

Bloch, Carolina

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Social spending in South Asia - an overview of government expenditure on health, education and social assistance

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Social spending in South Asia— an overview of government expenditure on health, education and social assistance

Carolina Bloch, International Policy Centre for Inclusive Growth (IPC-IG)



Research Report No. 44

Social spending in South Asia—an overview of government expenditure on health, education and social assistance

By Carolina Bloch

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United Nations Development Programme and the United Nations Children's Fund

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Research team

Research Coordinators

Carolina Bloch (IPC-IG)

Rafael Guerreiro Osorio (Ipea and IPC-IG)

Pedro Arruda (IPC-IG)

Fábio Veras Soares (Ipea and IPC-IG)

Researchers

Anna Carolina Machado (IPC-IG)

Beatriz Burattini (IPC-IG)

Charlotte Bilo (IPC-IG)

Fabianna Ferreira (IPC-IG)

Isabela Franciscon (IPC-IG)

Krista Alvarenga (IPC-IG)

Lea Smidt (IPC-IG, Carlo Schmid Programme fellow)

Luca Lazzarini (IPC-IG)

Lucas Sato (IPC-IG)

Marcela Ramirez (IPC-IG)

Nicolò Bird (IPC-IG)

Sergei Soares (Ipea and IPC-IG)

Wesley Silva (IPC-IG)

Yannick Markhof (IPC-IG)

Research Assistants

João Pedro Ditz and Juliana Bernardino (IPC-IG, interns)

United Nations Online Volunteer

Ifham Adam Ibrahim

Designed by the IPC-IG Publications team

Roberto Astorino, Flávia Amaral, Priscilla Minari
and Manoel Salles

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**SOCIAL SPENDING IN SOUTH ASIA—
AN OVERVIEW OF GOVERNMENT
EXPENDITURE ON HEALTH, EDUCATION
AND SOCIAL ASSISTANCE**

This study is part of a series of papers developed as a partnership between the UNICEF Regional Office for South Asia and the IPC-IG, to assess different aspects of social protection in the region.

1. Social spending in South Asia: an overview of government expenditure on health, education and social assistance.
2. Overview of non-contributory social protection programmes in South Asia from a child and equity lens.
3. Gender and social protection in South Asia: an assessment of the design of non-contributory programmes.
4. Social protection legislative frameworks in South Asia from a child-rights perspective.
5. Evidence linking social protection programmes in South Asia with child poverty, economic growth and improvement in human development.

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We travelled to five countries in South Asia: Afghanistan, India, Nepal, Sri Lanka and Maldives, which has given us the opportunity to learn more about social protection in different contexts. This work would not have been possible without the collaboration of our counterparts from UNICEF, governments and non-governmental organisations.

We would like to thank all the government officials and experts from the following countries and institutions:

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FOREWORD

This report is the first in a series on social protection programmes of South Asia. It provides a broad macroeconomic backdrop for the rest of the series, presenting an overview of South Asian countries' public expenditures on social protection, education and health.

The region spends less on health, education and social protection than any other region in the world. On average, it also stands below recommended expenditure benchmarks such as those laid out in UNESCO's Education 2030 Framework for Action. As a percentage of gross domestic product (GDP), education has the lion's share of the region's average expenditures—3.37 per cent, followed by the health sector at 0.95 per cent, with the lowest expenditure for social assistance at only 0.90 per cent.

Countries in South Asia are evidently very heterogeneous regarding expenditure levels, as well as in their distinct structural and path-dependency factors. Therefore, high short-term expenditure levels are not a 'silver bullet' that works for every country, and sustained long-term expenditures rely on adequate macroeconomic conditions and institutional set-ups to be converted into good results. However, once the necessary conditions are aligned, countries can expect to reap increasingly better outcomes at marginally higher to gradually decreasing costs. Under a structurally favourable context, Sri Lanka's long-term public health and education policies have resulted in increasingly better outcomes, at a lower cost as a share of the country's GDP than its neighbours.

There is still much room to improve the progressivity of government expenditures on education, health and social assistance in South Asia. Benefit incidence analysis of social assistance, based on the World Bank's ASPIRE database, reveals that only Bangladesh, India and Sri Lanka have a high degree of progressivity. It is worth pointing out that the region is more open than others to the idea of universal social protection; however, with limited budgets, this alignment does not directly translate into programmes with adequate coverage. Therefore, it is recommended that countries follow the principle of progressive universalisation and prioritise poor and vulnerable populations. Importantly, this report identifies the need to improve access to comparable data that allow for benefit incidence analysis of the expenditures on health and education.

South Asia is the fastest-growing region in the world, and even countries with tight budgets have the potential to increase their expenditures on health, education and social assistance. This expansion should be carried out with sustainable fund allocation to avoid the disruption of services. Efforts have been made to increase social spending; however, taxation remains an underused financing mechanism in the region, while growing fiscal deficits hinder government borrowing. Nonetheless, there is much space to improve and reprioritise expenditures across sectors and programmes. These measures should be complemented by efforts to strengthen governance and accountability in the management of public resources.

Enjoy your reading!

Jean Gough
UNICEF Regional Director for South Asia

CONTENTS

ACKNOWLEDGMENTS	5
FOREWORD	6
ACRONYMS AND ABBREVIATIONS	11
EXECUTIVE SUMMARY	12
Context and motivation	12
Overview of social spending in South Asia	12
Health	14
Education	14
Social assistance	16
Fiscal space for social spending in South Asia	16
Conclusion and final policy recommendations	17
1. INTRODUCTION	18
2. SETTING THE SCENE	20
Overview of key development outcomes in South Asia	20
Social spending in South Asia—a general picture	21
3. GOVERNMENT EXPENDITURE ON HEALTH CARE IN SOUTH ASIA	22
Recent trends in public spending for health care	23
Who carries the burden of health care funding?	24
The role of government in financing health care	25
How does expenditure on health care compare to health outcomes?	27
4. GOVERNMENT EXPENDITURE ON EDUCATION IN SOUTH ASIA	30
Recent trends in education spending	30
Government priorities in education spending	32
How does expenditure on education compare to education outcomes?	35

CONTENTS

5. GOVERNMENT EXPENDITURE ON SOCIAL ASSISTANCE IN SOUTH ASIA	37
Social assistance data	38
Analysis of social assistance spending	39
Performance of social assistance programmes	40
6. FISCAL SPACE FOR SOCIAL SPENDING IN SOUTH ASIA	42
Macro-fiscal framework	43
Options for increasing social expenditure	44
7. CONCLUDING REMARKS	48
REFERENCES	50

LIST OF BOXES

Box 1. Benefit Incidence Analysis of health care in South Asia	26
Box 2. Sri Lanka: Challenging the status quo on good practices in the health system	29
Box 3. Nepal's challenge to improve the funding, access and quality of education services	37
Box 4. The Mahatma Gandhi National Rural Employment Guarantee Act and management challenges for effective social assistance in India	41
Box 5. Afghanistan case study—Challenges to resource mobilisation and sustainable social spending in a crisis context	46
Box 6. Economic reforms programmes in South Asia	48

LIST OF FIGURES

Figure 1. Social expenditure (health, education and social assistance) as a percentage of GDP, regional averages	21
Figure 2. Social expenditure (health, education and social assistance) by country, as a percentage of GDP (latest available data)	22
Figure 3. Domestic general government health expenditure (percentage of general government expenditure), 2016	23
Figure 4. GNI per capita vs. health expenditure (various indicators) in South Asia	24
Figure 5. Sources of health financing as a percentage of current health expenditures	25
Figure 6. Government spending as a proportion of current health expenditure vs. life expectancy and maternal mortality rates, 2000–2016	27
Figure 7. Government expenditure on education (percentage of government expenditure), latest available data	31
Figure 8. Education expenditure as a share of GDP, circa 2005, 2010, 2015 and latest available data	31
Figure 9. Expenditure on each level of education as a percentage of total government expenditure on education	32

LIST OF FIGURES

Figure 10. Graduation rate vs. expenditure on primary education as a share of education spending and per student (bubbles are proportional to the number of children of primary school age)	34
Figure 11. Nature of education expenditure (as a percentage of total expenditure in public institutions), latest available data	34
Figure 12. Comparison of social protection and social assistance data for South Asia	39
Figure 13. Benefit incidence of social assistance in South Asia	40
Figure 14. Impact of social assistance on poverty and inequality reduction in South Asia	41
Figure 15. Real GDP growth (annual percentage change)	43
Figure 16. Government total revenue, expenditure and gross debt (as a percentage of GDP, 2017)	44
Figure 17. Tax revenues as a percentage of GDP	45
Figure 18. Sources of tax revenues as a percentage of GDP, latest available data	45
Figure 19. Social expenditure vs. military expenditure in South Asia (as a percentage of GDP), latest available data	47

LIST OF TABLES

Table 1. Socio-economic indicators of South Asian countries (latest available data)	20
Table 2. Catastrophic and impoverishing health expenditure for South Asian countries	26
Table 3. Health indicators for South Asian countries, latest available data	28
Table 4. Government expenditure per student by level of education, latest available data	33
Table 5. Education indicators for South Asian countries, latest available data	36
Table 6. Public expenditure on social assistance by type of programme	40

ACRONYMS AND ABBREVIATIONS

ASPIRE	Atlas of Social Protection Indicators of Resilience and Equity
GDP	Gross domestic product
GNI	Gross national income
IMF	International Monetary Fund
IPC-IG	International Policy Centre for Inclusive Growth
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
ODA	Official Development Assistance
PPP	Purchasing Power Parity
SDG	Sustainable Development Goal
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
USD	United States Dollars

EXECUTIVE SUMMARY

Context and motivation

Government spending on the social sector is crucial to ensure that South Asia's population has access to basic health care, education and social safety nets, which are all key elements of policymakers' strategy to reduce poverty, improve welfare and spread the accumulation of human capital. The market often fails to deliver health and education services, at least to those who cannot afford them, leading to underinvestment and limited access to basic services, which in turn can have long-lasting and even irreversible effects on the population's well-being.

The provision of social services and transfers is thus intrinsically related to government responsibility for anchoring its expenditures to the country's development needs. Since the early 2000s, when many South Asian countries experienced changes in governments and strong economic growth, poverty and social exclusion started receiving growing attention, which was also reinforced by the call to action brought about by international development goals. It followed that South Asian governments strengthened their commitments of ensuring equal access to basic health care, education and an adequate income, which led to certain expectations regarding the role of the State to deliver social services. However, there still seems to be a huge gap between government intention and concrete policy action, as these commitments have not consistently been translated into adequate allocation and management of funds in the social sector.

South Asian countries differ considerably in terms of level of development: the regional average Human Development Index is around 0.6, ranging from 0.5 for Afghanistan to 0.8 for Sri Lanka. Poverty continues to affect millions of people in the region, with incidence particularly high in Bangladesh, Nepal, India and Afghanistan, while Bhutan, Maldives and Sri Lanka have the lowest rates. Income inequality and other forms of social exclusion hinder development across the region. Challenging geographical and demographic settings in the region hamper the provision of public services—such is the case in Nepal, where a significant share of the population lives in remote locations with limited access to basic health and education services, and in Maldives, where the population is spread across around 200 islands. Policymakers also struggle to provide public services to people living in emergency settings—for instance, school participation is lower in areas affected by security and natural disasters in India, Sri Lanka, Bangladesh and Pakistan. In some countries, public investment must keep up with the needs of a huge population (India) or density (Bangladesh and Maldives). These structural challenges result in a persisting need for public investment, and while government efforts have improved, they are hindered by gaps in budgetary and institutional capacity as well as contexts of political instability and social tensions.

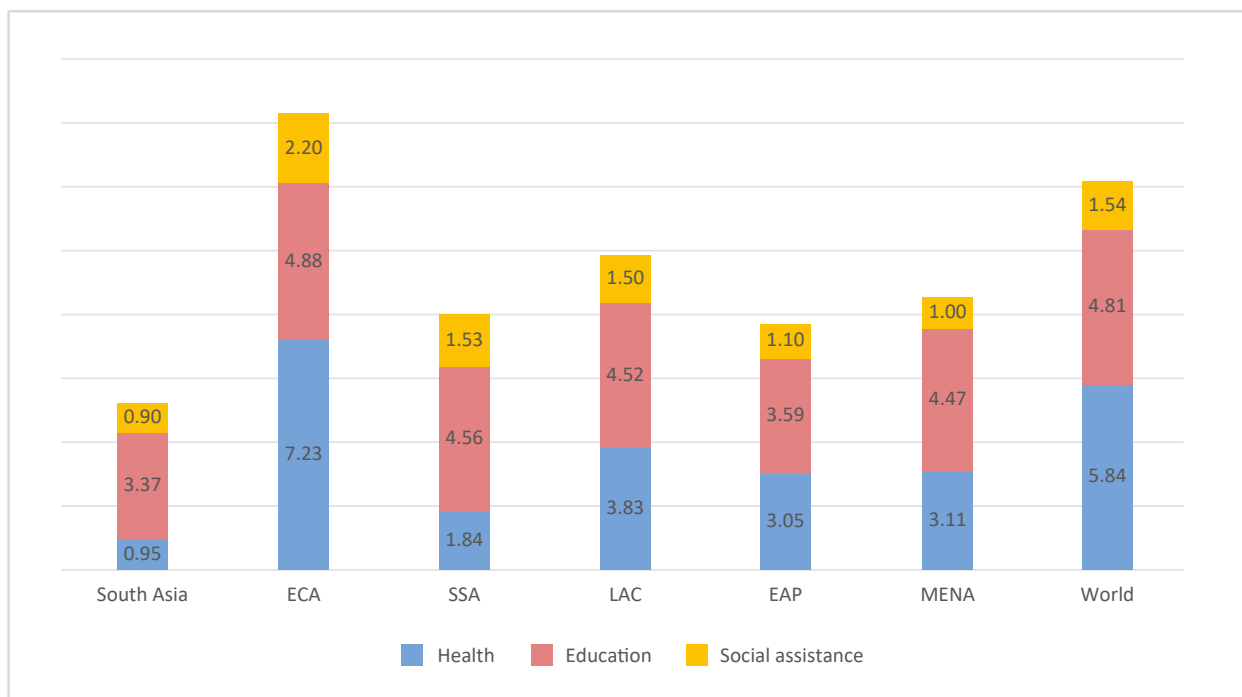
The objective of this report is to paint a broad picture of how governments in South Asia spend their resources on the social sector, focusing on health, education and social assistance, which are commonly seen as public policy priorities. It discusses the main trends, challenges and opportunities for financing social spending in the region, thus providing some guidelines on how public social expenditure in South Asia can be improved.

Overview of social spending in South Asia

On average, South Asian governments spend less on health, education and social assistance (as a percent of gross domestic product—GDP) than other regions (Figure 1), but there is a great heterogeneity across the region.

Figure 2 provides an overview of spending on these three sectors in each country in South Asia. When adding up government spending on health, education and social assistance, Bhutan and Maldives have the highest level of public social spending as a percentage of GDP. Compared to other countries in the region, Bhutan devotes comparatively more public funds to education, while Maldives spends the most on health, and India on social assistance. At the other end of the spectrum, Bangladesh spends the least on both health and education, and Bhutan spends the least on social assistance.¹

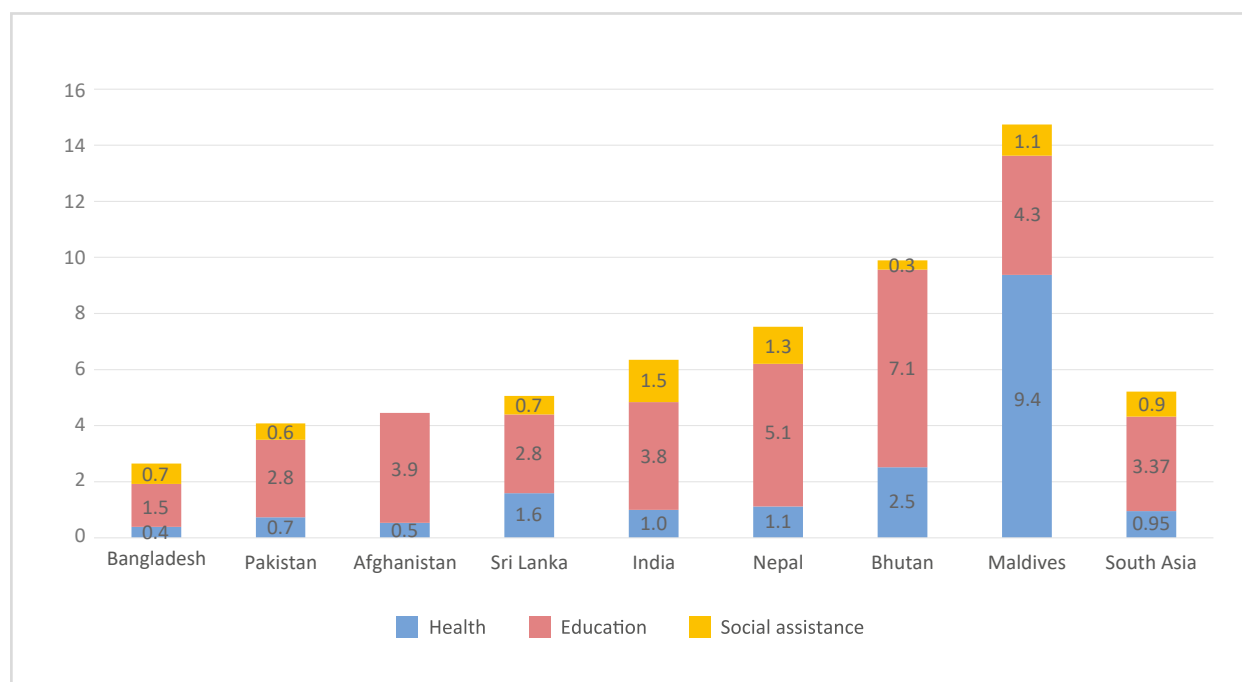
Figure 1. Social expenditure (health, education and social assistance) as a percentage of GDP, regional averages



Note: ECA = Europe and Central Asia; SSA = Sub-Saharan Africa; LAC = Latin America and Caribbean; EAP = East Asia and Pacific; MENA = Middle East and North Africa.

Source: Author's elaboration based on World Bank (2019a) and World Bank (2019d) and International Labour Organization (2017).

Figure 2. Social expenditure (health, education and social assistance) by country, as a percentage of GDP (latest available data)



Source: Author's elaboration based on World Health Organization (2019), UNESCO (2019) and World Bank (2019d).

Health

Universal health care, as described in the Sustainable Development Goals (SDGs),² has two important dimensions: service coverage and financial protection. Thus, moving towards universal health care means ensuring that: a) the population has access to essential health care services (indicator 3.8.1); and b) no one needs to suffer financial hardship to have access to necessary health care (indicator 3.8.2). Achieving universal health care seems to be an aspiration of governments in every country of the region. However, despite the improvement of health outcomes, there is still much to be done in South Asia, and progress has been uneven across the region.

On average, governments of South Asian countries spend very little on health care compared to other regions, but the funds allocated to the health sector have been increasing with growth in income per capita. There is, however, a great variation within the region: while the governments of Afghanistan, Bangladesh, India and Pakistan spend below 1 per cent of GDP on health care, public spending is higher in Maldives, Bhutan, Sri Lanka and, to some extent, Nepal.

Maldives, Bhutan and Sri Lanka have the best indicators of financial protection, in the sense that government health spending is the highest in the region: the government is responsible for over 70 per cent of health care financing in Bhutan and Maldives, and 43 per cent in Sri Lanka (where out-of-pocket payments are mainly made by richer households). Maldives and Sri Lanka are the only countries in the region that have achieved SDG mortality rate targets and have life expectancy over 75 years and nearly universal immunisation. Bhutan's indicators are not as good (but overall above the regional average), which could be due to the high inequality of health service coverage.

In other South Asian countries, funding of health care comes mainly from out-of-pocket spending (i.e. health spending directly paid by households): the share of out-of-pocket spending is particularly high in Afghanistan (77 per cent) and Bangladesh (72 per cent). This illustrates the burden of health care payments on households in these countries—a consequence of the inadequacy of government provision of health services. Health care costs can be unpredictable (in terms of both occurrence and amount), and when it is left to households to bear excessive out-of-pocket expenditures, the consequences might be inadequate treatment, no treatment at all, or impoverishment due to the high burden of expenses. In Afghanistan and Pakistan in particular, health indicators of underweight prevalence, mortality rates, immunisation and skilled attendance at birth have been improving but remain at worrying levels, which indicates an urgent need for investment in maternal and child health care interventions.

