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SHA-Based National Health Accounts in Thirteen OECD Countries: A Comparative Analysis

Eva Orosz,

David Morgan

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The Health Policy Unit at the OECD, along with experts from thirteen member countries, under the co-ordination of Eva Orosz and David Morgan, carried out a project to present the initial results from the implementation of the System of Health Accounts. The results are presented in this comparative study and in a set of OECD Health Technical Papers, presenting individual country studies. The authors of the country studies were: Lindy Ingham, Rebecca Bennetts and Tony Hynes (Australia), Gilles Fortin (Canada), Iben Kamp Nielsen (Denmark), Natalie Zifonun (Germany), Maria Manno and Mihalyne Hajdu (Hungary), Hiroyuki Sakamaki, Sumie Ikezaki, Manabu Yamazaki and Koki Hayamizu (Japan), Hyoung-Sun Jeong (Korea), María-Fernanda Merino-Juárez, Maluin-Gabriela Alarcón-Gómez, Rafael Lozano-Ascencio (Mexico), Cor van Mosseveld (The Netherlands), Dorota Kawiorska (Poland), Jorge Relaño Toledano and María Luisa García Calatayud (Spain), Raymond Rossel and Yves-Alain Gerber (Switzerland), Mehtap Kartal, Huseyin Ozbay and Halil Erkan Eristi (Turkey).

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FOREWORD

1. In response to the pressing need for reliable and comparable statistics on health expenditure and financing, the OECD, in co-operation with experts from OECD member countries, developed the manual, *A System of Health Accounts* (SHA), releasing the initial 1.0 version in 2000. Since its publication, a wealth of experience has been accumulated in a number of OECD countries during the process of SHA implementation, and several national publications have already been issued. Furthermore, the Communiqué of Health Ministers, issued at the first meeting of OECD Health Ministers held on May 13-14 2004, emphasised the implementation of the *System of Health Accounts* in member countries as a key item in the future OECD work programme on health.

2. With this paper the Secretariat intends to launch a regular (biennial) series that – together with the related Health Technical Papers – will provide a unique source of systematic and comparable health expenditure data with comparative analysis and interpretation of the results from SHA-based health accounts. This paper analyses in a comparative way, how the main types of services (functions of care) are financed and provided, and for what purposes, money is spent by the main financing agents in the health systems of the participating countries. In addition, the key results are presented on a country-by-country basis in thirteen Health Technical Papers, supported by detailed methodological documentation. Also, the analysis of data availability and comparability shows where further harmonisation of national classifications with the International Classification for Health Accounts (SHA-ICHA) should be pursued.

3. Thirteen countries participated in this pioneering study: Australia, Canada, Denmark, Germany, Hungary, Japan, Korea, Mexico, the Netherlands, Poland, Spain, Switzerland and Turkey. The next edition, to be published in 2006, is expected to include several additional countries.

4. This series of studies on SHA has been written with a number of different target audiences in mind: policy-makers, policy-analysts, health accounting experts and researchers alike. While the analytical parts of the papers might be of interest for all these audiences, the detailed tables and methodological chapters are primarily expected to be a valuable source of information for health accounting experts and researchers.

5. In order to make the results more widely available, this working paper and the Health Technical Papers are also accessible via the internet: www.oecd.org/els/health/workingpapers.

AVANT-PROPOS

6. En réponse aux besoins urgents de statistiques fiables et comparables sur le financement et les dépenses et de santé, l'OCDE, en coopération avec des experts de pays membres de l'OCDE, a développé le manuel *Système de comptes de la santé (SCS)*, dont la première version (1.0) a été publiée en 2000. Depuis sa parution, une abondance d'information a été recueillie dans plusieurs pays membres de l'OCDE pendant le processus de mise en place du SCS, et plusieurs publications nationales ont déjà parues. Par ailleurs, le Communiqué des Ministres de la Santé, distribué au moment de la première réunion des Ministres de la Santé de l'OCDE le 13 et le 14 mai, a souligné l'importance de la mise en place du SCS dans les pays membres, comme étant une partie clé du programme de travail de l'OCDE sur la santé.

7. Avec ce document de travail le Secrétariat prévoit de lancer une série de publications biannuelle qui, en conjonction avec les Rapports Techniques sur la Santé, servira d'une source unique de données systématiques et comparables des dépenses de santé, avec une analyse comparative et une interprétation des résultats des comptes de santé SCS. Ce document analyse de façon comparative, le financement et l'approvisionnement des types de services (fonctions de soins) et comment l'argent est dépensé par les agents de financement des systèmes de santé dans les pays participants à l'étude. En outre, les résultats principaux sont présentés pays par pays dans une série de treize Rapports Techniques sur la Santé, appuyés par une documentation méthodologique détaillée. Par ailleurs, l'analyse de la disponibilité et de la comparabilité des données détaille dans quels domaines une plus grande harmonisation des classifications nationales avec la Classification internationale pour les comptes de santé (SCS-ICHA) devrait se poursuivre.

8. Treize pays ont participé à cette étude pilote : l'Australie, le Canada, le Danemark, l'Allemagne, la Hongrie, le Japon, la Corée, le Mexique, les Pays-Bas, la Pologne, l'Espagne, la Suisse et la Turquie. La prochaine édition, qui sera publiée en 2006, comprendra davantage de pays.

9. Cette série de publications s'adresse à plusieurs publics : des responsables d'élaboration de politiques, des analystes politiques et des experts des comptes de systèmes de santé et des chercheurs. Tandis que les parties analytiques du document pourraient s'adresser à toutes ces personnes, les tableaux détaillés et les chapitres méthodologiques devraient surtout être une source d'information particulièrement riche pour les chercheurs et experts en comptabilité de santé

10. Pour mettre ces résultats à la disposition du plus grand nombre, ce document et les Rapports Techniques sur la Santé sont également disponibles sur le site Internet de l'OCDE : www.oecd.org/els/health/workingpapers.

INTRODUCTION

The purpose of the System of Health Accounts

11. Changes in health systems and concomitant health policy questions have been challenging the traditional system of health expenditure statistics over the last couple of decades. What are the major factors accounting for health expenditure growth? What factors explain the differences between countries in expenditure growth? How to ensure sustainable financing? What are the major factors accounting for the differences in the structure of health spending? How are the changes in health spending structure and the performance of health systems related? In order to answer such questions, reliable, comparable and appropriately detailed health expenditure data are required.[1] The *System of Health Accounts* intends to provide the foundation for health statistics that are able to meet these challenges.

Box 1
What is the System of Health Accounts?

The System of Health Accounts (SHA) proposes an integrated system of comprehensive and internationally comparable accounts and provides a uniform framework of basic accounting rules and a set of standard tables for reporting health expenditure data. Boundaries of the health system are defined in a wider sense by the SHA including long-term nursing care.

It proposes an *International Classification for Health Accounts (ICHA)* that – in its 1.0 version - covers three dimensions:

- health care **functions** (ICHA-HC);
- health care **service provider industries** (ICHA-HP);
- sources of **funding** health care (ICHA-HF).

Standard SHA tables cross-classify expenditures under the three basic classifications providing new and deeper analytic possibilities of how services are financed and provided.

The SHA[2] allows for the incorporation of further dimensions of health expenditure into national health accounts: for example, regions, age and gender groups, and disease categories, in order to more adequately answer the question of *"Who gets what, where, and how?"*[3]

12. Member countries are currently at varying stages of SHA implementation. In 11 OECD countries, SHA-based National Health Accounts have been institutionalised and also serve for data reporting to international organisations. In a few countries, a pilot SHA study has been carried out, but since then, SHA work has not been continued on a regular basis. SHA tables are therefore only available for one, or in some cases, a few years. In several other countries, implementation of the SHA has been

1. Obviously, reliable and comparable health expenditure data are necessary, but not sufficient in themselves to answer such policy questions.

2. The term "SHA" is used for the health accounting statistical system (the theoretical framework) with the system of International Classification for Health Accounts. The term of "NHAs (national health accounts)" is used for concrete systems of particular countries. As several countries had health accounts developed before the SHA, the term of "SHA-based health accounts" indicates that a specific health accounts applies the SHA-ICHA.

3. The ten standard tables presented in the SHA Manual do not include distribution of expenditure by different groups of population. The SHA Manual proposes this as an additional possibility in a more advanced stage of producing health accounts.

started, but as of June 2004, results have not yet been made available to the OECD Secretariat. Finally, according to the latest information available, implementation has not yet commenced in 4 OECD countries.

13. Experience has shown that SHA implementation and its stable institutionalisation are of vital importance for improving the availability and comparability of health expenditure data across OECD countries. Since traditional health expenditure statistics were based on vastly different national institutional structures, the comparability of health expenditure data across countries and over time was severely limited. Moreover, in many instances, such statistics only provided a partial picture of how money was spent on types of health care services. By contrast, the SHA is able to compare spending by functions of care (for example, between in-patient and out-patient care) regardless of the institutional structure of health systems.[4]

14. Implementation of SHA in the countries covered by this study has shown that the basic SHA framework is appropriate and feasible as a statistical methodology.[5] Moreover, the results illustrate the "added value" of SHA-based national health accounts from a health policy perspective. They are able to present policy relevant information that could not be obtained from pre-SHA expenditure statistics. Firstly, the wider definition for total health care expenditure takes into account recent changes in health care systems, for example, the growing importance of services for the elderly (long-term care including home care). Secondly, by distinguishing between the functional and provider classifications and by cross-classifying health expenditure, the SHA allows a deeper comparative analysis of how health services are financed and provided. Furthermore, the SHA will allow – as longer time series become available - the monitoring of structural changes in health systems: for example, the growing importance of day care, home care and diagnostic imaging services.

15. National health accounts are being increasingly produced all over the world with the support of international organisations and several foundations. The spread of the core concepts and classifications contained in the SHA manual across non-OECD countries has recently been boosted by the publication of a *Guide to producing national health accounts with special applications for low-income and middle-income countries* (World Bank, WHO, and USAID, 2003).

Box 2

What can SHA-based health accounts provide for policy-makers?

The SHA helps health policy-making by providing internationally comparable information regarding the overall level of spending on health care.

It allows for a multifaceted analysis of how financial resources in health care systems are raised (by different financing programmes/agents), how these resources are allocated among functions and service providers, as well as – in a more developed stage - it will show how resources are utilised by regional and social groups in the population.

It provides information about changes in the composition of spending, the factors that drive growth in health spending and how such growth differs across countries.

It provides a tool to monitor the effects of particular health reform measures over time.

It enables analysts to monitor changes in health care systems from an economic point of view; to describe the position and main tendencies of health care within the national economy.

At the current stage of implementation, the available SHA-based health accounts are only able to partly fulfil all of the potential of the SHA as a statistical framework. Its modular structure as a system of accounts, however, allows for a step-wise implementation.

4. For example, the role of hospitals providing out-patient care differs across countries. Traditional statistics report only hospital expenditure, which obscures the functionally vital distinction between in-patient expenditure and out-patient expenditure.

5. See "Basic criteria for the System of Health Accounts", page 17-19, SHA Manual.

The purpose of this working paper on SHA-based health accounts

16. The SHA Manual proposes a number of basic SHA tables for a country. However, it does not address the issue of how to present the information from these country-specific SHA tables in a comparative way. This working paper is a first attempt to design a set of cross-country tables and to define the analytical issues that enable the comparison of health spending across countries. Furthermore, a standard framework for country studies has been drawn up to serve both international comparisons and national purposes.[6]

Box 3
What does this paper provide for the Reader?

- This is predominantly a statistical publication providing a unique source of systematic and fairly comparable health expenditure tables with a related descriptive, **comparative analysis** of the spending structure of health systems - that would not have been possible to obtain using pre-SHA statistics- , *i.e.* how major health care functions are both provided and financed. The additional *Health Technical Papers* with **country studies** provide a similar analysis for each country.
- Together with the separately published country studies , it provides:
  - unique, **detailed data sources** for experts in member countries that will be made available on a regular basis (biennially). Data sources are accompanied by a transparent picture of the limitations in the comparability of the currently available data.
  - a more detailed and clearer picture of the current status of an individual country's health statistics with respect to international comparability
- It provides input for further **methodological work** in the field of health accounting for experts in member countries

17. As a first edition, this publication is developmental in several respects, including the exercise in itself to design a basic set of tables for comparative analysis. Differences between national and international figures[7] demonstrate that the SHA has improved the comparability of total health expenditure across countries, mainly by referring to the harmonised boundaries of the health sector as well as classification categories. On the other hand, the country studies and the comparative analysis in this paper have revealed a number of persistent departures of national SHA–pilots from the SHA–ICHA that call for further harmonisation. A key issue is how to interpret and present these departures of national health accounts from the SHA. The approach taken here is that such departures from the SHA-ICHA do not question the meaningfulness of making comparative analysis of figures that are not perfectly comparable. We believe that improvements in the presentation of results and the harmonisation of national health accounting practices can and should go hand in hand in the coming years. Feedback from readers on these particular issues will be beneficial for future editions.

18. Another issue requiring further attention is the fact that some SHA studies have yet to be incorporated into national statistical publications or are reported in parallel to national accounting frames. Box 4 presents the current status of SHA in the countries covered by this publication: this is supplemented in Annex III by a 'snapshot' picture (as of May 2004) of the status of SHA implementation in those countries not participating in this volume.

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6. Contrasting national purposes and international comparison is, to some extent, an oversimplification. OECD countries use international comparisons extensively for evaluating the national situation and possible policy options - therefore reliable international comparability can directly serve national policy-making. However, on the other hand, specific features of a given health care system may justify the need for national health accounts to have additional, country-specific elements within the broader SHA framework.

7. Differences between total health expenditure estimates for international and national purposes are presented in Box 6.

Box 4
Status of the SHA-based health accounts

	Status of institutionalisation of the SHA-based health accounts	SHA Tables available as of June 2004	Is there a difference between value of total expenditure on health for national and international reporting?
Australia	Institutionalised[8]	1999/2000; 2000/2001	yes
Canada	Institutionalised	1999	yes
Denmark	Pilot SHA study[9]	1999	yes
Germany	Institutionalised	1992-2002	yes
Hungary	Institutionalised	1998-2002	no
Japan	Institutionalised	2000	yes
Korea	Institutionalised	1998-2001	yes
Mexico	Institutionalised	1999-2001	yes
Netherlands	Health and Social Care Accounts are published annually	1998 - 2002	yes
Poland	Pilot study	1999	yes
Spain	Institutionalised	1999-2001	yes
Switzerland	Institutionalised	1995 - 2002	no
Turkey	Pilot study[10]	1999, 2000	yes

19. Work for this series of papers included not only the analysis, but substantial methodological work in a number of the participating countries. The process of producing the country studies has already proved that the presentation of results and methodological work on harmonisation of national practices with ICHA can support each other. For example, the Canadian country paper presents a mapping of basic data sources to ICHA. Based on this work, health expenditure data reporting to OECD Health Data has also been revised for Canada. Mexico and Spain have also carried out a revision of certain components of previous SHA tables that have resulted in more detailed and comparable data.

20. As a consequence of the varying stages in institutionalising and using SHA-based health accounts in national practice, the latest available year for the basic SHA tables differs from country to country. For six out of the thirteen countries, only data for 1999 are available. However, the experimental nature of this publication makes such a time lag acceptable. It is intended that subsequent editions will present data with no more than a 2-year time-lag.

21. This working paper is organised in two major parts:

- **Part I** presents a comparative analysis. It starts out with a discussion on how the SHA-based health accounts affected the comparability of total health expenditure across countries. , followed by a summary of the key challenges encountered by countries during the implementation of the International Classification for Health Accounts. The next chapter provides a comparative analysis of health expenditure based on thirty comparative tables.
- **Part II** presents the comparative, cross-country tables and charts covered under Part I.

8. In countries where SHA-based health accounts have been institutionalised, the annual data reporting to OECD Health Data (HD) database is based on them.

9. In annual data reporting to OECD HD, Total expenditure is adjusted according to boundaries of health in SHA.

10. It is planned for NHA to be institutionalised in SIS (State Institute of Statistics) allowing the regular reporting of data.

22. In addition, Annex I provides further methodological notes to Part I, and includes ICHA classification together with the three most widely used SHA Tables. Annex II lists the contributors of this project, and finally, Annex III gives a 'snapshot' picture of the current status of implementation of SHA in those OECD countries not participating in this first study.

23. **The related OECD Health Technical Papers Nos. 1 to 13** contain the 13 country studies with individual analysis of health expenditure and a description of the basic data sources and methodology.

IMPLEMENTING SHA-BASED BOUNDARIES OF THE HEALTH SYSTEM

24. To produce internationally comparable health expenditure data requires consensus on the boundaries of the health system. A key impetus for developing the SHA was that the realisation by experts in member countries of the limited comparability of total health expenditure (and related indicators, such as the ratio of health expenditure to Gross Domestic Product) due to the wide variation in boundary definitions and in the institutional settings of the health systems across countries.

A functional approach proposed by the System of Health Accounts

25. The System of Health Accounts provides a consistent functional approach in order to define the boundaries of the health system. This approach is "functional" in that it refers to the goals and purposes of health care such as disease prevention, health promotion, treatment, rehabilitation and long-term care. The SHA requires the accounting of expenditure spent on these functions regardless whether their providers are considered as health care organisations or institutions outside the health sector in national statistics. This wider definition[11] of the health system includes long-term nursing care services that were traditionally considered as social services in many countries. Box 5 presents the main functional components and the sub-totals of health expenditure.

Box 5
Sub-categories of total health expenditure[12]

ICHA Code	Description
HC.1; HC.2	Services of curative and rehabilitative care (inpatient care, day-cases, outpatient and home care)
HC.3	Services of long-term nursing care (inpatient, day-cases and home care)
HC.4	Ancillary services to health care
HC.1-HC.4	*Medical services*
HC.5	Medical goods dispensed to outpatients
HC.1-HC.5	***Total expenditure on personal health services and goods***
HC.6	Services of prevention and public health
HC.7	Health administration and health insurance
HC.6+HC.7	***Total expenditure on collective health services***
HC.1-HC.7	***Total current expenditure***
HC.R.1	Investment (gross capital formation) in health
HC.1-HC.7 + HC.R.1	***TOTAL EXPENDITURE ON HEALTH***

11. The SHA defines **total expenditure on health** as "the final use of resident units of health care goods and services plus gross capital formation in health care provider industries." (SHA Manual, p. 57).It defines the functional boundaries of health care as follows: "Activities of health care in a country comprises the sum of activities performed either by institutions or individuals pursuing, through the application of medical, paramedical and nursing knowledge and technology, the goals of: promoting health and preventing disease; curing illness and reducing premature mortality; caring for persons affected by chronic illness who require nursing care; caring for persons with health-related impairment, disability, and handicaps who require nursing care; assisting patients to die with dignity; providing and administering public health; providing and administering health programmes, health insurance and other funding arrangements" (SHA Manual, p. 42).

12. The detailed functional classification of the ICHA is presented in Annex I.

26. In order to implement the boundaries of health care and develop comprehensive and internationally comparable data on total expenditure according to the SHA manual, the following requirements need to be fulfilled:

(i) The functional classification of health care (ICHA-HC) is applied in an internationally harmonised way;

(ii) Expenditure by all the financing agents defined by the SHA is accounted for;

(iii) All primary and secondary providers of health care are included regardless of whether they are classified as health care institutions in national industry statistics or not. Furthermore, providers' health, health-related and non-health expenditure are distinguished (and the latter two are excluded);

(iv) Foreign trade of health services is estimated;

(v) Common methods for valuation of health services are applied following the SHA framework.

Estimating total health expenditure and harmonising overall functional boundaries in national health accounts

27. A foremost question is how comparable are the total health expenditures of the countries included in this study. To sum up, SHA implementation has resulted in more comparable figures than in the case of pre-SHA systems. However, the results of any analysis may still be influenced by some differences in methodology. The following two issues are addressed in relation to the SHA-based estimates of total expenditure (THE) in the 13 countries: (i) the differences between THE and estimates of total health expenditure presented in national statistics; (ii) the compliance of the estimates of THE with the SHA definitions.

Differences between national and international statistics

28. Currently most countries use SHA-based estimates (THE) only for international reporting. For national statistics, pre-SHA figures of total health expenditure (NHE) or SHA-based figures supplemented with research and education (which are health related items according to the SHA) are used. Box 6 displays the differences between these figures. These differences are a good indication of the improvement in harmonisation of overall expenditure estimates that have been achieved with SHA implementation. In Hungary and Switzerland, SHA-based figures are used both for national purposes and international data reporting.[13]

13. SHA implementation also resulted in changes in total expenditure in Hungary and Switzerland. In Hungary, total health expenditure was not previously reported in official domestic health statistics. SHA-based total expenditure was only 1% higher than the pre-SHA estimates for 1998 reported to the OECD HD 2000, but the public-private share differed considerably. In Switzerland, SHA-based total expenditure was only 1% higher than the pre-SHA figure in 1998 but many corrections of under and overestimation among provider categories or functions compensated so that the overall difference is not very significant.

Box 6
Main differences between the estimates of total expenditure as presented in SHA-based health accounts (THE) and as reported in national statistics (NHE)

	Year	THE as % of NHE	Explanation for the differences
Australia	2000	99.4%	NHE includes all the 'health' and 'health-related' functional classifications, except HC.R.2 – 'Education and training of health personnel'.
Canada	1999	96.7%	NHE includes training of health workers; health research; non-health and health related activities performed in hospitals (social work, pastoral work, etc.); private sector expenditure on residents receiving only "non-health" services in residential care facilities.
Denmark	1999	124.3%	NHE excludes long-term nursing care.
Germany	2000	97.8%	NHE includes expenditure on R&D and education of healthcare personnel.
Hungary	2001	100.0%	No difference.
Japan	2000	127.4%	NHE excludes services not covered by public health insurance and services financed by long-term care insurance.
Korea	2000	83.2%	THE estimates for household expenditure are based on the "Health and Nutrition Survey" (interviewed household survey) as well as "general household survey" (diary household survey); whereas for NHE, it is based mainly on the latter. In addition, THE estimates eliminated double counting under the item of private health insurance in the case of NHE.
Mexico	2001	99.1%	NHE includes health related functions HC.R.2-5
Netherlands	2001	112% of NHE 78.0% of TCE	In national statistics "total health and social care expenditure" (TCE) is the starting point for both national and international reporting. Within that total health expenditure excluding long-term care and administration (NHE) is reported.
Poland	1999	108.3%	NHE excludes private insurance, non-profit institutions and corporations; as well as expenditure on household production (HP.7.2).
Spain	2001	99.7%	THE excludes Research and Development.
Switzerland	2001	100.0%	No difference.
Turkey	2000	95.7%	NHE includes health related functions HC.R.2-5

Compliance of SHA-based total health expenditure figures (THE) with the SHA definitions

29. To fulfil the requirements listed above (under the section 'A functional approach proposed by the System of Health Accounts") usually requires new data sources, as well as the development and international harmonisation of estimation methods that can not be achieved overnight.

30. The most important factor affecting comparability remains the different treatment of long-term nursing care (LTC) across countries. It has an effect on the overall magnitude of total health spending (and consequently on health expenditure to GDP ratio), the public-private share of financing, as well as the breakdown by function and provider. Different estimation methods of long-term nursing care may affect total health expenditure by up to more than 10%.[14]

31. Other items affecting the comparability of total health expenditure are: the services financed by non-profit institutions and companies (occupational health services) may not be included in total

14. Huber et al. (2004, forthcoming) will provide detailed estimates on LTC expenditure for 15 OECD countries. In order to improve the comparability of health expenditure, in 2004 the Secretariat will issue more detailed guidelines for estimating long-term nursing care.

expenditure; and data on investments may not cover all components of investments (both public and private). These could affect total health expenditure by between 1 and 2% each.

