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# Tracking Urban Health Expenditures— Preliminary Results from Secondary Analysis of Bangladesh National Health Accounts

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## National Health Accounts

National Health Accounts (NHA) encompass total health spending in a country – including public, private, non-government organizations (NGOs), households, and donor expenditures. NHAs carefully track the amount and flow of funds from one health care actor to another, such as the distribution of funds from the Ministry of Health to each government health provider and health service. NHAs are a standardized tool designed to help governments determine how best to shape health financing policy and then later determine whether those policies are working as intended. These policies include those that affect public and private health spending to improve efficiency, quality, equity, financial protection in the context of universal health coverage and, ultimately, in saving lives. In short, NHA measures the “financial pulse” of national health systems and answers such questions as:

- What is the total expenditure on health in a country?
- Who in the country pays for health care services?
- How much is spent on which health services?
- How much is paid to different health service providers?

In addition, secondary analyses of NHA help answer questions such as, what proportion of spending goes to urban/rural, RMNCH, HIV/AIDS, tuberculosis, or other specific diseases or areas. This brief presents preliminary findings of a secondary analysis of Bangladesh National Health Accounts (BNHA) IV focused on tracking urban health expenditures. This analysis is important given the rapid urbanization in Bangladesh, with 23% of the population currently living in urban areas.

*“This secondary analysis of BNHA-IV allows us to see the range of differences in health expenditures by urban and rural, and start to understand the real implications for our planning and programming.”*

—Ashadul Islam, Director General,  
Health Economics Unit,  
Ministry of Health and Family  
Welfare, Government of Bangladesh

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## Bangladesh

### National Health Accounts

There have been four rounds of NHAs in Bangladesh since 1997. The recently completed BNHA-IV covers 1996/97–2011/12 and it is based on the System of Health Accounts (SHA) 2011 framework. BNHA-IV estimates total health expenditures (THE) at 3.5% of GDP (BDT 325,094 million) and a relatively low per capita THE at BDT 2,144 (US\$27). Figure 1 shows that nationally, household out-of-pocket (OOP) makes up the largest share at 63% of THE while government financing accounts for 23% of THE.

### Overview of Methodology

The urban health secondary analysis uses the same data sources as BNHA-IV and the same framework. Available data does not include, by facility, what percentage of clients reside in urban or rural areas. There are, however, data on expenditures on health by urban vs. rural households in the Household Income and Expenditure Survey (HIES) 2010. A distribution key for apportioning urban/rural expenditures in BNHA-IV was developed. This key allows for estimation of THE by/for urban populations. It does not allow tracking of expenditures by urban facilities on urban populations. The estimates presented below will need to be interpreted accordingly.

