Health Expenditure by Functions	OECD Code
1	**Personal Healthcare**	
1.1	Hospital services	
1.1.1	In-patient curative care	HC 1.1
1.1.2	Out-patient curative care	HC 1.3
1.1.3	In-patient rehabilitative care	HC 2.1
1.1.4	Out-patient rehabilitative care	HC 2.3
1.1.5	Out-patient dental care	HC 1.3.2
1.2	Ambulatory healthcare services	HC 1.3.9
2	**Diagnostic and Imaging**	HC 4.2
3	**Medicine and Other Medical Goods**	HC 5
3.1	Drug retail outlets	HC 5.1.1
3.2	Other medical goods outlets	HC 5.1.3
4	**Collective Healthcare**	
4.1	Family planning service	HC 6.1
4.2	School health services	HC 6.2
4.3	Prevention of communicable disease	HC 6.3
4.4	Health awareness creation	HC 6.9
4.5	Occupational healthcare	HC 6.5
5	**Health Administration and Insurance**	HC 7
5.1	General government administration of health	HC 7.1.1
5.2	Private health insurance administration	HC 7.2.2
5.3	Community health insurance	HC 7.2.1
	Health Related Functions	
6	Capital Formation	HCR 1
7	Health Education and Training	HCR 2
8	Health Research	HCR 3

Table 2.7: Health Financing Source Classification (with corresponding ICHA codes)

BNHA Code	Financing Sources	ICHA code
1	Government of Bangladesh	HF 1
1.1	Central Government	HF 1.1.1
1.1.1	Ministry of Health and Family Welfare	HF 1.1.1
1.1.1.1	Revenue Budget	HF 1.1.1
1.1.1.2	Development Budget (ADP)	HF 1.1.1
1.1.2	Ministry of Defense	HF 1.1.1
1.1.3	Ministry of Home Affairs	HF 1.1.1
1.1.4	Ministry of Education	HF 1.1.1
1.1.5	Railway Division	HF 1.1.1
1.1.6	Other Ministries and Divisions	HF 1.1.1
1.2	Local Government	HF 1.1.3
1.3	Corporations and Autonomous Bodies	HF 1.1.4
2	Foreign Development Partners	
3	Non-profit Institutions/NGOs	HF 2.4
4	Private Insurance	HF 2.2
5	Community Health Insurance	HF 2.1
6	For-profit Enterprises	HF 2.5
7	Households	HF 2.3

III. Major Findings

3.1 This chapter presents the salient findings under NHA-2. In conformity with the Conceptual Framework delineated in the preceding chapter, the estimates are provided in the following sequence. First, overall health expenditures and its relevance to the economy and its various key players are discussed. Effort is made in providing absolute and relative changes in health expenditure over the 1996-2001 period. Second, according to Bangladesh National Health Accounts (BNHA) codes, which are based on International Classified Health Accounts (ICHA), health expenditure by functions, providers, and sources of funding are estimated for 1996-2001. Third, the one-way tables are further disaggregated into two-way classification tables. More specifically, (a) Function by Provider; (b) Provider by Source of Funding; and (c) Function by Source of Funding are analyzed. The estimates are presented in local currency, Taka, and converted into US dollars in selected cases. The prevailing official exchange rate during each year was used to quote in dollar figures. The estimates are presented in nominal terms. The real value estimates (adjusted for inflation) appear in selected tables.

Total Health Expenditure Estimates

3.2 As defined in Chapter II, National Health Expenditure (NHE), encompasses health expenditures of a country during the accounting years comprising expenditures on all healthcare functions. Total Health Expenditure (THE) which include NHE plus capital formations, education and research expenditures of all healthcare providers during the accounting period. The System of Health Accounts Total Health Expenditures (SHA THE) include entire THE minus health education and research expenditures.

3.3 THE, NHE, and SHA THE Bangladesh estimates for the period 1996-97 to 2001-02 are presented in Table 3.1. The figures are presented both in local currency as well as in US dollars. Share of key expenditure sources are also presented in Table 3.1. In the most recent NHA-2 year estimate, 2001-02, THE amounted to over Taka 88.3 billion ($1.54 billion); comparable NHE and SHA THE figures for 2001-2002 are Taka 82.8 billion ($1.45 billion) and Taka 85.3 billion ($1.49 billion) respectively. THE witnessed a real growth (adjusted for inflation) of around 5.7% during the 1996-97 to 2001-02 period while NHE increased at closer to 7% during the comparable period.

Table 3.1: Total Health Expenditures, 1996-97 to 2001-02

Indicators	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
Total Health Expenditure (THE) in million Taka	55,763	62,022	68,281	74,785	80,966	88,313
National Health Expenditure (NHE) in million Taka	50,750	57,043	63,337	69,877	75,158	82,881
SHA THE in million Taka	53,038	59,438	65,838	72,485	78,225	85,301
THE in million US$	1,358	1,369	1,420	1,487	1,499	1,549
NHE in million US$	1,236	1,259	1,318	1,389	1,392	1,454
SHA THE in million US$	1,291	1,312	1,370	1,441	1,449	1,497
Real growth rate of THE	-	5.6	5.2	7.5	6.6	5.7
Real growth rate of NHE	-	6.8	6.1	8.3	5.9	6.9
Real growth rate of SHA THE	-	6.4	5.8	8.1	6.2	5.7
MOHFW as % of THE	27.6	28.3	27.2	25.7	24.0	24.3
NGO as % of THE	2.9	3	4.1	6.8	8.8	9.2
HH as % of THE	64.1	65.1	65.7	64.6	64.4	63.8
Development partners as % of THE	10.5	-	-	12.2	12.9	13.3
ESP as % of THE	-	-	-	19.7	19.1	19.9

Source: NHA-2

Note: HH = Household, SHA = System of Health Accounts
NGO = Non Government Organization, MOHFW = Ministry of Health and Family Welfare
NHA = National Health Accounts, NHE = National Health Expenditure

3.4 NHA-2 captures changes occurring in the financing pattern of the national health expenditure. Share of the public sector in the overall financing of the national expenditure, which is dominated by MOHFW expenditures, suggest a declining trend. On the other hand, shares of NGO and Household Out of Pocket (OOP) health expenditure have been on the rise. Compared to 27.6% in 1996-97, as measured by NHA-1, the share of MOHFW in THE declined to 24.3% in 2001-2002 (Table 3.1). The share of NGO expenditures increased from 3% to 9%. Share of household OOP expenditure has remained relatively steady during the period studied at around 64%.

3.5 Overall donor funding increased from 12.2% of THE in 1999-2000 to 13.3% in 2001-2002. Along with the overall increase, the share of donor support to MOHFW and NGO expenditures also increased significantly in the same period both in relative and absolute terms.

3.6 Major structural adjustments are arguably occurring in the pattern of MOHFW expenditures. It is in conformity with the major reforms in public health policy and the impetus of Health and Population Sector Program (HPSP). Essential Services Package (ESP) has emerged as the dominant mode of MOHFW healthcare provision in the period 1999-2000 to 2001-2002. ESP expenditures are estimated to account for around 54% of MOHFW current expenditure excluding proportionate allocation of expenditure on

health administration (alternatively termed as "super overhead expenditure"). In terms of percentage of NHE, ESP's share is approximately 20% in 1999-2000 (Table 3.1). ESP commenced around 1998, and therefore its estimates are limited to the recent years.

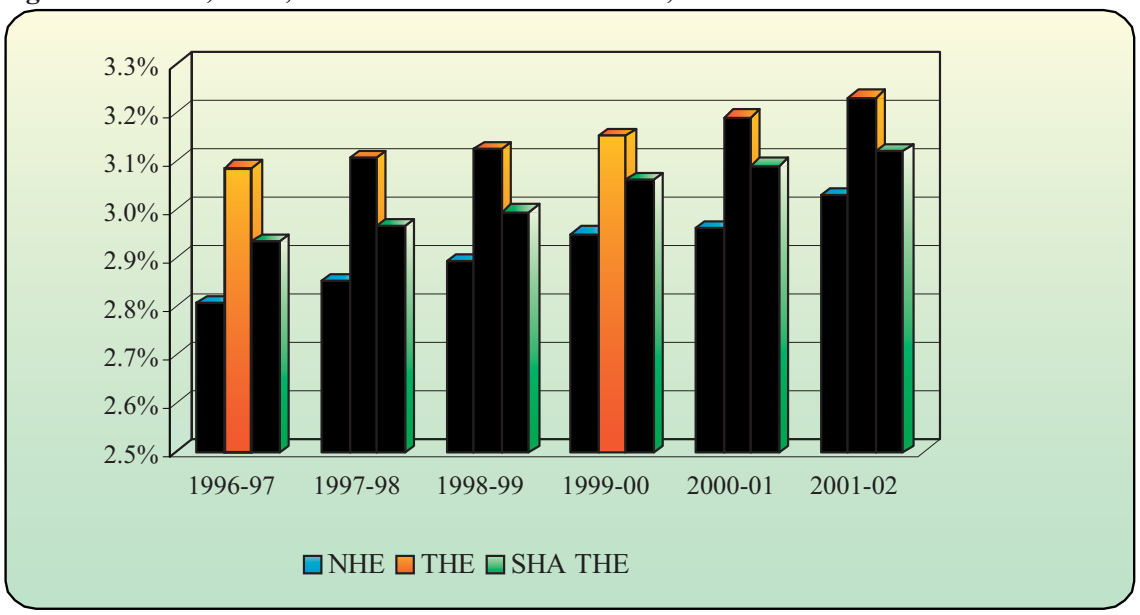
3.7 Table 3.2 and Figure 3.1 presents THE, NHE, and SHA THE as a percent share of Gross Domestic Product (GDP) of Bangladesh. Both NHE and THE have shown a modest increase in their share to GDP. In 1996-97, THE's share to GDP was 3.1%, which increased to 3.2% in 2001-02. Comparable figures for NHE are 2.8% and 3.03% for 1996-97 and 2001-02 respectively.

Table 3.2: THE, NHE, SHA THE as Percent of GDP, 1996-2001

Indicator	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
NHE	2.81	2.85	2.89	2.95	2.96	3.03
THE	3.09	3.11	3.12	3.15	3.19	3.23
SHA THE	2.94	2.97	3.00	3.06	3.09	3.12

Source:NHA-2

Figure 3.1: THE, NHE, SHA THE as Percent of GDP, 1996-2001



Source: NHA-2

3.8 Per capita real (adjusted for inflation) THE, NHE, SHA THE are presented in Table 3.3. For 1996-97 to 2001-02, computed dollar figures are also provided. Compared to Taka 486 ($11.8) in 1996-97, in 2001-02 per capita THE is Taka 592 ($10.4).

Table 3.3: Real Per Capita THE, NHE, SHA THE, 1996-2001

Indicator	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
NHE (Taka)	442 ($10.8)	471 ($10.4)	500 ($10.4)	497 ($9.9)	519 ($9.6)	555 ($9.7)
THE (Taka)	486 ($11.8)	513 ($11.3)	539 ($11.2)	532 ($10.6)	560 ($10.4)	592 ($10.4)
SHA THE (Taka)	462 ($11.2)	491 ($10.8)	520 ($10.8)	516 ($10.3)	541 ($10.0)	571 ($10.0)

Source: NHA-2

One-Way Classification of Health Expenditure

Functions

3.9 Total Health Expenditure (THE) by healthcare functions, categorized by ICHA code, is presented in Table 3.4. The table provides both Bangladesh NHA code and the corresponding ICHA/OECD code. Within the subcategory of personal health services, drug retail outlets make up for more than 57% of the expenditure by function. In-patient curative care is the second largest component under personal health services, amounting to around 14% of personal health services expenditure. International comparisons suggest in-patient expenditure as a percent of THE is relatively low in Bangladesh. Ambulatory healthcare services suggest an increase in value of services in recent years, amounting to Taka 8,082 million ($141.79 million) in 2001-02. Out-patient curative care and diagnostic facilities are the other major functional expenditures under personal health services – Taka 6,574 million ($115.33 million) and Taka 3,751 million ($65.81million) respectively in 2001-02.

Table 3.4: Total Health Expenditure by NHA-2 Functions, 1996- 2001

BNHA Code	Health Expenditure by Functions	OECD Code	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
1	**Personal Health Services**							
1.1	Hospital services							
1.1.1	In-patient curative care	HC 1.1	5,943	7,525	9,107	10,254	10,173	11,185
1.1.2	Out-patient curative care	HC1.3	2,670	3,475	4,280	5,456	5,737	6,574
1.1.3	In-patient rehabilitative care	HC 2.1		42	83	125	90	99
1.1.4	Out-patient rehabilitative care	HC 2.3		12	25	37	43	43
1.1.5	Out-patient dental care	HC 3.2		33	66	99	111	125
1.2	Ambulatory healthcare services	HC 1.3.9	4,447	5,123	5,797	6,473	7,221	8,082
2	**Diagnostic and Imaging**	HC 4.2	3,122	3,273	3,423	3,574	3,660	3,751
3	**Medicine and Other Medical Goods**	HC 5						
3.1	Drug retail outlets	HC 5.1.1	25,234	28,156	31,078	34,000	36,687	39,625
3.2	Other medical goods outlets	HC 5.1.3		40	81	121	136	172
4	**Collective Health Services**							
4.1	Family planning service	HC 6.1	6,760	6,214	5,671	5,422	6,807	8,117
4.2	School health services	HC 6.2		1	3	4	11	13
4.3	Prevention of communicable disease	HC 6.3		144	288	432	586	643
4.4	Health awareness creation	HC 6.9		605	1,211	1,830	1,915	2,039
4.5	Occupational healthcare	HC 6.5	1,044	865	686	507	507	521
5	**Health Administration and Insurance**	HC 7						
5.1	General government administration of health	HC 7.1.1	1,525	1,526	1,526	1,527	1,447	1,860
5.2	Private health insurance administration	HC 7.2.2	2	2	3	3	10	11
5.3	Community health insurance	HC 7.2.1	3	7	9	13	17	21
	Health Related Functions							
6	Capital Formation	HCR 1	2,288	2,395	2,501	2,608	3,067	2,420
7	Health Education	HCR 2	2,725	2,491	2,256	2,020	2,638	2,940
8	Health Research	HCR 3		93	187	280	103	72
	THE		55,768	62,022	68,281	74,785	80,966	88,313
	SHA THE		53,038	59,438	65,838	72,485	78,225	85,301
	NHE		50,750	57,043	63,337	69,877	75,158	82,881

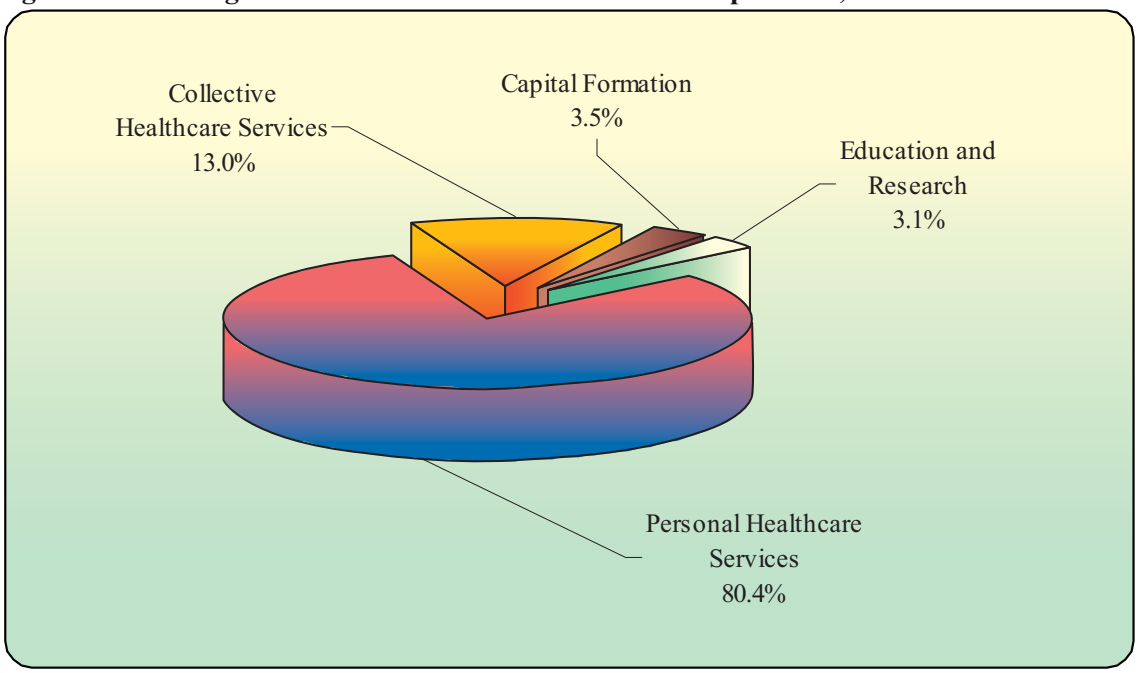
Source: NHA-2

3.10 Expenditures on curative care service has increased both in absolute and relative terms over the years. From a share of Taka 8.6 billion (16%) of Total Health Expenditure (THE) in 1996-97 (NHA-1), curative care (HC 1.1, HC 1.3) expenditures' share increased to Taka 15.7 billion (21%) in NHA-2 terminal year, 1999-2000.

3.11 Expenditure on prescribed medicine remained fairly steady at 46% of THE during the NHA-1 and NHA-2 periods. Maternal and Child healthcare expenditures have declined from over Taka 6,760 (12%) (Table 3.4) in NHA-1 to around Taka 5,422 million (7%) in the NHA-2 period. Health administration of MOHFW remained relatively unchanged at 2% of THE, while capital formation increased from over Taka 2,288 million (4%) in NHA-1 to around Taka 2,608 million (3%) in 1999-2000 of NHA-2. Education and training followed the pattern of health research expenditure – an insignificant 0.1% of THE.

3.12 Family planning services dominate the collective health services component. Over Taka 8,117 million ($142 million) was spent under this activity in 2001-02, making up for 72% of the collective health service category. Capital formation and education and research contribute a relatively small percentage – both 3% respectively – of the total expenditure under functional classification (Figure 3.2). According to Figure 3.2 personal healthcare service is the dominant functional component (80.4%) followed by collective health services (13%).

Figure 3.2: Percentage Functional Distribution of Total Health Expenditure, 1999-2000



Source: NHA-2

Providers

3.13 Health providers of Bangladesh can be subdivided into four broad categories: Public, NGO, Private and Foreign (countries). Table 3.5 identifies the key health providers under the Government of Bangladesh, private and NGO sectors.

Table 3.5: Key Healthcare Providers in Bangladesh

Government of Bangladesh	Private	NGOs
University and Medical College Hospitals	Private Clinics and Hospitals	NGO Hospitals
District Hospitals	Private Practitioners	NGO Clinics
Upazila Health Complex	Traditional Providers	
Union Health and Family Welfare Center	Homeopathic Providers	
Community Clinics	Unqualified Providers	
Specialized Hospitals	Drug Retail Outlets	
Other Facilities	Retail Sale of Other Medical Goods	
Health Facilities in Other Ministries and Autonomous Corporations		

Source: NHA-2

3.14 Total Health Expenditure (THE) by providers according to ICHA categories is presented in Table 3.6. Over the years, expenditures of all categories of providers have increased. In relative terms, or as proportion of total expenditure, public sector expenditure however fell from 33% in 1996-97 (NHA-1) to around 26% in the subsequent years studied. THE share of the Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh also exhibit a decline – from Taka 15,410 million (28%) in 1996-97 (NHA-1) to around Taka 20,511 million (26%) in 2001-02. Percentage distribution of health expenditure by major providers is presented in Figure 3.3.

3.15 NGOs share of Total Health Expenditure (THE) has increased from 3% in 1996-97 to over 6% in recent years. Private providers – private clinics, diagnostic facilities, drug retail outlets, traditional providers, and others – accounted for about two-third of THE according to NHA-1. Comparing 1996-97 distribution of THE to 2001-02 suggest that private providers share has increased to almost three-fourth (73%) of THE in terms of share of providers. Drugs retail expenditure is a dominant activity accounting for around 46% of total expenditure in both NHA-1 and NHA-2 years. The Health and Demographic Survey (HDS), 1999-2000 data provides data on expenditure on foreign providers. In 1996-97, foreign treatment expenditure was around Taka 904 million ($22.01 million), which has increased to Taka 1,288 million ($25.61 million) in 1999-2000. In percentage terms, expenditure share of foreign providers is 1.7%.

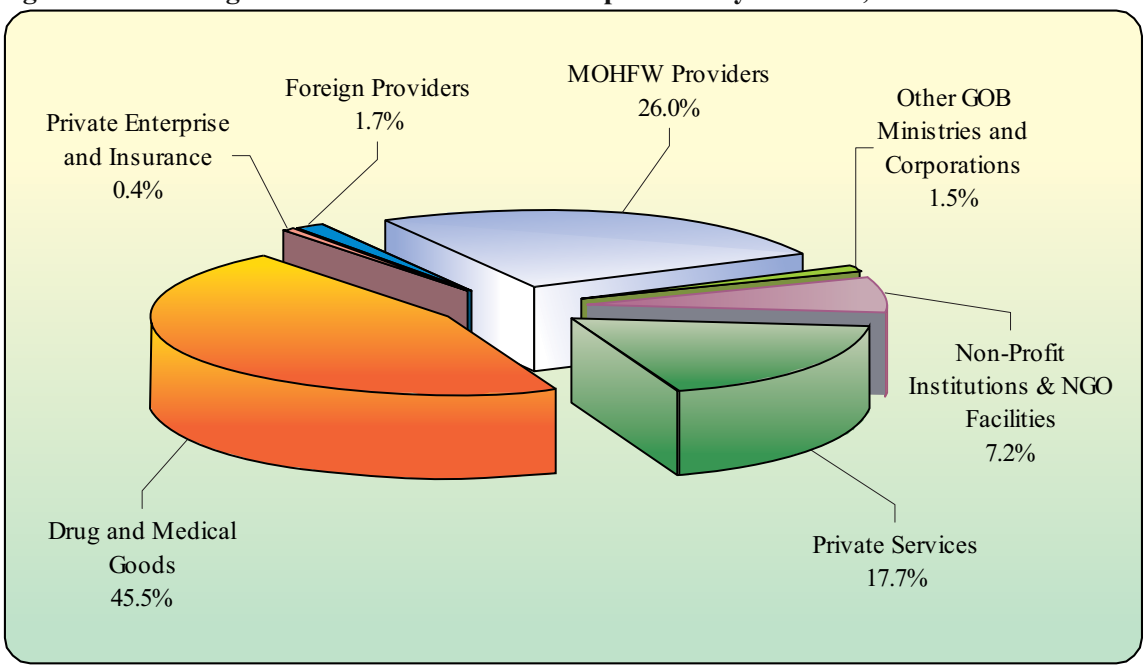
Table 3.6: Total Health Expenditure by Providers, 1996-2001 (in million Taka)

Providers of Healthcare	1996-97	1997-98	1998-99	1999-2000	2000-2001	2001-2002
MOHFW Providers	15,410	17,580	18,570	18,811	18,642	20,511
Other GOB Facilities	604	672	750	800	919	991
Local Government Facilities	181	175	172	161	170	164
Corporations and Autonomous Bodies Facilities	60	91	112	155	160	159
GOB NPI Facilities				39	44	42
Research and Training Institutions	1,946	1,539	1,365	625	1,007	1,197
Total Expenditure on Public Providers	**18,201**	**20,057**	**20,969**	**20,591**	**20,942**	**23,064**
Non-profit Institutions and NGO Facilities	**1,590**	**1,831**	**2,805**	**5,347**	**7,365**	**8,400**
Private Education and Research Institute	779	701	659	849	891	938
Private Clinics/Hospitals	1,136	1,429	1,782	2,098	2,136	2,134
Private Practitioners	2,005	2,206	2,405	2,578	2,739	2,913
Private Modern Unqualified Providers	1,400	1,608	1,831	2,041	2,264	2,513
Private Traditional Providers	102	280	459	620	594	916
Private Homeopathic Providers	939	1,011	1,126	1,234	1,624	1,740
Diagnostic/Imaging Service Providers	3,122	3,273	3,423	3,574	3,660	3,751
Drug Retail Outlets	25,234	28,205	31,233	34,000	36,687	39,625
Private Retail Sale of Glass and Vision Products	78	87	96	110	124	157
Crutches	6	8	9	10	11	13
Dental Service	61	78	88	99	111	125
Hearing Aids	1	1	1	1	1	2
Private Enterprise	200	221	239	329	340	359
Private Health Insurance Administration	2	2	3	3	10	11
Community Health Insurance	3	*7*	*9*	13	17	21
Foreign Providers	904	1,017	1,144	1,288	1,450	1,631
Total Private Providers	**35,972**	**40,134**	**44,507**	**48,847**	**52,659**	**56,849**
Total Health Expenditure (THE)	**55,763**	**62,022**	**68,281**	**74,785**	**80,966**	**88,313**

Source: NHA-2

3.16 Drugs and medical goods comprise almost half of the providers share, followed by Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh, who make up for one quarter of the share (Figure 3.3). Private services comprising of clinics, diagnostic services, qualified and unqualified traditional, and homeopath private health practitioners collectively contribute 17.7% of the provider's distribution. The share of medical services of health insurance or that of private businesses is a meager 0.4%.

Figure 3.3: Percentage Distribution of Total Health Expenditure by Providers, 1999-2000



Source: NHA-2

3.17 Table 3.7 presents the Total Health Expenditure by providers for 1996-97 to 2001-02 after adjusting for inflation. In real terms, THE grew between 5.7% (1996-97 to 1997-98) and 6.6% (1999-2000 to 2000-01). As evidenced in the last two rows of Table 3.7, THE annual growth kept pace with GDP growth during the last years studied under NHA-2. However, real public expenditure consistently fell below the GDP growth rates.

Table 3.7: Real Total Health Expenditure by Provider, 1996-2001 (in million Taka)

Providers of Healthcare Public Providers	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
MOHFW Providers	14,948	16,198	16,349	16,260	15,861	16,912
Other GOB Facilities	586	619	660	692	782	817
Local Government Facilities	176	162	152	139	145	135
Corporations and Autonomous Bodies Facilities	58	84	99	134	136	131
GOB NPI Facilities				34	37	35
Research and Training Institutions	1,888	1,418	1,202	540	857	987
Total Expenditure by Public Providers	17,656	18,481	18,462	17,798	17,818	19,017
Growth Rate of Public Providers (%)		4.7	-0.1	-3.6	0.1	6.7
Non-Profit Institutions and NGO Facilities	1,545	1,695	2,481	4,633	6,281	6,943
Private Education and Research Institute	756	646	581	734	758	773
Private Clinics/Hospitals	1,102	1,317	1,569	1,813	1,817	1,760
Private Practitioners	1,945	2,033	2,116	2,228	2,330	2,402
Private Modern Unqualified Providers	1,358	1,481	1,612	1,764	1,926	2,072
Private Traditional Providers	99	258	404	536	505	755
Private Homeopathic Providers	911	932	991	1,067	1,382	1,435
Diagnostic/Imaging Service Providers	3,028	3,016	3,013	3,089	3,114	3,093
Drug Retail Outlets	24,477	25,987	27,497	29,389	31,215	32,672
Private Retail Sale of Glass and Vision Products	76	80	85	95	106	129
Crutches	6	7	8	9	9	11
Dental Service	59	72	77	86	94	103
Hearing Aids	1	1	1	1	1	2
Private Enterprise	194	204	210	284	289	296
Private Health Insurance Administration	2	2	3	3	9	9
Foreign Providers	877	937	1,007	1,113	1,234	1,345
Total Health Expenditure (THE)	54,092	57,149	60,117	64,643	68,890	72,817
THE Growth Rate (%)		5.7	5.2	7.5	6.6	5.7
GDP Growth Rate (%)		5.2	4.9	5.9	5.2	4.4

Source: NHA-2
Note: Base 1995-96 = 100

Sources of Financing

3.18 The major sources of healthcare funding include: household, government, NGOs and development partners. Insurance makes up a small percent share of the total source of financing in Bangladesh. As evidenced in Table 3.8, while government financing has increased in absolute terms, it has declined as a percentage of Total Health Expenditure (THE). From around Taka 13.4 billion ($0.33 billion) in 1996-97, in 2001-02, government expenditure increased to Taka 18.6 billion. As a percentage share of THE, government expenditure has declined from 24% in 1996-97 to 21% in 2001-02. Development partners

funding to Bangladesh's healthcare has increased from around Taka 5.8 billion ($0.14 billion) in 1996-97 to Taka 11.7 billion ($0.21 billion) in 2001-02. In percentage terms, relative to THE, development partners contributions has increased from 10.5% of THE in 1996-97 to 13.3% in 2001-02. Household expenditure, commonly known as Out of Pocket (OOP) health expenditure, had a modest decrease in its share of THE – from 64.1% in 1996-97 to 63.8% in 2000-01.

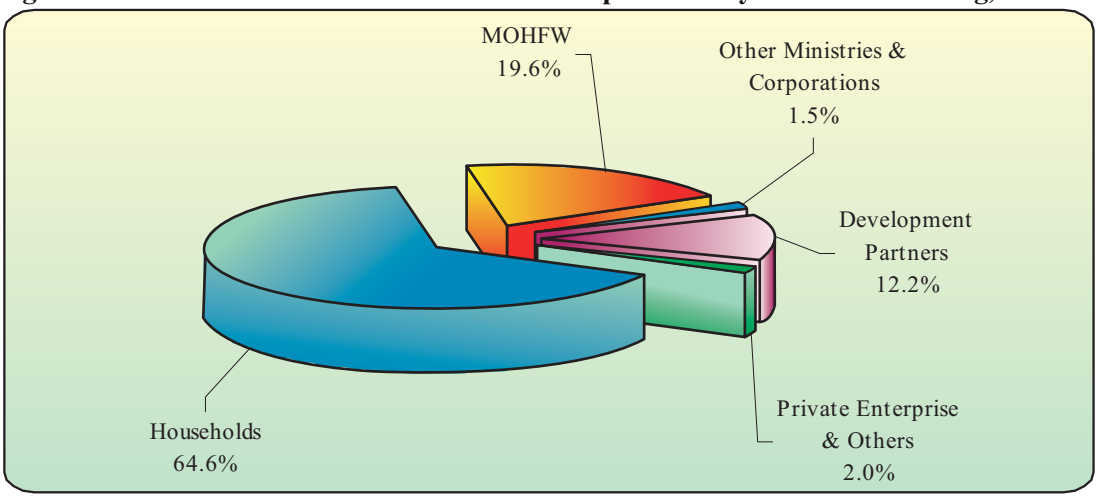
Table 3.8: Total Health Expenditure by Sources of Funding, 1996-2001 (in million Taka)

THE (in million Taka)	1996-97	1997-98	1998-99	1999-00	2000-01	2001-02
GOB	13,450	13,998	14,550	15,818	16,590	18,597
Development Partners	5,842	7,295	8,391	9,158	10,453	11,745
NGOs	194	224	259	271	512	301
Household OOP	35,293	39,579	44,021	48,344	52,153	56,341
Private Enterprises	979	917	1,048	1,178	1,231	1,297
Private Insurance	2	2	3	3	10	11
Community Insurance	3	7	9	13	17	21
Total Health Expenditure (THE)	**55,763**	**62,022**	**68,281**	**74,785**	**80,966**	**88,313**

Source: NHA-2

3.19 For 1999-2000, Total Health Expenditure (THE) by major sources of funding are presented in percentage terms in Figure 3.4. Households are the main source of funding (64.6%), followed by MOHFW (19.6%), and the development partners (12.2%).

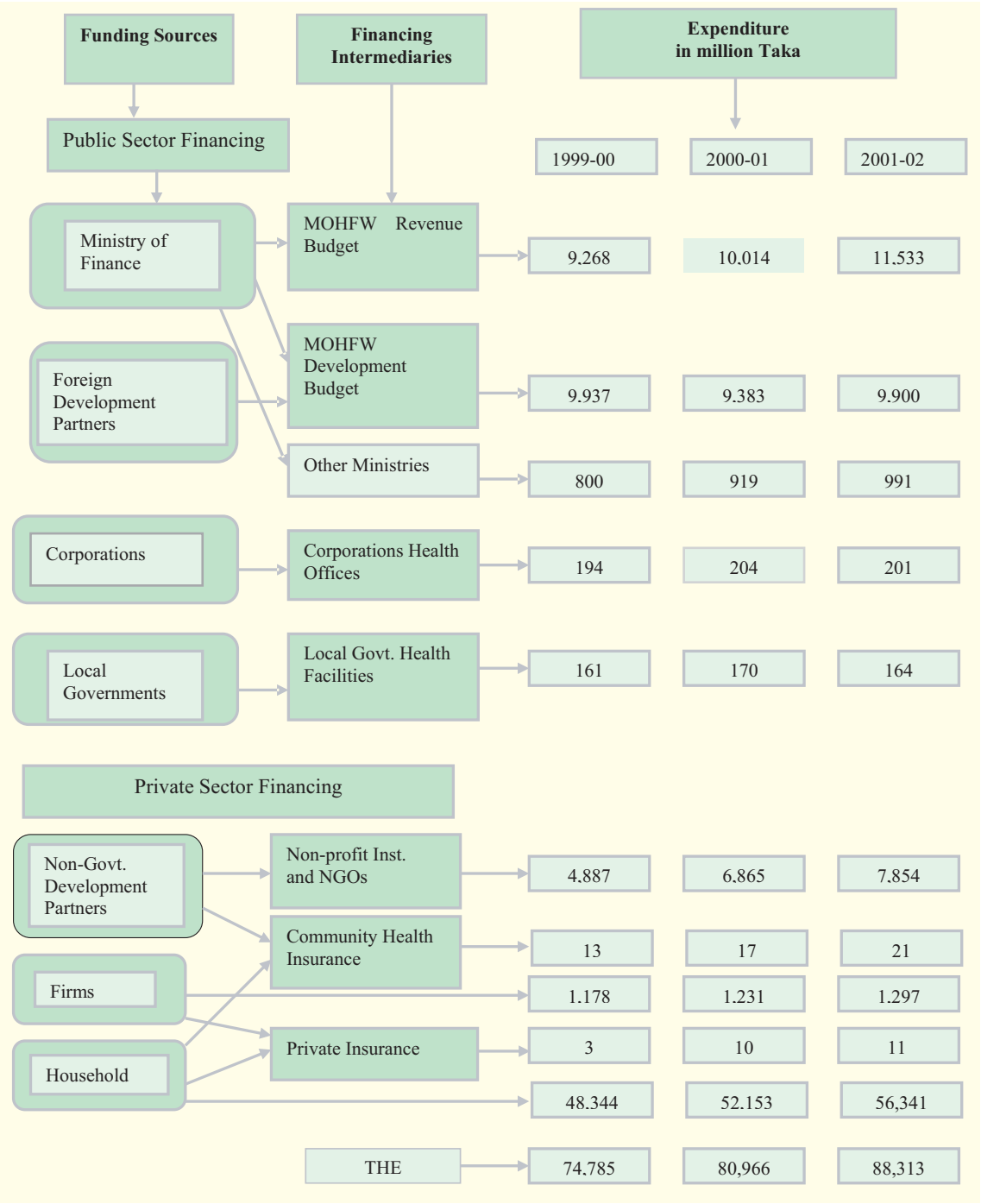
Figure 3.4: Percent Distribution of Total Health Expenditure by Sources of Funding, 1999-2000



Source: NHA-2

3.20 Flow of funds into the Bangladesh healthcare system by source, financing intermediaries, and actual expenditures for three periods – 1999-2000, 2000-01, and 2001-02 – are presented in Table 3.9.

Table 3.9: Flow of funds in Bangladesh Healthcare System



Two-Way Health Expenditure Classification

Function by Provider

3.21 As discussed in the Conceptual Framework (Chapter 2), NHA-2 attempts to provide health expenditures disaggregated by two-way matrices. These are: (a) Function by Provider; (b) Provider by Source of Funding; and (c) Function by Source of Funding. Due to the elaborate characteristics of such tables, only 1999-2000 functional estimates are provided in this chapter. For other years, they appear in the annex tables (Annex 2, Tables A5-A10). The ICHA classifications have been adhered to in identifying various components of the expenditure.

3.22 Table 3.10 represents the Total Health Expenditure (THE) and National Health Expenditure (NHE) by healthcare functions cross-classified by providers. The BNHA classified functions are matched with providers in this table. In 1999-2000, NHE was Taka 69.88 billion ($1.39 billion). With the addition of expenditure on capital formation to NHE, the estimated THE is Taka 74.79 billion ($1.49 billion). For international comparison, System of Health Accounts Total Health Expenditure (SHA THE) has been estimated for Bangladesh. SHA THE exclude education from THE. For Bangladesh, in 1999-2000 SHA THE was Taka 72.49 billion ($1.44 billion).

3.23 Table 3.10 provides the pattern of expenditures by functional categories. Prescribed medicine, categorized by HC 5.1.1, was the highest expenditure amongst the functional categories. In 1999-2000 expenditure on prescribed medicine was Taka 34 billion ($0.68 billion) while expenditure on other medical goods was relatively small, Taka 121 million ($2.41 million).

