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An Analysis of Diseases Burden and Out of Pocket Health Expenditure among South Asian Countries

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ABSTRACT

Health is an important determinant of human development, which is about enhancing freedom of human beings. Good health brings freedom to people to enjoy their life and attain desires. Incidence of diseases curtails this freedom of people and incurs burden on households and society. In this broader background the present paper attempts to examine burden of diseases and out of pocket expenditure on health in South Asian countries. This region is home to large proportion of poor people; and high incidence of diseases is likely to put more burdens. Information on diseases, i.e., number of deaths by causes has been collected from WHO data base and data on expenditure on health is obtained from World Bank's World Development Indicators. The analysis reveals that non-communicable diseases have increased between 2000 and 2015; and communicable diseases have decreased in the region, with variation between countries. Private health expenditure incurred by people also has increased during the same time and out of pocket health expenditure, which constitutes around 90 per cent of private health expenditure, indicates the higher burden on households in South Asia.

Keywords: *Burden of diseases; Out of pocket health expenditure; Public expenditure; Private expenditure; Communicable and non-communicable diseases; South Asia.*

1.0 Introduction

Good health is a significant contributor to human development. Human Development Report (2016) states that human development is about enlarging freedoms so that all human beings can pursue choices that they value; these freedoms have two fundamental aspects (1) freedom of well-being represented by functionings and capabilities and (2) freedom of agency represented by voice and autonomy. Functionings are the various things a person may value being and doing such as being happy, adequately nourished and in good health, as well as having self-respect and taking part in the life of the community (UNDP 2016).

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It indicates that good health is a freedom of well-being represented by functionings and capabilities which are valued by persons; and also freedom of good health is preferred by individuals and society. Good health augments economic development by enhancing capability thus increasing labour productivity and income; besides reducing burden of health expenditure on individuals and nation. Health is a condition of well-being of people, as World Health Organization (WHO) defines it is a 'state of complete physical, mental and social well-being and not merely absence of disease or infirmity'. It is to be noted that absence of illness is an important factor in determining health status of people which in turn determines their physical, mental and social well-being. In order to maintain good health governments and individuals incur expenditure. Governments have initiated various public health programs to increase public health care provision and health improving services like vaccination to control diseases, creation of safe drinking water supply and sanitation facilities and health awareness programs by devoting monetary resources through budgets, while individuals spend money out of their pocket to avail health services for curing illness and maintain good health. Expenditure on health by both governments and individuals is directly related with incidence of diseases. High incidence of diseases, communicable and non-communicable, incur huge burden on government and persons. According to WHO, both communicable and non-communicable diseases accounted for 91.25 per cent of 56.44 million deaths in 2015 at global level (WHO data base).

2.0 Review of Literature and Objectives

Non-communicable diseases (NCDs) are diseases of long duration and slow in progression as defined by World Health Organization (2011). Four major non communicable diseases causing adult mortality and morbidity are cardiovascular diseases (including heart disease and stroke), diabetes, cancers and chronic respiratory diseases (including chronic obstructive pulmonary disease (COPD) and asthma). According to the above WHO report NCDs would cost more than US\$ 30 trillion in next 20 years accounting for 48 per cent of global gross domestic product in 2010 (WHO, 2011). Several factors like ageing population, urbanization and globalisation which increases the prevalence of NCDs particularly in developing countries have contributed for rise in NCDs.

In India non-communicable diseases have caused more deaths, 42%, compared to communicable diseases. But, the scenario changes across rural and urban India where in rural area number of deaths caused by communicable diseases are high while in urban areas non-communicable diseases have caused more deaths (GoI, 2018). Progress of

NCDs has seen tremendous changes over the years as there is a major shift from communicable to non-communicable diseases and NCDs were believed to be related to economic development and diseases of rich people. But, nowadays almost all sections i.e., both rich and poor people are suffering from NCDs, which is mainly due to life style based reasons (Boutayeb, 2006). It is to be observed that NCDs are spreading all over the world, with a high level increase in developing nations. Studies have observed main causes or risk factors of this trend are dietary consumption patterns, physical inactivity, tobacco use and environmental pollution. The above study shows that cardiovascular diseases are the major contributors to mortality and disability in South Asia. Among South Asian countries number of people with diabetes is high in India than any other country in the world, a third of Pakistan aged above 45 years report hypertension, and in India 52 per cent of deaths by cardiovascular occur below age of 70 years. All this indicates that non-communicable diseases are taking a major toll on the economy.

