**Target Journal: *Health Expectations* (Willey Publication IF 2.173, Q1)**

**Title:** Cost of caregivers for treating hospitalized diarrheal patients in Bangladesh

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**Acknowledgements**

icddr,b is thankful to the Governments of Australia, Bangladesh, Canada,Sweden and the UK for providing core/unrestricted support. We would like to thank Health Economics and Financing Research Group of icddr,b for their earlier comments in this research.

**Funding:**

The project is a part of the SIDA young investigator award.

**Conflict of interest:**

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article

**Title:** Cost of caregivers for treating hospitalized diarrheal patients in Bangladesh

**Abstract**

**Background:** Diarrheal diseases are a global public health problem and one of the leading causes of mortality, morbidity and economic loss. The objective of the study is to estimate the economic cost of caregivers and cost distribution for diarrheal episodes in Bangladesh.

**Methods:** This was a cross-sectional hospital-based study conducted in public hospitals in Bangladesh. A total of 801 diarrheal patients were randomly selected and interviewed during January to December 2015. Respondents were adult caregivers or economic contributors or adult patients. Simple descriptive statistics including frequencies, percentage, mean with 95% CI and median are presented in local currency, i.e., Bangladeshi Taka (BDT) and US dollars (US$).

**Results:** The overall average cost of caregivers was BDT 2,243 (US$ 28.58) while only BDT 259 (US$ 3.29) was spent as out of pocket payments. Caregivers mostly spent money (BDT 128 or US$ 1.63) for food, lodging, utility bill and other lump sum costs followed by the transportation costs (BDT 123 or US$ 1.57). The caregivers’ spent more (BDT 3,490 or US$ 44.45) when they accompanied the patients who were admitted in inpatients care and almost 3.6 times higher than for out-patients care (BDT 975 or US$ 12.42).

**Conclusions:** Diarrhea is still an overwhelming public health problem in Bangladesh. The study delivers an empirical evidence to the health-care programmers and policy makers about the economic cost of caregivers during diarrheal treatment care, which should be accounted for in designing future diarrheal prevention program. Indeed the additional caregivers cost is likely to be even higher than what has been observed in this empirical study. These findings will help policy makers to evaluate and design the diarrhea related preventive or promotive health intervention at the household level.

KEY WORDS

Caregivers, Diarrheal Disease, Indirect cost, Inpatient services, Outpatient services, Out of pocket payment, Bangladesh

**1 | INTRODUCTION**

Diarrheal diseases remains one of the major causes of mortality and morbidity worldwide. Every year, approximately 2.39 billion diarrheal cases occurs globally, and in 2015 an estimated 0.53 million of under five children died due to diarrhea1,2 which was about nine per cent of all deaths among children under five years of age.3 Specifically, incidence and case-fatality ratios are much higher in lower and middle income (LMI) countries than developed regions.4 Like many other developing countries, diarrhea is an overwhelming public health problem in Bangladesh. Though the mortality due to diarrheal illness has significantly declined over the last decade, however, the morbidity remains stable in Bangladesh. In the last five years, approximately 12.9 million patients had visited health facilities for seeking care while at least 115 patients died.5 However, numerous diarrheal cases occurred in community level and many of them were managed at household level and remain unreported, thus the real diarrheal burden is still unknown.

Diarrhea is often referred as an alteration in normal bowel movement characterized by an increase in water content, volume, or frequency of stools.6 A diarrheal episode is considered as the passage of three or more loose or liquid stools in 24 hours prior to presentation for care, which is considered the most practicable definition among children and adults.7 If the disease lasts “more than 7 days” and “at least 14 days” then the terms “prolonged” and “persistent” diarrhea are used respectively.8,9 Diarrhea is caused by many infectious organisms, including bacteria (e.g. *Escherichia coli,* *Vibrio chollerae Shigella, Salmonella),* viruses *(e.g. Rotavirus, Adenovirus, Norovirus)* and parasites (e.g. *Entamoeba Histolytia, Giardia Lamblia*). Poor sanitation systems, lack of potable water and inadequate personal hygiene are important risk factors for diarrheal disease which is accountable for up to 90% of all diarrheal cases,10 although it is the most prevalent disease that affects all irrespective of socio-economic status. The disease can be prevented and managed at household level with low cost Oral Rehydration Therapy (ORT), however, the patient frequently visits the health facilities which imposes a substantial economic burden for the affected households.11,12 Recent study showed that by controlling diarrheal diseases household could save approximately US$ 136.03 million which usually exhausted for receiving treatment.13