Table 3.10: Functions by Provider Expenditure, 1999-2000 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	Public Sector						NGOs	Private sector									Overall Total
			MOHFW	Other Ministries	Auto. Corp.	GOB NPIs	Local Govt.	Total Public		Pvt. Cl.	Ambulatory providers			Pvt. Corp.	Diag.	Med.	Pvt. Heal.	For. Pro.	
											Mode. Qua.	Mode. Unq.	Trad. Hom.						
	Services of curative care	HC 1	10,342	800	0	39	161	11,342	982	2,098								1,288	15,710
1.1.1	In-patient curative care	HC1.1	6,789	617				7,406	69	1,558								1,221	10,254
1.1.2	Out-patient curative care	HC 1.3	3,553	183		39	161	3,936	913	540								67	5,456
1.1.5	Out-patient dental care	HC 1.3.2									99								99
	Services of rehabilitative care	HC 2	162					162											162
1.1.3	In-patient rehabilitative care	HC 2.1	125					125											125
1.1.4	Out-patient rehabilitative care	HC 2.2	37					37											37
1.2	Ambulatory healthcare services	HC 1.3.9									2,578	2,041	1,854						6,473
2	Diagnostic imaging	HC 4.2													3,574				3,574
3.1	Prescribed medicine	HC 5.1.1														34,000			34,000
3.2	Glasses and vision products	HC 5.2.1														110			110
3.2	Orthopedic appliances and others	HC 5.2.2														10			10
3.2	Hearing aids	HC 5.2.3														1			1
4.1	Family planning services	HC 6.1	2,989					2,989	2,433										5,422
4.2	School health	HC 6.2	4					4											4
4.3	Prevention of communicable disease	HC 6.3	83					83	349										432
4.5	Occupational healthcare	HC 6.5	23		155			178						329					507
4.4	Health awareness creations	HC 6.9	933					933	897										1,830
5.1	Health administration	HC 7.1.1	1,527					1,527											1,527
5.3	Community Insurance	HC 7.2.1							13										
5.2	Health administration and insurance: private	HC 7.2.2															3		3
National Health Expenditure (NHE)			**16,063**	**800**	**155**	**39**	**161**	**17,218**	**4,674**	**2,098**	**2,677**	**2,041**	**1,854**	**329**	**3,574**	**34,121**	**3**	**1,288**	**69,877**
6	Capital formation	HCR 1	2,468					2,468	140										2,608
7	Education and training	HCR 2	625					625	546					849					2,020
8	Research	HCR 3	280					280											280
Total Health Expenditure (THE)			**19,436**	**800**	**155**	**39**	**161**	**20,591**	**5,360**	**2,098**	**2,677**	**2,041**	**1,854**	**1,178**	**3,574**	**34,121**	**3**	**1,288**	74,785
SHA THE			**18,531**	**800**	**155**	**39**	**161**	**19,686**	**4,814**	**2,098**	**2,677**	**2,041**	**1,854**	**329**	**3,574**	**34,121**	**3**	**1,288**	**72,485**

Source: NHA-2

Note: Auto. Corp. = Autonomous Corporation, Govt. = Government; Pvt. Cl. = Private Clinic and Hospital, Mode. Qua. = Modern Qualified, Mode. Unq. = Modern Unqualified, Trad. Hom. = Traditional and Homeopathic, Pvt. Corp. = Private Corporation, Diag. = Diagnostic and Imaging, Med. = Medicine and Medical Goods, Pvt. Heal. = Private Health Insurance, For.Pro.= Foreign Providers.

3.24 Services of curative care comprise in-patient curative care (HC1.1) and out-patient curative care (HC1.2), and include a large category of providers. Service of curative care (HC 1) was the second highest expenditure among the providers. It amounted to Taka 15.7 billion ($0.31 billion) in 1999-2000. All expenditures on ambulatory providers are grouped into out-patient category. Expenditures on hospital services by the Ministry of Health and Family Welfare (MOHFW), Nongovernmental Organizations (NGOs) and private clinics were classified into in-patient and out-patient categories. MOHFW is the largest curative care provider in Bangladesh. In 1999-2000, of the Taka 10.3 billion ($0.2 billion) of curative care provided by MOHFW, Taka 6.8 billion (66%) was spent on in-patient category; Taka 3.6 billion was expended under out-patient classification.

3.25 In 1999-2000, expenditure on maternal and child health was Taka 5.42 billion ($0.11 billion). In Table 3.10, in-patient and out-patient service categorization has not been attempted, in conformity with international classification.

3.26 Expenditure on rehabilitative care is relatively modest in Bangladesh – Taka 162 million in 1999-2000. Expenditures on health by ministries other than MOHFW and that of autonomous bodies are collectively grouped under the heading "Occupational Healthcare". Occupational healthcare expenditure in 1999-2000 was approximately Taka 507 million (Table 3.10). Expenditure of the MOHFW secretariat, and headquarter expenses of various health directorates are summed under "Health Administration". In 1999-2000, health administration expenditure amounted to Taka 1.53 billion ($30.4 million).

Provider by Sources of Funding

3.27 In Bangladesh, various governmental ministries and departments receive budgetary allocation from two sources: revenue budget and development budget. The development budget is funded both by the government and in many instances supplemented by development partners. Table 3.11 presents funding sources for various governmental and non-governmental providers.

3.28 The Ministry of Health and Family Welfare (MOHFW) of the Government of Bangladesh supports both secondary and tertiary healthcare through various hospitals and health facilities. In 1999-2000, expenditure of MOHFW providers was Taka 19.2 billion ($0.38 billion).

3.29 Consistent with the NHA-1 findings of 1996-97, drug retail outlets continue to be the highest expenditure category among the private providers. In 1999-2000, households spent around Taka 34 billion ($0.68 billion) at drug outlets (Table 3.11). In 1999-2000 expenditure on services provided by private clinics was Taka 2.1 billion ($41.7 million).

Households spent more on diagnostic services compared to expenditures on private clinics – Taka 3.57 billion ($71.1 million). Along with modern ambulatory practitioners, expenditures on services provided by traditional and homeopathic healthcare providers continue to be significant recipient of household funding. In 1999-2000, homeopathic and traditional providers received Taka 1.85 billion ($36.86 million) for their services. Comparable figure for modern practitioners for 1999-2000 was Taka 2.04 billion ($40.58 million).

Table 3.11: Providers by Sources of Funding, 1999-2000 (in million Taka)

BNHA Code	BNHA Providers	ICHA Code	MOHFW				Other Ministries	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance	Private Insurance	Private Enterprise	Households	Grand Total
			Rev.	Dev.		Total									
				GOB	Dev. Partners										
1	Government Providers														
1.1.1.1	MOHFW Administration	HP 6.1	1,185	269	471	1,925									1,925
1.1.1.2	University Medical College Hospitals	HP1.1	255			255									255
1.1.1.3	Medical College Hospitals	HP1.1	1,053	190		1,243								157	1,400
1.1.1.4	District Hospitals	HP1.1	778	210	119	1,107								74	1,181
1.1.1.5	Thana Level Facilities	HP1.1	4,695	3,704	4,128	12,527									12,527
1.1.1.6	Specialized Hospitals	HP 1.3	683	340		1,023									1,023
1.1..1.7	Other MOHFW Facilities	HP1	146	12	342	500									500
1.2	Other GOB Facilities	HP1.1					800								800
1.3	Local Government Facilities	HP 1.1					161								161
1.4	Corporations and Autonomous Bodies	HP 1.1					155								155
1.4	GOB NPI Facilities	HP 1.1					39								39
1.5	Research and Training Institutions	NEC													1,474
1.5.1	Govt. Education and Training Institutes	NEC	473	77	75	625									625
1.5.2	Private Education and Training Institutes	NEC											849		849
2	Non-Profit Institutions and NGO Facilities	HP 1.1						593	271	4,023	13			460	5,360
4.1.1	Private Clinics/Hospitals	HP 1.1												2,098	2,098
4.1.2	Private Practitioners	HP 3.3												2,578	2,578
4.1.3	Dental Providers	HP 3.2												99	99
4.2.1	Private Modern Unqualified Providers	HP 3.9.9												2,041	2,041
4.2.1.5	Private Traditional Providers	HP 3.9.9												620	620
4.2.1.3	Private Homeopathic Providers	HP 3.9.9												1,234	1,234
4.5.1	Diagnostic/Imaging Service Providers	HP 3.5												3,574	3,574
4.6.1	Drug Retail Outlets	HP 4.1												34,000	34,000
4.6.3	Private Sale of Glass and Vision Products	HP 4.2												110	110
4.6.2	Crutches	HP 4.4												10	10
4.6.4	Hearing Aids	HP 4.3												1	1
3.1	Private Enterprise	HP 1.1											329		329
4.8.1	Pvt. Health Insurance Administration	HP 6.4										3			3
5	Foreign Providers	HP 9												1,288	1,288
Total Health Expenditure (THE)			9,268	4,802	5,135	19,205	1,155	593	271	4,023	13	3	1,178	48,344	74,785

Source: NHA-2

Note: Rev. = Revenue, Dev.= Development.

Function by Sources of Funding

3.30 Healthcare functions describe the types of services provided. These include: in-patient and out-patient care, rehabilitative care and public health services. Table 3.12 exhibits Bangladesh's Total Health Expenditure (THE) cross-classified by healthcare functions and financial agents (or financial intermediaries) in 1999-2000. Households directly financed about Taka 3.8 billion (24.5%) of the Taka 15.71 billion ($312 million) on total expenditure of curative care services (Table 3.12). Private sector enterprises and insurance expenditure were modest as sources of funding categories. In 1999-2000, Taka 849 million was financed by private enterprises for health education and research. The Government of Bangladesh expenditure on health related education and research in 1999-2000 was Taka 905 million. Insurance administration expenditure, relatively speaking, was a meager Taka 3 million in 1999-2000. Households finance about 65% of the Total Health Expenditure amounting to Taka 48.3 billion ($.96 billion) in 1999-2000.

Table 3.12: Function by Sources of Funding, 1999-2000 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	MOHFW				GoB (Other than MOHFW)	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance (NGOs)	Pvt. Ins.	Private Enterprise	HH	Grand Total
			Rev.	Dev.		Total									
				GOB	Dev. Partners										
	Services of curative care	HC 1	6,656	1,115	2,340	10,111	1,000	96		652				3,851	15,710
1.1.1	In-patient curative care	HC1.1	4,352	736	1,544	6,632	616			3				3,003	10,254
1.1.2	Out- patient curative care	HC 1.3	2,304	379	796	3,479	384	96		649				848	5,456
1.1.5	Out-patient dental care	HC 1.3.2												99	99
	Services of rehabilitative care	HC 2	162			162									162
1.1.3	In-patient rehabilitative care	HC 2.1	125			125									125
1.1.4	Out-patient rehabilitative care	HC 2.2	37			37									37
1.2	Ambulatory healthcare services	HC 1.3.9												6,473	6,473
2	Diagnostic imaging	HC 4.2												3,574	3,574
3.1	Prescribed medicine	HC 5.1.1												34,000	34,000
3.2	Glasses and vision products	HC 5.2.1												110	110
3.2	Orthopedic appliances and other prosthetics	HC 5.2.2												10	10
3.2	Hearing aids	HC 5.2.3												1	1
4.1	Family planning service	HC 6.1	788	1,030	1,171	2,989		282	241	1,910					5,422
4.2	School health	HC 6.2	4			4									4
4.3	Prevention of communicable disease	HC 6.3		24	59	83		45		304					432
4.5	Occupational healthcare	HC 6.5			23	23	155						329		507
4.4	Health awareness creation	HC 6.9		29	904	933		115		782					1,830
5.1	MOHFW administration of health	HC 7.1.1	1,066	264	197	1,527									1,527
5.3	Community health insurance	HC 7.2.1									13				13
5.2	Health administration and insurance: private	HC 7.2.2										3			3
6	Capital formation	HCR 1	119	2,258	91	2,468		18		122					2,608
7	Education and training	HCR 2	473	77	75	625		37	30	253			849	226	2,020
8	Research	HCR 3		5	275	280									280
Total Health Expenditure (THE)			9,268	4,802	5,135	19,205	1,155	593	271	4,023	13	3	1,178	48,344	74,785

Source: NHA-2

Note: Rev.= Revenue, Dev. = Development, Pvt. Ins. = Private Insurance, HH = Household

International Comparison

3.31 Comparison of Bangladesh national health accounts estimates with other comparable countries in the region is difficult and challenging, since most countries either do not have national health accounts or are still in the process of compiling them for the first time. Published statistics on health expenditures in most countries can only be used with caution, because of lack of consistency in concepts of what is measured, and in how it is measured. In fact, Bangladesh is only one of seven developing countries in the Asia-Pacific region to have produced health accounts which attempted to meet international standard; the others being China, Philippines, Thailand, Sri Lanka, Samoa and Papua New Guinea. For the other developing countries in Asia, there are generally no reliable estimates available of overall spending. Nevertheless, many countries in the region are now working on developing NHA systems compatible with the OECD SHA approach. Since Bangladesh has based the NHA-2 estimates on the OECD SHA standard, it will be possible in two to three years time to make comparison with many more countries in Asia. This section makes some comparison of the structure and level of national health expenditures in Bangladesh with other countries for which reliable, comparable data exist.

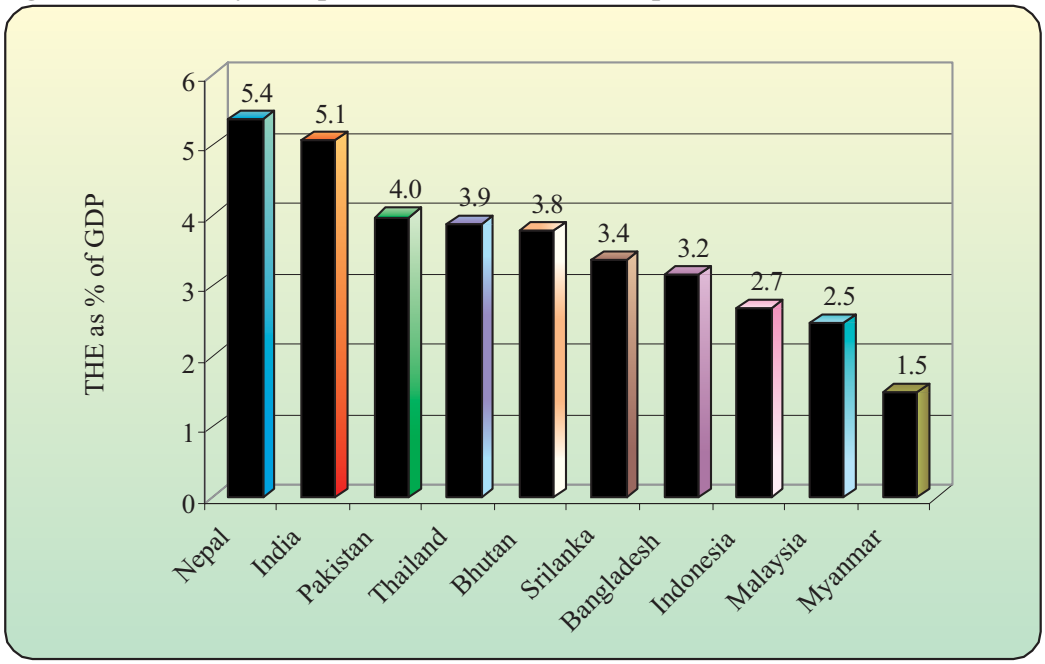
3.32 In terms of overall levels of spending, Bangladesh is clearly a low spender on health (Table 3.13, Figure 3.5). Most low-income developing countries spend 3% to 4.5% of GDP on health, which places Bangladesh at the lower end of the range. This is largely consistent with Bangladesh's low income per capita, since health expenditures as a share of GDP generally rise as income per capita increases.

Table 3.13: International Comparison of Selected National Health Accounts Indicators

Country	Year	GDP Per Capita	Per Capita THE in Nominal US$	Per Capita THE in PPP$	THE as Percent of GDP
Bangladesh	1999-2000	358	12	49	3.2
Bhutan	1998-1999		23	71	3.8
India	1998-1999	461	22	110	5.1
Indonesia	1998-1999	681	12	54	2.7
Myanmar	1998-1999		86	32	1.5
Nepal	1998-1999	213	11	58	5.4
Sri Lanka	1998-1999	827	29	99	3.4
Thailand	1998-1999	2,008	71	197	3.9
Malaysia	1998-1999	3,288	84	168	2.5
Pakistan	1998-1999	444	18	67	4

Source: NHA-2, Asia Pacific National Health Accounts Network and OECD

Figure 3.5: Country Comparison of Total Health Expenditure as Percent of GDP



Source: NHA-2, Asia Pacific National Health Accounts Network and OECD

3.33 In comparison with other countries, in Bangladesh a high proportion of overall national health expenditures is funded from out-of-pocket payments, and a correspondingly low proportion from public sources (including donors). The 65% share from out-of-pocket sources compares with 35-60% in other Asian developing countries such as China, Sri Lanka, Philippines and Thailand (Table 3.14). Generally, richer countries rely more on government taxation and social insurance funding for health care, but even in comparison with other low-income developing countries, a disproportionate share of the financing burden is placed on households.

Table 3.14: Percentage Distribution of THE by Financing Agents in Selected Asian Countries

Country	Year	Public Sector	Social Insurance	Private Sector	Private Insurance	Household	Total
Bangladesh	1999-2000	27	0	8	0	65	100
Taiwan	1998	7	52	4	10	27	100
Hong Kong	1996-97	54	0	7	2	37	100
Sri Lanka	1997	48	0	1	1	51	100

Source: NHA-2, Asia Pacific National Health Accounts Network and OECD

3.34 Since NHA-2 classifies national health expenditure by function using the OECD SHA ICHA classification system, it is possible to compare the allocation of overall healthcare spending by type of service in Bangladesh and other countries. Table 3.15 provides this type of comparison with some selected Asian countries. As evident, the pattern of expenditure in Bangladesh is unusual for two reasons. First, Bangladesh is an outlier in the share of total national spending allocated to in-patient care. Bangladesh spends 14% of recurrent expenditure on in-patient services compared with 25-40% in other countries. This suggests that Bangladesh may be under-spending on in-patient care. Second, a large proportion of total spending is accounted for by expenditures on medical goods purchased from retail outlets, for the most part medicines. The proportion of 46% expenditure in Bangladesh is considerably higher than in the other countries, and again might point to a potential area for policy concern (Table 3.15).

Table 3.15: Percentage Distribution of Total Expenditure on Health by SelectedAsian Countries

ICHA Code	Functions of Healthcare	Bangladesh	Sri Lanka	Thailand	Taiwan	Hong Kong
HC 1	Curative Care	30	53.9	66.8	71.7	76.2
HC 2	Rehabilitative Care		0.1	0.1	1.2	
HC 3	Long Term Nursing Care				1.2	2.8
HC 4	Ancillary Services to Healthcare	5	4.2			2.8
HC 5	Drug Retail Outlets	46	22.5	5.5	10.2	7.7
HC 6	Public Health Services	11	6.6	8.1	1.8	2
HC 7	Health Administration and Insurance	2	2.6	7	2.2	0.3
HCR 1-7	Health Related Functions	6	10.5	12.4	6.1	6.2

Source: NHA-2, Asia Pacific National Health Accounts Network and OECD

IV. Healthcare Expenditure by Providers

4.1 Under the Conceptual Framework chapter of this report (Chapter II), discussion of various types of healthcare providers in Bangladesh has been presented. Three broad categories of providers have been identified: (a) public providers; (b) Non-Profit Institutions Serving Households (NPISH), commonly known as Non Government Organization (NGO) providers; and (c) private providers. This chapter attempts to provide a detailed description, characteristics, expenditure and sources of income of the key providers.

4.1 Public Sector Providers

For the purposes of NHA, public sector expenditures consist of expenditures undertaken by:

4a. Ministry of Health and Family Welfare (MOHFW)

4b. Other Ministries

4c. GOB owned Corporations

4d. GOB Non Profit Institutions (NPIs indicating Public Universities)

4e. Local Bodies

4a. Ministry of Health and Family Welfare (MOHFW)

4.2 The Ministry of Health and Family Welfare (MOHFW) is the largest institutional healthcare provider in Bangladesh with an extensive network of facilities across the country. A large number of healthcare facilities are owned and operated by the MOHFW, and it provides varied services ranging from primary healthcare typified by Essential Services Package (ESP) to complex treatment care. For simplifying the analysis, they are grouped into four categories based on location and complexity of services. These four types are: (a) Union and grass root level facilities (which include urban satellite and such clinics); (b) Upazila or thana level facilities; (c) District hospitals; and (c) National level facilities that include specialized hospitals, medical colleges and institutions.

4.3 In general, union and upazila facilities serve as primary healthcare centers, district hospitals as secondary level facilities and national level institutions as referral facilities. Table 4.1 provides the distribution of facilities by Bangladesh's administrative divisions. The distribution of facilities by division with respective divisional population is juxtaposed, since average number of population per facility provides a perspective of the size of the apparent service area of facilities.

Table 4.1: Number and Types of MOHFW Healthcare Facilities, 1999-2000

Division	Union Health and Family Welfare Center	Upazila Complex	District Hospitals	National Level Institutions	Total MOHFW Facilities	Population in '000
Barisal	311	40	6	1	358	8,112
Chittagong	573	81	11	5	670	23,999
Dhaka	982	102	15	24	1,123	38,678
Khulna	289	49	10	1	349	14,468
Rajshahi	827	113	14	5	959	29,993
Sylhet	196	32	3	1	232	7,899
National	3,178	417	59	37	3,691	123,149

Source: UMIS, DGHS, August 2001, BBS, Statistical Pocketbook 2000, DGFP 2003

4.4 Table 4.2 uses Table 4.1 and the divisional population distribution to deduce the number of persons served by different types of government health facilities. Understandably, the lower tier (union health and family welfare center) caters to a smaller population compared to the tertiary level facilities. A crude estimate of the availability of all MOHFW facilities is around 33,000 persons in 1999-2000. Divisional comparisons suggest Khulna and Dhaka to be least served when judged by number of households served.

Table 4.2: Population ('000) per Health Institutions in Bangladesh

Division	Union Health and Family Welfare Center	Upazila Health Complex	District Hospital	National Hospital	All MOHFW Facilities
Barisal	26	203	1,352	8,112	23
Chittagong	42	296	2,182	4,800	36
Dhaka	39	379	2,579	1,612	34
Khulna	50	295	1,447	14,468	41
Rajshahi	36	265	2,142	5,999	31
Sylhet	40	247	2,633	7,899	34
National Total	39	295	2,087	3,328	33

Source: UMIS, DGHS, August 2001, BBS, Statistical pocket book 2000, DGFP 2003

4.5 Table 4.3 lists major MOHFW healthcare institutions, the personnel employed and expenses relating to employing them. The largest number of employees and compensation is made at the upazila and below level facilities. Over 100,000 government employees serve the MOHFW, receiving around Taka 6,854 million ($136 million) annually in salary and other benefits.

Table 4.3: Structure of MOHFW Providers and Expenditures (in '000 Taka)

Healthcare provider	Facility	Officer	Employee	Total	Employee per officer	Pay and allowance (in '000 Taka)	Pay and allowance per worker	Pay and allowance per facility	Officer per facility	Employee per facility	Total expenditure (in million)
Health Administration		2,399	4,863	7,262	2	815,791	112				2,518
Medical University and Hospital	1	237	857	1,094	4	158,600	145	158,600	237	857	255
Medical College Hospitals	13	1,246	6,533	7,779	5	706,293	91	54,330	96	503	1,400
District Hospitals	59	1,279	5,739	7,018	4	542,199	77	9,190	22	97	1,181
Specialized Hospitals	29	822	4,252	5,074	5	386,986	76	13,344	28	147	1,023
Upazila and Below Level Facilities	402	6,289	64,589	70,878	10	3,831,213	54	9,530	16	161	12,527
Other Facilities	115	260	1,243	1,503	5	88,599	59	770	2	11	500
HERTI	83	1,515	3,029	4,544	2	324,179	71	3,906	18	36	625
Total		14,047	91,105	105,152	6	6,853,860	65				20,029

Source : FMAU

4.6 To highlight the key role played by the MOHFW administration in policy and management, a disaggregated profile of the MOHFW administration is provided in Table 4.4. The MOHFW administration, in 1999-2000, employed around 7,262 personnel with an annual expenditure of Taka 1,185 million.

Table 4.4: Structure of MOHFW Administration, 1999-2000

Administration	Officer	Employee	Total worker	Total expenditure 1999-2000 (million Taka)	Percent of total MOHFW expenditure 1999-2000
Secretariat	293	337	630	414	2
Directorate of Health	965	636	1,601	216	1
Directorate of Family Planning	234	996	1,230	151	1
Divisional Institutions	27	159	186	19	0
Civil Surgeon Offices	670	1,881	2,551	253	1
Drug Administration	61	132	193	18	0
Directorate of Nursing	132	582	714	96	0
National Health Library and Document Storage Center	3	21	24	2	0
Transport and Equipment Storage Center	5	63	68	9	0
Electro Medical Equipment Maintenance Center	9	56	65	7	0
Total Administration	2,399	4,863	7,262	1,185	5

Source: UMIS, DGHS, August 2001, BBS, Statistical Pocketbook 2000, FMAU

4.7 The MOHFW operates as a financial intermediary of the Government of Bangladesh (GOB) obtaining funds from the Ministry of Finance (MOF) and allocating and disbursing them to its healthcare providing units. It also provides regular annual transfers or grants-in-aids to health and family welfare NGOs. As in other government ministries in Bangladesh, MOHFW expenditures are funded from and classified under two GOB budget categories: (1) Revenue Budget and (2) Development Budget or the Annual Development Programme (ADP). The Revenue Budget is financed by the GOB by its tax and non-tax revenues including borrowing from the domestic market and self-financing by Public (or GOB owned) autonomous corporations. The ADP is primarily financed by the GOB revenue surpluses. ADP also relies on development partner assistance in the form of development grants and loans.

4.8 MOHFW recurrent expenditures (termed revenue expenditures) are funded through the Revenue Budget and are divided into the following major economic categories:

- Salary and allowances
- Contingencies (or operational expenses)
- Medical and Surgical Requisites (MSR) and Supplies (MSS)
- Repairs and maintenance
- Transfers (grants in aid) to NPIs and contributions to the United Nations (UN) bodies

MOHFW Development Budget finance expenditures on capital formation (buildings and equipment), Medical and Surgical Supplies (MSS) and other contingent expenses, salaries and allowances of the development project personnel and transfers to Health and Family Planning NGOs.

4.9 In compiling NHA-2 and classifying MOHFW expenditures, the primary source of the data was the Financial Management and Audit Unit (FMAU) database. The FMAU database provides details of the actual annual expenditures of the individual MOHFW organizations and its entire healthcare providers classified by broad economic categories. In addition, the FMAU database classified all development expenditures of the providers by sources of funding (GOB funding and development partners funding classified into Reimbursable Program Aid (RPA) and Development Program Aid (DPA)), ESP and non-ESP expenditures.

4.10 As identified earlier, the Upazila and below health facilities command higher share of MOHFW's annual budget. In 2001-02, out of the Taka 23,810 million ($417.7 million) spent by MOHFW, approximately 60% of the fund was channeled through the lower level health facilities (Table 4.5). In 2001-02, Taka 4,247 million ($74.5 million) was needed to operate the health administration of the MOHFW.

Table 4.5: MOHFW Expenditures by Providers, 1996-97, 1999-2000 to 2001-02

Providers of Healthcare	1996-97	1999-2000	2000-2001	2001-2002
Health Administration	2,205	2,518	2,644	4,247
University Medical Hospital	-	255	205	225
Medical College Hospitals	1,935	1,400	1,323	1,316
District Hospitals	1,765	1,181	1,153	1,454
Upazila and Below Level Health Facilities	6,553	12,527	13,532	14,393
Specialized Hospitals	2,663	1,023	621	812
Other Health Facilities	130	500	142	166
Education, Research and Training Institutes	1,920	625	1,007	1,197
Total Expenditure	17,171	20,029	20,627	23,810

Source: FMAU

4.11 The overall share of the revenue and development budget health expenditure is similar. However, the revenue share in recent years has increased modestly. According to Table 4.6, in 1996-97 health expenditure from the revenue budget was Taka 7,066 million ($172 million) while the development budget source provided Taka 10,104 million ($246 million). In 2001-02, Taka 12,139 million ($213 million) came from the revenue budget and Taka 11,671 million ($204.7 million) was spent from the development budget allocation.

Table 4.6: Revenue and Development Expenditures of MOHFW, 1996-97, 1999-2000 to 2001-02 (in million Taka)

Providers of Healthcare	1996-97			1999-2000			2000-01			2001-02		
	Rev.	Dev.	Total	Rev.	Dev.	Total	Rev.	Dev.	Total	Rev.	Dev.	Total
Health Administration	840	1,365	2,205	1,389	1,129	2,518	1,145	1,498	2,643	1,343	2,904	4,247
University Medical Hospital	-	-	-	255	-	255	205	-	205	225	-	225
Medical College Hospitals	923	1,012	1,935	1,209	191	1,400	1,121	202	1,323	1,245	71	1,316
District Hospitals	646	1,119	1,765	852	329	1,181	985	168	1,153	1,104	350	1,454
Upazila and Below Level Health Facilities	3,148	3,405	6,553	4,695	7,833	12,528	5,814	7,718	13,532	6,788	7,605	14,393
Specialized Hospitals	1,041	1,621	2,662	683	340	1,023	591	30	621	680	132	812
Other Health Facilities	92	38	130	146	353	499	136	7	143	163	3	166
Education, Research and Training Institutes	376	1,544	1,920	485	140	625	500	507	1,007	591	606	1,197
Total Expenditure	7,066	10,104	17,170	9,714	10,315	20,029	10,497	10,130	20,627	12,139	11,671	23,810

Source: FMAU
Note: Rev. = Revenue, Dev. = Development

Functional Classification of MOHFW Expenditures

4.12 MOHFW expenditures classified by ICHA broad functional, provider, source of financing categories are provided in Annex 4 (Tables A11-A28). These are also compared to NHA-1 (1996-97) expenditures to highlight the trends in expenditure categories.

4.13 Delivery of Essential Services Package (ESP) through the upazila and below and the district level facilities, which constitute the primary healthcare system of the MOHFW. It is the core component of the healthcare strategy of the GOB. ESP consists of all collective services and a selected component of the personal healthcare services of the ICHA functional categories. The economic classification of ESP expenditures by the revenue and development expenditure of MOHFW expenditures is presented in Table 4.7. Compensation to MOHFW staff in the form of salaries and allowances constitute 60% (Taka 6,870 million) of expenditure while supplies and services make up for about 37% (Taka 4,295 million) of expenses in 2001-02.

Table 4.7: Economic Classification of ESP Total Expenditure (in million Taka)

Economic Classification	1999-2000			2000-2001			2001-2002		
	Rev.	Dev.	Total	Rev.	Dev.	Total	Rev.	Dev.	Total
Pay and Allowances	4,052	2,318	6,370	5,176	1,518	6,694	6,134	736	6,870
Supplies and Services	802	3,352	4,154	736	2,398	3,134	831	3,464	4,295
Repair and Maintenance	189	12	201	212	12	224	174	12	186
Total	5,043	5,682	10,725	6,124	3,928	10,052	7,139	4,212	11,351
Percent of Total	47	53	100	61	39	100	63	37	100

Source: FMAU

4.14 Table 4.8 presents the allocation of revenue and development expenditure by type of services. A greater proportion of the development expenditure is disbursed to family planning services while health services rely on revenue allocation. Almost half (48%) of MHOFW annual expenditure is made on ESP services.

Table 4.8: MOHFW Essential Service Package Expenditure (in million Taka)

Service	1999-2000			2000-2001			2001-2002		
	Rev.	Dev.	Total	Rev.	Dev.	Total	Rev.	Dev.	Total
ESP Health	4,305	821	5,126	4,385	1,291	5,676	4,553	1,089	5,642
ESP Family Planning	738	4,861	5,599	1,740	2,637	4,377	2,586	3,123	5,709
Total ESP	5,043	5,682	10,725	6,125	3,928	10,053	7,139	4,212	11,351
Total MOHFW Expenditure	9,715	10,314	20,029	10,131	10,411	20,542	12,140	11,755	23,810
Percent of Total ESP	47	53	100	61	39	100	63	37	100
Percent of Total MOHFW	25	28	54	30	19	49	30	18	48

Source: FMAU

User Fees from MOHFW Facilities

4.15 User fees realized from services provided by healthcare providing facilities of MOHFW has declined substantially since NHA-1 (1996-97). These fees are realized on two counts: for health and family welfare (family planning) services and as hospital receipts. Total receipts from these two sources for the three years, 1999-2000 to 2001-02 are presented in Table 4.9. In 2001-02, Taka 125 million was collected as user fee and deposited into the consolidated funds. For comparison, NHA-1 receipts for 1996-97 are also provided. User fee constitute an insignificant proportion of MOHFW outlays.

Table 4.9: User Fees Deposited into Consolidated Funds (in million Taka)

Year	H and FP	Hospitals	Total
1996-1997	na	na	159
1999-2000	61	16	77
2000-2001	65	24	89
2001-2002	106	19	125

Source: FMAU

Note : H = Health, FP = Family Planning, na = not available

4.16 In recent years, policy focus of mobilization of additional resources through user fees appear to have shifted to better utilization of resources through reduction of wastage and emphasis on higher productivity of service delivery. Ensuring spatial equity by spreading the network of Close To Client (CTC) facilities, interpersonal equity through delivery of ESP, and primary health care services have emerged as the overriding healthcare policy goals of the MOHFW.

4.17 Policies regarding realization of user fees have also been reformed. Exemption or abolishing user fees at the upazila and below level facilities and granting some autonomy or discretion with regard to retention of realized charges with the facilities themselves have been achieved. It has been attained through bypassing the general rule of depositing all realized fees with the GOB consolidated fund. Such a strategy has contributed to a decline in consolidated fund, health and family planning receipts. In addition, fees realized by the MOHFW's Health Education Research and Training Institutes (HERTI) are not reported.

4.18 A better measure of actual user fees paid by healthcare seekers in the MOHFW healthcare facilities is available from the Health and Demographic Survey (HDS), 1999-2000. HDS estimates of user fee expenditure by households are presented in Table 4.10 for 1999-2000. A total of Taka 231 million was paid by households as user fees to MOHFW facilities. More than half of the total user fee is paid to public medical college hospitals.

Table 4.10: Household User Fee Expenditure by Provider Type (in million Taka)

Provider	Household OOP expenditures on MOHFW healthcare facilities					
	In-patient	Percent	Out-patient	Percent	Overall	Percent
Medical College Hospitals	34	46	89	57	123	53
District Hospitals	11	15	20	13	31	13
Upazila Health Complex	20	27	21	13	41	18
Other Facilities	9	12	27	17	36	16
Total	74	100	157	100	231	100

Source: FMAU

Geographical Distribution of MOHFW Expenditures

4.19 Effectiveness of MOHFW goal of spatial equity can be broadly assessed by disaggregating the MOHFW expenditures by rural-urban categories and by the six administrative divisions of Bangladesh. Tables containing the expenditure of MOHFW in rural-urban categories are provided in Annex 4 (Tables A20-A28). Divisional distribution of MOHFW expenditure suggests that almost one-third is spent in Dhaka division while Barisal and Sylhet receiving less than 10% of the total allocation (Table 4.11).

Table 4.11: Divisional Distribution of MOHFW Expenditure, 1999-2002 (in million Taka)

Division	1999-2000	2000-2001	2001-2002
Dhaka	5,766	6,078	6,511
Chittagong	3,530	3,254	3,516
Rajshahi	3,952	4,020	4,253
Khulna	1,986	2,088	2,173
Barisal	1,209	1,294	1,599
Sylhet	1,057	1,251	1,509
Total	17,500	17,985	19,561

Source: FMAU

Note: Expenditures on Administration and Transfer are not distributed. Expenditures on HERTI are included

4.20 When per capita divisional estimate is attempted, it suggests the allocation is reasonably equitable, i.e. not skewed. It ranges between Taka 142 for Rajshahi and Taka 197 for Barisal divisions in 2001-02 (Table 4.12).

Table 4.12: Per Capita Divisional Distribution of MOHFW Expenditure, 1999-2002 (in Taka)

Division	1999-2000	2000-2001	2001-2002
Dhaka	170	157	168
Chittagong	161	136	147
Rajshahi	144	134	142
Khulna	150	144	150
Barisal	156	160	197
Sylhet	148	158	191
Total	157	146	159

Source: FMAU, Bangladesh Bureau of Statistics, Statistical Pocketbook 1999, 2000, 2001

Challenges for MOHFW and Conclusions

4.21 The MOHFW is the dominant public sector and the overall front line provider of healthcare in the country. It has progressively built up an extensive network of healthcare facilities through out the country with numerous Close To Client (CTC) facilities at the grass root level targeting the poor. By implementing the health policy of the Government, MOHFW sets the general pace and pattern of health expenditure of the nation. It regulates and facilitates the healthcare development of the NGOs and private sector providers and is the focal point of donor assistance and financing of healthcare in the country. The above analysis of the pattern and trend of MOHFW expenditures lead to various conclusions and implications.

4.22 The overall expenditure of MOHFW as a proportion of the Total Health Expenditure (THE) is declining. From 27.6% of THE in 1996-97 (the NHA-1 year), MOHFW's share has diminished to 24.3% in 2001-2002 (the last year of NHA-2). Largely due to this phenomena, the proportion of public sector to THE has declined from 33% in 1996-97 to 26% in 2001-02. This decline together with the continued absence of social insurance initiative and a minuscule private insurance market is compelling the households, particularly the rural poor, to bear a very large proportion of national health expenditure through direct or Out Of Pocket (OOP) payments.

