

3. SOCIAL SECTORS IN TRANSITION

Section 2 described the challenges South Asia faces to achieve the MDGs and improve the quality, effectiveness, and efficiency of health and education. In this section, we focus on a number of emerging global and regional trends: economic growth led increasingly by the private sector, and changes in technology, labor markets, demography, and epidemiology. These trends are creating new opportunities as well as challenges for the education and health sectors in South Asia. Some of the changes are fundamental and inevitable; some opportunities, if properly exploited, can foster prosperity and improve the quality of life for the citizens in the region; some present downside risks that need to be managed with better policies and programs. Box 3.1 presents the main implications of these trends for the education and health sectors.

Box 3.1: Transition Impact Framework

Overall Trend	Implications for Education	Implications for Health
<p>Economic Growth</p> <p>Trends</p> <ul style="list-style-type: none"> • South Asia emerging as one of the engines of regional and global economic growth • South Asia increasingly integrating with the world economy <p>Opportunities</p> <ul style="list-style-type: none"> • New economic opportunities • Increasing purchasing power • Increased role of outsourcing <p>Challenges</p> <ul style="list-style-type: none"> • Accentuation of inequalities • Increasing vulnerability to global events 	<p>Opportunities</p> <ul style="list-style-type: none"> • More resources available for public education • Increased demand for educated and skilled workers <p>Challenges</p> <ul style="list-style-type: none"> • While countries are still under stress to achieve good quality universal primary education, more resources are needed for secondary education • Need for good quality higher education, including technical and vocational education and training (TVET), in line with global market needs • Need for continuing education and lifelong learning to upgrade skills and knowledge to adapt to rapid changes in labor markets • Risk of widening inequalities in education 	<p>Opportunities</p> <ul style="list-style-type: none"> • More resources for public health services and health infrastructure, including water and sanitation • Increasing business opportunities in health services—e.g., outsourcing and hospital care <p>Challenges</p> <ul style="list-style-type: none"> • Global trade agreements and intellectual property rights have implications for access to essential medicines and technologies • Risk of increase in health inequalities • Globalization increases threats of cross-border and faster spread of diseases and epidemics—e.g., severe acute respiratory syndrome (SARS) and avian influenza
<p>Technological Changes</p> <p>Trend</p> <ul style="list-style-type: none"> • Access to and use of information and communication technology (ICT) is increasing <p>Opportunities</p> <ul style="list-style-type: none"> • Anything that can be digitized is becoming tradable, facilitating outsourcing, particularly of services 	<p>Opportunities</p> <ul style="list-style-type: none"> • Improving access and quality of education • Enhancing teaching and learning experience by using ICT • ICT as a tool for education governance <p>Challenges</p> <ul style="list-style-type: none"> • Technology is changing the labor skills 	<p>Opportunities</p> <ul style="list-style-type: none"> • Improving health service provision by remotely located health workers • Technology leveraged to strengthen governance and transparency • New opportunities to strengthen disease surveillance with more

Box 3.1, continued

Overall Trend	Implications for Education	Implications for Health
<ul style="list-style-type: none"> • Faster spread of information can improve delivery of public services and improve governance • Communications and increasing technology-driven networking redefine ways people and governments work <p>Challenges</p> <ul style="list-style-type: none"> • Increasing demand for skilled and highly skilled labor • Digital divide can lead to increasing disparity in access to economic opportunities 	<p>in demand: need to reskill labor</p> <ul style="list-style-type: none"> • Demand for higher education and higher skill is increasing • Need for additional investment to facilitate technology adoption in classrooms • Need to retrain education workers as the skills mix required for delivering education may change • Potential exclusion of the poor from opportunities in ICT and other markets 	<ul style="list-style-type: none"> • prompt response to outbreaks • Potential to reduce information asymmetry in health care provision • Technology-enabled unbundling and outsourcing create new business opportunities <p>Challenges</p> <ul style="list-style-type: none"> • Training existing health staff in using new technology • Curriculum changes in training of health workers to keep pace with changing technology • Demand for specialized health care skills to meet demands of health service outsourcing at the cost of domestic public health needs • Rapid dissemination of information on disease spread can create panic and financial market crisis
<p>Labor Market Transformation Trend</p> <ul style="list-style-type: none"> • Increasing labor mobility, within and across countries <p>Opportunities</p> <ul style="list-style-type: none"> • Domestic and international labor mobility allow for better skills match • Language as leverage for South Asians in the international labor market <p>Challenges</p> <ul style="list-style-type: none"> • Rapid and uncontrolled urbanization • Labor skills need to cater to global labor market requirements 	<p>Opportunity</p> <ul style="list-style-type: none"> • Labor market includes both national and international markets <p>Challenges</p> <ul style="list-style-type: none"> • Increased challenge for the governments to align education and training investments in the country with both national and international labor markets • Need for higher and more diversified skills; including for English language, communication, and life skills • Migration of teachers and TVET instructors to other countries, from public to private sectors, among sectors, and from rural to urban areas 	<p>Challenges</p> <ul style="list-style-type: none"> • Rapid urbanization further stresses weak urban primary health care systems • Growing urban slums exhibit greater vulnerability to emerging diseases • Potential worsening of human resource shortage in rural areas
<p>Private Provision of Social Services Trend</p> <ul style="list-style-type: none"> • Increasing role of the private sector in social service delivery <p>Opportunities</p> <ul style="list-style-type: none"> • Private sector setting higher benchmarks in quality and consumer satisfaction • Increasing employment opportunities in the private sector • Public-private partnerships in public services <p>Challenges</p> <ul style="list-style-type: none"> • Aggravation of income- and skill-based inequalities 	<p>Opportunities</p> <ul style="list-style-type: none"> • Partnerships with the private sector for provision and financing of education services • Benchmarking and competition with the private sector may improve quality in the public sector <p>Challenges</p> <ul style="list-style-type: none"> • Need to refine frameworks for facilitating public-private partnerships • Need to strengthen governments' capacity in regulation, facilitation, standards-setting, and quality assurance • Potential worsening of inequalities between poor and nonpoor students 	<p>Opportunities</p> <ul style="list-style-type: none"> • New partners in provision and financing of health services • Involvement of the private sector in risk pooling and mitigation • Benchmark setting and competition provided by the private sector may improve quality in the public sector <p>Challenges</p> <ul style="list-style-type: none"> • Potential aggravation of inequities in health care use and outcomes • Weak public sector capacity to regulate the private sector,

