DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS COMMITTEE

Working Party on Social Policy. Health Policy Statistics,

HEALTH EXPENDITURE AND FINANCING (PARTS 4 & 5) IN OECD HEALTH DATA 2005

to be held at the Château de la Muette, Paris, 30 September and 1 October 2004, starting at 14.00 on the first day

Following the Meeting of OECD Health Data National Correspondents, starting at 09:30 on 29-30 September 2004 - DEELSA/ELSA/WP1/HS/2004/1

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NOTE BY THE SECRETARIAT

1. In response to the need to provide reliable and comparative statistics on health expenditure and financing, the network of health accounts experts and correspondents for health expenditure data, together with the Secretariat, agreed at the previous meeting on a set of priorities to expand and improve the reporting of data for *OECD Health Data* [DELSA/ELSA/WP1/HS(2003)4]. Despite improvements in many countries, a major breakthrough is still needed in the availability of core variables of health expenditure in eleven countries.

2. The main purpose of this paper is to report on the status and progress of these priorities, and to develop further proposals to continue the process. Firstly, a review is presented on the current status of harmonisation between *OECD Health Data* and the SHA-based National Health Accounts. This is followed by a review of the data availability by variable and country for *OECD Health Data 2004*. Finally the next steps in relation to *OECD Health Data 2005* are presented. The Annex contains information on data availability in *OECD Health Data 2004* by variable and by country.

3. Note that following the adopted proposal at the meeting of experts in 2003, for the first time this year, the meeting of the *OECD Health Data* national correspondents will be directly followed by the meeting of Health Accounts Experts and Correspondents for Health Expenditure Data. This enables this meeting to cover issues related to Parts 4 and 5 of *OECD Health Data* as well as SHA implementation in member countries and related methodological issues.

4. The delegates to the Meeting of Health Accounts Experts and Correspondents for Health Expenditure Data are invited to:
   
   − REPORT on their progress and future plans for harmonising health expenditure data reporting to *OECD Health Data* with the SHA-ICHA since the last experts’ meeting;
   
   − REPORT on their efforts and future strategy to expand and improve data reporting and improve timeliness for Parts 4 (Expenditure on Health) and 5 (Financing of Health);
   
   − COMMENT on the Secretariat’s ongoing strategy to improve the availability and comparability of health expenditure and financing data in *OECD Health Data 2005*; and
   
   − COMMENT on the options relating to the future collection of SHA tables in relation to the regular data collection round of *OECD Health Data*. 


INTRODUCTION

5. In recent years, one of the priorities of the Secretariat has been the development of reliable and comparable statistics on health expenditure and financing across OECD countries. The harmonisation of reporting to Parts 4 and 5 of the database and the development of SHA-based National Health Accounts is seen as paramount in achieving this goal. In reinforcing this, the Communiqué of Health Ministers, issued at the first meeting of OECD Ministers, held on 13-14 May 2004, emphasised further development of OECD Health Data and the implementation of the System of Health Accounts in member countries as key items in any future OECD Programme of work on health.

STATE OF HARMONISATION

6. One of the main objectives of the Secretariat over recent years has been to enhance the comparability of the expenditure and financing data in OECD Health Data between countries and over time. The adoption of the main definitions and concepts of the International Classification of Health Accounts (ICHA) in Parts 4 and 5 of the database is seen as paramount in achieving this goal.

7. In a step-wise approach, OECD Health Data has harmonised the overall boundary definitions of total health expenditure in line with the ICHA, and has introduced functional categories and sub-categories of the mode of production. Further harmonisation has also been achieved by the introduction of categories of current health expenditure by provider. Last year, a small but useful innovation has been the introduction of ICHA codes into the Part 4 and 5 questionnaire to aid the data correspondents in attributing expenditure to the correct series.

8. However, certain differences continue to exist between the structures of OECD Health Data and the System of Health Accounts. In particular, the standard SHA tables allow the cross classification of expenditures under the three basis classifications (functions, service provider industries and sources of funding), and therefore provide detailed analysis of the corresponding relationships. At present, OECD Health Data is restricted in such cross-classifying analysis – in effect limited to the aggregate public and private expenditure of function and provider. As a result, there is no possibility for a cross classification of function by provider or a further breakdown of financing agents (e.g. the role of households out-of-pocket funding) by function or provider industry. Finally, OECD Health Data is less detailed in certain aspects, e.g. ‘All other private funds’ currently covers NPISHs (HF.2.4), Corporations (HF.2.5) and Rest of the World (HF.3).