Moreover, the regional comparison shows that countries with similar levels of health spending (especially countries where this level is low) can have widely different performance when it comes to service and financial coverage. Sri Lanka, for instance, has achieved outstanding health indicators with lower spending than countries such as Maldives and Bhutan. This indicates that, beyond increasing the allocation of resources to health sectors, governments can focus on improving expenditure management and service delivery to broaden access to essential health care and reduce the burden of health spending on households.

Education

According to UNESCO Institute for Statistics estimates, South Asia is home to more than 11 million out-of-school children of primary school age. The number is even higher for lower secondary, as 18 million South Asian adolescents are not attending school. To achieve universal access to basic education (i.e. ensuring that all children of primary and lower secondary age are enrolled in school and benefit from quality education) by improving intake, completion and learning, it is crucial that South Asian governments direct the appropriate funds to education.

South Asian countries spend, on average, around 4 per cent of GDP on education, which remains below the world average (4.8 per cent) and is the lowest of all regions. Despite the overall low level of public spending as a share of GDP, of the three social sectors considered in this study, education is typically the one receiving the most public funding in the region, which suggests that it is considered a policy priority. All countries allocate over 10 per cent of the government budget to education expenditures (in Bhutan, the share exceeds 20 per cent), and the regional average is around 15 per cent (against 7 per cent for health).

Four countries exceed the regional average: Bhutan (6.6 per cent), Nepal (5.2 per cent), Afghanistan and Maldives (4.1 per cent). However, education spending in these four countries results in widely different outcomes:

- In Afghanistan, over half the population is illiterate, and available data on education indicators show that the country fares worse than others in the region (except Pakistan, in some cases).
- Maldives has some of the best outcomes in the region, with nearly 100 per cent literacy rates and primary school enrolment.
- Bhutan devotes almost a quarter of government expenditures to education, but only 67 per cent of the adult population is literate, and the share of out-of-school children of primary school age is among the highest in the region (indicators for secondary education are slightly better).
- Nepal stands out as spending over half its education budget on primary education, resulting in encouraging primary education outcomes: net enrolment and completion rates are well above the regional average.

At the other end of the spectrum, India, Pakistan, Sri Lanka and Bangladesh all have government spending on education below 4 per cent of GDP, but also with varying education indicators:

- Sri Lanka has the second lowest level of spending but some of the best outcomes in the region, especially literacy rates and school enrolment, and the rates of out-of-school children are extremely low.
- Similarly, Bangladesh has the lowest level of education expenditures in the region, but its literacy rates and school enrolment exceed the regional averages.³
- India's education spending is about the same as the regional average. In terms of outcomes of basic education, there is still much room for improvement, especially as the share of out-of-school children of lower secondary age remains very high.
- Pakistan has a particularly alarming situation: school enrolment and literacy rates remain extremely low. Around a quarter of Pakistan's children are out of school. Around half of the over 20 million out-of-school children in South Asia of primary and lower secondary age live in Pakistan.

The case of South Asia suggests that a similar proportion of public spending on education can lead to completely different outcomes. Possible explanations for this heterogeneity include a lack of administrative capacity, inadequate use of public resources directed to education, and inequality of spending incidence. This is in line with the idea that more public investment in education does lead, on average, to better education outcomes, but this relationship depends strongly on factors such as a country's income, institutions, demography etc., which should be key inputs to determining current and future financial needs.

Social assistance

One of the main targets of SDG 1, “end poverty in all its forms everywhere”, is to “implement nationally appropriate social protection systems and measures for all” (target 1.3). In this sense, the point of expanding the coverage of social protection programmes⁴ is to protect the population from situations of poverty and vulnerability. In the case of South Asia, the governments of Afghanistan, India, Maldives, Nepal and Sri Lanka have made efforts to include social protection in their legislation, strengthening commitments to improve social protection systems. However, this does not seem to be the case in Bhutan, Bangladesh and Pakistan, three countries where expanding coverage of social safety nets is urgent, since according to ASPIRE estimates,⁵ less than 20 per cent of the population is covered by social protection and labour programmes (coverage in Bhutan is particularly low, reaching only 3 per cent of the total population).

Moreover, even in countries where legal coverage has expanded, a huge share of the population remains excluded from social safety nets. Such is the case in Afghanistan, where less than 10 per cent of the population is covered by social protection programmes. Even lower is the share of the population benefiting from contributory social protection, as informality remains a considerable obstacle across South Asia.

As shown in Figure 1, countries in South Asia spend, on average, 0.9 per cent of GDP on social assistance, which places the region at the bottom of the global distribution, as other regions spend comparatively more. Of all South Asian countries for which ASPIRE data are available, India, Nepal and Maldives are the only ones where public spending on social assistance exceeds 1 per cent of GDP. These estimates indicate that India has the highest spending in the region (1.5 per cent of GDP). At the other end of the distribution, Bangladesh, Sri Lanka, Pakistan and Bhutan all spend less than 1 per cent of GDP on social assistance.

ASPIRE data also suggest that social assistance programmes in South Asia do not always benefit the poorest deciles most. In the cases of Bangladesh, India and Sri Lanka, there is some indication that the largest share of benefits goes to lower quintiles, and, therefore, that social assistance is progressive (in absolute terms). Conversely, better-off households tend to benefit more from social assistance in Afghanistan, Bhutan, Maldives, Nepal and Pakistan. As for the impact of social assistance programmes on poverty and inequality, ASPIRE finds by far the greatest impacts in Maldives: extreme poverty falls by nearly half, and the Gini Index by 4 per cent, when accounting for benefits from social assistance. Sri Lankan social protection programmes have the second largest impacts on poverty (31 per cent), and the Indian ones have the largest impacts on inequality. (2 per cent). The impact of social assistance in other countries of the region is comparatively low (Bhutan and Afghanistan show the lowest reductions, though the numbers are somewhat out of date).

Overall, much needs to be done to expand the coverage and adequacy of social assistance programmes in South Asia. To enhance public spending on social policy, it is crucial that governments direct a share of their budgets to improving the adequacy of social assistance programmes. This means investing in programme design (including adequate identification of beneficiaries and their needs) as well as monitoring and evaluation (to ensure that programmes are achieving their objectives and produce evidence to substantiate the scale-up of programmes that have shown good results).

Fiscal space for social spending in South Asia

In South Asia, the combination of low domestic revenue generation, inadequate spending and deterioration of economic conditions continues to lead to increasing fiscal deficits and weak macroeconomic buffers, which in turn affect the capacity of countries to allocate resources to health, education and social assistance. However, South Asia is the fastest-growing region in the world, and even countries with tight budgets have the potential to increase investment in social sectors.

As the provision of health, education and social assistance requires stable and significant sources of financing, South Asian countries could consider the option of creating fiscal space through sustainable and equitable revenue mobilisation. Despite many efforts to increase tax-financed social policies (e.g. in Bhutan, Maldives, Nepal and Sri Lanka), inadequate domestic revenue mobilisation remains a considerable obstacle to development in the region. Overall, it seems that South Asian countries underexploit tax collection as a financing mechanism for social policies, which can be explained, to some extent, by structural factors such as low formal employment, widespread tax exemption and evasion, and weak tax administration. Direct taxation in the region is particularly low—increasing it would create more room for introducing more progressive taxation, especially in countries with high inequality, such as Maldives and Sri Lanka.

Beyond increasing domestic resource mobilisation, South Asian countries could improve social expenditure by addressing equity, efficiency and effectiveness issues on the spending side of the budget. A high level of expenditure on the military across the region, for instance, suggests that South Asian countries could consider switching expenditures as a way to create fiscal space for investment in the social sector. Improving fiscal management also requires systematic budget assessment, fiscal and benefit incidence analyses and transparency, as well as monitoring and evaluation of public policies.

Strong institutions and adequate budgeting and planning are key to support governments in their reprioritisation efforts. One common issue for many countries in South Asia concerns the heterogeneity of governance between different government units. In Nepal, for instance, poor implementation capacity at subnational government levels leads to budget under-execution. Similarly, in India, fiscal discipline is not uniform across states, and some manage to spend public resources more efficiently than others (in the sense that they achieve better social outcomes).

South Asian countries can alternatively explore other resources to increase the budget of social policies. Official Development Assistance (ODA), for instance, could be a starting point for financing social policies in countries where tax reforms are more difficult to implement, such as Afghanistan.

Conclusion and final policy recommendations

As South Asia countries continue to struggle with many forms of social exclusion (e.g. poverty, inequality, informality), which are caused to some extent by gaps in provision of health care, education and social assistance, governments should ensure that investments in these sectors reach those who are most in need. Moreover, policymakers need to align their spending on the social sector with their country's development needs, which means, *inter alia*, taking concrete steps to put political intent into practice (through legal and budgetary commitments, for instance) and setting expenditure targets according to countries' and sectors' specific contexts. South Asia is the fastest-growing region in the world, and even countries with a tight budget have the potential to increase investment in the social sector. Policymakers should make the most of economic, political and demographic opportunities to strengthen and fulfil commitments to provide health care, education and social safety nets.

Additional efforts are necessary to fill data collection and management gaps, to better understand these needs and inform decision-making, improve information systems and monitoring progress towards the achievement of development outcomes. As there are different government sectors competing to capture the often scarce public resources, it is crucial that policymakers rely on evidence on the effectiveness and efficiency of current spending to make better-informed decisions. All government expenses that seem excessive should be carefully evaluated to identify inefficiencies. Conversely, evidence pointing to the effectiveness of health care, education and social assistance policies can be used to scale up such programmes.

1. INTRODUCTION

Government spending on the social sector is crucial to ensure that South Asia's population has access to basic health care, education and social safety nets—key elements in policymakers' strategies to reduce poverty and improve overall well-being. Investments in the social sector are also known to generate positive externalities, given that an educated and healthy population benefits society as a whole—a widespread accumulation of human capital can improve productivity, increase tax collection, reduce disease transmission etc. (UNICEF 2015; De Janvry and Sadoulet 2015). The achievement of Sustainable Development Goal (SDG) 1 (“End poverty in all its forms everywhere”), SDG 3 (“Ensure healthy lives and promote well-being for all at all ages”) and SDG 4 (“Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all”), among others, depends on directing adequate funds to the social sector.

The market often fails to deliver health and education services, at least to those who cannot afford them, leading to underinvestment and limited access to basic services, which in turn can have long-lasting and even irreversible effects on the population's well-being (De Janvry and Sadoulet 2015). Such gaps in government provision of social services and adequate safety nets also mean that households are more vulnerable to financial distress caused by unemployment, pregnancy, old age, excessive expenditures on health and education etc. This can lead to situations where households resort to informal systems, such as uncertified medical assistance or relying on family networks for financial support, which are common practices in South Asia (Bonnerjee 2014).

These factors illustrate the case for the need for public investment in the provision of social services. Therefore, governments have the duty of anchoring their expenditures to the development needs of their country, to ensure that the population can develop their skills and health to have a decent quality of life without suffering financial hardships. Of course, it is not only the level of spending that matters—policymakers should also be concerned about efficiency and equity when allocating resources to different parts of the social sector.

The provision of social services and transfers is thus intrinsically related to government responsibility. In the case of South Asia, the role of governments is best described by Koehler (2014): “...the state in South Asian countries is tasked to advance economic growth and restructuring, as well as to deliver social, economic and political justice [...] Notably, it has the responsibility of tackling poverty and generating employment; in other words, taking on a developmental as well as a welfare role.” The establishment of a social contract is key for South Asian governments to fulfil this role, in the sense that welfare systems should be based on trust in the government to guarantee social cohesion through adequate revenue collection and mobilisation, and, as a counterpart, the delivery of quality social services and coverage of social protection (Alim and Mahato 2019).

Koehler (2014) identifies 2004 as a turning point in the importance of social policy, driven by a reshaping of the socio-political context of South Asia. As many countries experienced changes in government and strong economic growth, poverty and social exclusion started to receive growing attention, which was also reinforced by the call for action of international development goals (such as the Millennium Development Goals, the SDGs, Education for All, Universal Health Care, Universal Social Protection etc.). South Asian countries, therefore, strengthened their commitments to ensure equal access to basic health care, education and an adequate income, which led to certain expectations regarding the role of the State to deliver social services. However, there still seems to be a huge gap between government goodwill and concrete policy action, as these commitments have not been consistently translated into adequate allocation and management of funds in the social sector.

The objective of this report is to paint a broad picture of how governments in South Asia spend their resources on the social sector, focusing on health, education and social assistance, which are commonly seen as public policy priorities. A detailed assessment of health, education and social assistance expenditure, such as those conducted in benefit incidence and cost–benefit analyses, is beyond the scope of our study, as it requires an extensive analysis of budgets,

as well as other information such as utilisation rates or indicators that are sector- and/or country-specific. Our study will, however, discuss the main trends, challenges and opportunities, thus providing some guidance on how public social expenditure in South Asia can be improved. The arguments developed in our comparative analyses are not enough to prove any causality between social expenditure and outcomes—specific interventions in each sector need to undergo rigorous evaluations to generate evidence for policymaking. Moreover, as this is a regional analysis, we will not discuss country-specific characteristics and issues in detail, although we will provide country cases to illustrate our arguments.

We will base our analyses on country-level data on government expenditure in each social sector as well as key indicators of aggregate health, education and other social outcomes of the population of South Asian countries. As the scope of this study is to paint a broad picture of social expenditure, we will limit the analysis to the most relevant (or commonly used) aggregate measures of health, education and other development indicators. To that end, we will rely on data retrieved from international databases that use a uniform approach to the collection of data on social expenditures.⁶ It is important to keep in mind that official definitions of social spending may vary across countries, and this might be a problem even when using harmonised databases, as they often rely on reported national data. In some cases, we will look at the composition of social spending in each sector, but the report does not go into detail about which programmes are included in or excluded from country-specific definitions of health, education and social assistance expenditure.

Regarding data sources, numbers for government spending on health were retrieved from the World Health Organization's Global Health Expenditure Database (2019), which relies on information from national accounts or reports from Ministries of Health (or other public administrations), and eventually on estimations based on official information/literature/expert analysis. This data set is particularly complete, as it also disaggregates current health expenditure by source (government, out-of-pocket spending, external etc.). Public education expenditure was extracted from the United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute for Statistics (2019), which gathers data using surveys sent to UNESCO Member States (data reporting is based on national accounts or reports from Ministries of Finance and/or Education and/or National Statistical Offices). Finally, the main database used for government spending on social assistance was the World Bank's Atlas of Social Protection Indicators of Resilience and Equity (ASPIRE), which collects data from administrative programme records (World Bank 2019a). However, as will be discussed later in more detail, this data set has some limitations, such as out-of-date or missing information.

As for data on social outcomes and other indicators, other data sources were used, such as the World Economic Outlook (International Monetary Fund—IMF), World Development Indicators (World Bank), World Population Prospects (United Nations Department of Economic and Social Affairs), Human Development Indicators (United Nations Development Programme—UNDP) etc. Though some of these databases provided relatively comprehensive information, in some cases, missing data for some countries and/or years hindered comparability and detailed analysis of data. A great deal of the information is out of date, and though it provided important insights for our analysis, it would be extremely useful to update it in the future. This is the case, for instance, for data on catastrophic and impoverishing health spending (for South Asian countries, data are only available for a given year between 2007 and 2011).

For deeper analysis, it could be interesting to have access to more data disaggregated by income quantiles and by groups (for example, incidence of expenditure by gender, age, ethnicity, etc.). This would provide a clearer picture of inequity in service provision. For instance, in some countries, access at the national level might be high, but some groups (such as people living in remote or conflict-affected areas) might be excluded or have access to services of lower quality (UNICEF 2015). It would also have been useful to have compiled data on funding of education by source (as we have for health): the UNESCO Institute for Statistics website only provided this type of data for Nepal (household and government initial funding of education). Finally, there are some important sectors of social policy that will not be covered in this report but that might be interesting to explore in further research, such as housing programmes.

This study is divided into five parts. It starts by setting the scene by painting an overall picture of key development outcomes in South Asia and introducing some indicators of government spending in social sectors. The following

three chapters focus on public spending on health, education and social assistance, respectively. We chose to treat them separately, as the analyses for each sector answer different types of questions. Before concluding the report, we dedicate our last chapter to a discussion on the macro-fiscal issues related to social spending in the region and begin to explore how South Asian countries can improve their allocation of resources to these sectors.

2. SETTING THE SCENE

Overview of key development outcomes in South Asia

Despite the strong growth in gross domestic product (GDP) that most South Asian countries have been experiencing, all of them (except Maldives and Sri Lanka) remain classified as low-income or lower-middle-income countries (as per their level of gross national income (GNI) per capita). Moreover, the fact that different types of deprivations and social exclusion continue to affect large shares of the population suggests that the resources generated from economic growth were not consistently invested in the social sector (and thus that there is little redistribution of gains from growth).

Table 1. Socio-economic indicators of South Asian countries (latest available data)

Country	GDP growth	Income group (1)	HDI (2)	Poverty rate (3)	Gini Index (4)
Afghanistan	2.2	Low-income	0.498	54.5	
Bangladesh	7.4	Lower-middle income	0.608	14.8	32.4
Bhutan	7.3	Lower-middle income	0.612	1.5	37.4
India	7.3	Lower-middle income	0.64	21.2	35.7
Maldives	4.8	Upper-middle income	0.717	7.3	38.4
Nepal	6.3	Low-income	0.574	15	32.8
Pakistan	5.4	Lower-middle income	0.562	3.9	33.5
Sri Lanka	3.3	Upper-middle income	0.77	0.8	39.8

Notes: (1) The World Bank classifies as low-income countries those with a GNI per capita of USD1,025 or less in 2018; as lower middle-income economies those with a GNI per capita between USD1,026 and USD3,995; as upper middle-income economies those with a GNI per capita between USD3,996 and USD12,375; and as high-income economies those with a GNI per capita of USD12,376 or more.

(2) HDI = Human Development Index—an index ranging from 0 to 1 that combines three indicators: life expectancy at birth (health indicator), the geometric average of mean years of schooling for adults and expected years of schooling for school-aged children (education indicator), and the log of GNI adjusted by Purchasing Power Parity (PPP) per capita (income indicator).

(3) Poverty rates are measured as the poverty headcount ratio at USD1.90 a day (2011 PPP, percentage of population), except for Afghanistan, as the indicator was only available using the national poverty line.

(4) The Gini Index is an indicator of income inequality. It measures how far the distribution of income in a country differs from a situation of perfect equality, represented by a Gini Index of zero. A Gini Index of 100, on the contrary, corresponds to perfect inequality.

Source: Author's elaboration based on World Bank (2019c): income group; UNDP (2019): Human Development Index; IMF (2019b): GDP growth; and World Bank (2019b): poverty rate and Gini Index.

South Asian countries differ considerably in terms of their level of development: the regional average Human Development Index is around 0.6, ranging from 0.5 (Afghanistan) to 0.8 (Sri Lanka) (UNDP 2019). Poverty continues to affect millions of people in the region; incidence is particularly high in Bangladesh, Nepal, India and Afghanistan,⁷ while Bhutan, Maldives and Sri Lanka have the lowest rates (World Bank 2019b). Income inequality (which is particularly high in Sri Lanka, Maldives and Bhutan) and other forms of social exclusion such as limited access to public services hinder development across the region. According to UNESCO (2019) estimates, 11 million children of primary school age and 18 million of lower secondary age are out of school in South Asia. Many efforts are also needed to broaden the coverage of basic health care services such as essential immunisation and skilled attendance at birth (only Bhutan, Maldives and Sri Lanka are close to universalisation).