Diarrheal diseases are one of the major causes of hospitalization among under-five children in Bangladesh. According to the latest hospital based surveillance in Bangladesh, childhood diarrheal diseases were responsible for 40% and 18% of hospital admissions in sub-district and district level hospitals respectively, while at least 7% of under-five children were admitted to the medical college hospitals.5 Although diarrheal diseases can be managed by low-cost interventions, however, an earlier study observed that about 75% of the under five children receive treatment care from any formal healthcare provider.14 However the treatment seeking pattern for diarrheal disease varies to a greater extent for children than for adults as children frequently visit the local private practitioners before hospitalization which eventually is reflected in its treatment costs.14,15 Caregivers’ time and direct expenditure is an important cost component and has an impact on the livelihoods of families and particularly for those who live further away from treatment facilities.13,16–18 There are numerous studies focusing on the economics of diarrheal disease around the world however, research focusing on the caregivers’ cost during the diarrheal episode is still limited globally.13 To our knowledge, this is the first study to analyze the distribution of caregivers’ cost in Bangladesh, although caregivers’ time and financial resources could upturns the overall cost of treatment for household perspective. In this aspect, the objective of the study is to estimate the average cost of caregivers and cost distribution during diarrheal episodes in Bangladesh. We expect that our findings will help policy makers to evaluate and design the diarrhea related preventive or promotive health intervention at the household level.

**2 | METHODS**

**2.1 | Design and study population**

This was a cross-sectional descriptive study conducted in public hospitals in Bangladesh. Public hospitals play a major role in providing treatment to the relatively large population with low cost, as those hospitals are highly subsidized and financed by the government of Bangladesh. Thus a large number of patients irrespective of socio-economic strata frequently seek care from public hospitals. A total of 801 diarrheal patients were randomly selected and interviewed during January to December 2015. Respondents of this study were adult caregivers or economic contributors or adult patients. The study was conducted from a caregiver’s perspective which means all types of caregivers costs were identified, measured and valued.19

**2.2 | Cost estimates**

The aim of this study was to analyze the caregivers’ cost associated with the diarrheal treatment. In the study caregivers can be mother, father, spouses, descendants, siblings or close relative, who have no training in child health or education except their own experience and accompany during the hospitalization and aged 18 and above.16 To estimate the cost of caregivers’ both direct and indirect costs were captured. *Out of pocket costs* were defined as expenditure by caregivers for themselves which includes transportation, lodging, food items, informal payment, utility bills and other associated payments which was not directly linked with the treatment of patients. *Indirect cost* was considered as the income losses as well as productivity losses of caregivers because of travel and stay at the health centre and costs due to absence from work. Self-reported wage rates were used for estimating the income losses. The inclusion of caregiving time based on the assumption that time dedicated to caregiving may represent foregone non-market activities such as education, household chores, child care, and leisure or domestic work.20,21 Productivity costs were estimated using the human capital approach.22 To capture the productivity losses for non-market activities, the minimum wage rate of Bangladesh according to the national level was considered. Caring for a patient with diarrhoea may have in negative impact on the emotional and physical condition of the caregivers which was not captured.21,23 Furthermore, time cost of visitors and extra irregular expense borne by the caregivers and visitors were not included in the analysis.