32. Another fairly common departure from the SHA-ICHA framework is that the **export and import of health services** is not taken into account. According to the SHA, total expenditure should exclude exports of health services and goods (*i.e.* services provided by domestic providers to foreigners and medical goods purchased by foreigners); but should include imports of health care, such as health spending abroad by residents when travelling abroad as tourists, or services provided abroad and financed by public or private third party payers. The import of services is only partly accounted for in Canada, Denmark, Germany, Hungary, Netherlands and Poland; whereas it is excluded in all other countries.

33. Box 7 summarises the current stage of applying the requirements for estimating SHA-based total health expenditure figures (THE) in the participating countries.

Box 7

Departures of SHA-based total health expenditure figures (THE) from requirements of SHA

Australia	No data available for HF.2.4 (Non-profit institutions)
Canada	No data available for HF.2.4 and HF.2.5 (Corporations)
Denmark	No data available for HF.2.4 and HF.2.5. Long-term nursing care (LTC) is overestimated: includes accommodation costs in all residential care facilities.
Germany	
Hungary	LTC is underestimated: it includes only LTC services financed by compulsory health insurance and cost of health manpower employed in residential care facilities (financed by local governments). Home care provided by households is not included.
Japan	No data available for HF.2.4. Certain services (private room charges, massage, acupuncture, etc.) not covered by insurance cannot be estimated.
Korea	LTC provided outside the nationally defined health sector is not included.
Mexico	LTC provided outside the nationally defined health sector is not included.
Netherlands	No separate data presented for HF.2.4 and HF.2.5 due to quality of the separate items
Poland	LTC provided outside the nationally defined health sector is only partially included.
Spain	No data available for HF.2.5. LTC provided outside the nationally defined health sector is not included.
Switzerland	No data available for HF.2.5. LTC figure is in the upper range, partly because it includes overall costs of institutions where expenditure for nursing care, surveillance and ADL represents at least half of the total expenditure.
Turkey	No data available for long-term care (HC.3) and home care, furthermore providers outside the nationally defined health sector (HP.7 and HP.9) are not included.

KEY CHALLENGES IN IMPLEMENTING THE INTERNATIONAL CLASSIFICATION FOR HEALTH ACCOUNTS

34. Introduction of the ICHA[15] into a national statistics implies adjusting pre-SHA national boundaries to SHA-based boundaries and mapping pre-SHA classifications to ICHA. Undoubtedly, this requires a longer, iterative process.[16] Hence, documentation of the actual deviations of a national version from the SHA-ICHA is an integral part of the implementation process.

Applying the health care financing classification (ICHA-HF)

35. There are generally two basic perspectives on the classification of health care financing:

- The classification according to financing agents. Financing agents are the organisations or individuals that directly pay for the health care; that is third-party-payment arrangements and direct payments by households.

- The classification according to primary sources of funding bearing the ultimate burden of financing. In this kind of analysis, intermediary sources of funding (social security funds, private insurance and NPISH) are traced back to their origin.

36. Following the suggestion of the SHA manual, in the first phase of implementation, countries – including the thirteen countries in this volume –produced basic SHA tables using the first perspective.

37. SHA implementation projects appear to be able to apply the ICHA-HF classification in the case of the public financing agents within their domestic systems of health care financing. However, in the case of the private sector, the availability of data sources for estimating expenditure by private insurance, non-profit institutions and corporations is still incomplete for several countries. Furthermore, there is a well-known tendency for data from household surveys to underestimate private health spending. A particular problem is the estimation of informal or illegal payments, for example, so called 'under-the-table payments' in Hungary and Poland.

38. Moreover, within this study, only seven countries were able to report data on expenditure by non-profit organisations (Germany, Hungary, Korea Poland, Spain, Switzerland and Turkey). In addition, the example of Canada shows that Health care providers may also receive revenues from their entrepreneurial activities that are used for patients' care. (For more details, see the Canadian country study, OECD Health

15. The Introduction highlights the main goals and components of the System of Health Accounts, and the OECD SHA Manual is available from the OECD web-site. Therefore, this chapter does not intend to go into a detailed description of the SHA and the ICHA

16. Implementations of the SHA helped to identify the gaps and data deficiencies in the current national reporting systems. They also have highlighted that there is a need for further methodological developments, improving the availability and reliability of data, and further international co-operation for harmonising the way boundaries and basic functional breakdown of health expenditure are estimated

Technical Paper No. 2.)[17] Box A1 in Annex I displays the current stage of applying the financing agent component of the ICHA.

Applying the functional classification (ICHA-HC)

39. As has already been emphasised, for international comparability of data, the functional classification is the most crucial element of the SHA. Health care functions defined and estimated in an internationally harmonised way can provide comparable health expenditure figures for countries with differing institutional arrangements. A basic task in applying functional classification is to separate functions within the provider organisations, in particular within hospitals.

40. The most important factor affecting the comparability of functional structure of expenditure across the thirteen examined countries is the difference in estimating long-term nursing care (LTC). The SHA broadens the boundaries of health care sector and includes expenditure on long-term nursing care given to '*individuals who need assistance on a continuing basis due to chronic impairments and a reduced degree of independence and activities of daily living'*. Long-term care is typically a mix of medical and social services provided in hospitals, nursing homes (classified usually as health care providers) and other forms of residential-care facilities for the aged and handicapped (classified usually as social-care institutions). According to the SHA Manual, only medical services (including nursing care) are to be recorded in the SHA under health expenditure. However, information concerning the costs of medical services provided in social institutions is limited in many countries. A more detailed definition together with guidance on estimation methods is needed in order to obtain a more accurate separation of long-term nursing care from social care. A further point regarding home care services is the fact that, in the majority of countries, the curative & rehabilitative and LTC sub-components cannot be distinguished.

Estimating long-term nursing care expenditure

41. With regard to its significant effect on the comparability of total health expenditure, the differences in estimating methods of long-term care requires a separate discussion. In many OECD countries long-term care - apart from long-term nursing care provided in hospitals- is provided and financed outside of the traditional national boundaries of health systems. Within the public administrations, it is often the ministries of welfare or social affairs who hold responsibility for public programmes for the elderly needing long-term care, or for the handicapped. Therefore, national statistics often report public expenditure on such programs under social benefits (or social support) and not health expenditure.

42. Countries currently use different approaches to estimate the health-related components of long-term care. The SHA methodology needs further development to provide more detailed guidance on how to estimate long-term nursing care. This issue is being addressed in a detailed study on long-term care expenditure as part of the Long-term care study under the OECD Health Project. (OECD Health Working Paper (forthcoming) "Long-Term Care for Older People")

43. Box 8 summarises the various estimation methods applied by countries contributing to this publication (for further details, see the relevant country papers). In general, estimation methods are based on: (i) expenditure related to individuals (assessment of dependency of individuals); or (ii) costs of manpower; or (iii) total expenditure of institutions (providing predominantly nursing care).

17. In Hungary, in order to distribute this type of revenue among categories of ICHA-HF, a special survey on hospitals' "other revenues" was conducted.

Box 8
Methods applied for estimating long-term nursing care expenditure

	Year	LTC as % of THE	Estimation method
Australia	2000	6.9%	Expenditure on residential care homes in respect of a particular resident are based on an assessment of dependency under an eight-level Residential Classification Scale (RCS). For the purpose of determining which expenditures are health or welfare, it has been assumed that the majority of those residents with higher dependency levels (that is, in RCS levels 1 to 4) are receiving health care services.
Canada	1999	13.8%	Based on an assessment of the dependency of individuals. Expenditure on long-term nursing care provided by the private sector is estimated from the *Residential Care Facilities Survey,* conducted annually by Statistics Canada. Based on the definitions of SHA, estimates of private sector expenditure are limited to expenditures on residents receiving "higher type" care in three categories of facilities.
Denmark	1999	27.4%	LTC provided outside the nationally-defined health care sector is estimated and added to health expenditure. A time-study was used to allocate expenditure between the different functions performed in social care institutions. Expenditure is distributed between social and health expenditure based on the time share of nursing care activities.
Germany	2000	10.7%	Expenditure by long-term care insurance is the basis for estimates. Long-term nursing care expenditure may include expenditure on certain social support services if it was not possible to estimate these separately.
Hungary	2001	1.6%	LTC provided outside the nationally-defined health care sector is estimated and added to health expenditure. Estimates include only manpower costs of health personnel employed in social sector.
Japan	2000	10.4%	Expenditure by long-term care insurance is the basis for estimates. Long-term nursing care expenditure may include expenditure on certain social support services if it was not possible to estimate these separately.
Korea	2001	-	Long-term care is not separately estimated in health statistics. (Inpatient care provided in hospital may include long-term care, but information is not available.)
Mexico	2001	-	Long-term care is not separately estimated in health statistics. (Inpatient care provided in hospital may include long-term care, but information is not available.)
Netherlands	2001	11.9%	Estimation is based on revenues of providers
Poland	1999	6.0%	LTC includes mainly allowanced paid for households providing home care for relatives. LTC is underestimated due to lack of data on medical component of all services delivered within centres /home/hostels under social care. Part of LTC could be included in inpatient curative care.
Spain	2001	2.1%	Estimates of long-term nursing care include only LTC provided in hospitals.
Switzerland	2001	19.6%	Estimation is based on those institutions providing long-term care (annual statistical survey of all homes for elderly and other institutions providing nursing and residential facilities). All expenditure of a given institution is reported as health if more than half of the expenditure is related to health needs.
Turkey	2000	-	Long-term care is not separately estimated in health statistics. (Inpatient care provided in hospital may include long-term care, but information is not available.)

Other functional issues

44. One of the other important issues related to the functional classification is that in a few countries, under current reporting practice, in-patient expenditure is still identical to hospital expenditures and consequently includes day-care and out-patient care provided in hospitals.[18] Also, ancillary services may be provided by separate health care organisations (laboratories, diagnostic centres) or may be activities performed in complex health care organisations. In the latter case, the separation of ancillary services from revenues of providers of out-patient care or hospitals has not yet been resolved in several countries.

45. Another general issue is that in the majority of countries current statistics are unable to separate expenditure on curative and rehabilitative care. However, this is not a departure from the SHA-ICHA, since the basic SHA Tables present these two categories together. Box A2 in Annex I displays the current stage of applying the functional component of the ICHA.

46. An important feature of the functional classification should be emphasised. By definition, *Ancillary services* (HC.4) only includes ancillary services provided to out-patients and – as the category name suggests - this is also the case for *Medical goods dispensed to outpatients* (HC.5); whereas in-patient curative-rehabilitative expenditure covers all services provided during an episode of in-patient care, including pharmaceuticals and ancillary services. This is justified by the fact that ancillary services and pharmaceuticals are integral parts of an in-patient treatment. Therefore, it is not possible to analyse the total expenditure on pharmaceuticals utilised by a health system regardless of the mode of service production. The subsequent version of the ICHA intends to resolve this issue.

Applying the classification of health care providers (ICHA-HP)

47. In applying the ICHA-HP, the most important challenges are posed by those complex institutions that perform both health and non-health activities at the same time, such as residential-care facilities for the elderly and handicapped; public health authorities; medical universities; furthermore, economic and educational organisations providing health services for their employees or members. The SHA project had to identify the organisations providing health services outside the nationally defined health sector and estimate the expenditure only on their health care activities.

Separation of health, health-related and non-health expenditure

48. When records on revenues of, and/or expenditure by, providers are used to produce health accounts, it is important to estimate only the value of health services provided by the given provider, that is, to separate any health related and non-health expenditure (for example, spending on medical research, running a hotel for nursing staff or selling food for other institutions, etc).[19] To produce HF x HP matrices (*i.e.* SHA Table 3) a main difficulty might be to deduct non-health expenditure by financing agents (when for a given provider, only the total revenues by financing agents is known)[20]. This was the case for the Netherlands, for example.

18. The data on day-care are usually available in those countries where day-care has separate financing (e.g., in DRGs), and data are available from the financing agents (e.g. Denmark, Hungary).

19. Note: revenues from non-health activities may be used for patient care (therefore, the main source should be the expenditure by providers). A special estimation problem might be to attach non-health expenditure of providers to financing agents.

20. The Dutch country study provides an example of this.

Nursing and residential care facilities

49. A wide range of institutions providing long-term care (both health and social services) exists in most countries. In several countries, national statistics classify long-term nursing care provided in residential homes for the elderly and residential homes for the handicapped as social institutions and social expenditure. The implementation of SHA requires a clarification of which institutions should be considered under (HP.2) and the development of a methodology in order to separate health and social expenditure in the given institutions. (These issues are obviously interconnected to those discussed under estimating long-term care expenditure.) Countries followed different practices in this respect that require further harmonisation.

Rest of the economy

50. Rest of the economy comprises private households as providers of (health) care services at home and secondary providers of health care,[21] for example, occupational health care, military health services that are not provided in separate health care establishment. Estimation of the activities of these providers is not fully resolved in several countries.

Rest of the world (RoW)

51. Estimating RoW (HP.9) as a provider category is a problem interconnected to estimating exports and imports in health services. As previously mentioned, spending on services provided abroad (HP.9: Rest of the World) is not or only partially included for most countries.

52. Box A3 in Annex I displays the current stage of applying the provider component of the ICHA.

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53. The process of producing this series of papers has made the differences in national health accounting practices and the departures from the SHA more transparent. Their presentation should serve as input for further statistical work in member countries in order to better harmonise national practices.

21. By definition the SHA includes personal services provided within households by family members, in cases where they correspond to social transfer payments granted for this purpose.

WHAT CAN BE LEARNT FROM SHA-BASED HEALTH ACCOUNTS? A COMPARATIVE ANALYSIS OF HEALTH EXPENDITURE ACROSS 13 COUNTRIES

54. This comparative analysis includes five non-European countries (Australia, Canada, Japan, Korea and Mexico), six members of the European Union with different health financing models (Denmark, Germany, Netherlands and Spain, including two new members: Hungary and Poland); as well as Switzerland and Turkey.

55. The major questions addressed in this chapter are the following:

- What differences can be discerned in the level and structure of health spending across countries?
- What differences exist in the role of public and private spending across countries (with particular regard to households' expenditure)?
- What kind of functional patterns of health expenditure prevail?
- How do the roles of the different providers differ across countries?
- How are the different functions financed?
- How does the spending structure of the particular financing agents differ across countries?
- How are the different providers financed?
- How are the different functions provided?

56. In general, the following measures are used throughout this chapter when comparing health expenditure across countries at a given point of time:

- health expenditure as a percentage of GDP;
- per capita expenditure on health (in USD PPP);22
- percent share of expenditure categories within total (or total current) expenditure; or within their relevant sub-aggregates; and
- percent share of expenditure categories as a result of cross-classifying any two of the three dimensions of the SHA.

57. Per capita expenditure shows the overall level of consumption of health care (or a given type of health service) by the population across the countries.[23] The health spending to GDP ratio reflects a macro-economic approach, comparing the share of national income devoted to health care without any

22. Purchasing power parities (PPPs) provide a means of comparing spending between countries on a common base. PPPs are the rates of currency conversion that equalise the cost of a given 'basket' of goods and services in different countries.

23. More accurately, it measures the opportunity cost of health care consumption.

information on the absolute magnitude of these resources. Different percentage distributions of expenditure reflect various aspects of the structural characteristics of a health care system.

58. The comparative tables are presented in Part II of this Working Paper. Tables 1 to 4 show a comparison of the main aggregates of health expenditure by financing agent, function, and provider.[24] Tables 5 to 30 provide a more detailed insight into the structure of health spending using three types of cross classification: expenditure by function and financing agents (Tables 5 to 20); expenditure by function and provider (Tables 21 to 24), and expenditure by provider and financing agent (Tables 25 to 30).

The level and the public-private mix of total health expenditure

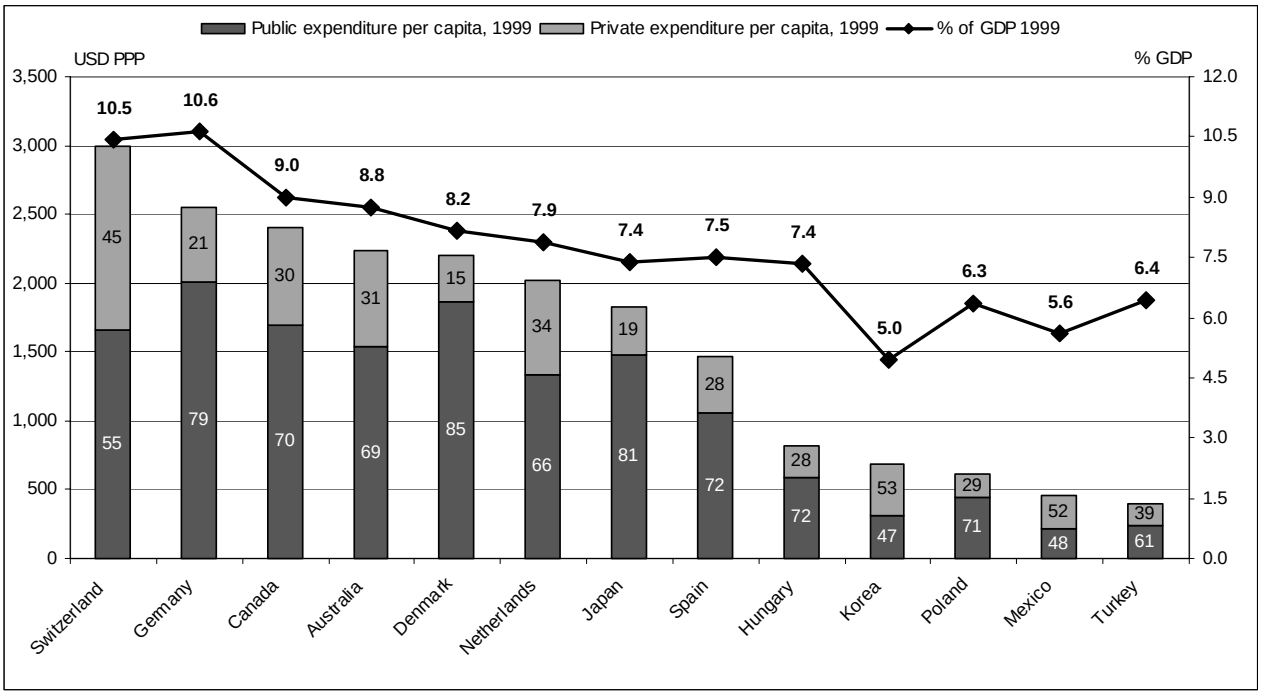
59. Tables 1.1 shows *total health expenditure* by financing agent expressed in USD PPP and Tables 1.2 as a percentage of GDP. Figure 1 highlights the fact that differences in the share of countries' national income devoted to health are considerably smaller than in absolute spending levels. Health expenditure to GDP ratio varied around twofold, in 1999, from 5.0% in Korea up to 10.5% in Switzerland, while a wider variation in overall health spending levels can be observed, ranging from Switzerland with total health spending per capita of 2 993 USD PPP in 1999,[25] eight times that of the lowest spending country, Turkey. Some way behind Switzerland is a group of countries (Germany, Canada, Australia Denmark and the Netherlands) which spent between 2 000 and 2 600 USD PPP; followed by Japan and Spain with some lag. A final group of countries each spent less than 1 000 USD PPP per capita in 1999 (Hungary, Korea, Poland, Mexico and finally Turkey).[26]

24. These primary comparative tables are provided, both in terms of percentage of total or current health spending, and in USD PPP. Furthermore, the tables in USD PPP display both the figures for the latest available year and also for 1999 – the latter allowing a comparison between actual spending levels across countries for a common year. Note that for some countries the latest available year will also be 1999.

25. 3289 USD PPP in 2001.

26. For further information on methodological and country specific issues consult tables in Annex I and the individual country studies.

Figure 1. Total expenditure on health, as per capita PPP and % of GDP, 1999



60. Concerning public spending on health, Germany and Denmark spent slightly more per capita than Switzerland (around 1 900-2 000 USD PPP in 1999). At the other end of the spectrum is a group of countries each spending less than 600 USD PPP per capita on health from public sources. The difference between those countries with the highest and the lowest public spending level is slightly greater than the range observed in the case of total expenditure.

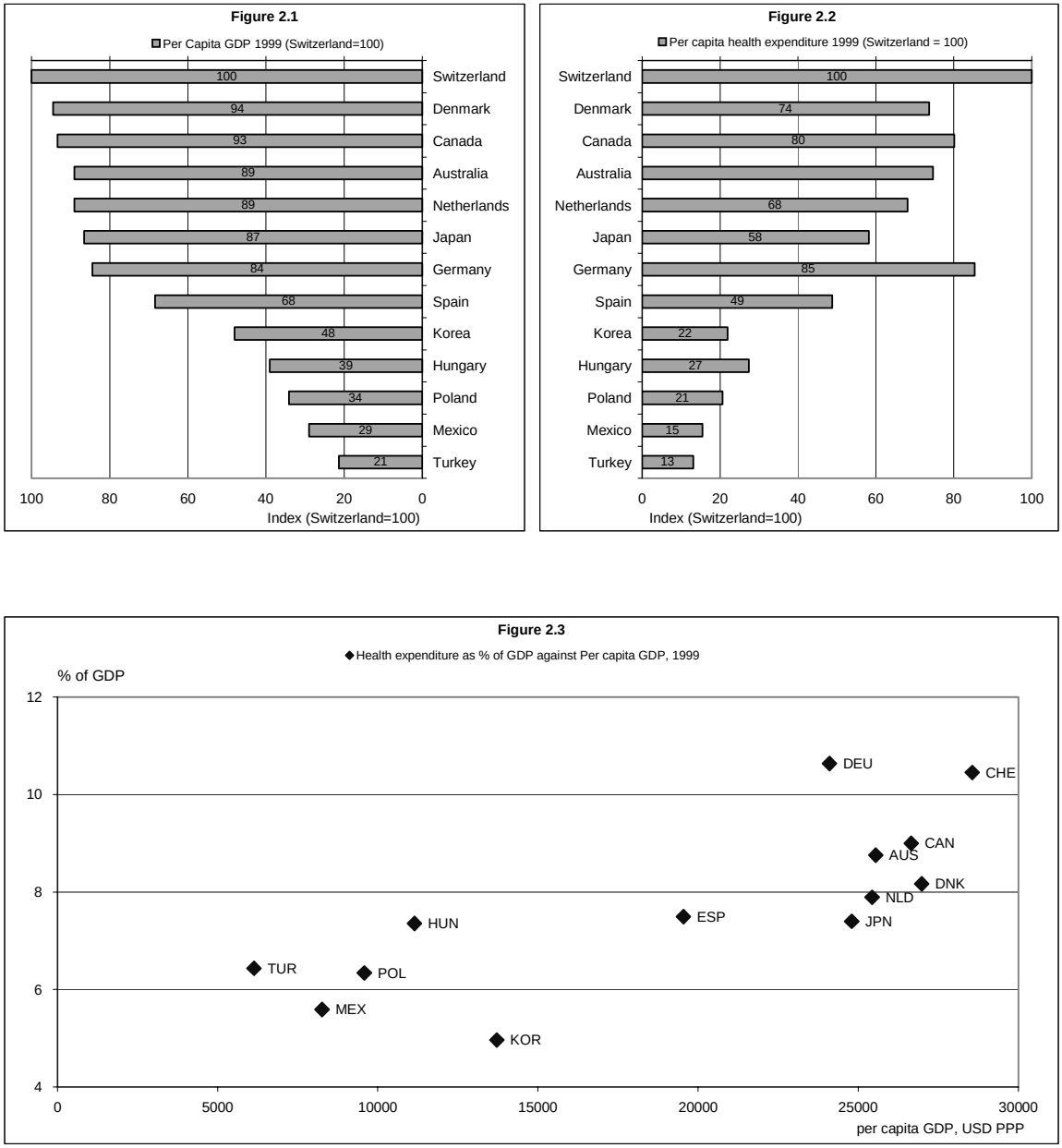
61. The observed differences in health spending across countries appear far greater than for average incomes (measured by GDP per capita) (Figure 2.1 and 2.2.).[27] Furthermore, Figure 2.3 seems to suggest that above a certain level of economic development the relationship between GDP per capita and the share of GDP spent on health care is rather weak, with other factors (*i.e.* budgetary and health policies, as well as history and structure of the health systems) perhaps exerting a larger influence.[28] To draw firm conclusions, however, would obviously require a more thorough analysis.[29]

27. For example, Poland's per capita GDP reached 34% of Switzerland, while its per capita health expenditure amounted to only 21% of the Swiss (Figure 2.1 and 2.2).