9. OECD Member countries are at various stages of implementation of SHA and thus the regular reporting of SHA-based national health accounts to OECD Health Data differs. Table 1 shows the main sources for expenditure data as reported to OECD Health Data 2004, with almost half the OECD countries now using SHA-based NHA for the data reporting, or at least reporting harmonised major health expenditure aggregates with the functional boundaries of the SHA. In addition, another dozen countries are
either undergoing or are considering an SHA pilot study, leaving only a couple of countries with no immediate plans for SHA implementation.

10. Table 1 also shows the 13 countries which made a contribution to the Working Paper reporting on SHA-based National Health Accounts in OECD Countries [DELSA/ELSA/WD/HEA(2004)7] and the SHA tables provided under this project [DELSA/ELSA/WP1/HS(2004)5].

11. This project has facilitated the harmonisation and consistency, and enhanced the coverage, of health expenditure data. It has also contributed to improve the methodological information in OECD Health Data for the vast majority of the countries involved. It is hoped that the inclusion of additional countries in subsequent Working Papers will further enhance the consistency of published health expenditure data.

12. Regarding the harmonisation of data reporting to OECD Health Data 2004, important examples of progress made are as follows:

- Following the successful completion of the National Health Accounts project and involvement in the SHA Working Paper, Turkey was able to supply detailed SHA-based data for 1999 and 2000.
- A thorough review of the functional classification in Canada led to revised series from 1998 onwards.
- Health expenditure reimbursement paid by government for civil servants in Germany was reclassified as public expenditure.
- A review of existing sources has permitted Sweden to significantly improve the reporting of expenditure by function variables.

13. The regular collection of SHA Tables is relevant for future data reporting to OECD Health Data. There are two options in this regard:

- Either, to connect reporting of the SHA tables to reporting data for Parts 4 and 5 of the OECD Health Data (i.e. SHA tables for 2003 would be reported in February/March 2005.) Standard tables and guidelines (similar to those for Parts 4 & 5) would be prepared.
- Or, to collect SHA tables separately from data collection for the OECD Health Data, preferably in April/May of every year. This seems to be the latest date to ensure that the comparative tables present data with 2 years time-lag, at least for most of the countries.

14. The countries’ SHA tables and the related comparative tables are planned to be presented on the SHA Implementation webpage. It is then envisaged that hyperlinks from the country-specific pages of the Sources and Methods will allow the user to pass directly to these SHA pages.

15. Due to the differing methods in estimating expenditure on long-term nursing care, this continues to be one of the most important factors affecting the comparability of total health expenditure between OECD countries. In many OECD countries, long-term care provided away from the hospital sector is often financed and accounted for outside of the traditional national boundaries of the health systems. Thus the expenditure on such programs may be included under social benefits or support rather than health expenditure. Countries then apply different methods in estimating the health-related components of this long-term care element.

1. www.oecd.org/health/sha
Table 1: Sources of Health Expenditure and Finance Data in OECD Health Data 2004

<table>
<thead>
<tr>
<th>Basis for Health expenditure and finance data reported to OECD Health Data 2004</th>
<th>SHA Tables provided for SHA Working Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>A System of Health Accounts (SHA)</td>
<td></td>
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<tr>
<td>Locally produced national health accounts</td>
<td></td>
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<tr>
<td>National accounts estimates</td>
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<td>OECD Secretariat estimates</td>
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<td>Austria</td>
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<td>Poland</td>
<td>1991-2002</td>
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<tr>
<td>Sweden</td>
<td>1960-2002</td>
</tr>
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</table>
16. At the same stage of data collection, i.e. early September, prior to the final Internet update of OECD Health Data 2004, there has been general improvement in the number of countries reporting the core variables for the key reference year (e.g. 2002 data for OECD Health Data 2004) (Chart 1 in the Annex). For Total Health Expenditure, 26 countries (all Member countries, except Australia, Korea, Japan and Turkey) were able to report 2002 data. Korea and Japan are expected to report preliminary figures before the final internet update in late September.

17. Figure 1 presents the availability of the major sub-aggregates for 2002. The number of countries in a position to divide Total Health Expenditure into Current Health Expenditure and Investments stood at 23. The further division to Personal and Collective Health Care shows that 17 countries were able to provide both figures for 2002. Finally, 18 countries were able to sub-divide Personal Health Care into Medical Services and Goods. This figure clearly demonstrates the pressing need for improvement in availability for these major aggregates.

