

A technical report on

The geographical variation of catastrophic health expenditure and impoverishment due to out-of-pocket payments in Bangladesh

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Acronyms

BBS – Bangladesh Bureau of Statistics
BPL-Below poverty line
CBN – Cost of basic needs
CHE – Catastrophic health expenditure
FRP – Financial risk protection
HIES – Household Income and Expenditure Survey
NCD- Noncommunicable diseases
NHC-National Health Commission
OOP – Out-of-pocket
PCA – Principal component analysis
PPS – Probability proportional to size
PSUs – Primary sampling units
SDGs-Sustainable development Goals
SSK- Shasthyo Surokhsha Karmasuchi
THCE – Total household consumption expenditure
THE – Total health expenditure
UHC – Universal health coverage
HEU – Health economics unit
MOHFW – Ministry of Health and Family Welfare
PPRC –Power and Participation Research Centre

1. Background

Promoting and protecting health through universal health coverage (UHC) is essential to human welfare and sustainable economic and social development. 'Universal health coverage' is defined as ensuring people's access to health services without any financial hardship [1]. Achieving UHC is one of the key targets of sustainable development goals (SDGs) [2]. Catastrophic health expenditure (CHE) and impoverishment due to out-of-pocket (OOP) payments are the prime indicators for measuring UHC [3]. Catastrophic health expenditure occurs when a household's OOP expenditures exceed a certain amount compared with overall food and non-food household expenditures. Inadequate public health spending on health services in many low and middle-income countries like Bangladesh causes OOP spending, leading to CHE and impoverishment [4-8]. Impoverishment due to OOP payments occurs when a household is forced to live below the poverty line as a result of making higher healthcare payments [6]. It is widely acknowledged that healthcare expenditures can impoverish individuals and household [9, 10].

Many studies have documented the impact of OOP payments and their effect on CHE and poverty in recent years [8, 10, 11]. Globally, approximately 150 million people from 44 million households face CHE annually, and approximately 100 million people from 25 million households are pushed into poverty due to OOP payments for healthcare [11, 12]. One study found that more than one-quarter of household net resources for food costs in at least 10% of all households were absorbed by OOP spending for healthcare in Bangladesh, China, India, Nepal and Vietnam [8]. The prevalence of CHE is generally higher in low-to-middle-income countries [8]. More than 90% of people affected by CHE live in low-income countries [3]. Xu et al. (2007) found the prevalence rate of CHE was 3.1%, 1.8% and 0.6% in low, middle and high-income countries, respectively [11].

In Bangladesh, a recently published study analysed the impact of OOP payments on CHE and poverty using the Household Income and Expenditure Survey (HIES, 2016). The study found that 4.5% of the total population fell into poverty due to OOP spending for healthcare, representing the economic impoverishment of 8.61 million people annually [5]. It was also found that 24.2% of households incurred CHE nationally. The concentration index of CHE

affected rural (25.6%) more than urban (21.1%) populations, as well as lower-income families [6].

Two additional studies on the impoverishment impact of OOP payments conducted in Bangladesh considered urban and rural populations separately [4, 7]. Hamid et al. (2014) explored the disease-specific impact of OOP payments for healthcare on poverty among low-income rural groups and found that OOP payments pushed 3.4% of households into poverty annually [4]. Islam et al. (2017) conducted a study in a Bangladeshi city and found that approximately 9% of households incurred catastrophic payments, 6% experienced impoverishing health payments and 7% faced financial distress in Bangladesh [7]. Age, sex, marital status, place of residence and family wealth were significantly associated with higher OOP health expenditures. It was also found that urban patients spent more money on healthcare (USD38.3) compared with rural patients (USD21.2) [13].

Although several studies have been conducted on CHE and impoverishment due to OOP payments in Bangladesh [4, 6, 7], there is no evidence of such studies based on geographical area (e.g. administrative divisional level). The evidence derived from such research will be important for implementing region-specific initiatives to reduce CHE and impoverishment impacts. The present study aimed to understand CHE and impoverishment due to OOP payments for healthcare at both national and divisional levels and based on place of residence (urban/rural/city corporation).

2. Method

2.1 Data

This paper used data from the latest Household Income and Expenditure Survey 2016 (HIES) of Bangladesh [14]. The HIES is a nationally representative cross-sectional survey conducted every five years by the Bangladesh Bureau of Statistics (BBS) under the Ministry of Planning (Bangladesh). This survey provides information related to both household and individual levels. The survey collects socio-economic data including family earnings, consumption and expenditures, assets, housing conditions and individual-level data on demographic variables (age, sex and marital status), education, employment, health, disability and additional information.