28. For example, Japan and Germany had around the same per capita GDP in 1999, while the share of health expenditure in GDP was 7.0% in Japan and 10.6% in Germany. Per capita GDP in Hungary was less than half that of Japan, while the share of health expenditure in GDP was higher than in Japan.

29. For further discussion, see OECD (2003), Health at a Glance – OECD Indicators 2003, Paris.

Figure 2. Per capita GDP and Total Expenditure on Health



62. Table 1.3 presents the differences in the overall characteristics of the public-private mix in health care financing across countries. The public share of total health expenditure ranged from 45% in Mexico up to 85% in Denmark. Mexico was the only country in this study where less than half of health spending comes from public funds.

63. There are distinct systems of public funding: Australia, Canada, Denmark and Spain are almost exclusively funded by *general government (excluding social security)* (HF.1.1)[30] – encompassing central, state or provincial and local or municipal government. In Canada and Denmark the role of local government is greater than that of the central government. The other countries fund the public part of health through the operation of *social insurance schemes* (HF.1.2), although with a varying degree of involvement of central government. In Germany, Japan, Hungary Korea and Poland social insurance accounted for 80-90% of public expenditure, with a considerably smaller, but still dominant share (55-70% of public expenditure) in Mexico, Switzerland and Turkey.

64. In contrast to pre-SHA statistics in most countries, the SHA-based health accounts differentiate between different sub-components of private expenditure. The private sector (HF.2) comprises: p*rivate insurance* (HF.2.1 and HF.2.2),[31] *private household out of pocket spending* (HF.2.3), *non-profit institutions* (NPISHs) (HF.2.4) and *corporations* (HF.2.5)[32]. The role of the two major components of private funding varies to a great extent across countries (Figure 3).[33] In all of the countries, apart from the Netherlands, private *households' out-of-pocket* payments[34] formed the largest part of private funding sources. This ranged from just under 30% of private sources in the Netherlands to 95% in Mexico (which corresponds to 10% of total health expenditure in the Netherlands and over half of all health spending in Mexico). For Hungary, out-of-pocket payments include estimated under-the-table payments (so called gratitude-money), which the Polish health accounts currently exclude. In terms of per capita expenditure, household out-of-pocket payments equated to an average[35] of 332 USD PPP in 1999, ranging from 114 USD PPP in Turkey to 995 USD PPP in Switzerland.

65. Table 1.3 and Figure 3 also suggest that – apart from Denmark – private insurance tend to be more prevalent in higher income OECD countries, than in the middle and lower income ones. The Netherlands, Canada, Switzerland and Germany report relatively high levels of funding through *private insurance* at between 7% and 15% of total health expenditure. In the Netherlands, private insurance comprises 44% of private funds, while in Canada and Germany the share is just below 40%, and in Australia and Switzerland around a quarter. Private insurance forms a relatively small source of health funding in the other countries, generally between 1 and 4% of total expenditure on health.

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30. General government (HF.1) refers to the whole of the public sector, i.e. comprises General government excluding social security funds (HF.1.1) and Social security funds (HF.1.2).

31. The SHA distinguishes between private social insurance (HF.2.1) and other private insurance (HF.2.2) using the definitions of the System of National Accounts (SNA 93). (For further detail, see SHA Manual, page 152-153). These concepts are not widely used in health statistics and health policy analysis. The analysis in this study has also not distinguished between sub-components of private insurance, partly because further harmonisation is needed in this respects across national statistics.

32. HF.2.4 "Non-profit institutions (other than social insurance)"does not include non-profit insurance funds ; and HF.2.5 "Corporations (other than insurance)" does not include for-profit insurance companies.

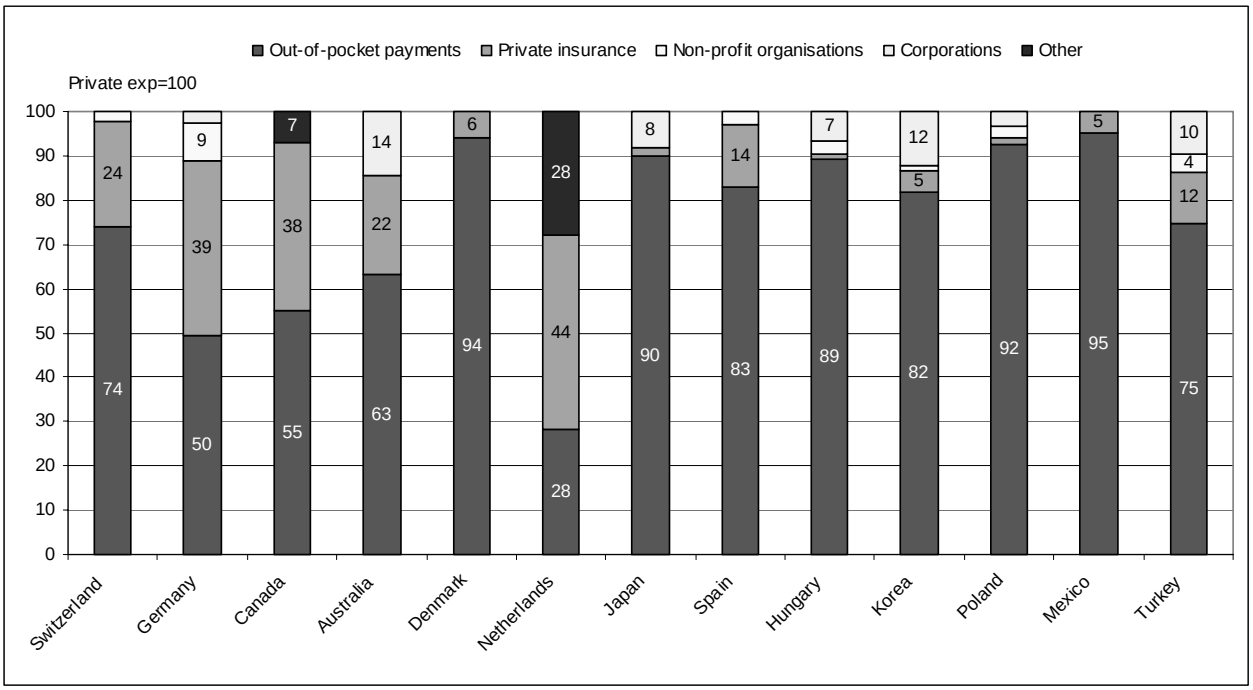
33. A major component of the OECD Health Project (2001-2004) was a study on private insurance for which SHA-based health accounts provided information. (See Colombo, F. and Tapay, N. (2004). Private Health Insurance in OECD Countries. The Benefits and Costs for Individuals and Health Systems. Health Working Paper No. 15, Paris: OECD.)

34. Private household out-of-pocket payments comprise of direct payments, cost-sharing and co-payments.

35. Averages in this paper are calculated as unweighted averages of the 13 countries, unless indicated otherwise.

Figure 3. Private expenditure on health by financing agent

Countries ranked by per capita total health spending



66. Another important feature of the SHA is that, in contrast to pre-SHA statistics, it demands expenditure by non-profit organisations and corporations be recorded. As a consequence, SHA implementation usually requires producers of health accounts to identify new data sources or conduct new surveys. Figure 3 reflects the fact that these are not negligible amounts and in several countries the share of non-profit organisations and corporations in private (and total) expenditure might be similar or even greater than that of private insurance.

Total health expenditure by function[36]

67. One of the most important features of the SHA is the distinction made between function of care and providers of care. For international comparability of data, the functional classification is of vital importance. The OECD SHA Manual applies two approaches in functional classification: (i) the purpose of health care (curative care, rehabilitation and long-term care, etc.); and (ii) the mode of production that reflects characteristics of technical and managerial organisation of health care. These two approaches primarily apply to personal medical services that are comprised of curative and rehabilitative care, long-term nursing care and ancillary services. Regarding the mode of production of curative and rehabilitative care, the SHA distinguishes between inpatient care, day care, out-patient care[37] and home care. For long-term nursing care, the SHA distinguishes between inpatient care, day care and home care as the modes of

36. The relationship between subcategories of total expenditure on health used in this and the following sections are as follows: Total expenditure on health = Current expenditure on health + Gross capital formation; Current expenditure on health = Personal medical services and goods (HC.1-HC.5) + Collective health services (HC.6-HC.7).

37. According to the SHA, out-patient care includes curative and rehabilitative services (HC.1 and HC.2) delivered to patients in ambulatory health care establishments, out-patients wards of hospitals, or in community or other integrated care facilities. This definition differs from the practice in some countries where the term “out-patient” is used only for services provided in out-patient wards of hospitals.

production. Under the current definition, ancillary services are provided to out-patients.[38] In line with the SHA Manual, the functional division of health expenditure is presented in both ways in this paper: Tables 2 focuses on the division according to the purpose of health care, while Tables 3 focuses on the mode of production.

68. Table 2.1 allows a comparison between the magnitudes of per capita spending on different types of health services across countries, while Table 2.2 (and Figure 4) displays the functional patterns of health expenditure according to purpose of care.[39] It is striking that differences in per capita expenditure on medical goods[40] are far smaller (around 5-fold) than in total expenditure on health (with an 8-fold difference), mainly due to the fact that domestic prices of pharmaceuticals reflect international market prices whereas labour costs are normally based on national wage structures. For example, in 2001, total spending was 3.4 times higher in Switzerland than in Hungary, while spending on medical goods was only 1.3 times higher.[41] This feature of pharmaceutical spending levels has an implication on the overall functional structure of health expenditure, with lower-income OECD countries tending to spend a greater share of their health expenditure on pharmaceuticals. As Table 2.2 shows, Hungary, Korea, Poland and Turkey devote the highest proportion of expenditure on medical goods (for example, 33% in Hungary) and the lowest on medical services.[42]

38. Many countries currently experience problems in properly reporting ancillary services. By definition, SHA-based health accounts report only ancillary services provided to out-patient under this category; ancillary services provided to in-patients are included in in-patient expenditure.

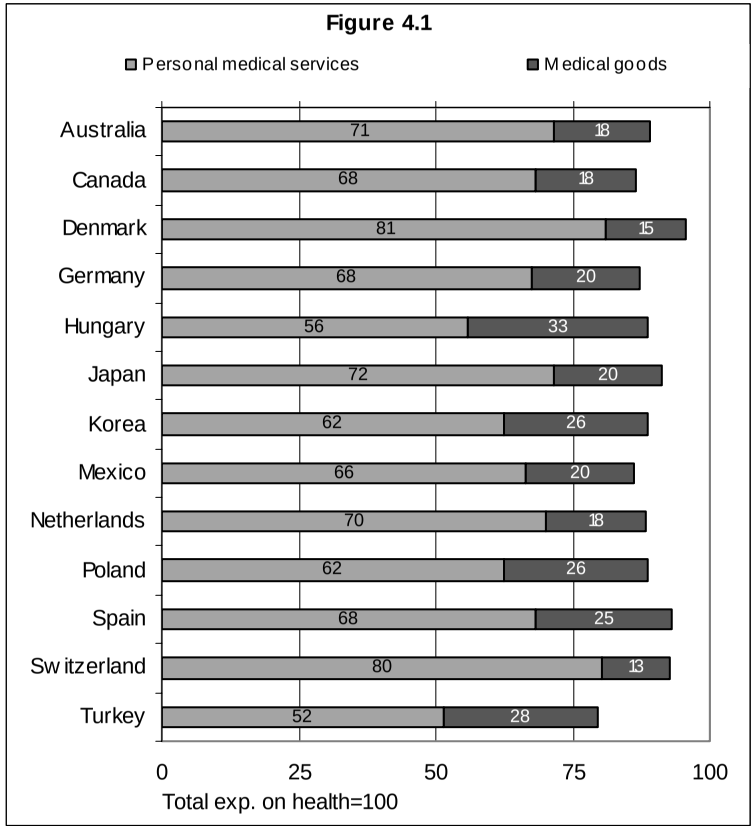
39. Mapping total expenditure to ICHA-HC could not be fully achieved in some countries. In these cases the countries (e.g., Canada, Mexico, Poland, Turkey) used so called “unspecified ” or “non-distributable” categories that affect the comparability with other countries. Generally expenditure in this category equates to between 0.5 and 2% of total expenditure. In the case of Turkey expenditure “not specified by kind” was 11.7% of total health expenditure in 2000.

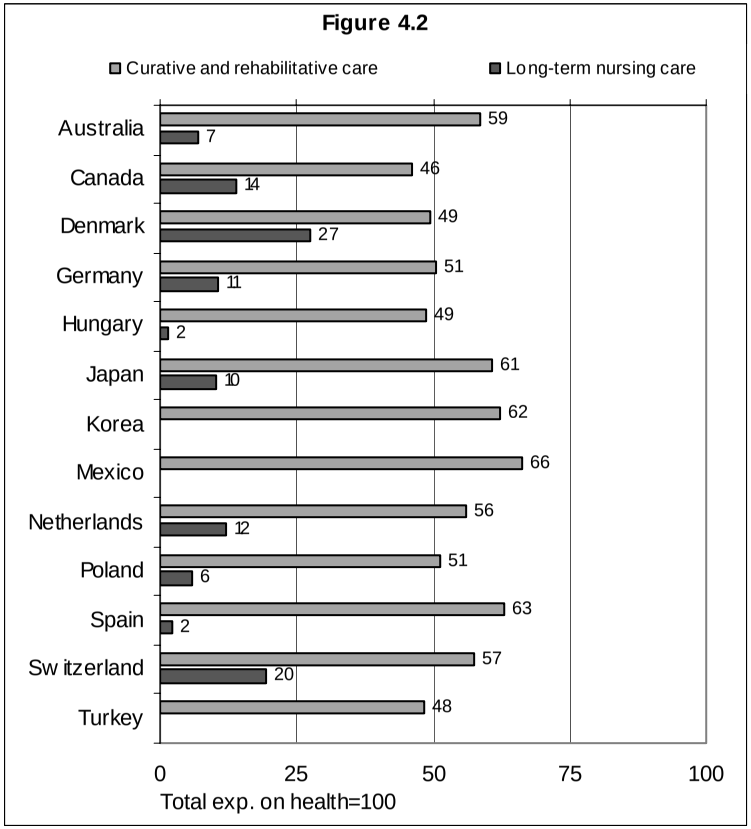
40. Medical goods (HC.5) include pharmaceuticals (HC.5.1) and therapeutic appliances and other medical durables (HC.5.2) provided to out-patients. Pharmaceuticals and therapeutic appliances used in inpatient treatments are included in inpatient expenditure

41. Similarly, in 1999, the difference in total spending was 6.5 times higher in Germany than in Turkey, while corresponding spending on pharmaceuticals was only 3.6 times higher.

42. For example, in per capita terms (Table 2.1), Hungary spent only a quarter of the amount spent by Denmark on personal medical services in 1999, but only 17% less on medical goods.

Figure 4. Total health expenditure by function of care





69. Table 2.2 also answers the questions, among others, of how total expenditure is distributed between current expenditure and investments (gross capital formation); to what extent current expenditure is used for personal medical services and goods and collective health services. Furthermore, it shows the distribution of expenditure on personal services between curative-rehabilitative and long-term nursing care. On average, countries devoted around 89% of total health expenditure to *personal medical services and goods* (HC.1 to HC.5), ranging from a low of 79% in Turkey up to 96% in Denmark.[43] Capital investment accounts for between 1% and 6% of total health expenditure. The remainder is split between the functions of collective health services, namely *prevention and public health* (HC.6) and *health administration and insurance* (HC.7). In terms of the split between personal medical services and goods, *personal medical services* (HC.1 to HC.4) comprise around 68% of total health expenditure on average, with 21% being spent on *medical goods*, although with a considerable degree of variation between countries.

70. C*urative and rehabilitative care* (HC.1 and HC.2) accounts for more than half of total health expenditure on average[44] across the countries studied - ranging from 46% in Canada to 63% in Spain.[45] The proportion of total health expenditure reported to be spent on *long-term nursing care displays a striking range* from between 2 and 6%[46] at the bottom end, up to a high of 27%. The low share reported in countries such as Hungary and Spain is partly due to the greater role of informal care by private households, but also to the lack of data sources concerning the services provided in the social care sector (that under the SHA should also be included under HC.3). A further problem may be the inability to fully separate long-term care from other in-patient services, as is the case in Poland. At the other end of the scale, Denmark and Switzerland report 27% and 20% of total health expenditure devoted to long-term nursing care respectively. The high share in Denmark reflects an overestimation since it includes expenditure on accommodation in all nursing and residential facilities for the elderly, not only in nursing homes.

71. Expenditure on *prevention and public health services* (HC.6) does not reflect the total amount spent on prevention by a society. In many cases a curative-rehabilitative episode of care includes preventive components that cannot be separated. Expenditure on diagnostic procedures initiated by patients for preventive purposes cannot normally be separated from diagnostic procedures performed as part of a curative treatment. Consequently, HC.6 reflect only those preventive services provided in the form of preventive programmes (public or private, including occupational health checks), that is, expenditure on collective prevention; whereas "personal prevention" related to the individual initiatives of doctors or patients is included in curative-rehabilitative care. There appear two distinct groups: Canada,[47] Germany, Hungary, Netherlands and Poland devote 4 to 7% of total expenditure to prevention and public health, while the others allocate between 1 and 3% (Table 2.2). The relatively high shares in Germany, Hungary and Poland can be partly explained by the role of private corporations in providing obligatory occupational health checks.

72. Expenditure on *health administration and health insurance* (HC.7) includes expenditure on activities of central and local authorities (and related agencies engaged in regulation), social security and

43. However, the higher values are in part due to the omission or inability to estimate capital investment as a part of total health expenditure. The lower values are due to non-classified or undistributed expenditure.

44. Note that curative and rehabilitative care accounts for over 80% of personal medical services.

45. It should be noted that in several countries, for example Japan, Korea and Mexico, data on curative and rehabilitative care can include, either fully or partly, ancillary services (HC.4); and aspects of long-term nursing care (HC.3) (e.g., Poland).

46. Some countries actually report 0%, where either it is considered negligible, such as in Korea and Turkey, or data are not available (Mexico)

47. However, the 7% for Canada is over-estimated as it also includes general administration of health departments.

private insurers. Countries with a decentralised social security system and/or considerable private insurance, such as Germany, Netherlands and Switzerland, spent 5% of total expenditure on administration, while the others typically spent 2 to 4% (Table 2.2). It should be noted that some countries currently do not include all components of administration in their data, especially administration by local governments are underreported. Germany, for example does not include administration by central government due to lack of data. Mexico – due to its importance for national policy-making purposes - reports stewardship[48] as one of the functions of the health system separately. This amount is included in total health administration in the SHA tables and helps explain the high 9% of total health spending on this function.

Current health expenditure by mode of production[49]

73. Tables 3.1, 3.2 show the split of current health expenditure into modes of production.[50] Table 3.3 shows only total expenditure on personal health services distributed by the various modes of production. These tables can provide a real picture about the share of in-patient and out-patient care, whereas pre-SHA statistics usually report only hospital expenditure. Furthermore, and again in contrast to most pre-SHA statistics, they are able to distinguish between day care, ancillary services (including diagnostic imaging and laboratory services) and home care. Thereby they are able to serve as a basis for examining changes in the structure of service provision (*e.g.* replacement of in-patient care by day care and home care) as longer time series become available. In analysing the relationship between in-patient and *out-patient care* expenditure, it is notable that Korea, Turkey and Spain all show a higher share of expenditure for out-patient care than in-patient care. In the case of Korea, this can in part be explained by the dual role of doctors indirectly dispensing drugs to out-patients in 1999. *In-patient care* ranges from 21% of current health expenditure in Turkey up to 52% in Denmark – with an average of around 35% overall. Out-patient care varies from 19% of current health expenditure in Denmark up to a high of 42% in Korea. Where the differences are large between in-patient and out-patient care – Denmark and Switzerland – this can again be put down to the relatively large expenditures devoted to long-term nursing care.

74. Figure 5.2 shows that this pattern is significantly modified if the effect of the differences in long-term care estimation methods is removed by applying the mode of production only to *curative-rehabilitative medical services*. Comparison between Figure 5.1 and 5.2[51] shows that there is more similarity between countries as to *in-patient curative and rehabilitative care*, than in the case of the whole of in-patient care.[52] The other feature of key importance seen from Figure 5.2 is that the share of out-

48. In the Mexican statistics stewardship includes the following activities: design and implementation of health policies, information and performance assessment, emission of normative frameworks and sanitary regulation.

49. In health care systems data are usually generated in correspondence with the administrative structures of health care provision and health care financing. Usually provider organisations constitute the basic elements of health expenditure databases. Therefore, a basic task in applying the classification for mode of production is to separate functions within provider organisations, in particular within hospitals.

50. Many countries have difficulties in making a complete separation of personal medical services into the various modes of production. Four countries (Germany, Mexico, the Netherlands and Poland) are currently unable to report a true estimate of in-patient care because out-patient care in hospitals cannot be separated out. Similarly many countries are unable to fully allocate expenditures to the categories of day-care, home care and ancillary services. All or part of these categories may be included either in in-patient or out-patient services.

51. Note that the basis for calculation for Figure 5.1 is Personal medical services (HC.1-4) while for Figure 5.2 it is Curative and rehabilitative services (HC.1-2).

52. It is partly due to the fact that this sub-aggregate of health expenditure is more comparable than total expenditure.

patient care within *curative-rehabilitative medical services* was higher than inpatient care in half of the countries.[53] Denmark, Germany and Poland spent the highest share of *curative-rehabilitative medical services* on in-patient care (with the highest 55% value for Denmark).

75. To conclude, if in-patient care is considered separately from hospital expenditure, and curative-rehabilitative and long-term care are separated within in-patient care, a far more accurate picture can be obtained. These data show that in-patient curative and rehabilitative care occupy a smaller share of health expenditure than is typically supposed, and therefore, is one of the most important findings from a health policy analysis point of view.

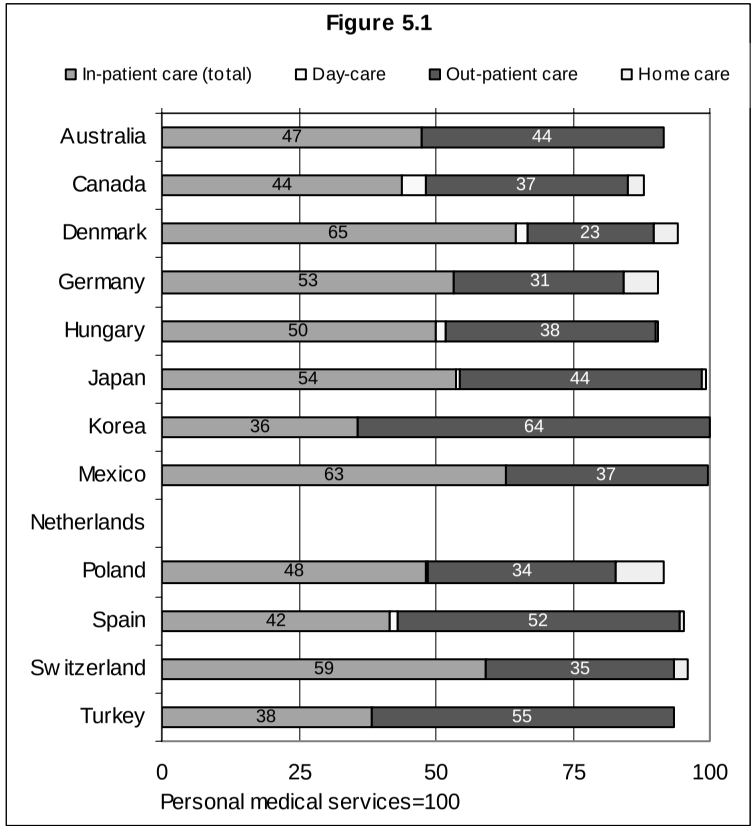
76. *Day care* and *home care*[54] are generally believed to have been developing dynamically.[55] Health statistics, however, have only recently started to register these services in some countries. Canada reported the highest share for day-care at 3% of total expenditure. Between 1992 and 2001, German expenditure on home care services increased more than five-fold. This enormous increase was caused by the introduction of the German long-term nursing care insurance. Since 1995 this insurance pays for home care provided by ambulatory institutions and by persons who care for their relatives or neighbours.