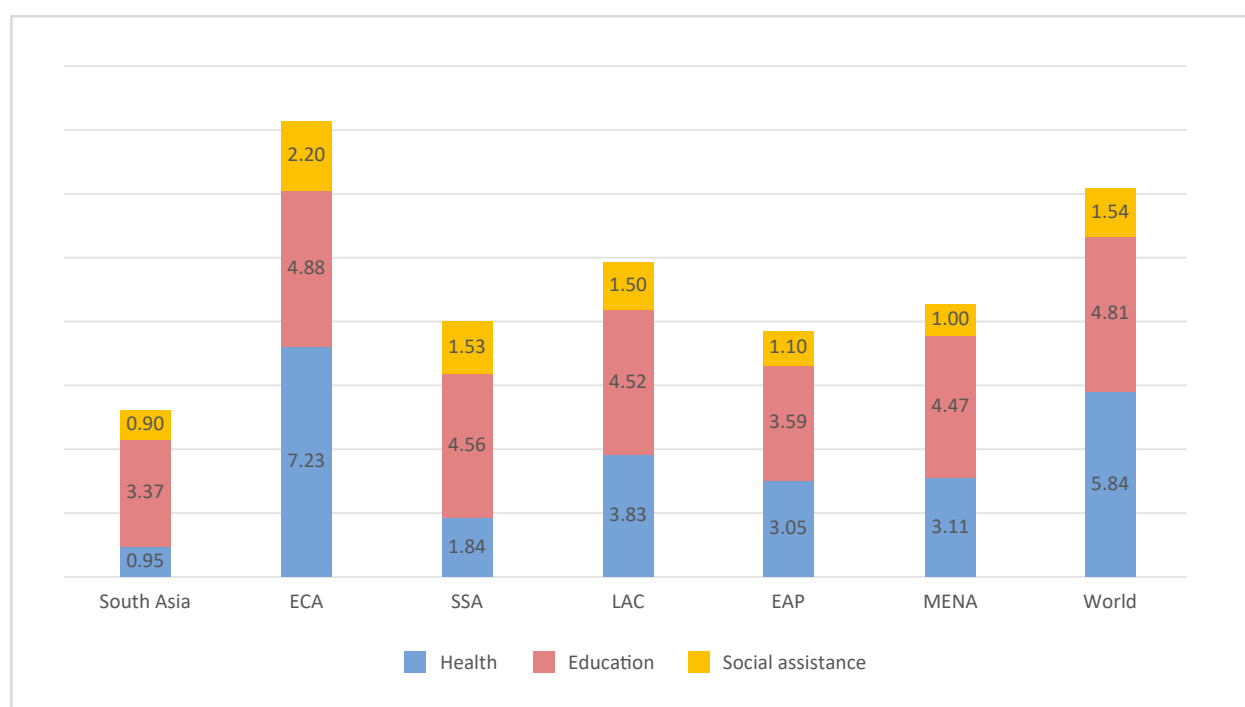
Challenging geographical settings in the region hamper the provision of public services (World Bank 2019b)—such is the case in Nepal, where a significant share of the population lives in remote locations with limited access to basic health and education services, and in Maldives, where the population is spread across around 200 islands. Policymakers also struggle to provide public services to people living in emergency settings—for instance, school participation is lower in areas affected by security and natural disasters in India, Sri Lanka, Bangladesh and Pakistan (UNICEF Regional Office for South Asia 2014).

The demographic contexts vary widely across South Asia. In some countries, public investment must keep up with the needs of a huge population (India) or density (Bangladesh and Maldives). The population remains relatively young in most countries: in Afghanistan, Nepal and Pakistan, over half the population is under 24 years old, but other countries have an ageing population (e.g. Sri Lanka) (United Nations Department of Economic and Social Affairs 2019). As countries experience different stages of the demographic transition, it is crucial for governments to invest in human capital to make the most of their demographic dividend.

Social spending in South Asia—a general picture

The path towards concretising government promises into population well-being has been uneven across South Asia. Structural challenges such as those discussed above result in a persisting need for public investment, and while government efforts have improved, they are hindered by gaps in budgetary and institutional capacity as well as contexts of political instability and social tensions. Figure 1 compares South Asia’s average social spending as a percent of GDP to those of other regions, revealing that the region is lagging behind in all sectors, as **average government expenditures on health, education and social assistance as a percentage of GDP are the lowest of all regions**.

Figure 1. Social expenditure (health, education and social assistance) as a percentage of GDP, regional averages

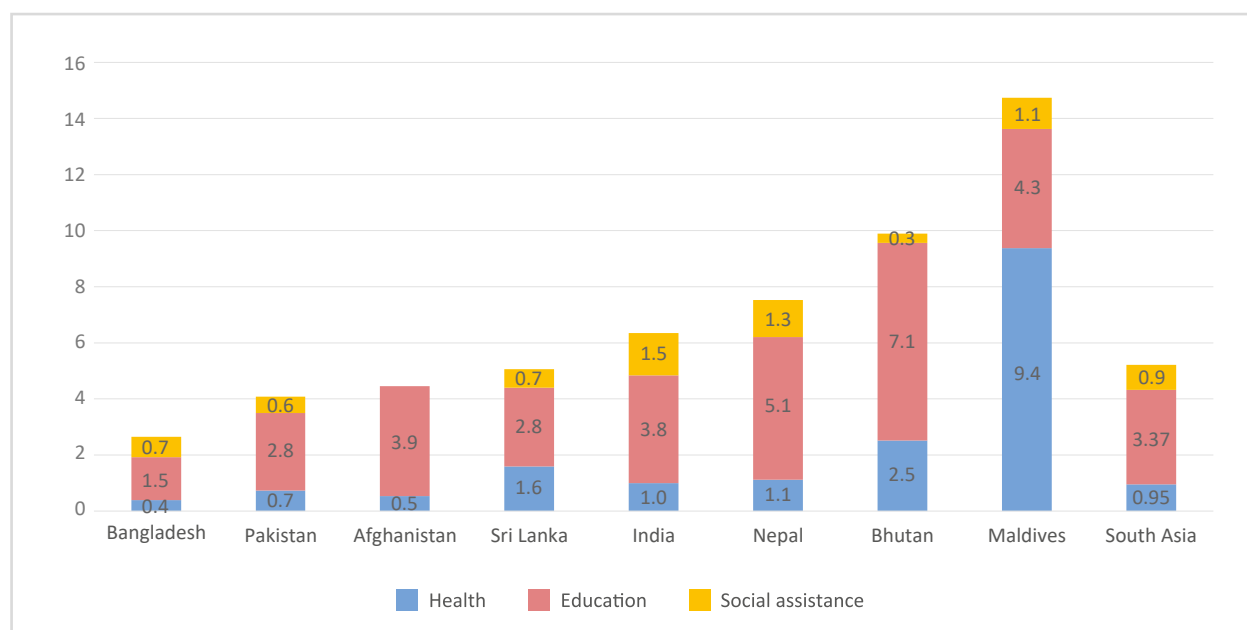


Note: ECA = Europe and Central Asia; SSA = Sub-Saharan Africa; LAC = Latin America and Caribbean; EAP = East Asia and Pacific; MENA = Middle East and North Africa.

Source: Author’s elaboration based on World Bank (2019a) and World Bank (2019d) and International Labour Organization (2017).

Figure 2 provides a first overview of social spending in South Asia, revealing a great heterogeneity within the region. When adding up government spending on health, education and social assistance, Bhutan and Maldives have the highest public social spending (they are also two of the countries with the highest total government expenditures as a share of GDP—see Figure 16) in the region. Bhutan devotes comparatively more public funds to education than its neighbours, while Maldives spends the most on health, and India on social assistance. At the other end of the spectrum, Bangladesh has the lowest share of spending on both health and education, and Bhutan spends the least on social assistance.⁸

Figure 2. Social expenditure (health, education and social assistance) by country, as a percentage of GDP (latest available data)



Source: Author's elaboration based on World Health Organization (2019), UNESCO (2019) and World Bank (2019d).

Though there is evidence of the critical role of public spending for improving social and economic development outcomes, especially for low- and middle-income countries, there is no consensus on the benchmark indicating which level of public spending is enough to meet a country's development needs (World Bank 2018b; Jowett et al. 2016). There is also no clear relationship between the amount spent in each sector and the related outcomes, as countries with similar levels of expenditure may vary in terms of performance. For instance, as we will see further in the report, Maldives and Sri Lanka have the best health and education outcomes of the region, but public expenditure in Maldives is considerably higher than in Sri Lanka. Other important factors explain differences in outcomes, as both supply- and demand-side challenges to the provision of social services affect the effectiveness of public spending. Some of these points will be developed in the following chapters, which focus on health, education and social assistance spending in South Asia.

3. GOVERNMENT EXPENDITURE ON HEALTH CARE IN SOUTH ASIA

Universal health care, as described in the SDGs,⁹ has two important dimensions: service coverage and financial protection. Thus, moving towards universal health care means ensuring that: a) the population has access to essential health care services (indicator 3.8.1); and b) no one needs to suffer financial hardship to access the health care they need (indicator 3.8.2) (United Nations 2019). Achieving universal health care seems to be an aspiration of governments in every country of the region (Scammell et al. 2016). However, government intent is not consistently translated in terms of public investment in the health sector, as in most countries government spending remains low. Despite the improvement of health outcomes, there is still much to be done in South Asia, and progress has been

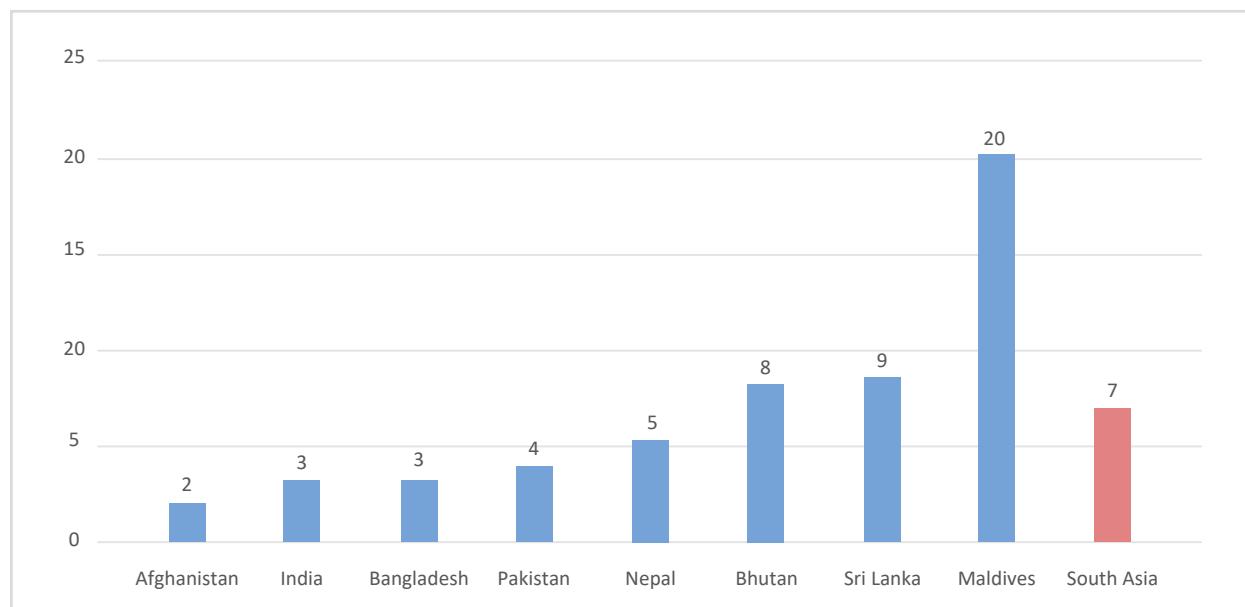
uneven across the region. This is illustrated by the huge variation in life expectancy at birth, ranging from 64 years in Afghanistan to 78 in Maldives. Similarly, while only Maldives and Sri Lanka have achieved SDG mortality rate targets, other countries (Afghanistan in particular) still have a long way to go.

This section discusses the general trends and patterns of health spending in South Asia. To do so, we will estimate countries' performance towards achieving universal health coverage using proxy indicators of coverage (immunisation rates and the proportion of births attended by skilled staff) and of financial protection (government expenditure on health per capita, as a share of GDP and of total health expenditure etc.). We will also look at other health outcomes such as life expectancy, mortality rates and underweight prevalence, as well as the sources of funding for countries' current health expenditure.

Recent trends in public spending for health care

Figure 1 in the previous chapter showed that governments of South Asian countries spend, on average, very little on health care compared to other regions: average public spending on health represents only 0.95 per cent of GDP, whereas sub-Saharan Africa, the next lowest, spends double as a percentage of GDP (World Bank 2019d), and the world average is 5.8 per cent. There is, however, great variation within the region: while the governments of Afghanistan, Bangladesh, India and Pakistan spend less than 1 per cent of GDP on health care, public spending is higher in Maldives, Bhutan, Sri Lanka and, to some extent, Nepal (Figure 2). This variation is also shown in terms of government priorities, as health spending as a share of total public expenditure ranges from 2 per cent in Afghanistan to 20 per cent in Maldives (clearly an outlier in the region), with a regional average of 7 per cent (Figure 3).

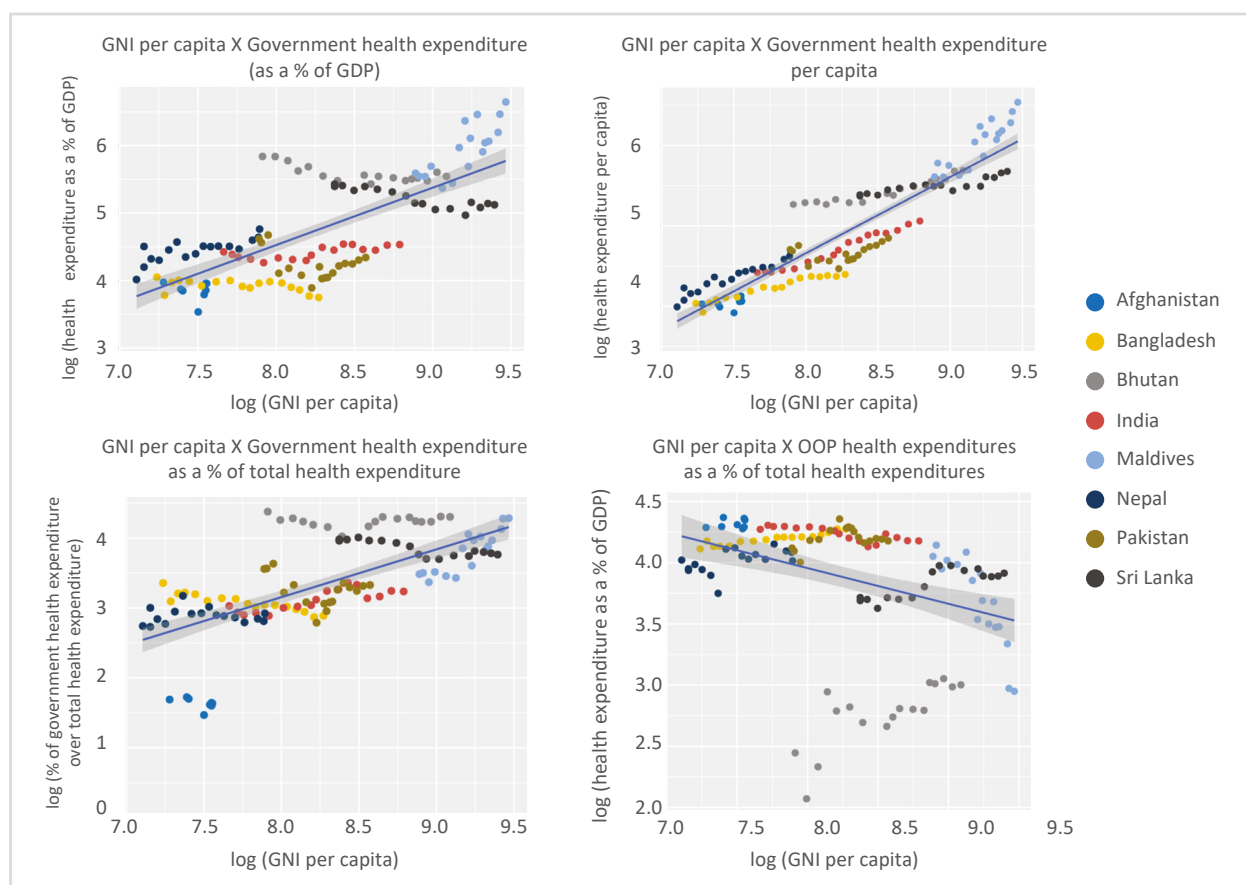
Figure 3. Domestic general government health expenditure (percentage of general government expenditure), 2016



Source: Author's elaboration based on World Health Organization (2019).

Turning to recent trends (Figure 4), we can see that growth in income per capita since 2000 in South Asian countries has typically been followed by increases in government spending on health (measured in per capita terms as a percentage of GDP and of total health spending). Government spending per capita, in particular, has increased in all countries, though in some more than others: since 2005 it has increased almost five-fold in Maldives and more than doubled in Bhutan, India and Nepal.

Figure 4. GNI per capita vs. health expenditure (various indicators) in South Asia



Note: GNI and spending per capita are measured in current international dollars (using PPP).

Source: Author's elaboration based on World Health Organization (2019) and World Bank (2019d).

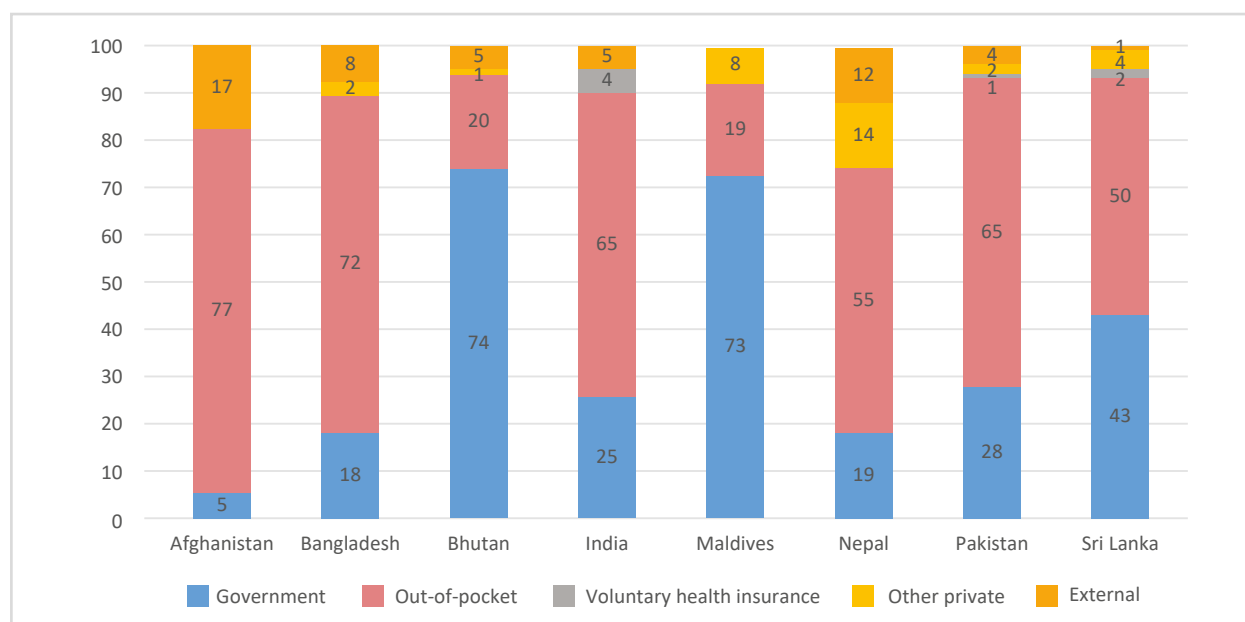
Who carries the burden of health care funding?

Figure 5 presents the main sources of health care financing in South Asian countries. In most countries, funding of health care comes mainly from private resources—more specifically, out-of-pocket spending (i.e. health spending directly paid by households). This type of financing corresponds to over half of total health expenditure in most countries in the region, and a particularly high proportion in Afghanistan (77 per cent) and Bangladesh (72 per cent). The high level of out-of-pocket spending in these countries illustrates the burden of health care payments on households, a consequence of the inadequacy of government provision of health services (Zaidi et al. 2017). In contrast, government is responsible for over 70 per cent of health care financing in Bhutan and Maldives, and 43 per cent in Sri Lanka (where out-of-pocket payments are mainly made by richer households) (Gottret et al. 2008).

