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 (either through 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.

The overall pattern of rising per capita health spending appears to be dominated by government and compulsory health insurance schemes sources especially in upper-middle and high income countries. On average, per capita spending from these sources increased from 610 to 797 international dollars (in constant 2017 USD PPP) in Asia-Pacific from 2010 to 2017. Figure 6.5 highlights the change in the government and compulsory health insurance schemes spending as a share of GDP between 2010-17. On average, there was a slight increase in upper-middle and high income countries in Asia-Pacific from 2.1% and 4.7% in 2010 to 2.4% and 5.2% of GDP in 2017 respectively, whereas the share for low and lower-middle income countries remained unchanged at 1.6% of GDP during the same period. Solomon Islands reported a decrease of around two percentage points in the period in study, whereas Japan[1] reported an increase of around two percentage points.

In 15 out of 24 Asia-Pacific countries, government schemes and compulsory health insurance constitute the main health care financing arrangements. The higher the income level the higher the share of health care spending financed through government and compulsory health insurance schemes in Asia-Pacific: 70.7% in high-income countries versus 42.3% in low and lower-middle income countries (Figure 6.6). In Thailand, New Zealand, Japan, Solomon Islands, Papua New Guinea and Brunei Darussalam more than 75% of all health expenditure was paid for through government schemes and compulsory health insurance in 2017. By contrast, in Myanmar, Bangladesh and Cambodia less than 25% of health spending was purchased by these schemes.

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, the general government revenue, 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 2017, health spending by government schemes and compulsory insurance stood at around 6.4% of total government expenditure across low and lower-middle income countries, whereas it represented 10% of total government expenditure in upper-middle income countries in Asia-Pacific (Figure 6.7). In Japan, Australia, New Zealand and Thailand more than 15% of public spending was dedicated to health care. On the other hand, less than 4% of government expenditure was allocated to health care in Lao PDR, India, Pakistan, 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 on 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 2017.

Definition and comparability

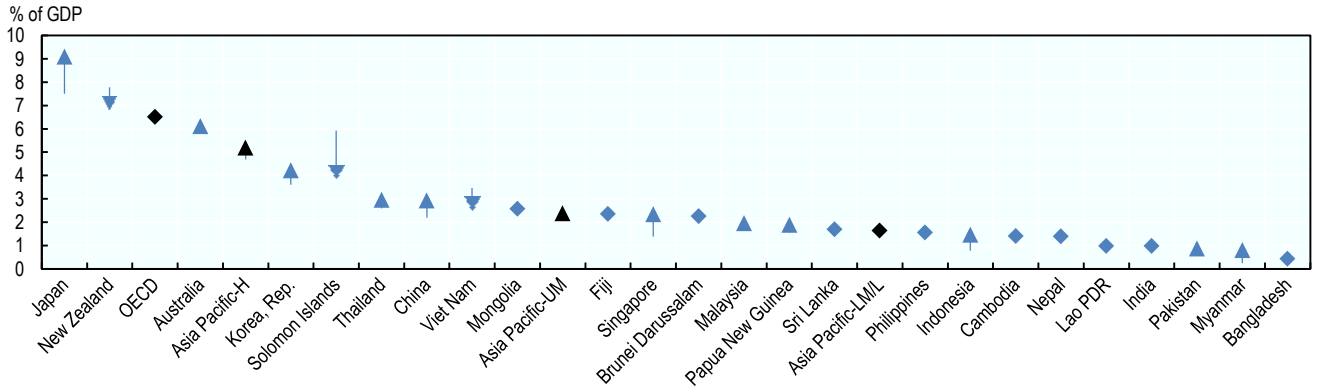
The financing classification used in the System of Health Accounts enables a complete breakdown of health expenditure into public and private units incurring expenditure on health. Public financing includes general government expenditure and social security funds.