The most recent HIES 2016 employed a stratified two-stage cluster sampling design. In the first stage, 2,304 primary sampling units (PSUs) from 20 strata (eight rural, eight urban and four city corporations) across the country were selected using probability proportional-to-size (PPS) systematic sampling. The selection of PSUs was based on the Population and Housing Census 2011 [14]. In the second stage, 20 households were randomly selected from the listed households of each PSU. The survey questionnaire included nine separate sections including health and household consumption.

2.2 Measuring out-of-pocket payment

The HIES 2016 questionnaire included a health module that asked individuals about chronic (suffering from last 12 months) and recent illness (suffering from last 30 days) and the healthcare applied for these conditions. In the current study, all the variables related to healthcare expenditures were transformed into monthly (30 days) measures to maintain consistency. This data provided us with the opportunity to observe the cost of outpatient and inpatient service utilisation. For both outpatient and inpatient groups, the cost of consultation, medicine, tests and transport were collected separately. Other costs related to healthcare, such as hospital fees, cabin charge, informal tip and midwifery services were only available for those receiving inpatient treatment. The costs associated with immunisation, contraceptives use, oral rehydration solution (ORS), routine medical check-ups were also collected. The OOP payments for healthcare was defined as the proportion of total healthcare expenditure as a share of total household consumption expenditure.

2.3 Measuring the intensity of catastrophic health expenditure

The intensity of CHE was measured by calculating the proportion of household expenditure on health as a share of the total household consumption expenditure (THCE).^{1,2,3} The

¹ We considered both food and non-food expenditures as a proxy for household income. For estimating food expenditure, we used the monthly food consumption expenditure of households including consumption from own crop production, domestic animal products, own poultry products and fishing products. For non-food expenditure, the following items were considered: fuel and lighting, clothing, footwear, cosmetics, personal articles and other expenses, household hygiene (washing and cleaning) expenses, household equipment, furniture, health, education, transport/travel and other charges, the maintenance and repair of own vehicles, all types of household maintenance bills, rent and salaries paid to whom are involved in household maintenance, ceremonies, recreation and leisure and other contingencies expenses.

² To get rational estimates, data were handled by replacing the 99% percentile values with the median values.

³ All the expenditures were measured over 30 days.

household expenditure was considered as catastrophic if the expenditure on health exceeded certain THCE thresholds. Several thresholds were proposed in existing studies [15, 16]. In the present study, a household health expenditure that exceeded 10%, 25% and 40% of the THCE thresholds were considered as CHE. The intensity of CHE reflected the percentage at which the households incurred them and exceeded the threshold [3, 17].

2.4 The impoverishment impact of out-of-pocket health payments

The conventional method of measuring household poverty compares household total consumption (or non-food consumption) with a poverty line. The cost of basic needs (CBN) approach is typically used to estimate the poverty line, which involves calculating the expenditure required to meet subsistence nutrition requirements (2,122 kcal/person/day) and the addition of allowances for non-food needs [18]. The cost of a normative food bundle (comprising coarse rice, wheat, pulses, milk, oil, meat, fish, potatoes, vegetables, sugar and fruits) that provides the minimal nutritional requirements was captured to estimate the food poverty line [19]. Then, non-food allowances for the poverty line were determined using two methods. The lower non-food allowance was calculated as the median amount spent on non-food items by a group of households that had per capita total expenditures close to the food poverty line. The upper non-food allowance was estimated as the median amount spent for non-food items by a group of households that had per capita food expenditures close to the food-poverty line [14]. Finally, the lower and upper poverty lines were obtained by adding the food poverty line to the lower and upper non-food allowances. In this study, the incidence of poverty was estimated at the administrative divisional level, taking into account the variability of the locality (urban, rural and city corporation) to improve the precision of using both the lower and upper divisional poverty lines from the HIES 2016 report. The poverty line for the Mymensingh and Rangpur divisions were not provided. Hence, we considered the poverty line threshold for the Mymensingh division as same as Dhaka and the poverty line threshold for Rangpur division as same as Rajshahi considering their geographical proximity. Finally, the national level of poverty was estimated according to the divisional poverty incidence.

We estimated the poverty impact of OOP health expenditure by comparing the difference between the average level poverty headcount with and without OOP payment to observe the

proportion of individuals below the poverty line [4, 6]. The poverty headcount was estimated using the total household consumption expenditures and expenditures without OOP payments for healthcare. The difference between these two poverty headcount measurements captured the impact of OOP payments on poverty.

3. Results

3.1 The characteristics of health-related indicators by division

The results showed that the monthly incidence of acute illness, the prevalence of chronic illnesses and hospitalisation rates at the national level were 21%, 18% and 2.2% respectively. At the divisional level, the monthly incidence of acute illness ranged from 17.2%–27.2% with the highest observed for the Rajshahi division (27.2%) and the lowest for the Mymensingh division; the prevalence of chronic illnesses ranged from 11.0%–26.9% with the highest observed for the Barishal division (26.9%) and the lowest again observed for the Mymensingh division. The hospitalisation rate at the national level was 2.2; at the divisional level, this rate ranged from 2.9%–1.6% with the highest observed for the Barishal division (2.9%).

