

Across Asia-Pacific countries, per capita health spending continues to rise. Low and lower-middle income countries reported an increase from 173 to 247 international dollars (in constant 2017 USD PPP) between 2010 and 2017, whereas upper middle and high income countries spending grew from 466 to 689 and from 2 922 to 3 712 international dollars (in constant 2017 USD PPP) during the same period, respectively. However, large inequalities in per capita health care spending can be observed in Asia-Pacific countries in 2017 (Figure 6.1), ranging from only 94 international dollars (USD PPP) in Bangladesh to 4 816 international dollars (USD PPP) in Australia. The average OECD current health spending per capita in 2017 was around 16 times that of the low income countries in Asia-Pacific (3 996 versus USD PPP 247).

The health care sector continues to expand faster than the economy in Asia-Pacific. On average, between 2010 and 2017, the growth rate in per capita health spending in real terms was 4.7% per year, higher than the 3.6% observed for gross domestic product (GDP) (Figure 6.2). For both, health spending and overall economic activity, growth in China was even more rapid – more than twice the average rate for the region. Brunei Darussalam and Solomon Islands reported a decrease in per capita health spending in real terms between 2010 and 2017. Health spending growth in many Asia-Pacific countries has exceeded economic growth over the past seven years, resulting in an increasing share of the economy devoted to health. All countries below the diagonal line in Figure 6.2 report that health expenditure has grown faster than income. This means that the share of health care expenditure in total expenditure has continued to increase. In all countries above the line, the increase in health spending – on average – was lower than the increase in GDP. Hence, the share of health spending in total spending declined.

How much countries spend on health care over time can be ascribed to overall health spending growth and economic performance. Health expenditure accounted for 4% and 7% of GDP in low and middle income, and high income Asia-Pacific countries respectively in 2017, an increase of 0.3 and 0.8 percentage points compared to 2010. This indicator varied from 2.3% in Bangladesh and Brunei Darussalam to up to 10.8% in Japan (Figure 6.3). Generally, the richer a country is, the greater the share of their income devoted to health care. The percentage of GDP spent on health across OECD countries is – on average – twice that of the Asia-Pacific low and middle income countries (8.7% versus 4%). Between 2010 and 2017, the share of health in relation to GDP declined by more than 2 percentage points in Solomon Islands, whereas it increased in Myanmar, Singapore, the Republic of Korea and Japan<sup>1</sup> by more than one percentage point (Figure 6.3).

Although health systems remain a highly labour-intensive sector, capital has been an increasingly important factor of production of health services over recent decades, as reflected for example by the growing importance of diagnostic and therapeutic equipment or the expansion of information and communications technology (ICT) in health care. Capital investments in health tend to fluctuate more with economic cycles than current spending on health care. However, slowing down investments in health infrastructure and equipment will affect service delivery. As a proportion of GDP, Japan was the highest spender on capital investment in 2017 with more than 1% of its GDP going on construction, equipment and technology in the health and social sector (Figure 6.4). However, capital spending can be significantly lower. On average, it represented 0.3% of GDP across reporting non-OECD Asia-Pacific countries, and accounted for 0.1% or less in Bangladesh and Cambodia in 2017.

### Definition and comparability

Current health expenditure is defined by the sum of expenditure for 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. Expenditure on these functions is included as long as it is final consumption for residents in the country or abroad. For this reason, imports for final use are included and exports for final use are excluded.

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.

The economy-wide (GDP) Purchasing Power Parities (PPPs) are used as the most available 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 using 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.

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

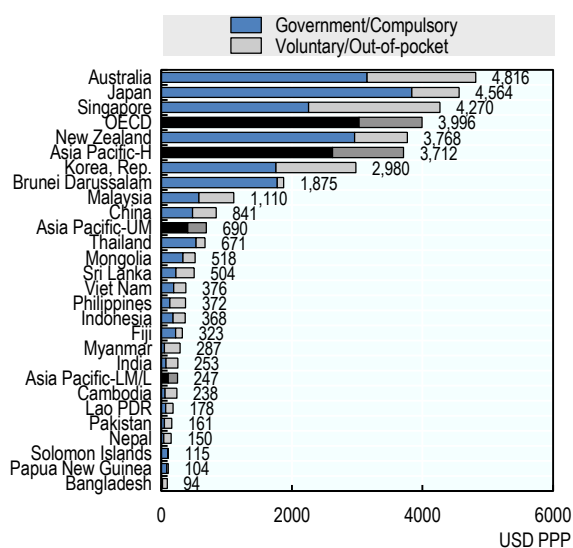
$$(\sqrt[7]{((2017 \text{ value})/(2010 \text{ value}))-1}) \times 100$$

Gross fixed capital formation in the health sector is measured by the total value of the fixed assets that health providers have acquired during the accounting period (less the value of the disposals of assets) and that are used repeatedly or continuously for more than one year in the production of health services. The breakdown by assets includes infrastructure (e.g. hospitals, clinics), machinery and equipment (including diagnostic and surgical machinery, ambulances, and ICT equipment), as well as software and databases. Gross fixed capital formation is reported by many countries under the System of Health Accounts. It is also reported under the National Accounts broken down by industrial sector according to the International Standard Industrial Classification (ISIC) Rev. 4 using Section Q: Human health and social work activities, Division 86: Human health activities.