4.23 Essential Service Package (ESP) has emerged as the dominant mode of MOHFW healthcare provisions in recent years, leading to a structural change in the pattern of MOHFW expenditure. As a consequence, overall expenditure within MOHFW shifted significantly from the tertiary and secondary level facilities to primary facilities at the upazila and below level CTC facilities. This pattern is likely to be sustained in the future as the NHA-2 analysis also shows significant shift in fixed investment expenditure of MOHFW for future capacity creation towards upazila and below level CTC facilities.

4.24 Resource costing or economic analysis exhibit imbalance between service (as calculated by the compensation of employees in the expenditure) and material components (as measured by Medical and Surgical Requisites (MSR) and Medical and Surgical Supplies (MSS) in the MOHFW expenditures. The lack of timely unequivocal allocation among the provider facilities results in MSR and MSS being shown as block allocations in the database and creates problem of transparency in accounting of MOHFW expenditure. Similar limitations are generated by large expenditures on repairs and maintenance, salary components of completed projects and new recruits shown as block allocations of the administrative organizations. These continue to be shown as unallocated even after closer of an accounting year, and inhibit accurate determination of the real expenditure on health administration.

4.25 NHA-2 accounting of user fees realized by MOHFW providers demonstrate significant decline compared to NHA-1. Non-realization at the primary level and CTC facilities and a

move to set user fee for selected services at tertiary and specialized level providers on costing of services are some of the innovative management practices introduced by MOHFW in recent years. In fact, all services provided by MOHFW providers, whether free or fee-based, should be properly costed preferably on the basis of appropriate cost centers within each type of providers. This would facilitate systematic allocation of resources including block-allocations among the provider organizations and ensure proper accounting of in-patient and out patient services of all MOHFW providers.

4.26 Licensing of all private healthcare practitioners, health NGOs and healthcare providing private enterprises is a major public service of the MOHFW administration. Currently, there is no system of accreditation (or effective licensing) of traditional, homeopathic and modern healthcare private practitioners. The present practice of accreditation of the private hospitals, clinics and diagnostic and imaging centers is irregular and done in an unprofessional way. A large number of operating enterprises are left out giving scope to corrupt accreditation practices. To be effective, licensing should be comprehensive and cover all practicing private practitioners and operating healthcare enterprises and health NGOs irrespective of size and location. The findings of the accreditation process must be systematically computerized to develop publicly accessible database on a timely basis. The extensive network of MOHFW administration needs to be engaged in the accreditation effort, and if necessary, assistance of the national tax administration could be sought to bring all private healthcare providers within the Value Added Tax (VAT) net work. Availability of a nation-wide computerized accreditation listing of providers would greatly facilitate collection and compilation of national health accounting.

4b. Expenditure by other GOB Ministries

4.27 Under NHA-2, ministries that operate their own healthcare facilities, and are not included in the MOHFW, were covered. Table 4.13 shows total healthcare expenditure and other indicators of these ministries. The Ministry of Defense spends over Taka 752 million annually on healthcare expenditure, making it the largest ministry outside MOHFW in terms of health expenditure. MOHFW annual expenditure is around Taka 23.8 billion ($ 418 million) in 2001-2002. The Ministry of Home Affairs annual health expenditure is approximately Taka 200 million.

Table 4.13: Other Ministries Healthcare Expenditures (in million Taka)

Name of the Ministry	1999-2000	2000-01	2001-02
Labor Ministries	3	3	3
Social Welfare Ministry	38	16	34
LGRD Ministry	2	2	2
Ministry of Home Affairs (Police, jails etc.)	195	197	200
Ministry of Defense	562	701	752
Total Ministries	800	919	991

Source: NHA –2

4c. Expenditures of GOB-owned Autonomous Corporations

4.28 The Government of Bangladesh (GOB) owns more than 40 autonomous corporations. Among these, only two – the Bangladesh Railways and Bangladesh Biman (the national airlines) – operate independent healthcare facilities. A third facility, under the Atomic Energy Commission, provides isotopes for radiation therapy. Table 4.14 presents expenditures and other relevant information of these three corporation-provided healthcare facilities for the last three years of NHA-2. Bangladesh Railway's health expenditure is approximately Taka 85 million while the Atomic Energy Commission's annual expenditure under the healthcare line item is Taka 63 million in 2001-02.

Table 4.14: Total Health Expenditures of Autonomous Corporations (in million Taka)

Autonomous Corporations	1999-00	2000-01	2001-02
Bangladesh Railway	81	85	85
Bangladesh Biman	11	11	11
Atomic Energy Commission	63	64	63
Total Autonomous Corporations	155	160	159

Source: NHA - 2

4d. Expenditures by Government of Bangladesh NPIs (Public Universities)

4.29 Public universities owned and controlled by the Government of Bangladesh (GOB) are regarded as GOB NPIs. Several public universities operate healthcare facilities on their own. Table 4.15 presents healthcare expenditures of the major public universities of Bangladesh. Collectively, the total health expenditure of these institutions is around Taka 43 million in 2001-02.

Table 4.15: Expenditures of Public University Medical Facilities (in million Taka)

Name of University	1999-2000	2000-2001	2001-2002
Dhaka University	12	11	11
Rajshahi University	4	7	7
Islamic University	2	2	3
Chittagong University	10	11	9
Jahangirnagar University	4	4	4
Bangladesh Agriculture University	8	9	9
Shahajalal University of Science and Technology	0	0	0
Total Public Universities	39	44	43

Source: NHA-2

4e. Expenditures by Local Bodies

4.5 Larger city corporations and municipalities have health related activities. Most of them have immunization and other public health activities. The two largest city corporations – Dhaka and Chittagong – operate healthcare facilities in urban areas. Table 4.16 provides health expenditure of city corporations and municipalities for 1999-2000, 2001-02 and 2001-02. The four major city corporations have a significantly higher health budget than the combined budget of the rest of the urban municipalities of Bangladesh.

Table 4.16: Health Expenditures of City Corporations and Municipalities, 1999-2002 (in million Taka)

Municipalities.	1999-2000	2000-2001	2001-2002
Total Municipalities Including Barisal and Sylhet	11.2	11.6	10.7
Four City Corporations (excluding Barisal and Sylhet)	149.6	158.1	153.3
Total (estimated for the whole country)	160.8	169.7	164.0

Source: NHA-2

4.2 NGO Expenditures and Funding

Introduction

4.31 Non-Profit Institutions Serving Households (NPISH), of which NGOs comprise the significant part in Bangladesh, play a key role in providing healthcare at the grass root level and complement the efforts of MOHFW. Compared to NHA-1, NGO activities in healthcare activities have expanded with the increased flow of donor and GOB transfers (Table 4.26). NGO healthcare expenditures in the NHA-2 benchmark year, 1999-2000, have increased to more than 6% of the total health expenditures compared to 3% estimated by NHA-1 for 1996-97. The bigger NGOs are also increasing their expenditures on education, training and research in health and population related areas.

4.32 This section of the report estimates the expenditures incurred by NGOs for providing services in the Health, Nutrition and Population (HNP) sector of Bangladesh. It also provides an estimation of the funding of HNP activities of NGOs. Non Governmental Organizations are an important service provider because they target their services mainly to the poor and vulnerable. In many areas, they complement the activities of the public healthcare system, which is unable to effectively reach out to the poorest sections of the population. Also they make up for the private for-profit sector's health services which the poor may not be able to afford. In recent years, the importance of NGO services has increased as a result of their expanded coverage and diversification of service delivery.

Methodology

4.33 For estimating the health expenditures incurred by the NGO sector during the three fiscal years of 1999-2000, 2000-01 and 2001-02, a sample survey of NGOs was carried out. The sampling frame was initially constructed from the list of NGOs surveyed under NHA-1. This frame was subsequently matched with the listing of NGOs compiled by the Voluntary Health Services Society (VHSS). The VHSS list was found to be comprehensive and contained up-dated listing of NGOs that specialize in health and family planning activities. As a consequence, the sampling frame was enlarged to include NGOs from the VHSS list as well. A total of 149 NGOs were surveyed under NHA-2.

4.34 The sampling frame has been stratified into the following four groups in terms of the size of NGOs' annual expenditure on healthcare:

- Small NGOs, whose annual spending on HNP is less than Taka 5 million;
- Medium NGOs, which spend more than Taka 5 million but less than Taka 20 million per year on HNP;
- Large NGOs that annually spend more than Taka 20 million but less than Taka 200 million on HNP;
- Very large NGOs, which spend Taka 200 million or more per year on HNP.

4.35 By using the above criteria for categorizing the NGOs, the sample frame is found to contain 334 small NGOs, 49 medium NGOs, 13 large NGOs and 5 very large NGOs. The numbers of NGOs interviewed from these four categories are 115, 17, 12 and 5 respectively. Detailed sampling figures are shown in Table 4.17. The primary reason for stratifying the sample into four NGO categories is to make the estimations of their healthcare expenditures realistic.

Table 4.17: Sample Frame and Coverage by NGO Size

NGO Categories	Sample Frame		Sample Interviewed	
	Number	Percent	Number	Percent
Small	334	83	115	77
Medium	49	12	17	11
Large	13	3	12	8
Very Large	5	1	5	3
Total	401	100	149	100

Source: NHA-2
Note: Percentages may not add up to 100 because of rounding

4.36 Structured questionnaires were used to obtain detailed data on HNP expenditures of the 149 surveyed NGOs. The quantitative findings of the NGO survey were used for making estimates of expenditures on and funding of the HNP activities of NGOs in Bangladesh for the fiscal years of 1999-2000, 2000-01 and 2001-02.

Proportion of HNP and Non-HNP Expenditures

4.37 Most of the NGOs surveyed implement both HNP and non-HNP programs. On average, expenditure on non-HNP programme (e.g., education, awareness raising, and microfinance) constitutes about 58% of the total expenditures incurred by the NGOs during the fiscal years under review, as shown in Table 4.18.

Table 4.18: Percentage of HNP and Non-HNP Expenditures of Surveyed NGOs

Programme	1999-2000	2000-01	2001-02	Average
HNP programme	42	43	42	42
Non-HNP programme	58	57	58	58
Total	100	100	100	100

Source: NHA-2

Provision of Direct Service Delivery

4.38 Almost all the NGOs interviewed (on average, more than 94%) were found to provide direct service delivery in the field of HNP (Table 4.19).

Table 4.19: Percentage of NGOs Providing Direct HNP Service Delivery

Program	1999-2000	2000-01	2001-02	Average
Provides direct services	93	96	94	94
Does not provide direct services	7	4	6	6
Total	100	100	100	100

Source: NHA-2

Expenditures of NGOs on HNP Activities

4.39 The estimated average annual expenditure incurred by NGOs on HNP-related activities during the three-year period under review (Table 4.20) was Taka 6,778 million ($127.8 million). It translates into approximately 8.4% (2000-01) of Total Health Expenditure (THE) of Bangladesh. The volume of expenditure, as expected, depends on the size of the NGOs. Very large NGOs taken together spent Taka 4,022 million or 59% of the total expenditure, while spending of the large NGOs stood at Taka 1,376 million or 20% of the total spending. The medium and small NGOs spent Taka 756 million (11%) and Taka 625 million (10%) respectively.

4.40 There was a steady increase in the amount spent by the NGOs over the years. From Taka 5,121 million in 1999-2000, it rose to Taka 7,107 million in 2000-01 and Taka 8,105 million in 2001-02, thereby registering a growth rate of 58% during the three-year period (Table 4.20). The biggest spenders, as mentioned above, were the very large NGOs, whose total spending increased from Taka 2,715 million ($53.9 million) in 1999-2000 to Taka 4,944 million ($86.7 million) in 2001-02, measuring a growth rate of 82%. Their share in the overall health expenditure also increased over the reference period from 53% in 1999-2000 to 61% in 2001-02.

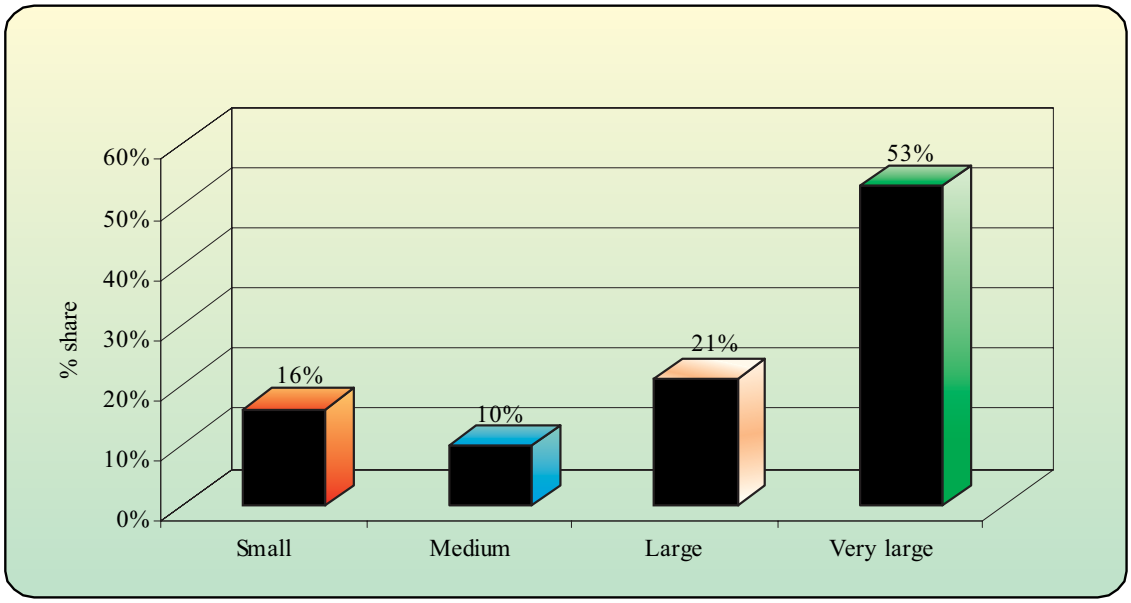
4.41 Table 4.20 shows that the expenditures of large NGOs grew by 58%, from Taka 1,075 million ($21.37 million) in 1999-2000 to Take 1,702 million ($29.86 million) in 2001-02. Their share in total NGO expenditure remained stable. The medium NGOs maintained a high growth of about 90%, increasing from Taka 512 million in 1999-2000 to Taka 973 million in 2001-2002. Their share in the overall expenditure rose by two percentage points, from 10% to 12%. In contrast, during the same period, the total expenditure of the small NGOs almost halved, from Taka 819 million to Taka 486 million. Their share in the overall expenditures dropped drastically, from 16% to 6%.

Table 4.20: Expenditure of NGOs on HNP, 1999-2000 to 2001-02 (in million Taka)

NGO Categories	1999-2000		2000-01		2001-02		Average	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Small	819	16	569	8	486	6	625	10
Medium	512	10	782	11	973	12	756	11
Large	1,075	21	1,350	19	1,702	21	1,376	20
Very Large	2,715	53	4,406	62	4,944	61	4,022	59
Total	5,121	100	7,107	100	8,105	100	6,778	100

Source: NHA-2

Figure 4.1: Percent Share of Expenditure of NGOs on HNP in 1999-2000



Source: NHA-2

Major Areas of HNP Expenditure

4.42 The estimated expenditures of NGOs are distributed in all major areas of healthcare. Family planning tops the list with an average of 25% of the expenditures taking place in that area followed by general health, Maternal and Child Health (MCH), communicable diseases, training, and immunization (Table 4.21). The respective shares of the above areas of healthcare in the total HNP expenditures have remained remarkably consistent over the three years of the reference period.

Table 4.21: Distribution of HNP Expenditures by Areas of Healthcare (in percent)

Types of Healthcare	1999-2000	2000-01	2001-02	Average
Family planning	24	26	26	25
General health	20	20	20	20
Maternal and child health	20	20	19	20
Communicable diseases	18	16	17	17
Training	11	11	11	11
Immunization	7	7	7	7
Total	100	100	100	100

Source: NHA-2

Major Modes of Service Delivery

4.43 The NGOs provide their HNP services through a number of service delivery modes. Community-based public health services are the main mode of service delivery, which account for on average 45% of the HNP expenditures, followed by out-patient services (41%). In-patient services account for only about 3% of the expenditures (Table 4.22).

Table 4.22: Distribution of HNP Expenditures by Mode of Service Delivery (in percent)

Modes of Service Delivery	1999-2000	2000-01	2001-02	Average
Community based public health activities	45	45	44	45
Out-patient services	41	41	42	41
In-patient services	3	3	4	3
Training	11	11	10	11
Total	100	100	100	100

Source: NHA-2

4.44 Detailed information was collected on the main modes of service delivery adopted by the surveyed NGOs. Based on the collected data, estimates were made of the total number of NGO outdoor service centers and the number of out-patient visits made during the years under review. The estimated number of outdoor service centers of the NGOs was 6,501 in 1999-2000. It increased to 7,947 in 2000-01, registering a growth of 22%. The number marginally declined in the following year. However, there is considerable variation amongst the different categories of NGOs on this count. The small and medium NGOs, which are much more in number compared to the large and very large NGOs, own on an average 90% of the outdoor service centers (Table 4.23).

Table 4.23: Number of Outdoor Service Centers of NGOs

NGO Categories	1999-2000		2000-01		2001-02	
	Number	Percent	Number	Percent	Number	Percent
Small	3,694	57	4,821	61	4,865	61
Medium	2,142	33	2,421	30	2,343	30
Large	559	9	616	8	616	8
Very Large	106	2	88	1	92	1
Total	6,501	100	7,947	100	7,916	100

Source: NHA-2

4.45 There has been growth in the number of out-patient activities of the NGOs, as apparent from Table 4.24. In 1999-2000, 12.2 million clients visited the NGO outdoor clinics. This number increased to 15.1 million in 2001-02, the rate of growth being 23% over the three-year period. As expected, the bulk of the clients were women and children. On average, they made up 62% and 22% respectively of total client visits. This finding is consistent with the earlier finding that the highest share of HNP expenditures of NGOs are in the areas of family planning and MCH, whose clientele are predominantly women and children.

Table 4.24: Number of Out-patient Visits to NGO Facilities (number in thousand)

Clients	1999-2000		2000-01		2001-02	
	Number	Percent	Number	Percent	Number	Percent
Men	1,957	16	2,213	16	2,412	16
Women	7,462	61	8,577	62	9,347	62
Children	2,813	23	3,043	22	3,316	22
Total	12,232	100	13,833	100	15,075	100

Source: NHA-2

NGO Capital Expenditures on HNP

4.46 The expenditures of NGOs on capital goods needed for delivering HNP services have also been estimated. On average, capital expenditures constituted about 3% of the total NGO expenditures on HNP during the period under review. In 1999-2000, such expenditures equaled Taka 144 million, which increased to Taka 205 million in 2001-02, registering a growth of 42% in three years. The major items of capital goods procured by the NGOs are furniture and fixtures, which accounted on average for about 44% of all capital expenditures. Other major items are buildings and motor vehicles (Table 4.25). It should be noted that the estimates of capital expenditures are on the lower side because it was not possible to obtain relevant data from all the large NGOs covered by the survey.

Table 4.25: NGO Capital Expenditures on HNP (in million Taka)

Line items	1999-2000		2000-01		2001-02		Average	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Land	4	3	4	2	3	1	4	2
Building	41	28	36	21	43	21	40	23
Furniture and fixtures	54	37	75	44	99	48	76	44
Machinery	11	8	16	10	18	9	15	9
Motor vehicles	34	24	38	23	42	21	38	22
Total	144	100	169	100	205	100	173	100
Percent of total expenditure	2.7		2.3		2.4		2.5	

Source: NHA-2

Note: Percentages may not add up to 100 because of rounding

Funding for HNP Activities of NGOs

4.47 Estimates of funding for HNP activities of NGOs were made on the basis of data received from secondary sources. In 1999-2000, such funds totaled Taka 5,121 million, which rose by 39% to Taka 7,107 million in 2000-01. The level of funds increased by 14% in 2001-02 and stood at Taka 8,105 million (Table 4.26).

4.48 The bulk of NGO funding during the period under review came from the donors. The NGOs also received significant funds from the Government of Bangladesh. On average,

development partner contributions accounted for 78% of the total funds compared to 12% that was provided by GOB. The balance was contributed by the NGOs from their own resources, which made up 10% of the total funds available for HNP activities (Figure 4.2).

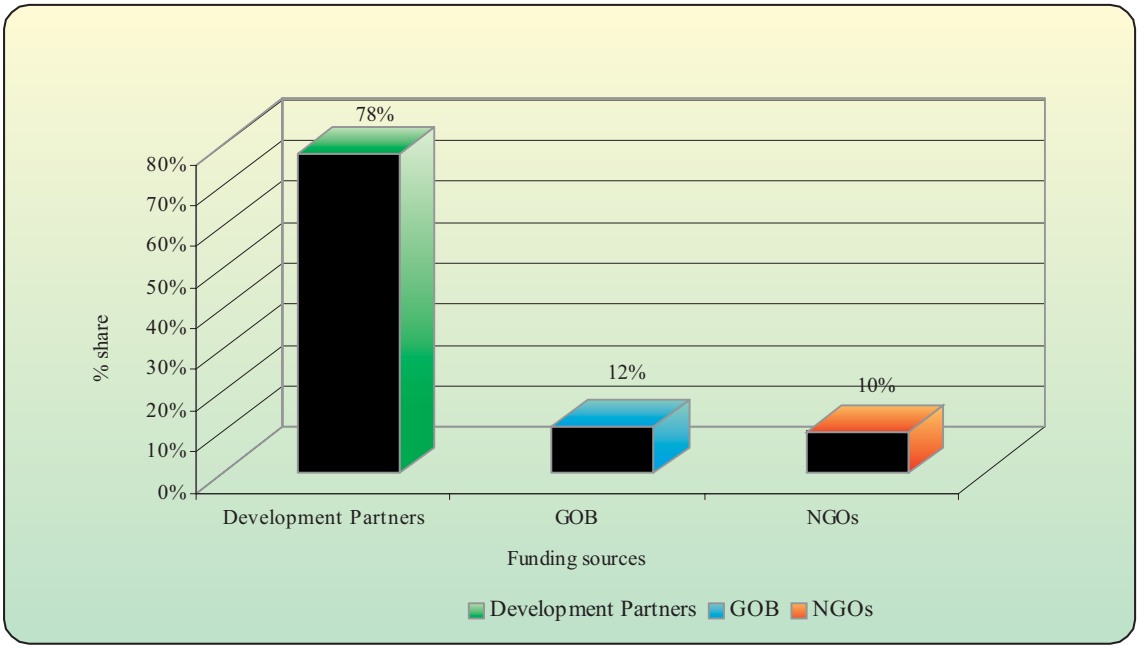
4.49 Development partners funding rose from Taka 4,023 million ($80 million) in 1999-2000 to Taka 5,375 million ($ 99.5 million) in 2000-01 (an increase of 33%) but fell to Taka 4,950 million in 2001-02 (a decrease of about 8%). Its share in total funding steadily decreased from 78% in 1999-2000 to 67% in 2001-02 because of the dramatic increase in GOB funds, which grew over three times during the three-year period (Table 4.26). GOB contributions rose from Taka 593 million (12% of total funds) in 1999-2000 to Taka 2,102 million (26% of total funds) in 2001-02. On the other hand, NGO's own funding demonstrated a modest increase of 10%, from Taka 505 million in 1999-2000 to Taka 552 million in 2001-02. Its share in total funding fell slightly, from 10% to 7%, during the same period.

Table 4.26: NGO Funding of HNP Expenditures by Source (in million Taka)

Funding Source	1999-2000		2000-01		2001-02		Average	
	Amount	Percent	Amount	Percent	Amount	Percent	Amount	Percent
Development Partners	4,023	78	5,375	76	5,451	67	4,950	73
GOB	593	12	978	14	2,102	26	1,224	18
NGOs	505	10	754	11	552	7	604	9
Total	5,121	100	7,107	100	8,105	100	6,778	100

Source: NHA-2
Note: Percentages may not add up to 100 because of rounding

Figure 4.2: NGO Funding of HNP Expenditures by Source, 1999-2000



Source: NHA-2

Funds Transferred by NGOs to Other NGOs

4.50 The NHA-2 survey revealed that on average about 2% of the interviewed NGOs transferred funds to other NGOs for conducting HNP programme. Estimates of the value of such transfers are presented in Table 4.27. It is estimated that, on average, about Taka 76 million was transferred annually during the three year period under review.

The amount increased from Taka 64 million in 1999-2000 to Taka 89 million in 2001-02, measuring a growth of 39%. The estimated fund transfers constituted nearly 10% of the NGOs' contribution to HNP funding.

Table 4.27: NGO Funds Transferred to Other NGOs (in million Taka)

Particulars	1999-2000	2000-01	2001-02	Average
Value of transferred funds	64	76	89	76
NGO contribution to HNP funding	656	735	898	763
Transfers as percentage of NGO contribution (%)	10	10	10	10

Source: NHA-2

NGO Employees in the HNP Sector

4.51 Estimates of the numbers of employees of NGOs engaged in the HNP sector have been made on the basis of survey results. In 1999-2000, a total of 20,972 persons were employed either on a part-time or a full-time basis. This number rose by about 10% to 23,083 in 2000-01 but declined by a similar rate in the following year and reached 20,925. Contrary to popular belief, the small NGOs taken together employed more people than any of the other categories. However, their employment size had fallen by almost 27% during the period under review. In contrast, the number of employees of medium, large and very large NGOs had increased by 29%, 13% and 26% respectively (Table 4.28).

Table 4.28: NGO Employees in the HNP Sector

NGO Categories	1999-00		2000-01		2001-02	
	Number	Percent	Number	Percent	Number	Percent
Small	9,878	47	9,944	43	7,243	35
Medium	4,038	19	5,197	22	5,223	25
Large	3,541	17	3,864	17	4,006	19
Very Large	3,515	17	4,078	18	4,453	21
Total	20,972	100	23,083	100	20,925	100

Source: NHA-2

4.3 Private Sector Providers

Three major health providers from the private sector are studied in this section of the report. These are: (a) Private Clinics and Hospitals; (b) Diagnostic Facilities; and (c)Private Health Insurance. Under NHA-2 no detailed sample survey of traditional healers including ayurvedic, kabiraji have been attempted.

Private Clinics and Hospitals

Characteristics

4.52 In Bangladesh, for-profit in-patient modern care is provided in clinics and hospitals. The terms "clinics and hospitals" are combined and freely used and often the two are attributed synonymously. "Clinics" are perceived to be relatively smaller than "hospitals", and the former in a few instances may be offering only out-patient services. For brevity, in this report, no distinction has been made between the two terms and this sector shall be referred to "private clinics and hospitals" or simply "clinics". They are typically urban-based, often the larger towns and cities catering to the population of that municipality as well as adjacent relatively smaller towns and rural areas. The city of Dhaka attracts patients from all across Bangladesh who seek in-patient care in both private clinics as well as government hospitals.

4.53 The Director General (DG) of Health, Ministry of Health and Family Welfare (MOHFW) maintains a listing of clinics across Bangladesh, which is a by-product of the official accreditation process. However, this listing is incomplete and dated. Two major reasons contribute to the limitations of this listing. First, a small but significant percentage of the clinics are not registered. The unregistered units either have their application for registration in process or they may have opted not to apply at all. Second, dearth of manpower and accountability within and between several regulatory and administrative bodies of MOHFW precludes close monitoring and updating of the accreditation process.

4.54 Based on the MOHFW listing, efforts were made to provide a better estimate of the total number of clinics and hospitals in Bangladesh. Under the NHA-2 project, field visits were made to major cities and towns, and a complete listing of private clinics attempted for those locations. However, NHA-2 did not entail visits to many smaller district towns. Based on the average number of clinics in existence by various categories of town size, estimates were made for the remaining district towns that were not visited.

4.55 According to NHA-2 estimates, at present there exist approximately 790 private clinics and hospitals in Bangladesh (Table 4.29). While information on annual exit of firms from this sector is unavailable, in 1996-97 there were around 584 private clinics (Data International Ltd., 1998). A comparison with NHA-1 estimates suggests an average growth rate of 12% annually during the 1996-97 to 1999-2000 periods.

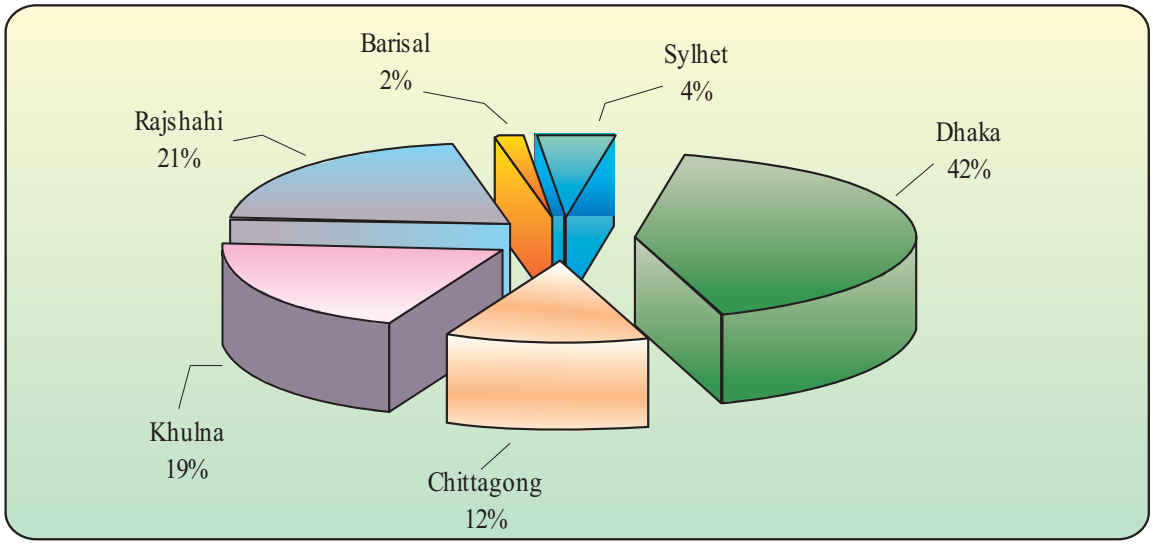
Table 4.29: Divisional Distribution of Clinics

Division	Sample		National	
	Count	Percent	Count	Percent
Dhaka	100	38	334	42
Chittagong	35	13	91	12
Khulna	36	14	154	19
Rajshahi	69	26	162	21
Barisal	9	3	14	2
Sylhet	17	6	35	4
Bangladesh	266	100	790	100

Source: NHA-2

4.56 A divisional comparison (Table 4.29, Figure 4.3) suggests that more than a third (42%) of the total private clinics is from Dhaka followed by Rajshahi division (21%). Barisal and Sylhet have the least number of clinics.

Figure 4.3: Percent Distribution of Clinics by Division

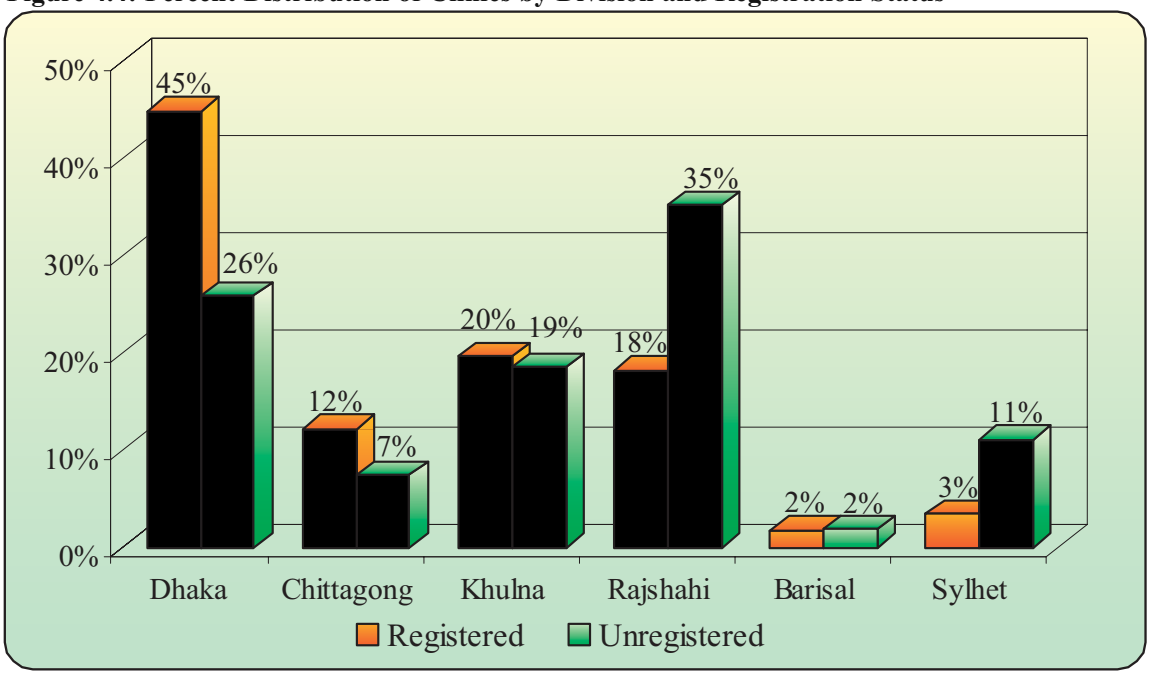


Source: NHA-2

Registration Status of Private Clinics and Hospitals

4.57 NHA-1 estimated that about 76 percent of the clinics are registered while NHA-2 findings suggest around 86 percent are currently registered (Figure 4.4). Predictably, the larger sized clinics have a higher propensity to register. A higher percentage of clinics are registered in Dhaka compared to other divisions (Table 4.30).

Figure 4.4: Percent Distribution of Clinics by Division and Registration Status



Source: NHA-2

Table 4.30: Distribution of Registration Status of Clinics

Division	Registration Status			
	Registered	Percent	Unregistered	Percent
Dhaka	306	45	28	26
Chittagong	83	12	8	7
Khulna	134	20	20	19
Rajshahi	124	18	38	35
Barisal	12	2	2	2
Sylhet	23	3	12	11
Bangladesh	682	100	108	100
Share	86		14	
Category				
Small	41	19	19	35
Medium	155	73	33	61
Large	16	8	2	4
Bangladesh	212	100	54	100
Share	80		20	

Source: NHA-2

Ownership of Private Clinics and Hospitals

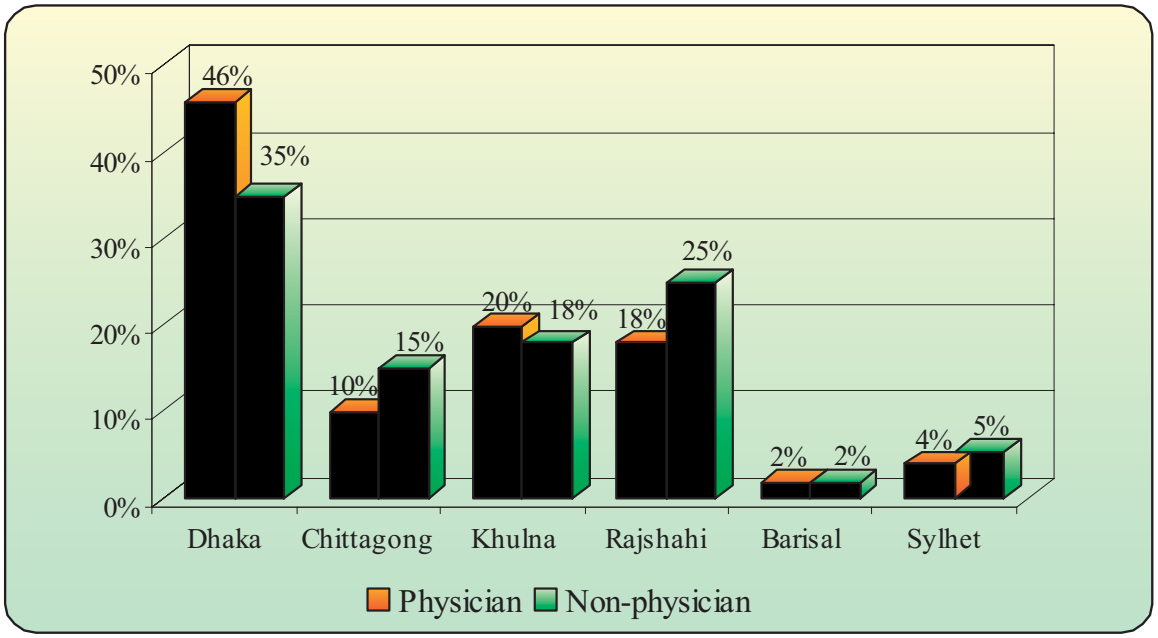
4.58 According to Table 4.31, NHA-2 estimates suggest a decline in physician-owned clinics – from 73 percent in 1996-97 (NHA-1) to 65 percent in 1999-2000 (NHA-2). Figure 4.5 presents the percentage distribution of clinics by physician and non-physician ownership in various divisions of Bangladesh.

Table 4.31: Distribution of Clinics by Ownership

Ownership	1996-97		1999-2000	
	Count	Percent	Count	Percent
Physician	185	73	174	65
Non- physician	67	27	92	35
Total	252	100	6	100

Source: NHA-2

Figure 4.5: Percent Distribution of Clinics by Division and Ownership



Source: NHA-2

Bed Capacity

4.59 The number of beds available in a hospital can serve as a proxy for size for clinics offering in-patient care. Table 4.32 presents the distribution of sampled and national estimate of clinics in terms of bed size. The size classes have been defined as follows in terms of bed capacity: (a) Small = 10 or less; (b) Medium = 11 to 50; and (c) Large = 51 and more.