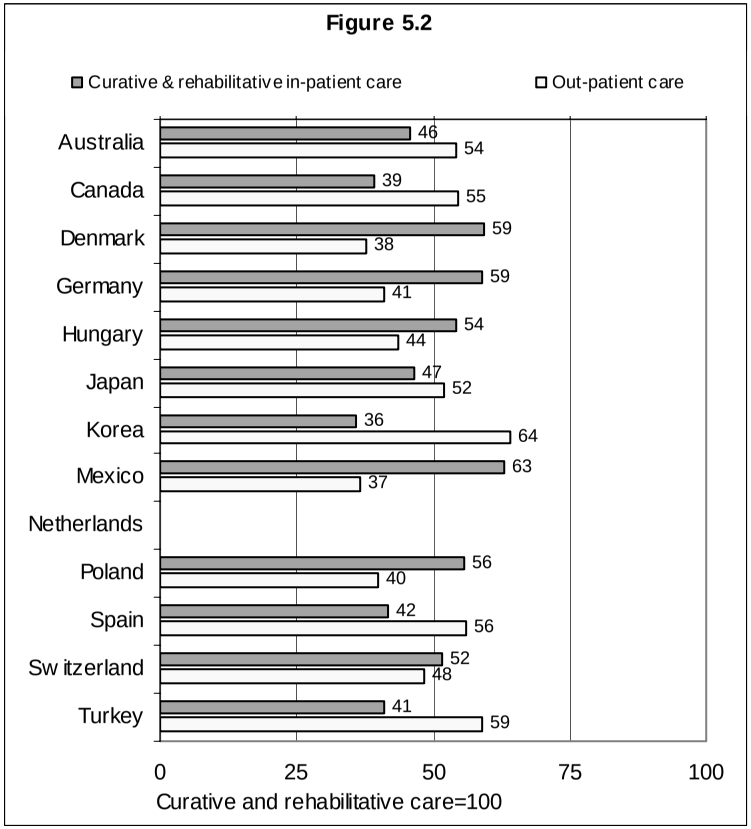
53. In-patient care in Canada is underestimated. The Canadian Institute for Health Information (CIHI) carried out a major study mapping the Canadian Health Accounts (CHA) to ICHA-HC (see the Canadian country chapter in Part III). Payments to private practice physicians for services provided in hospitals are classified as in-patient care according to SHA-based health accounts, however part of these payments could not be separated from out-patient expenditure and are thus reported as physicians care in the national statistics.

54. Home care includes household production. In most countries home care is almost equal to long-term nursing home care or reported solely under that category.

55. Due to the evolutionary nature of the data systems, comparison of day care and home care figures requires a degree of caution.

Figure 5. Health expenditure by mode of production





Current Health expenditure by provider

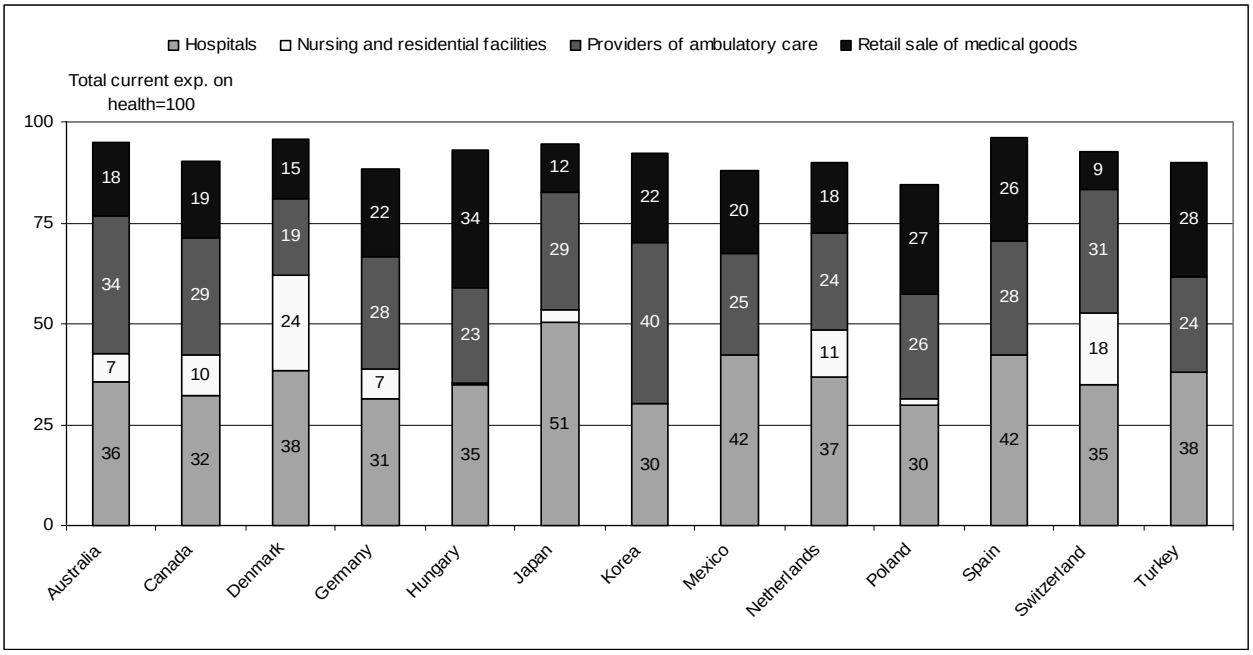
77. Health care providers (*e.g.*, hospitals) are key actors in the health care system. Tables 4.1 and 4.2 provide information about their relative share of the resources of the health system. Because of the country specific division of labour in health systems across health care providers, a provider category (for example, hospitals) may refer to a rather different set of activities in particular countries. There is no one-to-one correspondence between functions and providers: hospitals provide not only inpatient care, providers of ambulatory care might provide in-patient care and pharmaceuticals, etc.[56] Therefore, expenditure data by provider categories are, *in themselves*, less comparable across countries than the functions. However, in combining and cross-classifying with the functional classification in the standard SHA tables, this dimension contributes to a better description of the structure of a health care system.

78. In all countries, except Korea, *hospitals* (HP.1) account for the highest proportion of current health expenditure among health care providers (Figure 6). The percentage varies from around 30% in Poland, Korea, and Germany, and up to 51% in Japan, with an average among the participant countries of 37%. The *nursing and residential care facilities* account for 18% and 24% in Switzerland and Denmark, where long-term nursing care accounts for a large proportion of health expenditure.[57] Other countries report low or no expenditure either due to the real absence of such establishments, such as in Korea and Turkey, or the non- or under-estimation in the health accounts. Around 28% of current health expenditure is directed towards *providers of ambulatory health care* (HP.3), ranging from 19% in Denmark to 40% in Korea, where they consume the highest proportion of current health expenditure among health care providers.

56. Consequently, distribution of expenditure by provider can not be considered as simple corollary of distribution of expenditure by function.

57. This provider category (HP.2) is more problematic because of the different treatment of long-term care in health accounts already discussed. For example, the figure for Denmark is overestimated – as explained in the Tables in Annex I and the Danish country chapter.

Figure 6. Current health expenditure by provider[58]



HEALTH EXPENDITURE BY FUNCTION AND FINANCING AGENT

79. A key feature of the SHA is that it displays the flows of money from categories of financing agents to main types of services (functions) in a particular country. Tables 5 to 20 in this paper have been designed to provide the information gained from country-specific SHA tables in a comparative way and address two main issues: (i) how the different functions are financed, *i.e.*, what roles the different financing agents play in financing in-patient care, out-patient care and medical goods (with special regard to the analysis of the direct burden of costs of care on households); and (ii) how public and private expenditure (and their sub-components) are distributed among the different health care functions. Perhaps, the most important result of the SHA-based health accounts is that they provide detailed information on how the different functions are financed.[59] This provides, among other things, a better understanding of the role of both public and private sectors, and concerning the latter, the role of private insurance and direct out-of pocket spending by households.

How are the different functions financed?

Financing of personal medical services

80. Table 5 highlights the roles of the public and private sectors (and their sub-categories) in financing personal medical services (HC.1-HC.4) across countries. The role of the public sector is decisive[60] in Canada, Denmark, Germany, Japan and Poland. The share of public financing is smaller although still dominant (at around 70%) in Australia, Hungary and Spain; while in Korea, Switzerland and

58. Besides the listed components, current expenditure on health also includes HP.5 Provision and administration of public health programs, HP.6 General health administration and insurance, HP.7 Other industries (rest of the economy) and HP.9 Rest of the world.

59. Such information could not be obtained from pre-SHA health care statistics.

60. Around 80% or more of medical services are financed by general government (HF.1) in these countries.

Turkey 55-60% of medical services are financed by the public sector. Only in Mexico does the share of public financing fall below 50%. In all countries, apart from Switzerland and Turkey, the private sector plays a lesser role in financing medical services that in financing medical goods. These data also highlight that the *direct* burden of costs of care falling on households differs dramatically across countries – indicating considerable differences in equity in financing.[61] In Denmark and Germany less than 10% of personal medical services are financed from out-of-pocket payments of households, while this rises to more than 30% in Korea, Mexico, Switzerland and Turkey.

81. Personal medical services comprise curative and rehabilitative care, long term nursing care, and ancillary services. The financing of *curative and rehabilitative care* (HC.1-2) follows a similar pattern to that of personal medical services (HC.1-4), although with a slightly greater share of private funding (Table 6). The share of public financing in *long-term nursing care* is higher than for curative-rehabilitative in all countries (where data are available) apart from in Switzerland and Turkey (Table 7).

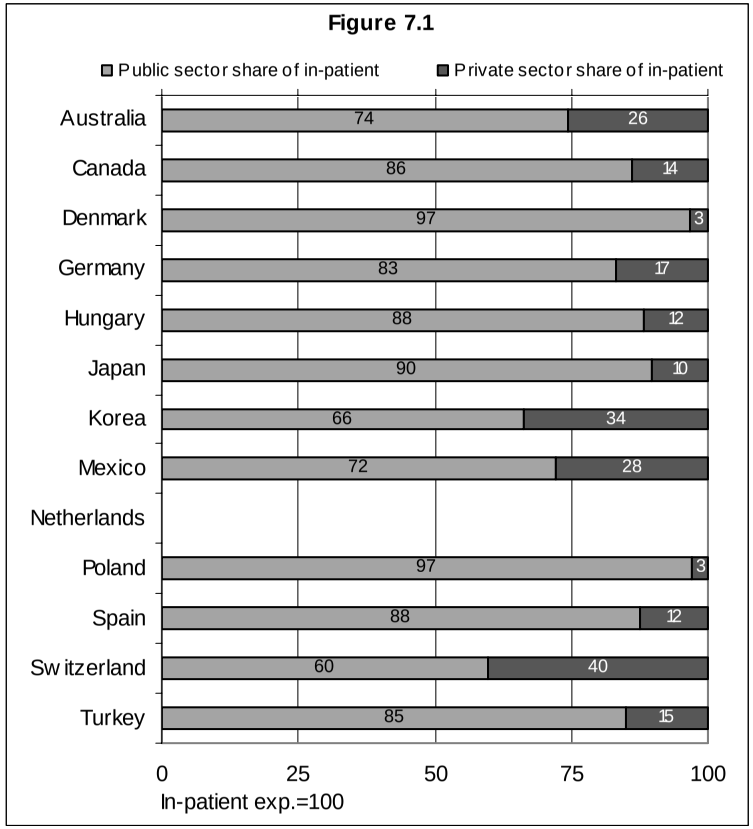
Financing of in-patient services

82. Table 8.1 presents the different roles of government, social security, private insurance and households' out-of pocket payments in financing in-patient care across countries. The SHA makes it possible to distinguish between hospital expenditure and in-patient care by separating out the out-patient care provided in hospitals. Public funds are the dominant source in financing *in-patient care* across the participant countries, covering on average 82% of the costs with the private sector funding the remaining 18% (Figure 7.1 and Table 8.1). The contribution varies between countries, from Switzerland, at 60%, to Denmark, where 97% of in-patient services are financed through public funds. The role of public funds in the financing of in-patient care is far more significant than in the financing of the other components of medical care. This is partly due to the high relevance of inpatient care in the treatment of the most serious medical conditions. Hence, the dominance of public funds in financing in-patient care also reflects the greater role of public sources in the dissemination of medical technologies. The fact that providers of inpatient care – regardless of whether they are publicly or privately owned – rely on public sources to a great extent, means that governments often focus more on containing in-patient care expenditure than is the case for out-patient care or medical goods. In some case, however, this may mean shifting the costs rather than affecting total expenditure on health. However, analysis of this kind of question will only be possible as longer time series become available. In this respect, the comparative tables provided in this paper can be regarded as a starting point.

83. Concerning the private role in the financing of in-patient services, the sub-division is dependant to some extent on whether there is a developed private insurance market. In countries such as Australia, Germany and Switzerland, private insurance takes on a bigger share of the financing of in-patient care (Figure 7.2). Out-of-pocket payments typically fund around 10% of in-patient costs in many countries, apart from Korea, Mexico and Switzerland where around a quarter of all in-patient expenditure come from such payments. In the latter case, this is mainly due to the high proportion of out-of-pocket payments on nursing and residential care. Hence, it is important to consider the two main components of in-patient care (curative-rehabilitative inpatient and long-term care inpatient care) separately.

61. An appropriate analysis of equity in finance, however, would need data on expenditure by population groups.

Figure 7. In-patient expenditure by financing agent



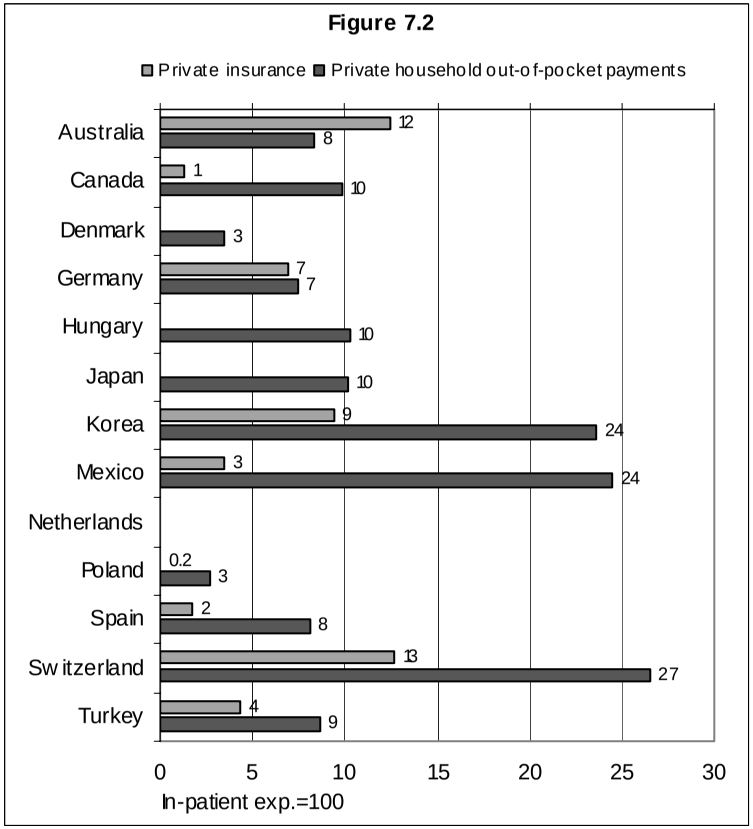
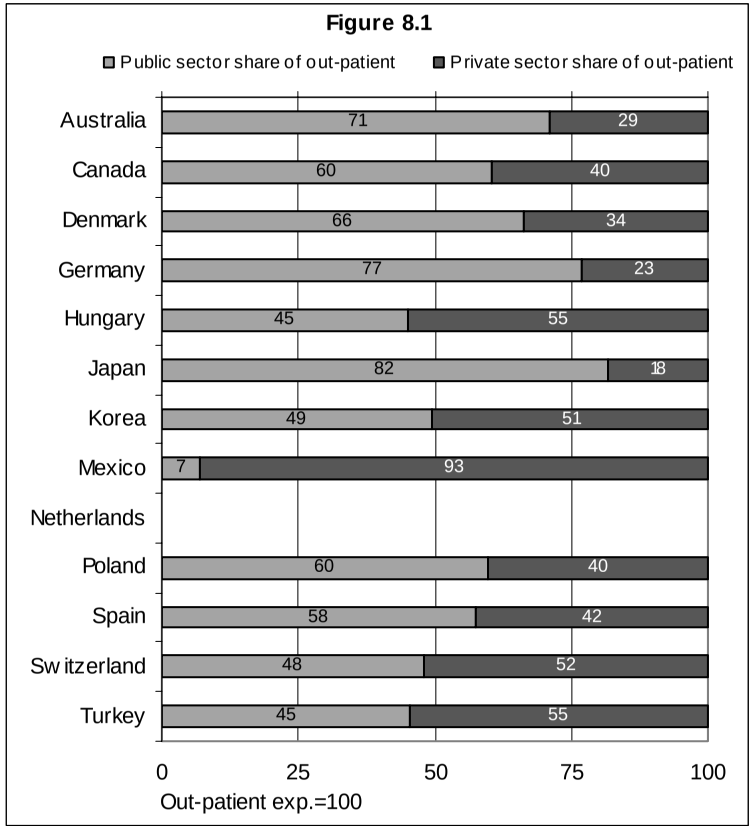
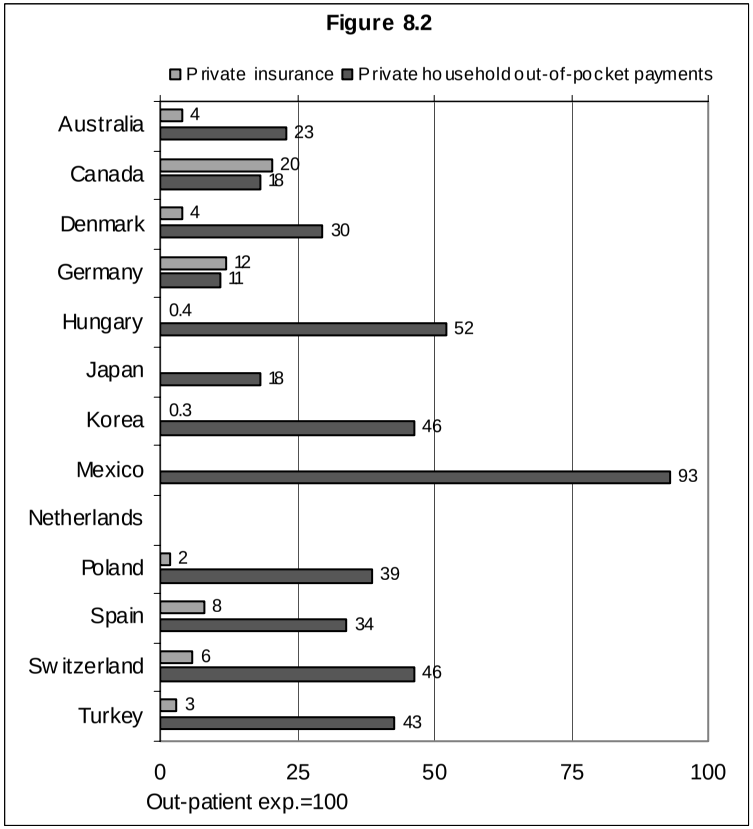


Figure 8. Out-patient expenditure by financing agent





84. Table 8.2 shows that the role of public sector is even more crucial in financing of *curative-rehabilitative* inpatient care than total in-patient care. These data reflect the fact that people in most examined countries are protected to a great extent against the costs of the most serious acute conditions needing inpatient care. Although in Australia, Germany and Switzerland the role of private sector in financing curative-rehabilitative in-patient care is considerable (16-28%), more than 60% of this, on average, is covered by private insurance. Across these countries (as well as in Canada and Poland) households' direct payments accounted for only 2-6% of expenditure on curative-rehabilitative in-patient care. A different situation is apparent in Turkey and Hungary where around 10% of spending on curative-rehabilitative in-patient care is through out-of-pocket payments. (Note that in Hungary the data include estimates for the under-the-table payments.)

Financing of out-patient services

85. Table 9 (Figure 8.1) reveal that out-patient care is financed in a substantially different way than is the case for in-patient care. On average, across all of the countries, almost half (around 45%) of *out-patient care* was financed through private sources. In the case of Hungary, Switzerland, Turkey and, in particular, Mexico, private financing plays the dominant role. In another group of countries (Australia, Germany and Japan) more than 70% of out-patient expenditure is covered by public funds.[62] For those countries where there is a mixture of public funding, out-patient funding tends to come predominantly through the social security channel.

86. Concerning the breakdown of private sources, out-of-pocket expenditure is the main component of private spending on out-patient services in all countries except Canada[63] and Germany, where private insurance plays the more important role (Figure 8.2).

62. The very high share of private financing in out-patient care in Mexico (97%) and, conversely, the high share of public funds (82%) in Japan are partly due to the unresolved issues in mapping of data concerned to SHA-ICHA.

63. In Canada dental care accounted for around 80% of the payments by private insurance on out-patient services in 1999.

Financing of pharmaceuticals

87. Table 10 shows that, in most countries, private funding plays an even more significant role in financing *medical goods* than in funding out-patient care. On average,[64] 54% of medical goods expenditure came from public sources, with 46% from private financing. In Canada and Poland, private funds play the greater role, whereas in all other countries the public share is the higher.

88. Medical goods comprises both pharmaceuticals and therapeutic appliances[65]. Due to its dominant share, only pharmaceutical expenditure is discussed in detail in the following. Table 11 and Figure 9.1 suggest the following patterns:

- General government (HF.1) pays for 60-70% of pharmaceuticals in Germany, Hungary, Japan, Spain, Switzerland and Turkey. The public share is the highest in Germany (74%).
- Public and private sectors share a roughly equal role in the expenditure on pharmaceuticals in Australia, Denmark and Korea.
- Private sector finances more than 60% of pharmaceuticals in Canada and Poland.

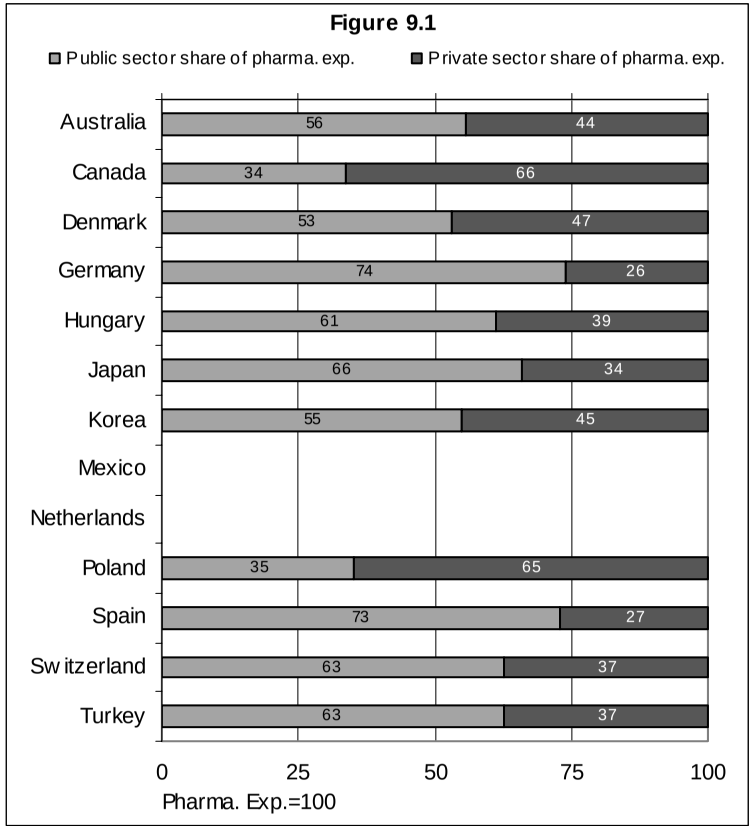
89. It should be noted again that in those countries where public funding is split between general government and social security, expenditure on pharmaceuticals is channelled from the social security funds.