Box 3.1, continued

Overall Trend	Implications for Education	Implications for Health
<ul style="list-style-type: none"> • Need for effective public policy to mitigate market failures and regulate the private sector • Development of innovative partnerships between public and private sectors to enhance social service delivery 	<ul style="list-style-type: none"> • Greater demand for educated and skilled labor requires strengthening of linkages between TVET and the private sector • Potential shortage of government teachers opting for private education or lucrative nonteaching jobs 	<p>including for disease surveillance</p> <ul style="list-style-type: none"> • Potential overall shortage of human resources in the health sector as people opt for more lucrative careers in the private sector • Escalation of health care cost with potential for increase in unwarranted medical procedures and use of prescription medicines
Demographic Transition Trend	Opportunities	Opportunities
<ul style="list-style-type: none"> • 0–9 year age group is likely to stabilize in size by 2015 • 10–19, 20–29, and 30–39 year groups are going to increase significantly • Increasing older population in both the developed and developing countries 	<ul style="list-style-type: none"> • Demand for primary schooling stabilizes • Education systems can focus on quality as access issues stabilize • Larger working age population increases tax revenues to improve public education 	<ul style="list-style-type: none"> • Increased tax revenues to improve public health
Opportunities	Challenges	Challenges
<ul style="list-style-type: none"> • Demographic dividend if the right skills and opportunities can be provided • Larger tax base, with increasing resource availability to governments • Lower child dependency ratio 	<ul style="list-style-type: none"> • Increasing demand for secondary, postsecondary, and TVET education • More prospective secondary and higher education students coming from poor households • Challenge to sustain the quality and coverage of primary education while mobilizing more resources to deal with the increasing number of students entering secondary schools 	<ul style="list-style-type: none"> • Adapting the health systems to the changing demographic structure • Maintaining services for mother and child health while the health systems adjust to the needs of demographic and epidemiological transition • Increasing risk of sexually transmitted diseases, including HIV/AIDS, with current poor health status in the adolescent population • Demand for health workers and health services from an aging developed world
Epidemiological Transition Trend	Opportunity	Opportunity
<ul style="list-style-type: none"> • Shift of disease burden from communicable to noncommunicable diseases 	<ul style="list-style-type: none"> • Better education outcomes with decreasing school absenteeism due to lower communicable disease burden 	<ul style="list-style-type: none"> • Freeing-up of resources from communicable disease treatment
Opportunity	Challenge	Challenges
<ul style="list-style-type: none"> • Reduction in communicable disease burden especially among the better off 	<ul style="list-style-type: none"> • Need to integrate health education in school curricula to deal with the challenges of both noncommunicable and communicable diseases affecting mainly the young (HIV/AIDS) 	<ul style="list-style-type: none"> • Primary health care services ill-prepared for noncommunicable diseases • Need for risk pooling (insurance) due to costly noncommunicable diseases • Potential double burden of susceptibility to both communicable and noncommunicable diseases for the poor
Challenge		
<ul style="list-style-type: none"> • Increase in share of noncommunicable diseases, with considerably higher treatment costs 		

Economic Growth

South Asia has been recording rapid economic growth over the past few years. Provided the right policy choices are made, South Asia could emerge as an engine of Asian and global economic growth. Part of the growth is being fueled by South Asia's increasing integration with the world economy through rising trade flows (UNDP 2006). South Asia's participation in international trade, while still low compared to that of other regions, has accelerated rapidly in recent years. Economic reforms and the globalizing environment are driving the improving performance of South Asia's external sector (ADB 2007b).

This growth process has rapidly been creating and dividing winners and losers. People with the right skill mix have been able to benefit from the rapid economic expansion through employment and rising incomes. The benefits of these increased incomes from economic growth and lower trade barriers are also spreading to the wider economy through increased domestic consumption. At the same time, the growth process threatens to leave behind a large proportion of the region's population that works in traditional, low-income agricultural or nonformal occupations. For example, in India people benefiting from business process outsourcing (BPO) are "part of a small, educated elite," whereas India needs "more productive agriculture ... and job creation both in labor-intensive industry and in lower productivity services" (ADB 2007a). While the overall consensus on the economic prospects and potential of the region has been generally positive, poorly managed economic integration in the world economy, including its financial systems, increases vulnerability. The flexibility with which global manufacturing and services can be shifted may increase job uncertainty. The total cost of production will be the key determinant of a producer's decision on where the manufacturing or services industry will be located. Capital deployment has become extremely mobile in an increasingly "borderless world" (Ohmae 1990). Producers, investors, and employers are growing ever more nimble. Hence, South Asia will need to become and remain globally competitive (box 3.2).

Thus, the growth trend presents several challenges and opportunities. Education systems, in particular, will need to be prepared to quickly provide new skills that are in line with changing labor market demands. People who lose their jobs or livelihoods due to the forces of globalization will require social protection between jobs (Sipahimalani-Rao 2006). The social sectors will also need to respond if the benefits of growth are to reach all strata of society. Globalization will pose new challenges to the health systems, as countries have to deal with the risk of international transfer of diseases (Frenk and Gomez-Dantes 2002).

