HEALTH EXPENDITURE

Financial resources for health are unevenly distributed geographically. Australia and Japan have higher health expenditure per capita than the OECD average (USD 3715, 2015), while most of Asia/Pacific economies spend less than the Asia/Pacific average (USD 1120). On average across the Asia/Pacific, two thirds of health expenditure is financed by governments or compulsory insurance schemes, and the rest is financed from voluntary schemes or concerns patients’ out-of-pocket expenses (Figure 6.10). More than three-quarters of total health expenditure in Brunei Darussalam, Japan, New Zealand, and Thailand were financed publicly in 2015, while in countries with a lower GDP per capita such as Bangladesh, India, Myanmar and Nepal three-quarters of total health expenditure were financed privately.

For most Asia/Pacific economies, health expenditure per capita grew over last decade (Figure 6.11). On average the Asia/Pacific economies experienced annual growth in real health expenditure per capita of 6% over the 2006-10 and 2011-15 periods, while annual growth in real health among OECD economies was less than 4%. Armenia and Myanmar had the largest annual average spending growth of more than 30% over the 2011-15 period, while Azerbaijan, China, India, Lao PDR, Nepal, Singapore and Tajikistan also recorded growth in excess of 10%. By contrast in Cambodia, New Zealand and Samoa health expenditure increased by less than the OECD average (3.7%) over the same period.

Although health expenditure per capita grew steadily, the public/private health financing ratios are relatively stable for most Asia/Pacific countries (Figure 6.12). Over the 2011-15 period health expenditure financed by government/compulsory schemes increased in Singapore, China, and Indonesia, while in Mongolia and Viet Nam saw an increase in the share of health-financing through voluntary health schemes and households’ out-of-pocket expenditures.

Definition and measurement

Health expenditure measures the final consumption of health goods and services. This includes spending by both public and private sources on medical services and goods, public health and prevention programmes and administration, but excludes spending on capital formation (investments). To compare spending levels across countries, per capita health expenditures are converted to a common currency (US dollar) and adjusted to take account of the different purchasing power of the national currencies.

The financing of health care can be analysed from the point of view of the sources of funding (households, employers and the state), financing schemes (compulsory or voluntary insurance), and financing agents (organisations managing the financing schemes). Here “financing” is used in the sense of financing schemes as defined in the System of Health Accounts (OECD/WHO/Eurostat, 2011). Public financing includes expenditure by the general government and social security funds. Private financing covers households’ out-of-pocket payments, private health insurance and other private funds (NGOs and private corporations).
Figure 6.10. **Total health expenditure varies considerably across Asia and the Pacific**

Total health expenditure per capita, public and private, USD PPP, 2015


Figure 6.11. **Health expenditure per capita increased over the past decade**

Real annual average growth rate in per capita health expenditure, USD PPP, 2006-10 and 2011-15


Figure 6.12. **Public/private health financing ratios are relatively stable for most countries**

Change in health expenditure, by government/compulsory insurance scheme and voluntary/households’ out-of-pocket, % of health expenditure, 2010 and 2015