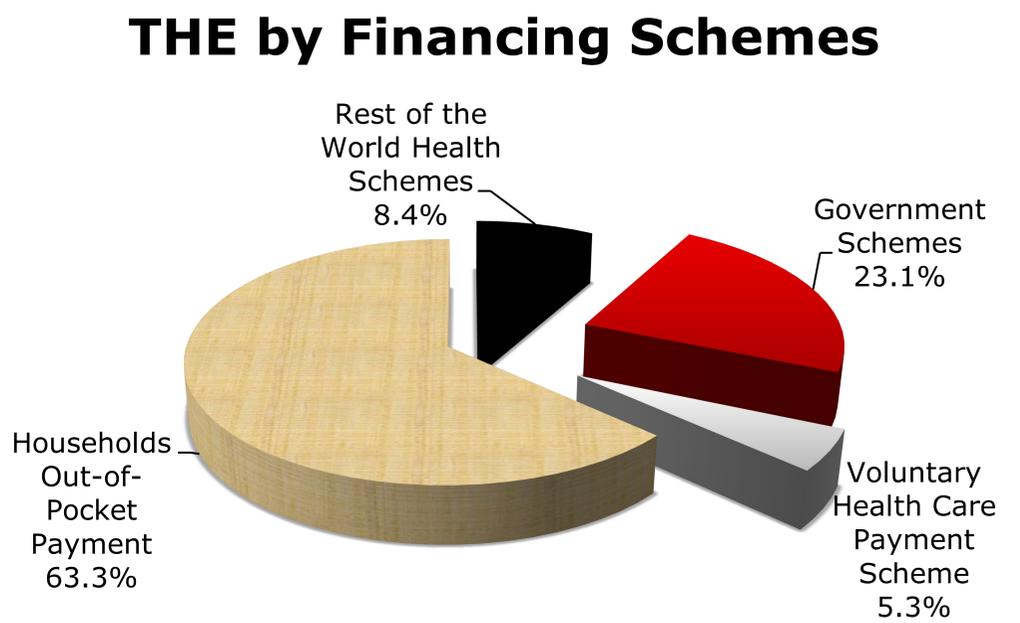
### Preliminary Estimates

While urban population is 23% of the total population in Bangladesh, urban expenditures on health is 33% of THE. Per capita THE is BDT 3,083 for urban populations compared with BDT 1,894 for rural population (see Figure 2).

### Urban vs. Rural THE by Division

Further exploration is needed to understand what is driving these higher urban health expenditures, such as a combination of higher prices, more secondary/tertiary

Figure 1: THE by Financing Schemes (BNHA-IV)