Box 3.2: Global Competitiveness, Education, and Health

The *Global Competitiveness Report 2006–2007* ranked countries using a global competitiveness index based on nine pillars: institutions, infrastructure, macroeconomy, health and primary education, higher education and training, market efficiency, technological readiness, business sophistication, and innovation (*World Economic Forum 2006*). The components of pillars relating to education and health are as follows:

- (1) Fourth Pillar: Health and Primary Education
 - (a) Health
 - 4.01 Medium-term business impact of malaria
 - 4.02 Medium-term business impact of tuberculosis
 - 4.03 Medium-term business impact of HIV/AIDS
 - 4.04 Infant mortality
 - 4.05 Life expectancy
 - 4.06 Tuberculosis prevalence
 - 4.07 Malaria prevalence
 - 4.08 HIV/AIDS prevalence
 - (b) Primary education
 - 4.09 Primary enrollment
- (2) Fifth pillar: Higher education and training
 - (a) Quantity of education
 - 5.01 Secondary enrollment ratio
 - 5.02 Tertiary enrollment ratio
 - (b) Quality of education
 - 5.03 Quality of the educational system
 - 5.04 Quality of math and science education
 - 5.05 Quality of management schools
 - (c) On-the-job training
 - 5.06 Local availability of specialized research and training services
 - 5.07 Extent of staff training

The report ranks 125 countries. The table below shows the rankings for five South Asian countries. India, which has the highest overall ranking for South Asia, performs poorly in pillar 4 relating to health and primary education, with only Sri Lanka ranking relatively high. For pillar 5, only India ranks reasonably high. (Afghanistan, Bhutan, and Nepal are not among the 125 countries ranked.)

Note: Lall (2001) questions the methodology used in the *Global Competitiveness Report's* analysis.

Global Competitiveness Ranking of Five South Asian Countries

	1	2	3	4	5	6	7	8	9
Pillar	Institutions	Infrastructure	Macroeconomy	Health and Primary Education	Higher Education and Training	Market Efficiencies	Technological Readiness	Business Sophistication	Innovation
Sector	Institutions	Infrastructure	Macroeconomy	Health and Primary Education	Higher Education and Training	Market Efficiencies	Technological Readiness	Business Sophistication	Innovation
Bangladesh	121	117	47	90	108	83	114	96	109
India	34	60	88	93	49	21	55	25	26
Nepal	99	122	59	102	109	105	116	108	112
Pakistan	79	67	86	108	104	54	89	66	60
Sri Lanka	82	76	110	36	81	71	83	71	53

The education sector also has to deliver the higher knowledge and skills required in the labor force as South Asia moves up the development ladder. Whether catering to international or domestic demand, skill requirements are bound to increase as manufacturing and services become more sophisticated. Governments face the dual challenges of aligning education investments with national and international labor markets, while at the same time making growth inclusive by promoting human development on the broadest possible scale. During the transition phase, more resources will be needed for secondary and postsecondary education (Devarajan and Nabi 2006). This may put countries under stress while they are still struggling to achieve universal primary education. However, in the longer run, increased income, a growing economically active population, and a growing middle class are expected to provide a wider tax base that will make more resources available for education and other social sector investments.

The Asia-Pacific Human Development Report 2006 aptly sums up the situation: “the Asia-Pacific region has embraced free trade, but free trade will not embrace the poor unless countries pursue a bold new policy agenda harnessing economic growth to promote human development” (UNDP 2006).

Technological Changes

A second trend is the ongoing development and dissemination of ICT on a global scale (UNDP 2001 and 2005). Access to and use of ICT has been steadily increasing in South Asia (table 3.1). Mobile phone use had increased dramatically to about 117 million subscribers by 2005 from a very low base in the mid-1990s. Information technology is also widespread, with a significant rise in the number of Internet users and personal computers in the region.

The technological breakthroughs have boosted outsourcing and exports of ICT-enabled services (Friedman 2005). Technology now

Table 3.1: Technology and Infrastructure Data, 1997 and 2002

Category	World		South Asia	
	1995	2005	1995	2005
Fixed Lines and Mobile Telephones (per 1,000 people)	137.8	522.6	12.1	118.9
Personal Computers (per 1,000 people)	42.0	130.4 ^a	1.6	15.5
Internet Users (per 1,000 people)	8.0	136.7	0.2	49.0

^a 2004 data.

Source: World Bank. World Development Indicators Database.
www.worldbank.org/data/countrydata/countrydata.html. Accessed June 2007.

allows parts of the production process to be unbundled and shifted to locations where they can be executed at a lower cost. Anything that can be digitized and done remotely now provides an opportunity for outsourcing (*The Economist* 2007b). South Asia, with its relatively inexpensive skilled labor, has benefited from these advances. The availability of skilled, English-speaking labor and low costs have driven Asia's growth in BPO at more than 10% per annum in the last few years. India, in particular, has seen the number of outsourced jobs, mostly in ICT, grow rapidly and is the world's number one destination for them; the process has raised the incomes of the highly skilled and is contributing to the growth of some urban centers. India accounts for 40% of the global BPO market, and has had 260,000 jobs created in the sector since the beginning of the BPO outsourcing trend (*The Economist* 2005, 2006a, 2006b, and 2006d). The new technology also provides the opportunity to outsource medical services such as analyzing X-rays (*The Economist* 2004b and 2006c).

However, India is increasingly facing a supply gap of these highly skilled workers. Consequently, offered wages are increasing and employee turnover is high. The number and qualifications of graduates from the top Indian universities may not suffice to fill this gap (ADB 2007a). For India to keep its comparative advantage, more highly skilled labor is needed. India has to provide good quality, relevant education to more students—the overall quality of the education system should improve.

Technology also has a profound impact on the way education can be provided (Chittaro and Ranon 2007 and ADB 2001b and 2005a). ICT can improve access to education by remote communities and enhance the quality of teaching and learning. ICT applications can be used to improve governance and efficiency in education (although its use should be evaluated for cost effectiveness versus traditional methods). The role of teachers can be altered significantly as learning can become less teacher-driven and more student-controlled, with teachers becoming moderators or facilitators of learning. Technology can also be a key driver in improving the effectiveness of health care. ICT can be used to inform the population more effectively about health-related issues like child mortality, maternal health, and HIV/AIDS, malaria, and other major diseases. With the help of new technologies, access to health care in remote areas can be improved. Health workers with access to relevant web-based content in the local language can deliver health care for common diseases more reliably (Zolfo et al. 2006).

Labor Market Transformation

Labor markets in South Asia are being transformed by economic growth, technological change, and changes in government policies and international agreements, among other factors. Work opportunities for South Asians are local as well as international (ADB 2004e). The global and regional trends will create jobs for people who have the

right skills and education, but will not address the region's larger challenges for employment generation. (For more information on underemployment, job creation, and policy measures for economic growth that generates jobs, see Felipe and Hasan 2007.)

