

Much variation in health spending levels can be observed in Asia/Pacific countries and economies (Figure 4.1.1), ranging from Australia with a total health spending per capita of USD PPP 3 441 to Myanmar with spending of only USD PPP 34. The average OECD health spending per capita in 2010 was around five times that of the Asian economies (3 265 versus 616). In Asia, USD PPP 382 (62% of the total) are from public sources, as compared to USD PPP 2 354 (72.2%) reported in OECD countries.

On average, between 2000 and 2010, the growth rate in per capita health spending in real terms was 5.6% per year in Asia, higher than the 3.6% observed across OECD countries (Figure 4.1.2). The growth rate for China, Myanmar and Viet Nam was even more rapid – almost twice the average rate for the region. Two countries – Pakistan and Brunei Darussalam – reported a negative growth rate in health spending between 2000 and 2010.

In general, health expenditures as a share of GDP increase with per capita GDP. Figure 4.1.3 shows the relationship between per capita health expenditures and per capita GDP in 2010 (on a logarithmic scale). This underlines the existence of a relationship between income and health spending in Asia/Pacific, which parallels that seen among OECD economies as a whole. On the top-right of the graph there is a group that includes OECD countries, Singapore, and Brunei Darussalam. At the bottom-left of the graph there are all the other economies under study. Thailand, China and Malaysia are three middle-income, middle-spending countries. There is evidence of a transition for those countries towards high-income high-spending.

Definition and comparability

Total health expenditure is given by the sum of expenditure on all the core health care functions – that is total health care services, medical goods dispensed to outpatient, prevention and public health services, and health administration and health insurance – plus capital formation in the health care provider industry. Expenditure on these functions is included as long as it is borne for final use of resident units i.e. as long as it is final consumption by nationals in the country or abroad. For this reason, imports for final use are included and exports for final use are excluded.

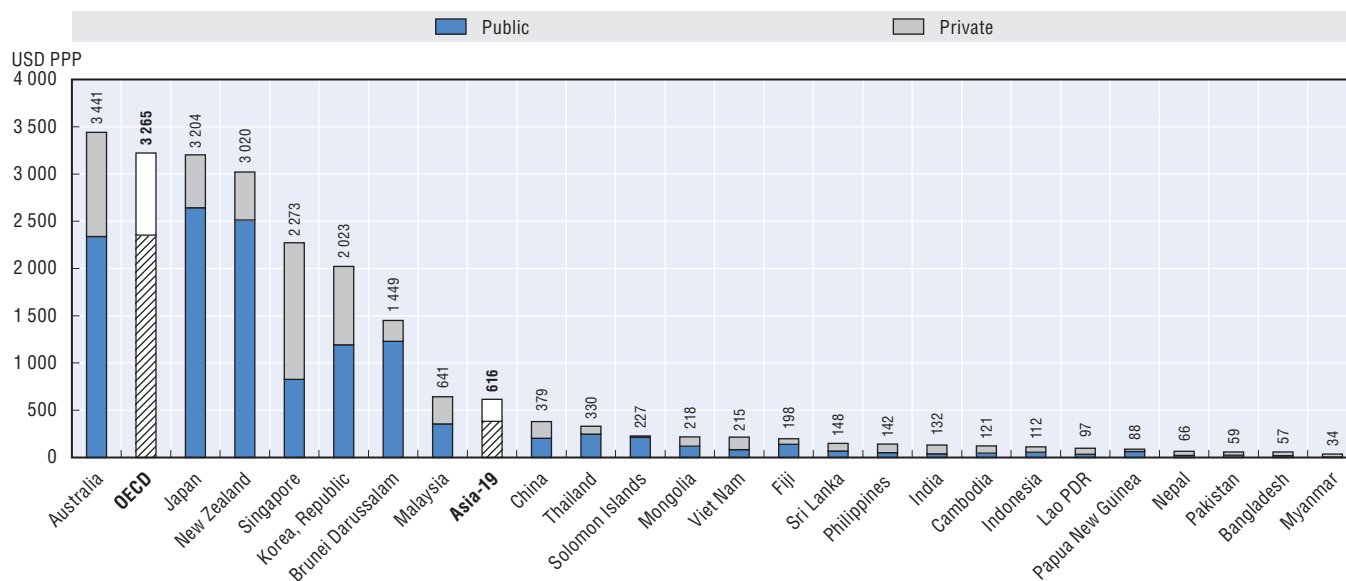
The economy-wide (GDP) PPPs are used as the most available and reliable conversion rates. These are based on a broad basket of goods and services, chosen to be representative of all economic activity. The use of economy-wide PPPs means that the resulting variations in health expenditure across countries might reflect not only variations in the volume of health services, but also any variations in the prices of health services relative to prices in the rest of the economy.

To make useful comparisons of real growth rates over time, it is necessary to deflate (i.e. remove inflation from) nominal health expenditure through the use of a suitable price index, and also to divide by the population, to derive real spending per capita. Due to the limited availability of reliable health price indices, an economy-wide (GDP) price index is used in this publication, at 2005 GDP price levels (from IMF).

The annual average growth rate was computed using a geometric growth rate formula:

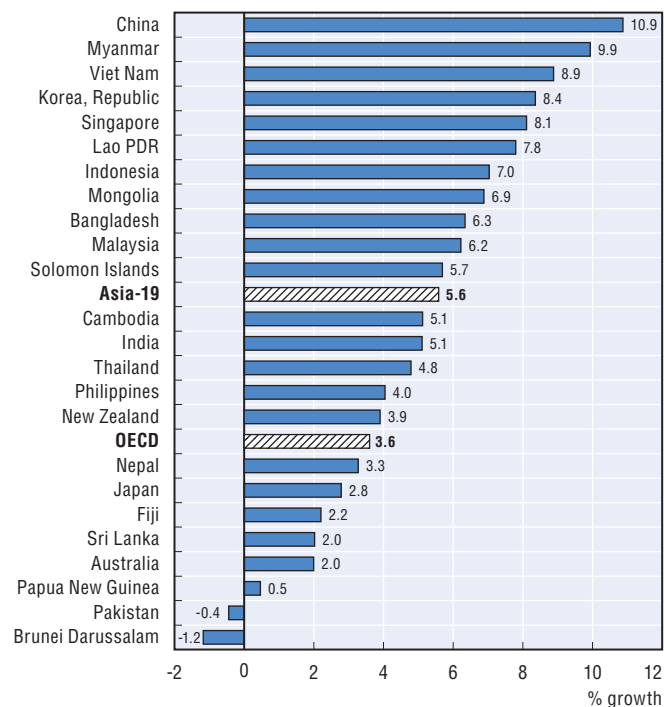
$$\sqrt[10]{\frac{2010 \text{ value}}{2000 \text{ value}}}$$

4.1.1. Total health expenditure per capita, public and private, 2010



Source: WHO Global Health Expenditure Database; OECD Health Data 2012.

4.1.2. Annual average growth rate in real health spending per capita, 2000-10



Source: WHO Global Health Expenditure Database; IMF World Economic Outlook, April 2012; OECD Health Data 2012.

4.1.3. Total health expenditure per capita and GDP per capita, 2010



Source: WHO Global Health Expenditure Database.

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