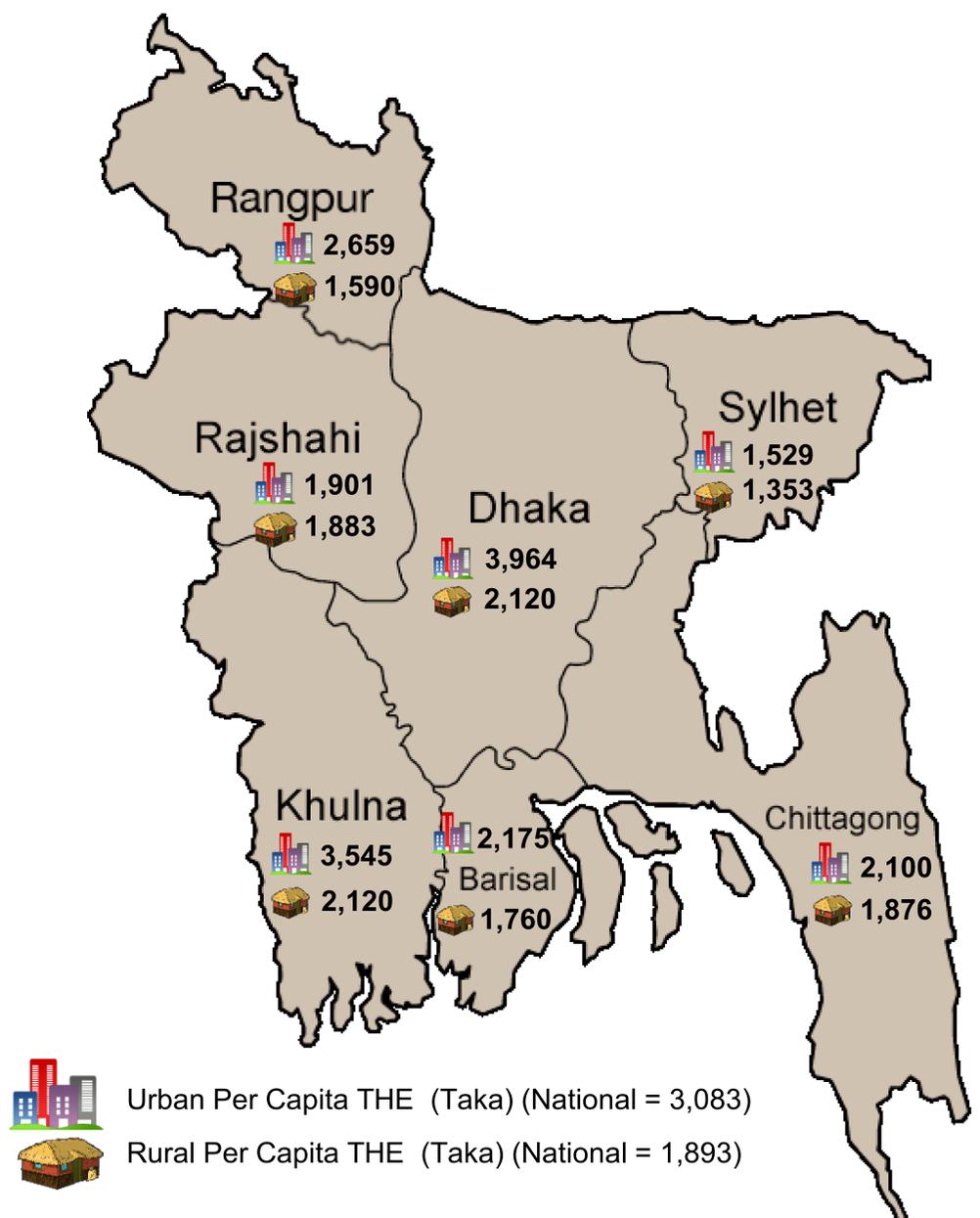


### BNHA-IV THE: BDT 325,094 million

Figure 2: Overview of Estimates of Urban Secondary Analysis

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

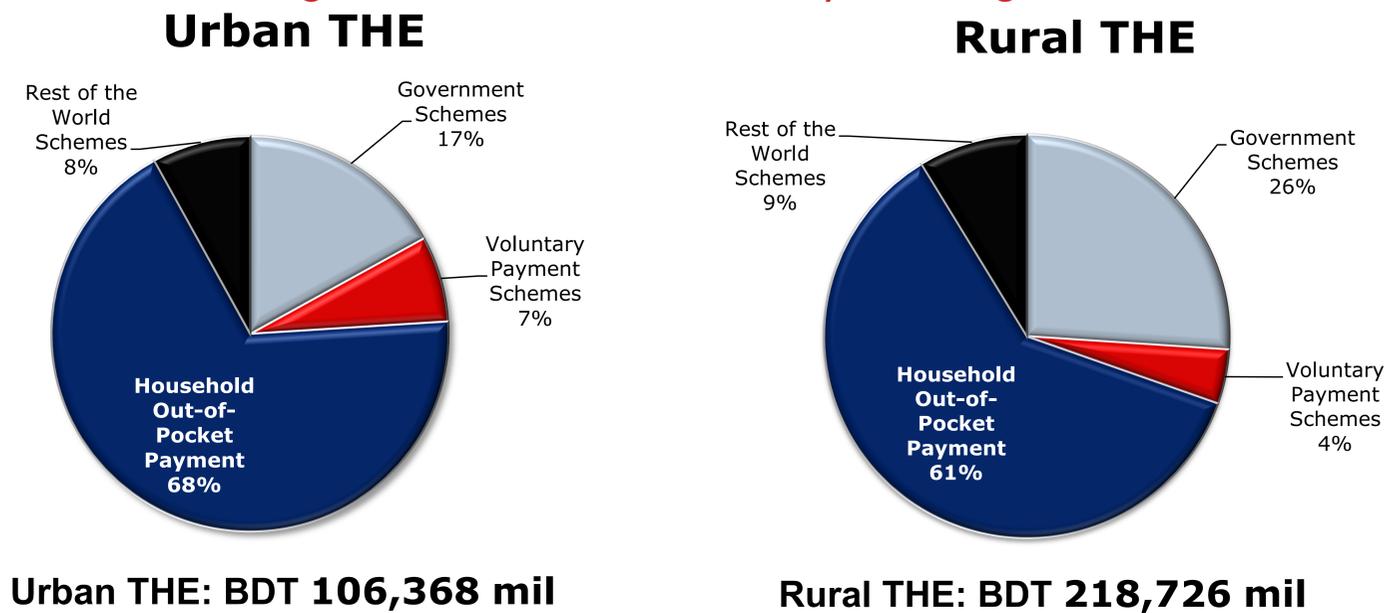
Figure 3: Per Capita Urban vs. Rural THE by Division



## Urban vs. Rural THE by Financing Scheme

Government financing of urban health expenditures is 17% of urban THE, while that of rural health expenditures is 26% of rural THE. Urban household OOP health expenditures is 68% of urban THE, while rural household OOP health expenditures is 61% of rural THE (see Figure 4). Surprisingly, there is little difference in urban/rural expenditures shares by provider type. As with the national level, more than two thirds of the household OOP expenditures for both rural and urban are on pharmacies/retail drug stores.

