

6. FINANCING OF HEALTH CARE FROM HOUSEHOLDS' OUT-OF-POCKET PAYMENTS, VOLUNTARY PAYMENT SCHEMES AND EXTERNAL RESOURCES

Alongside economic growth, out-of-pocket spending for health care increased – on average – from 227 to 293 international dollars (USD PPP) per capita in Asia-Pacific between 2010 and 2017. However, the increase was slower than that of government spending, so the share of out-of-pocket expenditure in overall health spending has been declining across all country income groups since 2010. On average, the share of health spending paid out-of-pocket has fallen by around 3 percentage points to 19% and 29.4% in high and upper-middle income Asia-Pacific countries between 2010 and 2017, respectively, whereas it has slightly decreased to 47.4% in low and lower-middle income Asia-Pacific countries during the same period (Figure 6.8). The pattern is quite diverse across the countries in the region. However, more than two thirds of the Asia-Pacific countries reported a decrease in the share of out-of-pocket spending, including more than 10 and 20 percentage points for Pakistan and Indonesia, respectively, while Lao PDR reported a growth of around 10 percentage points in the same period. For each dollar spent on health, more than 60 cents were “out-of-pocket” in Cambodia, Bangladesh, Pakistan, India and Myanmar in 2017.

Research has suggested that the main driver of households' out-of-pocket expenditure is medicines, composing more than 60% of total out-of-pocket in countries of the WHO South-East Asia Regional Office. In Bangladesh and India, the percentage could be as high as 80%. Furthermore, the share of medicines was even higher among the poorer population, suggesting a disproportionately higher financial burden (Wang, Torres and Travis, 2018[2]). In line with these findings, WHO and The World Bank has reported that Asia had the highest percentage of the population in the world facing catastrophic health spending in 2015, pushing more people below the poverty line (WHO and World Bank, 2019[3]).

Figure 6.9 shows that health expenditure by voluntary payment schemes represented – on average – around 10% of current expenditure on health in countries of all income groups in Asia-Pacific. This share increased by more than 2 percentage points in upper-middle income countries, whereas it increased by more than 1 percentage point in high income and low and lower-middle income Asia-Pacific countries from 2010 to 2017. Less than 5% of current health expenditure was from voluntary payment schemes in Viet Nam, Mongolia, Japan and Bangladesh in 2017, while it represented 15% or more in Singapore, Lao PDR, Cambodia, Australia, Indonesia, Fiji and Nepal in the same year. Fiji reported an increase of 9.4 percentage points between 2010 and 2017, whereas Nepal and Lao PDR reported an increase of almost 5 percentage points.

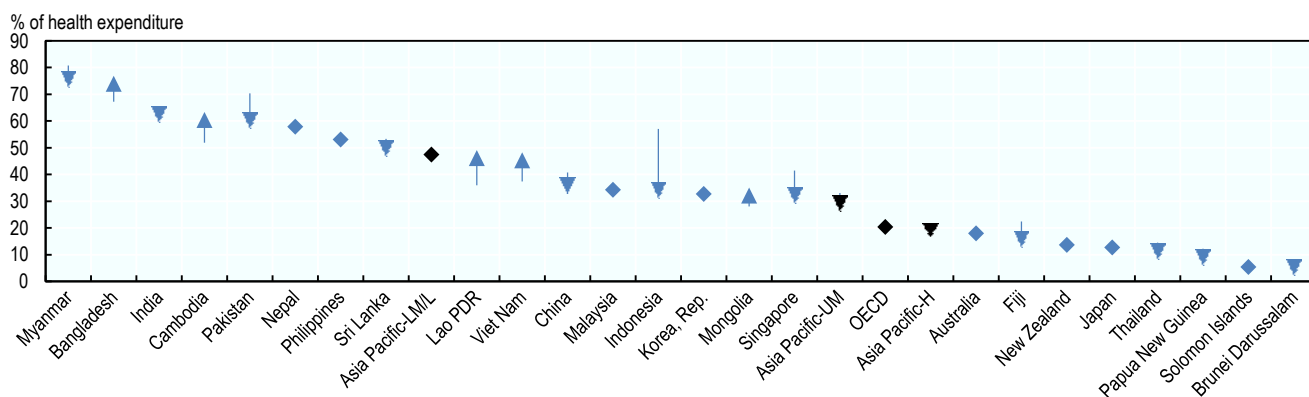
External funding for health care is quite relevant in many developing countries in Asia-Pacific, but increasingly less so over the period of observation. In Solomon Islands around one fourth of funds spent on health were from external resources in 2017 (Figure 6.10), whereas external resources accounted for between 15 and 25% of total health expenditure in Lao PDR, Cambodia, Nepal and Papua New Guinea. A decrease of more than 10 percentage points in external funding for health as a share of current health expenditure was reported for Papua New Guinea and Solomon Island between 2010 and 2017.