4.60 According to Table 4.32, of the 266 sampled clinics, 60 (22%) are small, 188 (71%) are medium, and the remaining 18 (7%) belong to the large category. The national estimate of the distribution of clinics by size class varies from the sample distribution. A significantly higher percentage of the larger units have been interviewed. More specifically, the national distribution of clinics reveals the majority is in the small category (67%), while the medium and large units make up for 29% (n = 233) and 4% (n = 31) respectively.

Table 4.32: Distribution of Clinics by Bed Size Class

Category	Sample		National	
	Total	Percent	Total	Percent
Small	60	22	526	67
Medium	188	71	233	29
Large	18	7	31	4
Bangladesh	266	100	790	100

Source: NHA-2

4.61 Several factors contributed to NHA-2's rationale for covering a higher percentage of larger firms and correspondingly a smaller percentage of the small clinics. First, there is more homogeneity in types of services offered by small firms, and therefore, compared to more diverse category, a small sample can be a representative of its group. In other words, to enhance reliability in extrapolation of sample based national blown-up estimates, added effort was expended to cover the larger medical units. Second, NHA-2's efforts are to ensure accurate estimation of income and expenditure for different types of medical service providers. Incomplete or missing observation of the few large firms would yield larger errors in estimation than similar limitations with small sized firms.

4.62 A proxy for in-patient care provided by the private sector and by government hospitals is to assess the capacity of beds offered by the two sectors. NHA-2 estimates that the 790 private clinics collectively offered 10,250 beds in 1999, 11,231 in 2000, and 12,522 in 2001 (Table 4.33). The corresponding figures for the public hospitals are 37,934, 38,915 and 40,206 for 1999, 2000, and 2001 respectively. In percentage terms, the share of private sector's supply of beds for in-patient health care has shown a steady increase –- 37% in 1999 to 45% in 2001. In 1996-97, the ratio of private-public beds was 36%.

Table 4.33: Total Number of Beds in Clinics and in Government Facilities

Division	Clinics Covered	Clinics Not Covered	Private Clinic	Estimated Bed in Private Clinics			Total GOB Beds	Total Number of Beds			Private as a Percent of GOB Beds		
				1999	2000	2001		1999	2000	2001	1999	2000	2001
Dhaka	100	190	290	4,294	4,668	5,716	9,837	14,131	14,505	15,553	44	47	58
Chittagong	35	73	108	1,759	1,952	1,971	4,495	6,254	6,447	6,466	39	43	44
Rajshahi	36	121	157	1,503	1,704	1,704	6,416	7,919	8,120	8,120	23	27	27
Khulna	69	88	157	1,728	1,835	2,058	2,807	4,535	4,642	4,865	62	65	73
Sylhet	9	23	32	382	400	400	1,927	2,309	2,327	2,327	20	21	21
Barisal	17	29	46	584	672	673	2,202	2,786	2,874	2,875	27	31	31
Total	266	524	790	10,250	11,231	12,522	27,684	37,934	38,915	40,206	37	41	45

Source: NHA-2

Income of Clinics

4.63 NHA-2 estimates an annual gross income of Taka 2,098 million ($41.71 million) in 1999-2000 for the private clinics and hospitals of Bangladesh. Table 4.34 presents the income for the three class categories for three subsequent years, 1999-2000, 2000-01, and 2001-2002.

4.64 According to NHA-1, in 1996-97, the aggregate national income of private clinics and hospitals was Taka 1,135 million. A comparison of 1996-97 to 1999-2000 estimates suggests a nominal increase of 84.8%, and 64% when adjusted for inflation. In 1999-2000 aggregate income was Taka 2,098 million ($41.7 million). In 2001-02 aggregate income of clinics was Taka 2,134 million ($42.4 million) which suggests a modest 1.7% increase (Table 4.34).

Table 4.34: Aggregate Income of Clinics by Size Class, 1999-2002 (in million Taka)

Category	1999-2000		2000-01		2001-02	
	Income	Percent	Income	Percent	Income	Percent
Small	581	28	583	27	600	28
Medium	536	26	556	26	582	27
Large	981	47	997	47	952	45
Overall	2,098	100	2,136	100	2,134	100

Source: NHA-2

4.65 Although the number of clinics in Dhaka division make up for about 37% of the national estimate, its share in terms of revenue or income generated is significantly higher. In 1999-2000, gross income of the Dhaka division clinics was Taka 1,358 million, which constitute 65% of the total earnings from this sector (Table 4.35) over a two year period.

Table 4.35: Aggregate Income of Clinics by Division, 1999-2002 (in million Taka)

Division	1999-2000		2000-01		2001-02	
	Income	Percent	Income	Percent	Income	Percent
Dhaka	1,358	65	1,356	63	1,378	65
Chittagong	328	16	360	17	352	16
Khulna	88	4	92	4	88	4
Rajshahi	183	9	182	9	183	9
Barisal	27	1	27	1	26	1
Sylhet	114	5	119	6	107	5
Bangladesh	2,098	100	2,136	100	2,134	100

Source: NHA-2

4.66 Annual Operating Profit (Income minus Expenditure) estimates were attempted by size class (Table 4.36) as well as by administrative divisions (Table 4.37). The larger unit earnings are higher – almost twice compared to the medium and 1.7 times that of smaller units.

Table 4.36: Operating Profit of Clinics by Size Class, 1999-2002 (in million Taka)

Category	1999-2000	2000-01	2001-02
Small	246	207	176
Medium	210	166	139
Large	414	382	277
Overall	870	755	592

Source: NHA-2

Table 4.37: Operating Profit of Clinics by Division, 1999-2002 (in million Taka)

Division	1999-2000	2000-01	2001-02
Dhaka	592	520	428
Chittagong	110	93	62
Khulna	41	36	28
Rajshahi	81	68	53
Barisal	9	8	6
Sylhet	37	30	16
Bangladesh	870	755	593

Source: NHA-2

4.67 A limitation on the findings on gross income of private clinics and hospitals needs to be highlighted. In general, akin to other sectors of the economy, private for-profit clinic enterprises tend to under-report their income. Efforts were made to circumvent such propensity by providing assurances that information on individual clinics will kept confidential. Also, consistency and plausibility checks were followed by assessing the size of the clinics, reviewing their records and accounts (when permitted). Nevertheless, if under-reporting is widespread one can assume that relative differences between different size classes would still be captured.

Employment

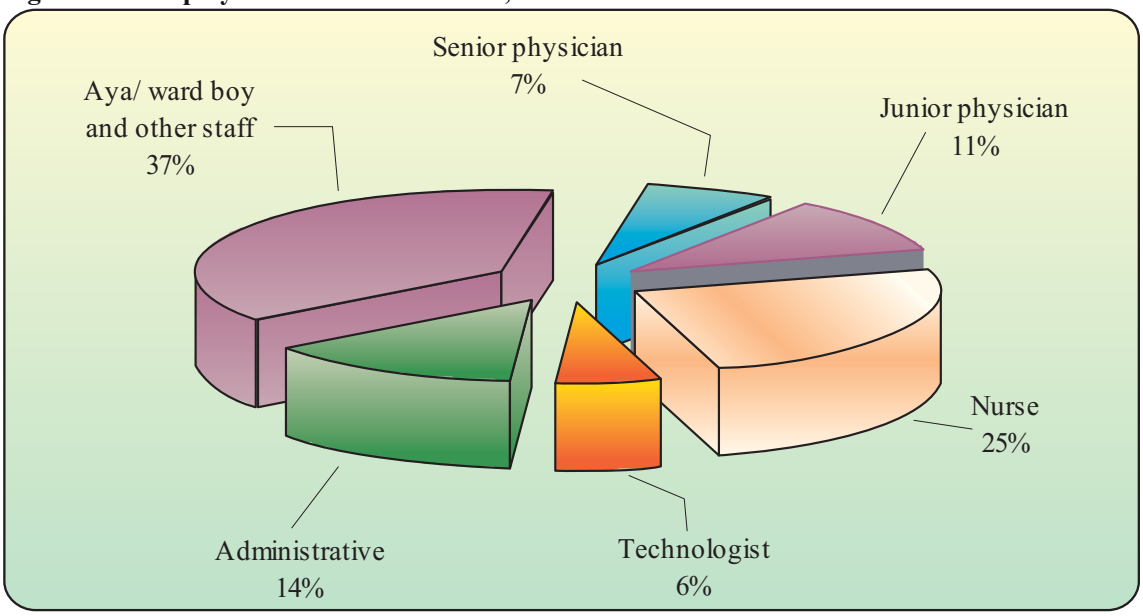
4.68 NHA-2 attempts to capture employment generated in various segments of the health sector by providers. Table 4.38 and Figure 4.6 presents the full-time and part-time employment of technical, administrative and support staff, by gender, in private clinics. Senior physicians are likely to have professional commitment in more than one institution. Accordingly, for every one full-time senior physician in this sector, there is one part-time professional. Female nurses are more prevalent, and supporting staff comprise of more than one-third of the total staff in a private clinic.

Table 4.38: Employment Profile of Clinics by Gender, 1999-2000

Personnel	Full-time		Part-time		Total	
	Male	Female	Male	Female	Male	Female
Senior physician	487	173	509	141	996	314
Junior physician	1,177	440	353	103	1,530	544
Nurse	133	4,539	0	18	133	4,557
Technologist	904	125	44	0	948	125
Administrative	2,093	436	41	0	2,134	436
Other staff	3,755	3,379	21	17	3,776	3,397
Total staff	8,549	9,092	968	279	9,517	9,373

Source: NHA-2

Figure 4.6: Employment Profile of Clinics, 1999-2000



Source: NHA-2

Essential Services Package (ESP) and Private Clinics

4.69 One of Bangladesh Government's key health expected outcomes is successful implementation of the Essential Services Package (ESP). Figure 2.2 in Chapter II provides a schematic presentation of the major areas and sub-areas covered under ESP. Table 4.39 suggests that very little ESP is offered by the private sector. Reproductive health care, child healthcare, communicable disease and behavior change communication services are offered by 6%, 10%, 5% and 1% of the private clinics respectively.

Table 4.39: Percent Distribution of Types of Essential Service Package (ESP) Provided by Clinics

Type of Services	Percent
Reproductive health	6
Child healthcare	10
Communicable disease	5
Behavior change communication	1

Source: NHA-2

4.4 Diagnostic Facilities

Characteristics

4.70 Although public hospitals offer various types of diagnostic facilities, in recent years, the private sector has become the dominant supplier of such services. Not only has the number of such private providers increased in absolute numbers, the range of tests performed has become more comprehensive. Today diagnostic facilities, especially the large units of big cities, conduct tests ranging from routine pathological examinations to such sophisticated efforts as Magnetic Resonance Imagery (MRI) and Cerebral Tomography (CT)-scan. Under NHA-2, aggregate national estimates of revenue and expenditure accrued by the diagnostic centers have been attempted.

Sampling Methodology

4.71 Akin to the private clinic listing from the Directorate of Health, MOHFW, a listing of diagnostic facilities was obtained from the same office. The sampling methodology pursued was similar to the private clinic study. In most urban locations, effort was expended to interview all the facilities, excepting in the two largest cities of Bangladesh – Dhaka and Chittagong. In these two large cosmopolitan centers, a stratified sampling by location was pursued, with an additional effort to include the larger sized facilities. Despite a disproportionate high level of effort made to obtain data from the larger diagnostic facilities, a few refused to participate in the study. NHA-2 did not entail visits to many smaller district towns. Based on the average number of diagnostic facilities in existence by various category of town size, estimates were made for the remaining district towns that were not visited.

Findings

4.72 NHA-2 estimates that at present there are approximately 1,097 diagnostic facilities in Bangladesh. Under NHA-2, a total of 156 diagnostic facilities and imaging facilities were interviewed. Table 4.40 presents both the national estimate and the divisional distribution of units surveyed.

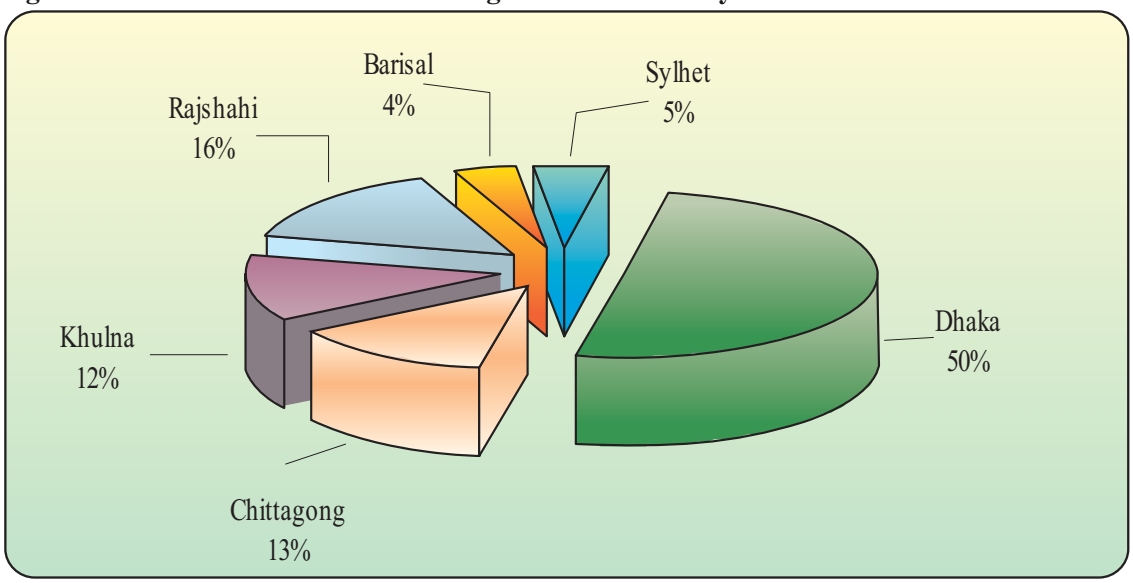
Table 4.40: Divisional Distribution of Diagnostic Facilities

Division	Sample		National	
	Count	Percent	Count	Percent
Dhaka	47	30	551	50
Chittagong	16	10	145	13
Khulna	20	13	137	12
Rajshahi	50	32	171	16
Barisal	10	7	42	4
Sylhet	13	8	51	5
Bangladesh	156	100	1,097	100

Source: NHA-2

A divisional comparison (Table 4.40, Figure 4.7) suggests that the highest concentration in Dhaka (50%) division followed by Chittagong (13%) and Rajshahi (16%).

Figure 4.7: Percent Distribution of Diagnostic Facilities by Division



Source: NHA-2

Registration

4.73 Of the 156 diagnostic facilities studied, 69% have obtained registration from the relevant department of MOHFW. It may be highlighted that comparable figure of the registration status of private clinics and hospitals is around 76%. Division-wise registration status of diagnostic facilities appears in Table 4.41.

Table 4.41: Divisional Distribution of Registration Status of Diagnostic Facilities

Division	Sample				National			
	Registered		Unregistered		Registered		Unregistered	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Dhaka	32	30	15	31	251	30	79	31
Chittagong	13	12	3	6	102	12	16	6
Khulna	15	14	5	10	118	14	26	10
Rajshahi	34	32	16	33	266	32	85	33
Barisal	4	4	6	12	31	4	32	12
Sylhet	9	8	4	8	70	8	21	8
Bangladesh	107	100	49	100	838	100	259	100
Percent of population	69		31		76		24	

Source: NHA-2

Ownership

4.74 Table 4.42 presents the percentage distribution of diagnostic facilities by physician and non-physician ownership in various divisions of Bangladesh. The overall national sample reflects that more than half (56%) are not owned by doctors while 44% have physicians as principal owners. In the case of private clinics and hospitals, according to NHA-2 survey, 65% are physician-owned.

Table 4.42: Divisional Distribution of Diagnostic Facilities by Ownership

Division	Sample				National			
	Physician		Non-physician		Physician		Non-physician	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Dhaka	20	29	27	31	257	53	294	48
Chittagong	5	7	11	13	50	10	95	15
Khulna	8	12	12	14	57	12	80	13
Rajshahi	23	33	27	31	72	15	99	16
Barisal	4	6	6	7	13	3	29	5
Sylhet	9	13	4	5	34	7	17	3
Bangladesh	69	100	87	100	483	100	614	100

Source: NHA-2

Income

4.75 NHA-2 estimates an annual income of Taka 3,574 million in 1999-2000 for the diagnostic facilities of Bangladesh (Table 4.43). The comparable income generated by private clinics and hospitals in that year is Taka 2,098 million. It implies that income of diagnostic facilities is approximately 59% that of private clinics and hospitals. Table 4.43 presents divisional breakdown of income for three subsequent years, 1999-2000, 2000-01, and 2001-02. In 1999-2000, gross income of the Dhaka division diagnostic facilities was Taka 1,746 million, which constitute 49% of the total earnings from this sector (Table 4.43).

Table 4.43: Income of Diagnostic Facilities by Division (in million Taka)

Division	1999-2000		2000-2001		2001-2002	
	Income	Percent	Income	Percent	Income	Percent
Dhaka	1,746	49	1,957	49	2,251	50
Chittagong	563	16	642	16	723	16
Khulna	641	18	677	17	714	16
Rajshahi	307	9	387	10	431	9
Barisal	85	2	105	311	5	3
Sylhet	232	6	261	626	6	6
Bangladesh	3,574	100	4,029	100	4,500	100

Source: NHA-2

Investment and Expenditure

4.76 Table 4.44 provides the expenditure incurred by diagnostic facilities on new machinery and equipment for three recent years. The level of investment varied significantly between the three periods.

Table 4.44: Diagnostic Facilities Expenditure on New Machinery and Equipment (in million Taka)

Components	1999-2000	2000-01	2001-02
New machine and equipment	75	375	180
Repair and maintenance of equipment	37	34	45

Source: NHA-2

Types of Services

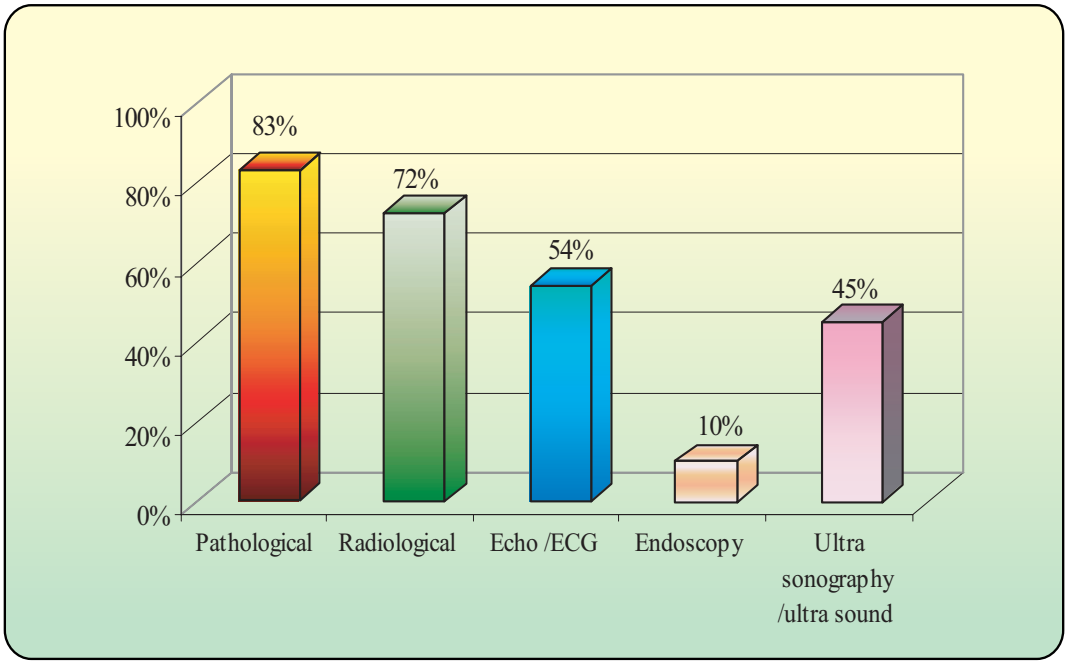
4.77 The NHA-2 survey queried if a diagnostic facility had one or more of the following broad category of services: (a) pathological; (b) radiological; (c) Echo/ECG; (d) endoscopy; and (e) ultra sonography or ultra sound. As evidenced in Table 4.45, almost all diagnostic units provide pathological (96%) and radiological (84%) services. Echo/ECG is available at two out of three facilities, and sonography is offered in one out of two surveyed. Endoscopy can be performed by only 12 percent of the diagnostic units in 2001-02. Compared to 1999-2000, the range of services has increased in recent years.

Table 4.45: Percentage Distribution of Services Provided by Diagnostic Facilities

Services	1999-2000		2000-01		2001-02	
	Yes (%)	No (%)	Yes (%)	No (%)	Yes (%)	No (%)
Pathological	83	17	92	8	96	4
Radiological	72	28	81	19	84	16
Echo /ECG	54	46	63	37	66	34
Endoscopy	10	90	12	88	12	88
Ultra sonography/ultra sound	45	55	49	51	51	49

Source: NHA-2

Figure 4.8: Percent of Diagnostic Facilities Providing Different Services, 1999-2000



Source: NHA-2

Pricing

4.78 Table 4.46 presents a listing of the wide range of tests that are performed by diagnostic facilities and prices charged. Mean, median and range of price per unit charged is presented in the table. It is evident that there are significant variations in prices charged across diagnostic facilities.

Table 4.46: Types of Service Provided by Diagnostic Facilities and Rates Charged (in Taka)

Name of Tests	Mean	Median	Minimum	Maximum
TC. DC. HB% ESR	96	100	15	200
Grouping Rh	75	80	20	150
Urine Routine	32	30	10	50
Urine Culture/Sensitivity	153	150	75	250
Stool Routine	32	30	10	50
Stool Culture and Sensitivity	158	150	75	350
Triglyseride /LDL/HDL	356	400	120	650
Serum Bilirubin	93	80	50	1,000
Urea (Renal Function Test)	95	100	50	200
VDRL	88	80	20	250
Widal	162	160	80	250
HIV	513	525	100	800
24 Hrs Urine Total Protein	159	150	50	400
Skin Scraping Fungus	107	100	50	280
Platelets Count	56	50	20	110
Blood for Culture and Sensitivity (C/S)	322	300	150	500
Acid Phosphate and Biochemical Test	206	200	80	500
S. Cholesterol /Cholesterol Test	124	120	60	800
Lipid Profile	490	500	2	800
Pregnancy Test	104	100	60	180

Table 4.46 : Types of Service Provided by Diagnostic Facilities and Rates Charged (in Taka) (continued)

Name of Tests	Mean	Median	Minimum	Maximum
ASO Title	179	180	80	300
Chest P/A X-Ray	103	100	60	250
Apical Skull (B/V) X-Ray	157	160	50	250
PNS X-Ray	96	80	50	200
NAC X				
CPD X-Ray	101	100	80	120
KUB X-Ray	114	100	50	240
Barium-Meal Stomach and Duodenum	272	280	100	400
Barium-swallow Esophagus X-Ray	287	263	120	450
OCG X-Ray	343	350	100	600
Barium-Follow Through X-Ray	436	450	80	800
IVC X-Ray	500	500	50	1,300
Dental X-Ray	67	50	20	350
Cretinine	125	120	60	200
ECG	139	128	80	200
SGPT	114	100	60	200
Throat Swab C/S	160	150	60	250
ST-Scan	4,167	3,500	3,500	5,500
Ultra Sonography	408	400	300	650

Source: NHA-2

Employment

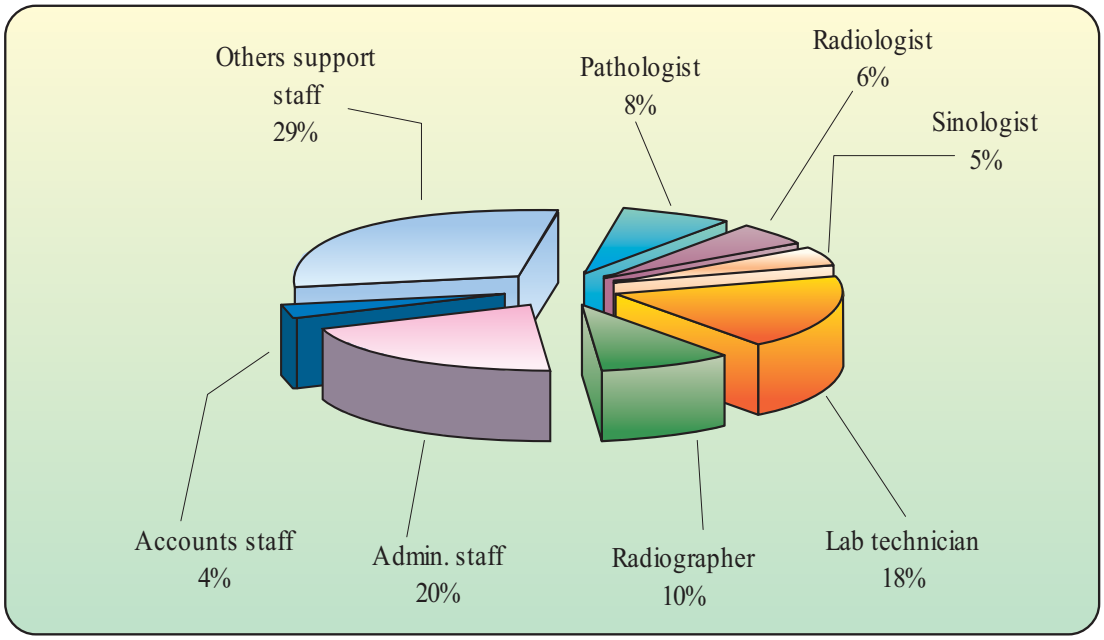
4.79 NHA-2 attempts to capture employment generated in various segments of the health sector providers. Table 4.47 presents the national estimate of full-time and part-time employment of technical, administrative and support staff, by gender, in diagnostic facilities. Figure 4.9 presents percent share of different occupational categories of employment in diagnostic facilities. Administration and supporting staff collectively comprise almost half of the employment force in this sector.

Table 4.47: Employment Profile of Diagnostic Facilities, 1999-2000

Personnel	Full-time		Part-time		Total	
	Male	Female	Male	Female	Ma le	Female
Pathologist	348	61	464	42	812	103
Radiologist	210	37	399	3	609	40
Sinologist	110	40	263	113	373	153
Lab technician	1,685	203	157	13	1,841	215
Radiographer	930	45	108	15	1,037	60
Admin. staff	1,818	406	32	15	1,850	421
Accounts staff	409	11	15	-	424	11
Others support staff	2,143	1,184	90	59	2,233	1,243
Total staff	7,653	1,987	1,528	260	9,179	2,246

Source: NHA-2

Figure 4.9: Percentage Distribution of Employment of Diagnostic Facilities, 1999-2000



Source: NHA-2

Conclusions

4.80 Several observations can be made from the findings on gross income of diagnostic facilities. First, this is a high growth service sector, with the range of tests becoming more elaborate. A few larger units in the bigger towns and cities, especially Dhaka and Chittagong, are investing in high valued capital equipment in terms of machinery and equipment. Such strategy has been prudent as an increasing number of patients opt away from the public sector facilities or from an overseas visit aimed at such tests and treatment. Second, despite the high growth in terms of new firms entering this market, like most business sectors, under-reporting of revenue (income) is likely to be widespread among diagnostic facility owners.

4.5 Health Insurance Expenditures

Introduction

4.81 Health insurance schemes are an alternative approach to financing of healthcare services. Such schemes are yet to be introduced in the public sector, although there have been proposals to develop health insurance programmers for the employees of the Government of Bangladesh (GOB) and state-owned enterprises. Currently, a handful of private for-profit health insurance companies offer health insurance facilities. This section presents an estimate of the total revenue generated by such companies. A number of NGOs provide social health insurance to a relatively large population, mostly in the rural areas.[1] An estimate of the volume of expenditures incurred by households for procuring health insurance from NGOs is also attempted.

Expenditure on Health Insurance by the Private Sector

4.82 Data was collected from three major private for-profit health insurance companies. Based on a review of relevant documents and discussions with key informants, it is estimated that these three companies generate almost 100% of the total revenue of private health insurance providers. Table 4.48 presents the aggregate premiums, claims and use of insurance expenditures.

Table 4.48: Premiums, Claims and Use of Insurance Expenditure

Items	1999-2000	2000-2001	2001-2002
Total premiums collected (in million Taka)	8.97	16.09	19.42
Total claims paid out (in million Taka)	5.66	5.87	8.68
Net administrative costs and profits (in million Taka)	3.31	10.22	10.74
Use of Insurance Expenditure (%)			
Government hospitals	0	0	0
Private hospitals	100	100	100
Estimated Use of Insurance Expenditure (in million Taka – nominal)			
Government hospitals	0	0	0
Private hospitals	5.66	5.87	8.68

Source: NHA-2

4.83 The total amount collected in terms of premiums in 1999-2000 was nearly Taka 9 million (Table 4.48), which more than doubled to reach Taka 19 million in 2001-02. The total claims also increased during the same period, from Taka 5.66 million to Taka 8.68 million.

[1] Social health insurance is one where a third party (in this case, an NGO) obliges or encourages thepolicy-holder to insure against health risks. Alternatively it is known as Micro Health Insurance (MHI) or Community Health Insurance.

The ratio of claims to premiums declined by almost a third, from 63% to 45%, signifying a healthy growth in the profitability of the insurance companies. However, it should be noted that the expenditure incurred by households for health insurance, which is equivalent to the total premiums collected by the companies, is highly insignificant compared to their spending on medicines, in-patient care, and other health services. Out of a total of Taka 48,347 million that households spent on healtcare in 1999-2000, only Taka 8.97 million or 0.02% went for health insurance.

Expenditure on Health Insurance Provided by NGOs

4.84 A number of leading NGOs and Micro Finance Institutions (MFIs) provide various health insurance schemes, which have come to be known as Micro Health Insurance (MHI) initiatives. The major providers include Gonoshasthya Kendra (GK), Dhaka Community Hospital, Grameen Bank, BRAC, Proshika, Dhustho Shasthya Kendra (DSK), Sajeda Foundation, and a few more. The main beneficiaries of these schemes, in the case of MFIs, are the members of micro credit groups and their families. [2]

4.85 According to a recent study (K. Islam, et. al, 2003), an estimated 1 million people are covered by some form of Micro Health Insurance (MHI).[3] The study found that the average premium is Taka 100 per person.[4] Assuming that the average family size is 5, the annual premium collected can be estimated at Taka 21 million, which is more than what the private health insurance companies collected in 2001-02. This amount constituted about 8% of the estimated earnings of NGOs from user fees and other household payments in that year. Health insurance premiums made up an insignificant 0.3% of the total revenues/funds of NGOs in 2001-02. Table 4.49 provides selective health insurance indicators for 2001-02.

Table 4.49: Health Insurance Premium and Funding of NGOs (in million Taka)

Items	2001-2002
Health insurance premium	21
Total NGO funds from all sources (million Taka)	8,084
Health insurance premium as a percentage of total NGO funds (%)	0.3
NGO revenue from user funds and other household payments	275
Health insurance premium as a percentage of NGO revenue from user fees and other household payments	7.6

Source: NHA-2

4.86 Despite the small share of premiums in NGO revenues, it should be noted that health insurance is an important means of demand-side financing of healthcare services. By targeting the poor, MHI has the potential to significantly increase the access of the poor to such services.

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[2] For a detailed discussion of micro health insurance schemes see: Islam, K: Health Financing Options for the Poor, WHO, Dhaka, April 2003; and Standing, H, et al: Bangladesh Demand Side Financing Scoping Study, DFID Health Systems Resource Centre, August 2003.

[3] Islam, K: Health Financing Options for the Poor, WHO, Dhaka, April 2003

[4] Ibid

4.6 Business Firms Health Expenditure

4.87 On-site provision of healthcare by private firms for their employees is yet to develop in Bangladesh, and limited services are currently provided by a few large firms in selected sectors. No comprehensive data however are available from secondary sources on such expenditures of private firms to facilitate compilation of NHA. Three types of firms were found to be relevant to NHA-2 compilation:

- Tea gardens ;
- Export-oriented readymade garment factories ;
- Selected large manufacturing enterprises engaged in hazardous production activities,

4.88 Tea gardens provide the largest known example of employer provided on-site healthcare services in Bangladesh. Due to their isolated locations and community type clustering of garden workers, tea gardens have traditionally provided on-site medical services to their workers and their families. NHA-2 collected comprehensive information from a few typically representative gardens and on the basis of the collected information estimated the total expenditures of the tea gardens.

4.89 Currently the Export-Oriented Readymade Garments (RMG) sector consists of around 3,000 enterprises of which 15% may be considered large. The larger units employ on the average more than 500 employees and maintain healthcare facilities to provide on-site healthcare to their workers. NHA-2 discussions and review of secondary documents reveal that the total annual expenditures are minimal compared to the enterprises outlays – between Taka 16 million to Taka 18 million per annum. In addition, a few RMG firms maintain insurance-like arrangements with the Marie Stopes Clinic Society (MSCS), a health service provider NGO. MSCS impart selective health care services to the garment workers in the three metropolitan cities of Dhaka, Chittagong and Khulna. The charge or premium payment varies between Taka 10 to Taka 25 per month per worker in lieu of which MSCS provide a Health Card Package (HCP) scheme.

4.90 The HCP includes general health check up with selected drugs, health certificates, skin problems, treatment of Sexually Transmitted Disease(STD) and Reproductive Tract Infection (RTI) with drugs, pregnancy check ups, gynecological problems, family planning, health education and referral services. Since expenditures on HCP services are included in NGO expenditures, they are not separately estimated and included as an additional expenditure item in order to avoid duplication.

4.91 Healthcare expenditures of the selected manufacturing enterprises engaged in hazardous production activities are estimated in consultation with the Bangladesh Bureau of Statistics (BBS) who recently conducted a survey on the labor force of hazardous industries. The estimates of expenditures from the three types of private firms providing on–site healthcare

services are presented in Table 4.50. Approximately Taka 350 million is annually spent by private firms on health expenditure on its employees.

Table 4.50: Health Expenditures on Employees by Private Firms (in million Taka)

Types of Private Enterprise	1999-2000	2000-2001	2000-2002
Tea gardens	208	218	230
Garment manufacturers	16	17	18
Selected hazardous manufacturers	105	105	111
Total	329	340	359

Source: NHA-2

4.7 Expenditures by Health Education, Research and Training Institutions (HERTI)

4.92 The International Classified Health Accounts (ICHA) classifies expenditures on education, research and training as health related expenditures along with expenditures on capital formation. The Government of Bangladesh (GOB), through the Ministry of Health and Family Welfare (MOHFW), operates an elaborate network of Health Education Research and Training Institutes (HERTI). HERTI offers professional health education for the public and occupational research and training for different categories of MOHFW health workers including nurses, family welfare workers, health technicians and paramedics. The Bangabandhu Sheikh Mujibur Rahman University (BSMRU) Medical College imparts postgraduate training and research on health. The National Institute of Population Research and Training (NIPORT) carries out population, health and demographic studies and surveys, while the National Institute of Preventative and Social Medicine (NIPSOM) conducts research on social and public health issues. Recognizing the renewed interests in traditional medicine GOB has recently setup Ayurvedic, Unani and Homeopathic Colleges for imparting modern education in these traditional healthcare areas.

4.93 Supplementing the GOB/MOHFW on HERTI, privately funded medical and dental colleges have been established in recent years for producing trained doctors, dentists and nurses. Of the 23 such institutions, 18 are medical and 5 are dental colleges. Larger NGOs are also getting involved in this sector. The Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic Disorders (BIRDEM) has recently setup the Bangladesh Institute of Research and Rehabilitation in Diabetes, Endocrine and Metabolic (BIRDEM) Academy, which imparts postgraduate training in several specialized healthcare disciplines. In addition, International Center for Diarrhea Disease Research, Bangladesh International Center for Diarrhoea Disease Research, Bangladesh (ICDDR,B), the large internationally funded NPI operating in Bangladesh, devotes a major portion of its expenditures to training and research. Expenditure of private HERTIs for the period of 1999-2000 to 2001-02 are shown in Table 4.51.

4.94 As evidenced in Table 4.51, private expenditures on health education research and training institutes is presently almost at par with the public sector. In 2001-02, public sector expenditure was Taka 1,197 million compared to Taka 938 million from the private sector. Private sector investment and expenditure in post graduate and medical colleges are significant, and presently larger than public sector contributions. No intervention is evident from the private sector in establishing educational institutes imparting unani, homeopath training or investing in research establishments.

Table 4.51: Expenditures on Health Education Research and Training Institutes (in million Taka)

Type of Institution	Government			Private		
	1999-2000	2000-01	2001-02	1999-2000	2000-01	2001-02
Post-graduate	91	85	85	120	128	130
Medical colleges	300	265	421	535	561	595
Nursing schools/colleges	20	26	51	5	6	10
Paramedical schools	14	12	13			
Specialized institutions	74	487	478			
Dental	33	27	18	189	196	203
Medical Assistant Training School (MATS)	34	36	37			
Unani, ayurvedic and tibbia college	5	15	16			
Homeopathic degree college	13	13	11			
Research	41	41	67			
Total	625	1,007	1,197	849	891	938

Source: FMAU database and NHA -2

Note: NGO research (e.g. ICDDR,B) is included in NGO sector; Govt. HERTI expenditures are already included in the MOHFW providers; Medical University is an autonomous organization and should strictly be classified as GOB NPI. However, for the sake of comparability, NHA-2 has included it as MOHFW provider.

