

HEALTH EXPENDITURE PER CAPITA AND IN RELATION TO GDP

Much variation in per capita health care spending levels can be observed in Asia-Pacific countries and territories in 2015 (Figure 6.1), ranging from Bangladesh health spending per capita of only 88 international dollars (USD PPP) to Australia's 4 491 international dollars (USD PPP). The average OECD current health spending per capita in 2015 was around twenty times that of the low-income countries and territories in Asia-Pacific (3 800 versus USD PPP 193). The higher the income level of a country the higher the share of health spending per capita funded by government/compulsory sources in Asia-Pacific: 71.6% in high-income countries versus 36.8% in low and lower-middle income countries.

On average, between 2010-15, the growth rate in per capita health spending in real terms was 5.3% per year in Asia-Pacific, higher than the 3.9% observed for gross domestic product (GDP) (Figure 6.2). The growth for China was even more rapid – more than twice the average rate for the region. Brunei Darussalam and New Zealand reported the lowest growth rate in per capita health spending in real terms between 2010-15 at 1.3% and 0.9% respectively. Health spending growth in many Asia-Pacific countries has exceeded economic growth over the past five years, resulting in an increasing share of the economy devoted to health in most countries. All territories above 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 territories below 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 in those countries and territories.

How much countries spend on health care over time can be ascribed to overall health spending growth

and economic performance. Health expenditure accounted for 4.3% and 7.3% of GDP in low- and middle-income and high-income Asia-Pacific countries respectively in the Asia-Pacific region in 2015, an increase of 0.4 and 0.8 percentage points respectively from 2010. This indicator varied from 2.6% in Bangladesh and Brunei Darussalam to up to 10.9% in Japan (Figure 6.3). Generally, the richer a country is, the more it spends on health. The percentage of GDP spent on health across OECD countries is – on average – twice that of the Asia-Pacific low- and middle-income countries (8.9 versus 4.3). Between 2010 and 2015, the share of health in relation to GDP declined of around one percentage point Cambodia, whereas it increased in Nepal, Singapore and Japan of more than 1 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 tends 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 2015 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 represents 0.3% of GDP across reporting non-OECD Asia-Pacific countries, and accounts for less than 0.2% in Bangladesh, Brunei Darussalam, Malaysia, Cambodia and the Philippines in 2015.

Definition and comparability

Health expenditure is given by the sum of expenditure on 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 borne by final use of resident units i.e. as long as it is final consumption by nationals 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, Eurostat and WHO, 2011) 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.

The economy-wide (GDP) 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 through the use of 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.

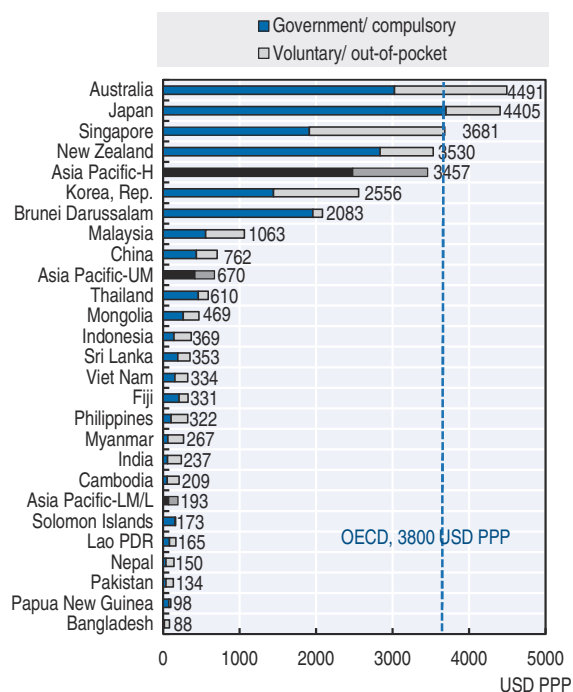
To take into account the timing of the government budget allocation process, comparison over time look at the latest five years for which expenditure data are available.

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

$$(\sqrt[n]{(2015 \text{ value})/(2010 \text{ value})}-1)*100$$

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, etc.), 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 or Division 86: Human health activities. The former is normally broader than the SHA boundary while the latter is narrower.