**2.3 | Data collection**

Data were collected by face to face interviews during discharge from the hospitals. Respondents were adult patients or the accompanying person who was most familiar with the costs incurred during the treatment of the patient. A research assistant reviewed patient's records, and data extraction forms were updated daily until the discharge of the patients. A telephone interview was also conducted for taking necessary information within one week after discharge from hospital. Questions were asked regarding transportation, expenses during the hospitalization, and losses of wages resulting from absence from work.

**2.4 | Data analysis**

Data analysis was performed using Microsoft Excel and Stata/SE 13.0 (StataCorp. College Station, TX, USA). Simple descriptive statistics including frequencies, percentage, mean (95% CI) and median were presented in local currency, i.e., Bangladeshi Taka (BDT) and US dollars (US$) applying the exchange rate (US$ 1 = 78.5 BDT) during the year of the survey; mid 2014- mid 2015 24.

**2.5 | Ethical approval:**

The research protocol of this study was approved by the Institutional Review Board of the International Centre for Diarrheal Disease Research, Bangladesh (icddr,b). Informed consent was obtained from all respondents before data collection

**3 | FINDINGS**

**3.1 | Background characteristics of study participants**

The background characteristics of patients and their caregivers are presented in Table 1. A higher proportion of the diarrheal patients were children aged less than 5 years (57%) followed by adult patients aged 20 to 64 years (25%). The proportion of male and female patients were almost same (50%), and utilization of inpatient care service was slightly higher (52%) than outpatient services. Except the children aged less than five years (57%), housewives (16%) and students (10%) were two most vulnerable occupational group for diarrheal infection. Parents (64%) were the most common person caring for their children during diarrheal treatment, indeed most of the caregivers were housewives (90%). The monthly income and expenditure of the households were BDT 19,603 (US$ 250) and BDT 15,470 (US$ 197) respectively, while the average last three months healthcare expenditure was BDT 5,191 (US$ 66) considering last three months preceding to the survey.

(Table 1 will be inserted)

**3.2 | Average caregivers’ cost**

The average caregivers’ economic cost and its distribution were reported in Table 2. The overall average caregivers cost for attending with their diarrheal patients was BDT 2, 243 (US$ 28.58) while only BDT 258.57 (US$ 3.29) was spent as out of pocket payment. Among this expenditure, caregivers spent most for food, lodging, utility bill and other lump sum costs jointly (BDT 127.87 or US$ 1.63) followed by the transportation costs (BDT 123.29 or US$ 1.57). As with overall care, the cost distribution pattern was similar for inpatient care but different for outpatient care where caregivers spent more for transportation cost than food and lodging purpose (Table 2). Indeed caregivers spent more when they accompanied the inpatients than the outpatients and this amount was almost 3.6 times higher than outpatients (BDT 3,490 or US$ 44.45 V/S BDT 975 or US$ 12.42).

(Table 2 will be inserted here)

**3.3 | Distribution of caregivers’ cost by socio-demographic characteristics**

Considering the age group of patients, the average total cost of caregivers ranged from BDT 2,529 (US$ 32.22) to BDT 4,407 (US$ 56.14) for inpatient care. For inpatient care, caregivers’ cost was significantly higher (BDT 4,407 or US$ 56.14) when they accompanied under-five children followed by the older aged (64+) patients (BDT 3,777 or US$ 48.11). A similar cost distributional pattern was observed regarding direct and indirect cost of caregivers for both the inpatient and outpatient care. Caregivers’ average total expenditure was slightly higher (BDT 3,616 or US$ 46.06) for male patients than female patients (BDT 3,357 or US$ 42.76), and a similar scenario was observed for direct and indirect cost for inpatient care (Table 3). However, this situation was quite different for outpatient care where cost of caregivers were comparatively higher for female out patients. In poorest quintile, the average total cost of caregivers for inpatients were BDT 3,377 (US$ 43.02) while that for the richest quintile were BDT 3,896 (US$ 49.62). Regarding the direct cost of caregivers for poorest quintile (BDT 379 or US$ 4.82) was lower than that of richest (5th) quintile (BDT 519 or US$ 6.61). A similar pattern was also observed for indirect costs (Table 3). However, such a pattern was not observed when they accompanied the patients for out-patient care.