Per month per capita, health expenditures were also the highest in the Barishal division (Bangladeshi taka (BDT) 356). However, the utilisation of healthcare was the highest (94.6%) in the Mymensingh division. Nationwide, more than 10% of household expenditures (both food and non-food) was spent as OOP payments for healthcare, the highest in Barishal (14.0%) and the lowest in Rangpur (7.4%) (see Table 1).

It is worth noting that the incidence of acute illnesses and the prevalence of chronic illnesses were significantly higher among women than men across the country, irrespective of age group. The hospitalisation rate was also significantly higher among women compared with men. However, no such disparity was observed for healthcare utilisation between women and men in any age group (see Tables A1 and A2 in the Annexe).

Table 1: The characteristics of health-related indicators by division.

3.2 Catastrophic health expenditure

The results showed that nationwide, approximately 23.4%, 9.8% and 4.6% of the population encountered catastrophic health spending i.e. the household health expenditure as a share of total household expenditures that exceeded a 10%, 25% and 40% threshold, respectively (see Figure 1).

Division	Percentage of people with an acute illness*	Percentage of people with a chronic disease	Percentage of people who received healthcare (for all diseases)	Percentage of people hospitalised	Per-capita healthcare expenditure (BDT per month)	Per-capita household expenditure (BDT per month)	Healthcare expenditure as a percentage of household expenditure
Barishal	21.4	26.9	86.5	2.9	356	2536	14.0
Chattogram	22.1	15.7	82.4	2.2	331	2825	11.7
Dhaka	18.2	16.1	88.9	1.9	321	3205	10.0
Khulna	23.9	21.8	89.3	2.5	257	2480	10.4
Mymensingh	17.2	11.0	94.6	1.6	212	2277	9.3
Rajshahi	27.2	22.2	91.9	2.5	265	2449	10.8
Rangpur	20.5	14.3	87.5	1.6	158	2132	7.4
Sylhet	17.6	17.4	90.5	1.7	200	2448	8.2
National	21.1	18.2	88.18	2.2	274	2630	10.4

* Diarrhoea, fever, dysentery, pain, injury/accident, blood pressure, heart disease, respiratory disease, asthma, bronchitis, weakness, dizziness, pneumonia, typhoid, tuberculosis, malaria, jaundice, female disease, pregnancy-related, cancer, mental health, paralysis, epilepsy, scabies, skin disease, kidney disease, liver disease, ear/ear, nose and throat problems, eye problem and others.

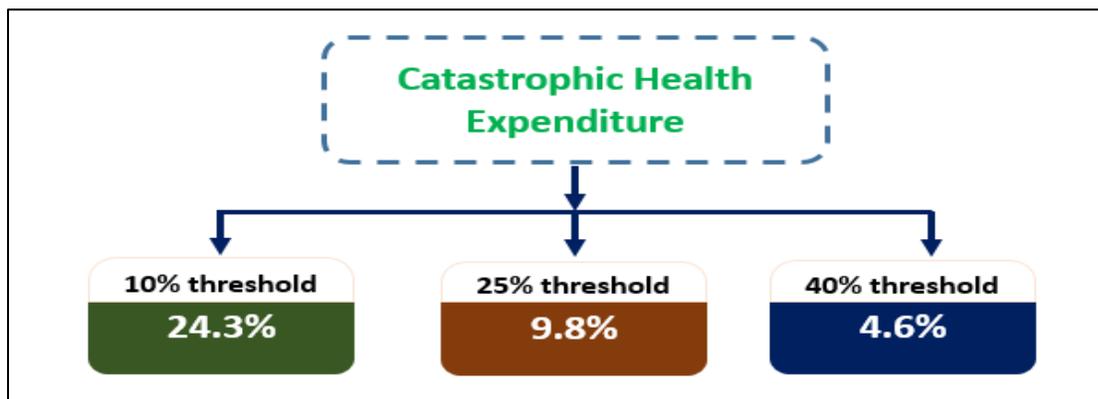


Figure 1: Catastrophic health spending at 10%, 25% and 40% thresholds.

The highest rate of CHE was observed for the Barishal division (31.3%) at all threshold levels, which was consistent with the highest prevalence of chronic illnesses and hospitalisation rates (see Table 2). At 10% and 25% threshold levels, CHE was the lowest for the Rangpur division; the Sylhet division showed the lowest rate (3.0%) at a 40% threshold level. In terms of rural/urban comparison, the highest incidence of CHE at all thresholds was also observed for the Barishal division.