Any type of disease, communicable or non-communicable renders an individual inactive and unproductive during the episode of ill-health. Besides, expenditure incurred by the family to treat illness of its member brings financial shock since large number of households diverts money for health from other necessary expenditures. Health expenditure incurred by the family, i. e, out of pocket expenditure on health, causes severe economic impacts on households, particularly in developing countries. Xu et al. (2007) found that the financial catastrophe of health expenditure occurs at all levels of income; however, the problem is most severe in low-income countries and more severe in middle than high-income settings indicating adverse impacts. Out of pocket expenditure on health has pushed 100 million under the poverty line, where more than 90 per cent of these people are from low income countries.

It is to be noted that out-of-pocket expenditure on health might impact on household consumption pattern; because the threat that out-of-pocket payments pose to household living standards is increasingly recognised as a major consideration in the financing of health care, which depends on the magnitude and distribution of out-of-payment expenditure (Doorslaer et al., 2007). It is found that out-of-pocket health expenditure constitutes at 30 per cent of total health expenditure, which is mainly direct payment in poorer countries, particularly in countries like Nepal, India and Vietnam.

In this respect understanding the burden of diseases is an important task by exploring the pattern of disease and out of pocket health expenditure as high incidence of diseases is an impediment on path to economic and human development. This paper attempts to examine the burden of diseases and pattern of out of pocket expenditure on health in South Asian countries namely Afghanistan, Bangladesh, Bhutan, India, Sri Lanka, Maldives, Nepal and Pakistan. South Asia is considered to be a developing

region possessing large number of poor people where 15.1 per cent of population live below \$1.90 a day. Countries in South Asia score relatively less in human development index also. HDR 2016 shows that two countries i.e., Sri Lanka and Maldives come in the category of high human development, while India, Bhutan, Bangladesh, Nepal and Pakistan are in medium human development group; and Afghanistan is in low human development group. Six out of eight countries lie low in the ranking of human development index; therefore human development is a major issue in this region. Since, health is an important component of human development this study specifically attempts to examine the pattern of communicable and non-communicable diseases and to study the pattern of out of pocket expenditure on health among South Asian countries.

In order to analyse disease pattern information on incidence of diseases is necessary, but these data are not available. WHO has published data on number of deaths by causes for years 2000, 2005, 2010 and 2015 (Global Health Estimates, 2015). Hence, this study has used data on number of deaths by causes published by WHO for examining disease pattern across South Asian countries. Further, data on out of pocket health expenditure, private expenditure on health and government spending on health have been collected from World Development Indicators published by World Bank.

3.0 Pattern and Burden of Diseases in South Asian Countries

At the global level number of deaths caused by all diseases is at 56.44 million in 2015 which increased from 52.13 million in 2000 as revealed in Table 1. In 2015 over 70 per cent of deaths occurred due to non-communicable diseases, while 21 per cent are due to communicable, maternal, perinatal and nutritional conditions. Proportion of deaths caused due to communicable diseases has decreased from 31 per cent in 2000 to 21 per cent in 2015, which is likely to be because of various public health programs under taken by governments to control contagious diseases, improve maternal and children health care and supplement nutritional intake. However, number of deaths due to non-communicable diseases has increased from 60 per cent to 70 per cent during the same period at the global level. In South Asia number of deaths caused by communicable diseases is over 28 per cent in 2015, which is higher than that at global level. The non-communicable diseases in South Asia have caused deaths over 60 per cent in 2015. The table shows that the mortality caused by non-communicable diseases increased over the years in South Asian region also, where as that of communicable diseases decreased during the same period. This trend is similar to that observed at global level, but the per cent of decline in communicable diseases and increase in non-communicable diseases is less in South Asian countries compared to that at world level. Another point to be

observed is that death caused by injuries has increased between 2000 and 2015 in South Asia, from 9.82 per cent to 10.71 per cent respectively, while it has slightly declined at global level.