Official Development Assistance (ODA) for health care is considerable in Afghanistan and Nepal, as can be seen by the high proportion of external financing (17 per cent and 12 per cent, respectively). Bangladesh, Bhutan and Pakistan also have some share of their health care financed by ODA. External financing for India, Maldives and Sri Lanka is insignificant.

Finally, the graph shows that voluntary health insurance and other private sources of health expenditure are not widespread in the region. In most countries, the share of current health expenditure funded by voluntary health insurance is close to zero. The countries with higher rates are India (5 per cent), Pakistan (1 per cent) and Sri Lanka (2 per cent), and in Nepal the category 'other private' represents 12 per cent of current health expenditures.

Figure 5. Sources of health financing as a percentage of current health expenditures



Source: Author's elaboration based on World Health Organization (2019).

The role of government in financing health care

Health care costs can be unpredictable (in terms of both occurrence and amount), and when it is left to households to bear excessive out-of-pocket expenditures, the consequences might be inadequate treatment, no treatment at all, or impoverishment due to the high burden of expenses. Therefore, among the key roles of governments in health care provision is risk pooling by: i) collecting the necessary resources to finance public health care services; and ii) organising mechanisms to reduce financial risks caused by excessive out-of-pocket spending (Gottret et al. 2008; Jowett et al. 2016).

Wagstaff et al. (2018a; 2018b) measure the incidence of out-of-pocket health expenditures on households' income using data from household surveys in over 100 countries. Data for seven countries of South Asia (all except Bhutan) are presented in Table 2. They define catastrophic health spending as out-of-pocket expenditures that exceed 10 per cent and 25 per cent of household consumption (or income, depending on the survey). When aggregated at the country level, it is measured as the percentage of the population whose out-of-pocket health care expenditures are above the threshold. In Bangladesh, India, Maldives and Nepal, over 10 per cent of the population spends more than 10 per cent of their income/consumption on out-of-pocket health care expenditures. Nepal has the highest rate (27 per cent of the population). When considering the threshold of 25 per cent of household income/consumption, the highest incidences of catastrophic health spending are found in Bangladesh (4.8 per cent), India (3.9 per cent) and Nepal (3.3 per cent of the population).

Impoverishing health spending, on the other hand, is defined as a situation where a household is pushed below the poverty line by its out-of-pocket health expenditures. The underlying idea is that some households have to pay excessive health care costs; thus their consumption of essential non-health goods and services (such as food) is affected, sometimes to the point of creating or deepening a situation of poverty. As for catastrophic health spending, Table 2 presents aggregate results, measured in terms of incidence (proportion of the population pushed below the poverty line by out-of-pocket health spending) as well as depth (i.e. increase in the country's poverty gap due to out-of-pocket expenditure). Among all the countries studied by Wagtsaff et al., Bangladesh and India are those with the highest incidence of impoverishing health expenditure (using the USD1.90 poverty line): according to data from household surveys (2010–2011), more than 4 per cent of the population is estimated to have been pushed below the poverty line by out-of-pocket spending on health care.

Table 2. Catastrophic and impoverishing health expenditure for South Asian countries

Country	Year	Catastrophic health expenditure		Impoverishing health expenditure			
		Proportion of population spending above the threshold of household consumption or income on out-of-pocket health care expenditure [%]		Proportion of population pushed below poverty line by out-of-pocket health care expenditure [%]		Increase in poverty gap due to out-of-pocket health care expenditure [% of poverty line]	
		10%	25%	USD1.90	USD3.10	USD1.90	USD3.10
Afghanistan	2007	4.8	0.1	0.6	2.5	0.1	0.7
Bangladesh	2010	13.6	4.8	4.5	4.1	3.4	3.9
India	2011	17.3	3.9	4.2	4.6	1.1	2.5
Maldives	2009	20.1	1.6	0.5	0.6	0.1	0.4
Nepal	2010	27.4	3.3	1.9	5.6	0.5	2.0
Pakistan	2010	1.0	0.0	1.0	2.4	0.1	0.8
Sri Lanka	2009	2.9	0.1	0.0	0.4	0.0	0.1

Source: Author's elaboration based on Wagstaff et al. (2018a; 2018b).

Box 1. Benefit Incidence Analysis of health care in South Asia

As poverty and income inequality persist as challenges in South Asia, so do other types of social exclusion such as those related to access to public services. Some vulnerable categories of the population do not benefit as much as others from investment in the social sector, and this seems to be particularly the case for health.

Different studies have tried to analyse the incidence of social expenditure in South Asian countries. As household questionnaire surveys have become more widely available, there has been an increase in the number of studies adopting a Benefit Incidence Analysis (BIA) framework¹⁰ in South Asia.

Most BIA studies on public expenditure in South Asia have focused on health care. Among more recent studies, Bowser et al. (2019) use BIA to analyse the distribution of health care utilisation and spending in India using 2014 national survey data. They find that utilisation of government inpatient and delivery services is pro-poor, but when gross and net benefits are included, services become more equalising and less pro-poor. Despite overall improvements in terms of equity, the authors find that government spending on health care has not resulted in significantly pro-poor services. In addition, they find significant heterogeneity across Indian states, including worse outcomes, in terms of equity, in some rural states.

Saito et al. (2016) use cross-sectional data to analyse inequality in access to health care in urban Nepal. They find a significant pro-rich distribution of general health care utilisation among all service providers, and especially among private providers. They find that, despite the provision of free services by public health care providers, there is no evidence of poor people making more use of public health services.

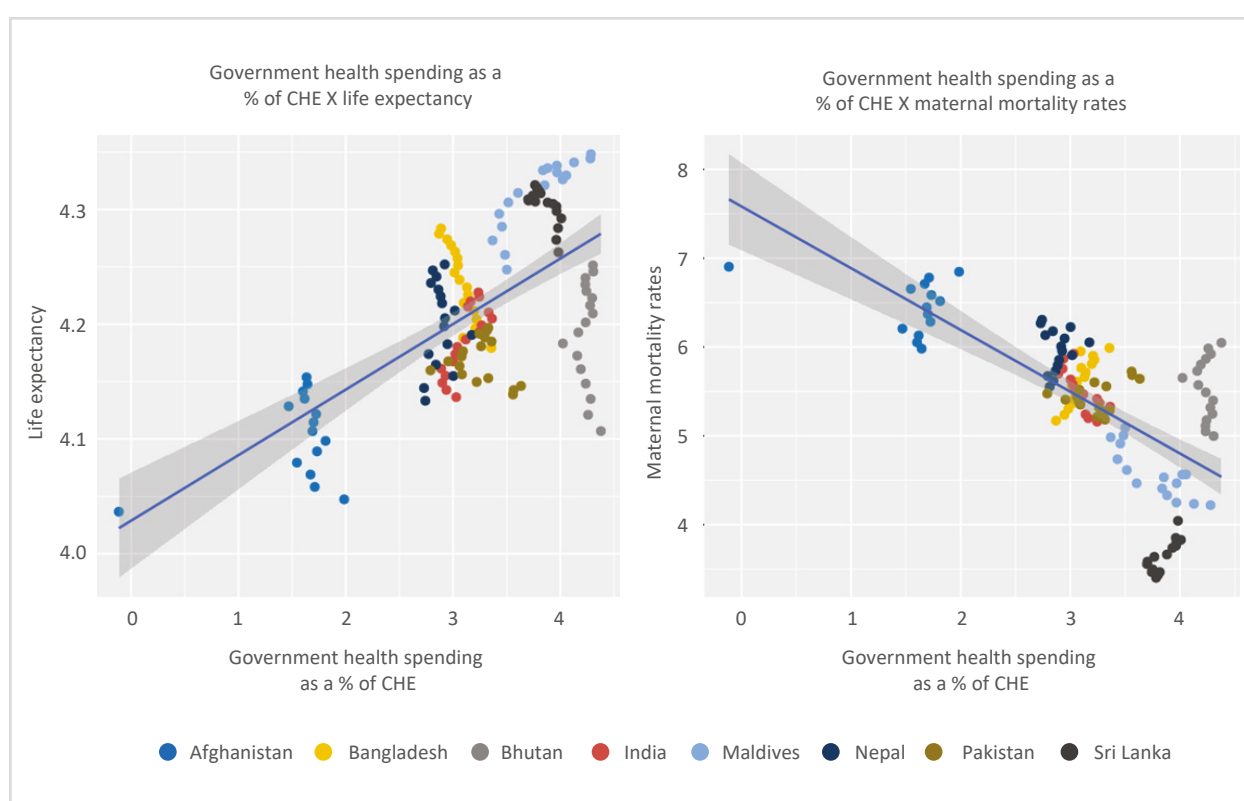
Asante et al. (2016) conduct a systematic review of evidence from studies using BIA and Financing Incidence Analysis (FIA) in low- and middle-income countries. Of the 24 studies included, five were from South Asia (India, Nepal, Pakistan, Bangladesh and Sri Lanka). In India, they find a pro-poor distribution of health benefits at the primary health care level and a pro-rich distribution at the hospital level. In Pakistan, Nepal and Bangladesh, they find a pro-rich distribution at both primary health care and hospital levels, making the distribution in these countries firmly pro-rich. In the case of Sri Lanka, they find that both primary health care and hospital services are pro-poor, although inpatient care is marginally pro-rich.

To reduce financial risks caused by excessive health care spending, it is crucial that public health care policies reach the most vulnerable categories of the population. In this sense, Benefit Incidence Analysis (see Box 1) can be very useful to assess whether government spending on health is pro-poor or pro-rich.

How does expenditure on health care compare to health outcomes?

The importance of government participation in health care financing (typically as opposed to a high proportion of out-of-pocket spending) is also shown in Figure 6, which shows its correlation to key population health outcomes in South Asian countries: life expectancy tends to be higher and child and maternal mortality rates¹¹ lower when government spending as a share current health expenditure (CHE) is higher.

Figure 6. Government spending as a proportion of current health expenditure vs. life expectancy and maternal mortality rates, 2000–2016



Source: Author's elaboration based on World Health Organization (2019) and World Bank (2019d).

Table 3 compares public spending in the health sector to key health outcomes for all countries in South Asia. Maldives, Bhutan and Sri Lanka have the best indicators of financial protection, in the sense that government health spending (as a share of GDP per capita, of total government expenditures and of current health expenditures) are the highest in the region. Maldives is the country in the region spending the most on public health by all measures, making it an outlier in South Asia in terms of health spending. One exception is the share of government spending in total health expenditure, but it is not far behind Bhutan, and the indicator is over 70 per cent for both countries (whereas for all other countries, the government participates in less than half of health spending). Accordingly, they have the lowest out-of-pocket expenditures of the region. Maldives has experienced the fastest increase in public health spending since circa 2005, both as a share of GDP and in per capita terms. Health outcomes are among the best in the region for most indicators,¹² as can be illustrated by the impressive life expectancy at birth, which is close to 78 years.

Table 3. Health indicators for South Asian countries, latest available data

	Financial protection				Life expectancy at birth	Outcomes				Coverage			
	Government expenditure					Mortality rates			Underweight prevalence [3]	Immunisation			% of births attended by skilled health staff
	% of GDP	% of government expenditures	Per capita (PPP)	% of current health expenditures		Maternal [1]	Infant [2]	Under 5 [2]		DPT [4]	Measles [4]	HEPB3 [5]	
Afghanistan	0.5	2.0	8.3	5.1	64	396	51.5	67.9	25	65	62	65	50.5
Bangladesh	0.4	3.4	16.3	18.0	73	176	26.9	32.4	32.6	97	94	97	49.8
Bhutan	2.6	8.3	216.8	74.0	71	148	25.6	30.8	12.8	98	97	98	89
India	0.9	3.1	61.4	25.4	69	174	32	39.4	35.7	88	88	88	81.4
Maldives	7.7	20.2	1181.7	72.6	78	68	6.8	7.9	17.8	99	99	99	99.5
Nepal	1.2	5.3	29.0	18.6	71	258	27.8	33.7	27	90	90	90	58
Pakistan	0.8	3.9	40.2	27.9	67	178	61.2	74.9	31.6	75	76	75	69.3
Sri Lanka	1.7	8.6	211.8	43.1	75	30	7.5	8.8	20.5	99	99	99	99.95
Average	2.0	6.8	220.7	35.6	70.8	178.5	29.9	37.0	25.4	88.9	88.1	88.9	74.7
Median	1.0	4.6	50.8	26.7	70.6	175.0	27.4	33.1	26.0	93.5	92.0	93.5	75.4

Notes: DPT = Diphtheria, pertussis and tetanus; HEPB3 = Hepatitis B (three doses); (1) Modelled estimate, per 100,000 live births; (2) Per 1,000 live births; (3) Percentage of children under 5 years; (4) Percentage of children aged 12–23 months; (5) Percentage of children aged 1 year.

Source: World Health Organization (2019) and World Bank (2019d).

While Bhutan follows in second place in terms of financial protection, some of its health outcomes are lagging behind: life expectancy is not very high (around the regional average) but has increased by around 5 years since 2005, and mortality rates have steadily decreased. In terms of broad coverage, immunisation rates are above 97 per cent, and 89 per cent of births are attended by skilled health staff. Both of these indicators are significantly higher than the regional average. Bhutan has the lowest underweight prevalence in the region, but it is high nonetheless, at 12.8 per cent of children under 5. One possible explanation for this lower-than-expected progress could be the high inequality of health service coverage. For instance, the proportion of births attended by skilled health staff is estimated to vary between less than 40 per cent for the poorest quintile and 100 per cent for the highest, with considerable inequalities also between urban and rural areas (Scammell et al. 2016; Akseer et al. 2017).

Sri Lanka also has an overall positive outlook. Government health expenditure as a percentage of GDP is not exactly exceptional, but when measured as a share of total government spending, it stands out from most countries in the region. The Government of Sri Lanka is responsible for over 40 per cent of current health expenditures, while out-of-pocket expenditures represent over half. Health outcomes in Sri Lanka are among the best in the region, with the second highest life expectancy and extremely low mortality rates (especially maternal, which are the lowest in the region). The country has almost 100 per cent immunisation rates, and nearly all births are attended by skilled health staff.

At the other end of the spectrum, Afghanistan directs a mere 2 per cent of government spending to health, which corresponds to around 0.5 per cent of the country's GDP and 5 per cent of total current health expenditures. Overall, the health outlook in Afghanistan is worrying, as out-of-pocket expenditures are the highest in the region, and life expectancy and immunisation rates are the lowest. Mortality rates (especially maternal) are extremely high, which might be partially explained by the fact that only half of births are estimated to be attended by skilled staff. This overall negative outlook is to be balanced against an impressive evolution in some outcomes—for instance, Afghanistan has experienced a decrease in mortality rates and an increase in the share of births attended by skilled staff since the early 2000s.

Bangladesh also has extremely low health financial protection, especially when considering health spending as a percentage of GDP, in per capita terms and as a share of current health expenditures. Public health spending as a share of GDP has even slightly decreased since circa 2005, and out-of-pocket health expenditure is worryingly high in the country (exceeding 70 per cent). Health outcomes, however, are not exactly among the worst in the region, and the trends are actually rather positive: life expectancy is above the regional average, mortality rates and, to a lesser extent, underweight prevalence have been steadily decreasing, and immunisation rates are increasing. One exception is the share of births attended by skilled health staff, which is estimated to be the lowest in the region (less than 50 per cent), although Bangladesh is also showing improvements.

Pakistan is also at the low end of the spectrum in terms of health expenditure and outcomes: as a share of GDP, government spending on health is only higher than that of Afghanistan and Bangladesh. Out-of-pocket expenditures are also very high, and life expectancy is the second lowest in the region. Moreover, health indicators of underweight prevalence, mortality rates, immunisation and skilled attendance at birth have been improving but remain at worrying levels, which indicates the need for investment in maternal and child health care interventions.

Box 2. Sri Lanka: Challenging the status quo on good practices in the health system

Due to its strong performance in the health sector in the last 50 years, Sri Lanka is regarded as a positive outlier among countries at its income level. For instance, it has achieved outstanding results in maternal and child health and in control of infectious diseases. Since the 1930s the government has maintained a policy of universal free public health care for all, so the public health system is funded solely by tax revenues. This situation is even more notable as, by regional standards, government expenditure on health as a share of GDP is relatively low in Sri Lanka. Or, in other words, Sri Lanka's case shows how to achieve satisfactory health outcomes at low cost, defying common claims regarding good practices for health care systems (Smith 2018).

Instead of carrying on health financing reforms, Sri Lanka has achieved effective service delivery through effective resource management. Sri Lanka shows that it is possible to achieve universal public health coverage without relying on user fees, community financing or mandatory insurance schemes. On the contrary, to deal with budget constraints, the country improved its supply-side management (Rannan-Eliya and Sikurajapathy 2009). For instance, Sri Lanka spends around 10 per cent of its health budget on primary care, responsible for the excellent outcomes in maternal and child health and, in this way, indicating that an effective preventive system can be afforded relatively cheaply (Smith 2018).

Sri Lanka has selected options with the greatest marginal welfare benefits, going beyond the classical cost-benefit criterion (Rannan-Eliya and Sikurajapathy 2009; Smith 2018). Even though investing in primary care is a more cost-effective option, Sri Lanka's government has chosen to devote a greater share of its health budget to inpatient care. Given that primary care (e.g. consultations) is a cheaper service and that the private sector competes with an effective public system (which pushes the prices down), many households are able to pay for those services from private sources. In this way, in the Sri Lankan context, inpatient care leads to a greater welfare gain in terms of financial and social protection, as the public sector covers around 90 per cent of inpatient care and around 50 per cent of outpatient care.

Sri Lanka's experience shows that a high level of out-of-pocket expenditure does not necessarily mean ineffective financial protection for poor people (Smith 2018). The out-of-pocket share of health expenditures in Sri Lanka is high, exceeding 40 per cent of current health expenditures in the country, but these costs are incurred mostly by richer households. This can be partly explained by the fact that private consultations are relatively cheap, given that the private sector competes with an effective free public sector. In general, those who use private outpatient services are looking for a more client-oriented experience. For instance, in the private sector, patients can see the doctor they prefer, at a more convenient time for them. In this way, Sri Lanka's health care system can be regarded as relatively equitable.

India's government spending on health care is lower than the regional average, and out-of-pocket spending is very high. Health outcomes are usually not far from the regional average, except for underweight prevalence, which is the highest in the region. However, the overall scenario seems to have been improving since the early 2000s, especially when considering coverage indicators such as immunisation rates and skilled attendance at birth (exceeding 80 per cent, which is above the regional average and has almost doubled).

Nepal's government expenditures on health as a share of GDP are around the average for the region, and slightly above the average in terms of total government spending. When measured as per capita spending and as a share of total current health expenditures, however, government expenditures are only higher than those of Afghanistan and Bangladesh. Out-of-pocket spending is a bit lower than the regional average. Regarding key health outcomes, Nepal usually fares slightly better than several South Asian countries (for all indicators except maternal mortality rates and underweight prevalence). Mortality rates have been decreasing, though maternal mortality rates remain quite high, and less than 60 per cent of births are attended by skilled health staff. However, we should note that Nepal has seen the greatest improvement of this last indicator since circa 2005, as it has more than tripled.

This regional comparison shows us that countries with similar levels of health spending (especially countries where this level is low) can have widely different performance when it comes to service and financial coverage. Sri Lanka, for instance, has achieved outstanding health indicators with lower spending than countries such as Maldives and Bhutan. This indicates that, beyond increasing the allocation of resources to the health sector, governments can focus on improving expenditure management and service delivery to broaden access to essential health care and reduce the burden of health spending on households (Jowett et al. 2016).

4. GOVERNMENT EXPENDITURE ON EDUCATION IN SOUTH ASIA

According to UNESCO Institute for Statistics estimates, South Asia is home to more than 11 million out-of-school children of primary school age. The number is even higher for lower secondary, as 18 million South Asian adolescents are not attending school. The proportion of out-of-school children is particularly high in Bhutan and Pakistan.¹³ In contrast, some countries are coming close to universal basic education for primary and lower secondary education: in Sri Lanka and Maldives, nearly all children of these age groups attend school, and this is also true for Nepal, but only for primary education (UNESCO 2019).