V. Special Themes

5.1 Household Out of Pocket (OOP) Health Expenditures

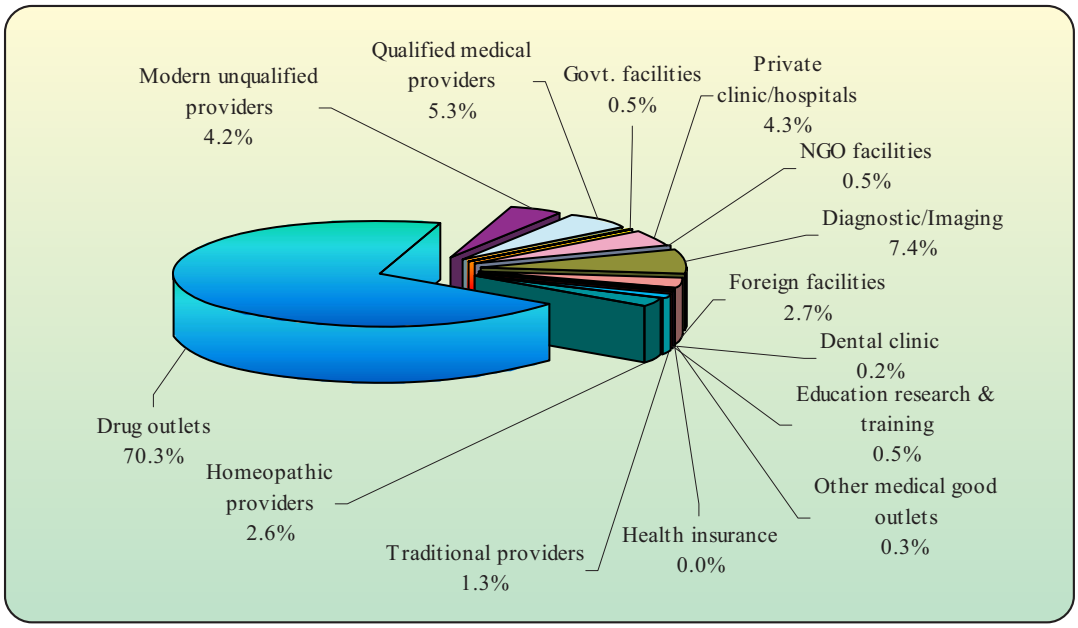
5.1 Household Out Of Pocket (OOP) health expenditures (or payments) are defined as payments made directly by a member of a household as a patient for the purchase of a medical service and goods. It includes all payments made without the benefit of insurance.

5.2 Bangladesh NHA-2 relied on the Bangladesh Bureau of Statistics' (BBS) household surveys for OOP health expenditures. In particular, NHA-2 used two nationally representative BBS surveys for estimating 1999-2000 households OOP health expenditure. The two surveys were: (a) Household Income and Expenditure Survey (HIES), 1999-2000 (sample size = 7,440 households) and the Heath and Demographic Survey (HDS), 1999-2000 (sample size = 11,219 households). Using 1999-2000 as the benchmark data, both the preceding two years (1997-98, 1998-99) as well as the following two years (2000-01, 2001-02) were computed using ratio estimates. Changes in annual GDP linear growth rates formed the basis for making the ratio estimates.

5.3 Bangladeshi households collectively spent approximately Taka 48.35 billion ($0.96 billion) during 1999-2000 period on health related expenditure (Table 5.1). Translated into per capita estimate, an average Bangladeshi expends Taka 398 ($8) annually. The predominant component of household expenditure is on drugs. Taka 34 billion ($676 million) or 70% of the health expenditure in on drugs (Table 5.1, Figure 5.1). A very distant second and third, in terms of share of households medical expenditure, are diagnostic and imaging (7.4%) and qualified medical providers (5.3%) respectively.

5.4 The Health and Demographic Survey (HDS), 1999-2000 provides information for estimating household expenditures on foreign treatment. Based on 1999-2000 information, approximation of foreign treatment expenditure has been made for the other five periods – 1996-97, 1997-98, 1998-99, 2000-01, and 2001-02. Methodology used to estimate drug expenditures for missing years have similarly been used in the case of foreign treatment expenditure. The 1999-2000 household OOP expenditure on foreign treatment was Taka 1.29 billion ($25.61 million), which is equivalent to 2.7% of total household health expenditure (Table 5.1).

Figure 5.1: Percent Distribution of Household Health Expenditure by Provider, 1999-2000



Source: NHA 2

5.5 The distribution of out of pocket health expenditure by providers reveals that household health expenditures at government facilities as well as NGO facilities collectively is highly insignificant – 1% of their total health expenditure. Out of pocket expenditure on homeopathic and traditional providers, reveal a steady increase – from 2.9% in 1996-97 to 4.7% in 2001-02 (Table 5.1).

5.6 The continued dominance of household OOP expenditure in National Health Expenditure (NHE) stresses the near total absence of third party payments through health care insurance or social insurance in Bangladesh. Similarly, predominance of expenditure on drugs in household health expenditures is a reflection of the national propensity to self-prescribe and general non-availability of medicine from public and NGO providers.

5.7 Household out of pocket expenditures constitute by far the largest component of the National Health Expenditure (NHE). Its share of NHE has remained between 68% and 69%, during 1996-97 to 2001-02 periods (Table 5.2). As percentage share of Total Health Expenditure (THE), household OOP health expenditure has been in the 64% to 65% range.

Table 5.1: Household Health Expenditure by Provider, 1996-97 to 2001-02 (in million Taka)

Provider	1996-1997		1997-1998		1998-1999		1999-2000		2000-2001		2001-2002	
	Expenditure	Percent	Expenditure	Percent	Expenditure	Percent	Expenditure	Percent	Expenditure	Percent	Expenditure	Percent
Homeopathic and traditional providers	1,042	2.9	1,291	3.2	1,585	3.6	1,854	3.8	2,218	4.3	2,656	4.7
Drug outlets	25,234	71.1	28,205	70.8	31,233	70.5	34,000	70.3	36,687	70.3	39,625	70.3
Modern unqualified providers	1,400	3.9	1,608	4	1,831	4.1	2,041	4.2	2,264	4.3	2,513	4.5
Qualified medical providers	2,005	5.6	2,206	5.5	2,405	5.4	2,578	5.3	2,739	5.3	2,913	5.2
Govt. facilities	159	0.4	188	0.5	210	0.5	231	0.5	252	0.5	275	0.5
Private clinic/hospitals	1,136	3.2	1,429	3.6	1,782	4	2,098	4.3	2,136	4.1	2,134	3.8
NGO facilities	197	0.6	211	0.5	225	0.5	234	0.5	242	0.5	251	0.4
Diagnostic/imaging	3,122	8.8	3,311	8.3	3,480	7.9	3,574	7.4	3,660	7	3,751	6.7
Foreign facilities	904	2.5	1,017	2.6	1,144	2.6	1,288	2.7	1,450	2.8	1,631	2.9
Dental clinic	61	0.2	78	0.2	88	0.2	99	0.2	111	0.2	125	0.2
Other medical good outlets	85	0.2	96	0.2	108	0.2	121	0.3	136	0.3	172	0.3
Health insurance	2	0	2	03		0	3	0	10	0	11	0
Education research and training	143	0.4	169	0.4	198	0.4	226	0.5	258	0.5	295	0.5
Total	35,490	100	39,811	100	44,292	100	48,347	100	52,163	100	56,352	100

Source: NHA-2

Table 5.2: Household Health OOP as Percent of Total Health Expenditure and National Health Expenditure, 1996-2002

	1996-97	1997-98	1998-99	1999-2000	2000-01	2001-02
HH as % of THE	64.1	65 .1	65.7	64.6	64.4	63.8
HH OOP on Drugs as % of THE	45.3	45 .5	45.7	45.5	45.3	44.9
HH as % of NHE	69.9	69 .8	69.9	69.2	69.4	68.0
HH OOP on Drugs as % of NHE	49.7	49 .4	49.3	48.7	48.8	47.8

Source: NHA -2

5.8 Extrapolation or interpolation estimates have its limitations. Accordingly, such effort was limited to the overall household OOP expenditure by provider source. The remaining tables (Table 5.3 to Table 5.5) and analysis have been limited to actual data collected for 1999-2000. Estimates by gender, rural-urban location, and administrative division have been attempted and discussed.

5.9 A discernible difference is apparent in in-patient and out-patient health expenditure patterns in terms of availing provider services. Households spend a significantly higher amount for out-patient care – 88% as compared to 12% on in-patient care (Table 5.3). For out-patient care, expenditure on drug outlets remains the highest share (74%). For in-patient care, the predominant components of household health expenditure are on drug outlets (45%) followed by private clinics (27%) and foreign health providers (21%).

Table 5.3: Household Health Expenditures by In-patient–Out-patient and Provider, 1999-2000 (in million Taka)

Provider	In-patient		Out-patient	
	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	-	0.0	620	1.5
Homeopathic providers	-	0.0	1,234	2.9
Drug outlets	2,584	45.3	31,416	73.7
Modern unqualified providers	-	0.0	2,041	4.8
Qualified medical providers	-	0.0	2,578	6.0
Govt. facilities	157	2.7	74	0.2
Private clinic/hospitals	1,558	27.3	540	1.3
NGO facilities	67	1.2	167	0.4
Diagnostic/imaging	121	2.1	3,453	8.1
Foreign facilities	1,221	21.4	67	0.2
Dental clinic	-	0.0	99	0.2
Other medical good outlets	-	0.0	121	0.3
Health insurance	-	0.0	3	0.0
Education research and training	-	0.0	226	0.5
Total	5,708	100	42,639	100

Source: NHA -2

5.10 An urban-rural comparison of household health expenditure for 1999-2000 suggests that 74% of the total household expenditure is made by rural families (Table 5.4). When compared in per capita terms, overall spending by rural households is lower than their urban cohorts. In 1999-2000 rural household spent Taka 367 on an average while health expenditure by urban household was Taka 523 per year.

Table 5.4: Per Capita Annual Household Health Expenditure by Location, 1999-2000

Location	Health Expenditure (in million Taka)	Percent	Per Capita (in Taka)
Rural	35,740	73.9	367
Urban	12,607	26.1	523
National	48,347	100	398

Source: NHA -2

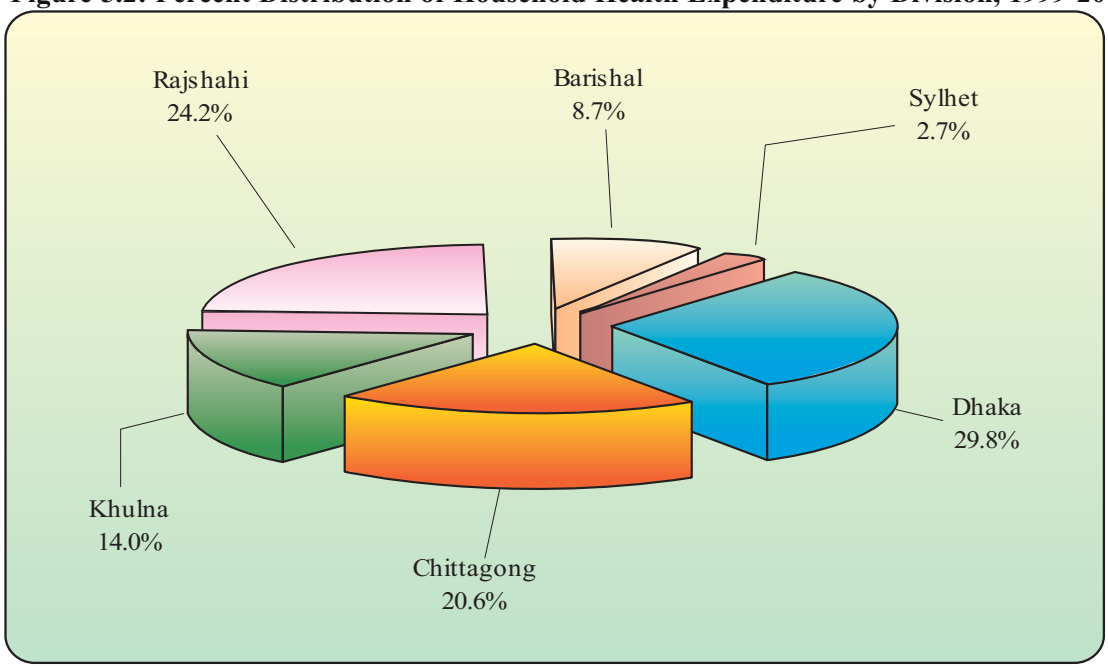
5.11 Household OOP health expenditure for the six administrative divisions is presented in Table 5.5. The estimates suggest higher share for Dhaka division (30%) and Rajshahi (24%), with Sylhet's share being a meager 3% (Table 5.5, Figure 5.2). Per capita health expenditure by division suggests that Khulna division has the highest per capita health expenditure (Taka 505) followed by Barisal division (Taka 457) and Rajshahi division (Taka 404). The lowest per capita health expenditure is reported in Sylhet division – Taka 263. Several per capita household OOP health expenditure by location, gender, age groups and consumption deciles appears in Annex 5.

Table 5.5: Household Health Expenditure by Division, 1999-2000

Division	Expenditure (in million Taka)	Percent	Per Capita (in Taka)
Barisal	4,198	9	457
Chittagong	9,973	20	389
Dhaka	14,410	30	377
Khulna	6,755	14	505
Rajshahi	11,719	24	404
Sylhet	1,292	3	263
National	48,347	100	398

Source: NHA -2

Figure 5.2: Percent Distribution of Household Health Expenditure by Division, 1999-2000



Source: NHA -2

5.2 Benefit Incidence Analysis

5.12 The objective of the Benefit Incidence Analysis (BIA) is to identify whether the healthcare subsidies are well targeted to the poor individuals of a nation. BIA describes the distribution of health sector subsidies across individuals in relation to their living standards. On the basis of this distribution, it is possible to assess whether healthcare subsidization is consistent with narrowing the gap between the living standards of the rich and the poor.

5.13 Under BIA, the estimated National Health Expenditure (NHE) is distributed among the resident population of Bangladesh in order to assess the ultimate beneficiary of NHE. Distribution of household Out of Pocket (OOP) health expenditure has been analyzed for the beneficiary household members classified by selected variables such as age, gender, residence and consumption deciles representing the socio-economic status of households. BIA studies NHE and the distribution of expenditures of all the non-profit providers – Public and NGOs – as well as for-profit private providers.

5.14 The Public and the NGOs are non-market providers and provide their services largely free or charging nominal user fees (i.e. at prices that are not economically significant) in contrast to the private for-profit providers who charge full market fees at economically significant prices. Distribution of NHE among the beneficiary households and individuals ultimately settles down to allocation of the Public and NGO expenditures (net of user fees charged) on the basis of identifying their utilization in the household survey database. Household data from the Bangladesh Bureau of Statistics (BBS) conducted Health and Demographic Survey (HDS), 1999-2000 was used for the benefit incidence analysis of NHE.

5.15 The target efficiency of BIA is assessed by estimating several indices – Concentration index, Gini coefficient, and Kakwani index. The Concentration index provides the quantitative measure of inequality of the variable under study across income groups. The Gini coefficient assesses the inequality of income distribution across the entire population. The Kakwani index is defined as the difference between a payments' concentration index and the Gini coefficient, and is calculated as $K = C - G$, where C is the health payments' concentration index and G is the Gini coefficient of the ability to pay variable. A negative value of Kakwani index indicates that government subsidies are well targeted to the poor people of the society. On the contrary, a positive value of the index indicates biasness towards pro-rich.

5.16 Availability of the HDS household survey for a single year, 1999-2000, restricted the scope of the beneficiary analysis of NHE to one year, i.e. to 1999-2000 (the benchmark year of NHA-2). Since changes in the country's healthcare expenditure in the following two years are observed to be gradual, results of the beneficiary analysis for these two years are likely to be similar to 1999-2000.

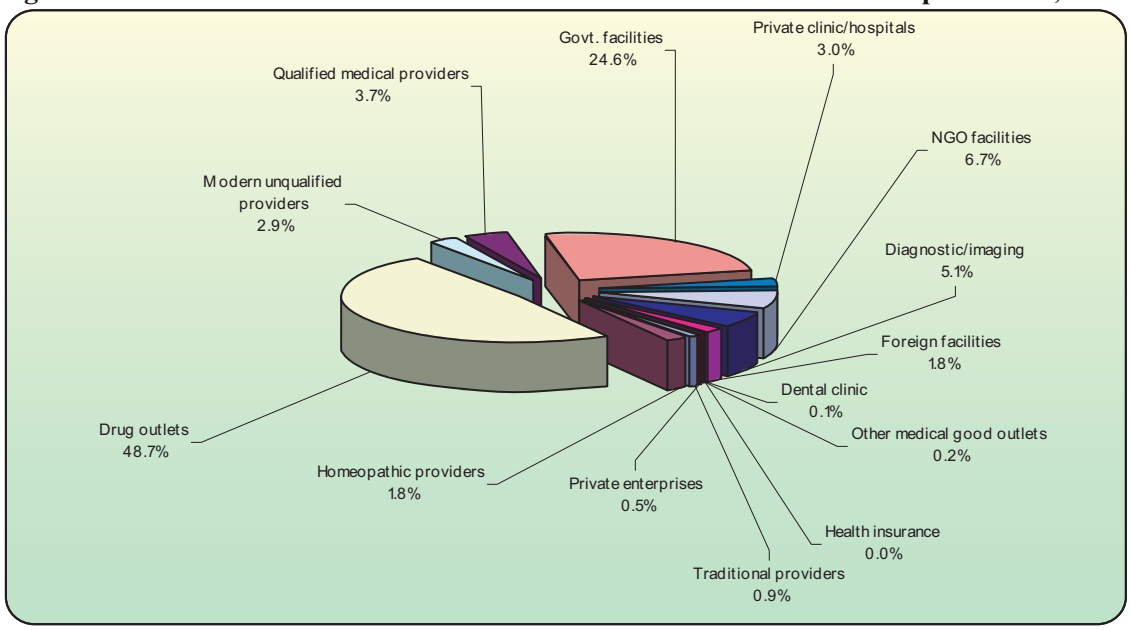
5.17 Table 5.6 and Figure 5.3 present the distribution of NHE among the ultimate beneficiaries by all provider groups identified in NHA-2. Drug outlets account for 48.7% of the NHE followed by Government facilities (24.6%), and NGOs (6.7%). Varied private facilities collectively account for 15.5% of NHE, while foreign facilities (representing bypassing expenditures) share was 1.8%. Homeopathic providers account for 1.8%, while traditional providers share is 0.9%.

Table 5.6: National Health Expenditures by Provider, 1999-2000 (in million Taka)

Provider	HealthExpenditure	Percent
Traditional providers	620	0.9
Homeopathic providers	1,234	1.8
Drug outlets	34,000	48.7
Modern unqualified providers	2,041	2.9
Qualified medical providers	2,578	3.7
Govt. facilities	17,217	24.6
Private clinic/hospitals	2,098	3.0
NGO facilities	4,674	6.7
Diagnostic/imaging	3,574	5.1
Foreign facilities	1,289	1.8
Dental clinic	99	0.1
Other medical good outlets	121	0.2
Health insurance administration	3	0.0
Private enterprises	329	0.5
Total	69,877	100

Source: NHA -2

Figure 5.3: Percent Distribution of Providers in National Health Expenditure,



Source: NHA -2

5.18 Poor-rich comparison in the utilization of NHE and its three broad component provider groups – public, NGO and private facilities – is estimated through the consumption or living standard based decile distribution (Table 5.7). The tenth or the richest decile is the largest beneficiary group using 15.4% of NHE, while the poorest represented by the lowest decile account for around 8.2%. The richest decile as a group utilized more than one and half time the healthcare utilized by the poorest decile.

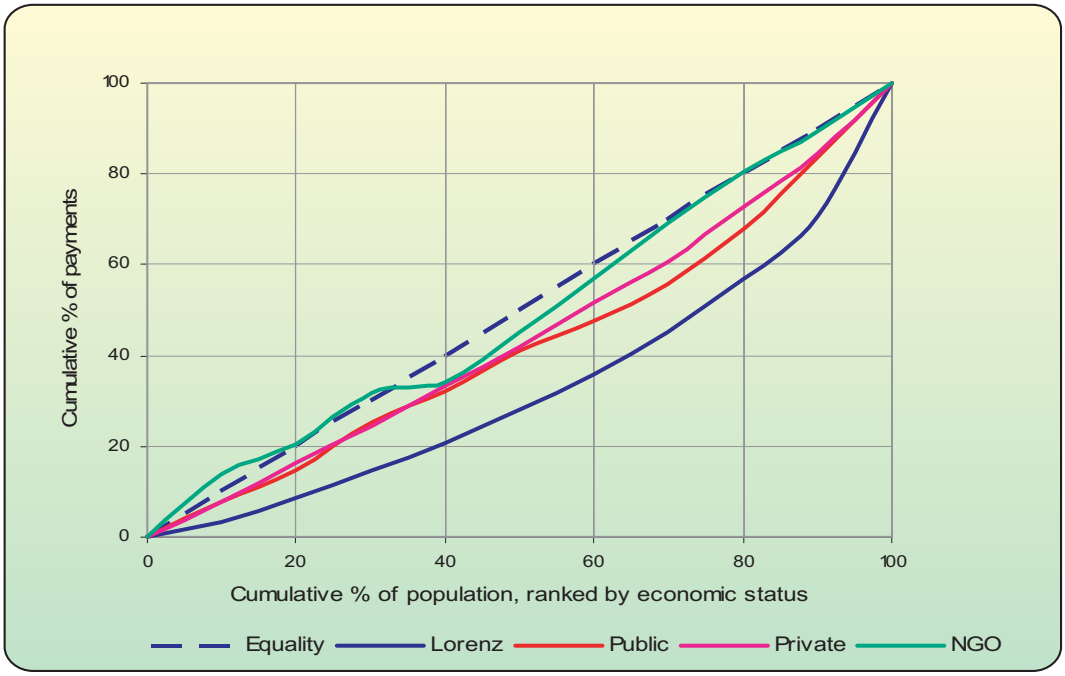
Table 5.7: Decile Shares of National Health Expenditure by Living Standards, 1999-2000

Deciles	Living Standards	Public Health Facilities	Private Health Facilities	NGO Health Facilities	National Health Expenditure
Poorest 10%	3.32	7.67	7.84	14.01	8.19
2nd poorest	5.11	7.04	8.51	6.20	7.99
3rd	6.02	10.50	7.91	11.63	8.79
4th	6.20	6.72	9.25	2.44	8.19
5th	7.34	9.01	8.46	11.00	8.76
6th	7.87	6.48	9.74	11.47	9.04
7th	9.25	8.15	9.03	12.32	9.02
8th	11.83	12.43	12.03	11.52	12.10
2nd richest	13.86	15.62	11.76	8.94	12.54
Richest 10%	29.20	16.38	15.47	10.46	15.37
Total	100%	100%	100%	100%	100%
Concentration index	0.3789	0.1899	0.1528	0.0578	0.1560
Kakwani index		-0.1891	-0.2261	-0.3212	-0.2230

Source: NHA-2

5.19 Relative progressivity of the utilization pattern of NHE and its three major components are assessed from the computed Kakwani index. Judged by the Kakwani index, expenditures by the NGO facilities are relatively progressive, benefiting the poor more compared to the richer deciles, while public provisions were the least progressive (Figure 5.4). NGO provision was similar to the overall distribution, and was less regressive than the private provisions. However, NGO expenditure was less progressive than the public provisions.

Figure 5.4: Lorenz and Concentration Curve for Healthcare Facilities, 1999-2000



Source: NHA-2

5.20 Distribution of NHE utilization disaggregated by gender and broad age groups reveals almost equal sharing of NHE among the country's male and female population. Significant variation in the pattern of utilization of the two gender groups is evident, when disaggregated by broad age groups. According to the reproductive age group, female utilization is much higher compared to the male – 46% for the females compared to 31% for the males (Table 5.8). Utilization by the female children of age group 0-4 is slightly higher (10%), compared to 14% by the male children of same age group. For the elderly group above 65 years of age, utilization by males is significantly higher, 19% compared to only 8% by the females.

Table 5.8: National Health Expenditure by Gender and Age Group, 1999-2000 (in million Taka)

Age Group	Male		Female		Total	
	Expenditure	Percent	Expenditure	Percent	Expenditure	Percent
Below 1 year	1,396	4	797	2	2,193	3
1-4	3,668	10	2,601	8	6,269	9
5-14	4,859	14	4,715	14	9,574	14
15-44	10,823	31	15,904	46	26,727	38
45-64	7,890	22	7,793	22	15,683	22
65-74	4,103	12	2,079	6	6,182	9
75-84	1,662	5	352	1	2,014	3
85+	742	2	493	1	1,235	2
Total	35,143	100	34,734	100	69,877	100

Source: NHA-2

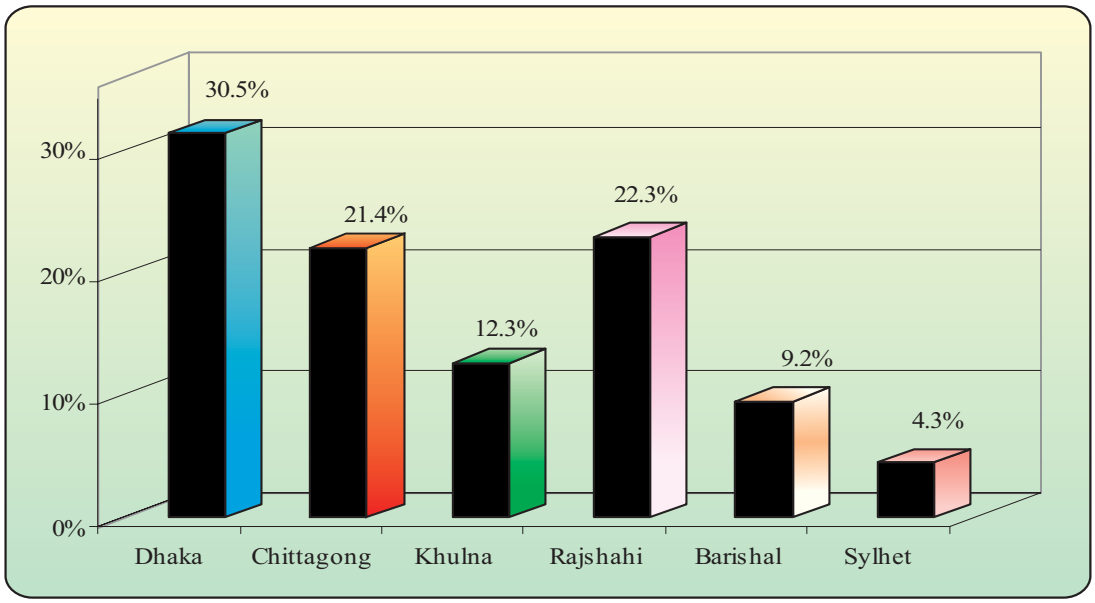
5.21 Divisional distribution of NHE is a broad indicator of its spatial, i.e. regional distribution. The divisional distribution is aligned with the population distribution except for Sylhet. The share of the divisional distribution for Sylhet is only 4% compared to 7% of its population share (Table 5.9 and Figure 5.5). The per capita distribution by division also follows the overall pattern. Per capita NHE for Sylhet is the lowest among the divisions while the highest is Barisal.

Table 5.9: Divisional Distribution of National Health Expenditure, 1999-2000

Division	Expenditure (in million Taka)	Percent	Per Capita (in Taka)
Barisal	6,449	9	711
Chittagong	14,958	22	599
Dhaka	21,298	31	566
Khulna	8,567	12	640
Rajshahi	15,584	22	552
Sylhet	3,021	4	372
National	69,877	100	575

Source: NHA -2

Figure 5.5: Percent Distribution of National Health Expenditure by Division, 1999-2000



Source: NHA -2

5.22 Disaggregation of NHE by in-patient and out-patient categories suggests that about 20% of NHE is in the form of in-patient services. And the government facilities are the largest provider of in-patient services (Table 5.10). It accounts for 60% of the total in-patient NHE and 24.6% of overall NHE. Drugs purchased by household expenditure account for 19% of the total national in-patient expenditures and indicate general exclusion of drugs.

In reality, drug expenditure is not insignificant for in-patients, thereby underestimating the actual OOP expenditure for households under such scenario.

Table 5.10: National Health Expenditure by In-patient, Out-patient Categories, 1999-2000 (in million Taka)

Provider	In-patient		Out-patient		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	-	0.0	620	1.1	620	0.9
Homeopathic providers	-	0.0	1,234	2.2	1,234	1.8
Drug outlets	2,584	18.6	31,416	56.1	34,000	48.7
Modern unqualified providers	-	0.0	2,041	3.6	2,041	2.9
Qualified medical providers	-	0.0	2,578	4.6	2,578	3.7
Govt. facilities	8,327	60.0	8,891	15.9	17,217	24.6
Private clinic/hospitals	1,558	11.2	540	1.0	2,098	3.0
NGO facilities	69	0.5	4,605	8.2	4,674	6.7
Diagnostic/imaging	121	0.9	3,453	6.2	3,574	5.1
Foreign facilities	1,221	8.8	67	0.1	1,289	1.8
Dental clinic	-	0.0	99	0.2	99	0.1
Other medical good outlets	-	0.0	121	0.2	121	0.2
Health insurance	-	0.0	3	0.0	3	0.0
Private enterprises	-	0.0	329	0.6	329	0.5
Total	13,879	100	55,998	100	69,877	100

Source: NHA-2

5.23 Disaggregation of NHE by gender and provider shows broad and even distribution of expenditures between male and female. Female have higher use of NGO facilities (8%) compared to their male cohort (Table 5.11). Although the aggregate NHE expenditure by gender is almost equal, male patients use relatively lower level of NGO provided services. In 1999-2000 female patients used almost 1.6 times more of NGO resources than their male cohorts. Male patients have a higher propensity to access foreign treatment.

Table 5.11: National Health Expenditure by Gender and Provider, 1999-2000 (in million Taka)

Provider	Male		Female	
	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	387	1.1	233	0.7
Homeopathic providers	641	1.8	593	1.7
Drug outlets	16,785	47.8	17,215	49.6
Modern unqualified providers	1,074	3.1	967	2.8
Qualified medical providers	1,268	3.6	1,310	3.8
Govt. facilities	8,814	25.1	8,404	24.2
Private clinic/hospitals	1,030	2.9	1,068	3.1
NGO facilities	1,808	5.1	2,866	8.3
Diagnostic/imaging	1,827	5.2	1,747	5.0
Foreign facilities	1,233	3.5	560.	2
Dental clinic	49	0.1	490.	1
Other medical good outlets	60	0.2	610.	2
Health insurance	1	0.0	20.	0
Private enterprises	164	0.5	165	0.5
Total	35,141	100	34,736	100

Source: NHA-2

5.24 Distribution of NHE by provider and broader age groups demonstrate fairly even pattern among the three border categories – Public, Private and NGO (Table 5.12). Children below five-year old category were the exception. Young children have access to the public and NGO facilities more readily than the private facilities.

Table 5.12: National Health Expenditure by Age Group and Providers, 1999-2000 (in million Taka)

Age Group	Public		Private		NGO		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	881	5	1,310	3	57	1%	2,248	3
1 – 4	2,438	14	3,826	8	392	8%	6,656	10
5 - 14	2,192	13	6,189	13	1,189	25%	9,570	14
15 - 44	6,213	36	18 ,714	39	1,804	39%	26,730	38
45 - 64	3,866	22	10 ,908	23	911	19%	15,685	22
65 - 74	1,003	6	4,618	10	226	5%	5,847	9
75 - 84	265	2	1,568	3	73	2%	1,906	3
85+	359	2	853	2	23	0%	1,236	2
Total	17,217	100	47,986	101	4,674	100%	69,877	100

Source: NHA-2

5.25 NHE has also been analyzed in per capita terms providing measures of per capita NHE by the six divisions, by rural urban locations, by gender, age groups and deciles. Per capita NHE in rural area is Taka 549 compared to Taka 682 for the urban population annually (Table 5.13). It may be noted that nearly 80% of Bangladeshis reside in the rural area.

Table 5.13: Per capita National Health Expenditure by Location, 1999-2000 (in Taka)

Location	PerCapita(Taka)
Rural	549
Urban	682
National	575

Source: NHA-2

Annex 6 Provides Additional Benefit Incidence Analysis (BIA) Tables Including Per Capita National Health Expenditure Cross Classification By Providers, Age Groups, Gender, Location, And Consumption Deciles.

5.3 Expenditure by Essential Service Package

5.26 The Essential Service Package (ESP), as defined in the health sector of Bangladesh, comprise of reproductive health, child health, prevention of communicable disease control, maternal health, and behavior change communication. It is in conformity with the recent reforms in public health policy and the impetus of Health and Population Sector Program (HPSP). Essential Services Package (ESP) has emerged as the dominant mode of Ministry of Health and Family Welfare (MOHFW) healthcare provision in the period 1999-2000 to 2001-2002.

5.27 The emergence of ESP as an important service mode of the MOHFW providers has resulted in a major shift of focus in its expenditure. Relatively speaking, it has swayed away from the tertiary and secondary level providers to the primary providers represented by the Upazila – the third administrative tier of the government – and below level Close to Client (CTC) facilities. The shift was arguably precipitated by an adjustment in donor funding to Upazila and other CTC facilities at the grass root level, and to the provision of ESP related health goods. To enhance access, non-realization of user fees at the grass root level facilities also has been made a part of the MOHFW policy.

5.28 In 1999-2000, Taka 14.7 billion ($292 million) was spent on ESP, which increased to Taka 17.57 billion ($308 million) in 2001-02 (Table 5.14). During the 1999-2000 to 2001-02 period, ESP as percentage of NHE has hovered around 21%. Although MOHFW share in ESP expenditure is dominant, it demonstrates a declining trend in recent years – from 73% in 1999-2000 to 64.6% in 2001-02. Correspondingly, NGOs share on ESP has increased from 27% in 1999-2000 to 35% in 2001-02. Private sector contribution to ESP is almost absent.

Table 5.14: National Health Expenditure on ESP, 1999-2002 (in million Taka)

Type of ESP	1999-2000				2000-2001				2001-2002			
	MOHFW	NGO	Pvt. Clinic	Total	MOHFW	NGO	Pvt. Clinic	Total	MOHFW	NGO	Pvt. Clinic	Total
ESP Health	5,127	2,161	10	7,298	5,676	2,851	11	8,538	5,642	3,315	12	8,969
ESP Family Planning	5,598	1,808	11	7,417	4,376	2,573	12	6,961	5,709	2,880	13	8,602
Total	10,725	3,969	21	14,715	10,052	5,424	23	15,499	11,351	6,195	25	17,571
% of Total ESP	72.9	27.0	0.1	100	64.9	35.0	0.1	100	64.6	35.3	0.1	100
ESP % of THE	14.3	5.3	0.03	19.7	12.4	6.7	0.03	19.1	12.9	7.0	0.03	19.9

Source: NHA -2

5.29 ESP facilities are primarily delivered in rural Bangladesh. Upazila and below level facilities are the major providers of ESP. Table 5.15 shows the divisional distribution of ESP. Dhaka division expenditure was the highest (Taka 2,893 million), while Sylhet is the lowest (Taka 643 million) in 1999-2000. Per capita ESP expenditure in Bangladesh was Taka 83 in 1999-2000. The per capita expenditure of Chittagong division was highest, around Taka 96.

Table 5.15: Divisional Expenditure on ESP by MOHFW, 1999-2002

Division	1999-2000		2000-2001		2001-2002	
	Expenditure (in million Taka)	Per Capita (in Taka)	Expenditure (in million Taka)	Per Capita (in Taka)	Expenditure (in million Taka)	Per Capita (in Taka)
Dhaka	2,893	75	2,911	71	3,286	74
Chittagong	2,460	96	2,006	80	2,264	83
Rajshahi	2,674	83	2,410	76	2,611	76
Khulna	1,297	86	1,315	89	1,375	86
Barisal	758	79	711	85	915	100
Sylhet	643	75	699	83	900	98
Total	10,725	83	10,052	78	11,351	87

Source: NHA -2

5.4 Health Professionals and Workers in the Healthcare Sector

5.30 There is no reliable and comprehensive estimate of the healthcare providers (i.e. healthcare providing professional human resources) in Bangladesh. NHA-2 primarily combined the findings of the Bangladesh Health Labor Market Study, 2003 (BHLMS) and the Health and Demographic Survey (HDS), 1999-2000 to determine the size of health providers as well as their earnings. Selective estimates for the public sector including Ministry of Health and Family Welfare (MOHFW) and other public sector facilities are possible from the Government of Bangladesh Human Resource Department (HRD) Data Sheet of MOHFW and other public records. However, systematic estimate of the MOHFW and other public sector personnel by skill categories is not possible. Estimates for the private sector, which comprises the large unorganized and informal rural private health providers and the relatively smaller numbers of formal providers, are mainly conjectural in the absence of comprehensive rural or national healthcare provider surveys. Public sector personnel providing part-time private healthcare services at all levels also complicate the public–private dichotomy of the healthcare personnel.