Table 1: Number of Deaths by Causes at Global and South Asia Level

Cause of death	2000	2005	2010	2015
Global				
Death by all causes (in 000's)	52134.56	53357.49	54429.50	56441.31
Communicable, maternal, perinatal and nutritional conditions (in percent)	31.00	28.16	24.05	21.19
Non- communicable diseases (in percent)	60.21	62.98	66.89	70.06
Injuries(in percent)	8.79	8.86	9.07	8.75
South Asia				
All causes death (in 000's)	11889.98	12060.76	12152.24	12394.28
Communicable, maternal, perinatal and nutritional conditions (in percent)	44.75	39.84	33.94	28.57
Non- communicable diseases (in percent)	45.42	49.60	55.49	60.69
Injuries (in percent)	9.82	10.51	10.57	10.74

Source: WHO - Department of Information, Evidence and Research, March 2017

Disease pattern in terms of deaths by causes in South Asian countries (Table 2) shows decline in mortality caused by communicable diseases and increase in deaths occurred due to non-communicable diseases between 2000 and 2015. It is to be noted that the total number of deaths have not decreased significantly between 2000 and 2015, but there is a significant shift in composition of causes from communicable diseases towards non-communicable diseases .

Communicable diseases include communicable, maternal, perinatal and nutritional conditions in the region. Among South Asian countries number of deaths occurred due to communicable diseases was highest in Afghanistan (39 per cent) and lowest in Sri Lanka (7.7 per cent), where as in India communicable diseases have accounted for 28 per cent of deaths in 2015. During the same time mortality due to non-communicable diseases is highest in Sri Lanka and lowest in Afghanistan. India which has large number of population recorded 60 percent of deaths due to non-communicable diseases. We can observe a continuous increase in per cent of deaths caused by non-communicable diseases in all South Asian countries between 2000 and 2015 from 45 per cent to 60 per cent respectively.

Table 2: Pattern of Diseases in South Asian Countries

GHE cause	Afghanistan	Bangladesh	Bhutan	India	Maldives	Nepal	Pakistan	Sri Lanka	All together
2000									
Estimated death by all causes (000's)	249.76	917.35	5.08	9184.59	1.32	203.49	1203.21	125.17	11890.0
I.Communicable Diseases (% to total deaths)	59.61	48.29	38.09	43.71	22.48	46.33	50.32	10.52	44.75
II.Non-communicable diseases (% to total deaths)	27.50	43.46	48.61	46.09	65.54	45.55	42.78	71.56	45.42
III.Injuries (% to total deaths)	12.89	8.24	13.30	10.21	11.99	8.13	6.90	17.92	9.82
2005									
Estimated death by all causes (000's)	253.55	902.76	4.58	9305.83	1.14	189.65	1284.64	118.60	12060.8
I.Communicable Diseases (% to total deaths)	52.97	39.75	31.78	39.55	14.78	36.75	42.73	9.85	39.84
II.Non-communicable diseases (% to total deaths)	33.55	52.07	57.87	50.01	73.05	53.97	44.99	75.31	49.60
III.Injuries (% to total deaths)	13.37	8.11	10.31	10.41	12.12	9.24	12.20	14.81	10.51
2010									
Estimated death by all causes (000's)	261.92	858.11	4.60	9389.56	1.16	180.05	1328.92	127.91	12152.2
I.Communicable Diseases (% to total deaths)	47.56	30.89	27.87	33.43	11.47	30.42	39.81	8.55	33.94
II.Non-communicable diseases (% to total deaths)	36.64	61.02	62.03	55.69	77.25	61.89	51.13	78.42	55.49
III.Injuries (% to total deaths)	15.80	8.10	10.10	10.88	11.28	7.69	9.07	13.03	10.57
2015									
Estimated death by all causes (000's)	259.96	867.30	4.79	9559.07	1.18	188.60	1370.83	142.56	12394.3
I.Communicable Diseases (% to total deaths)	39.44	25.25	22.64	28.09	10.85	23.81	34.82	7.73	28.57
II.Non-communicable diseases (% to total deaths)	42.48	66.91	67.82	60.85	78.45	64.54	56.53	79.69	60.69
III.Injuries (% to total deaths)	18.09	7.84	9.54	11.06	10.70	11.65	8.65	12.58	10.74

Source: WHO

Notes: (i) Calculation of per cent by author

(ii) GHE – Global Health Estimate

Another point to be noted is that in 2000 number of deaths due to communicable and non-communicable diseases was around 45 per cent, but in 2015 non-communicable diseases caused more mortality than communicable diseases. Incidence of non-communicable diseases is being attributed to life styles of people in terms of consumption pattern, sedentary life, environmental factor, etc. According to WHO while 25 per cent of all deaths in developing countries are attributable to environmental factors, only 17 per cent of deaths in the developed countries are due to such factors (WHO, 2002). In this respect non-communicable diseases have alarmingly increased in south Asian countries. During the same time number of deaths due to injuries has increased in Afghanistan, India, Nepal and Pakistan, while it has decreased in rest of South Asian countries. This shows that mortality by injuries is also becoming a major health issue in South Asian region.