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

Note

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

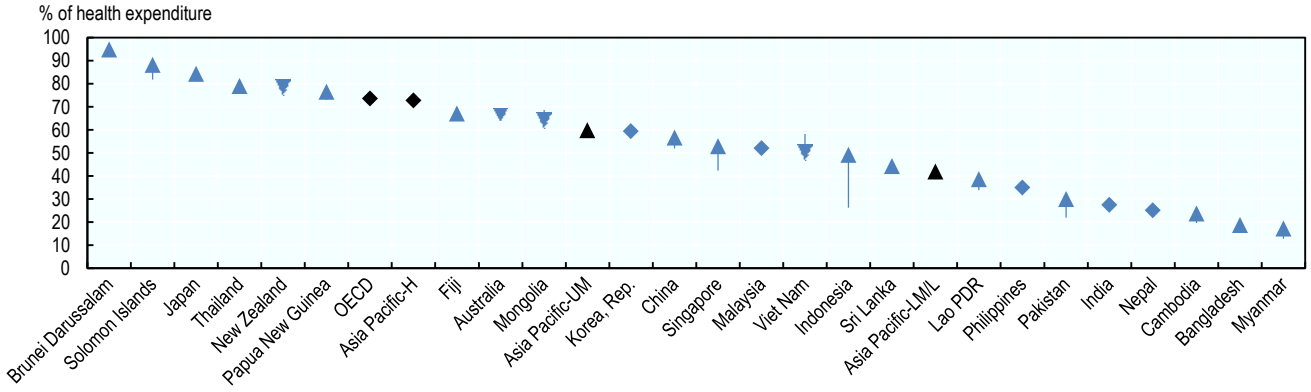
Figure 6.5. **Change in health expenditure by government scheme and compulsory insurance scheme as a share of GDP, 2010-17**



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

StatLink https://stat.link/udvq3n

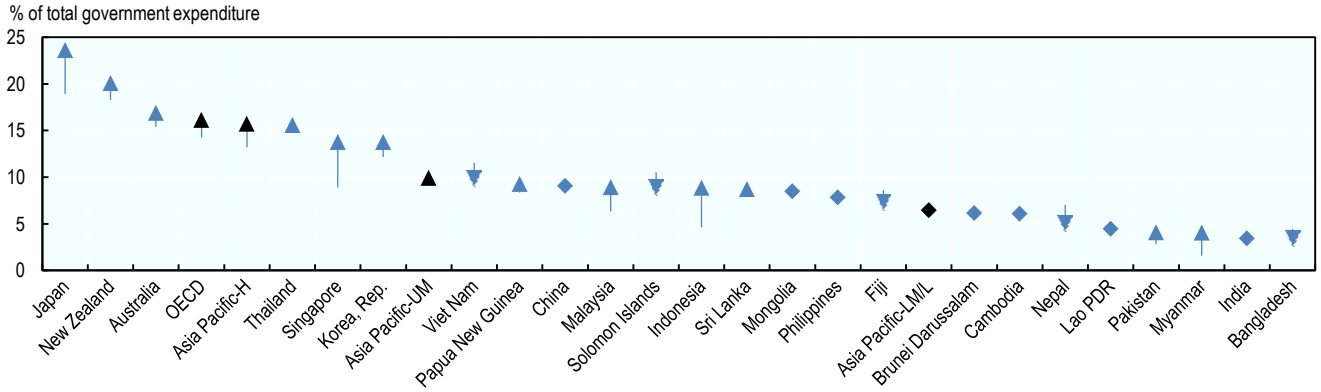
Figure 6.6. **Change in health expenditure by government scheme and compulsory insurance scheme as a share of health expenditure, 2010-17**



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

StatLink https://stat.link/g809ue

Figure 6.7. **Change in health expenditure by government and compulsory health insurance schemes as a share of total government expenditure, 2010-17**



Source: WHO Global Health Expenditure Database.

StatLink https://stat.link/9zmakd

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