Definition and comparability

The financing classification used in the System of Health Accounts provides a complete breakdown of health expenditure into public and private units incurring expenditure on health. Private sector comprises pre-paid and risk pooling plans, household out-of-pocket expenditure and non-profit institutions serving households and corporations. Out-of-pocket payments are expenditures borne directly by the patient. They include cost sharing and, in certain countries, estimations of informal payments to health care providers. Voluntary health care payments schemes include voluntary health insurance, NPISH and enterprises financing schemes.

External funding for health is measured as Official Development Assistance disbursements for health from all donors. Disbursements represent the actual international transfer of financial resources. Disbursements for health are identified by using the classification of sector of destination codes 121 (health, general except 12181, medical education/training and 12182, medical research), 122 (basic health) and 130 (population policies/programmes and reproductive health except 13010 Population policy and administrative management), and 510 (general budget support) (<http://www.oecd.org/dac/stats/aidtohealth.htm>). General budget support to health is estimated by applying the share of government expenditure on health over total general government expenditures to the value reported in ODA. Given that disbursement money is spent over several years by countries, funds disbursed at year t are compared to total health expenditure in year $t+1$.

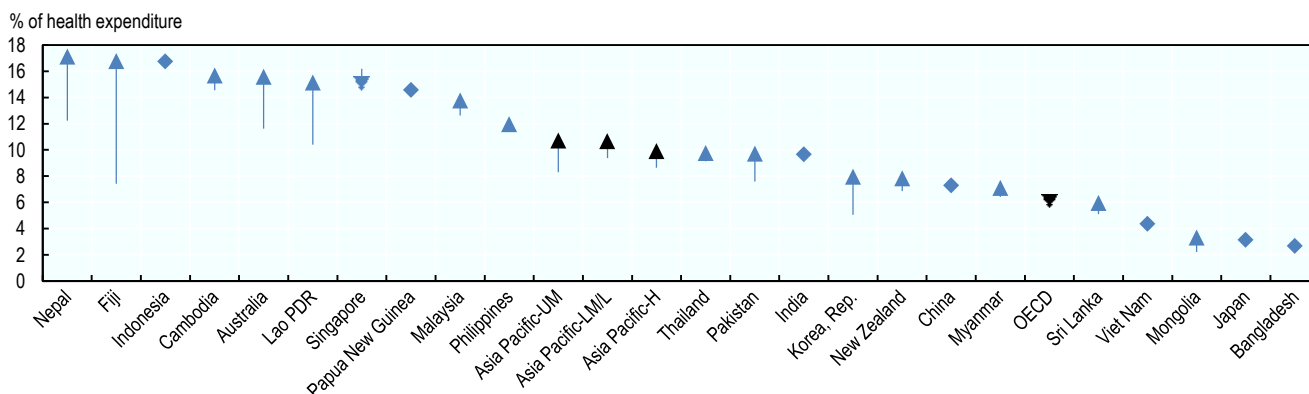
Figure 6.8. Change in health expenditure by households' out-of-pocket as a share of health expenditure, 2010-17



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

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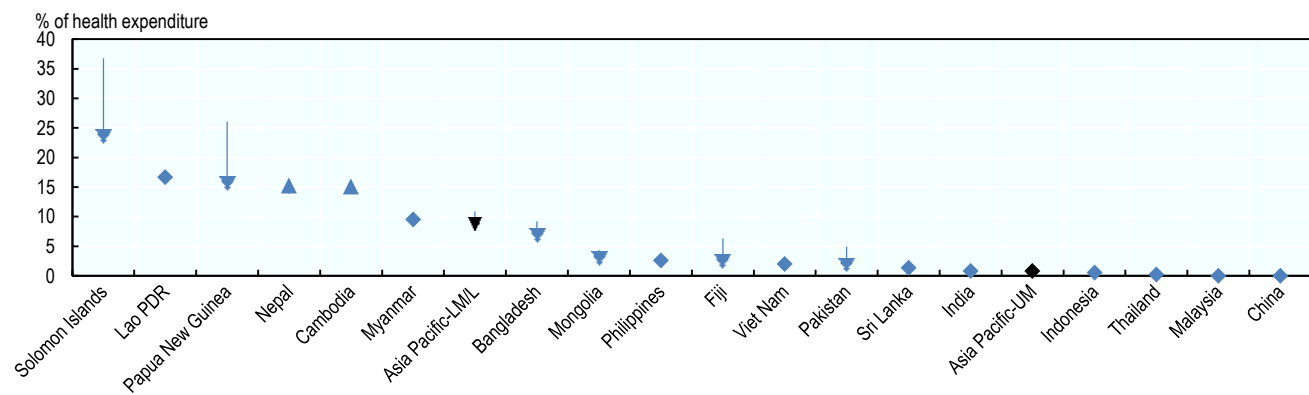
Figure 6.9. Change in health expenditure by voluntary health care payment schemes as a share of health expenditure, 2010-17



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

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

Figure 6.10. Change in external resources as a share of health expenditure, 2010-17



Source: WHO Global Health Expenditure Database.

StatLink <https://stat.link/rs6pf>



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