Number of deaths caused by different types of communicable and non-communicable diseases during 2015 is shown in Table 3 for South Asian countries. Among communicable diseases number of deaths caused by infectious and parasitic diseases constitute 46 per cent followed by neonatal and respiratory infection diseases respectively at 26 and 22 per cent taking all south Asian countries together. Across these nations around 50 per cent of mortality of communicable diseases is caused by infectious and parasitic diseases in Bangladesh, Bhutan, Nepal and India. Within infectious and parasitic caused deaths share of tuberculosis (36 per cent) and diarrheal diseases (32 per cent) is high in the region. Tuberculosis is the main cause of death in Bangladesh, Maldives, India and Afghanistan, while diarrhoea has caused more mortality in Pakistan (36 per cent), Nepal (35 per cent), India and Afghanistan (32 per cent), which shows that in these countries tuberculosis and diarrhoea are imposing more burden. Among other types of communicable diseases in Sri Lanka respiratory infections (48 per cent); in Bangladesh, Bhutan, India and Nepal infectious parasitic and neonatal conditions have caused more number of deaths.

As observed, non-communicable diseases constitute over 60 per cent of deaths in South Asia. Among NCDs cardiovascular disease (CVD) has accounted for nearly 44 per cent of deaths and in all south Asian countries. This is a major non-communicable disease as 41 to 53 per cent of deaths are due to cardiovascular diseases, being the highest in Pakistan and lowest in Bhutan. Malignant neoplasms and respiratory diseases have caused more number of deaths in all countries after CVD. Among the number of deaths by injuries unintentional injuries, particularly road accidents constitute a higher share in all south Asian countries.

Table 3: Per Cent of Deaths due to Various Diseases in 2015

Causes of deaths	Afghani stan	Bangla desh	Bhuta n	India	Maldiv es	Nepal	Pakista n	Sri Lanka	All togethe r
I. Communicable Diseases:									
A. Infectious and parasitic diseases (per cent to I)	36.50	53.85	53.33	48.98	36.26	50.01	33.75	38.05	46.85
Tuberculosis (per cent to A)	35.61	58.57	20.02	35.78	43.38	23.39	27.25	27.52	36.38
Diarrhoeal diseases (per cent to A)	32.46	16.92	21.51	32.78	16.22	35.10	36.00	13.20	31.94
Childhood-cluster diseases (per cent to A)	11.86	1.20	3.13	4.49	3.76	4.57	8.35	1.73	4.79
Meningitis (per cent to A)	9.49	1.56	4.72	3.06	4.90	4.89	7.85	11.86	3.61
Encephalitis (per cent to A)	0.50	1.58	4.08	3.03	5.17	3.61	1.56	9.09	2.75
Hepatitis (per cent to A)	1.25	2.47	5.62	5.98	4.54	3.34	2.81	0.34	5.27
Parasitic and vector diseases (per cent to A)	2.30	2.12	1.53	5.05	7.10	3.80	1.92	6.54	4.46
Other infectious diseases (per cent to A)	2.72	12.29	21.25	3.55	12.52	9.57	9.64	24.59	4.89
B. Respiratory Infectious	23.27	13.91	25.49	24.20	35.23	23.53	17.61	48.04	22.72
C. Maternal conditions	4.38	2.07	2.13	1.61	3.84	2.77	1.87	0.91	1.76
D. Neonatal conditions	34.20	27.28	17.53	22.44	22.01	22.13	45.21	11.28	26.11
E. Nutritional deficiencies	1.65	2.88	1.52	2.77	2.66	1.57	1.55	1.71	2.56
II. Non-communicable diseases:									
Malignant neoplasms (per cent to II)	16.08	16.56	12.28	13.30	19.33	13.70	14.45	17.16	13.77
Diabetes mellitus (per cent to II)	2.75	6.92	7.64	5.13	3.34	5.33	5.56	9.76	5.35
Neurological conditions (per cent to II)	3.25	2.91	3.46	3.26	6.26	3.61	2.68	4.10	3.20
Cardiovascular diseases (per cent to II)	49.81	44.20	41.30	42.54	44.02	42.58	53.43	44.66	43.93
Respiratory diseases (per cent to II)	7.01	14.21	13.89	17.86	8.86	19.12	9.21	10.84	16.44
Digestive diseases (per cent to II)	6.76	7.08	9.76	8.65	4.08	8.09	6.44	5.28	8.21
Genitourinary diseases (per cent to II)	4.58	3.50	6.51	5.06	7.04	4.34	2.78	5.86	4.70
Congenital anomalies (per cent to II)	5.52	2.39	2.84	2.00	2.68	1.86	3.42	1.15	2.21
III. Injuries:									
Unintentional injuries (per cent to III)	63.00	80.12	77.58	75.45	65.27	87.98	76.34	55.58	75.27
Intentional injuries (per cent to III)	37.00	19.88	22.42	24.55	34.73	12.02	23.66	44.42	24.73