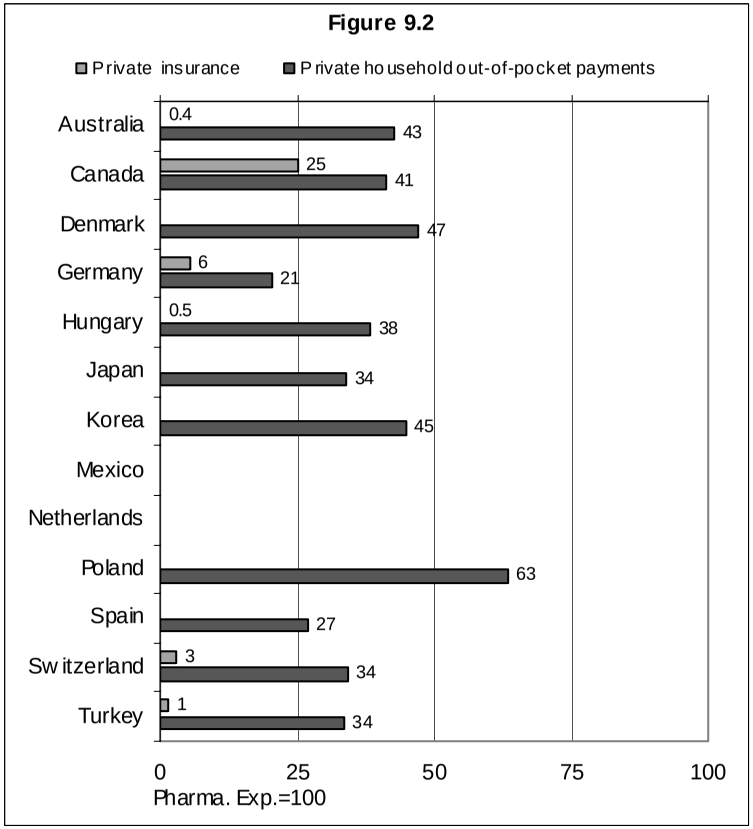
90. Even in those countries with more developed private insurance, out-of-pocket payments are the dominant source of private funding for pharmaceuticals (Figure 9.2).

64. Mexico is excluded from the average due to the fact that spending by social security cannot be disaggregated by function.

65. More precisely: HC.5.1 Pharmaceuticals and other medical non-durables (with sub-components of prescribed medicines, Over-the-counter medicines as well as Other medical non-durables); and HC.5.2 Therapeutic appliances and other medical durables.

Figure 9. Pharmaceutical expenditure by financing agent

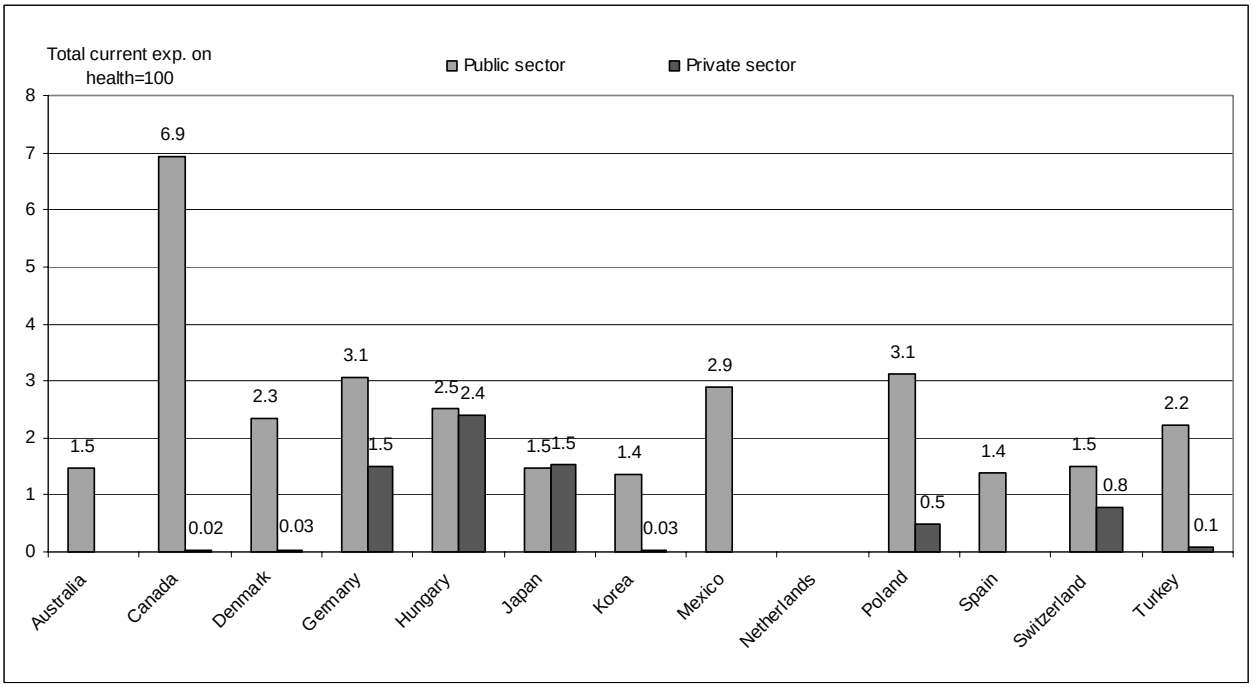




Financing of prevention and public health services

91. Two different patterns can be discerned from Table 12 (and Figure 10) depending on the role of occupational health care.[66] In Germany, Hungary, Japan and Switzerland, the private sector plays a significant role with 30-60% of the expenditure on prevention; amounting to 1-2% of total current expenditure (Figure 10). In most of these countries companies are obliged to pay for regular medical checks and these payments constitute a considerable part of organised programmes on prevention. Switzerland also sees an important role for the non profit organisations (19% of expenditure on prevention). In other countries, 90-100% of prevention expenditures are financed through public resources.

Figure 10. Prevention and public health expenditure by financing agent



Spending structure of the financing agents

92. Tables 13 to 19 consider the alternative way of analysing the distribution of health expenditure by function and financing agent: *How do the particular financing agents utilise their resources?* i.e., how is public and private expenditure (and their sub-components) distributed among the different health care functions.[67]

66. As previously mentioned, expenditure on prevention and public health services (HC.6) only covers organised prevention programmes. Except Canada, where figures for HC.6 also include general administration of health departments.

67. This feature of health expenditure is partly a by-product of the way each function is financed. However, it is also influenced by other factors such as characteristics of health service capacities/provision and consumption (e.g., over- or under-supply of hospital beds, population's pharmaceutical consumption behaviour, etc.); as well as the price structure of medical services and goods (especially pharmaceuticals).

Functional structure of public expenditure

93. Tables 13 to 15 show how **public spending** is distributed among the functions of health care [68]. From the point of view of sustainable financing, it is not enough to simply analyse the trend of overall public financing. The functional distribution and it's change over time is important information for policies aimed at controlling public expenditure, since these policies require different means in different areas of the health system. As longer time series from SHA-based health accounts become available, health accounts will also be able to indicate whether changes in priorities exert influence on the distribution of resources. Since variation in the importance of the major spending items is a combination of numerous factors, health accounts require to be complemented with additional information. For example, differences in spending on medical goods reflects variation in real consumption of such goods, in the extent to which such goods are covered by public funds, the price of such goods in the country in question, and the terms under which the public and private sector acquires them. Changes in all these need to be analysed to understand variations across countries and changes over time.

94. Table 13 shows that the two major aggregate components of health expenditure are: *personal health services and goods* (HC.1-5) and *collective health care* (HC.6-7). For most countries', 90-95% of total public health expenditure is accounted for by *personal health services and goods*: this share ranges from a low of 71% in Mexico up to 95% in Denmark. Expenditure on *collective health care* accounts for the remaining 5-10% of current public expenditure for the majority of the participant countries.[69]

95. Focusing on the major spending items (in-patient care, out-patient care and medical goods), the following patterns can be discerned (Figure 11 and Table 14):

- Financing in-patient care consumes a far greater share of public resources than the other two components in Denmark, Japan, Poland and Switzerland. (Each spends around or above 45% of public resources on in-patient care, 20-30% on out-patient care and ancillary services together; and only around 15% or less on medical goods.)
- In-patient care and out-patient care are given similar emphasis in public financing in Australia and Canada, with only a small share (8-13%) on medical goods.
- In Germany, Hungary and Spain medical goods (largely pharmaceuticals) consume a considerably higher share of public resources than in the countries in the previous group, while in-patient care consumes a similar, nearly 40%, share of public resources.
- Korea is the only country spending less on in-patient care from public resources than on out-patient care. The share of medical goods is also rather high at 24%.

Functional structure of private expenditure

96. Tables 16 to 19 and Figures 12 to 14 show how **private spending** is distributed among the functions of health care. Examining Figures 11 and 12 together, it can be seen that functional structure of private spending is influenced, to a great extent, by the characteristics of public financing – resulting in considerably different functional breakdown of the two sectors. Curative and rehabilitative in-patient care tends to account for 30-40% of public expenditure**,** but only around 11% of private spending. Medical

68. As previously discussed, the SHA applies for personal services two approaches in functional classification: (i) the purpose of health care (curative care, rehabilitative care and long-term care, etc.); and the (ii) mode of production (in-patient care, day cases, out-patient and home care). The discussion in this section only focuses on the spending structure by mode of production.

69. With the exception to this is Mexico, where around a quarter of all public health expenditure is devoted to collective health care: 18.3% on administration and 6.5% on prevention and public health services.

goods show a different picture with 34% of private expenditure on average directed to medical goods as opposed to only 16% of public funds.

Figure 11. Current public expenditure on health by function[70]

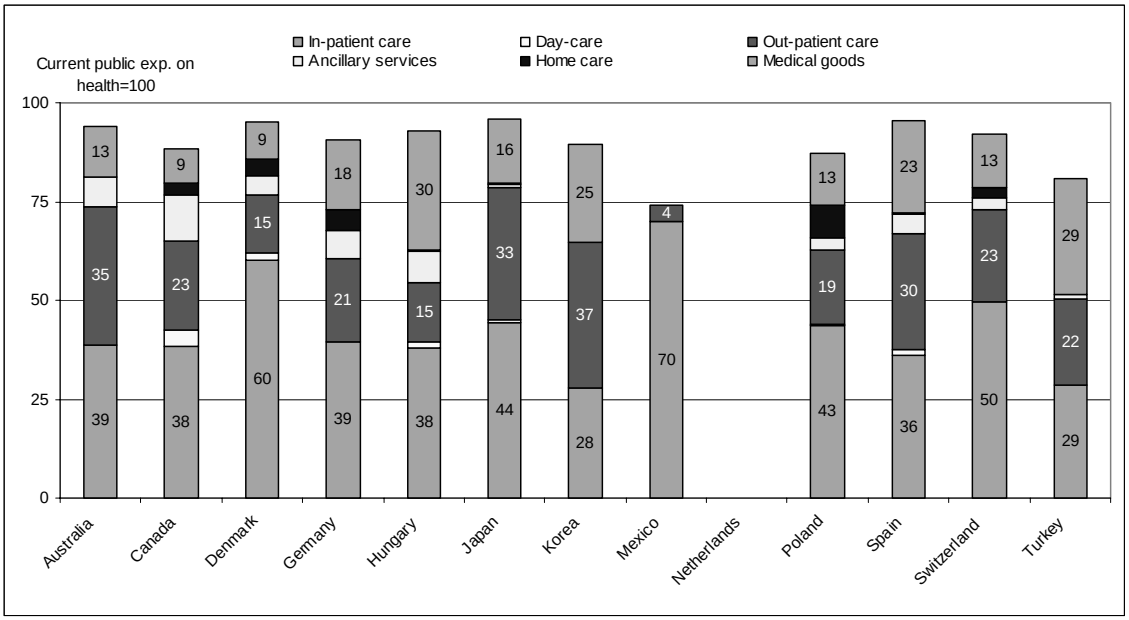
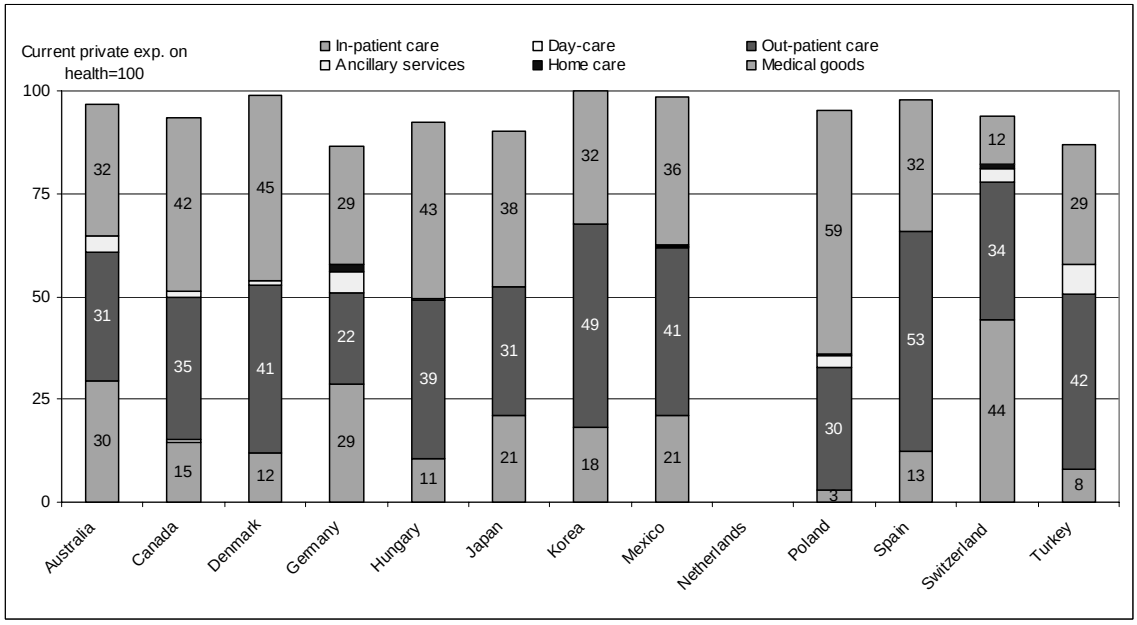


Figure 12. Current private expenditure on health by function[71]



70. Personal services are disaggregated by mode of production but not by type of care. Besides the components identified in this chart, current expenditure on health also includes Ancillary services (HC.4), Prevention and public health services (HC.6) and Health administration and health insurance (HC.7).

71. Note: Besides the components identified in this chart, current expenditure on health also includes Ancillary services (HC.4), Prevention and public health services (HC.6) and Health administration and health insurance (HC.7).

97. Table 16 shows that generally more than 90% of private financing is directed towards *personal medical services and goods,* leaving less than 10% for *collective services* and *capital investment*[72] . There are some differences to note regarding collective services. Germany, Hungary and Japan spend a relatively large share of private funds on prevention and public health services due to the role of companies financing occupational health care and the legal requirement for medical checks at the workplace in these countries. Medical goods consumes the largest share of private funds in six countries (more than 40% of the private expenditure in Canada, Denmark, Hungary and Poland); while out-patient services does in four (Korea, Mexico, Spain and Turkey)[73]. Switzerland is the only countries where in-patient care accounts for the greatest share of private spending.

Functional structure of private insurance

98. Of the sub-components of private financing, private insurance plays an important role in Australia, Canada, Germany, Netherlands and Switzerland (Table 18). Apart from Canada, it finances in-patient care to a greater extent than pharmaceuticals: for example, in Australia 60% of private insurance expenditure is spent on in-patient care, with only 5% on medical goods. In Germany the corresponding figures are: 30% on in-patient care with 13% on medical goods. By contrast, only 4% of private insurance expenditure in Canada is spent on in-patient care, whereas 35% goes on medical goods and 46% on out-patient care. In those countries where the overall share of private insurance is small (less than 5% of total expenditure), out-patient care (including dental care) tends to consume the highest share.

99. Comparing the functional structure of social security and private insurance in Germany and Switzerland, an important difference is that the share of administration (HC. 7) is far higher in private insurance spending. In Germany, 17% of expenditure by private insurance companies (HF.2.2) is spent on administration, while social security funds (HF.1.2) spent 6%. Similarly, in Switzerland, private insurance spent 16% on administration, while social security funds (HF.1.2) spent 6%.

Functional structure of households' expenditure on health

100. Functional structure of out-of-pocket payments reflects a combination of different factors: on the one hand, which type of services put the greatest burden on households due to limited public financing or lack of insurance, and on the other, individual preferences for services outside the publicly financed system.[74] Perhaps not surprisingly, households' expenditure on health[75] is devoted to personal medical services and goods with little or no spending on collective health services (Figure 13 and Table 19). Typically between 40-50% of households' spending on health pays for medical goods[76], 35-40% for out-patient care and 10-15% for in-patient care – Switzerland displays a rather different breakdown with only 14% on medical goods, and around 40% both on in-patient and out-patient care. This structure is again

72. However, 9.3% of total private health funds in Korea and 6.3% in Australia do finance capital investment.

73. In Germany, the share of in-patient, out-patient acre and medical goods in private expenditure are very similar.

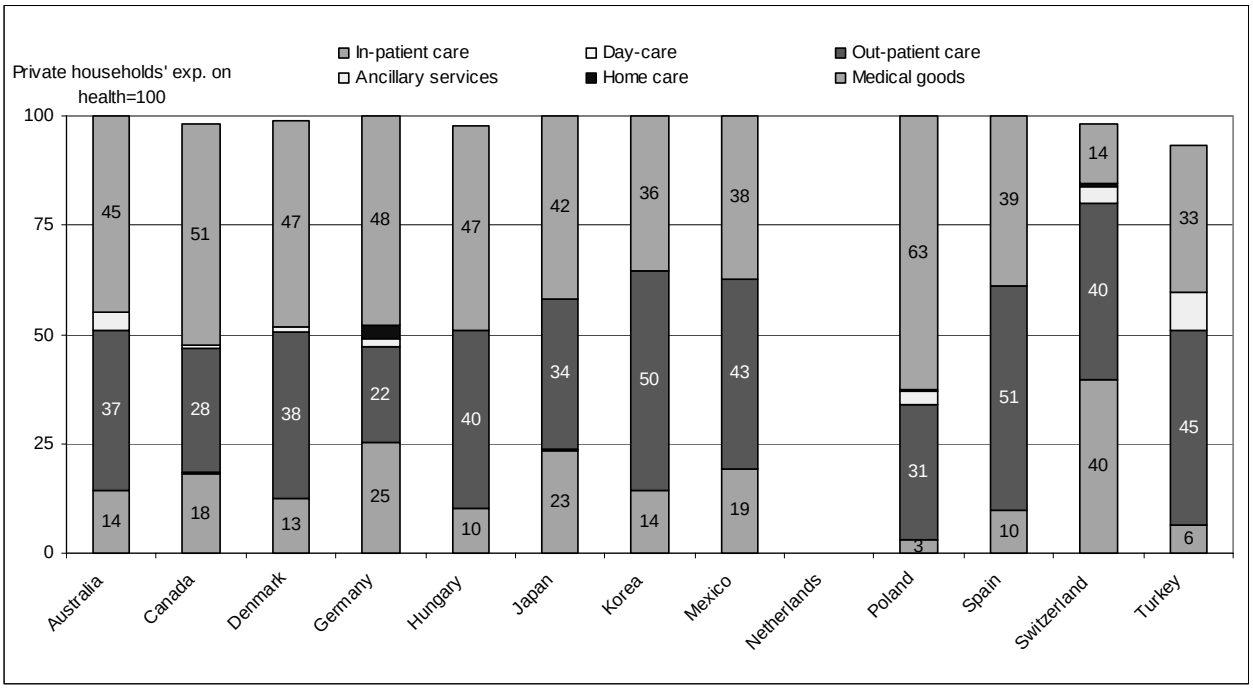
74. To distinguish between these factors would require more information on the different sub-categories of out-of-pocket payments (namely, cost-sharing to social insurance and out-of-pocket payments for services not covered by social insurance). The SHA has expenditure categories for this purpose, but such disaggregated data are not available in most countries.

75. An important advantage of SHA-based health accounts over existing OECD Health Data series is the possibility to study spending structure of households; currently OECD Health Data presents only the functional structure of total, private and public expenditure.

76. To analyse the burden of out-of-pocket payments on households, it would be important to distinguish between cost-sharing and over-the-counter medicines, furthermore to have data by income groups of society. Further development of health accounts might produce these data.

influenced by a high share of households' expenditure being devoted to long-term nursing care. The other outlier is Poland with 63% of all households' health expenditure on medical goods and only 3% on in-patient care.

Figure 13. Private households' out-of-pocket expenditure by function



CURRENT HEALTH EXPENDITURE BY FUNCTION AND PROVIDER

101. One of the most important innovations of the SHA is the distinction made between function and provider and the ability to cross-classify expenditure between them. Advances in medical technology influence structural changes in the way that health care services are delivered. An important and ongoing trend is the replacement of part of in-patient care by other forms of care, such as day care, out-patient care and home care. For example, an increasing number of surgical procedures are now performed on a day-case basis; and home care is playing an increasing role in long-term care. SHA-based health accounts will be able to exhibit this process, as longer time series become available.

102. Based on Tables 20 to 23, health expenditure by function and provider can be examined from two perspectives: (i) how the different functions are provided; and (ii) the functional structure of particular providers.

Functional structure of hospital expenditure

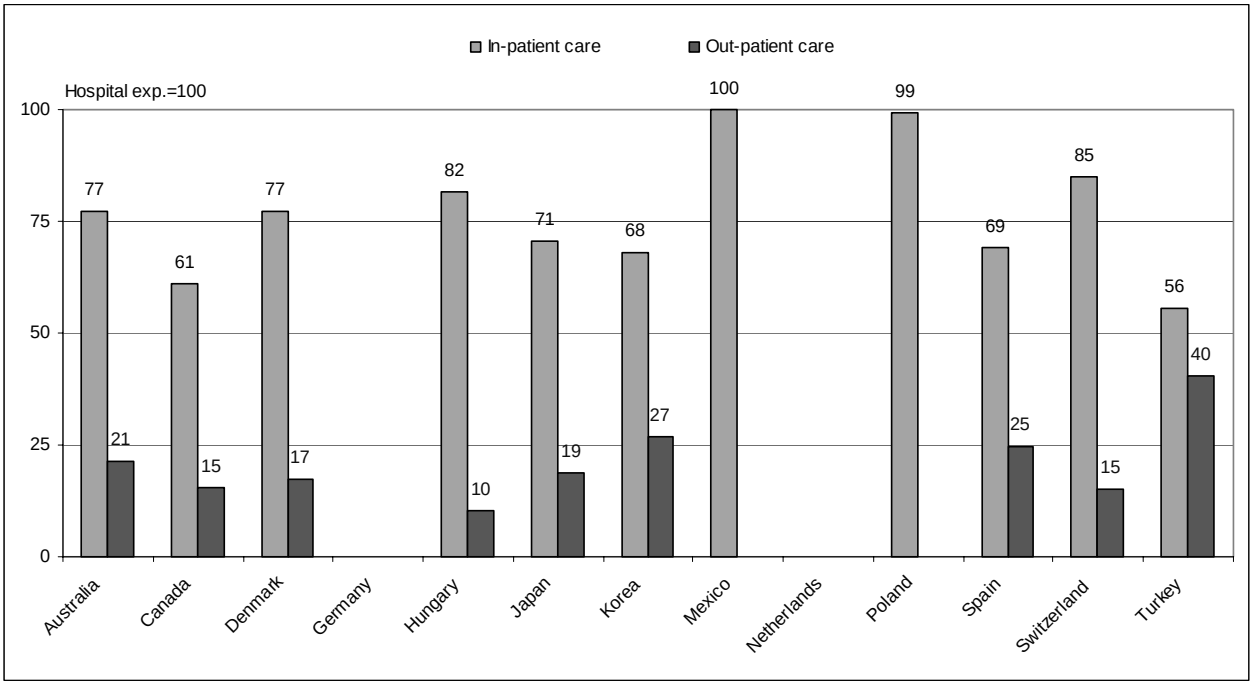
103. A particular and important new result provided by SHA is the in-depth information on the multi-functionality of hospitals (Table 20). In analysing the distribution of hospital services by mode of production, a number of countries are unable to distinguish out-patient care, and others tend to overestimate the reporting of in-patient services.[77] In countries where out-patient care in hospitals can be reported separately, this typically represents 15-25% of hospital expenses. Day-care and some ancillary

77. In some countries, such as Germany, Mexico, Netherlands and Poland, out-patient care in hospitals cannot be separated, totally or partially, from in-patient care.

service expenditure may also be included in hospital in-patient (or out-patient) services, though the percentages are generally less.