(Table 3 will be inserted)

**3.4 | Caregivers’ time**

The average time of caregivers during inpatient and outpatients care was 113 hours and 7.8 hours per episode respectively, while the caregiving time is higher when they accompanied inpatients (Figure). Furthermore, caregivers spent more time for caring under-five children as sometimes multiple caregivers attended during their course of treatment.

(Figure will be inserted here)

**4 | DISCUSSION**

Diarrheal diseases still remain a crucial public health concern in Bangladesh as large number of people (approximately 2.7 million) utilize the healthcare facilities annually due to diarrheal infection, which leads to an excessive pressure on the country’s health system. Furthermore, households have to spent noteworthy resources for the treatment purpose both directly and indirectly whereas caregivers’ expenditures and indirect cost are the important components of costs during the treatment courses. Caregivers’ support and services are vital for managing and treating patients particularly for under-five children and older aged and sometimes are specially essential when the patients felt difficulties to speak for him or herself.25 Caregiving during diarrheal infections may help the patients for their daily assistance (e.g., dressing, toileting, child care), monitoring activities (e.g., financial transaction, administration of medication) and emotional support.26 Caregivers’ help and support are often vital for inpatient cares which often associated with the caregivers’ burden both physically and economically.27 In the present study we aimed to investigate the caregivers’ direct and indirect cost due to their attendance and supervision during the treatment of diarrheal patients in tertiary district public hospitals in Bangladesh.

Our study demonstrated that the average total cost of caregivers was US$ 28.58 per diarrheal episode whereas the average total cost for caring inpatients and outpatient was US$ 44.45 and US$ 12.42 respectively. Our estimation suggested that annual caregivers cost during diarrheal infections to be US$ 74.71 million which constituted for 5.34% of the total health expenditure in Bangladesh.28 The out of pocket cost incurred by the caregivers was mainly for purchasing foods and lodging purposes while a vast indirect cost was also incurred due to their absence from daily productive activities. An economic analysis regarding cost of caregivers of DAZT (Diarrhoea alleviation through zinc and oral rehydration salts therapy) program was conducted in Gujrat, India and found that the average economic cost could be incurred up to US$ 4.04 per episode for rural under-five children.12 Several studies also indicated that caregivers’ cost is important aspect for households which might be increased the total treatment cost during diarrheal episode from societal perspective.13,21,29,30 An earlier study in this context observed that the additional caregiver cost could increase the average treatment costs up to US$ 110.51 per episode of diarrheal infection.13 In our study we have found that caregivers’ cost was highest when they provided care to the under-five children as under-five children were the most vulnerable for diarrheal infections.14,31 In another earlier study to this context, it was shown that healthcare seeking behavior of households were quite different regarding their young members when exposed diarrheal infections and they were often taken to the private providers or clinics (e.g., private practitioners) before hospitalization which was not observed for adult patients.21 Furthermore, household’s members particularly parents became terrified and restless when they found their young family members are at risk of ill-health which is reflected in their direct and indirect costs as both the time and person involvement required are generally comparatively more for children than adult patients.16

Like previous studies13,16,21,29,30 we also observed that households from the poorest quintile spent less than richest quintile because of their affordability but faced highest cost burden than richest quintile although the diarrheal prevalence are the highest among household members of the poorest quintile.13,14 For such consequences, many diarrheal cases are inadequately managed at household level which eventually pushes them to the point where the patients’ life is endangered.32 An earlier study observed that during diarrheal episode households often sought care from formal (e.g., qualified doctor, hospital) and informal providers (e.g., tradition healers, unqualified village doctors), even about 23% of diarrheal patients did not go seek formal care, although rapid and proper treatment is essential to avoid excessive costs of households and adverse health events.12,14 Although we did not capture the source of financing for caregivers particularly, an earlier study indicated that regular income and borrowing were the two common coping strategies for diarrheal treatment, which is crucial for Bangladesh as the social health protection scheme yet not implemented and out-of-pocket is the main payment strategy (67%) for seeking healthcare.13,33