Source: WHO website

Calculations are by author

4.0 Patterns in Private and Out of Pocket Health Expenditure in South Asia

Good health which enhances capability and well-being conditions needs to be achieved and maintained by preventing and avoiding incidence of diseases, and also by treating ill health as any type of ill health causes burden on individual and society. Prevention and treatment of diseases necessitates incurring expenditure by both governments and individuals. Governments spend on health, broadly known as public expenditure on health, mainly on creation of health care infrastructure, health care services, health manpower, prevention and control of diseases, awareness creation on health, provision of safe drinking water supply and facilities of sanitation, etc. In addition to government, private sector is also involved in providing health care services. Therefore, health care services at primary, secondary and tertiary levels have been created by both government and private sectors. People depend on both public and private health sectors for treatment of their diseases, where they have to incur expenditure on different types of health care services. While public health sector provides health care services at free of cost or subsidized prices, private health sector delivers health care services by charging health service seekers. People meet their health expenditure from sources like out of pocket, private insurance, charities, loan, etc. In this respect an analysis of private expenditure on health incurred by households needs to be examined to understand burden of diseases on households. Here an attempt has been made to analyse patterns in private health expenditure in South Asian countries. World Development Indicators published by World Bank provide information on private health expenditure as per cent of GDP, out of pocket health expenditure as per cent of total health expenditure and as per cent of private health expenditure across nations. This data helps to understand the magnitude of out of pocket of expenditure on health. Let us examine the pattern of private expenditure on health and out of pocket expenditure on health in the eight South Asian countries.

Private and public health spending as per cent of GDP (Table 4) for the period 2000 to 2014 across South Asian countries indicates that in all nations proportion of private health expenditure is more compared to public health expenditure. In 2014 private health expenditure ranged from 0.96 per cent of GDP in Bhutan to 5.25 per cent in Afghanistan. Private health expenditure is more in Afghanistan followed by Nepal and India at 3.46 and 3.28 per cent of their GDP respectively. Sri Lanka which ranked high in HDI among South Asian countries reports private health expenditure at 1.54 per cent of GDP. Public health expenditure as proportion to GDP, presented in the table, shows that Maldives is spending highest on health (10.76 per cent) followed by Bhutan (2.62 per cent) and Nepal (2.34 per cent).

Table 4: Health Expenditure, Private and Public (% of GDP)