104. Table 20 and Figure 14 show a considerable difference in the hospitals' functional structure across the countries studied. For example, in Canada, in-patient care represents about 61% of hospital expenses, whereas in Switzerland it accounts for 85%. Where out-patient care is able to be reported, it represents, on average, 17% of hospital expenditure – but up to 40% in the case of Turkey, where hospitals maintain large out-patient departments (Figure 14).

Figure 14. Hospitals' expenditure by function



105. A further 8% of hospital expenditure is devoted to day care in Canada, while in other countries this typically accounts for only between 1 and 3%. Also, in Canada, ancillary services are reported as accounting for 15.3 % of hospital expenditure – whereas other countries generally report between 2% and 7%. In Japan and Korea, doctors fulfil a dual role as dispensers of medicines and therefore 10% and 5% respectively of hospital expenditure is allocated to medical goods dispensed to out-patients.

106. Canada, Hungary, Japan and Spain are among the countries presenting the most detailed distribution of hospitals' expenditure by function. For example, in Canada, 53% of the hospital expenditure is devoted to curative-rehabilitative in-patient care, 8% to long-term nursing care, 7% to day care, 15.4% to out-patient care, 15.3% to ancillary services and 0.7% to prevention (Table 20).[78]

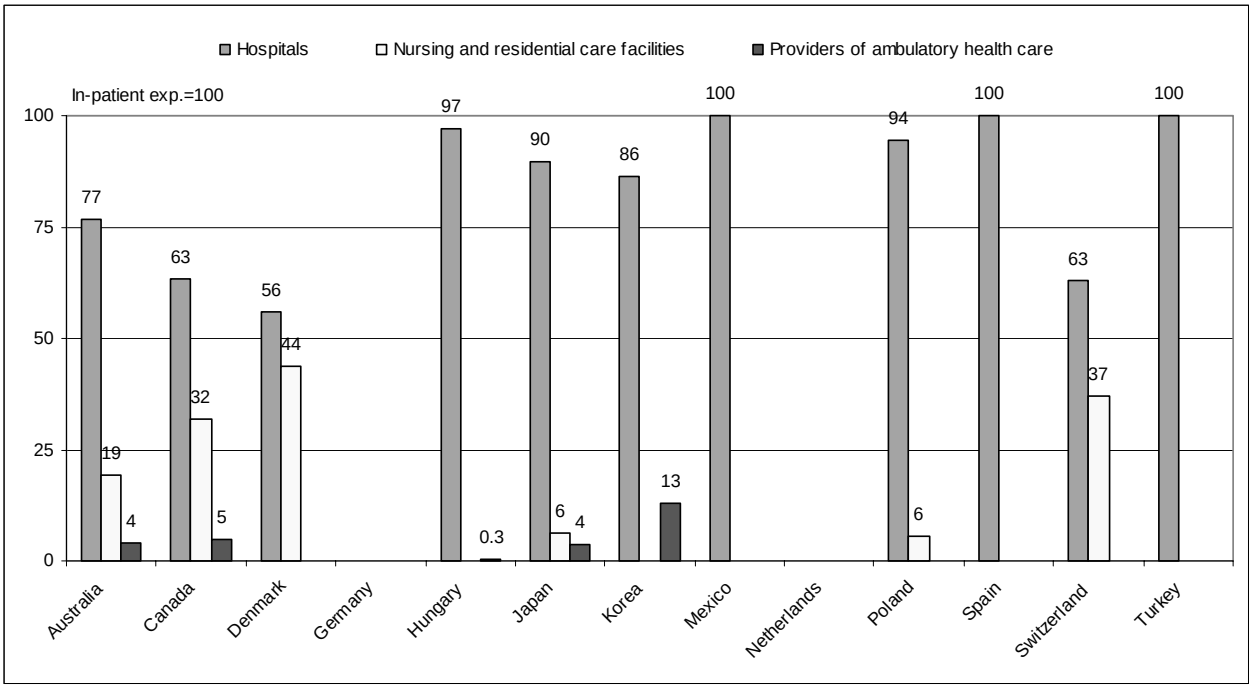
78. In Hungary, the share of curative-rehabilitative in-patient care was 79.3%, long-term nursing care 2.5%, day care 0.5%, out-patient care 10.3%, ancillary services 6.9% and prevention 0.3%

How are the different functions of health care provided?

Provision of in-patient care

107. Not surprisingly, hospitals play the leading role in the provision of in-patient care in all the countries analysed (Figure 15 and Table 21). The overall share is very much linked to the reporting of long-term in-patient care. So, in countries such as Denmark and Switzerland (and to a lesser extent Canada and Australia), where there is a high share of long-term nursing care, then nursing and residential care facilities will also have a significant share of the overall in-patient care expenditure. In the case of Denmark[79] this accounts for 44% and for Switzerland 37% of in-patient expenditure.

Figure 15. Provision of in-patient care[80]



108. Another point to note is the existence of clinics in Japan and specifically in Korea, which are classified as ambulatory health care providers but which also provide in-patient care (in the case of Korea providing up to 13% of in-patient care by expenditure). In Canada, expenditure on in-patient care by ambulatory care providers represents fee-for-service payments by provincial medical care insurance plans to physicians in private practice for care rendered to in-patients in hospitals and detention centres.

Provision of out-patient care

109. Table 22 reveals that hospitals and ambulatory health care providers play considerably different roles across countries in the provision of out-patient care. Overall, hospitals are reported as providing around 21% of out-patient care expenditure, with ambulatory health care providers accounting for 77%.[81]

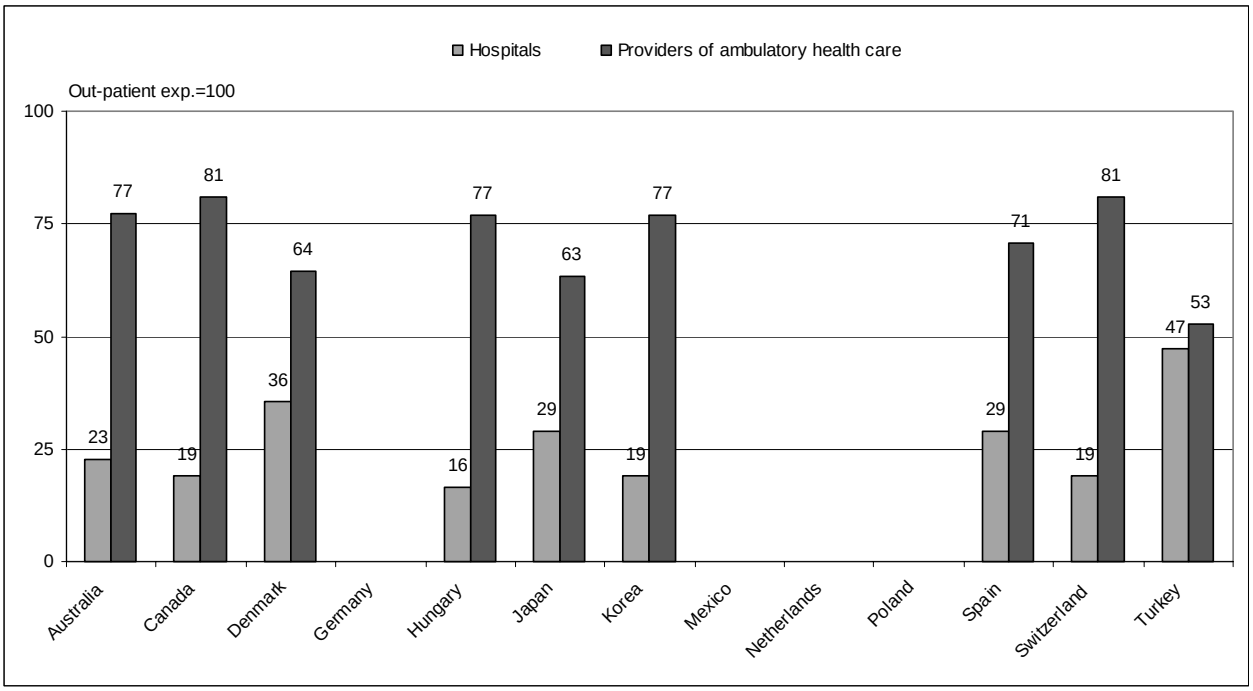
79. It should be noted that this high share is partly due to methodological problems.

80. Note: Besides the provider categories shown, in-patient may also be provided in certain countries under the category Other industries (rest of economy) (HP.7).

81. As mentioned, a number of countries – Germany, Mexico, Netherlands and Poland – are currently unable to properly separate out all or part of the out-patient component from in-patient care in hospitals.

In Turkey and Denmark hospitals play a particular role in the provision of out-patient care: with 47%, and 36%, of out-patient care by expenditure is provided by hospitals respectively (Figure 16).

Figure 16. Provision of out-patient care



110. Table 23 shows that ancillary services may be provided by separate health care organisations (laboratories, diagnostic centres) or be activities performed in complex health care organisations (hospitals). For example, in Canada and Spain, almost 60% of ancillary services are provided through hospitals. In the latter case, adequate reporting on expenditure on ancillary services is as yet unresolved in several countries. For example, in Japan, clinical laboratory and diagnostic imaging services could not be estimated separately and are included in curative care in hospitals. Therefore, all ancillary services to health care are shown provided by ambulatory health care for Japan.

CURRENT HEALTH EXPENDITURE BY PROVIDER AND FINANCING AGENT

111. Similar to the issues examined earlier in the section on health expenditure by function and financing agent, the two basic questions here are as follows: *How are the different providers financed?* and *What are the differences between the spending patterns of public and private financing agents?* These characteristics of health expenditure are influenced by the functional spending patterns of providers, but other factors[82] also play a role justifying a separate discussion. This information is especially important from a provider point of view: for example, to examine the principal sources of financing of each provider, which financing agents play a key role in terms of the operational viability of a provider group, as well as to analyse trends. A more detailed picture about these issues might also be useful for evaluating government regulation concerning specific types of providers. Again, in order to fully utilise the analytical potential of the SHA in these respects will require longer time series. Tables 24 to 29 present the relevant cross-classifications.

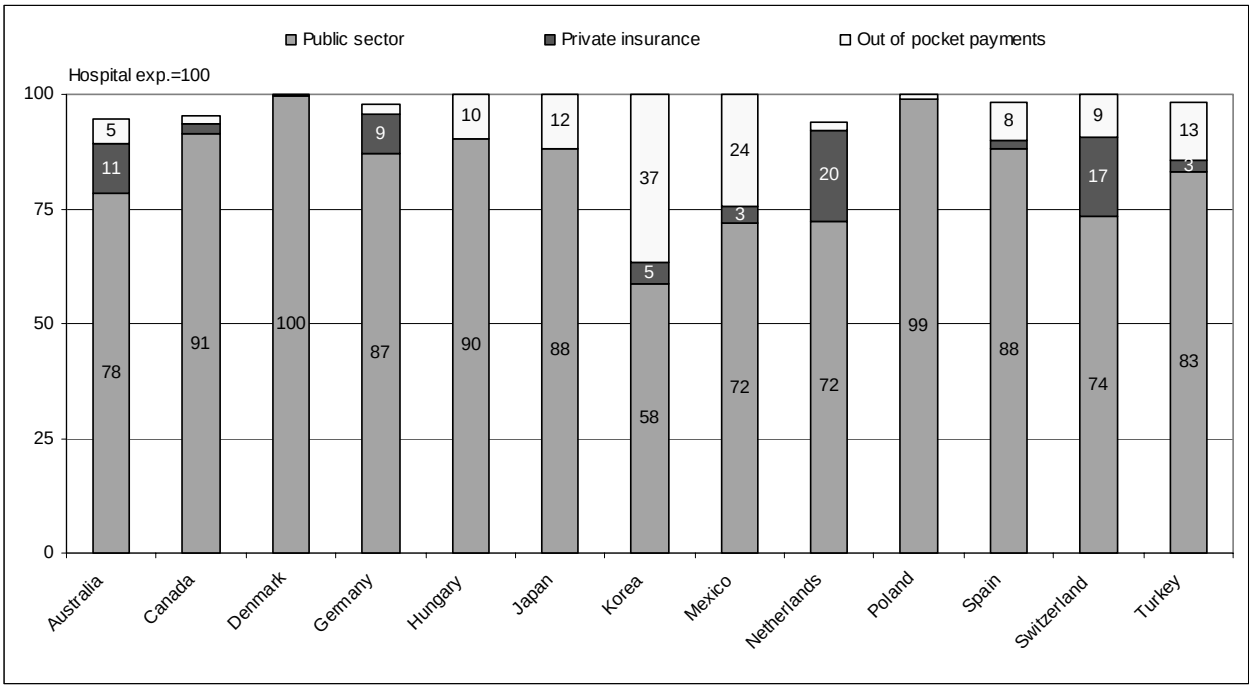
82. For example, those discussed under the heading “Current Health expenditure by provider”.

How are the different providers financed?

Financing of hospitals' services

112. Table 24 and Figure 17 suggest that although in all countries, *general government* (HF.1) plays the major role in financing hospitals, the variations are notable. In Canada, Denmark, Hungary and Poland between 90% and 100% of hospital revenues come from through public funds. Australia, Germany, Japan, Spain and Turkey report general government financing of between 78 and 90% of hospitals' expenditure, while at the lower end, the share from public funding is between 58 and 74% in Korea, Mexico and Switzerland. Of the countries where the private sector is a significant player, such as Korea and Mexico, out-of-pocket payments play an important role, with 37% and 23% of all hospital funding respectively. In Switzerland, where private insurance is more developed, 17% of hospital expenditure is funded through this source with a further 9% through out-of-pocket payments.[83]

Figure 17. Hospital services by financing agent



Financing of nursing and residential care facilities[84]

113. In Table 25, data on nursing and residential care facilities are available for only seven of the countries.[85] Apart from Switzerland, the great majority (70-90%) of the revenues of nursing and residential care facilities come from public sources. By contrast, in Switzerland, 62% of expenditure on services of nursing and residential care facilities was paid for by private household out-of-pocket payments and 2% by non-profit institutions. Social security funds covered 25% and general government (excluding social security) the remaining 11% (Table 25).

83. In these figures for Switzerland the means tested Social Security schemes are not taken into account.

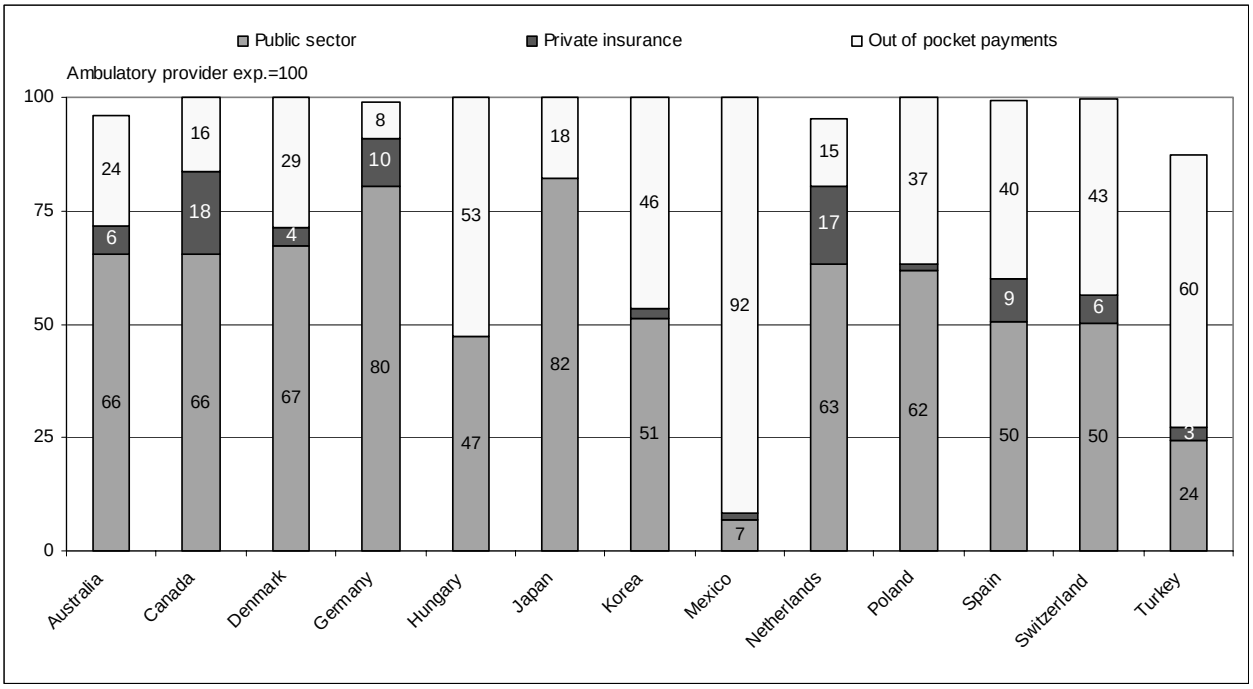
84. It should be noted that the same factors mentioned under the section on long-term care expenditure also apply to the comparability of these data.

85. Hungary only provides data on public spending on nursing care facilities.

Financing of ambulatory health care providers

114. Table 26 (and Figure 18) suggests that, in general, the private sector takes on a larger share of the funding of ambulatory health care providers than is the case for hospitals. However, public funds still provide the greater share of funding in seven countries (including Australia, Canada, Denmark and Germany). Turkey (76%) and Hungary (53%) see more than half of ambulatory care funding coming from private sources, mostly from households' payments, while Korea, Switzerland and Spain see an equal division between public and private funding.[86] Within the private sector, private insurance plays an important role in Canada and Germany, whereas in most other countries out-of-pocket payments form the main source of private funding.

Figure 18. Ambulatory health care providers by financing agent



Spending structure of financing agents by provider

115. The other question relating to distribution of health expenditure by provider and financing agent is: how the particular financing agents use their resources, *i.e.*, how are public and private expenditure (and their sub-components) distributed among different health care providers. This perspective – complementary to the spending structure by function – can provide information as to the balance of health insurance and the government's health budget as longer time series become available.

86. At the extreme position, 93% of ambulatory care setting financing is reported to be from private sources in Mexico, in particular households' payments (however this extreme share is partly due the difficulty in identifying ambulatory care costs within hospitals).

Spending structure of general government by provider

116. Table 27 demonstrates that hospitals are the main recipients of general government health financing – on average accounting for 43% of public health expenditure.[87] This share varies from 31% in Korea up to 55% in Japan. However, most of the countries lie in a band between 45% and 55%. The similar share devoted by public resources to hospitals might imply different roles of public financing in overall revenues of hospitals. For example, in Denmark the 45% of public expenditure spent on hospitals amounted to 99.6% of total hospital revenues, while in Switzerland, 45% of public expenditure amounted to 73.6% of total hospital expenditure.

117. Public expenditure on nursing and residential care facilities reaches 26% of current public spending in the case of Denmark, accounting for more than 90% of the revenues of these facilities. 7-11% of public expenditure in Australia, Canada and Germany accounted for 70-90% of the revenues of nursing and residential care facilities, while the corresponding figure in Switzerland was only 35%.

118. On average, 24% of public health funds are directed to ambulatory health care providers. 15-16% of public spending in Denmark and Hungary,[88] accounted for 67% of the revenues of the ambulatory health care providers in Denmark, while only for 47% in Hungary. Australia and Korea devoted the highest share of public resources to the services provided by ambulatory health care providers: 36% of public spending accounted for 51% of the revenues of this provider category in Korea, where doctors' clinics also play an considerable role in in-patient care as well as out-patient care.

Spending structure of households by provider

119. Table 29 demonstrates that the households pay their "medical budget" primarily to providers of ambulatory care and medical goods – at around 40% each on average. The share of households' payments to providers of medical goods generally varies between 30% and 50%. The exceptions are Switzerland where only 11% of households' health expenditure was spent on providers of medical goods[89], to the other extreme where it accounts for 63% of all out-of-pocket expenditure in Poland. Japan, Korea and Mexico see a relatively high share of households' health expenditure going to hospitals – 35% in the case of Japan – whereas in most other countries this tends to be a small proportion – generally less than 10%.

120. Households 'spending on ambulatory care varies from 20% and 28% in Germany and Canada to between 45% and 50% in Spain, Korea and Turkey. Ambulatory expenditure is between physicians' offices (or out-patient clinics) and dental practices – with a higher share (15%) in the case of dentists.

87. Mexico is excluded from the average because social security expenditure is not distributed by function (only reported under hospital expenditure).

88. The lowest figure is 4% for Mexico; however this is partly due to problems with the data.

89. In Switzerland, *nursing and residential care facilities* (HP.2) received 34% of the households' health spending, due to high share of long-term care services which was previously discussed.

CONCLUSIONS

121. A key impetus for developing the System of Health Accounts was that realisation by experts in member countries of the limited comparability of total health expenditure (and related indicators, such as the ratio of health expenditure to Gross Domestic Product) due to the wide variation in boundary definitions and in the institutional settings of the health systems across countries

122. SHA-based health accounts are expected to enable the comparison of health spending across countries with differing health care systems, while at the same time being suitable for national policy-making purposes. In addition, SHA-based health accounts aim to provide data comparable over time, even if administrative changes in the health system affect the national boundaries of health.

123. The paper summarises the key methodological challenges in implementing the SHA (applying the boundaries of health care and the functional classifications of financing agents, functions and providers), that countries have faced. Mapping national classifications to SHA-ICHA has required countries to find new data sources, redesign national classifications or add new components to their existing statistical system, as well as undertake new data processing. Some countries have gone even further and started to change the way data are reported for the health information system. At the current stage of implementation, the available SHA-based health accounts are only able to partly fulfil all of the potential of the SHA as a statistical framework. Its modular structure as a system of accounts, however, allows for a step-wise implementation.

124. At the same time, countries have had to adapt their health statistics to changes in the financing and provision of their health care services. Examples are the decentralisation in the administration and financing of health care in Spain; the transformation of budget financing into a health insurance system in Poland; the privatisation of health provision in Hungary and Poland, the creation of a new health-related social protection program in Mexico. Furthermore, countries have faced the challenge of adequately reflecting the evolution of service provision, due to changes in medical technology and practice (*e.g.,* the increasing role of day care surgeries), in their health statistics.

125. As a consequence of applying the SHA-defined boundaries of the health sector, SHA-based estimation of total health expenditure differs from pre-SHA figures to a varying extent across countries. In the case of Japan and Denmark, this difference accounts for more than 20% of previously reported total health expenditure. For most countries, however, it is less than 10%. The major differences between pre-SHA and SHA-based health expenditure data can be observed in the structure of health expenditure.