Table 2: The divisional distribution of catastrophic health expenditure across rural, urban and city corporation regions at different thresholds.

Division	10% Threshold				25% Threshold				40% Threshold			
	Urban	Rural	City corporation	Overall	Urban	Rural	City corporation	Overall	Urban	Rural	City corporation	Overall
Barishal	31.5	31.2		31.3	16.7	14.8		15.2	8.1	8.2		8.1
Chattogram	29.6	27.9	20.1	27.6	12.0	11.4	7.9	11.3	5.8	4.9	4.7	5.0
Dhaka	16.5	19.5	11.6	17.9	6.9	9.0	4.3	7.9	2.9	4.5	1.4	3.7
Khulna	25.0	25.7	10.0	24.5	8.7	10.6	3.9	9.7	4.1	5.2	1.4	4.6
Rajshahi	19.7	24.8	24.4	23.9	10.4	10.3	9.3	10.2	5.2	4.9	3.5	4.8
Sylhet	20.1	24.1		23.1	5.6	8.5		7.8	1.5	3.5		3.0
Mymensingh	20.9	21.7		21.5	8.7	9.7		9.4	3.9	4.5		4.3
Rangpur	18.7	19.9		19.6	6.1	8.3		7.8	2.3	3.4		3.1
National	24.3				9.8				4.6			