Figure 4: Urban vs. Rural THE by Financing Scheme

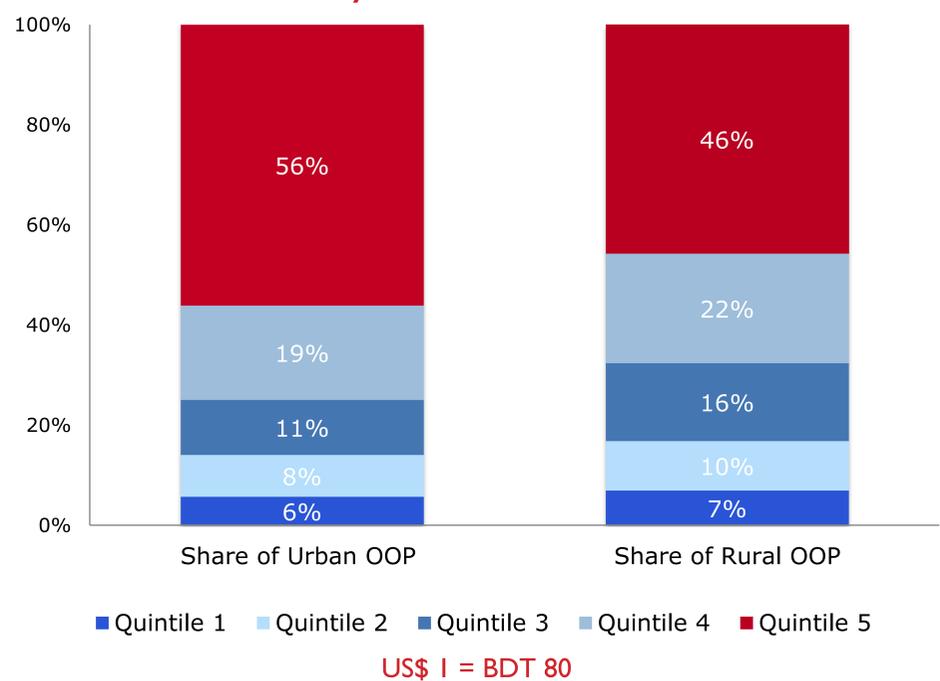


## Urban vs. Rural THE by Income Quintile

HIES 2010 allows for analysis of health expenditures by income quintile of households. Within the urban households, share of household OOP expenditures increases with income quintile, with the top quintiles making up the most. That is, the urban poor spend proportionately less on health than their richer counterparts (see Figure 5).

Comparing urban to rural, the lowest income quintile (quintile 1) of urban households spend 6% of urban household OOP expenditures while in rural areas they spend 7% of rural household OOP expenditures. Only the top income quintile in urban spends proportionally more than their rural counterparts (see Figure 5).

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



## Conclusions

Health expenditure estimates presented above show that urban THE is proportionately higher (at 33%) compared to the urban share of the population (23%). Government financing is 17% of urban THE while it is 26% of rural THE. Urban household OOP health expenditures is proportionately higher at 68% of urban THE compared with rural at 61% of rural THE.

These health expenditure estimates are consistent with findings on healthcare utilization. The Demographic and Health Survey (DHS) 2014 show stark differences between some urban and rural indicators: rates of urban women (with live births) delivering at private facilities, as well as delivering by C-section, are twice as high as for rural women. In addition, the Bangladesh Urban Health Survey 2013 finds that within urban areas, there are marked differences between urban slums vs. non-slums: rates of women in non-slums delivering in private facilities, as well as delivering by C-sections, are several times higher than women in slums. This is borne out by proportionately lower expenditures on health by lower income quintiles in urban areas.

These preliminary estimates suggest the need for further investigation into the underlying reasons for these differences in urban/rural health expenditures and within urban health expenditures, particularly household OOP expenditures on health. These differences are likely due to both supply-side reasons, such as higher prices and more secondary/tertiary services in urban areas, as well as demand-side reasons, such as socio-cultural reasons for health-seeking behavior and service utilization.

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