18. Further to the steps proposed for improving the data coverage, the number of countries in a position to provide a breakdown of medical services into functions and modes of production has increased.
Furthermore particular improvements in providing current expenditure data by provider category should be noted.

19. However, one of the particular points to note is the reduction in the number of countries reporting data on private investment. It appears that a number of countries are reviewing their data in this particular area, either because all the components are not being covered or because private investment is already included in their estimates of private current expenditure. The project on *Refinement and extension of the International Classification for Health Accounts* [DELSA/ELSA/WP1/HS(2004)6] is expected to provide a more detailed explanation for this area.

20. The agreed set of priorities also sets out the following sub-set of core variables that should be reported by member countries for 2002.

   **Part 4**
   - Total, public, private health expenditure
   - Total, public, private current expenditure on health
   - Total, public, private investment on medical facilities
   - Total expenditure on prevention and public health
   - Total, public, private expenditure on in-patient care
   - Total, public, private expenditure on out-patient care
   - Total, public, private expenditure on pharmaceuticals and other medical non-durables
   - Total expenditure on hospitals’ services
   - Total expenditure on services of ambulatory health care providers

   **Part 5**
   - Health expenditure by general government, excluding social security
   - Health expenditure by social security schemes
   - Out-of-pocket payments (households)

21. Currently, 20 countries are able to provide more than 75% of these core variables for the most recent year, with 9 countries able to supply all the required variables. A number of countries have improved their data coverage, notably Spain, Turkey, Korea, Iceland and Sweden. On the other hand, six countries were only able to provide 50% or less of the sub-set. In a number of countries, such as the Netherlands and the United Kingdom the proportion of these core variables provided has dropped significantly from previous years’ data reporting, reflecting in some cases an ongoing revision of national health expenditure data, which it is hoped will show benefits in subsequent data rounds. Country-specific reporting of core variables to *OECD Health Data 2004* are shown in the Annex.

22. Emphasis was placed on improving the information contained for each country in Sources and Methods, particularly with regard to the differences and departures existing between total expenditure and its main sub-components reported nationally and as defined in the OECD SHA Manual. To this extent, a number of countries provided significant additions and amendments to the information contained in the country-specific pages (in particular, Canada, Mexico, Sweden and Turkey).
FUTURE TASKS FOR OECD HEALTH DATA 2005

23. For OECD Health Data 2005, the main focus will be to improve availability.

24. In line with the tasks adopted at the previous experts’ meeting, countries are asked again to pay special attention to providing the sub-set of core variables listed in the previous section, in particular out-of-pocket payments, in-patient expenditure and pharmaceuticals with the agreed addition of the following two variables:
   - Total expenditure on curative and rehabilitative care
   - Total expenditure on long-term nursing care

25. In recognition of the complexity and importance of this issue the Secretariat is including, within its proposal for the Refinement and Extension of the International Classification for Health Accounts [DELSA/ELSA/WP1/HS(2004)6], specific reference to drawing up more detailed definitions and methodology for long-term care. However for the purposes of improving the comparability within OECD Health Data pending the results of this project the Secretariat proposes to work with the Member countries on a one-by-one basis during the coming data reporting round(ii).

26. In addition, the Secretariat continues to urge those member countries which provide less comparable data to focus on the following:
   - Provide clear indications of methodological departures of national health expenditure totals and major sub-components from the definitions of OECD SHA Manual.
   - Make clear distinctions between expenditure on hospitals and expenditures on in-patient care i.e. separate out non in-patient expenditure in hospitals.
   - Provide as far as possible separate expenditure on day care, home care and ancillary services from in-patient and out-patient care

27. As to the question of timeliness, the Secretariat wishes to ensure that the maximum number of countries are in a position to provide estimations of 2003 expenditure data for OECD Health Data 2005. In this respect, countries are urged to indicate the earliest time that they can provide such data to enable the Secretariat to establish the optimal dates for subsequent internet updates. Countries are also urged to provide preliminary estimates for 2003 if final estimates are only available after the published deadlines – this is particularly important for the coming data round since the publication of OECD Health at a Glance will be based on OECD Health Data 2005.

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(ii) The concrete issues of possible further harmonisation of LTC estimates with the SHA will be discussed on a country-by-country basis during November and December. This work will take into account the fact that a more definitive solution can only be expected from the project on “Refinement and extension of the International Classification for Health Accounts”.