Year	Afghanistan	Bangladesh	Bhutan	India	Sri Lanka	Maldives	Nepal	Pakistan
	Private Expenditure							
2000		1.38	1.59	3.15	1.93	2.88	4.08	2.18
2001		1.45	1.06	3.42	2.05	2.14	3.77	2.06
2002	7.21	1.53	1.14	3.38	2.2	2.21	3.96	1.95
2003	8.21	1.53	1.16	3.31	2.28	2.12	3.96	1.96
2004	7.82	1.57	1.21	3.2	2.28	2.01	4.23	1.88
2005	7.27	1.71	1.11	3.15	2.21	2.4	4.14	2.23
2006	6.37	1.76	0.98	3.14	2.11	2.13	3.65	2.61
2007	6.21	1.81	0.76	3.13	1.93	2.09	3.56	2.55
2008	6.94	1.89	1.02	3.18	1.86	2.28	3.71	2.42
2009	6.83	1.92	1.14	3.15	1.83	2.49	3.58	2.14
2010	6.34	2.01	0.63	3.12	1.88	2.66	3.56	2.06
2011	5.79	2.11	0.59	3.16	1.9	2.51	3.49	2.09
2012	5.6	2.1	1	3.21	1.99	2.66	3.43	1.74
2013	5.48	2.07	1.02	3.24	1.57	2.9	3.47	1.71
2014	5.25	2.03	0.96	3.28	1.54	2.98	3.46	1.7
	Public Expenditure							
2000		0.95	5.33	1.11	1.85	5.12	1.35	0.61
2001		1.02	4.85	1.08	1.76	3.7	1.59	0.55
2002	0.55	1.07	6.61	1.03	1.68	3.57	1.64	0.81
2003	0.61	0.98	3.75	0.98	1.68	3.78	1.53	0.65
2004	0.97	1.04	3.19	1.02	2.01	3.88	1.59	0.68
2005	0.8	0.97	4.17	1.13	1.85	7.13	1.59	0.69
2006	1.06	1.04	4.29	1.11	1.95	5.24	2.04	0.79
2007	0.52	0.99	5.12	1.1	1.83	4.55	2.28	0.8
2008	1.39	0.95	5.56	1.16	1.58	7.03	2.73	0.84
2009	2.59	0.99	4.89	1.22	1.54	6.73	2.82	0.8
2010	2.86	1.05	4.54	1.16	1.55	5.27	2.87	0.95
2011	2.08	1.04	4.14	1.18	1.38	5.61	3.24	0.92
2012	2.92	0.98	2.7	1.18	1.22	6.5	2.47	1.02
2013	2.65	0.81	2.8	1.29	2.1	8.26	2.22	0.99
2014	2.93	0.79	2.62	1.41	1.96	10.76	2.34	0.92

Source: World Development Indicators, World Bank (2017)

Note: 1. Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.

2. Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organizations), and social (or compulsory) health insurance funds.

In India public health spending is 1.41 per cent of GDP, while Bangladesh and Pakistan governments have allocated less than 1 per cent of their GDP for health sector. It is to be

noted that private expenditure on health is high in all countries where government spending is low. Contrarily, in Maldives and Bhutan where public spending as per cent of GDP is more private health spending is less. This indicates that higher allocation on health by governments reduces private expenditure on health thus burden on households. Across countries between 2000 and 2014 private spending on health as per cent of GDP shows a mixed scenario where in Afghanistan, Bhutan, Sri Lanka, Nepal and Pakistan the private health expenditure has decreased, while it has increased in Bangladesh, India and Maldives. During the same period public spending on health as per cent of GDP has increased in all countries except Bhutan.

Private health expenditure discussed above is a broader concept as it includes expenditure made out of pocket, private health insurance, private corporation payments. Let us examine out of pocket health expenditure or direct household spending on health as per cent of total expenditure on health, which indicates the share of expenditure directly borne by households (Table 5).

Table 5: Out-of-Pocket Health Expenditure (% of Total Expenditure on Health)

Year	Afghanistan	Bangladesh	Bhutan	India	Sri Lanka	Maldives	Nepal	Pakistan
2000		57.78	22.96	67.86	41.30	18.96	68.49	63.70
2001		56.76	17.99	70.26	44.30	20.67	63.99	62.39
2002	92.47	56.46	14.77	70.50	45.97	22.73	62.68	56.14
2003	92.69	58.91	23.55	70.61	46.86	22.79	64.53	61.08
2004	88.56	57.94	27.54	67.85	43.98	23.22	54.78	60.56
2005	89.63	59.92	20.65	65.90	44.93	18.07	52.74	66.01
2006	85.23	58.72	18.15	65.75	42.76	20.78	46.66	68.97
2007	91.77	61.18	12.53	65.25	41.70	22.85	50.48	67.78
2008	83.12	60.31	15.10	64.39	43.86	18.32	48.21	65.57
2009	72.31	61.13	18.43	63.33	43.98	21.11	45.45	64.32
2010	68.70	60.97	11.49	63.37	44.83	26.60	44.52	60.61
2011	73.26	61.32	11.79	64.43	48.06	25.22	41.38	61.49
2012	65.43	63.30	25.69	64.88	48.65	24.05	45.91	54.76
2013	67.13	66.84	25.23	63.81	41.03	21.59	48.68	54.87
2014	63.88	66.98	25.33	62.42	42.09	18.26	47.65	56.28

Source: World Development Indicators, World Bank (2017)

Note: Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

In 2014, out of pocket expenditure on health is high in Bangladesh (67 per cent) followed by Afghanistan and India, where more than 50 per cent of total health expenditure has been met from direct household spending. However, people in Maldives and Bhutan are spending less in terms out of pocket expenditure compared to other South Asian countries. As seen above public spending on health is more in these two countries, which may be the reason for people to spend less.