Regional average public spending on education of 3.4 per cent of GDP remains below the world average (4.8 per cent) and is the lowest of all regions. To achieve universal access to basic education (i.e. ensuring that all children of primary and lower secondary age are enrolled in school and benefit from quality education) by improving intake, completion and learning, it is crucial that South Asian governments direct the appropriate funds to the education sector. In this section, we will analyse the current public expenditures of South Asian countries and compare them to key education outcomes so as to estimate whether public spending responds adequately to the needs of its population.

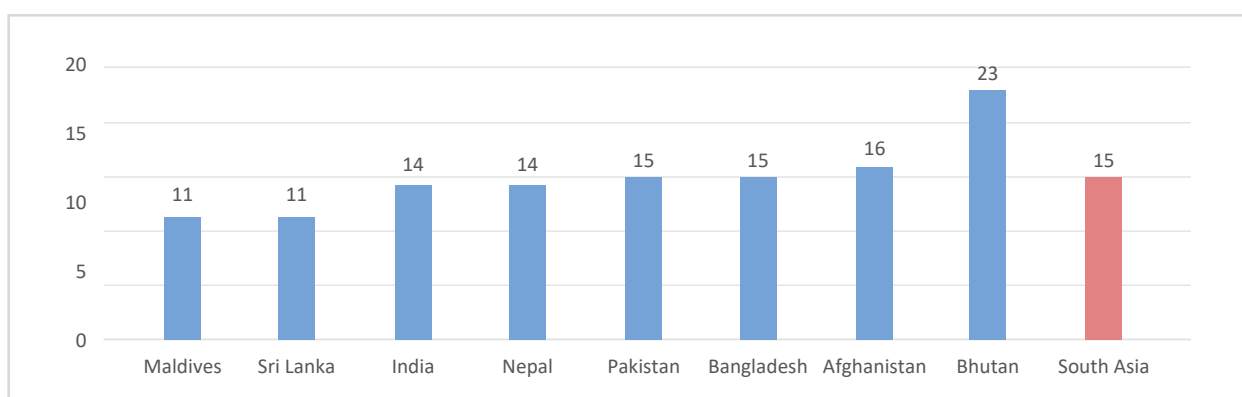
Recent trends in education spending

Despite the overall low level of public spending as a share of GDP, of the three social sectors considered in this study, education is typically the one receiving the most public funding in the region, which suggests that it is considered a priority. The only exception is Maldives, where health expenditure is higher. This is illustrated in Figure 7: all countries allocate over 10 per cent of the government budget to education expenditures (in Bhutan, the share exceeds 20 per cent), and the regional average is around 15 per cent (against 7 per cent for health). The Education 2030 Framework for Action (UNESCO 2015) proposes that governments must allocate 4-6 per cent of their GDP and/or 15-20 per cent of total public expenditure to education, ensuring efficient spending and prioritising the most marginalised groups.

According to these benchmarks, both South Asia's regional average and its countries considered individually are close to the lower limit of or below recommended expenditure.

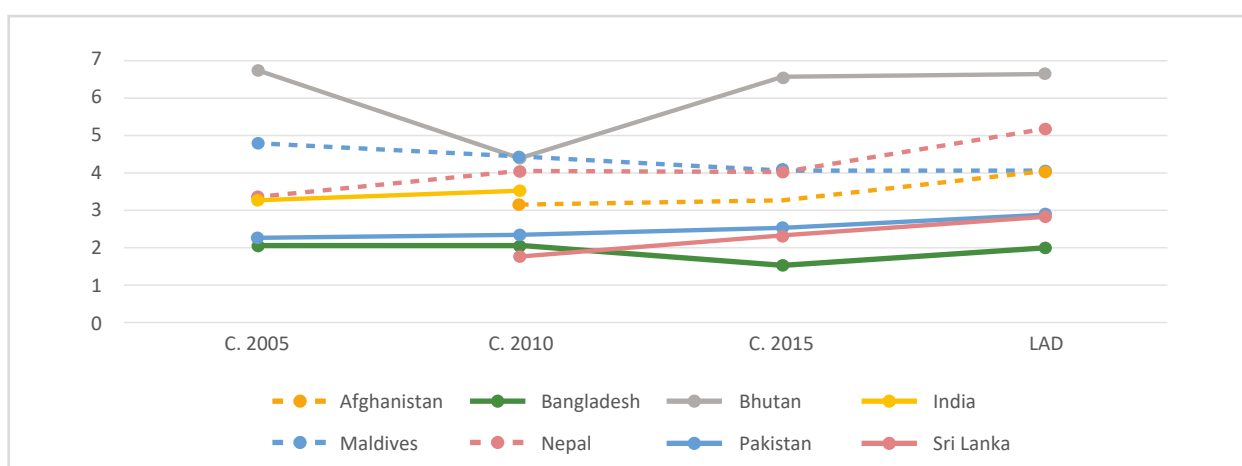
Figure 8 shows how government expenditures on education across South Asia have evolved since 2005. We can see that education spending as a share of GDP has increased since circa 2010 in Afghanistan, Bhutan, Nepal, Pakistan and Sri Lanka. Meanwhile, it has decreased in Bangladesh and Maldives. However, care should be taken to avoid mistakes with our analysis, as we are only considering public expenditure on education as a percentage of GDP, without delving deeper into each country's macroeconomic trajectory. Therefore, we do not consider whether some countries have had more or less elasticity in their expenditure budgets vis-à-vis variations in GDP, and whether a smaller proportion of GDP going to education might still mean increased allocations for the sector in real terms. In Maldives and Bangladesh, for example, GDP has increased significantly between 2010 and the latest available year for which data is available. This means that even though education expenditure as share of GDP has decreased, the actual allocation of funds for education has increased in real terms. Data for India (latest numbers are from 2013) suggest a slight increase in public spending on education since circa 2005 (from 3.3 per cent to 3.8 per cent of GDP).

Figure 7. Government expenditure on education (percentage of government expenditure), latest available data



Source: Author's elaboration based on UNESCO (2019).

Figure 8. Education expenditure as a share of GDP, circa 2005, 2010, 2015 and latest available data



Note: Because of the gaps in education expenditure data, we chose to aggregate this indicator by three-year periods (circa 2005 for the 2004–2006 period, circa 2010 for the 2009–2011 period and circa 2015 for the 2014–2015 period), adding the latest available data. No recent data were available for India (the latest available were for 2013).

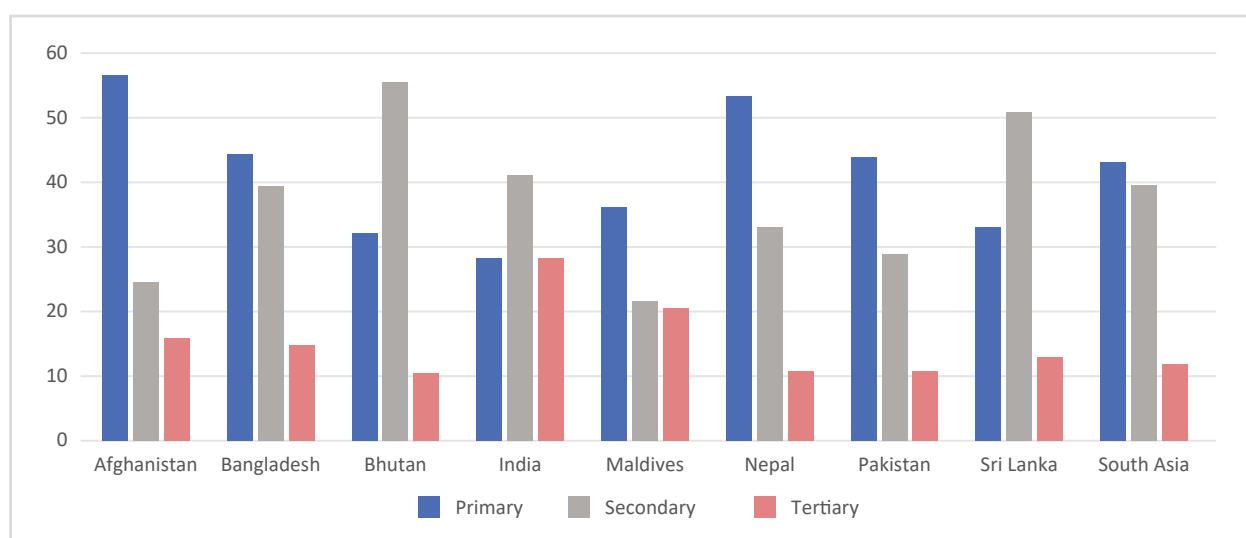
Source: Author's elaboration based on UNESCO (2019).

Government priorities in education spending

While in Bhutan (6.6 per cent) and Nepal (5.2 per cent), education expenditure as a share of GDP is even higher than the world average of 4.8 per cent, other countries have much lower expenditures, and, as we will see, the way in which funds are allocated within the education sector also varies in the region. One important factor to consider is that the incidence of education spending varies across school levels, as different categories of the population might benefit more from government investment in certain levels of education. UNICEF's Education Strategy 2019-2030 (UNICEF 2019) and many other landmark development guidelines posit that education should be guided by the principle of progressive universalism. According to The International Commission on Financing Global Education Opportunity (2016), this principle means "expanding provision of quality education for everyone while prioritizing the needs of the poor and disadvantaged. It provides a guiding principle to inform spending decisions, recognizing the scarcity of public funding. The Commission recommends that, when balancing spending across different levels of education and population groups, decision-makers should prioritize the poor and early years where social returns are highest, and minimize household spending on basic education by the poor." Accordingly, while expenditure on basic (primary and secondary) education tends to be more pro-poor (as households of the poorest quintiles tend to have more children), spending on tertiary education is usually considered regressive (World Bank 2018b).

Figure 9 shows how South Asian governments allocate education expenditure across levels. In Afghanistan and Nepal, over half of public education funds are allocated to primary education, whereas in Bhutan and Sri Lanka, the lion's share of the education budget goes to the secondary level. Regional average spending on tertiary education is 16 per cent of total government expenditure on education, but India (a fast-growing lower-middle-income country) and Maldives (an upper middle income country) invest considerably more than other countries (29 per cent and 21 per cent respectively). Naturally, these different allocation patterns across different educational levels by each country mirror not only budgetary 'preferences' in the volitional meaning of the word, but also responses to contingencies determined by a number of factors that shape their respective educational demands, namely: the specific demographics of each country, different levels of participation in secondary and tertiary education, the economic status of the population, country and population size, etc. Afghanistan and Nepal, the two countries in the region that dedicate more than 50 per cent of their educational budgets to primary education, illustrate two different demand-side reasons behind the expenditure profiles illustrated in Figure 9.

Figure 9. Expenditure on each level of education as a percentage of total government expenditure on education



Note: Numbers are from 2012 (Bangladesh), 2013 (India), 2014 (Bhutan), 2015 (Afghanistan and Nepal) and 2016 (Maldives, Pakistan and Sri Lanka). In some cases (for some countries/levels), more recent data were available, but for matters of comparability, we chose to use years with data available for all levels.

Source: Author's elaboration based on UNESCO (2019).

In Afghanistan, for example, the large investment in primary levels of education is broadly determined by the fact that it is the only country in the region with a pre-demographic dividend profile. Therefore, the pressure is high on primary education, as that age group is still undergoing rapid growth. In addition, the country has a large out-of-school population (UNESCO 2019).

In Nepal, the main determinant is not so much the demographic situation of the country but rather the different degrees of participation across educational levels. Despite children of primary education decreasing in numbers, the participation rate at the primary level is much higher than at other educational levels (in fact, participation rates at the primary level are higher than those at secondary and tertiary levels combined) (UNESCO 2019).

Expenditure per student for primary education as a share of per capita GDP ranges between 8 per cent in Bangladesh and Pakistan, and 14 per cent in Maldives and Bhutan (Table 4). There is more heterogeneity at secondary and tertiary levels: per student spending on secondary education ranges from 10 per cent of GDP per capita in Bangladesh and Sri Lanka to 32 per cent in Bhutan; for tertiary education, Nepal and Sri Lanka have the lowest per student spending (25 per cent and 26 per cent of GDP per capita, respectively), whereas Bhutan and Pakistan spend considerably more per student (55 per cent and 64 per cent of GDP per capita, respectively).

To see whether government priorities are in line with South Asian countries' needs, we can compare expenditure on each level of education with relevant educational outcomes. There is an ample choice of indicators that could be considered, such as internal efficiency coefficients (to see whether higher levels of spending over time in one level of education has led to efficiency gains), the proportion of qualified students per student, the infrastructure available for schools, student performance on standardised tests, and so on. Since these and other outcomes would be better discussed in an in-depth analysis of the education sector, we limit our analysis to compare expenditure profiles down to a simple, yet important outcome indicator, namely graduate rates per level. We chose this indicator because it is relatively simple, yet representative of broader trends in the education sector, and because it is readily available in a disaggregated format for each level of education. It is also an important indicator for measuring progress towards fulfilling SDG 4: "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all".

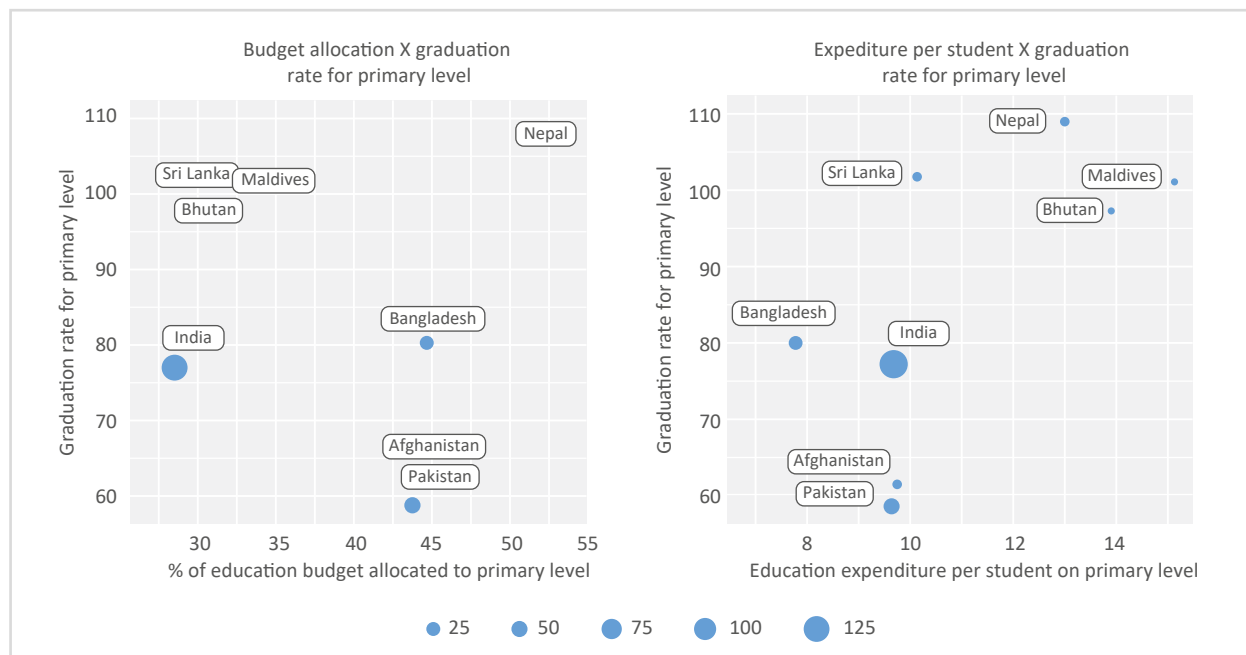
Table 4. Government expenditure per student by level of education, latest available data

	Primary		Secondary		Tertiary	
	% of GDP per capita	PPP USD	% of GDP per capita	PPP USD	% of GDP per capita	PPP USD
Afghanistan	10	192	11	211	41	799
Bangladesh	8	166	10	365	31	1,104
Bhutan	14	1,013	32	2,489	55	3,995
India	10	480	17	827	49	2,417
Maldives	14	2,321	17*	2,793*	30	4,328
Nepal	13	311	11	263	25	607
Pakistan	8	478	15	543	64	1,465
Sri Lanka	10	1,296	10	1,328	26	3,388

Note: * Data available for lower secondary only.

Source: Author's elaboration based on UNESCO (2019).

Figure 10. Graduation rate vs. expenditure on primary education as a share of education spending and per student (bubbles are proportional to the number of children of primary school age)

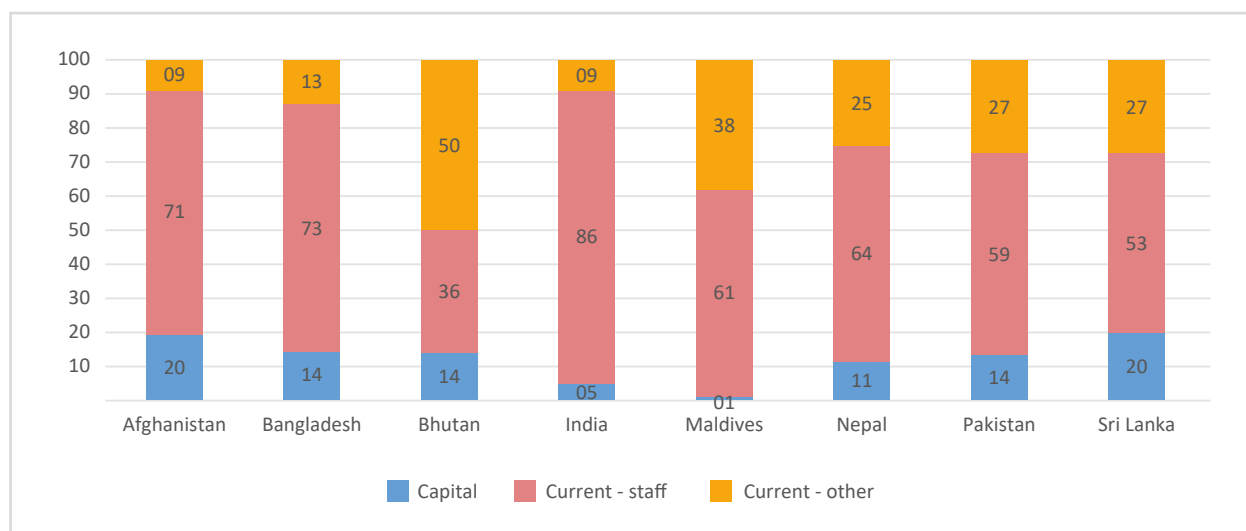


Note: Primary education expenditure per student is measured as a share of per capita GDP.

Source: Author's elaboration based on UNESCO (2019) and World Bank (2019d).

Finally, when disaggregating education spending by nature of expenditure (Figure 11), we can see that most public education funds are spent on current expenditure, including staff (and teacher) payments, representing over half of education expenditures in all countries except Bhutan.

Figure 11. Nature of education expenditure (as a percentage of total expenditure in public institutions), latest available data



Note: Data are from 2015–2017 for all countries except India (from 2005).

Source: Author's elaboration based on UNESCO (2019).

How does expenditure on education compare to education outcomes?

South Asian countries spend, on average, 3.4 per cent of GDP on education. Four countries exceed the regional average: Bhutan (6.6 per cent), Nepal (5.2 per cent), Afghanistan and Maldives (4.1 per cent). However, education spending in these four countries results in widely different indicators. Afghanistan struggles to achieve decent outcomes, as over half of the population is illiterate, and available data on education indicators show that the country fares worse than others in the region (except Pakistan, in some cases). Maldives,¹⁴ on the contrary, has some of the best outcomes in the region, with the highest literacy rates (almost 100 per cent for both adults and youth) and primary school enrolment, and the lowest rate of out-of-school children (primary education) in the region.

Bhutan has the highest spending as a share of GDP, but its education outcomes are not as good as they could be, also because some outcomes take longer to mature than others—in which case the mismatch between expenditure and outcomes shouldn't necessarily be interpreted as poor performance of the entire system. The country devotes almost a quarter of government expenditures to education, but only 67 per cent of the adult population is literate, and the proportion of out-of-school children of primary school age is among the highest in the region. The country fares a bit better than other South Asian countries in terms of secondary education, as expenditure per student is by far the highest in the region, and school enrolment and lower-secondary completion rates are above the regional average.