126. For international comparability of data, the functional classification is the most crucial element of the SHA. Health care functions, defined and estimated in an internationally harmonised way, are key to the production of comparable health expenditure figures for countries with differing institutional arrangements. The paper emphasises that implementing the functional classification is still an ongoing process requiring further harmonisation in several respects. (Chapter two and Annex I give a summary of the key relevant issues.) The most important factor currently limiting comparability is the differing treatment (both definition and estimation methods) of long-term care across countries.

127. The analysis of health expenditure data provides a picture of various health funding and spending patterns across the thirteen countries with a focus on how the main types of services (in-patient care, out-patient care and pharmaceuticals) are financed and provided. This enables a better understanding of the role of the public and private sector. The analysis highlights differences across countries in the public-private mix of financing not only the health sector as a whole, but also the main types of services. It also presents the variations in terms of functional structure of spending by public and private financing agents,

as well as the differences in financing of the main provider categories. Also, it gives a better picture about hospitals as multifunctional institutions.

128. The paper presents not only the differences in the overall characteristics of the public-private mix in health care financing across countries, but also gives an insight into the role of the different sub-components of private expenditure, comparing spending by private insurance and households out-of pocket payments. Private insurance tend to be more prevalent in higher income OECD countries, than in the middle and lower income ones; by contrast, the role of out-of-pocket payments tends to be greater in the middle and lower income OECD countries. Furthermore, data display the fact that spending by non-profit organisations and companies are not negligible amounts and in several countries their combined share in private (and total) expenditure might be similar or great greater than that of private insurance.

129. This paper reveals a rather different functional structure of health expenditure than is usually supposed, mainly concerning the share of in-patient and out-patient care.[90] *In-patient curative-rehabilitative care* occupies a smaller share of health expenditure than is usually assumed, while o*ut-patient care* together with *ancillary services* consumes a similar magnitude of, or even more, financial resources than in-patient curative-rehabilitative care in most of the countries, except Denmark, Mexico, Poland.

130. It is also emphasised that differences in per capita spending on pharmaceuticals across countries are far smaller than differences observed for total health expenditure. This is mainly due to the fact that domestic prices of pharmaceuticals reflect international market prices and as a result, lower income countries tend to spend a greater share of their health expenditure on pharmaceuticals.

131. By **cross-classifying expenditure by function and financing agent**, one of the most important questions to which SHA-based health accounts can provide an answer is: How are the different functions financed? What roles do the various financing agents play in financing the main spending components of in-patient care, out-patient care and medical goods? This information is obviously of great interest for health policy-making: to influence those areas with high private spending requires different health policy tools than those areas where public expenditure plays the dominant role.

132. In financing *in-patient care*, public funds are the dominant source contributing, on average, 82% of the costs, leaving the private sector to fund the remaining 18%. Out-patient care is financed in a substantially different way than is the case for in-patient care. On average, across countries, almost half (around 45%) of *out-patient care* was financed by private sources, and in the case of Hungary, Switzerland, Turkey, and, in particular, Mexico, private financing plays the greater role. In most countries, the role of private funding is still more important in financing medical goods than in paying for even out-patient care. In the majority of countries, private funds financed almost half, or in the case of Australia, Canada, Mexico, and Poland, more than half, of *medical goods* expenditure.

133. These results reveal that in many countries, the fact that the whole health care system is primarily publicly financed does not entail that public financing plays the dominant role in every area. In several countries (*e.g.*, Australia, Canada, Poland) public financing plays the dominant role mainly in in-patient care and in financing out-patient care while, for medical goods, the private sector plays an almost similar or even greater role. In only four of the thirteen countries covered in this study, namely Denmark, Germany, Japan and Spain, does the public sector play a dominant role in all three main areas (in-patient, out-patient care and medical goods).

90. Pre-SHA statistics present only hospital expenditure and do not separate different functions (out-patient care, long-term care, etc.) within hospitals.

134. While the paper also shows the well-known fact that *prevention and public health services* are devoted a low share of total expenditure and are mainly financed from public sources, it provides a new element to this picture. Contrary to the pre-SHA statistics, SHA-based health accounts register spending by private companies on occupational health care. As a consequence, two different patterns can be discerned in financing *prevention and public health services* depending on the role of occupational health care. In Germany, Hungary, Japan and Switzerland the private sector plays a considerable role covering 30-60% of the expenditure on prevention. In most of these countries companies are obliged to pay for regular medical checks and these payments constitute a considerable part of the organised programs on prevention. In the other countries, 90-100% of prevention expenditures are financed from public resources.

135. One of the more important innovations of the SHA is the distinction made between function and provider and the ability to cross-classify expenditure between them. Advances in medical technology influence structural changes in the way that health care services are delivered. An important and ongoing trend is the replacement of part of in-patient care by other forms of care, such as day care, out-patient care and home care. For example, an increasing number of surgical procedures are now performed on a day-case basis; and home care is playing an increasing role in long-term care. SHA-based health accounts will be able to exhibit this process, as longer time series become available

136. In this paper, the **cross-classification of health expenditure by function and provider** shows which industries provide services under the different functions, and the kinds of functional structure the different providers have. In particular, an important new result provided by SHA is the in-depth information on the multi-functionality of hospitals. This study already shows a considerable difference in the hospitals' functional structure. For example, in-patient care represents about less or around 70% of hospital expenses in five countries, whereas, out-patient care, day care and ancillary services (provided to out-patients) might accounted for 30-40%. Meanwhile in three countries in-patient care represented more than 85% of the hospital expenses.

137. Addressing the question of: *What roles do the different providers play in providing a particular type of function?*, the SHA-based health accounts identify the important role of hospitals in providing out-patient care. The share of hospitals providing out-patient care ranges from 16% of out-patient expenditure in Hungary, to 36% in Denmark.

138. The process of producing this series of papers has made the differences in national health accounting practices and the departures from the SHA more transparent, and raised several issues requiring further consideration or amendments to the SHA Manual. Their presentation in this paper should serve as input for further statistical work in member countries in order to better harmonise national practices.

139. As previously emphasised, any interpretation of the currently available results from SHA-based health accounts should take into consideration the limitations due to methodological and data problems as yet unresolved. It should be underlined that to utilise the full analytical power of the SHA requires longer time series. Despite these, SHA-based health accounts provide a far more reliable and detailed insight into the way money is spent in the health care sector than has been previously available. They reveal several characteristics of health spending, which had not been previously known, or had been supposed differently. Moreover, the comparative tables and the SHA tables in Part II should allow researchers and experts to conduct a more detailed or specific analysis.

140. The tables and figures in Part II are intended to be the basis for the regular publication of comparative data from SHA-based health accounts in the future, with the ultimate goal of providing a comparison over time as time series become available.

ANNEX 1 METHODOLOGICAL NOTES

141. Part I summarised the key challenges in implementation of the ICHA. The purpose of this section is to summarise the main issues by countries, based on the country studies (*OECD Health Technical Papers*, No. 1 to 13). Experience has shown that the implementation of SHA-ICHA in particular is an evolving and iterative process requiring a longer period with continuous refinements. Moreover, the first wave of SHA implementation can be considered as a test of the feasibility of the SHA. For these reasons, we believe that the departures are natural features rather than a weakness in the system itself, and in making them transparent in this publication, this should serve to further harmonise national practices.

142. The basic structures of these classifications and the three most widely used SHA tables are presented at the end of this Annex for reference.

Box A1

Main departures from ICHA-HF

Australia	No data available for HF.2.4 (Non-profit institutions)
Canada	No data available for HF.2.4 and HF.2.5 (Corporations) Additional category is created for "Non-consumption expenditure"
Denmark	No data available for HF.2.4 and HF.2.5
Germany	
Hungary	
Japan	No data available for HF.2.4 Under Private insurance (HF.2.2) only administration is reported. (Expenditure on benefits could not be separated from households.) Households' expenditure on some services (private room charges, massage, acupuncture, etc.) not covered by insurance are not included.
Korea	Central (HF.1.1.1) and local (HF.1.1.2) governments are not separately reported.
Mexico	Payments by municipal governments are not included No data available for HF.2.4 and HF.2.5
Netherlands	No data presented for HF.2.4 and HF.2.5 due to quality of the separate items
Poland	Expenditure by corporation includes estimates for debts by health care providers to suppliers of medical and other goods used in producing health services.
Spain	No data available for HF.2.5
Switzerland	No data available for HF.2.5
Turkey	

Note: This table presents information on whether all financing agents were taken into account. It does not, however, show whether all expenditure by a particular financing agent was accounted for. (This information is provided in Box A3.)

Box A2 **Main departures from ICHA-HC**	
Australia	Day care is included in in-patient care.
Canada	Out-patient curative& rehabilitative care include some part of the day cases and in-patient care The cost for general administration of health departments (that should be reported under HC.7.1.1) is included in HC.6
Denmark	In-patient long-term nursing care includes certain amount of social expenditure (accommodation in residential care homes) Most expenditure on prevention provided by municipalities is not included.
Germany	HC.3 Long-term nursing care includes certain expenditure on social care services In-patient care includes out-patient care provided in hospitals. Day care is included in HC.1.1. HC.4 Ancillary services also include clinical laboratory and diagnostic imaging provided to in-patients (that should be reported under HC.1 and HC.2).
Hungary	Home care provided by private households (HP.7.2) is not included HC.3 Long-term nursing care includes – besides services provided in hospitals – only the manpower costs of medical personnel employed in social sector (nursing and residential homes).
Japan	Day-surgery reported under out-patient services. (Note: Day-care rehabilitation covered by LTCI is reported under day care.) Ancillary services (HC.4) includes only patient transport. Clinical laboratory and Diagnostic imaging are not included.
Korea	Functional classification does not include Long-term nursing care. Part of LTC might be included in HC.1-2. Day care is not separated but included in out-patient or in-patient care.
Mexico	Functional classification does not include Long-term nursing care. Part of LTC might be included in HC.1-2. In-patient care includes out-patient care provided in hospitals. Expenditure on medical goods by social security is included under in-patient services Day care is included in in-patient care
Netherlands	Mode of production has not yet been structurally applied. In the accounts pilot data by mode of production, related to the providers of care, are currently available only for 1998
Poland	In-patient care includes out-patient care provided in hospitals and day cases. HC.3.3 Long-tern nursing care: home care includes certain cash benefits (that should be reported under HC.R.7). Clinical laboratory (HC.4.1) and Diagnostic imaging (HC.4.2) are included in HC.1. Services of curative care; "non-classified" category was needed
Spain	As for households' out-of-pocket payments, in-patient services identical with COICOP[91] 6.3 (hospital expenditure) and out-patient care identical with COICOP 6.2 (includes also ancillary services) Long-term care expenditure does not include services provided by nursing homes and residential care facilities Occupational health care financed by private enterprises is not included
Switzerland	Day care is included in In-patient services Home care provided by private households (HP.7.2) is not included
Turkey	Functional classification does not include Long-term nursing care (HC 3) Services of curative home care (HC 1.4) and Day care (HC 1.2, HC 2.2). Part of LTC might be included in HC.1-2. "non-classified" category was created

91. Classification of Individual Consumption by Purpose.

Box A3 **Main departures from ICHA-HP**	
Australia	RoW is not included
Canada	The cost for general administration of health departments (that should be reported under HP.6.1) is included in HP.5 Part of the payments to laboratories (that should be reported under HP.3.5) is included in HP.3.1 Spending on services provided by RoW is partly excluded. When included, it is not identified separately from payments for in-country care.
Denmark	RoW: only services financed by government are included
Germany	No data available for HP.6.1 Government (excluding social insurance) health administration. HP.6 includes only administration costs of social insurance and private insurance HP.3.6 includes also Private households as provider of home care (that should be reported under HP.7.2)
Hungary	No data are reported for Private households as provider of home care. RoW: only services financed by social insurance are included
Japan	RoW is not included
Korea	RoW is not included
Mexico	RoW is not included
Netherlands	RoW: due to the small numbers and the consequent lower reliability of the data, this category is not separately presented
Poland	Subcategories of Providers of ambulatory health care could not be adequately separated (See: country chapter). Medical and diagnostic laboratories: only revenue from private sources are recorded under HP.3.5 “non-classified” category was created
Spain	Nursing and residential care facilities are not included As for private expenditure, Offices of dentists can not be separated from HP.3.1 RoW is not included
Switzerland	RoW is not included
Turkey	No data available for nursing and residential care facilities (HP.2); for providers outside the nationally defined health sector (HP.7) and for RoW (as providers) “non-classified” category was created

Structure of International Classification for Health Accounts

143. In the following the categories of classification by financing, function and provider are presented. The definitions are available in the SHA Manual (www.oecd.org/health/sha).

Health Expenditure by Financing

ICHA-HF code	SHA Category
HF.1	General government
HF.1.1	General government excluding social security funds
HF.1.1.1	Central government
HF.1.1.2	State/provincial government
HF.1.1.3	Local/municipal government
HF.1.2	Social security funds
HF.2	Private sector
HF.2.1	Private social insurance
HF.2.2	Private insurance enterprises (other than social insurance)
HF.2.3	Private household out-of-pocket expenditure
HF.2.3.1	Out-of-pocket excluding cost sharing
HF.2.3.2	Cost sharing: central government
HF.2.3.3	Cost sharing: state/provincial government
HF.2.3.4	Cost sharing: local/municipal government
HF.2.3.5	Cost sharing: social security funds
HF.2.3.6	Cost sharing: private social security funds
HF.2.3.7	Cost sharing: other private insurance
HF.2.3.9	All other cost sharing
HF.2.4	Non-profit institutions serving households (other than social insurance)
HF.2.5	Corporations (other than health insurance)
HF.3	Rest of the world

Health Expenditure by Function

ICHA-HC code	SHA Category
HC.1; HC.2	Services of curative and rehabilitative care
HC.1.1, 2.1	In-patient curative and rehabilitative care
HC.1.2, 2.2	Day cases of curative and rehabilitative care
HC.1.3, 2.3	Out-patient curative and rehabilitative care
HC.1.3.1	Basic medical and diagnostic services
HC.1.3.2	Out-patient dental care
HC.1.3.3	All other specialised health care
HC.1.3.9	All other out-patient curative care
HC.1.4	Services of curative home care
HC.2	Services of rehabilitative care
HC.2.1	In-patient rehabilitative care
HC.2.2	Day cases of rehabilitative care
HC.2.3	Out-patient rehabilitative care
HC.2.4	Services of rehabilitative home care
HC.3	Services of long-term nursing care
HC.3.1	In-patient long-term nursing care
HC.3.2	Day cases of long-term nursing care
HC.3.3	Long-term nursing care: home care
HC.4	Ancillary services to health care
HC.4.1	Clinical laboratory
HC.4.2	Diagnostic imaging
HC.4.3	Patient transport and emergency rescue
HC.4.9	All other miscellaneous ancillary services
HC.5	Medical goods dispensed to out-patients
HC.5.1	Pharmaceuticals and other medical non-durables
HC.5.1.1	Prescribed medicines
HC.5.1.2	Over-the-counter medicines
HC.5.1.3	Other medical non-durables
HC.5.2	Therapeutic appliances and other medical durables
HC.6	Prevention and public health services
HC.6.1	Maternal and child health; family planning and counselling
HC.6.2	School health services
HC.6.3	Prevention of communicable diseases
HC.6.4	Prevention of non-communicable diseases
HC.6.5	Occupational health care
HC.6.9	All other miscellaneous public health services
HC.7	Health administration and health insurance
HC.7.1	General government administration of health
HC.7.1.1	General government administration of health (except social security)
HC.7.1.2	Administration, operation and support activities of social security funds
HC.7.2	Health administration and health insurance: private
HC.7.2.1	Health administration and health insurance: social insurance
HC.7.2.2	Health administration and health insurance: other private

Health Related Expenditures

HC.R.1	Capital formation of health care provider institutions
HC.R.2	Education and training of health personnel
HC.R.3	Research and development in health
HC.R.4	Food, hygiene and drinking water control
HC.R.5	Environmental health
HC.R.6	Administration and provision of social services in kind to assist living with disease and impairment
HC.R.7	Administration and provision of health-related cash-benefits

Health Expenditure by Provider

ICHA-HP code	SHA Category
HP.1	Hospitals
HP.1.1	General hospitals
HP.1.2	Mental health and substance abuse hospitals
HP.1.3	Speciality (other than mental health and substance abuse) hospitals
HP.2	Nursing and residential care facilities
HP.2.1	Nursing care facilities
HP.2.2	Residential mental retardation, mental health and substance abuse facilities
HP.2.3	Community care facilities for the elderly
HP.2.9	All other residential care facilities
HP.3	Providers of ambulatory health care
HP.3.1	Offices of physicians
HP.3.2	Offices of dentists
HP.3.3	Offices of other health practitioners
HP.3.4	Out-patient care centres
HP.3.4.1	Family planning centres
HP.3.4.2	Out-patient mental health and substance abuse centres
HP.3.4.3	Free-standing ambulatory surgery centres
HP.3.4.4	Dialysis care centres
HP.3.4.5	All other out-patient multi-speciality and co-operative service centres
HP.3.4.9	All other out-patient community and other integrated care centres
HP.3.5	Medical and diagnostic laboratories
HP.3.6	Providers of home health care services
HP.3.9	Other providers of ambulatory health care
HP.3.9.1	Ambulance services
HP.3.9.2	Blood and organ banks
HP.3.9.9	Providers of all other ambulatory health care services
HP.4	Retail sale and other providers of medical goods
HP.4.1	Dispensing chemists
HP.4.2	Retail sale and other suppliers of optical glasses and other vision products
HP.4.3	Retail sale and other suppliers of hearing aids
HP.4.4	Retail sale & other suppliers of medical appliances (other than optical glasses & hearing aids)
HP.4.9	All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods
HP.5	Provision and administration of public health programmes
HP.6	General health administration and insurance
HP.6.1	Government administration of health
HP.6.2	Social security funds
HP.6.3	Other social insurance
HP.6.4	Other (private) insurance
HP.6.9	All other providers of health administration
HP.7	Other industries (rest of the economy)
HP.7.1	Establishments as providers of occupational health care services
HP.7.2	Private households as providers of home care
HP.7.9	All other industries as secondary producers of health care
HP.9	Rest of the world

Structure of the three most widely used SHA Tables

Table 2. Current expenditure on health by function of care and provider industry

		Health care provider industry																				Other industries	RoW
		HP.1	**HP.2**	**HP.3**	HP.3.1	HP.3.2	HP.3.3	HP.3.4	HP.3.5	HP.3.6	HP.3.9	**HP.4**	HP.4.1	HP.4.2-4.9	**HP.5**	**HP.6**	HP.6.1	HP.6.2	HP.6.3	HP.6.4	HP.6.9	**HP.7**	**HP.9**
Health care by function	ICHA-HC code	Hospitals	Nursing and residential care facilities	Providers of ambulatory health care	Offices of physicians	Offices of dentists	Offices of other health practitioners	Out-patient care centres	Medical and diagnostic laboratories	Providers of home health care services	All other providers of ambulatory health care	Retail sale and other providers of medical goods	Dispensing chemists	All other sales of medical goods	Provision and administration of public health programmes	General health administration and insurance	Government administration of health	Social security funds	Other social insurance	Other (private) insurance	All other health administration	All other industries	Rest of the world
In-patient care																							
Curative and rehabilitative care	HC.1.1; 2.1																						
Long-term nursing care	HC.3.1																						
Services of day-care																							
Curative and rehabilitative care	HC.1.2; 2.2																						
Long-term nursing care	HC.3.2																						
Out-patient care																							
Out-patient curative and rehabilitative care	HC.1.3; 2.3																						
Basic medical and diagnostic services	HC.1.3.1																						
Out-patient dental care	HC.1.3.2																						
All other specialised health care	HC.1.3.3																						
All other out-patient care	HC.1.3.3																						
Home care																							
Curative and rehabilitative care	HC.1.4; 2.4																						
Long-term nursing care	HC.3.3																						
Ancillary services to health care	HC.4																						
Medical goods dispensed to out-patients	HC.5																						
Pharmaceut. and other medical non-durables	HC.5.1																						
Therap. appliances and other med. durables	HC.5.2																						
Total expenditure on personal health care																							
Prevention and public health services	HC.6																						
Health administration and health insurance	HC.7																						
Total current expenditure on health care																							

Table 3. Current expenditure on health by provider industry and source of funding

		Total current expenditure on health	**HF.1** General government	HF.1.1 General government (excl. social security)	HF.1.2 Social security funds	**HF.2** Private sector	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3** Rest of the world
Health care goods and services by provider industry													
Hospitals	HP.1												
Nursing and residential care facilities	HP.2												
Providers of ambulatory health care	HP.3												
Offices of physicians	HP.3.1												
Offices of dentists	HP.3.2												
Offices of other health practitioners	HP.3.3												
Out-patient care centres	HP.3.4												
Medical and diagnostic laboratories	HP.3.5												
Providers of home health care services	HP.3.6												
Other providers of ambulatory health care	HP.3.9												
Retail sale and other providers of medical goods	HP.4												
Dispensing chemists	HP.4.1												
All other sales of medical goods	HP.4.2-4.9												
Provision and administration of public health programmes	HP.5												
General health administration and insurance	HP.6												
Government (excluding social insurance)	HP.6.1												
Social security funds	HP.6.2												
Other social insurance	HP.6.3												
Other (private) insurance	HP.6.4												
All other providers of health administration	HP.6.9												
Other industries (rest of the economy)	HP.7												
Occupational health care	HP.7.1												
Private households	HP.7.2												
All other secondary producers	HP.7.9												
Rest of the world	HP.9												

Table 4. Current expenditure on health by function of care and source of funding

		Total expenditure	**HF.1** General government	HF.1.1 General government (excl. social security)	HF.1.2 Social security funds	**HF.2** Private sector	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance schemes	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit institutions (other than social insurance)	HF.2.5 Corporations (other than health insurance)	**HF.3** Rest of the world
Current expenditure on health care													
Personal health care services	HC.1-HC.4												
In-patient services													
Day care services													
Out-patient services													
Home care services													
Ancillary services to health care	HC.4												
Medical goods dispensed to out-patients	HC.5												
Pharmaceuticals and other medical non-durables	HC.5.1												
Therapeutic appliances and other medical durables	HC.5.2												
Personal health care services and goods	HC.1 - HC.5												
Prevention and public health services	HC.6												
Health administration and health insurance	HC.7												

ANNEX II

LIST OF CONTRIBUTORS TO THE *SHA-BASED NATIONAL HEALTH ACCOUNTS* PROJECT

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ANNEX III CURRENT STATUS OF SHA IMPLEMENTATION IN THE NON-PARTICIPATING OECD COUNTRIES

144. The following table provides a 'snapshot' picture of the current status of SHA implementation in OECD countries, including those that have not contributed SHA tables to this volume. The annex also presents further information provided by members of the *OECD Network of health accounts experts and correspondents for health expenditure data.*

Status of implementation of the *OECD System of Health Accounts*, as of May 2004

	SHA-based health accounts regularly produced / or a pilot SHA study already undertaken	SHA study / or preparatory work for SHA project currently under way	Considering implementation; resources not yet allocated	No immediate plans for SHA implementation
Australia	X			
Austria		X		
Belgium		X		
Canada	X			
Czech Republic		X		
Denmark	X			
Finland	X			
France		X		
Germany	X			
Greece			X	
Hungary	X			
Iceland			X	
Ireland		X		
Italy				X
Japan	X			
Korea	X			
Luxembourg		X		
Mexico	X			
Netherlands	X			
New Zealand				X
Norway		X		
Poland	X			
Portugal		X		
Slovak Republic		X		
Spain	X			
Sweden		X		
Switzerland	X			
Turkey	X			
United Kingdom	X			
United States	X			

Austria

145. In Austria, STATISTICS AUSTRIA is responsible for Data on health expenditure.

146. Data on health expenditure are produced by the Directorate of Macro-economic Statistics of STATISTICS AUSTRIA. The conceptual framework of these data is the European System of Accounts (ESA 95). Health expenditure is defined according to the aggregate of national accounts (Use-concept). Data on health expenditure are not generated from SHA implementation.