There are various proven interventions for preventing diarrheal infections. However, the vast of diarrheal cases could be prevented by implementing water, sanitation and hygiene (WASH) strategies.34,35 A couple of systematic reviews confirmed that hand washing36 and point-of-use water treatment37 were effective interventions for reducing diarrhoeal diseases. Cairncross and colleagues identified that the risk of diarrhoea could be reduced by implementing hand washing with soap (48%), improved water quality (17%) and adequate disposal of human waste (36%) in many developing countries.38 Since diarrhoea is manifested by dehydration in most of the cases, ORS has proven as effective treatment without any significant adverse effect;39 and as much as 69% of diarrhoea-related mortality could be prevented by administrating ORS and recommended home fluids40 which contribute to decrease length of stay or even hospitalization thus reduces the excessive cost during diarrheal treatment. The promotion of exclusive breastfeeding41 and complementary feeding practices42 might strengthen the immune system of children and reduce the prevalence of childhood diarrhea. Although WASH programs, such as improvements in water/sanitation infrastructure and personal hygiene contribute to decline the transmission of enteric pathogens, vaccine can hasten the waning of diarrhoea-related mortalities and morbidities, particularly in epidemic and endemic settings.43 It was reported that nearly one-third of the episodes of severe diarrhoea could be prevented by introducing vaccination against rotavirus and cholera infections.44 Policy makers should consider the caregivers cost found in our study for justifying the future diarrheal prevention programs.

The study has some limitations when interpreting these findings. There may be some recall bias as data were collected after receiving treatment although we have tried to capture all of the information within the two weeks of discharge from hospital. The limitations to this study also include the design; as a cross-sectional, hospital based study it is unable to capture the seasonal variation of caregivers cost as the incidence of diarrheal disease usually peaks during the hot and winter seasons in Bangladesh.45 The cost of caregivers relies heavily on households’ treatment seeking patterns, resources and ability to pay which were not captured.46 Similarly, the present study was also unable to observe the cost of adverse effects and emotional effects (such as anxiety, tiredness) of caregivers during the diarrheal effects. All these issues should be taken into account in future research.

**5 | CONCLUSION**

Diarrhea is still an overwhelming public health issue in Bangladesh. The study delivers empirical evidence for the health-care programmers and policy makers about the economic cost of caregivers during diarrheal treatment care. Our study observed that the average cost of caregivers for treating each episode of diarrhea was US$ 28.58 (BDT 2,243) which should be taken into account for in designing future diarrheal prevention programs as the additional caregivers cost is likely to be even higher than what has been observed in this empirical study.

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Table 1: Distribution of socio-demographic characteristics of diarrheal patients (N=801)