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28. The Secretariat does not intend to amend the structure of the questionnaire for the 2005 round of data collection, and therefore all existing series will be retained. Therefore the series on per capita expenditure by age and gender, and expenditure on day care will continue to be included in the questionnaire, although they are presently non reported due to the low level of response. The decision whether to retain these series in the final CD-ROM will depend on the future coverage and as such therefore countries are urged to try to complete these series.

29. A further issue is related to the recent expansion of the European Union. Although some of the new EU member states are not members of the OECD, the Secretariat intends to publish the main health expenditure indicators for these countries (Cyprus, Estonia, Latvia, Lithuania, Malta and Slovenia) under the ‘Get More Data’ section of the database to allow the user to make full EU comparisons. It is envisaged that this would be restricted to the main aggregates of Total, Public and Private expenditure expressed as USD PPP and percentage of GDP.
Chart 1: Number of countries reporting data ≤ 2 years

OECD Health Data

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Chart 3: Agreed Sub-set of Core Variables

% available (≤ 4 years)

- Australia
- Germany
- Hungary
- United States
- Canada
- Luxembourg
- Mexico
- Spain
- Turkey
- France
- Japan
- Switzerland
- Denmark
- Austria
- Italy
- Korea
- Czech Republic
- Finland
- Slovak Republic
- Iceland
- Sweden
- Ireland
- Norway
- Poland
- Netherlands
- Greece
- Belgium
- Portugal
- New Zealand
- United Kingdom

Australia: 100%
Germany: 100%
Hungary: 100%
United States: 100%
Canada: 100%
Luxembourg: 100%
Mexico: 100%
Spain: 100%
Turkey: 100%
France: 96%
Japan: 96%
Switzerland: 100%
Denmark: 100%
Austria: 96%
Italy: 92%
Korea: 83%
Czech Republic: 75%
Finland: 92%
Slovak Republic: 92%
Iceland: 75%
Sweden: 54%
Ireland: 71%
Norway: 58%
Poland: 58%
Netherlands: 50%
Greece: 50%
Belgium: 39%
Portugal: 29%
New Zealand: 22%
United Kingdom: 21%
Core variables - number of countries reporting
Health Data 2004

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| Part 5 | | |
|--------|---|---|---|---|
| Health expenditure by general government, excluding social security | 26 | 22 | 26 | 21 |
| Health expenditure by social security schemes | 25 | 18 | 25 | 20 |
| Out-of-pocket payments (households) | 26 | 21 | 25 | 21 |
| Health expenditure by private insurance | 23 | 18 | 20 | 16 |
| All other private expenditure | 24 | 16 | 21 | 17 |

| Average for core variables | 24 | 18 | 22 | 17 |
| Average for minimum dataset variables | 26 | 20 | 24 | 19 |
## Specific country overview

### Australia

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### Specific country overview

**Austria**

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- ■ Data available
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### Specific country overview

#### Belgium

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**Percentage of core variables**

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Specific country overview

Canada

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- ■ Data available
- □ Data not available
Specific country overview
Czech Republic

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■ Data available
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### Specific country overview

**Denmark**

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- ■ Data available
- □ Data not available
## Specific country overview

**Finland**

### Part 4

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### Percentage of Core Variables

- Data available: 84%
- Data not available: 78%

### Percentage of Minimum Dataset Variables

- Data available: 88%
- Data not available: 88%
### Specific country overview

**France**

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#### Percentage of core variables

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- Data not available: 97%

#### Percentage of minimum dataset variables

- Data available: 96%
- Data not available: 96%
Specific country overview
Germany

### Part 4

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### Part 5

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- □ Data not available
Specific country overview
Greece

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| Percentage of core variables | 44% | 38% | 38% | 38% |
| Percentage of minimum dataset variables | 58% | 50% | 50% | 50% |

■ Data available
□ Data not available
## Specific country overview

### Hungary

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### Part 5

| Health expenditure by general government, excluding social security | 97% 44% 97% 97% |
| Health expenditure by social security schemes | 97% 44% 97% 97% |
| Out-of-pocket payments (households) | 100% 58% 100% 100% |
| Health expenditure by private insurance | 97% 44% 97% 97% |
| All other private expenditure | 97% 44% 97% 97% |