5.31 One way of distinguishing the private healthcare providers is by the system of medicine they practice and whether or not they are qualified to practice in that system of medicine. Two broad systems of medicine can be distinguished: allopathic or modern scientific and traditional. Within the two systems, providers can be separated by formally qualified and unqualified. Qualified practitioners are defined as those possessing formal qualifications that allow them to be registered with a public regulatory agency.

5.32 The traditional non-allopathic practitioners include Kabiraj (who practice an Ayurvedic system medicine), Unani practitioners (practicing Unani or traditional Muslim system of medicine), spiritual or faith healers, homeopaths, dais (or traditional midwives) and hazams or private circumcisers (who perform circumcision of Muslim male children). Many of the traditional non-allopathic practitioners also prescribe allopathic medicine depending on their experience. Traditional non-allopathic practitioners are spread across the country and no official attempt has been made to determine accurately their numbers, earnings, types of services provided and other characteristics. Because of low cost of their service and easy accessibility, these traditional non-allopathic providers serve as the first healthcare resort (apart from self-administration) for a large number of rural and urban households.

5.33 The public sector employs only qualified allopathic doctors (i.e. doctors with a minimum of a MBBS degree), qualified nurses, qualified pharmacists and some cadres of qualified paramedical (e. g. medical assistants and laboratory technicians). NGOs employ qualified doctors, nurses and both qualified and unqualified paramedics, the latter mostly at the grass root level. A segment of allopathic doctors and other formal sector providers work entirely in the private sector and NGO clinics and hospitals, diagnostic centers and also as full time private practitioners providing ambulatory services. Many of the public sector physicians also practice privately, either by working at clinics and hospitals after public hours (dual job-holding) or by charging private fees while practicing at public facilities.

5.34 The recently conducted Bangladesh Health Labor Market Study (BHLMS), 2003 estimates that the private sector healthcare personnel outweigh the public sector and that the traditional providers in particular, constitute the bulk of healthcare providers in Bangladesh. According to BHLMS, 50% of doctors, 42% of nurses, 65% of paramedics and all the traditional practitioners are in the private sector and the traditional providers outnumber the qualified doctors by 12 to 1.

5.35 Based on NHA-2 surveys and other sources, estimates of the total current (in 2001) annual direct employment in the health sector of Bangladesh including MOHFW and other public sector organizations, NGOs and the private sector is presented in Table 5.16. It is estimated that there are around 450,000 private medical practitioners in Bangladesh, with an overwhelming 90% offering informal and traditional healing services. In the formal private sector, paramedics and administrative and support staff make up for around 88% of employment. The combined figure of formally trained practicing physicians in the public, NGO and private sector is around 25,198.

Table 5.16: Employment in the Health Sector, 2001

Economic Classification	Public Sector				NGO	Private Sector			
	MOHFW	Other GOB	Local Govt.	Total Public		Clinics and Hospitals	Diagnostic Centers	Private Practitioners	Total Private
Formal allopathic									
Doctors	12,842	856		13,698	1,320	4,491	2,452	3,237	10,180
Paramedics	26,000	1,540		27,540	1,494	1,306	3,718	46,942	51,966
Nurses	10,811	759		11,570	2,887	5,673			5,673
Administrative and other support staff	50,636			50,636	15,224	11,961	7,017		18,978
Total formal	100,289	3,155		103,444	20,925	23,431	13,187	50,179	86,797
Informal and traditional									
Allopathic informal								111,000	
Other traditional								173,000	
Untrained birth attendants								119,000	
Total informal								403,000	

Source: Bangladesh Health Labor Market Study, 2003

5.36 Employment estimates according to International Standard Classification of Occupation (ISCO-88) excludes administrative manpower. Table 5.17 provides employment estimates of various category of professional, technical and associate professionals. According to ISCO-88 classification, there are approximately 57,600 health professionals and more than 468,136 technical and associate professionals in Bangladesh.

Table 5.17: Health Professionals in Bangladesh in 2001 by International Standard Classfication of Occupations (ISCO-88)

Major Group 2	Professionals	Employment	% Public	% Private	Number Per '000 Population
22	Life sciences and health professionals				
222	Health professionals (except nursing)				
2221	Medical doctors	28,537	50	50	23
2222	Dentists	1,286			1
2224	Pharmacists	2,500	10	90	2
2229	Health professionals (except nursing) n.e.c				
	Family planning officer	357	100	0	0
	Family planning inspector	4,110	100	0	3
	Family welfare visitor	5,248	100	0	4
	Health inspector	1,401	100	0	1
223	Nursing and midwifery professionals				
	Nurses	14,200	58	42	12
2230	Nursing and midwifery professionals				0
	Sub total	**57,639**			**46**
Major Group 3	**Technical and Associate Professionals**				0
32	Life sciences and health associate professionals				
322	Modern health associate professionals (except nursing)				
3221	Medical assistants	5,598	100		5
3222	Sanitarians	952	100		1
3223	Dieticians and nutritionists				0
3224	Optometrists and opticians	976			1
3225	Dental assistants	454			0
3226	Physiotherapists and related associate professionals	139	100		0
3228	Pharmaceutical assistants	7,622	100		6
3229	Modern health associate professionals (except nursing) n.e.c				
	Allopathic APPs	111,000	0	100	90
	Health assistant	21,016	100	0	17
	Family welfare assistant	22,350	100	0	18
	Assistant health inspector	4,202	100	0	3
	Dental assistants	454	100	0	0
	Assistant radiologists	1,054	100	0	1
	Assistant family planning officer	319	100	0	0
323	Nursing and midwifery associate professionals				
3231	Nursing associate professionals				0
3232	Midwifery associate professionals				0
324	Traditional medicine practitioners and faith healers				
	Untrained birth attendants	119,000	0	100	97
3241	Traditional medicine practitioners	173,000	1	99	140
3242	Faith healers				0
	Subtotal	**468,136**			**379**

Source: (1) HRDU, HRD data Sheet 2003.
(2) David H. Peters, Richard D. Kane; Bangladesh Health Labor market Study, June 2003, (3) BBS Statistical Pocket Book 001.

5.5 Health Expenditures by Development Partners

5.37 Development partner assistance is a significant source of healthcare financing in Bangladesh. In 1999-2000 the amount disbursed by the development partners was Taka 9.2 billion ($182 million), which increased to Taka 11.7 billion ($206 million) in 2001-02. Bilateral development partners disbursed 30% of the total fund, and the remaining 70% was from multilateral donors. Total development partners funding increased 64% in nominal terms during the period 1996-97 to 1999-2000 (Table 5.18). A significant amount of donor assistance is channeled through the Ministry of Health and Family Welfare (MOHFW) and NGOs. With the restructuring of MOHFW expenditures towards Essential Service Package (ESP) development partners assistance to MOHFW catering to Upazila and lower administrative levels have been on the rise since 1999-2000. Development partners are also increasing their transfers to NGOs. In 1999-2000 NGOs received Taka 4 billion ($80 million) from the development partners, which increased to Taka 5 billion ($88million) in 2001-02.

Table: 5.18: Fund Disbursements by Development Partners (in million Taka)

Type of Development Partners	1996-97	1999-00	2000-01	2001-02
Bilateral	4,540	3,031	3,575	3,594
Multilateral	1,303	6,127	6,878	8,151
Grand Total	5,843	9,158	10,453	11,745

Source: NHA-2

5.38 Development partners provide financial assistance in terms of loans and grants. Expenditure of major development partners in percentage terms during 1996-97, 1999-2000 to 2001-02 is presented in Table 5.19. Among all development partners, the World Bank has the highest (52%) disbursement followed by USAID (20%) and DFID (9%) during the period 1999-2000. In 2001-02, the World Bank's share was 57% while USAID's share has dropped to 16.5% compared to 38.2% in 1996-97.

Table 5.19: Percent Share of Foreign Development Partners Expenditure on Health, 1996-97, 1999-2000 to 2001-02

Development Partners	1996-97	1999-2000	2000-01	2001-02
Canadian International Development Agency (CIDA)	13.4	2.5	1.7	0.6
Australian Agency for International Development (AusAID)	2.5	0.1	0.1	0.1
Embassy of Sweden and Swedish International Development Agency (SIDA)	6.1	0.5	0.5	0.4
Department For International Development (DFID)	8.5	8.8	10.2	12.4
United States Agency for International Development (USAID)	38.2	20	20.6	16.5
Royal Netherlands Embassy	1.3	0.7	0.6	0.2
Korea International Cooperation Agency (KOICA)	1.0	0.5	0.5	0.4
Other Bilateral Agencies	6.7	na	na	na
Bilateral Total	**77.7**	**33 .1**	**34 .2**	**30.6**
European Commission (EC)	8.2	3.8	3.3	2.5
UNICEF	5.6	1.5	1.6	1.7
UNFPA	5.0	2.3	1.8	2.2
World Health Organization (WHO)	0.0	5.6	4.6	3.5
Asian Development Bank (ADB)	3.2	1.4	2.4	2.4
World Bank RMB	0.4	52.3	52.1	57.1
Multilateral Total	**22.3**	**66 .9**	**65 .8**	**69.4**
Grand Total	**100**	**100**	**100**	**100**

VI. Conclusion

6.1 The Bangladesh National Health Accounts, 1996-2001 endeavors to provide a detailed, comprehensive and reliable account of two basic aggregates of national health accounting. These are: (a) National Health Expenditure (NHE), representing the health expenditures of the nation during the accounting years comprising expenditures on all healthcare functions; and (b) Total Health Expenditure (THE), which comprises NHE plus capital formations of all healthcare providers as well as expenditures on health education and research during the accounting period.

6.2 NHA-2 estimates are based on the concepts and accounting framework of the Organization for Economic Cooperation and Development–System of Health Accounts (OECD-SHA) manual. Availability of the World Health Organization–World Bank-United States Agency for International Development (WHO-WB-USAID) funded "Guide to Producing National Health Accounts" also facilitated compilations of NHA-2. The compiled accounts are also internationally comparable, as the Bangladesh National Health Accounts coding is an adaptation of the OECD-SHA framework. However, strict adherence to International Classification for Health Accounts (ICHA) occasionally led to omission of some locally relevant expenditure flows, such as household expenditure on health related transportation.

6.3 Compilation of NHA-2 was largely data driven, involving extensive efforts in data collection, inventorying, evaluating and analysis. This activity of national health accounting made critical use of all available public data sources and made best use of all available secondary data. NHA-2 undertook several nation-wide representative surveys to generate comprehensive data on public sector corporations, local government bodies, NGOs, private for-profit providers, private firms and private insurance companies. A survey of the development partners were also undertaken to collect data on development partners funding of healthcare expenditures in the country and to cross-check the data available from Financial Management and Audit Unit (FMAU) of the MOHFW database and other secondary sources.

6.4 The Ministry of Health and Family Welfare (MOHFW) is the largest institutional healthcare provider in Bangladesh with an extensive network of facilities through out the country. The FMAU database provides a comprehensive picture of all the expenditures of MOHFW by providers as well as by Financing Agents. This source of MOHFW health expenditure also provides information in a time series. Geographical disaggregation of revenue expenditure is available from the database but for development expenditure such recognition is incomplete. Expenditure by functions is not feasible to identify directly from the database. In order to strengthen the FMAU database, user fee information should also be provided. This will facilitate the NHA activities substantially.

6.5 "Piggy-backing" on existing surveys like Health and Demographic Survey (HDS), 1999-2000, had the advantage of saving time and resources but created problems of adapting the database to the complex requirements of NHA compilation and analysis. Moreover, it should be noted that HDS has a nationally representative sample survey but not representative at the district or lower level. Hence, household OOP health expenditure analysis beyond the divisional level was not attempted under NHA-2. Such an effort would lead to invalid estimates. NHA-2 experience suggests appropriate sampling methodology of household survey that would allow estimations at the district or even upazila levels. Arguably a separate NHA requirement-oriented household survey, as part of the overall NHA initiative, could be more cost-effective.

6.6 NGOs play an important role in providing healthcare and Health, Nutrition and Population (HNP) services at the grass root level and complement the MOHFW efforts. The absence of a complete and up-to-date listing of NGOs made it difficult to develop an efficient and effective sample design. Transitory nature of healthcare activities of smaller NGOs also creates problems for developing an accurate listing frame. Combining NHA-1 listing with the updated listing of the Voluntary Health Services Society (VHSS) was pursued, complemented by field visits to cross-check the activities of the sampled NGOs. The sample selection experience was time consuming and not cost-effective. Moreover, similar to the NHA-1 data collection experience, under NHA-2 level of cooperation from a few large NGOs in sharing information were severely wanting.

6.7 No reliable, up-to-date-comprehensive listing of either private clinics or diagnostic facilities exists. Even though Director General Health's accreditation provides the listing, it is incomplete due to the exclusion of the non-registered ones. The main focus of the private clinics as well as the diagnostic center's survey was to complement the BBS' HDS survey. Regrettably, several of the large units showed reluctance in providing information.

6.8 NHA-2 primarily combined the findings of the Bangladesh Health Labor Market Study, 2003 (BHLMS) and the Health and Demographic Survey (HDS) 2000 to determine the number and earnings of health providers. In the absence of reliable secondary sources, it was difficult to determine accurately the number and earnings of modern private practitioners as well as technical and associate professionals.

6.9 NHA compilation needs to be a regular undertaking. Its institutionalization within the MOHFW is a challenging but a desirable objective. The NHA-2 experience suggests a few steps that are essential to achieve such goals. First, enhanced intra and inter ministerial cooperation is essential. Departments and bodies within the MOHFW should be discouraged from lumping up various expenditures into broad categories. A disaggregated breakdown of sources of funding, functions, etc. are desirable not only for better NHA estimates but would also lead to improved accountability and transparency in the system. Second, the Bangladesh Bureau of Statistics (BBS) is the premier institution of Bangladesh

in conducting large-scale surveys, including on health. Greater collaboration between BBS and MOHFW in sharing of existing databases as well as initiating new surveys would be desirable and cost effective towards implementing future NHA efforts. Third, the MOHFW is well-positioned to seek greater cooperation of the non-government providers – NGOs, private clinics and diagnostic centers – to provide data. Reluctance of information sharing by large sized NGOs and private sector facilities is a major data collection challenge. Finally, the responsibility of effective use at the policy level of NHA findings lies primarily with the MOHFW. The role of researchers is limited to collating and collection of data and in preparing NHA-related statistical tables.

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Annex I: Sampling Methodology and Coverage

Sampling Methodology and Coverage

I. Background

A wide array of secondary and primary data have been collected and collated under the National Health Accounts, 1996-2001 (NHA-2) project. Most of the health expenditure data on Out Of Pocket (OOP) payments as well as government expenditure data have been derived from available data sources. Several sample based surveys have been conducted to complement the secondary data information as well as to fill in data gaps.

The sampling methodologies for the surveys varied. For the majority of the surveys, it was difficult to adopt a distinct sampling technique due to lack of a well-organized sampling frame. Nevertheless, several criteria were adhered to in drawing the samples. In order to ensure that the bulk of the expenditure or flow of funds is accounted for, large and medium size providers and funding sources were covered. When warranted, additional effort was expended, in the form of repeat visits, to ensure information on the larger units are captured. All major administrative districts, commonly known as the 19 old districts, were included while sampling most of the provider-based surveys.

In the event overall population size was known, and coverage feasible in terms of time and resource availability, a census was carried out. Such an effort was made in generating information on donor funding and the private health insurance companies. Interviews with key informants physicians, pharmacy owners, and few other groups – were aimed at cross – checking data and information from alternate sources. Sampling of key informant interview was purposive.

A brief discussion of specific secondary and primary data sources and methods are presented below.

II. Government Expenditure Data

For the bulk of the government expenditure data, the research team utilized a database from the Financial Management and Audit Unit (FMAU) of the Ministry of Health and Family Welfare (MOHFW). The FMAU database management/development is an ongoing activity under a DFID-funded technical assistance project. Data was collated from various branches of the MOHFW. Additional MOHFW expenditure data were collected from the following sources:

- Government of Bangladesh (GOB) revenue budget documents published by the Ministry of Finance (MOF)
- GOB Development Budget published by MOF
- Unpublished database from the Controller General of Accounts (CGA) of GOB

Aside from MOHFW, data was collected from several other GOB Ministries including: (a) Ministry of Defense; (b) Ministry of Home Affairs; (c) Ministry of Social Welfare;

(d) Ministry of Labor; (e) Ministry of Science and Technology; and (f) Local Government Engineering Department (LGED).

Six public universities in Bangladesh were surveyed as autonomous bodies. Public corporations – the state-owned airlines, Bangladesh railway and the sea-port were also covered.

III. Household OOP Expenditure Data

Bangladesh NHA-2 relied on the Bangladesh Bureau of Statistics' (BBS) nationally representative surveys for estimating 1999-2000 household OOP expenditure. The surveys were: (a) Household Income and Expenditure Survey (HIES), 1999-2000 (sample size =7,440 households) and the Heath and Demographic Survey (HDS), 1999-2000 (sample size =11,219 households). Using 1999-2000 as the benchmark data, both the preceding two years (1997-98, 1998-99) as well as the following two years (2000-01, 2001-02) were computed using ratio estimates. Changes in annual Gross Domestic Product (GDP) growth rates formed the basis for making the ratio estimates.

The BBS surveys are nationally based sample surveys, and are not representative at the district or lower level. Hence, it should be noted that household OOP health expenditure analysis beyond the divisional level has not been attempted under NHA-2. Such an effort would lead to inaccurate estimates.

IV. Sample Based Surveys

In order to validate the efficiency of the sample based estimates, the desired sample size has been determined by using the following formula:

$$n_o = \frac{z^2}{d^2} \cdot pq$$

and

$$n = \frac{n_0}{1 + \frac{n_0}{N}}$$

Where:

N = Population size
n = Desired sample size
n_o= Estimated sample size
z = Statistical certainty chosen; 1.96
p = Estimated prevalence; 0.5
q = 1-p; 0.5
d = Precision desired; 0.05

V. Sample Surveys

Table A1.1 presents the sample coverage of major primary data collection surveys conductedunder NHA-2. The sample surveys conducted under the NHA-2 are discussed in the subsequent paragraphs.

Table A1.1: Divisional Coverage of Surveys under NHA-2

Institution	Dhaka	Chittagong	Khulna	Rajshahi	Barisal	Sylhet	Total
Private Clinics and Hospitals	97	23	34	52	7	15	228
NGOs	24	12	19	30	12	9	149
Diagnostic Facilities	48	14	18	48	10	14	152
Private Practitioners	54	12	31	15	10	10	132
Key Informants	15	11	23	11	10	10	80
Training Institute	50	0	0	2	0	0	52
Other Ministries	4	NA	NA	NA	NA	NA	4
Autonomous Bodies, Corporations and Tea Garden	3	1	0	0	0	0	4
Local Government*	1	1	1	2	1	1	7
Development Partners	13	0	0	0	0	0	13
Insurance Company	3	0	0	0	0	0	3

*All four city corporations are to be covered in addition to a sample based survey for municipalities, NA=Not Available

V.1 NGO

The National Health Accounts (NHA), 1996-97 prepared a listing of NGOs involved in the health sector. Under NHA-2 NGO survey, the NHA 1996-97 listing was matched with the updated listing of the Voluntary Health Services Society (VHSS). VHSS periodically publishes a report on NGOs working in the health and population sector. Based on the sampling formula presented earlier, the minimum desired size of NGO survey coverage was 166. From the NHA 1996-97 listing 89 NGOs were sampled for the survey, while 77 were sampled from the new VHSS listing.

V.2 Private Clinics and Hospitals

For each of the 19 major districts towns and cities of Bangladesh, a listing of private clinics and hospitals was collected from two sources: (a) Director General Health's Accreditation; and (b) Civil Surgeon offices of old districts. Following compilation of the listing, it was decided that a minimum of 222 samples would be included to meet the desired 95 percent confidence level criteria. The total sample size was proportionally distributed to the old-19 districts of Bangladesh by using the following formula:

$$n_i = \frac{N_i}{N} \times n \; ; \quad i = 1,2,.....,19$$

Where:

N = Total number of private clinics and hospitals
n = Desired sample size
N_i = Number of private clinics and hospitals in i^{th} district
n_i = Sample size to be covered in i^{th} district

V.3 Private Enterprise

No comprehensive data were available from secondary sources on expenditures of private business firms to facilitate compilation of NHA-2. Three types of business were found to be relevant to NHA-2 compilation: (a) Tea gardens; (b) Export-oriented garment industry; and (c) Selected large manufacturing enterprises. While primary data was collected from a few tea gardens, health related expenditure information on the garments and tannery businesses were obtained from secondary sources.

VI. Supplementary Data

Aside from the surveys and secondary data collection efforts cited above, several smaller sized surveys, personal interviews and focus group discussions were conducted. Coverage included diagnostic centers, private practitioners and key informants such as pharmacy owners. These supplementary surveys and interviews were aimed at cross validation of secondary information and to make up for missing data gaps.

VII. An Overview of NHA-2 Data

A listing of the major providers, sources of data, and their strengths and weaknesses are highlighted in Table A1.2.

Table A1.2: Summary of Quality of Data Used in NHA-2

Providers	Sources	Strengths	Weaknesses
MOHFW	• GOB Revenue Budget, Ministry of Finance • GOB Development Budget, Ministry of Finance • Financial Management and Audit Unit (FMAU) database • Controller General of Accounts (CGA) database	• Comprehensive • Available in time series • Provider identification feasible for revenue expenditures • Financing Agents (FA) identification feasible • Expenditures on ESP feasible to identify • Geographical disaggregating of revenue expenditure available	• Expenditures by functions not feasible to identify directly • Direct provider identification in development expenditures not feasible • Geographical disaggregating of development expenditures incomplete • User fees realization incomplete
Other GOB Ministries include: • Defense • Home Affairs • Social Welfare • Labor • Local Government Engineering Department (LGED)	• Based on information collected from individual ministries	• Comprehensive • Available in time series	• Long lead time in providing data • Geographical disaggregating not indicated
GOB Corporations	• Same as above		
GOB NPIs	• Collected from University Grants Commission	• Same as above	• Same as above
Local Bodies: Corporations and Large Municipalities	• Complete coverage of corporations • Samples of large municipalities	• Available in time series	• Incomplete coverage of the reported data
NGOs	• NGO survey • Annual reports of very large NGO • NGO bureau database for cross check	• Comprehensive • Available in time series	• Lack of complete listing of NGOs created problems in sampling • Transitory nature of healthcare activities of smaller NGOs create problems for developing accurate listing frame • Functional expenditure categories unreported for small and medium NGOs • Long lead time in procuring information from some very large NGOs • Multiple use of professionals make accurate reporting of NGO manpower difficult
Foreign Development Partners	• Survey of development partners • Published information of ERD to cross check	• Comprehensive • Available in time series	• Long lead time in data procurement

Table A1.2: Summary of Quality of Data Used in NHA-2 (continued)

Providers	Sources	Strengths	Weaknesses
Private Clinics and Hospitals	● Sample survey using Director General (DG) Health accreditation list as survey frame ● Non-registered clinics sampled locally by procuring lists from former district Civil Surgeons	● Comprehensive ● Available in time series ● Geographical disaggregating feasible	● Accreditation list frame incomplete due to exclusion of non-registered clinics and hospitals ● The accreditation list is not updated periodically
Private Diagnostic and Imaging Centers	● Sample survey using DG Health's accreditation list of registered providers ● Unregistered providers sampled similar to private clinics ● Very large providers identified and completely enumerated	● Comprehensive ● Available in time series	● Same as above ● Very large providers showed great reluctance in providing information which they perceived as of high commercial value
Private Trained Practitioners	● Survey of trained private practitioners supplemented by survey of key informants ● Cross-checked with earnings data from Health Manpower Survey (2003)		● Non-availability of accreditation list from DG Health created problem for accurate sampling ● Reluctance in providing earning information for taxation fear
Private Health Insurance	● Survey of private companies providing private health insurance	● Comprehensive information based on published annual accounts ● Available in the form of time series	● Early stage of development as a result information limited to a very tiny section of the countries insurance industry
Private Enterprise	● Survey of private enterprise ● Supplementary information from secondary sources	● Divisional disaggregating feasible	● Not comprehensive ● Time series not available
Household Out Of Pocket Expenditures	● Household Income and Expenditure Survey (HIES),1999-2000 ● Health and Demographic Survey, 1999-2000-both of these two surveys conducted by BBS in 1999-2000	● Comprehensive database on household OOP and other expenditures making equity and benefit incidence analyses feasible ● Key source of information on household expenditures on medicine, foreign treatment, and services from traditional and untrained private providers, medical goods like spectacles, hearing aids and crutches data are available. ● Divisional disaggregating of expenditures feasible	● Not available in time series ● Identification of healthcare providers not comprehensive enough for analysis

Annex 2: International Classified Health Accounts (ICHA)

Table A2: ICHA 3-Digit Classification of Healthcare Functions

ICHA Code		Functions of Healthcare
HC1		Services of curative care
HC 1.1		In-patient curative care
HC 1.2		Day cases of curative care
HC 1.3		Out -patient curative care
	HC 1.3.1	Basic medical and diagnostic services
	HC 1.3.2	Out -patient dental care
	HC 1.3.3	All other specialized healthcare
	HC 1.3.9	All other out-patient curative care
HC 1.4		Services of curative home care
HC 2		Services of rehabilitative care
HC 2.1		In-patient rehabilitative care
HC 2.2		Day cases of rehabilitative care
HC 2.3		Out -patient rehabilitative care
HC 2.4		Services of rehabilitative home care
HC 3		Services of long term nursing care
HC 3.1		In-patient long term nursing care
HC 3.2		Day cases of long term nursing care
HC 3.3		Long term nursing care: home care
HC 4		Ancillary services to healthcare
HC 4.1		Clinical laboratory
HC 4.2		Diagnostic imaging
HC 4.3		Patient transport and emergency rescue
HC 4.9		All other miscellaneous ancillary services
HC 5		Medical goods dispensed to out-patients
HC 5.1		Pharmaceuticals and other medical non-durables
	HC 5.1.1	Prescribed medicine
	HC 5.1.2	Over the counter medicine
	HC 5.1.3	Other medical non-durables
HC 5.2		Therapeutic appliances and other medical durables
	HC 5.2.1	Glasses and other vision products
	HC 5.2.2	Orthopedic appliances and other prosthetics
	HC 5.2.3	Hearing aids
	HC 5.2.4	Medico-technical devices, including wheel chairs
	HC 5.2.9	All other miscellaneous medical durables
HC 6		Prevention and public health services
HC 6.1		Maternal and child health: family planning and counseling

Table A2: ICHA 3-Digit Classification of Healthcare Functions (continued)

ICHA Code		Functions of Healthcare
HC 6.2		School health services
HC 6.3		Prevention of communicable diseases
HC 6.4		Prevention of non-communicable diseases
HC 6.5		Occupational healthcare
HC 6.9		All other miscellaneous public health services
HC 7		Health administration and health insurance
HC 7.1		General government administration of health
	HC 7.1.1	General government administration of health (except social security)
	HC 7.1.2	Administration, operation and support activities of social security funds
HC 7.2		Health administration and health insurance: private
	HC 7.2.1	Health administration and health insurance: social insurance
	HC 7.2.2	Health administration and health insurance: other private
ICHA code		Health-related functions
HCR.1		Capital formation of healthcare provider institutions
HCR.2		Education and training of health personnel
HCR.3		Research and development in health
HCR.4		Food, hygiene and drinking water control
HCR.5		Environmental health
HCR.6		Administration and provision of social services in kind to assist living with disease and impairment
HCR.7		Administration and provision of health-related cash-benefits

Table A3: Categorization of Healtcare Providers for Bangladesh

ICHA Code		Healthcare Provider Industry
HP 1		Hospitals
HP.1.1		General hospitals
HP.1.2		Mental health and substance abuse hospitals
HP.1.3		Specialty (other than mental health and substance abuse) hospitals
HP.2		Nursing and residential care facilities
HP.2.1		Nursing care facilities
HP.2.2		Residential mental retardation, mental health and substance abuse facilities
HP.2.3		Community care facilities for the elderly
HP.2.9		All other residential care facilities
HP.3		Providers of ambulatory healthcare
HP.3.1		Office of physicians
HP.3.2		Office of dentists
HP.3.3		Offices of other health practitioners
HP.3.4		Out-patient care centres
	HP.3.4.1	Family planning centres
	HP.3.4.2	Out-patient mental health and substance abuse centres
	HP.3.4.3	Free-standing ambulatory surgery centres
	HP.3.4.4	Dialysis care centres
	HP.3.4.5	All other out-patient multi-specialty and cooperative service centres
	HP.3.4.9	All other out-patient community and other integrated care centres
HP.3.5		Medical and diagnostic laboratories
HP.3.6		Providers of home and healthcare services
HP.3.9		Other providers of ambulatory healthcare
	HP.3.9.1	Ambulance services
	HP.3.9.2	Blood and organ banks
	HP.3.9.9	Providers of all other ambulatory healthcare services
HP.4		Retail sale and other providers of medical goods
HP.4.1		Dispensing chemists
HP.4.2		Retail sale and other supplies of optical glasses and other vision products
HP.4.3		Retail sale and other supplies of hearing aids
HP.4.4		Retail sale and other supplies of medical appliances (other than optical glasses and hearing aids)
HP.4.9		All other miscellaneous sale and other supplies of pharmaceuticals and medical goods
HP5		Provision and administration of public health programme
HP6		General health administration and insurance
HP.6.1		Government administration of health
HP.6.2		Social security funds
HP.6.3		Other social insurance
HP.6.4		Other (private) insurance
HP.6.9		All other providers of health administration
HP.7		Other industries (rest of the economy)
HP.7.1		Establishments as providers of occupational healthcare services
HP.7.2		Private house holds as providers of home care
HP.7.9		All other industries as secondary producers of healthcare
HP.9		Rest of the world

Table A4: ICHA Classification of Sources of Healthcare Funding

ICHA- HF Classification of Sources of Funding	
ICHA Code	**Source of Funding**
HF.1	General government
HF.1.1	General government excluding social security funds
HF.1.1.1	Central government
HF.1.1.2	State/ provincial government
HF.1.1.3	Local /municipal government
HF.1.2	Social security funds
HF.2	Private sector
HF. 2.1	Private social insurance
HF. 2.2	Private insurance other than social insurance
HF. 2.3	Private households
HF. 2.4	Non-profit institutions serving households (other than social insurance)
HF. 2.5	Corporations (other than social insurance)
HF. 3	Rest of the world

Annex 3: Total Health Expenditure (THE) Two-way Tables

Table A5: Bangladesh National Health Accounts- 2, Functions by provider, 2000-01 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	Public Sector						NGOs	Private sector									Overall Total
			MOHFW	Other Ministries	Auto. Corp.	GOB NPIs	Local Govt.	Total Public		Pvt. Cl.	Ambulatory providers			Pvt. Corp.	Diag.	Med.	Pvt. Heal.	For. Pro.	
											Mode. Qua.	Mode. Unq.	Trad. Hom.						
	Services of curative care	HC 1	9,789	919		44	170	10,922	1,402	2,136								1,450	15,910
1.1.1	In-patient curative care	HC1.1	6,407	708				7,115	99	1,581								1,378	10,173
1.1.2	Out-patient curative care	HC 1.3	3,382	211		44	170	3,807	1,303	555								72	5,737
1.1.5	Out-patient dental care	HC 1.3.2									111								111
	Services of rehabilitative care	HC 2	133					133											133
1.1.3	In-patient rehabilitative care	HC 2.1	90					90											90
1.1.4	Out-patient rehabilitative care	HC 2.2	43					43											43
1.2	Ambulatory healthcare services	HC 1.3.9									2,739	2,264	2,218						7,221
2	Diagnostic imaging	HC 4.2													3,660				3,660
3.1	Prescribed medicine	HC 5.1.1														36,687			36,687
3.2	Glasses and vision products	HC 5.2.1														124			124
3.2	Orthopedic appliances and others	HC 5.2.2														11			11
3.2	Hearing aids	HC 5.2.3														1			1
4.1	Family planning services	HC 6.1	3,711					3,711	3,094										6,805
4.2	School health	HC 6.2	11					11											11
4.3	Prevention of communicable disease	HC 6.3	115					115	471										586
4.5	Occupational healthcare	HC 6.5	6		160			166						340					506
4.4	Health awareness creations	HC 6.9	778					778	1,140										1,918
5.1	Health administration	HC 7.1.1	1,447					1,447											1,447
5.3	Community Insurance	HC 7.2.1							17										17
5.2	Health administration and insurance: private	HC 7.2.2															10		10
National Health Expenditure (NHE)			**15,990**	**919**	**160**	**44**	**170**	**17,283**	**6,124**	**2,136**	**2,850**	**2,264**	**2,218**	**340**	**3,660**	**36,823**	**10**	**1,450**	**75,158**
6	Capital formation	HCR 1	2,585					2,585	482										3,067
7	Education and training	HCR 2	971					971	776					891					2,638
8	Research	HCR 3	103					103											103
Total Health Expenditure (THE)			**19,649**	**919**	**160**	**44**	**170**	**20,942**	**7,382**	**2,136**	**2,850**	**2,264**	**2,218**	**1,231**	**3,660**	**36,823**	**10**	**1,450**	**80,966**
SHA THE			**18,575**	**919**	**160**	**44**	**170**	**19,868**	**6,606**	**2,136**	**2,850**	**2,264**	**2,218**	**340**	**3,660**	**36,823**	**10**	**1,450**	**78,225**

Source: NHA-2

Note: Auto. Corp. = Autonomous Corporation, Govt. = Government; Pvt. Cl. = Private Clinic and Hospital, Mode. Qua. = Modern Qualified, Mode. Unq. = Modern Unqualified, Trad. Hom. = Traditional and Homeopathic, Pvt. Corp. = Private Corporation, Diag. = Diagnostic and Imaging, Med. = Medicine and Medical Goods, Pvt. Heal. = Private Health Insurance, For. Pro. = Foreign Providers.

Table A6: Bangladesh National Health Accounts-2, Provider by Sources of Funding, 2000-01 (in million Taka)

BNHA Code	BNHA Providers	ICHA Code	MOHFW				Other Ministries	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance	Private Insurance	Private Enterprise	Households	Grand Total
			Rev.	Dev		Total									
				GOB	Dev. Partners										
1	Government Providers														
1.1.1.1	MOHFW Administration	HP 6.1	915	419	332	1,666									1,666
1.1.1.2	University Medical College Hospitals	HP1.1	205			205									205
1.1.1.3	Medical College Hospitals	HP1.1	985	151	51	1,187								136	1,323
1.1.1.4	District Hospitals	HP1.1	869	49	119	1,037								116	1,153
1.1.1.5	Thana Level Facilities	HP1.1	5,814	3,601	4,117	13,532									13,532
1.1.1.6	Specialized Hospitals	HP 1.3	591	30		621									621
1.1..1.7	Other MOHFW Facilities	HP1	135	7		142									142
1.2	Other GOB Facilities	HP1.1					919								919
1.3	Local Government Facilities	HP 1.1					170								170
1.4	Corporations and Autonomous Bodies	HP 1.1					160								160
1.4	GOB NPI Facilities	HP 1.1					44								44
1.5	Research and Training Institutions	NEC													1,898
1.5.1	Govt. Education and Training Institutes	NEC	500	48	459	1,007									1,007
1.5.2	Private Education and Training Institutes	NEC											891		891
2	Non-Profit Institutions and NGO Facilities	HP 1.1						978	512	5,375	17			500	7,382
4.1.1	Private Clinics/Hospitals	HP 1.1												2,136	2,136
4.1.2	Private Practitioners	HP 3.3												2,739	2,739
4.1.3	Dental Providers	HP 3.2												111	111
4.2.1	Private Modern Unqualified Providers	HP 3.9.9												2,264	2,264
4.2.1.5	Private Traditional Providers	HP 3.9.9												594	594
4.2.1.3	Private Homeopathic Providers	HP 3.9.9												1,624	1,624
4.5.1	Diagnostic/Imaging Service Providers	HP 3.5												3,660	3,660
4.6.1	Drug Retail Outlets	HP 41												36,687	36,687
4.6.3	Private Sale of Glass and Vision Products	HP 4.2												124	124
4.6.2	Crutches	HP 4.4												11	11
4.6.4	Hearing Aids	HP 4.3												1	1
3.1	Private Enterprise	HP 1.1											340		340
4.8.1	Pvt. Health Insurance Administration	HP 6.4										10			10
5	Foreign Providers	HP 9												1,450	1,450
Total Health Expenditure (THE)			**10,014**	**4,305**	**5,078**	**19,397**	**1,293**	**978**	**512**	**5,375**	**17**	**10**	**1,231**	**52,153**	**80,966**

Source: NHA-2

Note: Rev. = Revenue, Dev. = Development.