|  |  |  |  |
| --- | --- | --- | --- |
| **Variables** | **n or mean** | **% or SD** | **95% CI** |
| **Patient age in years (%)** |  |  |  |
| Less than 5 | 460 | 57.43 | (53.97 , 60.82) |
| 5 to 12 | 52 | 6.49 | (04.98 , 08.43) |
| 13 to 19 | 38 | 4.74 | (03.47 , 06.46) |
| 20 to 64 | 199 | 24.84 | (21.97 , 27.96) |
| 64+ | 52 | 6.49 | (04.98 , 08.43) |
| **Gender (%)** |  |  |  |
| Male | 404 | 50.44 | (46.97 , 53.90) |
| Female | 397 | 49.56 | (46.10 , 53.03) |
| **Types of patient (%)** |  |  |  |
| Inpatient | 404 | 50.44 | (46.97 , 53.90) |
| Outpatient | 397 | 49.56 | (46.10 , 53.03) |
| **Patient education (%)** |  |  |  |
| Not applicable (Child<5 years) | 458 | 57.18 | (53.72 , 60.57) |
| No formal education | 95 | 11.86 | (09.79 , 14.29) |
| Up to primary | 112 | 13.98 | (11.74 , 16.57) |
| Secondary | 103 | 12.86 | (10.71 , 15.37) |
| Higher | 33 | 4.12 | (02.94 , 05.74) |
| **Patient occupation (%)** |  |  |  |
| Not applicable (Child<5 years) | 458 | 57.18 | (53.72 , 60.57) |
| Housewife | 130 | 16.23 | (13.83 , 18.95) |
| Students | 83 | 10.36 | (08.43 , 12.68) |
| Self-employment | 49 | 6.12 | (04.65 , 08.01) |
| Unemployed | 7 | 0.87 | (00.42 , 01.82) |
| Salaried employee | 31 | 3.87 | (02.73 , 05.45) |
| Business | 18 | 2.25 | (01.42 , 03.54) |
| Others | 25 | 3.12 | (02.12 , 04.58) |
| **Mother education level (%)** |  |  |  |
| No formal education | 270 | 33.71 | (30.51 , 37.06) |
| Up to primary | 199 | 24.84 | (21.97 , 27.96) |
| Secondary | 274 | 34.21 | (30.99 , 37.57) |
| Higher | 58 | 7.24 | (05.64 , 09.26) |
| **Father education level (%)** |  |  |  |
| No formal education | 278 | 34.71 | (31.48 , 38.08) |
| Up to primary | 191 | 23.85 | (21.01 , 26.93) |
| Secondary | 241 | 30.09 | (27.00 , 33.36) |
| Higher | 91 | 11.36 | (09.34 , 13.76) |
| **Patient-respondent relationship (%)** |  |  |  |
| Parent | 509 | 63.55 | (60.14 , 66.82) |
| Sibling | 17 | 2.12 | (01.32 , 03.39) |
| Grandparent | 17 | 2.12 | (01.32 , 03.39) |
| Relative | 29 | 3.62 | (02.53 , 05.17) |
| Spouse | 52 | 6.49 | (04.98 , 08.43) |
| Offspring | 49 | 6.12 | (04.65 , 08.01) |
| Others (i.e. neighbor, friend, self) | 128 | 15.98 | (13.60 , 18.69) |
| **Caregivers occupation (considered multiple responses)** |  |  |  |
| Housewife | 702 | 90.00 | - |
| Students | 73 | 09.36 | - |
| Self-employment | 114 | 14.62 | - |
| Unemployed | 31 | 03.97 | - |
| Salaried employee | 103 | 13.21 | - |
| Business | 118 | 15.13 | - |
| Others | 130 | 16.67 | - |
| **Household size (%)** |  |  |  |
| Less than 3 | 32 | 4.00 | (02.84 , 05.60) |
| 3 to 5 | 458 | 57.18 | (53.72 , 60.57) |
| More than 5 | 311 | 38.83 | (35.50 , 42.26) |
| **Household size (Mean, SD)** | 5.59 | 02.93 | (05.59 , 02.93) |
| **Patient household monthly income in BDT (Mean, SD)** | 19,603 | 26,642 | (17756 , 21451) |
| **Patient household monthly expenditure in BDT (Mean, SD)** | 15,470 | 10,702 | (14727 , 16212) |
| **Overall healthcare expenditure last 3 months in BDT (Mean, SD)** | 5,191 | 17,745 | (3961 , 6422) |
| **Income quintile in BDT (Mean, SD)** |  |  |  |
| Poorest quintile | 190 | 7042 | (6786 , 7298) |
| 2nd | 168 | 10938 | (10789 , 11086) |
| 3rd | 123 | 14638 | (14513 , 14763) |
| 4th | 178 | 20288 | (19893 , 20683) |
| Upper quintile | 142 | 50106 | (41466 , 58746) |