Real burden of health expenditure on households is felt when any household meets its health expenditure directly from its own outlay as this adversely affects the financial status. This can be understood by examining the share of out of pocket expenditure on health in private expenditure on health (Table 6). This analysis reveals the extent of expenditure directly borne by households. Out of pocket health expenditure as per cent of private expenditure is high in all South Asian countries during 2014, where in Afghanistan, Sri Lanka, Bhutan and Bangladesh more than 90 per cent of private expenditure on health is met from out of pocket.

Table 6: Out-of-Pocket Health Expenditure (% of Private Expenditure on Health)

Year	Afghanistan	Bangladesh	Bhutan	India	Sri Lanka	Maldives	Nepal	Pakistan
2000		97.41	100.00	91.81	80.83	52.70	91.21	81.49
2001		97.01	100.00	92.41	82.31	56.43	91.08	79.12
2002	99.53	95.99	100.00	91.92	81.08	59.42	88.65	79.39
2003	99.55	96.36	100.00	91.61	81.40	63.43	89.45	81.27
2004	99.54	96.32	100.00	89.55	82.71	67.96	75.36	82.37
2005	99.52	93.79	97.85	89.65	82.53	71.78	72.95	86.34
2006	99.45	93.44	97.74	89.03	82.23	71.82	72.78	89.79
2007	99.49	94.53	96.97	88.20	81.09	72.66	82.87	88.98
2008	99.71	90.71	97.68	87.96	81.08	74.81	83.63	88.31
2009	99.68	92.71	97.74	87.84	80.81	78.18	81.26	88.50
2010	99.63	92.78	94.74	86.96	81.90	79.43	80.33	88.65
2011	99.56	91.51	94.74	88.43	82.99	81.67	79.86	88.59
2012	99.56	93.03	94.87	88.85	78.47	82.83	78.97	86.79
2013	99.56	92.98	94.54	89.14	95.83	83.10	79.86	86.79
2014	99.56	92.89	94.49	89.21	95.79	84.26	79.86	86.79

Source: World Development Indicators, World Bank (2017)

Note: Out of pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups. It is a part of private health expenditure.

The scenario is not different in India and other countries like Pakistan, Maldives and Nepal where 80 to 90 per cent of private health expenditure is directly made by households. It shows that health financing sources like health insurance, corporation payments, etc. are yet to be developed among these countries. It is significant to note that in Maldives and Sri Lanka proportion of out of pocket expenditure has increased drastically over the years, while in Nepal it has declined during the same period. Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.

5.0 Conclusion

Good health is a freedom desired by persons to increase their capabilities and happiness and is a main determinant of human development and welfare. Incidence of diseases determines health status and economic burden on households. An analysis of diseases pattern, number of deaths by causes, among South Asian countries revealed that between 2000 and 2015 communicable diseases have decreased while non-communicable diseases have increased, putting more burden on people. Among nations deaths occurred due to communicable diseases are high in Afghanistan and less in Sri Lanka. Non-communicable diseases have caused high mortality in all South Asian countries. Among communicable diseases infectious and parasitic diseases share large number of deaths followed by respiratory diseases, showing that these contagious diseases are incurring more burdens in South Asian region. Tuberculosis (in Bangladesh, Maldives, India and Afghanistan) and diarrhoea (in Pakistan, Nepal, India and Afghanistan) are also imposing more mortality in the region. With respect to non-communicable diseases cardiovascular disease has taken high toll in all countries.

Pattern of private health expenditure revealed that in all South Asian nations per cent of private health expenditure to GDP is high compared to public spending on health. It shows that people value good health and spend money to maintain it, and in the absence of adequate spending by governments on health households require meeting higher share of health expenditure. But, higher share of private expenditure on health may adversely affect economic condition of households, which can push them to debt, poverty or reduce their consumption expenditure. Private health expenditure as per cent of GDP is less in Bhutan and high in Afghanistan. While private health expenditure has increased in some countries, public expenditure on health has increased in all South Asian countries. Analysis of out of pocket expenditure on health as per cent of private health expenditure revealed that around 90 per cent of private health expenditure is made

of out of pocket indicating higher burden of health expenditure on households in South Asian region.

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