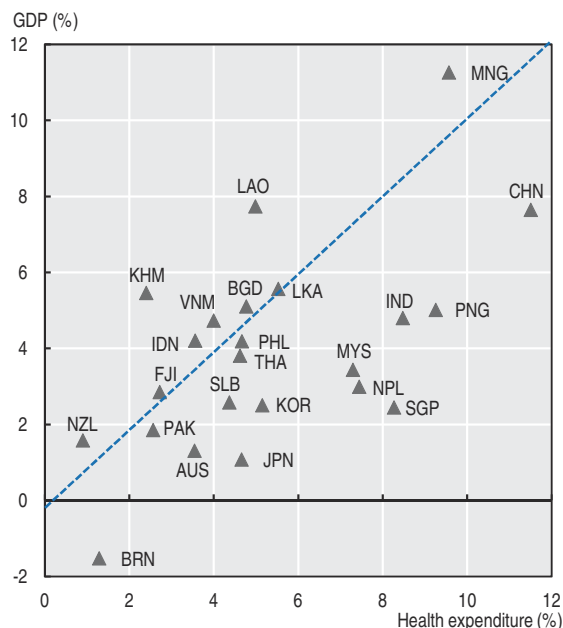
6.1. Health expenditure per capita, 2015



Source: WHO Global Health Expenditure Database (2018f); OECD Health Statistics (2018).

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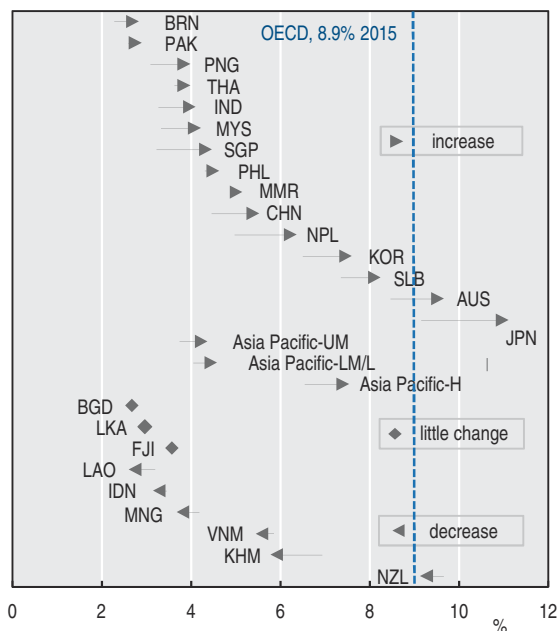
6.2. Annual average growth rate in per capita health expenditure and GDP, real terms, 2010 to 2015



Source: WHO Global Health Expenditure Database (2018f); OECD Health Statistics (2018).

StatLink <http://dx.doi.org/10.1787/888933868823>

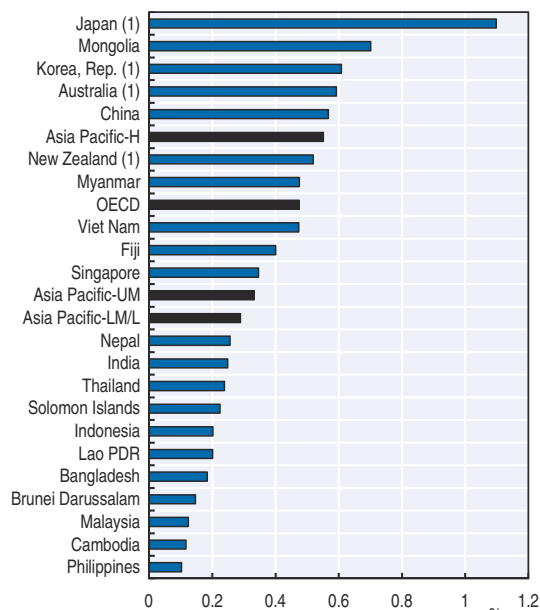
6.3. Change in health expenditure as a share of GDP, 2010 to 2015



Source: WHO Global Health Expenditure Database (2018f); OECD Health Statistics (2018).

StatLink <http://dx.doi.org/10.1787/888933868842>

6.4. Gross fixed capital formation in the health care sector as a share of GDP, 2015



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 (2018f); OECD Health Statistics (2018).

StatLink <http://dx.doi.org/10.1787/888933868861>



From:
Health at a Glance: Asia/Pacific 2018
Measuring Progress towards Universal Health Coverage

Access the complete publication at:
https://doi.org/10.1787/health_glance_ap-2018-en

Please cite this chapter as:

OECD/World Health Organization (2018), "Health expenditure per capita and in relation to GDP", in *Health at a Glance: Asia/Pacific 2018: Measuring Progress towards Universal Health Coverage*, OECD Publishing, Paris.

DOI: https://doi.org/10.1787/health_glance_ap-2018-37-en

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