 *Note:* *SD: Standard Deviation; CI: Confidence Interval*

Table 2: Distribution of average caregivers cost of diarrheal treatment for tertiary level hospital (N=801) BDT (US$)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Cost | Parameter | Overall cost | Inpatient cost | Outpatient cost |
| Average | SD | Average | SD | Average | SD |
| Out-of-pocket cost | Transportation cost | 123.29 (01.57) | 213.88 (02.72) | 189.18 (02.41) | 242.4 (03.09) | 56.24 (0.72) | 153.89 (01.96) |
| Informal payment (e.g. tips) | 07.40 (0.09) | 22.65 (0.29) | 14.23 (0.18) | 29.94 (0.38) | 0.45 (0.01) | 05.35 (0.07) |
| Caregiver’s payment | 0.01 (0.00) | 0.35 (0.00) | 0.00 (0.00) | 0.00 (0.00) | 0.03 (0.00) | 0.50 (0.01) |
| Caregivers expenditure (e.g. food, lodging) | 127.87 (01.63) | 456.8 (05.82) | 228.99 (02.92) | 438.94 (05.59) | 24.97 (0.32) | 452.15 (05.76) |
| **Total direct cost** |  | 258.57 (03.29) | 541.07 (06.89) | 432.4 (05.51) | 542.34 (06.91) | 81.69 (01.04) | 479.48 (06.11) |
| **In-direct cost** | Caregivers income loss | 1985.21 (25.29) | 2467.44 (31.43) | 3057.31 (38.95) | 2540.84 (32.37) | 894.2 (11.39) | 1834.02 (23.36) |
| **Total cost** |  | 2243.38 (28.58) | 2756.87 (35.12) | 3489.67 (44.45) | 2789.05 (35.53) | 975.11 (12.42) | 2059.31 (26.23) |

*Note: 1 US$ = 78.5 BDT; SD: Standard Deviation*

Table 3: Distribution of average care giver expenditure by socio-demographic characteristics (N=801), BDT, US$