After Bhutan, Nepal spends the most on education. It spends most of its education budget on primary education (54 per cent), and the expenditure per student in terms of GDP per capita is also quite high compared to other South Asian countries (only Bhutan and Maldives have higher numbers). Overall, primary education outcomes in Nepal are quite encouraging: net enrolment and completion rates are well above the regional average. However, Nepal still has room for improvement when it comes to secondary education, as school enrolment remains low.

At the other end of the spectrum, India, Pakistan, Sri Lanka and Bangladesh all have government spending on education below 4 per cent of GDP. As was the case for countries with higher spending, education outcomes are quite heterogeneous for this side of the distribution. For instance, while Bangladesh has the lowest education expenditures in the region, its literacy rates and school enrolment exceed the regional average.¹⁵ Sri Lanka is an even more surprising case, as it has the second lowest spending but among the best outcomes in the region. The country's literacy rates (adult and youth) are above 90 per cent, and school enrolment indicators are the highest in the region (except for tertiary education, where the country comes after India). Accordingly, Sri Lanka has extremely low rates of out-of-school children, estimated at 0.7 per cent for primary education and 1.6 per cent for lower secondary. Although this favourable situation is largely due to good educational system performance, it is also the result of favourable structural factors. Sri Lanka is an upper middle-income country, which means that a significant share of the population can afford certain out-of-pocket expenditures, reducing the need for public expenditure. The country has attained universal primary education and has a well-developed educational system, which reduces the pressure of investing in infrastructure, therefore freeing up resources that can be employed in recurring costs and accommodate the rising demand for secondary education. Sri Lanka is in the last stage of its demographic dividend: with a decreasing school-age population, there is progressively less strain on the system.

India's government spending on education policies is about the same as the regional average. In terms of outcomes of basic education, India still has much room for improvement, especially with the high proportion of out-of-school children of lower secondary age (15 per cent, amounting to around 11 million children). However, it is important to keep in mind that this figure, drawn from UNESCO's statistical database (2019), is highly contested, and therefore this inference might benefit from further analysis based on alternative sources. This discussion is presented in a report by UNESCO (2016), which shows alternative figures for

out-of-school children at less than 8 per cent, based on UNDP population projections. India has the highest enrolment in tertiary education in the region (27 per cent). Finally, Pakistan is also at the low end of the distribution regarding government spending on education. The situation is particularly alarming, as school enrolment and literacy rates remain extremely low. Around a quarter of Pakistan's children are out of school; of the over 20 million out-of-school children in South Asia of primary and lower secondary age, around half live in Pakistan.

Table 5. Education indicators for South Asian countries, latest available data

	Government expenditure									Outcomes/coverage										
	% of GDP	% of gov. spending	% of education budget (1)			per student, % of GDP per capita			Literacy rates		Graduation rates (gross)		School enrolment (net)						OOSC	
	Total	Total	P	S	T	P	S	T	Adult	Youth	P	Ls	P	S	Ls	Us	T	P	Ls	Us
Afghanistan	4.1	15.7	57	24	16	10.0	11.0	41.5	43.0	65.4	60.6	37.5		48.6	53.5	31.3	8.5			58.3
Bangladesh	2.0	14.6	45	39	15	7.7	10.2	30.8	73.9	93.3	87.0	71.1	90.5	63.7	65.8	46.3	17.6	5.0	25.7	42.0
Bhutan	6.6	22.8	32	56	10	13.8	32.1	54.6	66.6	93.1	93.0	86.5	88.0	70.2	67.3	30.7	10.5	8.1	12.0	27.7
India	3.8	14.1	28	41	29	9.8	16.8	49.2	74.4	91.7	76.9	70.1	92.3	61.6	66.3	44.5	27.5	2.3	14.9	47.9
Maldives	4.1	11.3	36	22	21	14.5		29.9	97.7	98.8	109.6	97.8	95.4	47.0	92.3		14.5	4.1	10.1	34.3
Nepal	5.2	14.2	54	33	11	13.0	11.0	25.4	67.9	92.4	117.6	89.5	96.3	57.5	57.6	38.3	11.8	3.5	5.3	24.1
Pakistan	2.9	14.5	44	29	11	7.7	15.2	63.8	59.1	74.5	57.9	46.1	67.7	38.5	27.0	25.5	10.1	24.6	29.8	51.5
Sri Lanka	2.8	11.3	33	51	13	10.1	10.3	26.4	91.9	98.9	102.6	103.0	99.1	89.0	97.3	78.3	19.0	0.7	1.3	18.9
Average	3.9	14.8	41	37	16	10.8	15.2	40.2	71.8	88.5	88.1	75.2	89.9	59.5	65.9	42.1	14.9	6.9	14.2	38.1
Median	4.0	14.4	40	36	14	10.1	11.0	36.2	70.9	92.7	90.0	78.8	92.3	59.6	66.0	38.3	13.1	4.1	12.0	38.1

Notes: P = Primary; S = Secondary; Ls = Lower secondary; Us = Upper secondary; T = Tertiary; OOSC = out-of-school children.

Data for pre-primary and other post-secondary education were not included due to the high proportion of missing information.

Some information was very out of date for some countries, especially Maldives.

(1) For some countries/levels of education, more recent data were available, but as we did for Figure 9, we present data from years for which information was available for all levels.

Source: Author's elaboration based on UNESCO (2019).

The analyses conducted in this chapter showed that a similar proportion of public spending on education in different countries can lead to completely different outcomes. Naturally, this should not be taken as a path of direct causality by itself, since many other factors (including structural aspects) can play relevant roles in determining how expenditures affect outcomes. Yet, and bearing in mind how relevant these structural factors can be, possible explanations for this heterogeneity should not neglect system and institutional-level features, such as those diagnosed by a World Bank (2018b) report for the region, namely: lack of administrative capacity, inadequate use of public resources directed to education, and inequality of spending incidence. This is in line with the idea that more public investment in education does lead, on average, to better education outcomes, but this relationship depends strongly on factors such as a country's income, institutions, demography etc., which should be key inputs to determining current and future financial needs (UNICEF 2015).

Box 3. Nepal's challenge to improve the funding, access and quality of education services

Formal education has been a government priority in Nepal since the 1950s. In 2015 the country had 34,806 schools, up from 321 in the 1950s, which suggests a significant increase in investment in the education system. The Nepalese government and households are the main funders of the education sector. There are also significant contributions from development partners (Government of Nepal et al. 2016). This case study will briefly present an overview of Nepal's education expenditure from 2009 to 2015 and discuss management issues—mainly concerning the primary education level, which is funded mostly by the government.

The report *National Education Accounts in Nepal: Expenditures for Education 2009–2015* (ibid.) shows that during this period there was a steady increase in Nepal's GDP, fiscal basis and government expenditure. At the same time, the share of educational funding from external sources decreased: from 12.7 per cent in 2009–2010 to 6.8 per cent in 2014–2015. In part, the government made up for this decrease, due also to its decisions to allocate further resources to the education sector, exceeding 5 per cent of GDP and 14 per cent of total government spending.

However, in 2015 public funding still represented less than half (43.4 per cent) of total expenditure on education, with other sources accounting for 56.3 per cent, including 48.8 per cent contributed by households. The government's share was higher for basic education, accounting for 62.3 per cent of total spending on the primary level. On the other hand, household funding prevailed for upper secondary (70.7 per cent) and higher education (69 per cent). At those two levels, the share of students enrolled in private institutions is higher; thus the household contribution is significant (ibid.).

Government efforts—in terms of legislation, policies and programmes—led to an increase in net enrolment rates at the primary level over the last 20 years. However, challenges remain regarding equity of access, completion rates and the quality of education. For instance, while 65 per cent of the children from the richest quintile are on track in literacy and numeracy, only 12 per cent of children from the poorest quintile are on track. Beyond socio-economic status, inequity occurs due to geographical remoteness, gender, ethnicity and disability, which are all factors of social exclusion in the country (Government of Nepal and UNICEF 2018). Schools in general do not offer a good environment for learning, and teachers are not adequately skilled, contributing for high dropout rates. In Province 2 there is just 1 teacher for every 86 children, while the national average is 1 teacher for 22 children. 29 per cent of all children who enrol quit before grade 8 (UNICEF 2019).

Given this scenario, to address inefficiency in the education sector, it is crucial that planning and implementation include equity concerns (UNICEF 2019; Lohani et al. 2010). In this sense, Nepal's government must ensure that increasing funds are indeed reaching the most disadvantaged social groups and that pro-poor programmes such as scholarships, grants to schools and cash transfers are efficient. In this sense, the learning assessment system should be improved to provide better feedback for evidence-based reforms of teacher training, pedagogy and curricula.

5. GOVERNMENT EXPENDITURE ON SOCIAL ASSISTANCE IN SOUTH ASIA

One of the main targets of SDG 1, “End poverty in all its forms everywhere,” is to “implement nationally appropriate social protection systems and measures for all” (target 1.3) (United Nations 2019). In this sense, the point of expanding the coverage of social protection programmes¹⁶ is to protect the population from situations of poverty and vulnerability. In the case of South Asia, the governments of Afghanistan, India, Maldives, Nepal and Sri Lanka have made efforts to include social protection in their legislation, strengthening commitments to improve social protection systems (Lazzarini 2020). However, this does not seem to be the case in Bhutan, Bangladesh or Pakistan, three countries where there is an urgent need to expand coverage of social safety nets, since, according to ASPIRE estimates,¹⁷

less than 20 per cent of the population is covered by social protection or labour programmes (coverage in Bhutan is particularly low, reaching only 3 per cent of the total population) (World Bank 2019a).

Moreover, even in countries where legal coverage has expanded, a huge share of the population remains excluded from social safety nets—such is the case in Afghanistan, where less than 10 per cent of the population is covered by social protection programmes (World Bank 2019a). Even lower is the share of the population benefiting from contributory social protection, as informality remains an important obstacle across South Asia. Estimates of the size of informality for selected countries¹⁸ suggest that the share of informal employment in the region ranges from 70 per cent in Sri Lanka to 94 per cent in Nepal, and that nearly all employment in agriculture is informal (ILO 2018). These workers are rarely covered by social protection and thus constitute a vulnerable group that urgently needs to be included in further expansions of social safety nets (Asian Development Bank 2016).

In this chapter, we will assess how countries in South Asia perform in terms of the allocation of public resources to social assistance. We will start by discussing some issues related to the existing available data, followed by analyses of indicators of social assistance expenditure and performance in South Asia.

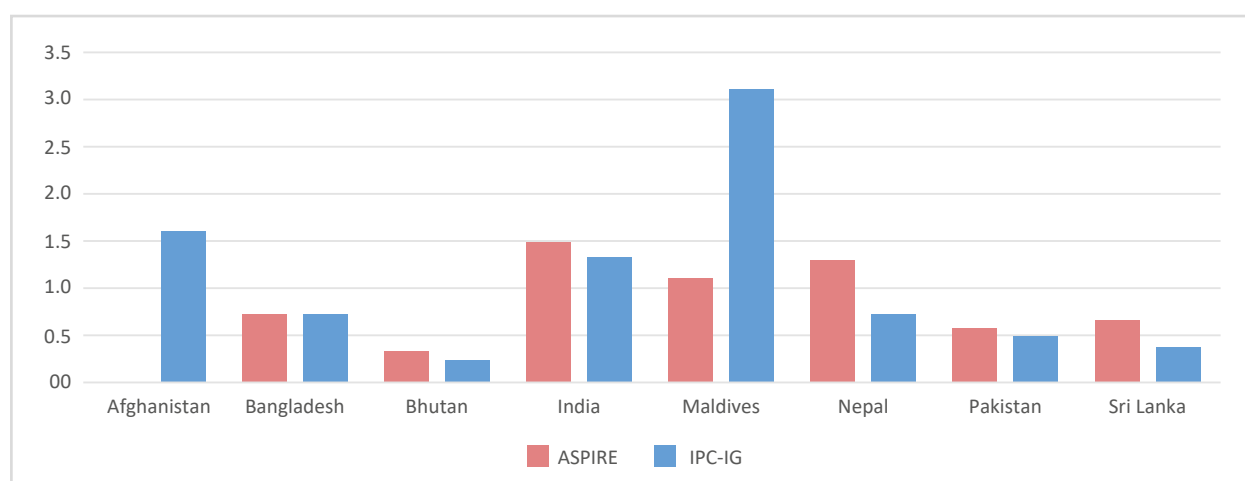
Social assistance data

One of the challenges of assessing government spending on social assistance regards the definition of the policies included in the analysis. This study focuses on non-contributory social protection, as these programmes tend to have more of a redistributive component than contributory social protection, since they mostly target vulnerable categories of the population. In the case of South Asia, it seems particularly relevant to concentrate on social assistance because of the high incidence of informal employment in South Asian labour markets. It is, therefore, important to specify which data are being used. Organisations such as the International Labour Organization, Classification of the Functions of Government and the Asian Development Bank which provide data on social protection and expenditure data include both contributory and non-contributory programmes. As our focus is on social assistance, we will favour databases that only use information on non-contributory programmes—for instance, the World Bank's ASPIRE database.

ASPIRE provides indicators such as government spending on social assistance, as well as aggregate indicators of coverage, incidence and the impact of social assistance on poverty and inequality. Expenditure data are collected from administrative programme records, whereas 'performance' indicators (i.e. incidence and impact on poverty and inequality) are based on data from household surveys. Among the data from South Asian countries, there is a large variation in both the number and type of social assistance programmes included. For some countries, data on social assistance spending are based on a limited number of programmes and are often out of date. Information concerning transfer amounts is often limited, as some surveys only collect information on participation without providing monetary values.

Under the framework of its collaboration with the United Nations Children's Fund Regional Office for South Asia (UNICEF ROSA), the International Policy Centre for Inclusive Growth (IPC-IG) has produced a mapping of social assistance programmes in the South Asia region (Arruda et al. 2020). Despite covering some of the most important programmes in each country and being illustrative of current arrangements and future trends for social protection, the Centre's sample of initiatives is not statistically representative and is subject to several selection biases, since it was built through a mix of non-probability convenience sampling¹⁹ and non-probability purposive expert sampling.²⁰ Nevertheless, it is possible to develop a proxy for total social assistance spending in each country based on this sample by aggregating the latest available data on all programme expenditures (or budgets, when expenditure amounts were not available).²¹ The latest available data on programme budget/expenditure can be harmonised to 2018 values (in local currency units) and these aggregates can be expressed as a percentage of current GDP and government expenditure.

Figure 12. Comparison of social protection and social assistance data for South Asia



Source: Arruda et al. (forthcoming).

Figure 12 compares the above-mentioned data sources. For some countries, such as Bangladesh, Bhutan, India, Pakistan and Sri Lanka, ASPIRE and IPC-IG data are not that different. However, the IPC-IG estimates that public expenditures on social assistance in Maldives are almost triple those estimated by ASPIRE, whereas for Nepal it is around half.²² Finally, while ASPIRE does not provide any information on public spending on social assistance for Afghanistan, the IPC-IG sample indicates that it ranges at around 1.6 per cent of GDP.

We will base our further analyses on data retrieved from ASPIRE's data set, as it also provides information on benefit incidence as well as the impact of social assistance programmes on poverty and inequality.

Analysis of social assistance spending

Table 6 presents ASPIRE data on expenditures on social assistance in South Asia—total spending and disaggregated by type of programme. For some countries, data are only available for a few categories. In the case of Bhutan, information is only presented at the aggregate level (and it is out of date, as the reference year is 2009), while no data were available for Afghanistan.

As was shown in Figure 1, countries in South Asia spend, on average, 0.9 per cent of GDP on social assistance, which places the region at the bottom of the global distribution, as other regions spend comparatively more. India, Nepal and Maldives are the only South Asian countries for which ASPIRE data are available where public spending on social assistance exceeds 1 per cent of GDP. These estimates indicate that India has the highest spending in the region (1.5 per cent of GDP). The largest proportion of its expenditures goes to food and in-kind transfers such as the Public Distribution System, followed, at some distance, by public works programmes (0.25 per cent). Nepal spends around 1.3 per cent of GDP on social assistance. With its many cash transfers (targeting children, single women, elderly people, endangered ethnic groups etc.), it allocates more funds than any other country in the region to unconditional cash transfers (0.85 per cent of GDP). Maldives spends considerably more on social pensions (1 per cent of GDP), including the Senior Citizens' Allowance, the country's old-age basic pension scheme.

On the other side of the distribution, Bangladesh, Sri Lanka, Pakistan and Bhutan all spend less than 1 per cent of GDP on social assistance. Bhutan spends the least on social assistance—amounting to only 0.3 per cent of its GDP. Bangladesh's numerous public works programmes (e.g. Employment Generation Programme for the Poorest, Food for Work etc.) capture the largest share of spending on social assistance, while Sri Lanka and Pakistan²³ spend comparatively more on unconditional cash transfers than on other programmes.

Table 6. Public expenditure on social assistance by type of programme

Country	CCT	UCT	Social pension	School feeding	Public works	Food and in kind	Fee waivers	Other social assistance	Total	Year
Bangladesh	0.1	0.05	0.17	0.03	0.28	0.09		0.01	0.73	2015
Bhutan									0.33	2009
India			0.06	0.06	0.25	1.03	0.06	0.06	1.51	2016
Maldives		0.02	1.02				0.1	0.07	1.11	2010–2011
Nepal		0.85	0.28	0.16				0.03	1.32	2010, 2014
Pakistan		0.43						0.14	0.58	2011, 2016
Sri Lanka	0.01	0.39	0.04	0.04		0.12	0.01	0.04	0.66	2013–2015

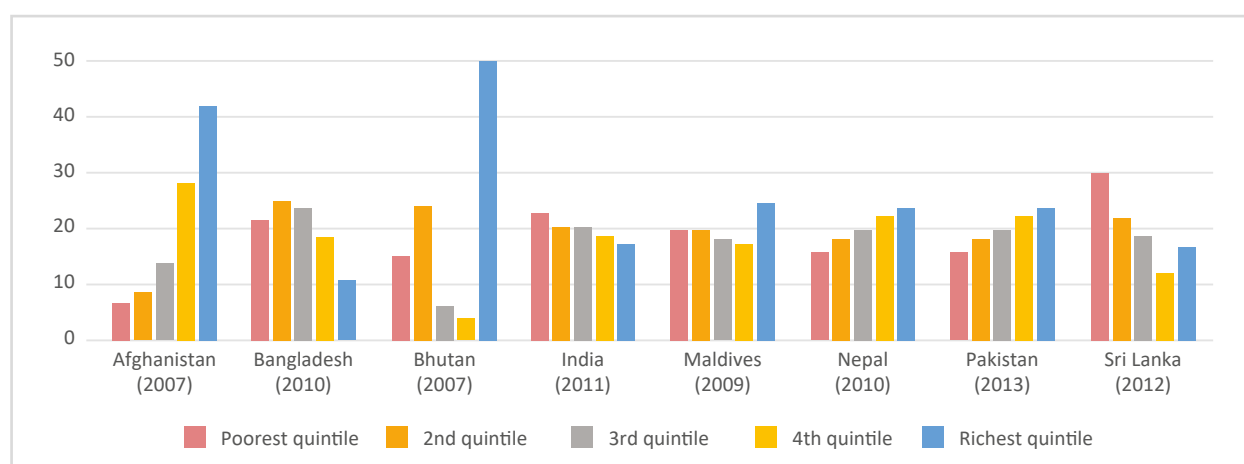
Note: CCT = conditional cash transfer; UCT = unconditional cash transfer.

Source: Author's elaboration based on World Bank (2019d).

Performance of social assistance programmes

The previous section provided some information on how much governments in South Asia spend on social assistance programmes, but do these benefits actually reach vulnerable populations? How effective are these transfers in reducing poverty and inequality? In this final section, we will look at some indicators of performance—namely, incidence and impacts of social assistance programmes on poverty and inequality. As previously mentioned, the lack of monetary information for social assistance makes it difficult to estimate the actual incidence and impact of anti-poverty programmes. For instance, India and Nepal each have three social assistance programmes for which only participation is reported; therefore, those reports are not included in the incidence analysis.