Table A7: Bangladesh National Health Accounts-2, Functions by Sources of Funding, 2000-01 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	MOHFW				GoB (Other than MOHFW)	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance (NGOs)	Pvt. Ins.	Private Enterprise	HH	Grand Total
			Rev.	Dev.		Total									
				GOB	Dev. Partners										
	Services of curative care	HC 1	6,606	1,159	1,772	9,537	1,133	175		985				4,080	15,910
1.1.1	In-patient curative care	HC1.1	4,375	736	1,143	6,254	708	10		86				3,115	10,173
1.1.2	Out- patient curative care	HC 1.3	2,231	423	629	3,283	425	165		899				965	5,737
1.1.5	Out-patient dental care	HC 1.3.2												111	111
	Services of rehabilitative care	HC 2	133			133									133
1.1.3	In-patient rehabilitative care	HC 2.1	90			90									90
1.1.4	Out-patient rehabilitative care	HC 2.2	43			43									43
1.2	Ambulatory healthcare services	HC 1.3.9												7,221	7,221
2	Diagnostic imaging	HC 4.2												3,660	3,660
3.1	Prescribed medicine	HC 5.1.1												36,687	36,687
3.2	Glasses and vision products	HC 5.2.1												124	124
3.2	Orthopedic appliances and other prosthetics	HC 5.2.2												11	11
3.2	Hearing aids	HC 5.2.3												1	1
4.1	Family planning service	HC 6.1	1,849	736	1,128	3,713		488		2,606					6,807
4.2	School health	HC 6.2	11			11									11
4.3	Prevention of communicable disease	HC 6.3		43	72	115		74		397					586
4.5	Occupational healthcare	HC 6.5		1	6	7	160						340		507
4.4	Health awareness creation	HC 6.9		27	748	775		170	129	841					1,915
5.1	MOHFW administration of health	HC 7.1.1	915	338	194	1,447									1,447
5.3	Community health insurance	HC 7.2.1									17				17
5.2	Health administration and insurance: private	HC 7.2.2										10			10
6	Capital formation	HCR 1		1,949	636	2,585		25	322	135					3,067
7	Education and training	HCR 2	500	45	426	971		46	61	411			891	258	2,638
8	Research	HCR 3		7	96	103									103
Total Health Expenditure (THE)			**10,014**	**4,305**	**5,078**	**19,397**	**1,293**	**978**	**512**	**5,375**	**17**	**10**	**1,231**	**52,153**	**80,966**

Source: NHA-2

Note: Rev. = Revenue, Dev. = Development, Pvt. Ins. = Private Insurance, HH = Household

Table A8: Bangladesh National Health Accounts- 2, Functions by provider, 2001-02 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	Public Sector						NGOs	Private sector									Overall Total
			MOHFW	Other Ministries	Auto. Corp.	GOB NPIs	Local Govt.	Total Public		Pvt. Cl.	Ambulatory providers			Pvt. Corp.	Diag.	Med.	Pvt. Heal.	For. Pro.	
											Mode. Qua.	Mode. Unq.	Trad. Hom.						
	Services of curative care	HC 1	10,940	991		42	164	12,137	1,857	2,134								1,631	17,759
1.1.1	In-patient curative care	HC1.1	7,162	763				7,925	132	1,579								1,549	11,185
1.1.2	Out-patient curative care	HC 1.3	3,778	228		42	164	4,212	1,725	555								82	6,574
1.1.5	Out-patient dental care	HC 1.3.2									125								125
	Services of rehabilitative care	HC 2	142					142											142
1.1.3	In-patient rehabilitative care	HC 2.1	99					99											99
1.1.4	Out-patient rehabilitative care	HC 2.2	43					43											43
1.2	Ambulatory healthcare services	HC 1.3.9									2,913	2,513	2,656						8,082
2	Diagnostic imaging	HC 4.2													3,751				3,751
3.1	Prescribed medicine	HC 5.1.1														39,625			39,625
3.2	Glasses and vision products	HC 5.2.1														157			157
3.2	Orthopedic appliances and others	HC 5.2.2														13			13
3.2	Hearing aids	HC 5.2.3														2			2
4.1	Family planning services	HC 6.1	4,551					4,551	3,566										8,117
4.2	School health	HC 6.2	13					13											13
4.3	Prevention of communicable disease	HC 6.3	88					88	555										643
4.5	Occupational healthcare	HC 6.5	3		159			162						359					521
4.4	Health awareness creations	HC 6.9	691					691	1,348										2,039
5.1	Health administration	HC 7.1.1	1,860					1,860											1,860
5.3	Community Insurance	HC 7.2.1							21										21
5.2	Health administration and insurance: private	HC 7.2.2															11		11
National Health Expenditure (NHE)			**18,288**	**991**	**159**	**42**	**164**	**19,644**	**7,347**	**2,134**	**3,038**	**2,513**	**2,656**	**359**	**3,751**	**39,797**	**11**	**1,631**	**82,881**
6	Capital formation	HCR 1	2,218					2,218	202										2,420
7	Education and training	HCR 2	1,130					1,130	872					938					2,940
8	Research	HCR 3	72					72											72
Total Health Expenditure (THE)			**21,708**	**991**	**159**	**42**	**164**	**23,064**	**8,421**	**2,134**	**3,038**	**2,513**	**2,656**	**1,297**	**3,751**	**39,797**	**11**	**1,631**	**88,313**
SHA THE			**20,506**	**991**	**159**	**42**	**164**	**21,862**	**7,549**	**2,134**	**3,038**	**2,513**	**2,656**	**359**	**3,751**	**39,797**	**11**	**1,631**	**85,301**

Source: NHA-2

Note: Auto. Corp. = Autonomous Corporation, Govt. = Government; Pvt. Cl. = Private Clinic and Hospital, Mode. Qua. = Modern Qualified, Mode. Unq. = Modern Unqualified, Trad. Hom. = Traditional and Homeopathic, Pvt. Corp. = Private Corporation, Diag. = Diagnostic and Imaging, Med. = Medicine and Medical Goods, Pvt. Heal. = Private Health Insurance, For. Pro. = Foreign Providers.

Table A9: Bangladesh National Health Accounts-2, Provider by Sources of Funding, 2001-02 (in million Taka)

BNHA Code	BNHA Providers	ICHA Code	MOHFW				Other Ministries	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance	Private Insurance	Private Enterprise	Households	Grand Total
			Rev.	Dev.		Total									
				GOB	Dev. Partners										
1	Government Providers														
1.1.1.1	MOHFW Administration	HP 6.1	1,012	654	479	2,145									2,145
1.1.1.2	University Medical College Hospitals	HP1.1	225			225									225
1.1.1.3	Medical College Hospitals	HP1.1	1,096	70	1	1,167								149	1,316
1.1.1.4	District Hospitals	HP1.1	978	199	151	1,328								126	1,454
1.1.1.5	Thana Level Facilities	HP1.1	6,788	2,361	5,244	14,393									14,393
1.1.1.6	Specialized Hospitals	HP 1.3	680	132		812									812
1.1.1.7	Other MOHFW Facilities	HP1	163	3		166									166
1.2	Other GOB Facilities	HP1.1					991								991
1.3	Local Government Facilities	HP 1.1					164								164
1.4	Corporations and Autonomous Bodies	HP 1.1					159								159
1.4	GOB NPI Facilities	HP 1.1					42								42
1.5	Research and Training Institutions	NEC													2,135
1.5.1	Govt. Education and Training Institutes	NEC	591	187	419	1,197									1,197
1.5.2	Private Education and Training Institutes	NEC											938		938
2	Non-Profit Institutions and NGO Facilities	HP 1.1						2,102	301	5,451	21			546	8,421
4.1.1	Private Clinics/Hospitals	HP 1.1												2,134	2,134
4.1.2	Private Practitioners	HP 3.3												2,913	2,913
4.1.3	Dental Providers	HP 3.2												125	125
4.2.1	Private Modern Unqualified Providers	HP 3.9.9												2,513	2,513
4.2.1.5	Private Traditional Providers	HP 3.9.9												916	916
4.2.1.3	Private Homeopathic Providers	HP 3.9.9												1,740	1,740
4.5.1	Diagnostic/Imaging Service Providers	HP 3.5												3,751	3,751
4.6.1	Drug Retail Outlets	HP 4.1												39,625	39,625
4.6.3	Private Sale of Glass and Vision Products	HP 4.2												156	156
4.6.2	Crutches	HP 4.4												13	13
4.6.4	Hearing Aids	HP 4.3												3	3
3.1	Private Enterprise	HP 1.1											359		359
4.8.1	Pvt. Health Insurance Administration	HP 6.4										11			11
5	Foreign Providers	HP 9												1,631	1,631
Total Health Expenditure (THE)			**11,533**	**3,606**	**6,294**	**21,433**	**1,356**	**2,102**	**301**	**5,451**	**21**	**11**	**1,297**	**56,341**	**88,313**

Source: NHA-2

Note: Rev.= Revenue, Dev. = Development.

Table A10: Bangladesh National Health Accounts-2, Functions by Sources of Funding, 2001-02 (in million Taka)

BNHA Code	BNHA Functions	ICHA Code	MOHFW				GoB (Other than MOHFW)	GOB Transfer to NGOs	NGOs Own Resource	Dev. Partners (NGO funding)	Community Insurance (NGOs)	Pvt. Ins.	Private Enterprise	HH	Grand Total
			Rev.	Dev.		Total									
				GOB	Dev. Partners										
	Services of curative care	HC 1	7,060	752	2,853	10,665	1,197	383	294	929				4,291	17,759
1.1.1	In-patient curative care	HC1.1	4,697	485	1,826	7,008	763	22	41	54				3,297	11,185
1.1.2	Out- patient curative care	HC 1.3	2,363	267	1,027	3,657	434	361	253	875				994	6,574
1.1.5	Out-patient dental care	HC 1.3.2												125	125
	Services of rehabilitative care	HC 2	142			142									142
1.1.3	In-patient rehabilitative care	HC 2.1	99			99									99
1.1.4	Out-patient rehabilitative care	HC 2.2	43			43									43
1.2	Ambulatory healthcare services	HC 1.3.9												8,082	8,082
2	Diagnostic imaging	HC 4.2												3,751	3,751
3.1	Prescribed medicine	HC 5.1.1												39,625	39,625
3.2	Glasses and vision products	HC 5.2.1												157	157
3.2	Orthopedic appliances and other prosthetics	HC 5.2.2												13	13
3.2	Hearing aids	HC 5.2.3												2	2
4.1	Family planning service	HC 6.1	2,715	381	1,455	4,551		1,024		2,542					8,117
4.2	School health	HC 6.2	13			13									13
4.3	Prevention of communicable disease	HC 6.3		12	76	88		159		396					643
4.5	Occupational healthcare	HC 6.5		1	2	3	159						359		521
4.4	Health awareness creation	HC 6.9		25	666	691		315		1,033					2,039
5.1	MOHFW administration of health	HC 7.1.1	1,012	629	219	1,860									1,860
5.3	Community health insurance	HC 7.2.1									21				21
5.2	Health administration and insurance: private	HC 7.2.2										11			11
6	Capital formation	HCR 1		1,635	583	2,218		58		144					2,420
7	Education and training	HCR 2	591	162	377	1,130		163	7	407			938	295	2,940
8	Research	HCR 3		9	63	72									72
Total Health Expenditure (THE)			**11,533**	**3,606**	**6,294**	**21,433**	**1,356**	**2,102**	**301**	**5,451**	**21**	**11**	**1,297**	**56,341**	**88,313**

Source: NHA-2

Note: Rev. = Revenue, Dev. = Development, Pvt. Ins. = Private Insurance, HH = Household

Annex 4: Ministry of Health and Family Welfare (MOHFW)
Health Expenditure Tables

Table A11: Total Expenditure of MOHFW, Function by Provider, 1999-2000 (in million Taka)

ICHA Code	ICHA Functions		Health Administration	University Medical College Hospital	Medical College Hospital	District Hospital	Upazila Health Complex	Union Sub Center	Community Clinics	Specialized Hospital	Other Facilities	Education Research and Training	Total	Percentage of Total
HC 1	Services of curative care			255	1,236	852	7,478			521			10,342	52
HC 1.1	In-patient curative care			196	952	528	4,711			401			6,788	34
HC 1.2	Out-patient curative care			59	284	324	2,767			120			3,554	18
HC 2	Services of rehabilitative care									162			162	1
HC 2.1	In-patient rehabilitative care									125			125	1
HC 2.2	Out-patient rehabilitative care									37			37	
HC 6.1	Maternal and child health							1,061	1,432		496		2,989	15
HC 6.2	School health										4		4	
HC 6.3	Prevention of communicable disease								83				83	
HC 6.5	Occupational healthcare		23										23	
HC 6.9	Miscellaneous public health services							933					933	5
HC 7.1.1	MOHFW administration of health	Administration	1,527										1,527	8
		Transfer	593										593	3
HCR 1	Capital formation		148		164	259		770	770	340		17	2,468	12
HCR 2	Education and training					70						555	625	3
HCR 3	Research		227									53	280	1
Total			2,518	255	1,400	1,181	7,478	2,764	2,285	1,023	500	625	20,029	100

Source: Computed from FMAU database

Table A12: Total Expenditure of MOHFW, Functions by Provider, 2000-01 (in million Taka)

ICHA Code	ICHA Functions		Health Administration	University Medical College Hospital	Medical College Hospital	District Hospital	Upazila and Below Level Facilities	Union Sub Center	Community Clinics	Specialized Hospital	Other Facilities	Education, Research and Training	Total	Percentage of Total
HC 1	Services of curative care			205	1,122	985	7,019			458			9,789	47
HC 1.1	In-patient curative care			158	864	611	4,422			353			6,408	31
HC 1.2	Out-patient curative care			47	258	374	2,597			105			3,381	16
HC 2	Services of rehabilitative care									133			133	1
HC 2.1	In-patient rehabilitative care									90			90	
HC 2.2	Out-patient rehabilitative care									43			43	
HC 6.1	Maternal and child health							1,952	1,627		132		3,711	18
HC 6.2	School health										11		11	
HC 6.3	Prevention of communicable disease							115					115	1
HC 6.5	Occupational healthcare		6										6	
HC 6.9	Miscellaneous public health services		4						774				778	4
HC 7.1.1	MOHFW administration of health	Administration	1,447										1,447	7
		Transfer	978										978	5
HCR 1	Capital formation		141		201	168		1,023	1,022	30			2,585	13
HCR 2	Education and training											971	971	5
HCR 3	Research		67									36	103	
Total			2,643	205	1,323	1,153	7,019	3,090	3,423	621	143	1,007	20,627	100

Source: Computed from FMAU database

Table A13: Total Expenditure of MOHFW, Function by Provider, 2001-02 (in million Taka)

ICHA Code	ICHA Functions		Health Administration	University Medical College Hospital	Medical College Hospital	District Hospital	Upazila Health Complex	Union Sub Center	Community Clinics	Specialized Hospital	Other Facilities	Health Education, Research and Training	Total	Percentage of Total
HC 1	Services of curative care			225	1,246	1,104	7,827			538			10,940	46
HC 1.1	In-patient curative care			173	959	684	4,931			414			7,161	
HC 1.2	Out-patient curative care			52	287	420	2,896			124			3,779	
HC 2	Services of rehabilitative care									142			142	1
HC 2.1	In-patient rehabilitative care									99			99	
HC 2.2	Out-patient rehabilitative care									43			43	
HC 6.1	Maternal and child health							2,399	1,999		153		4,551	19
HC 6.2	School health										13		13	
HC 6.3	Prevention of communicable disease							88					88	
HC 6.5	Occupational healthcare		3										3	
HC 6.9	Miscellaneous public health services		8						683				691	3
HC 7.1.1	MOHFW administration of health	Administration	1,860										1,860	8
		Transfer	2,102										2,102	9
HCR 1	Capital formation		203		70	350		699	698	132		66	2,218	9
HCR 2	Education and training											1,130	1,130	5
HCR 3	Research		71									1	72	
Total			4,247	225	1,316	1,454	7,827	3,186	3,380	812	166	1,197	23,810	100

Source: Computed from FMAU database

Table A14: Total Expenditure of MOHFW, Provider by Sources of Funding, 1999-2000 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total				
					GOB Expenditure				RPA				DPA				Total Dev.					
	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supplies	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Cap. For.	Transfer to NPIs	Total Exp	Supp.	Transfer to NPIS	Cap. For.	Total Exp		Current Exp	Transfer to NPIs	Cap. For.	Overall	Percent of Total
Health Administration	1,053	216	119	1,388	81	151	191	423	33		61	94	404	164	44	612	1,129	1,571	592	354	2,517	13
Hospitals																						
University Medical Hospital		255		255															255		255	1
Medical College Hospitals	1,209			1,209	40		151	191									191	1,249		151	1,400	7
District Hospitals	852			852	188		21	209	8			8	110		2	112	329	1,158		23	1,181	6
Upzila and Below Level Health Facilities	4,696			4,696	2,974		731	3,705	661			661	3,453		14	3,467	7,833	11,784		745	12,529	63
Specialized Hospitals	683			683	14		326	340									340	697		326	1,023	5
Other Health Facilities	146			146	11			11							342	342	353	157		342	499	2
Education Research																						
Education, Research and Training Institutes	486			486	75		1	76	39			39	24			24	139	624		1	625	3
Total Expenditure by Providers	9,125	471	119	9,715	3,383	151	1,421	4,955	741		61	802	3,991	164	402	4,557	10,314	17,240	847	1,942	20,029	100

Source: Computed from FMAU database

Note: RPA= Reimbursable Project Aid, DPA-=Direct Project Aid, Supp. = Supplies, Cap. For. = Capital Formation.

Table A15: Total Expenditure of MOHFW, Provider by Sources of Funding, 2000-01 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total				
					GOB Expenditure				RPA				DPA				Total Dev.					
	Current (Supply) Exp	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer To NPIs	Cap. For.	Total Exp		Current Exp	Transfer to NPIs	Cap. For.	Overall	Percent of Total
Health Administration	907	230	8	1,145	180	33	239	452	35	151		186	284	564	13	861	1,499	1,406	978	260	2,644	13
Hospitals																						
University Medical Hospital		205		205															205		205	1
Medical College Hospitals	1,121			1,121	151			151							51	51	202	1,272		51	1,323	6
District Hospitals	985			985	5		44	49	15		29	44	56		19	75	168	1,061		92	1,153	6
Upazila and Below Level Health Facilities	5,814			5,814	2,049		1,551	3,600	948		15	963	3,070		85	3,155	7,718	11,881		1,651	13,532	66
Specialized Hospitals	591			591	23		7	30									30	614		7	621	3
Other Health Facilities	135			135	7			7									7	142			142	1
Education Research																						
Education, Research and Training Institutes	500			500	45		2	47	201			201	259			259	507	1,005		2	1,007	5
Total Expenditure by Providers	10,053	435	8	10,496	2,460	33	1,843	4,336	1,199	151	44	1,394	3,669	564	168	4,401	10,131	17,381	1,183	2,063	20,627	100

Source: Computed from FMAU database

Note: RPA= Reimbursable Project Aid, DPA-=Direct Project Aid, Supp. = Supplies, Cap. For. = Capital Formation.

Table A16: Total Expenditure of MOHFW, Provider by Sources of Funding, 2001-02 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total				
					GOB Expenditure				RPA				DPA				Total Dev					
	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIS	Cap. For.	Total Exp		Current Exp	Transfer to NPIs	Cap. For.	Overall	Percent of Total
Health Administration	1,010	332	1	1,343	209	47	446	702	77	1,553		1,630	357	170	45	572	2,904	1,653	2,102	492	4,247	18
Hospitals																						
University Medical Hospital		225		225															225		225	1
Medical College Hospitals	1,236		9	1,245	2		68	70					1			1	71	1,239		77	1,316	6
District Hospitals	1,099		5	1,104	7		192	199	10		52	62	61		28	89	350	1,177		277	1,454	6
Upzilla and Below Level Health Facilities	6,788			6,788	1,186		1,174	2,360	695		18	713	4,408		124	4,532	7,605	13,077		1,316	14,393	60
Specialized Hospitals	680			680	48		84	132								0	132	728		84	812	3
Other Health Facilities	163			163	1		2	3								0	3	164		2	166	1
Education Research																0	0	0			0	
Education, Research and Training Institutes	591			591	44		143	187	176			176	242		1	243	606	1,053		144	1,197	5
Total Expenditure by Providers	11,567	557	15	12,139	1,497	47	2,109	3,653	958	1,553	70	2,581	5,069	170	198	5,437	11,671	19,091	2,327	2,392	23,810	100

Source: Computed from FMAU database

Note: RPA= Reimbursable Project Aid, DPA-=Direct Project Aid, Supp. = Supplies, Cap. For. = Capital Formation.

Table A17: Total Expenditure of MOHFW, Functions by Sources of Funding, 1999-2000 (in million Taka)

ICHA Code	ICHA Functions of Healthcare		GOB Rev.	GOB Dev.	RPA	DPA	Total	Percent of Total
HC 1	Services of curative care		6,887	1,115	18	2,322	10,342	52
HC 2	Services of rehabilitative care		162				162	1
HC 6.1	Maternal and child health		788	1,030	11	1,160	2,989	15
HC 6.2	School health		4				4	
HC 6.3	Prevention of communicable disease			24		59	83	
HC 6.5	Occupational healthcare					23	23	
HC 6.9	Miscellaneous public health services			29	575	329	933	5
HC 7.1.1	MOHFW administration of health	Administration	1,066	264	2	195	1,527	8
		Transfer	216	149	62	167	593	3
HCR 1	Capital formation		119	2,258	32	58	2,467	12
HCR 2	Education and training		473	77	62	13	625	3
HCR 3	Research			5	42	233	280	1
Total			9,715	4,951	804	4,559	20,029	100

Source: Computed from FMAU database
Note: Rev. Revenue, Dev. = Development.

Table A18: Total Expenditure of MOHFW, Functions by Sources of Funding, 2000-01 (in million Taka)

ICHA Code	ICHA Functions of Healthcare		GOB Rev.	GOB Dev.	RPA	DPA	Total	Percent of Total
HC 1	Services of curative care		6,858	1,159	11	1,761	9,789	47
HC 2	Services of rehabilitative care		133				133	1
HC 6.1	Maternal and child health		1,849	734	7	1,121	3,711	18
HC 6.2	School health		11				11	0
HC 6.3	Prevention of communicable disease			43		72	115	1
HC 6.5	Occupational healthcare			1	1	5	6	0
HC 6.9	Miscellaneous public health services			27	735	16	778	4
HC 7.1.1	MOHFW administration of health	Administration	915	338	26	168	1,447	7
		Transfer	230	33	151	564	978	5
HCR 1	Capital formation			1,949	255	381	2,585	13
HCR 2	Education and training		500	45	169	257	971	5
HCR 3	Research			7	40	56	103	0
Total			10,496	4,336	1,395	4,401	20,627	100

Source: Computed from FMAU database

Table A19: Total Expenditure of MOHFW, Functions by Sources of Funding, 2000-02 (in million Taka)

ICHA Code	ICHA Functions of Healthcare		GOB Rev.	GOB Dev.	RPA	DPA	Total	Percent of Total
HC 1	Services of curative care		7,335	752	17	2,836	10,940	46
HC 2	Services of rehabilitative care		142				142	1
HC 6.1	Maternal and child health		2,715	381	9	1,446	4,551	19
HC 6.2	School health		13				13	
HC 6.3	Prevention of communicable disease			12	17	59	88	
HC 6.5	Occupational healthcare			1		2	3	
HC 6.9	Miscellaneous public health services			25	647	19	691	3
HC 7.1.1	MOHFW administration of health	Administration	1,012	629	27	192	1,860	8
		Transfer	332	47	1,553	170	2,102	9
HCR 1	Capital formation			1,635	138	445	2,218	9
HCR 2	Education and training		591	162	174	203	1,130	5
HCR 3	Research			9		63	72	
Total			12,140	3,653	2,582	5,435	23,810	100

Source: Computed from FMAU database

Note: RPA= Reimbursable Project Aid, DPA-=Direct Project Aid

Table A20: Total Expenditure of MOHFW, Function by Provider by Rural-Urban Categories, 1999-2000 (in million Taka)

ICHA code	ICHA Functions		Health Administration	Education Research and Training	Urban						Rural				Total
					University Medical College Hospital	Medical College Hospital	District Hospital	Specialized Hospital	Other Facilities	Urban Total	Upazila Health Complex	Union Sub Center	Community Clinics	Rural Total	
HC 1	Services of curative care				255	1,236	852	521		2,864	7,478			7,478	10,342
HC 1.1	In-patient curative care				196	952	528	401		2,077	4,711			4,711	6,788
HC 1.2	Out-patient curative care				59	284	324	120		787	2,767			2,767	3,554
HC 2	Services of rehabilitative care							162		162					162
HC 2.1	In-patient rehabilitative care							125		125					125
HC 2.2	Out-patient rehabilitative care							37		37					37
HC 6.1	Maternal and child health								496	496		1,061	1,432	2,493	2,989
HC 6.2	School health								4	4					4
HC 6.3	Prevention of communicable disease												83	83	83
HC 6.5	Occupational healthcare		23											0	23
HC 6.9	Miscellaneous public health services											933		933	933
HC 7.1.1	MOHFW administration of health	Admin.	1,527												1,527
		Transfer	593												593
HCR 1	Capital formation		148	17		164	259	340		763		770	770	1,540	2,468
HCR 2	Education and training			555			70			70					625
HCR 3	Research		227	53											280
Total			2,518	625	255	1,400	1,181	1,023	500	4,359	7,478	2,764	2,285	12,527	20,029

Source: Computed from FMAU database

Table A21: Total Expenditure of MOHFW, Functions by Provider by Rural-Urban Categories, 2000-01 (in million Taka)

ICHA code	ICHA Functions		Health Administration	Education Research and Training	Urban						Rural				Total
					University Medical College Hospital	Medical College Hospital	District Hospital	Specialized Hospital	Other Facilities	Urban Total	Upazila Health Complex	Union Sub Center	Community Clinics	Rural Total	
HC 1	Services of curative care				205	1,122	985	458		2,770	7,019			7,019	9,789
HC 1.1	In-patient curative care				158	864	611	353		1,986	4,422			4,422	6,408
HC 1.2	Out-patient curative care				47	258	374	105		784	2,597			2,597	3,381
HC 2	Services of rehabilitative care							133		133					133
HC 2.1	In-patient rehabilitative care							90		90					90
HC 2.2	Out-patient rehabilitative care							43		43					43
HC 6.1	Maternal and child health								132	132		1,952	1,627	3,579	3,711
HC 6.2	School health								11	11					11
HC 6.3	Prevention of communicable disease											115		115	115
HC 6.5	Occupational healthcare		6												6
HC 6.9	Miscellaneous public health services		4										774	774	778
HC 7.1.1	MOHFW administration of health	Admin.	1,447												1,447
		Transfer	978												978
HCR 1	Capital formation		141			201	168	30		399		1,023	1,022	2,045	2,585
HCR 2	Education and training			971											971
HCR 3	Research		67	36											103
Total			2,643	1,007	205	1,323	1,153	621	143	3,445	7,019	3,090	3,423	13,532	20,627

Source: Computed from FMAU database

Table A22: Total Expenditure of MOHFW, Function by Provider by Rural -Urban Categories, 2001-02 (in million Taka)

ICHA code	ICHA Functions		Health Administration	Education Research and Training	Urban						Rural				Total
					University Medical College Hospital	Medical College Hospital	District Hospital	Specialized Hospital	Other Facilities	Urban Total	Upazila Health Complex	Union Sub Center	Community Clinics	Rural Total	
HC 1	Services of curative care				225	1,246	1,104	538		3,113	7,827			7,827	10,940
HC 1.1	In-patient curative care				173	959	684	414		2,230	4,931			4,931	7,161
HC 1.2	Out-patient curative care				52	287	420	124		883	2,896			2,896	3,779
HC 2	Services of rehabilitative care							142		142					142
HC 2.1	In-patient rehabilitative care							99		99					99
HC 2.2	Out-patient rehabilitative care							43		43					43
HC 6.1	Maternal and child health								153	153		2,399	1,999	4,398	4,551
HC 6.2	School health								13	13					13
HC 6.3	Prevention of communicable disease											88		88	88
HC 6.5	Occupational healthcare		3												3
HC 6.9	Miscellaneous public health services		8										683	683	691
HC 7.1.1	MOHFW administration of health	Admin.	1,860												1,860
		Transfer	2,102												2,102
HCR 1	Capital formation		203	66		70	350	132		552		699	698	1,397	2,218
HCR 2	Education and training			1,130											1,130
HCR 3	Research		71	1											72
Total			4,247	1,197	225	1,316	1,454	812	166	3,973	7,827	3,186	3,380	14,393	23,810

Source Computed from FMAU Database

Table A23: Total Expenditure of MOHFW, Provider by Sources of Funding by Rural-Urban Categories, 1999-2000 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total			
					GOB Expenditure				RPA				DPA				Total Dev.				
	Current (Supply) Exp	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp.	Supp	Transfer to NPIS	Cap. For.	Total Exp.		Current Exp.	Transfer to NPIs	Cap. For.	Overall
Upazila and Below Level Facilities	4,696			4,696	2,974		731	3705	661			661	3,453		14	3,467	7,833	11,784		745	12,529
Total Rural	**4,696**	0	0	4,696	2,974	0	731	3,705	661	0		661	3,453	0	14	3,467	7,833	11,784	0	745	**12,529**
University Medical Hospital		255		255								0							255		255
Medical College Hospitals	1,209			1,209	40		151	191				0					191	1,249		151	1,400
District Hospitals	852			852	188		21	209	8			8	110		2	112	329	1,158		23	1,181
Specialized Hospitals	683			683	14		326	340				0					340	697		326	1,023
Other Health Facilities	146			146	11			11				0			342	342	353	157		342	499
Total Urban	**2,890**	255	0	3,145	253	0	498	751	8	0		8	110	0	344	454	1,213	3,261	255	842	**4,358**
Health Administration	1,053	216	119	1,388	81	151	191	423	33	61		94	404	164	44	612	1,129	1,571	592	354	2,517
Education, Research and Training Institutes	486			486	75		1	76	39			39	24			24	139	624		1	625
Total Expenditure by Providers	9,125	471	119	9,715	3,383	151	1,421	4,955	741	61		802	3,991	164	402	4,557	10,314	17,240	847	1,942	**20,029**

Source: Computed from FMAU database

Note: i) Upazila and below level facilities are recognized as rural; ii). Expenditure on all hospital services excluding Upazila level facilities are recognized as Urban facilities Iii). Expenditure on Administration and Health Education research and training institutes are excluded iv) RPA= Reimbursable Project Aid, DPA-=Direct Project Aid, Supp. = Supplies, Cap. For. = Capital Formation

Table A24: Total Expenditure of MOHFW, Provider by Sources of Finding by Rural-Urban Catagories, 2001-02 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total			
					GOB Expenditure				RPA				DPA								
	Current (Supply) Exp	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp.	Supp	Transfer to NPIS	Cap. For.	Total Exp.	Total Dev.	Current Exp.	Transfer to NPIs	Cap. For.	Overall
Upazila and Below Level Facilities	5,814			5,814	2,049		1,551	3,600	948		15	963	3,070		85	3,155	7,718	11,881		1,651	13,532
Total Rural	**5,814**			5,814	2,049		1,551	3,600	948		15	963	3,070		85	3,155	7,718	11,881		1,651	**13,532**
University Medical Hospital		205		205															205		205
Medical College Hospitals	1,121			1,121	151			151							51	51	202	1,272		51	1,323
District Hospitals	985			985	5		44	49	15		29	44	56		19	75	168	1,061		92	1,153
Specialized Hospitals	591			591	23		7	30									30	614		7	621
Other Health Facilities	135			135	7			7									7	142			142
Total Urban	**2,832**	205		3,037	186		51	237	15		29	44	56		70	126	407	3,089	205	150	**3,444**
Health Administration	907	230	8	1,145	180	33	239	452	35	151		186	284	564	13	861	1,499	1,406	978	260	2,644
Education, Research and Training Institutes	500			500	45		2	47	201			201	259			259	507	1,005		2	1,007
Total Expenditure by Providers	10,053	435	8	10,496	2,460	33	1,843	4,336	1,199	151	44	1,394	3,669	564	168	4,401	10,131	17,381	1,183	2,063	**20,627**

Source: Computed from FMAU database

Note: Tran. = Transfer to NPIs, Cap. For. = Capital Formation, Supp. = Supplies, Exp.= Expenditure.

Table A25: Total Expenditure of MOHFW, Provider by Sources of Funding by Rural -Urban Categories, 2001-02 (in million Taka)

Providers	Revenue Expenditure				Development Expenditure													Total			
					GOB Expenditure				RPA				DPA								
	Current (Supply) Exp	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp	Supp.	Transfer to NPIs	Cap. For.	Total Exp.	Supp	Transfer to NPIS	Cap. For.	Total Exp.	Total Dev.	Current Exp.	Transfer to NPIs	Cap. For.	Overall
Upazila and Below Level Facilities	6,788			6,788	1,186		1,174	2,360	695		18	713	4,408		124	4,532	7,605	13,077		1,316	14,393
Total Rural	**6,788**			6,788	1,186		1,174	2,360	695		18	713	4,408		124	4,532	7,605	13,077		1,316	**14,393**
University Medical Hospital		225		225															225		225
Medical College Hospitals	1,236		9	1,245	2		68	70					1			1	71	1,239		77	1,316
District Hospitals	1,099		5	1,104	7		192	199	10		52	62	61		28	89	350	1,177		277	1,454
Specialized Hospitals	680			680	48		84	132									132	728		84	812
Other Health Facilities	163			163	1		2	3									3	164		2	166
Total Urban	**3,178**	225	14	3,417	58		346	404	10		52	62	62		28	90	556	3,308	225	440	**3,973**
Health Administration	1,010	332	1	1,343	209	47	446	702	77	1,553		1,630	357	170	45	572	2,904	1,653	2,102	492	4,247
Education, Research and Training Institutes	591			591	44		143	187	176			176	242		1	243	606	1,053		144	1,197
Total Expenditure by Providers	11,567	557	15	12,139	1,497	47	2,109	3,653	958	1,553	70	2,581	5,069	170	198	5,437	11,671	19,091	2,327	2,392	**23,810**

Source: Computed from FMAU database

Note: RPA= Reimbursable Project Aid, DPA-=Direct Project Aid, Supp. = Supplies,Tran. = Transfer to NPIs,Cap. For. = Capital Formation.