South Asian workers are now more mobile, moving from rural to urban areas as a result of domestic labor market changes, and increasingly seeking employment opportunities in other countries (Sheldon 2006). Shortages of highly skilled, skilled, and semiskilled workers are expected to continue. Labor markets in South Asia are now more affected by changes in international demand for South Asian products and services. Greater integration with global markets has increased competition from other countries and the vulnerability of domestic labor markets to economic recessions elsewhere. In addition, large segments of the population work in the informal sector or under informal contracts, with little or no social protection. The demand for better paid jobs in urban areas in particular skills is leading to labor shortages in rural areas for those skills or services. For example, anesthetists are increasingly in demand in urban private clinics and are therefore in short supply outside the larger towns and cities, with serious implications for maternal mortality and morbidity. Other such shortages have implications for the education and health sectors.

Demand for South Asian labor in the international market is strong, particularly in the Middle East. Foreign remittances from expatriate workers contribute significantly to South Asia's gross national product (Devarajan and Nabi 2006). The international demand for semiskilled and skilled work exceeds the supply from South Asia. For example, in 2001 Nepalese agencies sought almost 56,000 skilled and semiskilled workers, but fewer than 900 were recruited (NIDS 2003), while in 2004 Sri Lanka had over 366,000 job requests from foreign countries, but could supply less than 43% of these, and only 20% of the demand for technicians and professionals. With this demand trend for overseas contract workers likely to continue into the future, more semiskilled and skilled workers will be needed. The South Asian economies need to systematically address the expected shortfalls, lest they become constraints to sustainable economic growth (Devarajan and Nabi 2006). Demand for market-relevant TVET will continue in a wide range of sectors, from infrastructure to health care. In addition, employers are looking for workers that have good communication skills, especially in English, and good practical skills and work attitudes.

Despite the sources of growth in labor demand, much unemployment and underemployment persists, reflecting the region's inability to meet the opportunities from international labor markets, and the mismatch of demand and supply of labor with appropriate knowledge and skills. For example, many school leavers are unable to find work in agriculture, manufacturing, and services, and are resorting to jobs with little potential for growth. The physical capacities of current TVET institutions are low compared with other regions of

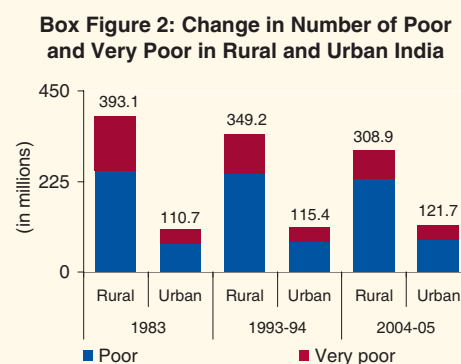
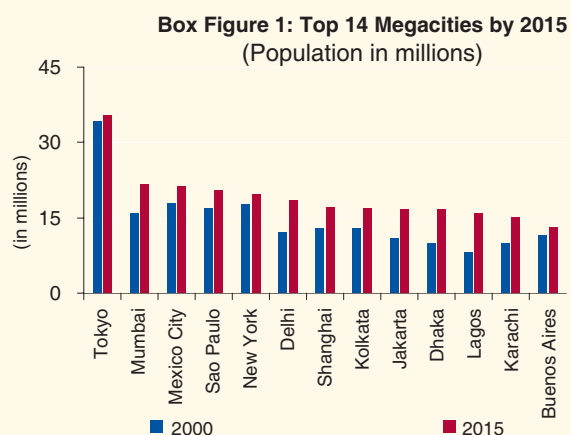
the world (figure 2.3), and their ability to respond to the dynamic needs of international and domestic labor markets is also limited. For example, India has only 12,000 training and vocational institutes, while the People's Republic of China has 500,000 vocational schools (Government of India 2006). Thus, education and training represent a crucial long-term investment, and identifying the education and training strategies that will allow youth to take advantage of growing domestic and international economic opportunities is critical.

Due to rapid economic growth in urban centers combined with slower growth of employment opportunities in rural areas, many poor people are migrating from rural to urban areas (box 3.3). This migration is stretching already weak urban infrastructure. New investments are unable to keep pace with the inflow of migrants, resulting in a steady increase in urban slums (Sclar, Garau, and Carolini 2005). Overcrowded slums with minimal basic services provide a harsh physical and social environment; hence, the worst child health indicators occur in the poorest income quintile of urban households.

Box 3.3: Urbanization of the Poor

Urbanization of the poor is occurring more slowly in South Asia than in other parts of the world (Ravallion 2002, Munshi and Rosenzweig 2005); however, the increasing number of absolute poor people in urban areas has serious policy implications. The urban population in South Asia, which was close to 27% in 2000, is likely to reach 32% by 2015. According to United Nations (UN) statistics, in 2015 South Asia will have 5 of the world's largest 14 megacities (box figure 1): Delhi, Dhaka, Karachi, Kolkata, and Mumbai.

In the 2001 census, approximately 31 million people, or 23% of Bangladesh's population, lived in urban areas, and this was increasing at 6% per annum. About 25% of the urban population is very poor and lives mostly in slums. Although hardcore poverty (defined as food availability of less than 1,805 kilocalories per day per person) decreased in rural areas by 1.36 million households between 1991 (4.83 million) and 2000 (3.47 million), it increased by 0.53 million in urban areas (from 0.65 million in 1991 to 1.18 million in 2000). The absolute number of the poor and very poor in urban areas of India increased similarly (box figure 2). India's rural poor population declined by 85 million between 1983 and 2004–2005, but the number of poor increased by 11 million in urban areas during the same period.



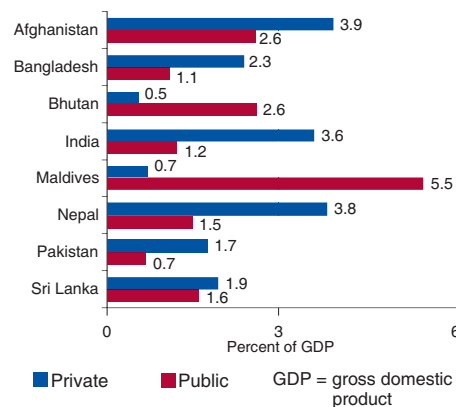
Source: Economic and Political Weekly. 2007. Poverty and Inequality: All-India and States, 1983–2005. 10 February.