- ■ Data available
- □ Data not available
## Specific country overview

### Iceland

### Part 4

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| Percentage of core variables                                           | 81%     | 81%       | 75%       | 16%  |
| Percentage of minimum dataset variables                                | 83%     | 83%       | 83%       | 21%  |

- ■ Data available
- □ Data not available
## Specific country overview

### Ireland

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### Part 5

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Specific country overview

Italy

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Part 5

Health expenditure by general government, excluding social security | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ |
Health expenditure by social security schemes | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ |
Out-of-pocket payments (households) | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ |
Health expenditure by private insurance | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ |
All other private expenditure | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ | ■ ■ ■ ■ |

Percentage of core variables | 75% 75% 75% 75% |
Percentage of minimum dataset variables | 92% 92% 92% 92% |

■ Data available
□ Data not available
Specific country overview

Japan

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■ Data available
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Specific country overview
Korea

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### Percentage of core variables
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- Data not available: 12% 12% 12% 0%

### Percentage of minimum dataset variables
- Data available: 92% 92% 92% 0%
### Specific country overview

**Luxembourg**

#### Part 4

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#### Part 5

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#### Percentage of core variables

| Percentage | 97% | 38% | 97% | 97% |

#### Percentage of minimum dataset variables

| Percentage | 100% | 46% | 100% | 100% |

■ Data available
□ Data not available
## Specific country overview

### Mexico

#### Part 4

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#### Part 5

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### Percentage of core variables

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### Percentage of minimum dataset variables

- 100% 42% 100% 100%

- Data available
- Data not available
Specific country overview
The Netherlands

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| Part 5 | | | | |
|--------|--------|--------|--------|
| Health expenditure by general government, excluding social security | ■ | ■ | ■ | ■ |
| Health expenditure by social security schemes | ■ | ■ | ■ | ■ |
| Out-of-pocket payments (households) | ■ | □ | □ | □ |
| Health expenditure by private insurance | ■ | □ | □ | □ |
| All other private expenditure | ■ | □ | □ | □ |

| Percentage of core variables | 97% | 78% | 59% | 59% |
| Percentage of minimum dataset variables | 100% | 88% | 50% | 50% |

- ■ Data available
- □ Data not available
## Specific country overview

### New Zealand

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### Percentage of core variables

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### Percentage of minimum dataset variables

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- Data available
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Specific country overview
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| Percentage of core variables                                         | 75%  | 75%  | 47%  | 47%  |
| Percentage of minimum dataset variables                              | 83%  | 83%  | 58%  | 58%  |

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## Specific country overview

### Poland

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Specific country overview
Portugal

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## Specific country overview

### Slovak Republic

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Specific country overview
Spain

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Part 5

| Health expenditure by general government, excluding social security | ■ | ■ | ■ | ■ |
| Health expenditure by social security schemes | ■ | ■ | ■ | ■ |
| Out-of-pocket payments (households) | ■ | ■ | ■ | ■ |
| Health expenditure by private insurance | ■ | ■ | ■ | ■ |
| All other private expenditure | ■ | ■ | ■ | ■ |

| Percentage of core variables | 94% | 75% | 94% | 88% |
| Percentage of minimum dataset variables | 100% | 79% | 100% | 92% |

■ Data available
□ Data not available
## Specific country overview

### Sweden

#### Part 4

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| Percentage of core variables | 59% | 44% | 56% | 56% |
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■ Data available
□ Data not available
### Specific country overview

**Switzerland**

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#### Percentage of core variables

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- □ Data available
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Specific country overview
Turkey

### Part 4

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### Part 5

<table>
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<td>Health expenditure by general government, excluding social security</td>
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<tr>
<td>Health expenditure by social security schemes</td>
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<tr>
<td>Out-of-pocket payments (households)</td>
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<tr>
<td>Health expenditure by private insurance</td>
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<tr>
<td>All other private expenditure</td>
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- ■ Data available
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## Specific country overview
### United Kingdom

### Part 4

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### Percentage of core variables

| Percentage          | 81% | 59% | 16% | 16% |

| Percentage          | 78% | 67% | 21% | 21% |

- ■ Data available
- □ Data not available
## Specific country overview
### United States

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### Part 5

| Health expenditure by general government, excluding social security |  |  |   |   |
| Health expenditure by social security schemes |  |  |   |   |
| Out-of-pocket payments (households) |  |  |   |   |
| Health expenditure by private insurance |  |  |   |   |
| All other private expenditure |  |  |   |   |

### Percentage of core variables

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