|  |  |  |
| --- | --- | --- |
| **Variables** | **In-patients** | **Out-patients** |
| **Total cost** | **Direct** | **Indirect** | **Total cost** | **Direct** | **Indirect** |
| **Average** | **SD** | **Average** | **SD** | **Average** | **SD** | **Average** | **SD** | **Average** | **SD** | **Average** | **SD** |
| **Patient age in years** |  |  |  |  |  |  |  |  |  |  |  |  |
| Less than 5 | 4407 (56.14) | 2639 (33.62) | 558 (7.11) | 566 (7.21) | 3848 (49.02) | 2400 (30.57) | 1173 (14.94) | 2256 (28.74) | 94 (1.20) | 535 (6.82) | 1079 (13.75) | 2006 (25.55) |
| 5 to 12 | 2529 (32.22) | 1619 (20.62) | 411 (5.24) | 532 (6.78) | 2119 (26.99) | 1563 (19.91) | 246 (3.13) | 230 (2.93) | 34 (0.43) | 43 (0.55) | 212 (2.70) | 217 (2.76) |
| 13 to 19 | 3405 (43.38) | 2884 (36.74) | 261 (3.32) | 305 (3.89) | 3144 (40.05) | 2808 (35.77) | 58 (0.74) | 98 (1.25) | 34 (0.43) | 25 (0.32) | 44 (0.56) | 72 (0.92) |
| 20 to 64 | 2714 (34.57) | 2741 (34.92) | 318 (4.05) | 388 (4.94) | 2396 (30.52) | 2525 (32.17) | 132 (1.68) | 159 (2.03) | 40 (0.51) | 35 (0.45) | 110 (1.40) | 128 (1.63) |
| 64+ | 3777 (48.11) | 2833 (36.09) | 568 (7.24) | 852 (10.85) | 3209 (40.88) | 2441 (31.10) | 130 (1.66) | 183 (2.33) | 40 (0.51) | 18 (0.23) | 110 (1.40) | 155 (1.97) |
| ***P-value*** | <0.001 |  | <0.001 |  | <0.001 |  | <0.001 |  | 0.89 |  | <0.001  |  |
| **Gender** |  |  |  |  |  |  |  |  |  |  |  |  |
| Male | 3616 (46.06) | 3081 (39.25) | 437 (5.56) | 616 (7.85) | 3179 (40.50) | 2774 (35.33) | 953 (12.14) | 1896 (24.15) | 67 (0.85) | 213 (2.71) | 887 (11.29) | 1816 (23.14) |
| Female | 3357 (42.76) | 2446 (31.16) | 428 (5.45) | 454 (5.78) | 2929 (37.32) | 2271 (28.92) | 997 (12.7) | 2213 (28.19) | 96 (1.23) | 642 (8.18) | 902 (11.49) | 1856 (23.64) |
| ***P-value*** | 0.35 |  | 0.87 |  | 0.32 |  | 0.83 |  | 0.54 |  | 0.93 |  |
| **Household size** |  |  |  |  |  |  |  |  |  |  |  |  |
| Less than 3 | 2360 (30.06) | 2148 (27.36) | 244 (3.11) | 262 (3.34) | 2116 (26.96) | 2036 (25.93) | 52 (0.67) | 81 (1.03) | 20 (0.25) | 12 (0.15) | 44 (0.56) | 69 (0.88) |
| 3 to 5 | 3372 (42.95) | 2659 (33.88) | 423 (5.39) | 547 (6.97) | 2949 (37.56) | 2367 (30.16) | 1096 (13.96) | 2343 (29.84) | 96 (1.22) | 594 (7.57) | 1000 (12.74) | 2037 (25.95) |
| More than 5 | 3794 (48.33) | 2974 (37.88) | 471 (6.00) | 563 (7.18) | 3323 (42.33) | 2763 (35.20) | 790 (10.06) | 1419 (18.07) | 57 (0.73) | 93 (1.18) | 733 (9.33) | 1406 (17.92) |
| ***P-value*** | 0.03 |  | 0.13 |  | 0.05 |  | 0.20 |  | 0.71 |  | 0.20 |  |
| **Income quintile** |  |  |  |  |  |  |  |  |  |  |  |  |
| Poorest quintile | 3377 (43.02) | 2620 (33.37) | 379 (4.82) | 522 (6.65) | 2998 (38.19) | 2363 (30.11) | 1074 (13.68) | 2649 (33.75) | 125 (1.59) | 883 (11.25) | 950 (12.10) | 2065 (26.30) |
| 2nd | 3289 (41.90) | 2498 (31.82) | 433 (5.51) | 469 (5.98) | 2856 (36.39) | 2304 (29.35) | 790 (10.06) | 1424 (18.15) | 51 (0.65) | 70 (0.89) | 740 (9.43) | 1393 (17.75) |
| 3rd | 3568 (45.46) | 2468 (31.44) | 417 (5.31) | 518 (6.60) | 3151 (40.14) | 2296 (29.25) | 821 (10.46) | 1718 (21.89) | 48 (0.61) | 87 (1.11) | 774 (9.86) | 1708 (21.75) |
| 4th | 3334 (42.47) | 2880 (36.69) | 413 (5.26) | 473 (6.03) | 2921 (37.21) | 2599 (33.11) | 1096 (13.96) | 1975 (25.16) | 77 (0.98) | 285 (3.63) | 1019 (12.99) | 1875 (23.89) |
| Upper quintile | 3896 (49.62) | 3335 (42.48) | 519 (6.61) | 695 (8.86) | 3377 (43.02) | 3035 (38.66) | 1033 (13.16) | 2114 (26.93) | 89 (1.14) | 162 (2.06) | 945 (12.03) | 2052 (26.14) |
| ***P-value*** | 0.62 |  | 0.54 |  | 0.70 |  | 0.81 |  | 0.83 |  | 0.84 |  |
| **Overall** | 3490 (44.45) | 2789 (35.53) | 432 (5.51) | 542 (6.91) | 3057 (38.95) | 2541 (32.37) | 975 (12.42) | 2059 (26.23) | 82 (1.04) | 479 (6.11) | 894 (11.39) | 1834 (23.36) |

*Note: 1 US$ = 78.5 BDT; SD: Standard Deviation*

Figure: Caregivers time across age of the patients