Figure 13 shows the benefit incidence of social assistance programmes in South Asian countries—i.e. the percentage of benefits (included in the data) that goes to each quintile of the population. We can see that incidence across the region is varied and that social assistance does not always benefit the poorest deciles most. In the cases of Bangladesh, India and Sri Lanka, there is some indication that a greater share of benefits goes to lower quintiles, and that, therefore, social assistance is progressive (in absolute terms). Conversely, richer households tend to benefit more from social assistance in Afghanistan, Maldives, Nepal and Pakistan. Results are mixed in Bhutan, as over 50 per cent of benefits go to households in the richest quintile, and around 40 per cent to those in the first two quintiles.

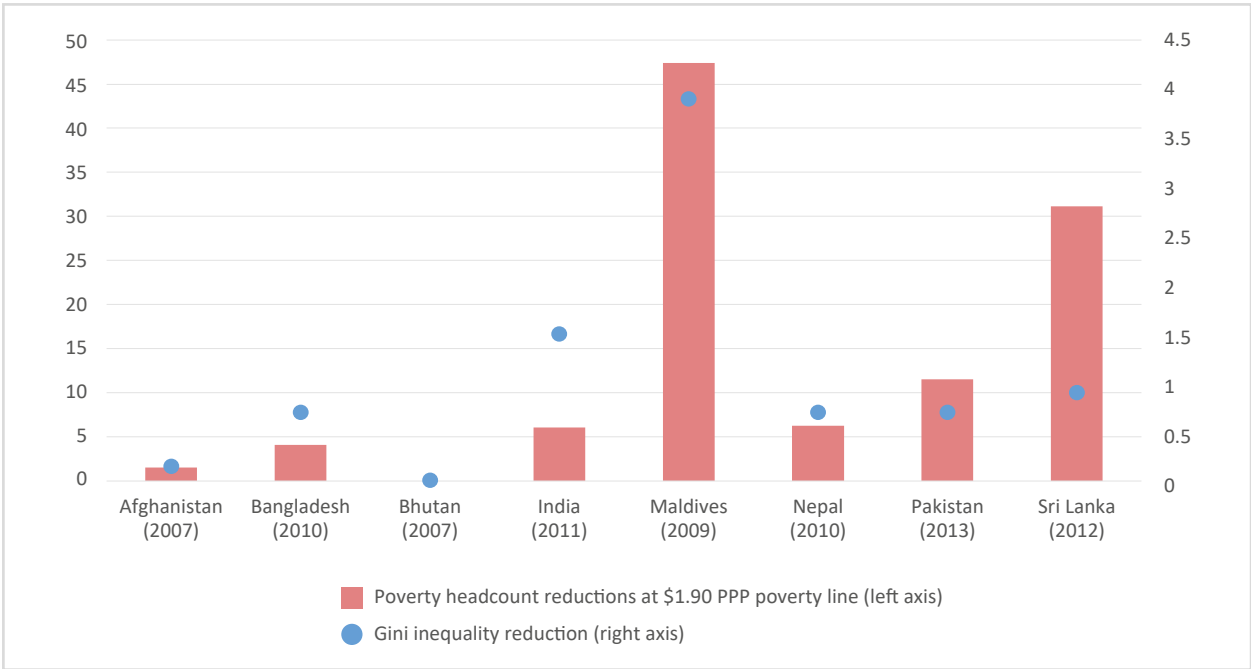
Figure 13. Benefit incidence of social assistance in South Asia

Source: Author's elaboration based on World Bank (2019d).



Figure 14 shows ASPIRE estimates of the impact of social assistance programmes on poverty and inequality.²⁴ ASPIRE finds by far the largest impacts in Maldives: extreme poverty falls by nearly half, and the Gini Index by 4 per cent, when accounting for benefits from social assistance. Sri Lanka has the second largest impacts on poverty (31 per cent), as does India regarding inequality (2 per cent). The impact of social assistance in other countries of the region is comparatively low (Bhutan and Afghanistan show the lowest reductions, though the numbers are rather out of date). It seems important to highlight that the data presented here are meant to be interpreted with caution, as they are estimates based on a limited number of programmes.

Figure 14. Impact of social assistance on poverty and inequality reduction in South Asia



Source: Author's elaboration based on World Bank (2019d).

Box 4. The Mahatma Gandhi National Rural Employment Guarantee Act and management challenges for effective social assistance in India

Since India's independence in 1947, its policymakers have declared a will to promote equitable economic development by reducing inequality and increasing social protection (Jha 2014). Nowadays, the country runs numerous anti-poverty and social protection policies such as the Targeted Public Distribution Scheme, the National Social Assistance Programme, housing schemes, the Rural Livelihood Mission, the Total Sanitation Campaign and the Right to Food Act (Ehmke 2015; World Bank 2011). This study case will focus on the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA), discussing its accomplishments and some potential improvements.

The MGNREGA determines the provision of 100 days of paid labour for all interested rural households (or the provision of grants equivalent to this remuneration if work is not available). In this way, it is a legal basis for a national employment scheme (Ehmke 2015; Datta and Pradhan 2012). According to Ehmke (2015), the MGNREGA is a pillar of India's social protection, given that it ensures relative income security for millions of rural households. Likewise, it contributes to improving rural infrastructure by directing government funds to it. Furthermore, it is recognised that the programme has attained high female participation rates. However, there is still room for improvement, as research suggests that it should be possible to achieve greater gains by addressing administrative inefficiencies (Jha 2014).

One possible management improvement could be to adjust MGNREGA's procedures to each state's capacities and needs (Ehmke 2015; World Bank 2011). The responsibility for the MGNREGA's policymaking lies chiefly at the central level, while the state governments play a subsidiary role in the formulation of each MGNREGA state plan and in implementation support. Similarly, the central government is the MGNREGA's main financier, while the states are responsible for paying for part of the materials, skilled labour and administrative costs and for employment allowances. The allocation of central government funding is based on each state's projected budget, and implementation is bottom-up.

However, capacities and needs are different across states; thus MGNREGA's procedures should be more flexible to satisfactorily respond to this heterogeneity (Ehmke 2015). First, not all states have the financial means to cover the MGNREGA's costs assigned to them, nor the administrative capacity to implement and monitor the programme (ibid.). In this sense, if, on the one hand, states with higher poverty rates are the ones which receive more funds, on the other hand, they are also the ones with the lowest capacity to administer resources efficiently (World Bank 2011). Furthermore, the central government does not strictly verify whether states comply with expenditure and accounting rules, which encourages ineffective spending (Ehmke 2015).

Given the multiplicity of social protection schemes in India, it is essential to improve coordination for comprehensive and sustainable social advancements and to avoid duplication of efforts (ibid.). Employment guarantees alone do not ensure strong social advancements. Therefore, the MGNREGA should be further coupled and coordinated with other social protection initiatives. In this sense, coherence with other social policies and across government institutions is essential for effective social protection delivery. Likewise, efforts should be made to improve rural livelihoods so that the rural population no longer needs to depend on the MGNREGA (ibid.). Finally, states should be given flexibility to allocate the overall funds received from the central government so that they can prioritise their own specific vulnerabilities (e.g. lack of proper housing and sanitation, child nutrition, urban livelihood support, among others) (World Bank 2011).

The analyses conducted in this chapter were hindered by a low level of data availability, which highlights the need to fill these data gaps. In this sense, efforts to mainstream official publications of programme budgets and expenditures would be commended. Nevertheless, our findings suggest that much needs to be done to expand the coverage and adequacy of social assistance programmes in South Asia. To enhance public spending on social policy, it is crucial that governments direct a share of their budgets to improving the adequacy of social assistance programmes. This means investing in programme design (including adequate identification of beneficiaries and their needs) as well as monitoring and evaluation (to ensure that programmes are achieving their objectives and produce evidence to substantiate the scale-up of programmes that have shown good results).

6. FISCAL SPACE FOR SOCIAL SPENDING IN SOUTH ASIA

Expanding social policy requires considerable and stable investment of public resources. The previous chapters revealed a significant heterogeneity across South Asia in terms of government spending on health, education and social assistance, as well as their related outcomes.

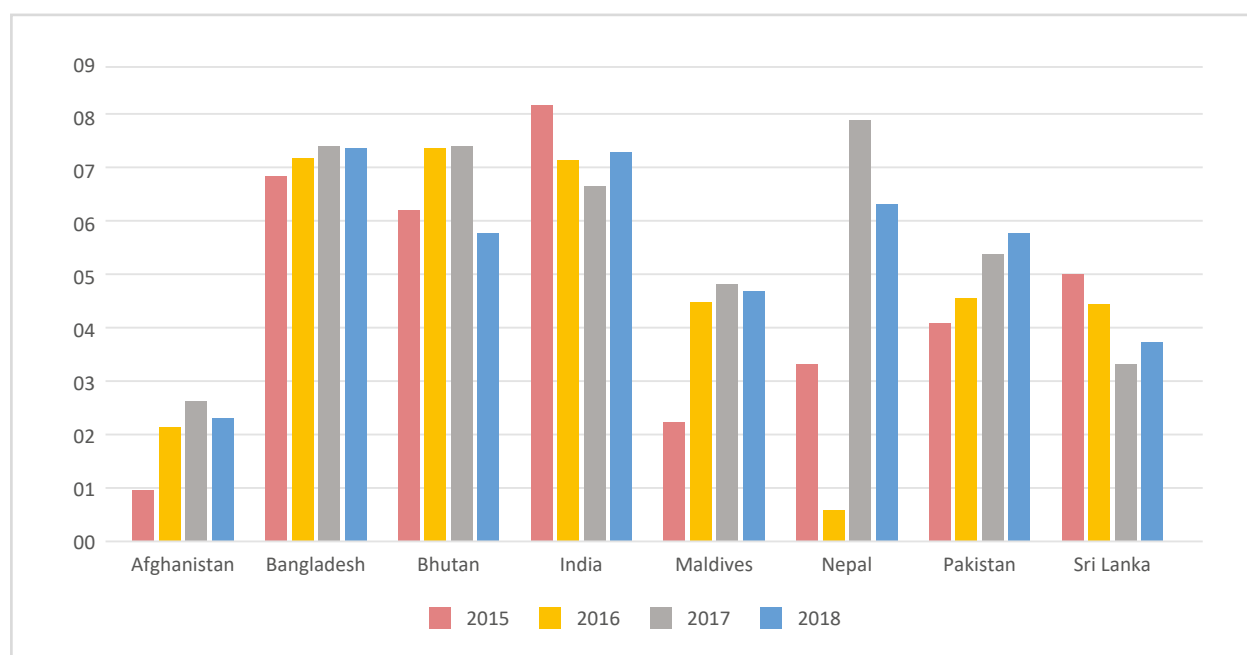
In South Asia, the combination of low domestic revenue generation, inadequate spending and deterioration of economic conditions continues to lead to increasing fiscal deficits and weak macroeconomic buffers, which in turn affect the capacity of countries to allocate resources to health, education and social assistance (World Bank 2018a). However, as we will see, even countries with tight budgets have the potential to increase investment in health, education and social assistance, including by improving domestic resource mobilisation and reprioritising public expenditures.

After providing an overall picture of the economic context in which South Asian policymakers operate, this final chapter discusses some options for them to improve the allocation of resources to the social sector.

Macro-fiscal framework

South Asia is the fastest-growing region in the world (IMF 2018). Between 2017 and 2018, GDP grew by more than 5 per cent in Bangladesh, Bhutan, India, Nepal and Pakistan (see Figure 15). The strong economic growth in the region is mainly driven by domestic demand, which highlights the importance of social policies to support it (IMF 2018; World Bank 2018a).

Figure 15. Real GDP growth (annual percentage change)



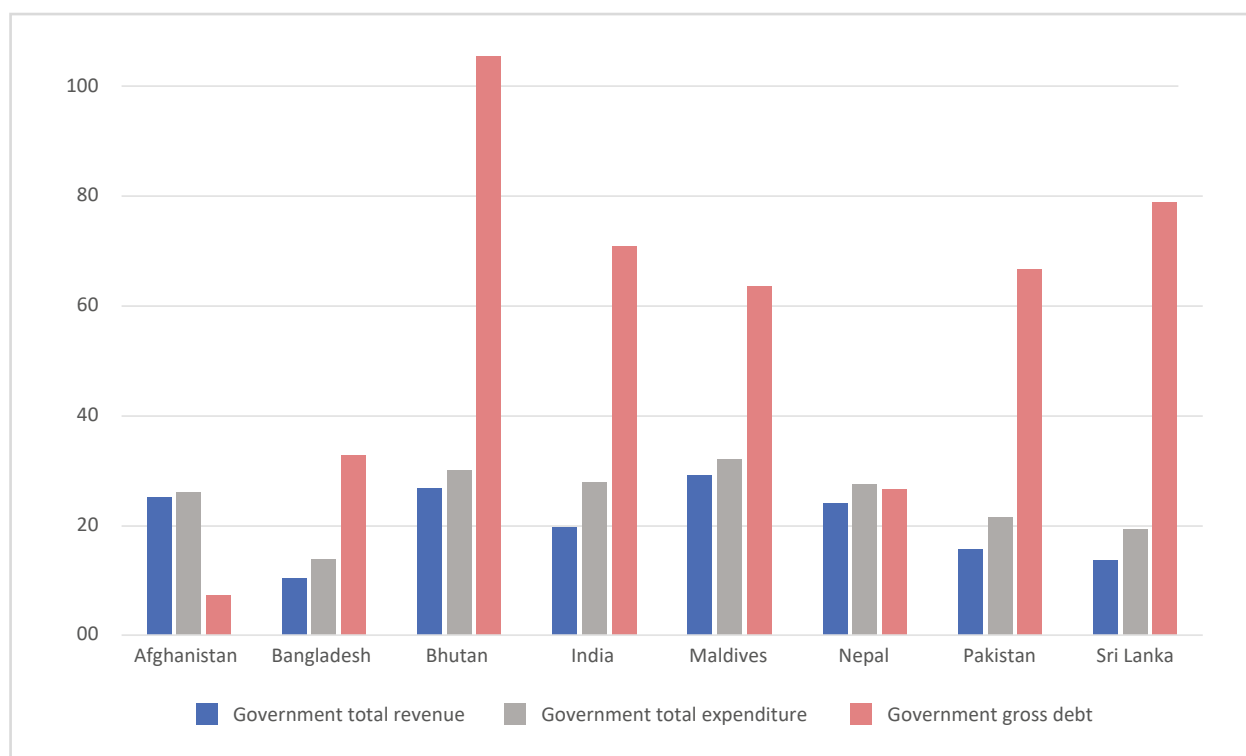
Note: Values for 2018 are IMF estimates/projections, except for India and Nepal. The 2017 values for Afghanistan and Bhutan are also estimates.

Source: Author's elaboration based on IMF (2019b).

Inflation is relatively under control in most countries due to responsive monetary policies (World Bank 2018a), except in Pakistan, where it is expected to reach 13 per cent in 2020 (IMF 2019a). The volatility of oil prices can be a risk for inflation, current account deficits and fiscal deficits. Other external shocks such as trade and geopolitical tensions are a risk to macroeconomic stability, but these remain limited, as the region is not deeply integrated in global value chains (ibid.). Internal or regional issues, on the other hand, such as the persistence of conflicts in Afghanistan and Pakistan or the frequent change of constitution in Nepal, generate political and security instability that pose obstacles to economic and social development in these countries (IMF 2018; 2019a). Similarly, the lack of diversification of some economies (e.g. Bhutan's high dependence on revenues from hydropower, and that of Maldives on the tourism sector) is also a potential vulnerability.

South Asian countries differ considerably in institutional and budgetary capacity, as public expenditure in the region ranges from 14 per cent of GDP in Bangladesh to 32 per cent in Maldives, and total government revenue (which includes non-tax revenues) varies from 10 per cent to 29 per cent (same countries). As we can see in Figure 16, all across South Asia, public spending is consistently higher than revenue collection, thus contributing to the already high debt ratios (especially compared to other regions (IMF 2019a). Afghanistan, Bangladesh and Nepal have all managed to keep their debt-to-GDP ratios below the IMF's recommended benchmark of 40 per cent for developing countries (IMF 2010), but all other South Asian countries have debt-to-GDP ratios above 60 per cent. Fiscal discipline should be a priority for South Asian policymakers, but it should not come at the expense of social expenditure (as might be the case in Bangladesh) (Davies 2015).

Figure 16. Government total revenue, expenditure and gross debt (as a percentage of GDP, 2017)



Source: Author's elaboration based on IMF (2019b).

Options for increasing social expenditure

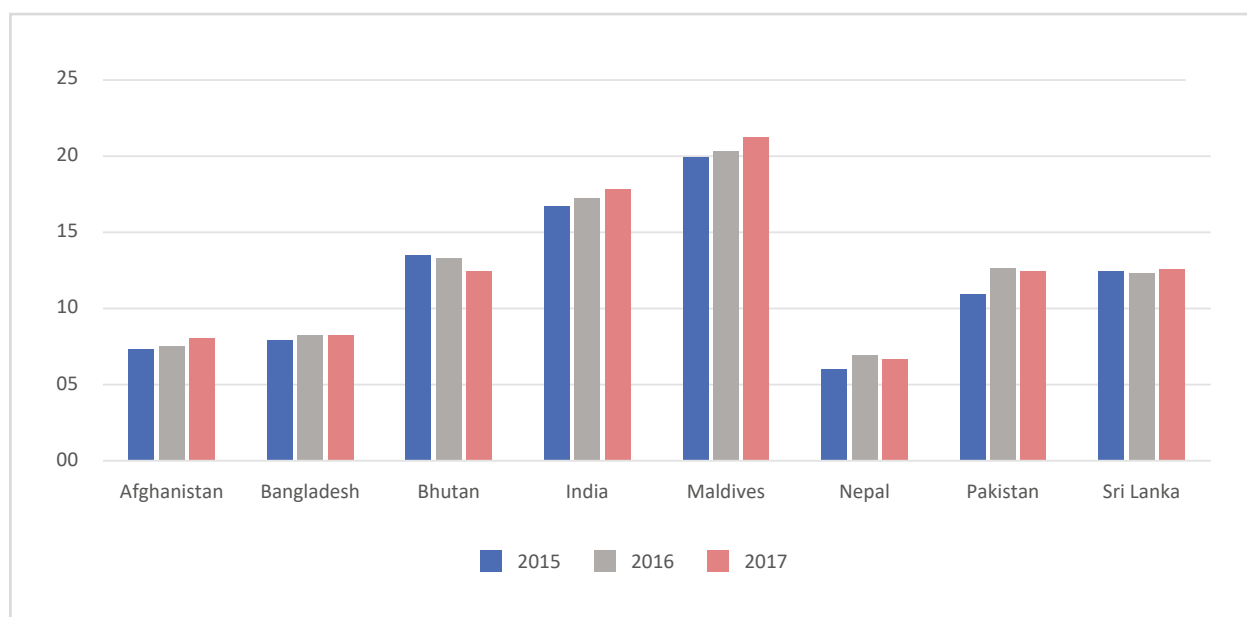
Domestic resource mobilisation

As the provision of health, education and social assistance requires stable and significant sources of financing, South Asian countries could consider the option of creating fiscal space through sustainable and equitable revenue mobilisation. Aligning financing mechanisms, especially tax collection, with the country's expenditure needs is key to improving social spending. Despite many efforts to increase tax-financed social policies (e.g. in Bhutan, Maldives, Nepal and Sri Lanka) (ESCAP/SDD 2015), inadequate domestic revenue mobilisation remains a considerable obstacle to development in the region.

According to the Platform for Collaboration on Tax,²⁵ tax revenues below 15 per cent of GDP are considered low, as this is the minimum required to provide basic services such as infrastructure, health care and public safety to all citizens. India, Maldives and Nepal are the only South Asian countries that have managed to exceed this benchmark, and not by much (see Figure 17), which suggests that all countries in the region have room for expanding their tax base. This overall low tax collection across South Asia can be explained, to some extent, by structural factors such as low formal employment, widespread tax exemption and evasion, and weak tax administration (World Bank 2015). A narrow tax base tends to overburden the categories that do pay taxes—for instance, tax exemptions for agriculture and service sectors put a strain on industry's tax burden (World Bank 2018a).

