Financing of health care from government and compulsory health insurance schemes

Health care can be paid for through a variety of financing arrangements. In some countries, health care might be predominantly financed through government schemes by which individuals are automatically entitled to health care based on their residency. In other cases, compulsory health insurance schemes (through either public or private entities) linked to the payment of social contributions or health insurance premiums finance the bulk of health spending. In addition to these, a varying proportion of health care spending consists of households' out-of-pocket payments – either as standalone payments or as part of co-payment arrangements – as well as various forms of voluntary payment schemes such as voluntary health insurance.

Generally, the higher the income level of a country, the higher the share of health care spending financed through government and compulsory health insurance schemes. This overall pattern of health care financing can be seen across Asia-Pacific countries: 74.1% in high-income countries versus 44.9% in low- and lower-middle-income countries (Figure 6.5). In New Zealand, Japan and Brunei Darussalam more than 75% of all health expenditure was paid for through government schemes and compulsory health insurance in 2019. The same pattern was observed in two low-income countries, Solomon Islands and Papua New Guinea. By contrast, in Myanmar and Bangladesh less than 25% of health spending was covered by such schemes. Between 2010 and 2019, the share of health expenditure financed by government and compulsory health insurance schemes increased by more than 10 percentage points in Pakistan, Indonesia, Singapore and Lao PDR, whereas it decreased by more than 10 percentage points in Viet Nam.

Figure 6.6 highlights the change in government and compulsory health insurance schemes spending as a share of GDP between 2010-19. On average, there was a slight increase in upper-middle- and high-income countries in Asia-Pacific from 2.2% to 2.6% and 4.7% to 5.5% of GDP respectively, whereas the share for low- and lower-middle-income countries remained unchanged at 1.7% of GDP over the same period. Japan[1] reported an increase of around 1.5 percentage points in the period in study.

Governments provide a multitude of goods and services out of their overall budgets. Hence, setting priorities for health in budget allocations is a choice by governments and society as health care is competing with many other sectors such as education, defence and poverty alleviation programmes. A number of factors including, among others, general government revenues, nondiscretionary obligations such as debt servicing, and the capacity of health ministers to influence the overall budgetary allocation to the health sector determines the size of public funds allocated to health. Relative budget priorities may also shift from year to year because of political decision-making and economic effects. In 2019, health spending by government schemes and compulsory insurance stood at around 7.2% of total government expenditure across low- and lower-middle-income countries, whereas it represented 10.1% of total government expenditure in upper-middle-income countries in Asia-Pacific (Figure 6.7). In Japan, Australia, New Zealand and Singapore more than 15% of public spending was dedicated to health care. On the other hand, less than 5% of government expenditure was allocated to health care in India, Nepal, Myanmar and Bangladesh. The level of public spending on health care is also linked to the capacity of spending by government as measured by the share of government spending in GDP. Government spending accounted for around one fourth of GDP in low- and middle-income countries, whereas it represented one-third of GDP in high-income Asia-Pacific countries in 2019.

Definition and comparability

Health care financing can be analysed from the point of view of financing schemes (financing arrangements through which health services are paid for and obtained by people, e.g. social health insurance), financing agents (organisations managing the financing schemes, e.g. social insurance agency), and types of revenues (e.g. social insurance contributions). Here "financing" is used in the sense of financing schemes as defined in the System of Health Accounts (OECD/WHO/Eurostat, 2011[1]) and includes government schemes, compulsory health insurance as well as voluntary health insurance and private funds such as households' out-of-pocket payments, NGOs and private corporations. Out-of-pocket payments are expenditures borne directly by patients and include cost-sharing arrangements and any informal payments to health care providers, but excludes prepayment to any insurance schemes.

Relating spending from government and compulsory insurance schemes to total government expenditure can lead to an overestimation of the share of government and compulsory insurance schemes spending in total government spending in countries where private insurers provide compulsory insurance.