Most countries in the region have weak primary health care systems, especially in urban areas, and an extremely limited ability to respond to health emergencies. Poor people migrating to urban slums must endure dismal living conditions, severe social tensions, and other hardships.² With new and emerging diseases that can spread on a pandemic scale and cause large-scale human and financial disaster, urban slums may remain the weakest link in global efforts to contain diseases like HIV/AIDS, tuberculosis, and avian influenza.

Private Sector Growth

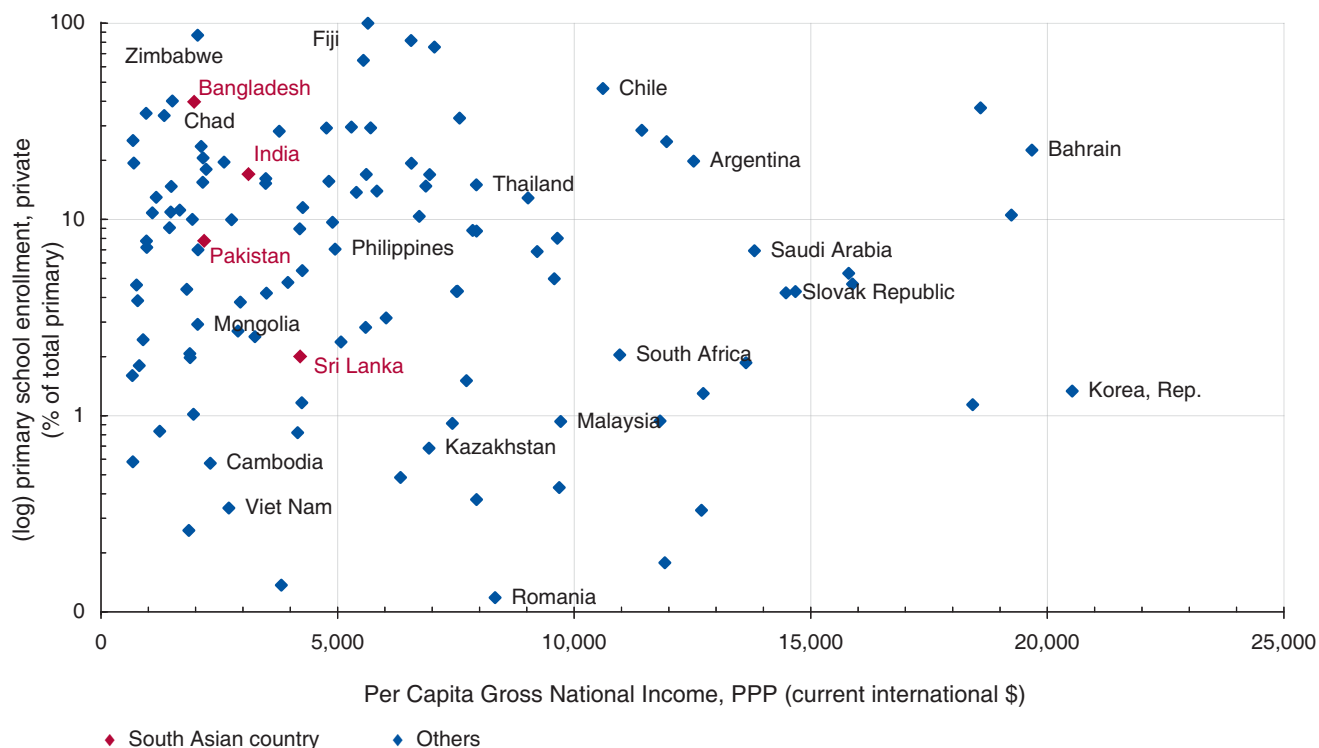
The main engine of economic growth in South Asia has been the private sector, and more and more industries and services are dominated by it. Sustained growth of the private sector and its integration with global markets in the region will depend partly on the availability of highly trained people with relevant skills. Vocational and higher education will therefore gain greater significance (UNESCO 2004). Already, many private industrial firms are attempting to fill the gap through in-house training of new recruits. Enrollments in private schools are increasing in the region (figure 3.1), with 39% of students enrolled in private schools at the primary level in Bangladesh, followed by 17% in India. The private sector is also responding to the inadequacies of public sector health care.

Figure 3.2: Public and Private Expenditure on Health



Source: World Bank. 2007. *World Development Indicators 2006*. Washington DC. (Data pertain to 2003.)

Figure 3.1: Enrollment in Private Primary Schools vis-à-vis Per Capita Gross National Income



◆ South Asian country ◆ Others
 Note: Each dot represents one country, although only a few are named.
 Source: World Bank. 2007. *World Development Indicators*. Washington DC

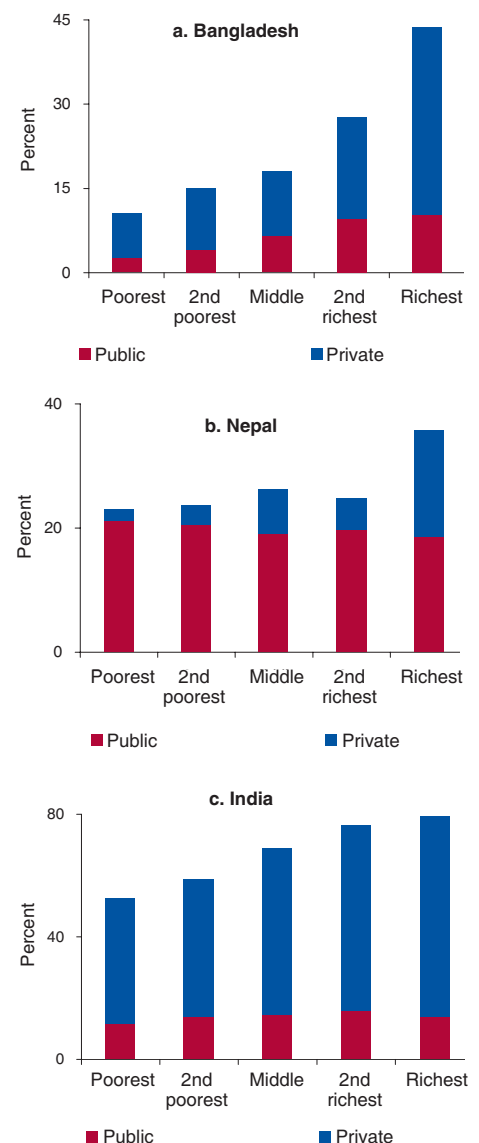
The growth of the private sector in education includes both nonprofit and for-profit provision of education and training. The choices for education and vocational training are increasing in South Asia. With economic growth and increasing incomes, more parents are willing to send their children to private schools and private coaching lessons to augment classroom learning; however, this aggravates the divide between the rich and the poor. A large number of higher education institutions are being opened in the private sector, which also raises concerns about access to higher education for the poor. Improving equity in access to quality education will become a serious concern as the private education sector increases in South Asia. With increased nongovernmental provision of education, the role of governments to facilitate, instead of provide, education will need to be strengthened. Measures to monitor the quality of education and regulate private schools will be necessary (ADB 2004f).