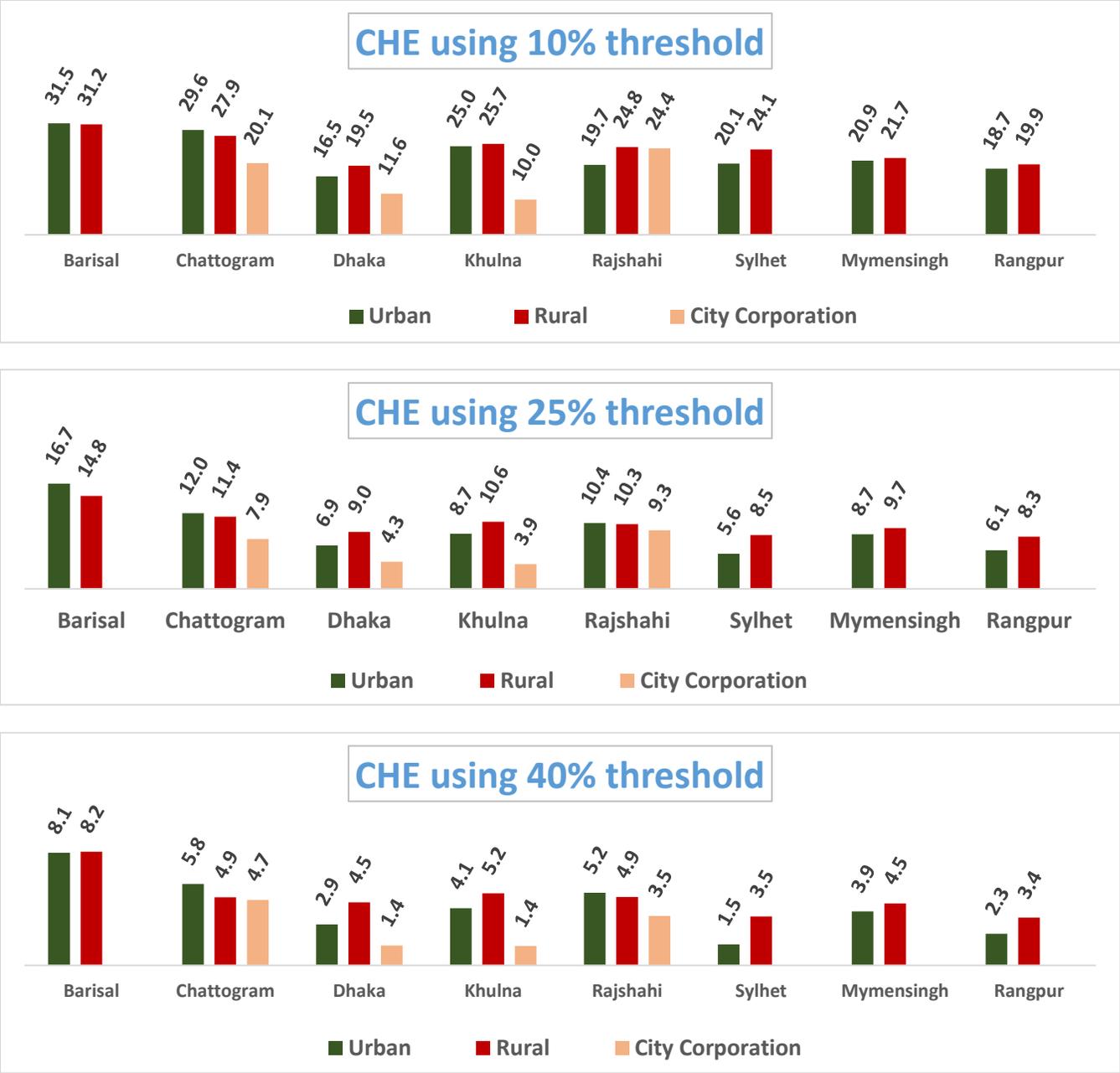


Figure 2: The divisional distribution of catastrophic health expenditure in rural, urban and city corporation regions at different thresholds.

At a 25% threshold, the incidence of CHE was the highest in the Barishal division (15.2%) followed by the Chattogram division (11.3%). The Sylhet and Rangpur division populations encountered CHE less frequently at this threshold (see Figure 3).

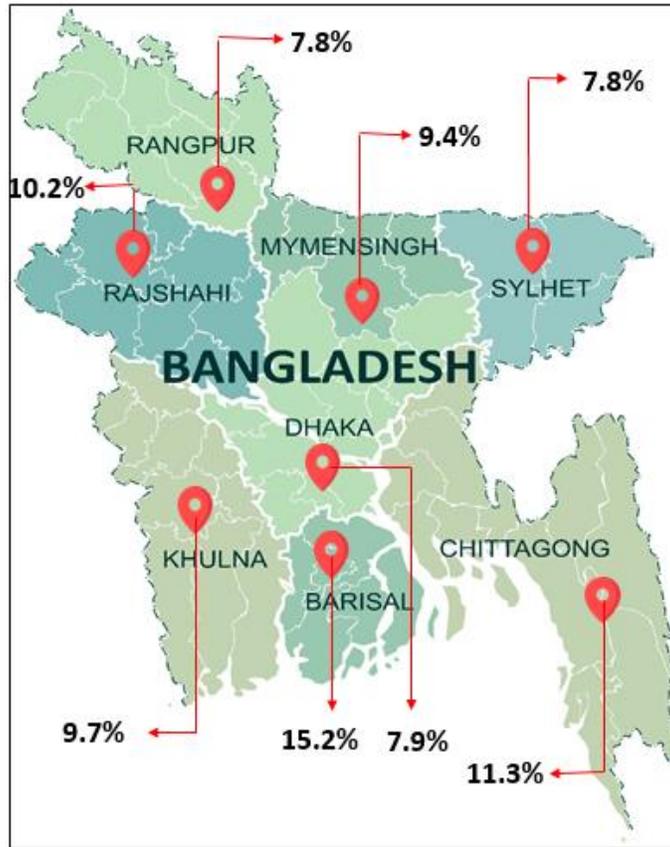


Figure 3: The divisional distribution of catastrophic health expenditure at the 25% threshold.

3.3 Impoverishment due to healthcare costs

The nationwide rate for impoverishment due to healthcare costs was 6%. The overall rates of impoverishment were 6.9%, 5.6% and 4.4% in rural, urban and city corporation areas, respectively. The rate of impoverishment was lower in the city corporation area, except for the Rajshahi division (8.8%) (Table 3).

Table 3: The incidence of poverty in the rural, urban and city corporation of Bangladesh.

Division	Rural			Urban			City corporation			Overall		
	Head count with gross OOP payment	Head count without gross OOP payment	Difference	Head count with gross OOP payment	Head count without gross OOP payment	Difference	Head count with gross OOP payment	Head count without gross OOP payment	Difference	Headcount with gross OOP payment	Head count without gross OOP payment	Difference
Barishal	62.2	71.4	9.1	56.3	66.1	9.8				59.3	68.7	9.5
Chattogram	58.1	67.3	9.2	57.9	65.9	8.0	50.2	54.9	4.7	55.4	62.7	7.3
Dhaka	52.8	58.41	5.6	42.9	46.4	3.6	34.5	36.7	2.1	43.4	47.2	3.8
Khulna	63.4	70.3	7.0	60.4	66.4	6.0	60.7	62.7	2.1	61.5	66.5	5.0
Rajshahi	64.5	72.5	8.0	57.2	63.3	6.1	48.2	57.0	8.8	56.7	64.3	7.6
Sylhet	56.4	62.7	6.2	52.2	57.5	5.3				54.3	60.1	5.7
Mymensingh	71.5	76.7	5.2	66.5	69.2	2.8				69.0	73.0	4.0
Rangpur	75.0	79.7	4.7	67.6	71.1	3.5				71.3	75.4	4.1
National												6.0

Impoverishment due to healthcare costs was the highest in the Barishal division (9.5%) (which is consistent with the incidence level of acute illness and the prevalence of chronic illnesses) followed by the Rajshahi division (7.6%); the lowest level was observed for the Dhaka division (3.8%) (see Figure 4).