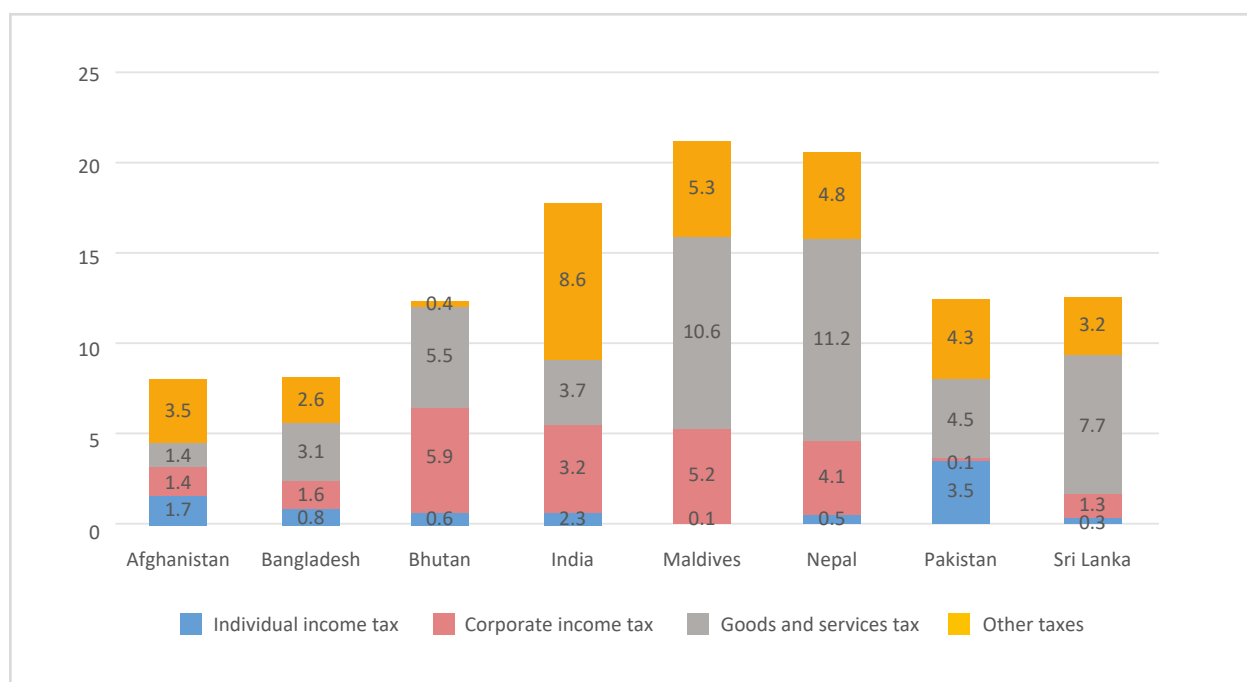
For all countries in South Asia (except Bhutan), less than half of total tax revenues comes from income taxes, and, in general, most of it corresponds to corporate taxation—except in Pakistan, where individuals contribute significantly more to tax revenues (see Figure 18). In countries such as Maldives, Nepal and Sri Lanka, revenues from direct taxation (individual and corporate income taxes) are relatively low compared to revenues from taxes on goods and services, which tend to be regressive, as they weigh more on the consumption of low- and middle-income households.

Figure 17. Tax revenues as a percentage of GDP



Source: Author's elaboration based on IMF (2019c).

Figure 18. Sources of tax revenues as a percentage of GDP, latest available data



Note: Data are from 2017 for Bhutan, Nepal and Sri Lanka, 2016 for Bangladesh and India, 2015 for Afghanistan, and 2014 for Maldives and Pakistan.

Source: Author's elaboration based on IMF (2019c).

Overall, it seems that South Asian countries underexploit tax collection as a financing mechanism for social policies. Bangladesh could be in a particularly good position to implement tax reforms, since its tax revenues remain low despite strong economic growth. There is also scope for introducing more progressive taxation and improving redistribution mechanisms, especially in countries with high inequality such as Maldives and Sri Lanka.

South Asian countries can alternatively explore other resources to increase the budget for social policies. ODA, for instance, can be a starting option for financing social policies in countries where tax reforms are more difficult to implement, such as Afghanistan (see Box 5). For other countries, assistance levels are insignificant (except maybe Bhutan and Nepal, where they represent around 5 per cent of GNI) (World Bank 2019d). However, it is important to keep in mind that ODA is not considered a sustainable way to mobilise resources, especially as they can crowd out government expenditure and are not necessarily invested in the country's most urgent needs (Roy et al. 2007; UNICEF 2015).

Box 5. Afghanistan case study—Challenges to resource mobilisation and sustainable social spending in a crisis context

Afghanistan has been in continuous conflict for around 40 years, which implies that unrest and security are severely hindering the country's social and economic development. According to the report *Afghanistan Living Conditions Survey 2016-17* (IRA 2018), the country has achieved improvements in some social indicators over the years (e.g. education, maternal health, water and sanitation). However, the report also states that gender equality and education indicators have now stagnated. Currently, Afghanistan's workforce tends to be poorly educated and, thus, poorly skilled. Moreover, compared to previous assessments, the labour market's performance has worsened, and poverty and food insecurity levels have increased. In 2016-2017, 55 per cent of the population were living below the poverty line, compared to 34 per cent in 2007-2008. The report concludes that the population's overall welfare has deteriorated (ibid.).

Since 2001, Afghanistan has been receiving substantial donor grants for its recovery, and the country is currently severely reliant on those funds (Aslam et al. 2013). According to Byrd and Farahi (2018), due to its structural revenue–expenditure gap, Afghanistan is now “one of the most aid-dependent countries in the world.” For instance, in 2017, 62 per cent of budgetary expenditures were covered by external funds, while domestic funds contributed 38 per cent (Byrd and Farahi 2018). The case of Afghanistan's public health care system illustrates this. The system is funded chiefly by the United States Agency for International Development (37 per cent), the World Bank (32 per cent) and the European Commission (29 per cent) (data from 2005–2009). The remaining 2 per cent is funded by other donors and by the Afghan government. Still, donors cover around 17 per cent of the country's total health expenditure, while the government finances 5 per cent, and out-of-pocket expenditures amount to around 77 per cent (Haidari et al. 2014), suggesting a low level of financial protection.

The above-mentioned gap is partially explained by the country's high level of spending on security (ibid.), which stands out compared to other fragile States. Noticeably, enforcing the rule of law is important for a conducive and stable socio-economic environment (Aslam et al. 2013). In this sense, Afghanistan's government justifies the high security expenditures “to strengthen government control over territory and combat the spread of terrorism” (IRA 2017). Hence, the crisis in Afghanistan clearly complicates the country's fiscal health and diverts resources away from social policies.

To achieve a more sustainable financing model, it is imperative that Afghanistan improves its domestic resource mobilisation and corrects shortfalls in its budget planning and execution. At some point in the peacebuilding process that Afghanistan is following, the share of donor grants should gradually decline, while the government takes over public expenditure—which is often covered by donors (Aslam et al. 2013; Byrd and Farahi 2018; IRA 2017). It is essential to keep in mind that donor resources cannot be withdrawn abruptly; otherwise, the consequent shocks could lead to unrest and throw the country into further chaos. Thus, for a successful transition, it is necessary to find a balance between introducing reforms and decreasing foreign assistance (Aslam et al. 2013; IRA 2017).

Prioritisation of expenditures

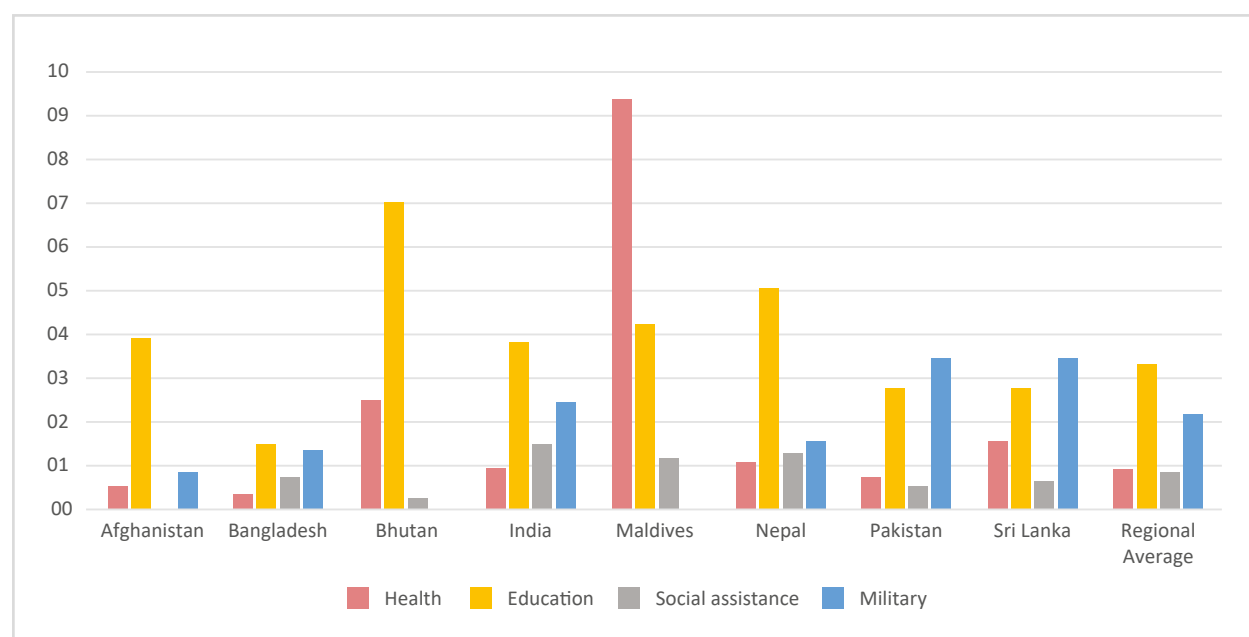
Some aspects of the difficult contexts in South Asia are beyond government control and could require a huge mobilisation of public resources. For instance, the destruction caused by conflicts in Afghanistan, the earthquake in Nepal, the tsunami in Maldives or recurrent floods in Bangladesh all demand significant investments in rebuilding infrastructure. However, there are other efforts that are within reach of South Asian policymakers which could improve

fiscal management and create fiscal space for greater investment in the social sector. In this sense, beyond increasing domestic resource mobilisation, South Asian countries can improve social expenditure by addressing equity, efficiency and effectiveness issues on the spending side of the budget.

As there are different government sectors competing to capture the often scarce public resources, it is crucial that policymakers rely on evidence on the effectiveness and efficiency of current spending to make better-informed decisions. All government expenses that seem excessive should be carefully evaluated to identify inefficiencies. Conversely, evidence pointing to the effectiveness of health, education and social assistance policies can be used to scale up such programmes.

High levels of expenditure on the military across the region, for instance, suggest that South Asian countries could consider switching expenditures as a way to create fiscal space for greater investment in the social sector. Figure 19 reveals that South Asian countries spend, on average, more than double the amount on security that they spend on health and social assistance. Military spending is particularly high in Pakistan (the highest in the region), India and Sri Lanka, exceeding 2 per cent of GDP.

Figure 19. Social expenditure vs. military expenditure in South Asia (as a percentage of GDP), latest available data



Source: Author's elaboration based on World Bank (2019a; 2019d), World Health Organization (2019) and UNESCO (2019).

Strong institutions and adequate budgeting and planning are key to support governments in their reprioritisation efforts. One common issue for many countries in South Asia concerns heterogeneity of governance between different government units. In Nepal, for instance, poor implementation capacity at subnational government levels leads to budget under-execution (World Bank 2018a). Similarly, in India, fiscal discipline is not uniform across states, and some manage to spend public resources more efficiently than others (in the sense that they achieve better social outcomes) (Mohanty and Bhanumurthy 2018).

Improving fiscal management also requires systematic budget assessment, fiscal and benefit incidence analyses and transparency as well as monitoring and evaluation of public policies. Tools such as the World Bank's Public Expenditure Reviews can be used to inform policymakers on the efficiency of current budgetary allocations.

The last such review available for a South Asian country analyses public spending in Bangladesh, bringing attention to its need and potential to invest more in the social sector. For instance, the diagnosis mentions implementation delays and poor coordination as some of the main causes of the country's inadequate institutional capacity to implement development budgets. Moreover, it highlights that Bangladesh's strong economic growth constitutes an opportunity to direct additional resources to the social sector through greater tax collection.

Box 6. Economic reforms programmes in South Asia

To increase resource mobilisation and reduce its dependency on foreign aid, the Government of **Afghanistan** intends to stimulate the private sector and job creation by improving business regulation. In this way, it is expected that the tax base will grow, eventually replacing foreign financial aid (IRA 2017). These are critical initiatives, since cutting expenditures and/or solely raising tax collection could have a negative impact on an already weak economy and a vulnerable population, provoking unrest. On the other hand, the existing resources can be used more efficiently. To do this, in 2018, Afghanistan introduced significant reforms to strengthen overall fiscal discipline and, particularly, to fight corruption (Aslam et al. 2013; Byrd and Farahi 2018).

As **Pakistan**'s economic downturn calls for stabilisation mechanisms, the IMF has been supporting the implementation of reforms in the country through Extended Fund Facilities. The IMF's interventions are expected to strengthen macroeconomic buffers by supporting fiscal consolidation, adjustment of monetary policy, improvement of social spending and implementation of institutional reforms in Pakistan (IMF 2019a).

Sri Lanka has also been improving fiscal consolidation through IMF support since 2016. The IMF's Extended Fund Facility in Sri Lanka has been extended until 2020, and the government has recently implemented tax reforms to expand and improve tax collection and administration (Inland Revenue Act) (ibid.).

Following the implementation of the Goods and Services Tax in **India** in 2017, the rise in tax collection took time to materialise, but there are already signs of an increase in government revenues. Further improvements are expected in the medium and long term, as the tax should help formalise transactions in India and accelerate the pace of GDP growth (IMF 2018; World Bank 2018a). A similar reform is planned in **Bhutan** and should contribute to expanding the tax base in the country (IMF 2019a).

Our analysis indicates that there is ample scope for improving public funding of health, education and social assistance in all South Asian countries. Governments should seize the opportunity of strong economic growth to implement the much-needed reforms that could broaden the tax base, improve compliance and redirect funds from high-cost, low-impact expenditures towards more progressive social policies. Some countries are implementing structural reforms (see Box 6) that are expected to gradually strengthen the economy and create fiscal space that could be used for social spending, which should in turn contribute to macroeconomic stability in the long term.

7. CONCLUDING REMARKS

The overall low level of government spending on health, education and social assistance seems to explain, to some extent, why most countries in South Asia are lagging behind in key development outcomes. There has been uneven progress towards universal health care, education and coverage of social safety nets, and the achievement of these development goals requires greater mobilisation and management of resources. Policymakers should make the most of economic, political and demographic opportunities to strengthen and fulfil commitments to provide health care, education and social safety nets.

The expansion of investments in these sectors should be done in such a way that the allocation of funds is sustainable and frequent, so that the provision of services is not disrupted. There have been efforts to improve social spending, but tax collection remains underutilised as a financing mechanism in the region, and there is great scope for improvement and reprioritisation of expenditures. These measures should be complemented by efforts to strengthen governance and accountability in the management of public resources.

As South Asian countries continue to struggle with many forms of social exclusion (e.g. poverty, inequality and informality), which are caused to some extent by gaps in the provision of health care, education and social assistance, governments should ensure that investments in these sectors reach those who are most in need. Moreover, policymakers need to align their spending on social sectors with their country's development needs, which means, *inter alia*, taking concrete steps to put political intent into practice (through legal and budgetary commitments, for instance) and setting expenditure targets according to countries' and sectors' specific contexts. Additional efforts are necessary to fill data collection and management gaps, to better understand these needs and inform decision-making, improve information systems and monitoring progress towards the achievement of development outcomes.

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NOTES

1. No data for spending on social assistance were available for Afghanistan in the database used for this graph (ASPIRE).
2. Target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”
3. The proportion of out-of-school children in Bangladesh is relatively high, but the indicators date from 2010.
4. UNICEF (2012) defines social protection as a “set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation”
5. It seems important to highlight that ASPIRE data should be interpreted with caution, as estimates are based on a limited number of programmes.
6. It is worth noting that while the figures reported in this text allow for a better comparison between countries, in some cases this means presenting figures that differ from national statistics of countries that are not subject to standardisation, as they are not intended for comparability. For instance, the numbers reported here for Bhutan (taken from harmonised international databases) are slightly different than those from national statistics, such as found in World Bank (2017) and Bhutan Ministry of Education (2019).
7. For Afghanistan, the poverty headcount ratio was only available using the national poverty line.
8. No data for spending on social assistance were available for Afghanistan in the database used for this graph (ASPIRE).
9. Target 3.8: “Achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”
10. A BIA relies on information on the cost of publicly provided goods and services as well as on information on their usage, typically through household or individual surveys. Results are usually presented for different income groups or geographical areas.
11. Graphs for infant and under-5 mortality rates were very similar, so we chose to illustrate using maternal mortality rates only.
12. Maldives has the best indicators of health outcomes and coverage, except maternal mortality rates, underweight prevalence and share of births attended by skilled staff, but it closely follows Sri Lanka.
13. There were no data on school enrolment or out-of-school children available for Afghanistan, but as primary and lower secondary completion rates are extremely low in the country, we can presume that the proportion of out-of-school children is high.
14. The data for Maldives was often out of date or missing, especially for secondary education outcomes.
15. The proportion of children out of school in Bangladesh is relatively high, but the indicators date from 2010.
16. UNICEF (2012) defines social protection as a “set of public and private policies and programmes aimed at preventing, reducing and eliminating economic and social vulnerabilities to poverty and deprivation”
17. ASPIRE measures coverage of programmes as the number of individuals in the population who live in a household where at least one member receives the benefit, divided by the number of individuals in the population.
18. South Asian countries included are Bangladesh, India, Nepal, Pakistan and Sri Lanka.
19. Etikan, Musa, and Sunusi (2016) define this as “a type of nonprobability or nonrandom sampling where members of the target population that meet certain practical criteria, such as easy accessibility, geographical proximity, availability at a given time, or the willingness to participate are included for the purpose of the study. It is also referred to the researching subjects of the population that are easily accessible to the researcher. Convenience samples are sometimes regarded as ‘accidental samples’ because elements may be selected in the sample simply as they just happen to be situated, spatially or administratively, near to where the researcher is conducting the data collection.”

20. According to Etikan, Musa, and Sunusi (2016), “Expert Sampling calls for experts in a particular field to be the subjects of the purposive sampling. This sort of sampling is useful when the research is expected to take a long time before it provides conclusive results or where there is currently a lack of observational evidence. Expert sampling is a positive tool to use when investigating new areas of research, to garner whether or not further study would be worth the effort.”

21. Specifically, the calculated social assistance expenditure proxy as a share of GDP or government expenditure had to rely on budget data (instead of expenditures) in the following cases: Afghanistan: all 3 programmes; Bangladesh: all 11 programmes; India: 3 out of 7 programmes; Nepal: 5 out of 10 programmes, with data missing for both budget and expenditures for an additional 2 programmes; Pakistan: all 4 programmes; Sri Lanka: 1 out of 6 programmes.

22. One possible explanation for this huge difference is that ASPIRE and the IPC-IG’s estimates rely on data from different periods. For instance, while ASPIRE’s estimates of social spending for Maldives date from 2010/2011, the IPC-IG relies on data from 2017.

23. For Pakistan, disaggregated data were only available for unconditional cash transfers (of which a share is financed through *zakat*) and ‘other social assistance’.

24. ASPIRE measures inequality reduction as: $(\text{Inequality pre-transfer} - \text{inequality post-transfer}) / \text{inequality pre-transfer}$. Similarly, poverty headcount reduction is measured as: $(\text{Poverty headcount pre-transfer} - \text{poverty headcount post-transfer}) / \text{poverty headcount pre-transfer}$.

25. The Platform for Collaboration on Tax is a joint initiative of the IMF, the Organisation for Economic Co-operation and Development (OECD), the United Nations and the World Bank Group, launched in April 2016 to strengthen collaboration on domestic resource mobilisation.



International Policy Centre for Inclusive Growth

SBS, Quadra 1, Bloco J, Ed. BNDES, 13º andar
70076-900 Brasília, DF - Brazil
Telephone: +55 61 2105 5000

ipc@ipc-undp.org • www.ipcig.org