Health systems in South Asia are dominated by private expenditures, which tend to increase rapidly with household income (figures 3.2 and 3.3). The proportion of private health expenditure to total health expenditure in this region surpasses that of most countries in the world. The private sector is a major provider of health services—including treatment of communicable diseases such as diarrhea, childhood pneumonia, malaria, and tuberculosis. Private health systems in most South Asian countries are diverse, largely unregulated, and often not coordinated with the public health systems.

While the private sector in South Asia has made curative services more accessible to the population, unregulated private health services are partly responsible for inappropriate prescriptions of drugs, resulting in an increased incidence of drug resistance and other adverse impacts. The rich can overcome public health sector failure by availing of high-cost, high-quality private health care. However, without appropriate health financing mechanisms, the poor must either settle for the available public health care or seek lower-end, unregulated private health care.

A large share of private health services is also provided by the informal sector, mainly by pharmacists and unqualified practitioners. The private sector is less interested in the “public” good part of the health care such as childhood immunization, disease surveillance, and health promotional activities. Private providers often do not share information among themselves or with public health systems. This is a recipe for a health care disaster. Without proper information sharing, otherwise controllable situations may become full-blown epidemics, with knowledge often spread through media reporting rather than public health surveillance. Where households prefer, or only have access to, private providers, the largely government-run health services, such as childhood immunization and tuberculosis and HIV/AIDS control, are increasingly becoming less effective due to underuse.

Figure 3.3: Use of Health Facilities for Acute Respiratory Illness, by Wealth Quintile



Sources: Demographic and health surveys (see pp. viii–ix).

Demographic Transition

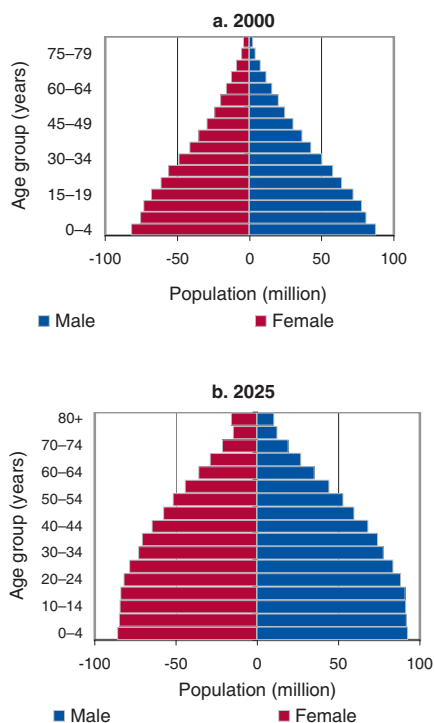
South Asia is undergoing a demographic transition from high to lower birth and death rates. As a result, during the next 4–5 decades, South Asia’s population in the 0–9 year age group will stabilize, while that aged 10–39 years will increase steadily. The structure of the population pyramid is going to flatten as the percentage of young and working age people grows (figure 3.4); the population above 60 years will increase, initially slowly, but on a significant scale in South Asia after 2025.

The population in the 0–9 year age group, which was about 325 million in 2000, is likely to stabilize at around 350 million by 2015. However, the 10–39 year age group will increase significantly due to high fertility in the past. By 2025, the populations in age groups 0–9, 10–19, 20–29, and 30–39 are likely to increase by 30 million, 60 million, 90 million, and 110 million, respectively (figure 3.5), from their 2000 levels.

When a relatively large share of the population reaches the economically active years, and if the economic circumstances and social sector and labor market policies are right, economic growth can be enhanced (1) due to the higher share of the population that is working, saving, and paying taxes; (2) from the potential this offers for more rapid investment; and (3) because of reduced spending on dependents. This phenomenon, known as the “demographic dividend” (Bloom, Canning, and Sevilla 2002), arises only if the burgeoning labor force has the right skills and opportunities to contribute to economic growth. In South Asia, one result of the changing demographics and labor market opportunities is that demand for secondary and postsecondary education is estimated to increase by 20% between 2000 and 2015, and by 30% between 2015 and 2025.

The demographic changes will have a range of implications for health systems. First, a healthy population will be better able to contribute to economic growth and, hence, to realize the demographic dividend. Second, a larger working-age population will have an increased likelihood of risky sexual behavior. HIV/AIDS in large parts of South Asia has not yet spread to the general population, but the increasing number of young adults may become the tipping point for HIV/AIDS to expand from an epidemic in high-risk groups to an epidemic in the general population if effective control measures are not taken. Third, the increasing young and middle-aged population will accelerate the epidemiological transition from communicable diseases to noncommunicable diseases. Finally, by 2050, the population aged 60 years and older will increase more than fivefold from 2000 levels. Old age care will need greater attention in the next few decades. Overall, health financing needs are going to increase significantly due to these demographic changes.