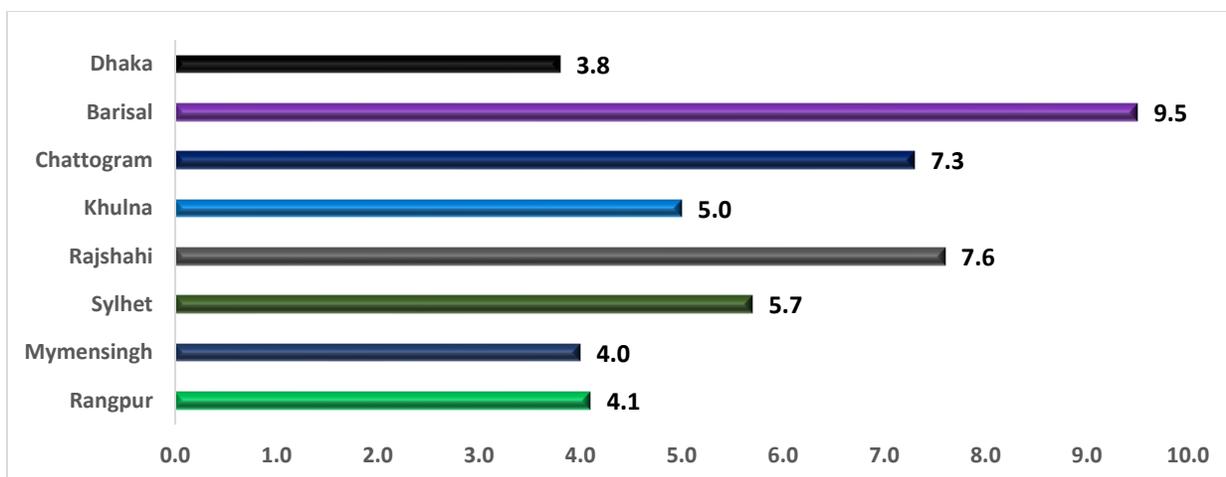


Figure 4: Impoverishment due to healthcare costs across divisions (%).

Impoverishment due to healthcare costs was more evident in rural (6.9%) compared with urban (5.6%) areas. We found higher impoverishment rates in rural areas in the Chattogram division (9.8) and lower rates in the Mymensingh division (2.8%). Conversely, the poverty impact due to OOP payments in the urban area of the Barishal division (9.8%) was much higher, and the city corporation area of the Khulna and Dhaka divisions (2.1%) showed lower rates than any other divisional area. Accordingly, the percentage of the populations of the Khulna and Dhaka city corporation regions were lower to fall below the poverty line (see Figure 5).

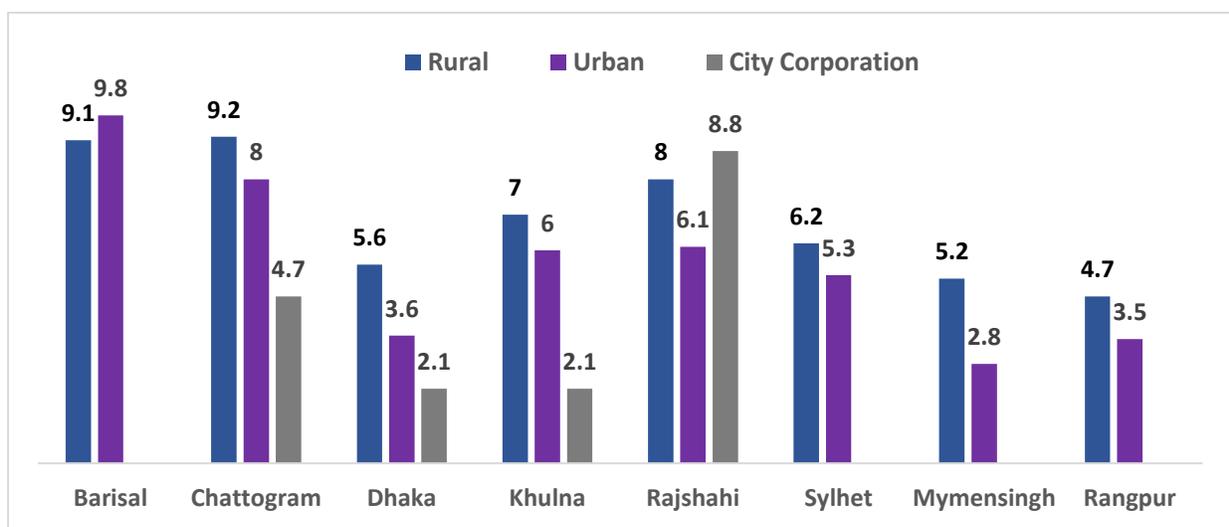


Figure 5: Impoverishment due to healthcare costs across rural and urban areas by division (%).