### Note

1. A break in series for Japan in 2011 contributes to this result.

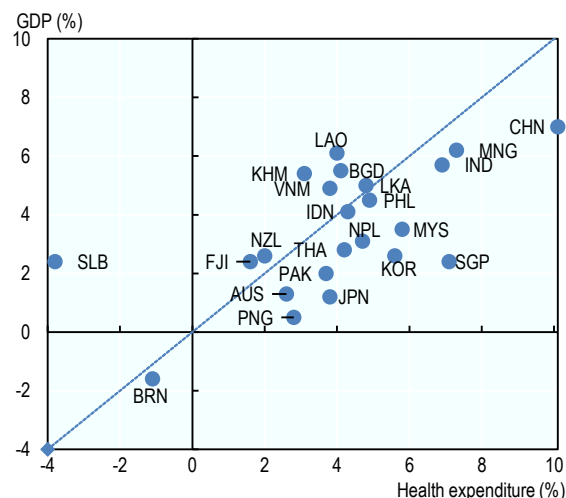
Figure 6.1. Health expenditure per capita, 2017



Source: WHO Global Health Expenditure Database.

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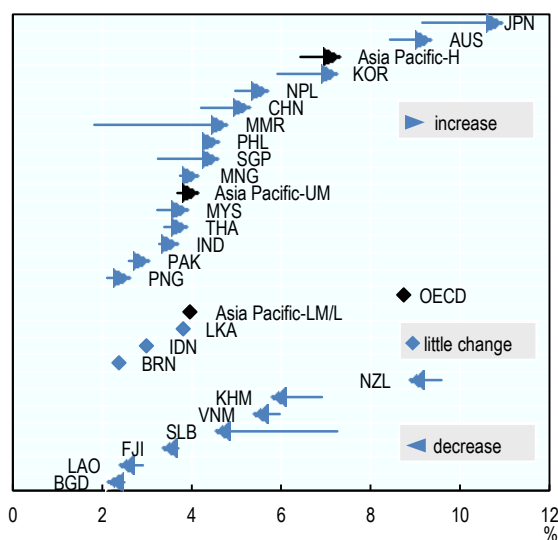
Figure 6.2. Annual average growth rate in per capita health expenditure and GDP, real terms, 2010-17



Source: WHO Global Health Expenditure Database.

StatLink <https://stat.link/amyc62>

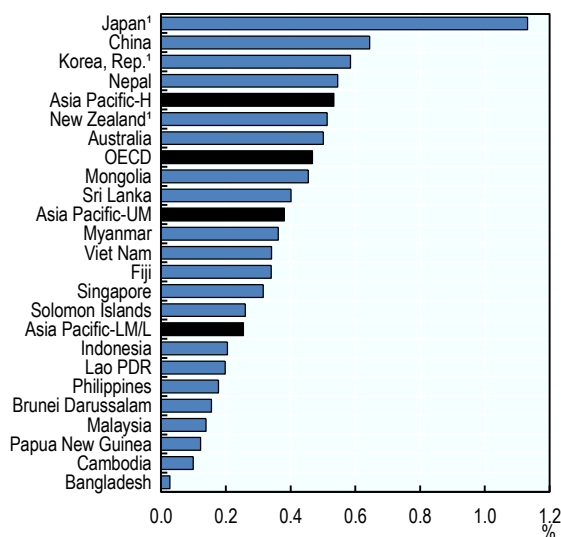
Figure 6.3. Change in health expenditure as a share of GDP, 2010-17



Source: WHO Global Health Expenditure Database; OECD Health Statistics 2020.

StatLink <https://stat.link/biw5rq>

Figure 6.4. Gross fixed capital formation in the health care sector as a share of GDP, 2017



1. Refers to gross fixed capital formation in ISIC Q: Human health and social work activities (ISIC Rev. 4).

Source: WHO Global Health Expenditure Database; OECD Health Statistics 2020; OECD Annual National Accounts.

StatLink <https://stat.link/82a3nj>



From:

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### Measuring Progress Towards Universal Health Coverage

Access the complete publication at:

<https://doi.org/10.1787/26b007cd-en>

#### Please cite this chapter as:

OECD/World Health Organization (2020), "Health expenditure per capita and in relation to GDP", in *Health at a Glance: Asia/Pacific 2020: Measuring Progress Towards Universal Health Coverage*, OECD Publishing, Paris.

DOI: <https://doi.org/10.1787/714791b2-en>

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