Figure 3.4: Changing Population Pyramid in South Asia, 2000–2050

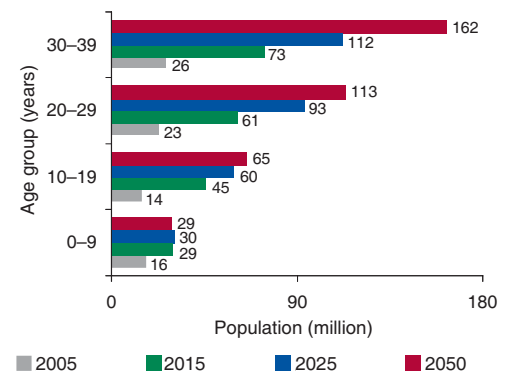


Source: Census Bureau of United States, International Data.

A large part of the demographic momentum is likely to come from rural areas and from poor households that depend on public schools and health services. Given the poor track record of public services in rural areas, much of the population entering the 10–29 age group is likely to be underskilled and unprepared to reap the benefits of an expanding economy. The rural youth need to catch up with youth from more privileged urban households or the demographic dividend will become a demographic divide, with potentially serious social and political ramifications (World Bank 2007).

Demographic changes in the developed world are also likely to create opportunities and challenges for South Asia. We are likely to witness an increasing trend toward outsourcing of medical care from the developed world (box 3.4 p. 28). An aging population in the developed world and increasing dependency ratios might lead to an increasing demand for medical personnel from South Asia. This could upset the availability of health workers in the region, a trend that needs to be carefully monitored and addressed.

Figure 3.5: Population Momentum in South Asia: Additional Children and Youth, to the 2000 Base Figures



Note: The base age group populations in 2000 are 326 million for age 0–9, 291 million for 10–19, 240 million for 20–29, and 184 million for 30–39.

Source: Census Bureau of United States, International Data.

Box 3.4: Medical Outsourcing

Medical outsourcing refers to patients traveling from abroad for medical care due to high costs and long waiting times in their own countries (Connell 2006). This trend is likely to increase with the aging population in the developed world, the increasing dependency ratio, and severe stress on social security systems resulting from increasing health care demand and costs.

Medical outsourcing has grown rapidly in India (Connell 2006; Milstein and Smith 2007; and *The Economist* 2004a, 2007a), Singapore, and Thailand in the last decade, assisted by large price differentials and highly trained doctors, privatization of health care, accelerated globalization of health care and tourism, new technologies and skills, reduced transport costs, and Internet marketing. To accelerate the growth of medical outsourcing, potential patients must be convinced that medical care and hygiene in developing countries are comparable with that in their own countries. As South Asian countries become an important global destination, they will need to upgrade technology, absorb Western medical protocols, and maintain low costs and good management.

Medical outsourcing received a boost in India following economic liberalization in the mid-1990s. Private hospitals expanded using imported technology and medical goods. As salaries improved, doctors returned from abroad with international qualifications and western experience. Global migration of doctors has also assisted medical outsourcing as patients in the developed world have become used to being treated by doctors from South Asia. About 150,000 medical tourists went to India in 2002, half of them from the Middle East. India predicts it will earn \$2 billion annually from medical outsourcing by 2012.

Although medical outsourcing will give impetus to economic growth in the region, it could also distort the availability of medical care away from South Asia's poor as the health systems cater to clients from the developed world.

Epidemiological Transition

The epidemiological transition is important to South Asia for the following reasons:

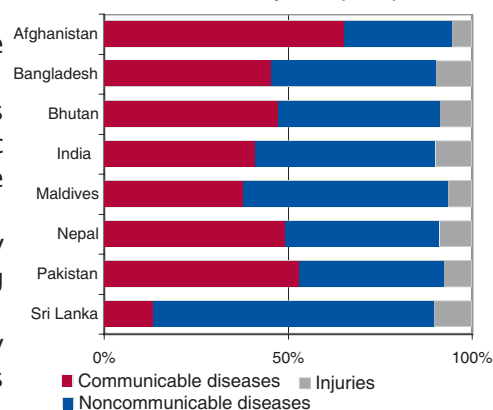
- the shift in the burden of diseases to noncommunicable diseases will increase health care costs, leading to increased catastrophic out-of-pocket health expenditures for the less well-off in the absence of health insurance;
- the poor are likely to suffer from a double burden of susceptibility to communicable and noncommunicable diseases, aggravating the inequalities they already face; and
- early onset of noncommunicable diseases can adversely affect labor productivity in the region and reduce the region's competitive edge.

Most South Asian countries are undergoing the epidemiological transition (Basnyat and Rajapaksa 2004). In South Asia, almost half of the disease burden is due to noncommunicable diseases, having risen by 10% since 1990. Moreover, as noted above, the burden of injuries is increasing in the region. Sri Lanka is in an advanced stage of the epidemiological transition, and in other South Asian countries the burden of communicable diseases is already lower than 50% except in Afghanistan and Pakistan (figure 3.6). Cardiovascular diseases and stroke are the largest sources of this burden. By 2020, the burden of disease in India from infectious, maternal, nutritional, and perinatal causes is likely to decline to 24% of the total, while the rest will comprise noncommunicable diseases (57%) and injuries (19%) (Murray and Lopez 1997). As indicated by figure 3.7, some of the risk factors for noncommunicable disease—including tobacco and alcohol consumption—are most common among the poorest population in South Asia (Ezzati et al. 2002; Room, Babor, and Rehm 2005).

By 2025, 6% of people in India and about 9% of people in Pakistan are expected to have diabetes. Cardiovascular deaths already account for 32% of all deaths in India. A third of Pakistan's adults have hypertension. Hypertension is high in South Asia due to risk factors like obesity, diabetes, smoking, and sedentary lifestyle. In India 52% of cardiovascular deaths occur among people below 70 years, whereas in the developed world it is only 22%, indicating the early onset of noncommunicable diseases in South Asia. Without effective health promotion and preventive activities to mitigate this burden, the incidence of noncommunicable diseases is likely to increase in relatively younger age groups, and much of this burden will occur during the productive middle age, adversely affecting labor productivity in the region (Danaei et al. 2006).