4. Discussion

This study revealed that CHE and impoverishment due to OOP payments were notably high in Bangladesh. Moreover, there were significant disparities within the CHE and impoverishment levels due to OOP payments across the administrative divisions in the country.

Higher CHE rates indicated that a wider proportion of households face financial obstacles in terms of healthcare access [20, 21]. The protection of households against CHE is a major public health concern in low and middle-income countries like Bangladesh, where OOP payments reflect the principal source of healthcare spending [22]. In this study, descriptive statistics revealed that in 2016, 24.3% of Bangladeshi households were affected by CHE at the 10% threshold, which is similar to figures in a report by the World Health Organization (WHO) (24.7%) [23]. This rate is higher than figures in previously published Bangladeshi studies [4, 6, 8, 24]. In the current study, estimations were calculated using the latest HIES (2016) data and by investigating the impact of OOP payments on poverty; regions included all administrative divisions and places of residence (urban/rural/city corporation) for each individual division. Existing work, however, considered rural/urban areas separately [4, 7]. Based on existing research, 4.5% of the total population and 3.4% of people from rural areas (the low-income group) fell into poverty annually due to OOP spending on healthcare in the previous year [4, 5]; the present study estimated that 6% of households fell into poverty due to OOP expenditures on healthcare. The steady decrease in healthcare spending by the Bangladeshi Government (as a percentage of total government spending) may be a reason for this [25]. The financial allocation for health spending in the 2009–2010 fiscal year (FY) was 6.2% of total government expenditures; this fell to 4.3% in the 2015–2016 FY, despite population growth and various types of emerging diseases increasing during the same period [25]. Accordingly, urgent attention is needed for enforcing appropriate health policies and the required budget allocations to reduce high CHE and impoverishment due to OOP healthcare payments.

To the best of our knowledge, this is the first study in Bangladesh to portray CHE in the context of geographical variation at the divisional level. Households in the Barishal division were experiencing higher CHE than households in other divisions, implying that households in this division face a higher burden and financial obstacles in relation to receiving healthcare compared with households in other divisions [26]. In addition, the incidence of poverty due to OOP payments in the rural area (9.8%) of the Barishal division was higher compared with all administrative divisions and places of residence (urban/rural/city corporation). The possible reasons for this division-based discrepancy include differences in the incidence of acute illness, the prevalence of chronic illness. This study found that the highest proportion of people were suffering from chronic illness in the Barishal division (26.9%) and were hospitalised (2.9%) compared with all other divisions. The disproportionate distribution of budget allocations in the health sector in different divisions may be another reason. Despite having higher chronic disease rate in Barishal, the budget allocation in this division was not in harmony to the fact[25]. Different demographic patterns, poverty rates, wages and economic status within divisions may also contribute to the varied prevalence of CHE across divisions[27].

This study was not beyond the limitations. First, lost or reduced income due to sickness was not considered for CHE measurements. Second, the measures used by households to cope with CHE were not investigated. These omissions arose from limitations in the data set.

5. Conclusions and recommendations

The current overall incidence of catastrophic CHE was very high (24.3% nationwide at 10 threshold level) and varied widely among administrative divisions; the highest was observed for the Barishal division (31.3%) and the lowest for the Rangpur division (19.6%). The national impoverishment impact was also high (6%) and varied widely among the administrative divisions; the highest level was observed for Barishal (9.5%) and the lowest for Mymensingh (4.0%). Recommendations are put forward below in the context of these broad observations.

The reduction of OOP payments for healthcare is the main endogenous factor for minimizing the incidence of CHE and the impact of impoverishment. The Bangladesh Health Care

Financing Strategy 2020–2032 was designed with the aim of reducing OOP payments to 32% in 2032. The strategy divides the population into three broad sub-groups: (i) those living below the poverty line (BPL), (ii) the informal sector and (iii) the formal sector. Three major strategies that are suggested for these three groups are Shasthyo Surokhsha Karmasuchi (SSK) for BPL, community based or micro health insurance for the informal sector and health protection schemes for the formal sector. Other than piloting efforts for SSK, these strategies have not yet been implemented. Thus, the government needs must pay stronger attention to implementing the strategy. However, major revisions are required before this can be done. For example, micro health insurance and community-based health insurance have been characterised as non-viable routes for providing healthcare. These approaches also cannot reduce CHE and impoverishment due to OOP payments for healthcare [28]. Additionally, SSK was also not accepted as an effective tool for reducing CHE and impoverishment due to its implementation challenges.