Table A26: Household Health Expenditures by In-patient–Outpatient and Provider, 1999-2000 (in million Taka)

Provider	In-patient		Out-patient		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Public facilities	157	2.7	74	0.2	231	0.5
Private facilities	5,484	96.1	42,172	98.9	47,656	98.5
NGO facilities	67	1.2	393	0.9	460	1.0
Total	5,708	100	42,639	100	48,347	100

Source: NHA-2

Table A27: Household Health Expenditures by Location and Provider, 1999-2000 (in million Taka)

Health Expenditure	Rural		Urban	
	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	521	1	99	1
Homeopathic providers	1,001	3	233	2
Drug outlets	25,863	72	8,137	65
Modern unqualified providers	1,772	5	269	2
Qualified medical providers	1,342	4	1,236	10
Govt. facilities	140		91	1
Private clinic/hospitals	1,272	4	826	7
NGO facilities	163		71	1
Diagnostic/imaging	2,247	4	1,327	11
Foreign facilities	1,089	3	199	2
Dental clinic	73		26	0
Other medical good outlets	90		31	0
Health insurance			3	0
Education research and training	167		59	0
Total	35,740	100	12,607	100

Source: NHA-2

Table A28: Health Expenditure by Location and Gender, 1999-2000 (in million Taka)

Gender	Rural		Urban		National	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Male	18,927	53	5,799	46	24,726	51
Female	16,813	47	6,808	54	23,621	49
Total	35,740	100	12,607	100	48,347	100

Source: NHA-2

Annex 5: Household Out Of Pocket (OOP) Health Expenditure Tables

Table A29: Health Expenditure by Gender and Provider, 1999-2000 (in milion Taka)

Provider	Male		Female	
	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	387	2	233	1
Homeopathic providers	641	3	593	3
Drug outlets	16,785	68	17,215	73
Modern unqualified providers	1,074	4	967	4
Qualified medical providers	1,268	5	1,310	6
Govt. facilities	104	0	127	1
Private clinic/hospitals	1,030	4	1,068	5
NGO facilities	149	1	85	0
Diagnostic/imaging	1,827	7	1,747	7
Foreign facilities	1,233	5	56	0
Dental clinic	50	0	48	0
Other medical good outlets	62	0	59	0
Health insurance	1	0	2	0
Education research and training	115	0	111	0
Total	24,726	100	23,621	100

Source: NHA-2

Table A30: Health Expenditure by Location and Age Group, 1999-2000 (in milion Taka)

Age Group	Rural		Urban		National	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	823	2	485	4	1,308	3
1-4	3,054	9	778	6	3,832	8
5-14	4,586	13	1,640	13	6,226	13
15-44	13,830	39	5,053	40	18,883	39
45-64	8,056	23	2,961	23	11,017	23
65-74	3,589	10	1,053	8	4,642	10
75-84	1,368	4	213	2	1,581	3
85+	434	1	424	3	858	2
Total	35,740	100	12,607	100	48,347	100

Source: NHA-2

Table A31a: Health Expenditure by Gender, Age and Type of Illness, 1999-2000(in milion Taka)

Age Group	Acute Illness					
	Male		Female		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	663	4	617	4	1,280	4
1-4	2,089	14	1,604	10	3,693	12
5-14	3,261	22	2,558	16	5,819	19
15-44	5,130	34	7,626	48	12,756	41
45-64	2,420	16	2,739	17	5,159	17
65-74	761	5	505	3	1,266	4
75-84	540	4	140	168	0	2
85+	226	1	55		281	1
Total	15,090	100	15,844	100	30,934	100

Source: NHA-2

Table A31b: Health Expenditure by Gender, Age Group and Type of Illness, 1999-2000
(in milion Taka)

Age Group	Chronic Illness					
	Male		Female		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	25	0	5	0	30	0
1-4	23	0	115	113	8	1
5-14	255	3	150	240	5	2
15-44	2,681	28	3,447	44	6,127	35
45-64	3,218	33	2,641	34	5,859	34
65-74	2,276	24	1,100	14	3,376	19
75-84	818	8	83	1	901	5
85+	340	4	236	357	7	3
Total	9,636	100	7,777	100	17,413	100

Source: NHA-2

Table A32: Health Expenditure by Provider and Division, 1999-2000 (in million Taka)

Provider	Barisal		Chittagong		Dhaka		Khulna		Rajshahi		Sylhet		National	
	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent
Traditional providers	7		123	1	191	1	96	1	185	2	17	1	619	1
Homeopathic providers	9		184	2	306	2	334	5	355	3	46	4	1,234	3
Drug outlets	3,073	73	6,908	69	9,729	68	4,464	66	8,817	75	1,007	78	33,998	70
Modern unqualified providers	132	3	572	6	454	3	323	5	445	4	115	9	2,041	4
Qualified medical providers	191	5	655	7	971	7	223	3	521	4	18	1	2,579	5
Govt. facilities	24	1	68	1	101	1	11		22		5		231	
Private clinic/hospitals	189	5	277	3	764	5	501	7	354	3	13	1	2,098	4
NGO facilities	39	1	47	0	87	1	28		26		7	1	234	
Diagnostic/imaging	381	9	781	8	1,291	9	532	8	573	5	17	1	3,575	7
Foreign facilities	112	3	266	3	384	3	180	3	312	3	34	3	1,288	3
Dental clinic	9				29	14			24		3		99	
Other medical good outlets	11		25	36		17			29		3		121	
Health insurance	0		1	1					1	0		3		
Education research and training	20		47		67	32			55		6		227	
Total	4,197	100	9,974	100	14,411	100	6,755	100	11,719	100	1,291	100	48,347	100

Source: NHA-2

Note: Exp. = Expenditure

Table A33 : Out of Pocket Payment Per Capita by Provider and Age, 1999-2000

Age Group	National			
	Public	Private	NGO	All
Below 1 year	1	559	1	561
1-4	1	341	1	343
5-14	0	180	1	181
15-44	2	351	2	355
45-64	5	693	3	701
65-74	3	1,484	3	1,490
75-84	9	1,405	2	1,416
85+	13	1,928	2	1,943
Total	2	394	2	398

Source: NHA-2

Table A34 : Out of Pocket Payment Per Capita by Gender and Age, 1999-2000

Age Group	Male	Female	Total
Below 1 year	574	545	560
1-4	377	307	342
5-14	201	162	182
15-44	294	415	355
45-64	671	737	702
65-74	1,623	1,302	1,495
75-84	2,054	492	1,419
85+	2,292	1,500	1,944
Total	398	398	398

Source: NHA-2

Table A35 : Out of Pocket Payment Per Capita by Location and Age, 1999-2000

Age Group	Rural	Urban	Total
Below 1 year	437	1,066	560
1-4	328	411	342
5-14	163	268	182
15-44	333	430	355
45-64	638	966	702
65-74	1,395	1,981	1,495
75-84	1,468	1,167	1,419
85+	1,237	4,679	1,944
Total	367	523	398

Source: NHA-2

Table A36: Out of Pocket Payment Per Capita by In-patient - Out-patient and Age, 1999-2000

Age Group	In-patient	Out-patient	Total
Below 1 year	12	547	560
1-4	11	331	342
5-14	6	176	182
15-44	46	309	355
45-64	80	622	702
65-74	434	1,061	1,495
75-84	188	1,231	1,419
85+	367	1,577	1,944
Total	47	351	398

Source: NHA-2

Table A37 : OOP Payments Per Capita by In-patient - Out-patient and Decile, 1999-2000

Decile Per Equivalent Adult	In-patient	Out-patient	Total
Poorest	25	315	340
20	14	334	348
30	20	308	328
40	29	343	372
50	11	296	307
60	21	371	392
70	28	318	346
80	81	361	442
90	67	409	476
Richest	179	458	637
National	47	351	398

Source: NHA-2

Table A38 : Distribution of Per Capita OOP Payments by Gender and Decile, 1999-2000

Decile Per Equivalent Adult	Male	Female	Total
Poorest	321	358	340
20	385	312	348
30	336	317	327
40	434	310	372
50	302	312	307
60	371	413	392
70	327	367	347
80	444	440	442
90	422	530	476
Richest	644	630	637
National	398	398	398

Source: NHA-2

Table A39 : Distribution of Per Capita OOP Payments by Location and Decile, 1999-2000

Decile Per Equivalent Adult	Rural	Urban	Total
Poorest	331	462	340
20	351	298	348
30	304	579	327
40	358	525	373
50	304	330	307
60	353	570	392
70	335	383	346
80	430	476	442
90	458	504	475
Richest	584	684	637
National	367	523	398

Source: NHA-2

Table A40 : Percentage Distribution of OOP Payment by Age and Decile, 1999-2000

Decile Per Equivalent Adult	Age Group								
	0-1	1- 4	5-14	15-44	45-64	65-74	75-84	85+	Overall
Poorest	3	11	10	38	23	8	6	1	100
20	2	7	11	40	25	13	1	1	100
30	3	9	11	42	26	6	3	1	100
40	3	8	15	41	17	4	12	0	100
50	3	9	16	40	25	6	1	0	100
60	2	10	11	38	25	6	4	3	100
70	2	9	11	45	19	11	1	2	100
80	2	8	12	43	26	4	2	2	100
90	2	7	10	37	25	13	4	2	100
Richest	4	4	19	31	18	18	1	5	100
Total	3	8	13	39	23	10	3	2	100

Source: NHA-2

Annex 6: National Health Expenditure (NHE) Tables

Table A41 : National Health Expenditures by Location and Gender, 1999-2000 (in millionTaka)

Gender	Rural		Urban		National	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Male	27,667	52	7,476	45	35,143	50
Female	25,773	48	8,961	55	34,734	50
Total	53,440	100	16,437	100	69,877	100

Source: NHA-2

Table A42 : Household Health Expenditures by In-patient - Out-patient and Provider, 1999-2000 (in million Taka)

Provider	In-patient		Out-patient		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Public facilities	8,327	60	8,891	16	17,217	24.6
Private facilities	5,484	40	42,502	76	47,986	68.7
NGO facilities	69	0	4,605	8	4,674	6.7
Total	13,879	100	55,998	100	69,877	100

Source: NHA-2

Table A43 : Health Expenditures by Location and Provider, 1999-2000 (in millionTaka)

Provider	Rural		Urban	
	Health Expenditure	Percent	Health Expenditure	Percent
Traditional providers	521	1	99	1
Homeopathic providers	1,001	2	233	1
Drug outlets	25,863	48	8,137	49
Modern unqualified providers	1,772	3	269	2
Qualified medical providers	1,342	3	1,236	8
Govt. facilities	14,284	27	2,934	18
Private clinic/hospitals	1,272	2	826	5
NGO facilities	3,629	7	1,045	6
Diagnostic/imaging	2,247	4	1,327	8
Foreign facilities	1,089	2	199	1
Dental clinic	73	0	26	0
Other medical good outlets	90	0	32	0
Health insurance		0	3	0
Private enterprises	243	0	86	1
Total	53,426	100	16,451	100

Source: NHA-2

Table A44: Health Expenditure by Location and Age Group 1999-2000 (in millionTaka)

Age Group	Rural		Urban		National	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	1,602	3	591	4	2,193	3
1-4	5,136	10	1,133	7	6,269	9
5-14	7,350	14	2,224	14	9,574	14
15-44	20,182	38	6,544	40	26,726	38
45-64	11,736	22	3,947	24	15,683	22
65-74	4,952	9	1,231	7	6,182	9
75-84	1,777	3	235	1	2,013	3
85+	704	1	531	3	1,236	2
Total	53,440	100	16,437	100	69,877	100

Source: NHA-2

Table A45: National Health Expenditure (NHE) by Gender, Age Group and Type of Illness, 1999-2000 (in millionTaka)

Age Group	Acute Illness					
	Male		Female		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	1,371	6	789	3	2,161	5
1-4	3,597	16	2,472	10	6,068	13
5-14	4,580	20	4,483	18	9,063	19
15-44	7,496	33	1,452	46	8,949	40
45-64	3,696	16	4,485	18	8,181	17
65-74	1,370	6	930	4	2,300	5
75-84	590	3	243	1	833	2
85+	268	1	92	0	360	1
Total	22,969	100	24,946	100	47,915	100

Source: NHA-2

Table A46 : National Health Expenditure (NHE) by Gender, Age Group and Type of Illness, 1999-2000 (in million Taka)

Age Group	Chronic Illness					
	Male		Female		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	25	0	8	0	33	0
1-4	72	1	130	1	201	1
5-14	279	2	232	2	511	2
15-44	3,326	27	4,452	45	7,778	35
45-64	4,194	34	3,308	34	7,502	34
65-74	2,733	22	1,150	12	3,882	18
75-84	1,071	9	108	1	1,179	5
85+	475	4	401	4	876	4
Total	12,175	100	9,787	100	21,962	100

Source: NHA-2

Table A47: National Health Expenditure (NHE) by Gender, Age Group and Type of Illness, 1999-2000 (in million Taka)

Age Group	Total					
	Male		Female		Total	
	Health Expenditure	Percent	Health Expenditure	Percent	Health Expenditure	Percent
Below 1 year	1,396	4	797	2	2,193	3
1-4	3,668	10	2,601	7	6,270	9
5-14	4,859	14	4,715	14	9,574	14
15-44	10,823	31	15,904	46	26,726	38
45-64	7,890	22	7,793	22	15,683	22
65-74	4,103	12	2,079	6	6,182	9
75-84	1,662	5	351	1	2,013	3
85+	742	2	493	1	1,235	2
Total	35,143	100	34,734	100	69,877	100

Source: NHA-2

Table A48: National Health Expenditure (NHE) by Decile, 1999-2000 (in million Taka)

Decile	Govt. Facilities	Percent	Private Facilities	Percent	NGO Facilities	Percent	All Facilities	Percent
Poorest	1,320	8	3,762	8	656	14	5,737	8
20	1,211	7	4,083	9	290	6	5,584	8
30	1,808	11	3,793	8	544	12	6,146	9
40	1,158	7	4,440	9	114	2	5,712	8
50	1,551	9	4,061	8	515	11	6,128	9
60	1,116	6	4,675	10	537	11	6,328	9
70	1,403	8	4,335	9	575	12	6,313	9
80	2,141	12	5,772	12	538	12	8,451	12
90	2,690	16	5,643	12	416	9	8,749	13
Richest	2,820	16	7,421	15	489	10	10,730	15
Total	17,217	100	47,986	100	4,674	100	69,877	100

Source: NHA-2

Table A49: National Health Expenditure (NHE) by provider and Division, 1999-2000 (in million Taka)

Provider	Barisal		Chittagong		Dhaka		Khulna		Rajshahi		Sylhet		National	
	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent	Exp.	Percent
Traditional providers	7		123	1	191	1	96	1	185	1	17	1	620	1
Homeopathic providers	9		184	1	306	1	334	4	355	2	46	2	1,234	2
Drug outlets	3,073	48	6,908	46	9,729	46	4,464	52	8,817	57	1,007	33	34,000	49
Modern unqualified providers	132	2	572	4	454	2	323	4	445	3	115	4	2,041	3
Qualified medical providers	191	3	655	4	971	5	223	3	521	3	18	1	2,578	4
Govt. facilities	1,461	23	4,926	33	5,682	27	1,197	14	3,208	21	742	25	17,217	25
Private clinic/hospitals	189	3	277	2	764	4	501	6	354	2	13		2,098	3
NGO facilities	894	14	411	3	1,574	7	639	7	1,001	6	154	5	4,674	7
Diagnostic/imaging	381	6	781	5	1,291	6	532	6	573	4	17	1	3,574	5
Foreign facilities	58	1			167	1	190	2			874	29	1,289	2
Dental clinic	9		21		30		12		22		3		99	
Other medical good outlets	11		26		37		15		28		4		121	
Health insurance			1		1		0		1				3	
Private enterprises	31		72		101		40		75		10		329	
Total	6,449	100	14,958	100	21,299	100	8,567	100	15,584	100	3,021	100	69,877	100

Source: NHA-2
Note: Exp. = Expenditure

Table A50: Per Capita NHE by provider and Age, 1999-2000

Age Group	National			
	Public	Private	NGO	All
Below 1 year	377	560	24	961
1-4	218	342	35	594
5-14	64	181	35	279
15-44	117	351	34	502
45-64	246	695	58	999
65-74	323	1,487	73	1,883
75-84	238	1,408	65	1,711
85+	815	1,932	53	2,800
Total	142	395	38	575

Source: NHA-2

Table A51: Per Capita NHE by Gender and Age, 1999-2000

Age Group	Male	Female	Total
Below 1 year	1,166	699	938
1-4	655	465	560
5-14	277	281	279
15-44	407	596	502
45-64	940	1,067	999
65-74	2,192	1,686	1,991
75-84	2,513	775	1,807
85+	3,001	2,543	2,800
Total	566	585	575

Source: NHA-2

Table A52: Per Capita NHE by Location and Age 1999-2000

Age Group	Rural	Urban	Total
Below 1 year	851	1,298	938
1-4	552	599	560
5-14	261	363	279
15-44	486	558	502
45-64	929	1,287	999
65-74	1,924	2,314	1,991
75-84	1,908	1,291	1,807
85+	2,008	5,868	2,800
Total	549	682	575

Source: NHA-2

Table A53: Per Capita NHE by In-patient-Out-patient and Age, 1999-2000

Age Group	In-patient	Out-patient	Total
Below 1 year	251	687	938
1-4	102	458	560
5-14	28	252	279
15-44	98	404	502
45-64	210	789	999
65-74	637	1,354	1,991
75-84	331	1,475	1,807
85+	1,048	1,752	2,800
Total	115	460	575

Source: NHA-2

Table A54: Per Capita NHE by provider and Decile, 1999-2000

Decile Per Equivalent Adult	National			
	Public	Private	NGO	All
Poorest	119	338	61	517
20	103	347	26	476
30	155	325	48	529
40	97	371	10	479
50	117	304	40	460
60	93	390	46	529
70	110	339	46	496
80	162	435	42	639
90	223	467	37	727
Richest	239	628	44	911
National	142	394	39	575

Source: NHA-2

Table A55: Per Capita NHE Distribution by In-patient-Out-patient and Decile, 1999-2000

Decile Per Equivalent Adult	In-patient	Out-patient	Total
Poorest	105	412	517
20	41	435	476
30	80	448	529
40	64	415	479
50	60	401	460
60	47	482	529
70	61	435	496
80	150	489	639
90	218	509	727
Richest	332	578	911
National	115	460	575

Source: NHA-2

Table A56: Per Capita NHE Distribution by Sex and Decile, 1999-2000

Decile Per Equivalent Adult	Male	Female	Total
Poorest	533	503	517
20	476	475	476
30	472	589	529
40	556	400	479
50	519	398	460
60	475	585	529
70	448	549	496
80	651	625	639
90	657	800	727
Richest	871	953	911
National	566	585	575

Source: NHA-2

Table A57: Per Capita NHE Distribution by Location and Decile, 1999-2000

Decile Per Equivalent Adult	Rural	Urban	Total
Poorest	502	728	517
20	478	440	476
30	506	770	529
40	467	609	479
50	465	427	460
60	473	788	529
70	480	549	496
80	659	578	639
90	759	672	727
Richest	972	856	911
National	549	682	575

Source: NHA-2

Annex 7: National Health Expenditure (NHE) Tables

Table A58: Current Expenditure on Health by Function of Care. Provider and Source of Funding, 1999-2000 (in millonTaka)

Expenditure Category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF Source of Funding										
	Function of Healthcare	Provider Industry		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving household (other than social insurance)	Corporations (other than health insurance)	Rest of the world
In-patient care including day cases	HC.1.1; 1.2; 2.1; 2.2;	All industries												
Curative and rehabilitative care														
ral hospitals		HP.1.1	10,379		7,373		3,006				3,003	3		
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Long-term nursing care	HC.3.1; 3.2	All industries												
General hospitals		HP.1.1												
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Out-patient curative and rehabilitative care	HC.1.3; 2.3	All industries												
Hospitals		HP.1	9,388		3,900		5,488				4,743	745		
Offices of physicians		HP.3.1												
Offices of dentists		HP.3.2	99				99				99			
Offices of other health practitioners (1)		HP.3.3	2,578				2,578				2,578			
Out-patient care centres		HP.3.4												
All other providers		All other												
Home healthcare	HC.1.4; 2.4; 3.3	All industries												
Ancillary services to healthcare (2)	HC.4	All industries	3,574				3,574				3,574			
Medical goods dispensed to out-patients (3)	HC.5	All industries												

Table A58: Current Expenditure on Health by Function of Care. Provider and Source of Funding, 1999-2000 (in millon Taka) (continued)

Expenditure Category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF Source of Funding										
	Function of Healthcare	Provider Industry		HF.1	HF.1.1	HF. 1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving households (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Pharmaceuticals; other med. non-durables	HC.5.1													
Prescribed medicines	HC.5.1.1		34,000				34,000				34,000			
Over-the-counter medicines	HC.5.1.2													
Other medical non-durables	HC.5.1.3													
Therapeutical ap pl.; other medical durables	HC.5.2													
Glasses and other vision products	HC.5.2.1		110				110				110			
Orthopedic appliances; other prosthetics	HC.5.2.2		11				11				11			
All other misc. durable medical goods	HC.5.2.3-5.2.9													
Prevention and public health services	HC.6	All industries	8,195		4,187		4,008					3,679	329	
Health administrat ion and health insurance	HC.7	All industries	1,543		1,527		16		13	3				
Total current expenditure on healthcare	HC.1-HC.7	All industries	69,877		16,987		52,890		13	3	48,118	4,427	329	

Source: NHA-2

Table A59: Current Expenditure on Health by Function of Care and Provider Industry, Bangladesh 1999-2000 (in million Taka)

		Healthcare Provider Industry																				Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	HP.4	HP.4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
In-patient care																							
Curative and rehabilitative care	HC.1.1; 2.1	9,158																					1,221
Long-term nursing care	HC.3.1																						
Services of day-care																							
Long-term nursing care	HC.3.2																						
Out-patient care																							
Out-patient curative and rehabilitative care	HC.1.3; 2.3	5,426									3,895												67
Basic medical and diagnostic services	HC.1.3.1																						
Out-patient dental care	HC.1.3.2					99	2,578																
All other specialized healthcare	HC.1.3.3																						
All other out-patient care	HC.1.3.3																						
Home care																							
Curative and rehabilitative care	HC.1.4; 2.4																						
Long-term nursing care	HC.3.3																						

Table A59: Current Expenditure on Health by Function of Care and Provider Industry, Bangladesh 1999-2000 (in million Taka) (continued)

		Healthcare Provider Industry																				Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	HP.4	HP.4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
Ancillary services to healthcare	HC.4								3,574														
Medical goods dispensed to out-patients	HC.5																						
Pharmacist. and other medical non-durables	HC.5.1												34,000										
Therapeutic. appliances and other med. durables	HC.5.2													121									
Total expenditure on personal healthcare		14,584				99	2,578		3,574		3,895		34,000	121									1,288
Prevention and public health services	HC.6	7,866																				329	
Health administration and health insurance	HC.7																1,527		13	3			
Total current expenditure on healthcare		22,450				99	2,578		3,574		3,895		34,000	121			1,527		13	3		329	1,288

Source: NHA-2

Table A60: Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 1999-2000 (in millionTaka)

Healthcare goods and services by provider industry	ICHA-HC code	Total current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Hospitals	HP.1	22,052	15,062	15,062		6,990				2,563	4,427		
Nursing and residential care facilities	HP.2												
Providers of ambulatory healthcare	HP.3												
Offices of physicians	HP.3.1												
Offices of dentists	HP.3.2	99				99				99			
Offices of other health practitioners	HP.3.3	2,578				2,578				2,578			
Out-patient care centres	HP.3.4												
Medical and diagnostic laboratories	HP.3.5	3,574				3,574				3,574			
Providers of home healthcare services	HP.3.6												
Other providers of ambulatory healthcare	HP.3.9	3,895				3,895				3,895			
Retail sale and other providers of medical goods	HP.4												
Dispensing chemists	HP.4.1	34,000				34,000				34,000			
All other sales of medical goods	HP.4.2-4.9	121				121				121			
Provision and administration of public health programmers	HP.5												
General health administration and insurance	HP.6												

Table A60: Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 1999-2000 (in million Taka) (continued)

Healthcare goods and services by provider industry	ICHA-HC code	Total current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Government (excluding social insurance)	HP.6.1	1,925	1,925	1,925									
Social security funds	HP.6.2												
Other social insurance	HP.6.3	13				13		13					
Other (private) insurance	HP.6.4	3				3	3						
All other providers of health administration	HP.6.9												
Other industries (rest of the economy)	HP.7												
Occupational healthcare	HP.7.1	329				329						329	
Private households	HP.7.2												
All other secondary producers	HP.7.9												
Rest of the world	HP.9	1,288				1,288				1,288			
Total current expenditure		69,877	16,987	16,987		52,890	3	13		48,118	4,427	329	

Source: NHA-2

Table A61: Current Expenditure on Health by Function of Care and Source of Funding, Bangladesh 1999-2000 (in million Taka)

Current expenditure on healthcare	ICHA-HC code	Total expenditure	HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance schemes	Other private insurance	Private household out-of-pocket payments	Non-profit institutions (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Personal healthcare services	HC.1-HC.3												
In-patient services		10,379	7,373	7,373		3,006				3,003	3		
Day care services													
Out-patient services		12,065	3,900	3,900		8,165				7,420	745		
Home care services													
Ancillary services to healthcare	HC.4	3,574				3,574				3,574			
Medical goods dispensed to out-patients	HC.5	34,121				34,121				34,121			
Pharmaceuticals and other medical non-durables	HC.5.1	34,000				34,000				34,000			
Therapeutic appliances and other medical durables	HC.5.2	121				121				121			
Personal healthcare services and goods	HC.1-HC.5	60,139	11,273	11,273		48,866				48,118	748		
Prevention and public health services	HC.6	8,195	4,187	4,187		4,008					3,679	329	
Health administration and health insurance	HC.7	1,543	1,527	1,527		16	3	13					
Total current expenditure		69,877	16,987	16,987		52,890	3	13		48,118	4,427	329	

Source: NHA-2

Table A62: Current Expenditure on Health by Function of Care, Provider and Source of Funding, 2000-2001 (in million Taka)

Expenditure category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF source of funding										
	Function of healthcare	Provider industry		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving households (other than social insurance)	Corporations (other than health insurance)	Rest of the world
In-patient care including day cases	HC.1.1; 1.2; 2.1; 2.2;	All industries												
Curative and rehabilitative care														
General hospitals		HP.1.1	10,263		7,052		3,211				3,115	96		
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Long-term nursing care	HC.3.1; 3.2	All industries												
General hospitals		HP.1.1												
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Outpatient curative and rehabilitative care	HC.1.3; 2.3	All industries												
Hospitals		HP.1	10,262		3,751		6,511				5,447	1,064		
Offices of physicians		HP.3.1												
Offices of dentists		HP.3.2	111				111				111			
Offices of other health practitioners (1)		HP.3.3	2,739				2,739				2,739			
Out-patient care centres		HP.3.4												

Table A62: Current Expenditure on Health by Function of Care, Provider and Source of Funding, 2000-2001 (in million Taka) (continued)

Expenditure category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF source of funding										
	Function of Healthcare	Provider industry		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving households (other than social insurance)	Corporations (other than health insurance)	Rest of the world
All other providers		All other												
Home healthcare	HC.1.4; 2.4; 3.3	All industries												
Ancillary services to healthcare (2)	HC.4	All industries	3,660				3,660				3,660			
Medical goods dispensed to out-patients (3)	HC.5	All industries												
Pharmaceuticals; other med. non-durables	HC.5.1													
Prescribed medicines	HC.5.1.1		36,687				36,687				36,687			
Over-the-counter medicines	HC.5.1.2													
Other medical non-durables	HC.5.1.3													
Therapeutical appliances.; other medical durables	HC.5.2													
Glasses and other vision products	HC.5.2.1		124				124				124			
Orthopedic appliances; other prosthetics	HC.5.2.2		11				11				11			
All other miscellaneous durable medical goods	HC.5.2.3-5.2.9		1				1				1			
Prevention and public health services	HC.6	All industries	9,826		4,781		5,045					4,705	340	
Health administrat ion and health insurance	HC.7	All industries	1,474		1,447		27		17	10				
Total current expenditure on healt hcare	HC.1-HC.7	All industries	75,158		17,031		58,127		17	10	51,895	5,865	340	

Source: NHA-2

Table A63: Current Expenditure On Health by Function of Care and Provider Industry, Bangladesh 2000-2001 (in million Taka)

		Healthcare provider industry																				Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	HP.4	HP.4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
In-patient care																							
Curative and rehabilitative care	HC.1.1; 2.1	8,885																					1,378
Long-term nursing care	HC.3.1																						
Services of day-care																							
Curative and rehabilitative care	HC.1.2; 2.2																						
Long-term nursing care	HC.3.2																						
Out-patient care																							
Out-patient curative and rehabilitative care	HC.1.3; 2.3	5,708									4,482												
Basic medical and diagnostic services	HC.1.3.1																						
Out-patient dental care	HC.1.3.2					111	2,739																
All other specialized healthcare	HC.1.3.3																						
All other out-patient care	HC.1.3.3																						
Home care																							
Curative and rehabilitative care	HC.1.4; 2.4																						

Table A63: Current Expenditure On Health by Function of Care and Provider Industry, Bangladesh 2000-2001 (in millionTaka) (continued)

		Healthcare provider industry																			Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP 3.1	HP 3.2	HP 3.3	HP 3.4	HP 3.5	HP 3.6	HP 3.9	HP.4	HP 4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
Long-term nursing care	HC.3.3																						
Ancillary services to healthcare	HC.4								3,660														
Medical goods dispensed to out-patients	HC.5																						
Pharmacist. and other medical non-durables	HC.5.1												36,687										
Therap. appliances and other med. Durables	HC.5.2													136									
Total expenditure on personal healthcare		14,593				111	2,739		3,660		4,482		36,687	136									1,450
Prevention and public health services	HC.6	9,486																				340	
Health administration and health insurance	HC.7																1,447		17	10			
Total current expenditure on healthcare		24,079				111	2,739		3,660		4,482		36,687	136			1,447		17	10		340	1,450

Source: NHA-2

Table 64:Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 2000-2001 (in million Taka)

Healthcare goods and services by provider industry	ICHA-HC code	Total Current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Hospitals	HP.1	23,860	15,365	15,365		8,495				2,630	5,865		
Nursing and residential care facilities	HP.2												
Providers of ambulatory healthcare	HP.3												
Offices of physicians	HP.3.1												
Offices of dentists	HP.3.2	111				111				111			
Offices of other health practitioners	HP.3.3	2,739				2,739				2,739			
Out-patient care centres	HP.3.4												
Medical and diagnostic laboratories	HP.3.5	3,660				3,660				3,660			
Providers of home healthcare services	HP.3.6												
Other providers of ambulatory healthcare	HP.3.9	4,482				4,482				4,482			
Retail sale and other providers of medical goods	HP.4												
Dispensing chemists	HP.4.1	36,687				36,687				36,687			
All other sales of medical goods	HP.4.2-4.9	136				136				136			
Provision and administration of public health programmers	HP.5												
General health administration and insurance	HP.6												

Table 64:Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 2000-2001 (in million Taka) (continued)

Healthcare goods and services by provider industry	ICHA-HC code	Total Current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Government (excluding social insurance)	HP.6.1	1,666	1,666	1,666									
Social security funds	HP.6.2												
Other social insurance	HP.6.3	17				17		17					
Other (private) insurance	HP.6.4	10				10	10						
All other providers of health administration	HP.6.9												
Other industries (rest of the economy)	HP.7												
Occupational healthcare	HP.7.1	340				340						340	
Private households	HP.7.2												
All other secondary producers	HP.7.9												
Rest of the world	HP.9	1,450				1,450				1,450			
Total current expenditure		75,158	17,031	17,031		58,127	10	17		51,895	5,865	340	

Source: NHA-2

Table A65: Current Expenditure on Health by Function of Care and Source of Funding, Bangladesh 2000-2001 (in million Taka)

Current expenditure on healthcare	ICHA-HC code	Total expenditure	HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance schemes	Other private insurance	Private household out-of-pocket payments	Non-profit institutions (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Personal healthcare services	HC.1-HC.3												
In-patient services		10,263	7,052	7,052		3,211				3,115	96		
Day care services													
Out-patient services		13,112	3,751	3,751		9,361				8,297	1,064		
Home care services													
Ancillary services to healthcare	HC.4	3,660				3,660				3,660			
Medical goods dispensed to out-patients	HC.5	36,823				36,823				36,823			
Pharmaceuticals and other medical non-durables	HC.5.1	36,687				36,687				36,687			
Therapeutic appliances and other medical durables	HC.5.2	136				136				136			
Personal healthcare services and goods	HC.1-HC.5	63,858	10,803	10,803		53,055				51,895	1,160		
Prevention and public health services	HC.6	9,826	4,781	4,781		5,045					4,705	340	
Health administration and health insurance	HC.7	1,474	1,447	1,447		27	10	17					
Total Current Expenditure		75,158	17,031	17,031		58,127	10	17		51,895	5,865	340	

Source: NHA-2

Table A66: Current Expenditure on Health by Function of Care, Provider and Source of Funding, 2001-2002 (in million Taka)

Expenditure category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF source of funding										
	Function of healthcare	Provider industry		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving households (other than social insurance)	Corporations (other than health insurance)	Rest of the world
In-patient care including day cases	HC.1.1; 1.2; 2.1; 2.2;	All industries												
Curative and rehabilitative care														
General hospitals		HP.1.1	11,284		7,870		3,414				3,297	117		
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Long-term nursing care	HC.3.1; 3.2	All industries												
General hospitals		HP.1.1												
Specialty hospitals		HP.1.2+1.3												
Nursing and residential care facilities		HP.2												
All other providers		All other												
Outpatient curative and rehabilitative care	HC.1.3; 2.3	All industries												
Hospitals		HP.1	11,491		4,134		7,357				5,868	1,489		
Offices of physicians		HP.3.1												
Offices of dentists		HP.3.2	125				125				125			
Offices of other health practitioners (1)		HP.3.3	2,913				2,913				2,913			

Table A66: Current Expenditure on Health by Function of Care, Provider and Source of Funding, 2001-2002 (in million Taka) (continued)

Expenditure category	ICHA-HC	ICHA-HP	Total current expenditure on health	ICHA-HF source of funding										
	Function of healthcare	Provider industry		HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	HF.3
									HF.2.1	HF.2.2				
				General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket expenditure	Non-profit organizations serving households (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Out-patient care centres		HP.3.4												
All other providers		All other												
Home healthcare	HC.1.4; 2.4; 3.3	All industries												
Ancillary services to healthcare (2)	HC.4	All industries	3,751				3,751				3,751			
Medical goods dispensed to out-patients (3)	HC.5	All industries												
Pharmaceuticals; other med. non-durables	HC.5.1													
Prescribed medicines	HC.5.1.1		39,625				39,625				39,625			
Over-the-counter medicines	HC.5.1.2													
Other medical non-durables	HC.5.1.3													
Therapeutical appl.; other medical durables	HC.5.2													
Glasses and other vision products	HC.5.2.1		157				157				157			
Orthopedic appliances; other prosthetics	HC.5.2.2		13				13				13			
All other misc. durable medical goods	HC.5.2.3-5.2.9		2				2				2			
Prevention and public health services	HC.6	All industries	11,628		5,505		6,123				295	5,469	359	
Health administration and health insurance	HC.7	All industries	1,892		1,860		32	11	21					
Total current expenditure on healthcare	HC.1-HC.7	All industries	82,881		19,369		63,512	11	21		56,046	7,075	359	

Source: NHA-2

Table A67: Current Expenditure on Health by Function of Care and Provider Industry, Bangladesh 2001-2002 (in million Taka)

		Healthcare provider industry																				Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3	HP 3 4	HP.3.5	HP.3.6	HP.3.9	HP.4	HP.4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
In-patient care																							
Curative and rehabilitative care	HC.1.1; 2.1	9,735																					1,549
Long-term nursing care	HC.3.1																						
Services of day-care																							
Curative and rehabilitative care	HC.1.2; 2.2																						
Long-term nursing care	HC.3.2																						
Out-patient care																							
Out-patient curative and rehabilitative care	HC.1.3; 2.3	6,535									5,169												82
Basic medical and diagnostic services	HC.1.3.1																						
Out-patient dental care	HC.1.3.2					125	2,913																
All other specialized healthcare	HC.1.3.3																						
All other out-patient care	HC.1.3.3																						
Home care																							
Curative and rehabilitative care	HC.1.4; 2.4																						

Table A67: Current Expenditure on Health by Function of Care and Provider Industry, Bangladesh 2001-2002 (in million Taka) (continued)

		Healthcare provider industry																				Other Ind. and ROW	
		HP.1	HP.2	HP.3	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	HP.4	HP.4.1	HP.4.2-4.9	HP.5	HP.6	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	HP.7	HP.9
Healthcare by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory healthcare	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home healthcare services	All other providers of ambulatory healthcare	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
Long-term nursing care	HC.3.3																						
Ancillary services to healthcare	HC.4								3,751														
Medical goods dispensed to out-patients	HC.5																						
Pharmacist. and other medical non-durables	HC.5.1												39,625										
Therap. appliances and other med. Durables	HC.5.2													172									
Total expenditure on personal healthcare		16,270				125	2,913		3,751		5,169		39,625	172									1,631
Prevention and public health services	HC.6	10,974																				359	
Health administration and health insurance	HC.7																1,860		21	11			
Total current expenditure on healthcare		27,244				125	2,913		3,751		5,169		39,625	172			1,860		21	11		359	1,631

Source: NHA-2

Table A68: Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 2001-2002 (in million Taka)

Healthcare goods and services by provider industry	ICHA-HC code	Total current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Hospitals	HP.1	26,959	17,224	17,224		9,735				2,660	7,075		
Nursing and residential care facilities	HP.2												
Providers of ambulatory healthcare	HP.3												
Offices of physicians	HP.3.1												
Offices of dentists	HP.3.2	125				125				125			
Offices of other health practitioners	HP.3.3	2,913				2,913				2,913			
Out-patient care centres	HP.3.4												
Medical and diagnostic laboratories	HP.3.5	3,751				3,751				3,751			
Providers of home healthcare services	HP.3.6												
Other providers of ambulatory healthcare	HP.3.9	5,169				5,169				5,169			
Retail sale and other providers of medical goods	HP.4												
Dispensing chemists	HP.4.1	39,625				39,625				39,625			
All other sales of medical goods	HP.4.2-4.9	172				172				172			
Provision and administration of public health programmers	HP.5												
General health administration and insurance	HP.6												

Table A68: Current Expenditure on Health by Provider Industry and Source of Funding, Bangladesh 2001-2002 (in million Taka) (continued)

Healthcare goods and services by provider industry	ICHA-HC code	Total current expenditure on health	HF 1	HF 1.1	HF 1.2	HF 2	HF 2.1 & HF 2.2			HF 2.3	HF 2.4	HF 2.5	HF 3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance	Other private insurance	Private household out-of-pocket payments	Non-profit organizations (other than social ins.)	Corporations (other than health insurance)	Rest of the world
Government (excluding social insurance)	HP.6.1	2,145	2,145	2,145									
Social security funds	HP.6.2												
Other social insurance	HP.6.3	21				21		21					
Other (private) insurance	HP.6.4	11				11	11						
All other providers of health administration	HP.6.9												
Other industries (rest of the economy)	HP.7												
Occupational healthcare	HP.7.1	359				359						359	
Private households	HP.7.2												
All other secondary producers	HP.7.9												
Rest of the world	HP.9	1,631				1,631				1,631			
Total current expenditure		82,881	19,369	19,369		63,512	11	21		56,046	7,075	359	

Source: NHA-2

Table A69: Current Expenditure On Health by Function Of Care and Source of Funding Bangladesh 2001-2002 (in millionTaka)

Current expenditure on healthcare	ICHA-HC code	Total expenditure	HF.1	HF.1.1	HF.1.2	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2 .5	HF.3
			General government	General government (excl. social security)	Social security funds	Private sector	Private insurance	Private social insurance schemes	Other private insurance	Private household out-of-pocket payments	Non-profit institutions (other than social insurance)	Corporations (other than health insurance)	Rest of the world
Personal healthcare services	HC.1-HC.3												
In-patient services		11,284	7,870	7,870		3,414				3,297	117		
Day care services													
Out-patient services		14,824	4,134	4,134		10,690				9,201	1,489		
Home care services													
Ancillary services to healthcare	HC.4	3,751				3,751				3,751			
Medical goods dispensed to out-patients	HC.5	39,797				39,797				39,797			
Pharmaceuticals and other medical non-durables	HC.5.1	39,625				39,625				39,625			
Therapeutic appliances and other medical durables	HC.5.2	172				172				172			
Personal healthcare services and goods	HC.1-HC.5	69,656	12,004	12,004		57,652				56,046	1,606		
Prevention and public health services	HC.6	11,333	5,505	5,505		5,828					5,469	359	
Health administration and health insurance	HC.7	1,892	1,860	1,860		32	11	21					
Total current expenditure		82,881	19,369	19,369		63,512	11	21		56,046	7,075	359	

Source: NHA-2