The treatment of noncommunicable diseases often requires expensive hospital care, which can be financially catastrophic in the absence of health insurance. Of approximately 24 million people who were hospitalized in India in 2004, about 10 million had hospital

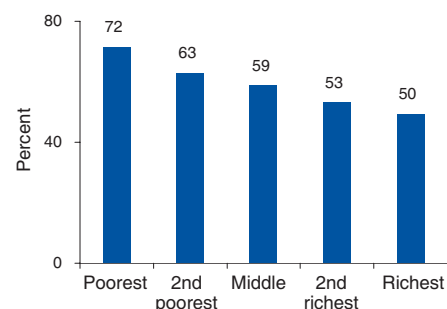
Figure 3.6: Proportion of Deaths Due To Disease and Injuries (2002)



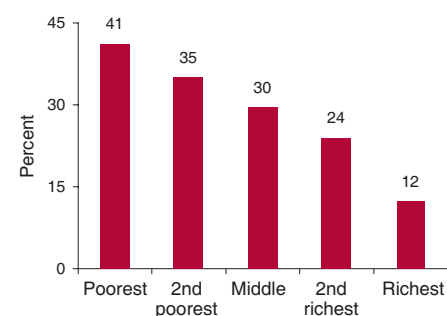
Source: World Health Organization. 2002. Global Burden of Disease Estimates. www.who.int/healthinfo/bodestimates/en.print.html. Accessed in June 2007.

Figure 3.7: Tobacco Use, by Wealth Quintile

a. Men (15–54 years) in Bangladesh, 2004



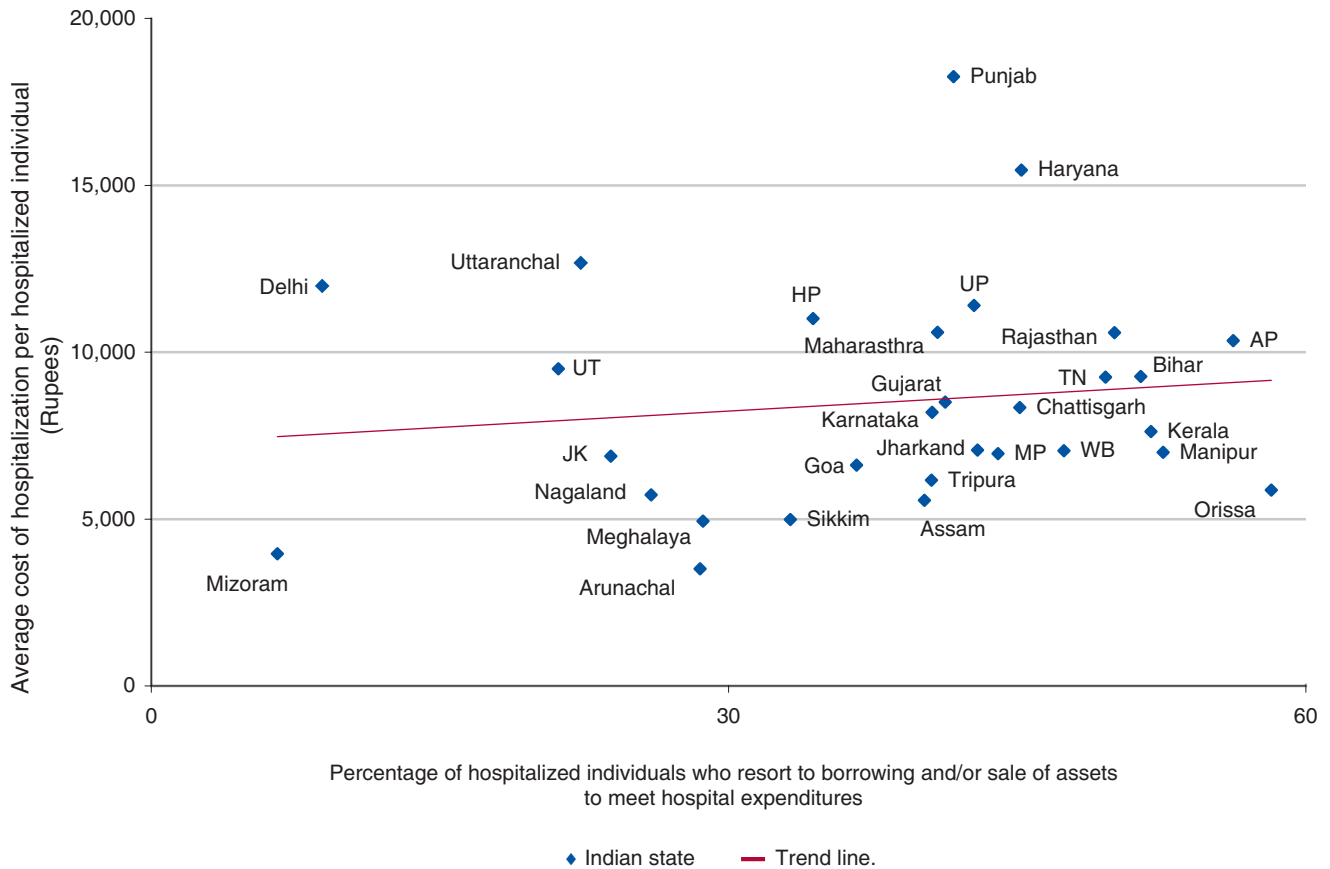
b. Women (15–49 years) in Nepal, 2001



Source: Demographic and health survey data (see pp. viii–ix).

expenditures exceeding 10% of their annual household expenditures. A majority of these people had to sell assets and/or borrow to meet the health care costs, increasing the likelihood of them becoming, or staying, impoverished. Figure 3.8 provides an example from Indian states, where from just below 10% to nearly 60% of hospitalized people had to borrow money or sell assets to pay hospital bills.

Figure 3.8: Borrowing and/or Sale of Assets to Meet Catastrophic Hospital Costs in Indian States (2004)



AP=Andhra Pradesh, HP=Himachal Pradesh, JK=Jammu and Kashmir, MP=Madhya Pradesh, TN=Tamil Nadu, UP=Uttar Pradesh, UT=Union Territories, WB=West Bengal.
 Source: National Sample Survey Organization. 2006. Morbidity, Health Care and Condition of the Aged: NSSO 60th Round (January–June 2004). National Sample Survey Organization, Ministry of Statistics and Programme Implementation, Government of India, New Delhi.