It is reasonable to propose that, due to a large informal sector (87.5%), a low tax–gross domestic product ratio (less than 10%) and a lack of adequate quality private hospitals outside Dhaka, introducing social health insurance for the entire population will not be feasible in the near future, particularly comprehensive benefit packages (covering all types of illnesses). However, it is feasible to introduce social health insurance for more burdensome chronic Noncommunicable diseases (NCDs) (e.g. cancer, kidney failure) through innovative financing, e.g. imposing a special levy on mobile phone call rates, earmarking a proportion of tobacco tax and mobilizing corporate social responsibility funds from pharmaceutical companies to improve access to healthcare [29, 30].

Achieving the above requires establishing a National Health Commission (NHC) similar to that in China, defined as a National Health Security Office in the Health Care Financing Strategy published by Ministry of Health and Family Welfare, Bangladesh [31]. Therefore, the government should focus more strongly on enacting the National Health Protection Act and establishing the NHC, based on this Act.

Furthermore, budgetary allocations for healthcare should gradually be increased from 5%–7% by 2025 and ultimately, to 10% by 2030; the administrative capacity of all tiers of

administration in the sector should also be increased to ensure the efficient utilisation of the provided budget.

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7. Annexe

Table A1: The characteristics of health-related indicators by division and gender.

Division	Percentage of people with an acute illness*			Percentage of people with chronic disease			Percentage of people who received healthcare (for all diseases)			Percentage of people who were hospitalised		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Barishal	18.7	24.3	21.4	23.5	30.4	26.9	87.6	85.6	86.5	2.4	3.4	2.9
Chattogram	19.4	22.5	22.1	14.4	16.9	15.7	80.8	83.7	82.4	1.8	2.5	2.2
Dhaka	16.9	19.5	18.2	14.6	17.5	16.1	89.4	88.5	88.9	1.8	2.0	1.9
Khulna	22.0	25.7	23.9	19.4	24.2	21.8	89.6	89.0	89.3	2.0	3.0	2.5
Mymensingh	16.2	18.3	17.2	10.6	11.4	11.0	94.5	94.7	94.6	1.6	1.7	1.6
Rajshahi	25.1	29.4	27.2	19.9	24.4	22.2	92.6	91.3	91.9	2.0	3.1	2.5
Rangpur	18.6	22.6	20.5	13.1	15.5	14.3	88.8	86.4	87.5	1.2	2.0	1.6
Sylhet	16.5	18.5	17.6	15.9	18.9	17.4	90.9	90.1	90.5	1.5	1.9	1.7
National	19.4	22.8	21.1	16.4	19.9	18.2	88.4	88.0	88.2	1.8	2.5	2.1

* Diarrhoea, fever, dysentery, pain, injury/accident, blood pressure, heart disease, respiratory disease, asthma, bronchitis, weakness, dizziness, pneumonia, typhoid, tuberculosis, malaria, jaundice, female disease, pregnancy-related, cancer, mental health, paralysis, epilepsy, scabies, skin disease, kidney disease, liver disease, ear/ear, nose and throat problems, eye problems and others.

Table A2: The characteristics of health-related indicators by age and gender.

Division	Percentage of people with an acute illness*			Percentage of people with a chronic disease			Percentage of people who received healthcare (for all diseases)			Percentage of people who were hospitalised		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0–14 years	23.6	23.1	23.4	4.6	4.1	4.4	90.3	90.0	90.2	1.4	1.0	1.2
15–19 years	13.2	16.3	14.7	5.4	6.1	5.7	86.2	86.3	86.3	0.9	2.0	1.4
20–29 years	12.9	19.2	16.4	8.8	13.3	11.3	84.8	86.5	85.9	1.0	3.6	2.5
30–39 years	16.0	23.0	19.6	17.9	25.1	21.6	88.1	87.0	87.5	1.7	3.3	2.5
40–49 years	19.0	25.4	22.2	27.3	37.5	32.3	88.1	88.3	88.2	2.2	3.2	2.7
50–59 years	20.9	27.5	24.1	37.2	45.5	41.2	88.5	86.8	87.6	2.9	3.2	3.1
60 and above	26.1	28.9	27.4	51.4	54.7	53.0	87.2	86.9	87.1	4.4	3.2	3.8

* Diarrhoea, fever, dysentery, pain, injury/accident, blood pressure, heart disease, respiratory disease, asthma, bronchitis, weakness, dizziness, pneumonia, typhoid, tuberculosis, malaria, jaundice, female disease, pregnancy-related, cancer, mental health, paralysis, epilepsy, scabies, skin disease, kidney disease, liver disease, ear/ear, nose and throat problems, eye problems and others.

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