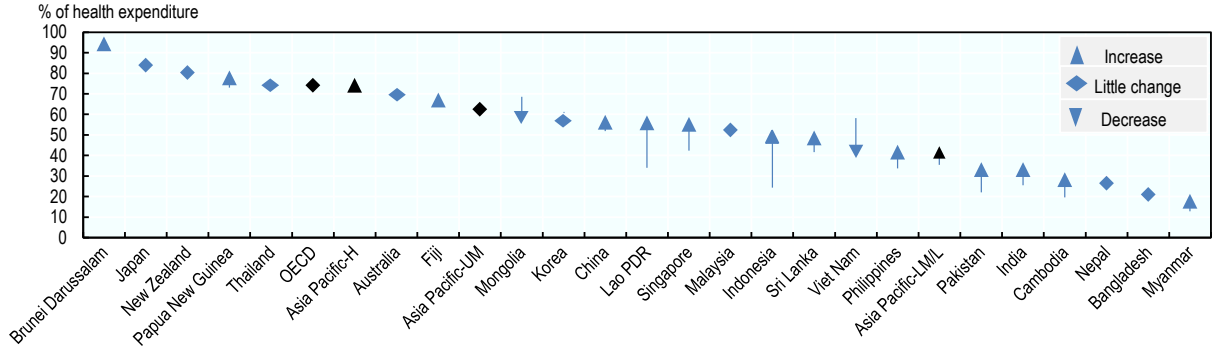
References

OECD/WHO/Eurostat (2011), *A System of Health Accounts: 2011 Edition*, OECD Publishing, Paris, https://doi.org/10.1787/9789264116016-en. [1]

Note

[1] A break in series in 2011 contributes to this result.

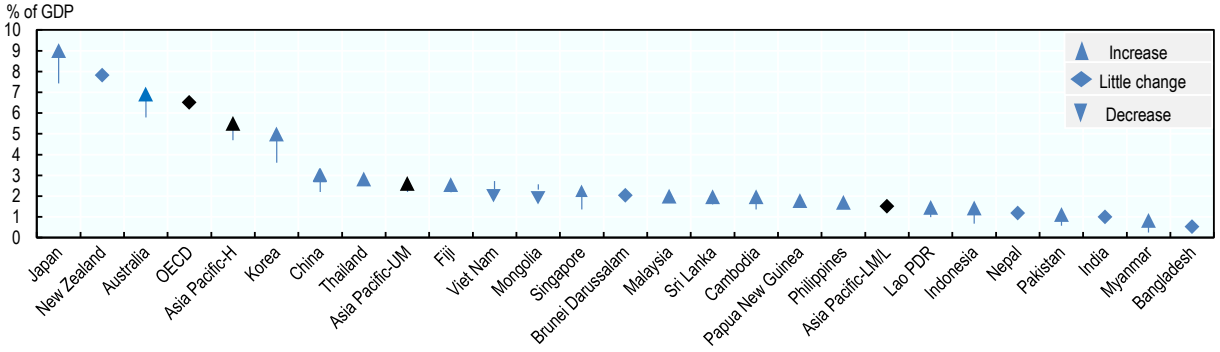
Figure 6.5. Health expenditure by government scheme and compulsory insurance scheme as a share of health expenditure, 2010 and 2019



Source: WHO Global Health Expenditure Database; OECD Health Statistics 2022.

StatLink https://stat.link/0i3cgl

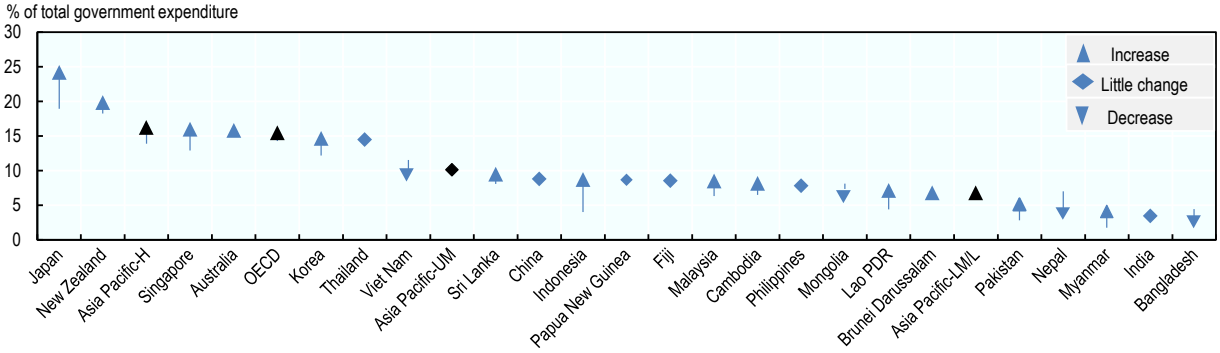
Figure 6.6. Health expenditure by government scheme and compulsory insurance scheme as a share of GDP, 2010 and 2019



Source: WHO Global Health Expenditure Database; OECD Health Statistics 2022.

StatLink https://stat.link/pxribn

Figure 6.7. Health expenditure by government and compulsory health insurance schemes as a share of total government expenditure, 2010 and 2019



Source: WHO Global Health Expenditure Database; OECD Health Statistics 2022.

StatLink https://stat.link/h4i618