147. Preparations for the SHA project are made under the Federal Ministry of Health and Women.

Czech Republic

148. In the Czech Republic there are several producers of health expenditure data that are prepared for different reasons and users. These data differ in the structure, methodology and data sources used. The need to improve national reporting on health expenditure, and use more comprehensive and consistent methodology in an international context, has prompted discussions on the implementation of the SHA methodology. A pilot study, initiated and undertaken by the Czech Statistical Office (CZSO) with the close cooperation of the Institute of Health Information and Statistics of the Czech Republic (IHIS), and with the support of other institutions, began in 2001.

149. The preparatory phase of this study consisted of the translation of the OECD manual, converting current classifications into ICHA, the monitoring of actual and potential data sources and the preparation of a methodology for new data collection and reporting. Proceedings with health insurance companies, the main financiers of health care in the Czech Republic, were of crucial importance because they provided a new interface for data collection reflecting SHA methodology. After a test collection of the data was carried out and evaluated, the first SHA estimates were presented by the CZSO in 2004 in "An Analysis of Health Accounts in the Czech Republic 2000-2002."

150. The work has been continuing by introducing other data sources, especially by adapting present statistical reports, solving appropriate evaluation of types of health care according to classifications of SHA and reviewing their consistency when combining data from different sources.

Finland

151. In 2001, the National Research and Development Centre for Welfare and Health (STAKES) assigned a working group to deal with the accounting of health expenditure and financing in Finland. The working group completed its work at the end of 2002 and proposed that Finland change to an accounting system based on the SHA framework for both national and international health expenditure accounting.

152. The SHA statistical framework will be fully implemented in the health expenditure accounting in 2006 with data for 2004. At the same time, data from previous years shall be made compliant with the new framework. The working group carried out a pilot implementation with data for 2000. According to the trial implementation with the 2000 data and the update of the content of the health expenditure account, the GDP share increased by 0.6 percentage points in 2000.

Greece

153. The Greek Government intends to start work on implementing the development of Health Accounts according to the SHA framework. To this purpose, the new government is considering the creation of an administrative mechanism including the National Statistical Service, the Ministry of National Economy, Division of National Accounts, and the University of Athens to oversee the adaptation of national accounts to the SHA methodology. The work plan provides for the initiation of work by early 2005 and completing a three-phase work schedule by the end of 2006.

Italy

154. The SHA framework is not used as central methodology for Italian Health Accounts. The implementation of the SHA needs the improvement of the available statistics and the development of new surveys. At the moment neither the National Institute of Statistics (Istat) nor the Ministry of Health have any plan to improve or reorganise the data due to lack of resources. However, during the OECD meeting of Health Ministries held in Paris on 12-13 May 2004 Italy indicated the SHA was one of the priority projects.

155. Istat provides yearly data on health expenditure to the OECD for the update of the Health Data database. The provided aggregates represent an estimate based on the National Accounts, calculated according to the European system of accounts ESA95 as close as possible to the SHA definitions.

156. Nevertheless, there are some problems when linking SHA tables to National Accounts. The national accounts do not allow the level of disaggregation indicated by the SHA tables.

157. The major part difficulty in the implementation of the SHA methodology is the lack of suitable statistics and surveys able to provide analysis of health activities by type, above all for the private sector, for which there are no specific surveys.

Norway

158. Statistics Norway is developing Health accounts according to the SHA framework. The project is partly funded by the Directorate for Health and Social Affairs. Norway has provided data for OECD Health Data 2004 dating back to the early nineties, including preliminary figures for 2002 and 2003. Norway is planning to send more comprehensive data by September 24, 2004, in time for the release of the second and final Internet update to OECD Health Data 2004.

159. Until recently, Norway has provided data on a regular basis but only for the main aggregates. The SHA manual presents a set of standard tables, and the initial aim is to provide the first five of these tables. According to the flexibility within the framework of SHA, not all aspects need to be developed at once, and we are continuously working on further enhancing the set of indicators and data needed for the complete set of tables.

160. Data in the System of Health Accounts is consistent and in line with macroeconomic data from the National Accounts. Due to the data needed within SHA, some classifications have been changed and new products established in the Norwegian NA.

161. We have received detailed data from hospitals and local government dating back to 2001 that have enabled us to compile SHA tables, such as the reporting of health care according to function of care

and the provider industry. Another example is the reconciliation of national boundaries between the function of health care, social care and health-related functions.

162. We are planning to publish the most recent tables from the Norwegian SHA on the website by late 2004.

Slovak Republic

163. In 2001 the Ministry of Health appointed the Institute of Health Information and Statistics to provide health indicators for the OECD Health Data database. The IHIS annually provides Slovak health expenditure data according to the definitions of OECD Health Data. This set of health expenditure indicators is gathered using a 'top-down' approach. The data is then recalculated and adjusted in order to comply with OECD definitions. The first results of SHA implementation were presented at the OECD Meeting of Experts in National Health Accounts held on 27-28 October, 2003.

164. In 2004, IHIS and the Statistical Office of the Slovak Republic (S.O.SR) submitted the study 'The System of Health Accounts in the Slovak Republic' to EUROSTAT. Both institutions believe that it is necessary to analyse health care providers on concrete activities. This analysis would be based on breaking down total health care expenditure into items as defined by SHA and SNA criteria. In the course of further implementation of the SHA method, a "bottom-up" approach has been recommended. This method will help identify some of the currently poorly implemented aspects of SHA and establish the priorities for their resolution in the national context.

165. At this moment the Ministry of Health, in cooperation with IHIS and S.O.SR, has identified an interbranch expert group to implement the SHA in SR. Representatives from the SR Ministry of Finance and health insurance companies (HIC) are also participating in this expert group. Implementing a common methodology in SR will be demanding due to the complex structure of the public health system and ongoing public health reform.

United Kingdom

166. In the UK, the Office for National Statistics (ONS) is developing Health Accounts according to the SHA framework. ONS first published UK Health Accounts on an experimental basis on 27 February 2003 with estimates for the financial year 1999/2000. The experimental status of the estimates indicates that they are in the testing phase and that the methods used are not fully developed. The primary purpose of publication was to provide users with a flavour of the UK Health Accounts, in order to stimulate debate about their value. The publication of UK Health Accounts will continue on an experimental basis with the next publication due by mid 2004.

167. Due to user demand the initial focus of the Health Accounts Team at ONS has been on producing reliable and consistent estimates for total UK health expenditure. The ONS has published total UK health expenditure on three separate occasions, twice on an experimental basis in February 2002 and February 2003, and most recently on 16 December 2003 as National Statistics. This latest release covers total health expenditure for 1997-2002 and is published as National Statistics as the figures have been judged to be fit for purpose and the sources and methods used have been more fully developed. In the next stage of development more focus will be put on improving the methods and processes used to compile the UK Health Accounts whilst ensuring that they are tailored to meet user demand and specific national needs.

168. On a separate but related workstream the ONS has recently produced a working draft of SHA Guidelines, which is a manual that provides practical guidance to EU countries wishing to implement the SHA. SHA Guidelines is the first and main output of a project entitled "Support Package for Applying the Manual of Health Accounts in the EU", which has been co-financed by Eurostat and the ONS. The development of the UK Health Accounts has directly benefited from this work, which will become apparent in the next Health Accounts publication in 2004.

169. For more information on UK Health Accounts and for the results from the first Health Accounts publication see the following web page and associated links www.statistics.gov.uk/healthaccounts, or contact the Health Accounts Team at health.accounts@ons.gov.uk

United States

170. In the US, the National Health Statistics Group, Office of the Actuary, Centers for Medicare & Medicaid Services, is responsible for developing National Health Accounts. These are produced on an annual basis and are available at our website (http://www.cms.hhs.gov/statistics/nhe/default.asp). These annual statistics are available for the period 1960-2002. The current U.S. health accounts are reported as a matrix of spending by source of funding and type of service.

171. Estimates of US total health expenditure reported to the OECD Health Data are harmonized with the SHA definition of total health expenditure. However, because there are differences in the definitions used in the SHA and the US health accounts, the estimates reported in the OECD Health Data do not to agree with the values reported in US National Health Accounts. The US has produced pilot SHA tables for 1997, which were presented at the OECD Meeting of Experts on NHA in 2001. We have not yet fully developed the U.S. accounts on a SHA basis, although we have begun to study the possibility and are hopeful in the near future to produce more elements on this basis.

PART II – COMPARATIVE TABLES

Notes to tables:

1. All tables except where indicated refer to the following years for each country:
   - Canada, Denmark, Poland: 1999
   - Australia, Japan, Turkey: 2000
   - Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001
2. In the case of Canada and the Netherlands the sum of the sub-components of private expenditure is smaller than the figure for total private expenditure due to the following deviations from the ICHA-HF:

   Canada: Private sector includes a specific sub-category, namely non-patient revenues received by health care providers (such as donations and investment income, health research funded by private sources, etc.) Such a sub-category is not distinguished by the ICHA-HF, but this amount is included in total private expenditure, therefore the sub-components of private expenditure do not add up to total private expenditure.

   Netherlands: In the Dutch health accounts, non-profit organisations and corporations are not separated, but reported together under the category of "other private" expenditure.
3. Switzerland: All tables refer to total health expenditure – capital formation is included in HC.1-HC.7.
4. Denmark: All tables refer to current health expenditure.
5. Mexico: Expenditure on ***medical goods*** by social security is included under in-patient services in all the relevant tables.
6. Germany, Mexico, Netherlands and Poland: ***In-patient*** care includes out-patient care provided in hospitals.
7. If not reported separately, ***day care*** might be included under in-patient or out-patient care (see Box A5 in Methodological Notes in Part I).
8. Japan, Korea, Mexico, Poland, : Clinical laboratory (HC.4.1) and Diagnostic imaging (HC.4.2) are included in curative-rehabilitative care (HC1-2)
9. Korea, Mexico, Turkey: services of ***long-term nursing care*** are not included in total health expenditure or not separated from curative-rehabilitative care
10. In the functional classification, Canada, Hungary, Poland and Turkey used so called "Other / non-classified" category (HC.9), due to the fact that mapping total expenditure to ICHA-HC could not be fully implemented.
11. **Zero or non-available values are denoted by the symbol '-'**. '0' or '0.0' values in a table signify that the actual value is less than 0.5 or 0.05 respectively
12. Annex I summarises the main departures from the SHA.

172. For further explanations on country specific deviations from SHA-ICHA please consult Annex I: Methodology of each of the OECD Health Technical Papers.

Table 1.1a. Total health expenditure per capita, by financing agent (US$ PPP per capita) - latest year available

	Total expenditure on health	**HF.1 General government**	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2 Private sector**	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	2,354	1,619	1,619	-	-	-	735	164	-	164	465	-	106	-
Canada	2,405	1,692	1,660	73	1,586	32	714	270	244	27	393	-	-	-
Denmark	2,205	1,866	1,866	3	1,823	-	339	20	-	20	319	-	-	-
Germany	2,725	2,140	266	-	-	1,874	585	229	-	229	290	51	15	-
Hungary	961	663	111	85	26	552	298	3	3	-	266	10	20	-
Japan	1,958	1,591	312	-	-	1,279	366	6	-	6	330	-	30	-
Korea	920	504	94	-	-	410	416	21	21	-	340	4	51	-
Mexico	536	240	80	69	12	159	296	15	-	15	281	-	-	-
Netherlands	2,339	1,537	58	-	-	1,471	807	354	161	193	227	-	-	-
Poland	618	439	84	58	26	355	178	3	2	1	165	5	6	0
Spain	1,564	1,122	1,019	916	103	103	447	63	-	63	370	14	-	-
Switzerland	3,289	1,879	556	12	545	1,323	1,410	335	134	201	1,042	33	-	-
Turkey	446	281	125	100	25	156	165	19	3	16	123	7	16	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 4 in Notes to Tables.

Table 1.1b. Total health expenditure per capita, by financing agent (US$ PPP per capita) - 1999

	Total expenditure on health	**HF.1 General government**	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2 Private sector**	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	2,233	1,545	1,545	-	-	2,233	688	147	-	147	456	-	85	-
Canada	2,405	1,692	1,660	73	1,586	32	714	270	244	27	393	-	-	-
Denmark	2,205	1,866	1,866	3	1,823	-	339	20	-	20	319	-	-	-
Germany	2,555	2,008	258	-	-	1,751	547	209	-	209	278	46	14	-
Hungary	820	593	96	78	18	497	226	1	1	-	204	0	1	-
Japan	1,829	1,483	290	251	38	1,193	346	5	-	5	313	-	27	-
Korea	681	317	62	-	-	255	364	15	15	-	309	3	37	-
Mexico	462	221	68	58	10	153	241	10	-	10	231	-	-	-
Netherlands	2,019	1,330	58	-	-	1,270	693	309	136	173	202	-	-	-
Poland	618	439	84	58	26	355	178	3	2	1	165	5	6	0
Spain	1,460	1,057	958	862	95	99	408	55	-	55	339	13	-	-
Switzerland	2,993	1,656	462	9	453	1,194	1,337	312	246	66	995	29	-	-
Turkey	392	240	113	100	12	113	152	17	3	14	114	8	14	-

See additional notes 2 and 4 in Notes to Tables.

Table 1.2a. Total health expenditure by financing agent (% of GDP) - latest year available

	Total expenditure on health	**HF.1 General government**	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2 Private sector**	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	8.9	6.1	6.1	-	-	-	2.8	0.6	-	0.6	1.8	-	0.4	-
Canada	9.0	6.3	6.2	0.3	5.9	0.1	2.7	1.0	0.9	0.1	1.5	-	-	-
Denmark	8.2	6.9	6.9	0.0	6.8	-	1.3	0.1	-	0.1	1.2	-	-	-
Germany	10.7	8.4	1.0	-	-	7.4	2.3	0.9	-	0.9	1.1	0.2	0.1	-
Hungary	7.4	5.1	0.8	0.6	0.2	4.2	2.3	0.0	0.0	-	2.0	0.1	0.2	-
Japan	7.6	6.1	1.2	-	-	4.9	1.4	0.0	-	0.0	1.3	-	0.1	-
Korea	5.8	3.2	0.6	-	-	2.6	2.6	0.1	0.1	-	2.1	0.0	0.3	-
Mexico	6.0	2.7	0.9	0.8	0.1	1.8	3.3	0.2	-	0.2	3.1	-	-	-
Netherlands	8.1	5.4	0.2	-	-	5.1	2.8	1.2	0.6	0.7	0.8	-	-	-
Poland	6.3	4.5	0.9	0.6	0.3	3.6	1.8	0.0	0.0	0.0	1.7	0.0	0.1	0.0
Spain	7.5	5.4	4.9	4.4	0.5	0.5	2.1	0.3	-	0.3	1.8	0.1	-	-
Switzerland	10.9	6.2	1.8	0.0	1.8	4.4	4.7	1.1	0.4	0.7	3.5	0.1	-	-
Turkey	6.6	4.2	1.9	1.5	0.4	2.3	2.5	0.3	0.0	0.2	1.8	0.1	0.2	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 4 in Notes to Tables.

Table 1.2b. Total health expenditure by financing agent (% of GDP) - 1999

	Total expenditure on health	**HF.1 General government**	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2 Private sector**	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	8.8	6.1	6.1	-	-	8.8	2.7	0.6	-	0.6	1.8	-	0.3	-
Canada	9.0	6.3	6.2	0.3	5.9	0.1	2.7	1.0	0.9	0.1	1.5	-	-	-
Denmark	8.2	6.9	6.9	0.0	6.8	-	1.3	0.1	-	0.1	1.2	-	-	-
Germany	10.6	8.4	1.1	-	-	7.3	2.3	0.9	-	0.9	1.2	0.2	0.1	-
Hungary	7.4	5.3	0.9	0.7	0.2	4.5	2.0	0.0	0.0	-	1.8	0.0	0.0	-
Japan	7.4	6.0	1.2	1.0	0.2	4.8	1.4	0.0	-	0.0	1.3	-	0.1	-
Korea	5.0	2.3	0.5	-	-	1.9	2.7	0.1	0.1	-	2.3	0.0	0.3	-
Mexico	5.6	2.7	0.8	0.7	0.1	1.8	2.9	0.1	-	0.1	2.8	-	-	-
Netherlands	7.9	5.2	0.2	-	-	5.0	2.7	1.2	0.5	0.7	0.8	-	-	-
Poland	6.3	4.5	0.9	0.6	0.3	3.6	1.8	0.0	0.0	0.0	1.7	0.0	0.1	0.0
Spain	7.5	5.4	4.9	4.4	0.5	0.5	2.1	0.3	-	0.3	1.7	0.1	-	-
Switzerland	10.5	5.8	1.6	-	-	4.2	4.7	1.1	0.9	0.2	3.5	0.1	-	-
Turkey	6.4	3.9	1.9	1.6	0.2	1.9	2.5	0.3	0.0	0.2	1.9	0.1	0.2	-

See additional notes 2 and 4 in Notes to Tables.

Table 1.3. Total health expenditure by financing agent (Total health expenditure = 100)

	Total expenditure on health	**HF.1** **General government**	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2** **Private sector**	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3** **Rest of the world**
Australia	100.0	68.8	68.8	-	-	-	31.2	7.0	-	7.0	19.7	-	4.5	-
Canada	100.0	70.3	69.0	3.0	66.0	1.3	29.7	11.2	10.1	1.1	16.3	-	-	-
Denmark	100.0	84.6	84.6	0.1	82.7	-	15.4	0.9	-	0.9	14.5	-	-	-
Germany	100.0	78.5	9.8	-	-	68.8	21.5	8.4	-	8.4	10.6	1.9	0.5	-
Hungary	100.0	69.0	11.5	8.8	2.7	57.4	31.0	0.3	0.3	-	27.7	1.0	2.0	-
Japan	100.0	81.3	15.9	-	-	65.4	18.7	0.3	-	0.3	16.9	-	1.5	-
Korea	100.0	54.7	10.2	-	-	44.6	45.3	2.2	2.2	-	37.0	0.4	5.6	-
Mexico	100.0	44.8	15.0	12.8	2.2	29.8	55.2	2.8	-	2.8	52.5	-	-	-
Netherlands	100.0	65.7	2.5	-	-	62.9	34.5	15.1	6.9	8.3	9.7	-	-	-
Poland	100.0	71.1	13.6	9.3	4.3	57.6	28.8	0.4	0.3	0.1	26.6	0.8	1.0	0.03
Spain	100.0	71.7	65.1	58.5	6.6	6.6	28.6	4.0	-	4.0	23.7	0.9	-	-
Switzerland	100.0	57.1	16.9	0.4	16.6	40.2	42.9	10.2	4.1	6.1	31.7	1.0	-	-
Turkey	100.0	62.9	28.0	22.4	5.6	34.9	37.1	4.4	0.7	3.6	27.6	1.5	3.6	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional note 2 in Notes to Tables.

Table 1.4. Total private expenditure on health by financing agent (Total private expenditure on health = 100)

	HF.2	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
	Private sector	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	22.3	-	22.3	63.2	-	14.5	
Canada	100.0	37.9	34.1	3.7	55.1	-	-	
Denmark	100.0	5.8	-	5.8	94.2	-	-	
Germany	100.0	39.2	-	39.2	49.6	8.7	2.5	
Hungary	100.0	1.0	1.0	-	89.3	3.2	6.6	
Japan	100.0	1.7	-	1.7	90.1	-	8.2	
Korea	100.0	5.0	5.0	-	81.8	0.9	12.3	
Mexico	100.0	5.0	-	5.0	95.0	-	-	
Netherlands	100.0	43.9	19.9	23.9	28.2	-	-	
Poland	100.0	1.5	1.2	0.3	92.4	2.7	3.4	
Spain	100.0	14.1	-	14.1	82.8	3.1	-	
Switzerland	100.0	23.8	9.5	14.3	73.9	2.3	-	
Turkey	100.0	11.8	2.0	9.8	74.6	3.9	9.7	

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional note 2 in Notes to Tables.

Table 2.1a. Total health expenditure per capita, by function (US$ PPP per capita) - latest year available

	HC.1;HC.2 Curative and rehabilitative care	HC.3 Long-term nursing care	HC.4 Ancillary services	**HC.1-4 Personal medical services**	HC.5 Medical goods	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	**HC.1-5 Personal medical services & goods**	HC.6 Prevention and public health	HC.7 Health admin. and insurance	HC.9 Other/non-classified	**CURRENT EXPENDITURE ON HEALTH**	HC.R.1 Gross capital formation	**TOTAL EXPENDITURE ON HEALTH**
Australia	1,377	163	142	1,682	419	329	89	2,100	35	77	-	2,212	142	2,354
Canada	1,114	332	197	1,643	434	373	61	2,077	167	47	20	2,311	94	2,405
Denmark	1,089	604	91	1,785	324	205	119	2,109	52	44	-	2,205	-	2,205
Germany	1,378	291	172	1,841	536	390	146	2,377	124	147	-	2,648	77	2,725
Hungary	468	15	53	537	316	274	42	852	47	16	4	920	37	957
Japan	1,188	203	12	1,403	383	365	17	1,786	59	43	-	1,887	71	1,958
Korea	574	-	-	574	243	220	23	817	13	39	-	869	51	920
Mexico	354	-	1	355	106	-	-	461	16	49	-	526	5	531
Netherlands	1,327	283	55	1,664	430	-	-	2,094	122	114	-	2,329	44	2,373
Poland	316	37	19	386	161	151	11	547	22	26	14	595	23	618
Spain	983	32	51	1,066	391	336	55	1,457	22	35	-	1,514	50	1,564
Switzerland	1,887	645	105	2,636	416	349	67	3,052	76	162	-		-	3,289
Turkey	215		15	230	124	110	5	354	10	10	52	426	19	446

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 4, 5, 8 and 9 in Notes to Tables.

Table 2.1b. Total health expenditure per capita, by function (US$ PPP per capita) - 1999

	HC.1;HC.2 Curative and rehabilitative care	HC.3 Long-term nursing care	HC.4 Ancillary services	**HC.1-4 Personal medical services**	HC.5 Medical goods	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	**HC.1-5 Personal medical services & goods**	HC.6 Prevention and public health	HC.7 Health admin. and insurance	HC.9 Other/non-classified	**CURRENT EXPENDITURE ON HEALTH**	HC.R.1 Gross capital formation	**TOTAL EXPENDITURE ON HEALTH**
Australia	1,313	167	139	1,619	363	285	78	1,982	35	78	-	2,095	138	2,233
Canada	1,114	332	197	1,643	434	373	61	2,077	167	47	20	2,311	94	2,405
Denmark	1,089	604	91	1,785	324	205	119	2,109	52	44	-	2,205	-	2,205
Germany	1,303	275	162	1,740	486	345	142	2,227	115	138	-	2,480	75	2,555
Hungary	396	16	40	453	269	-	1	721	40	17	3	781	42	823
Japan	1,126	174	10	1,310	351	336	15	1,662	54	36	-	1,751	77	1,829
Korea	441	-	-	441	156	141	15	597	12	32	-	641	40	681
Mexico	277	-	-	277	86	-	-	362	3	39	49	454	5	459
Netherlands	1,142	234	49	1,424	367	-	-	1,791	108	108	-	2,006	35	2,041
Poland	316	37	19	386	161	151	11	547	22	26	14	595	23	618
Spain	863	28	44	934	334	290	44	1,268	17	29	-	1,314	40	1,354
Switzerland	1,716	573	100	2,390	374	314	60	2,764	73	155	-		-	2,993
Turkey	200		13	213	107	95	4	320	11	7	38	376	16	392

See additional notes 3, 4, 5, 8 and 9 in Notes to Tables.

Table 2.2. Total health expenditure by function (Total health expenditure = 100)

	HC.1;HC.2 Curative and rehabilitative care	HC.3 Long-term nursing care	HC.4 Ancillary services	**HC.1-4 Personal medical services**	HC.5 Medical goods	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	**HC.1-5 Personal medical services & goods**	HC.6 Prevention and public health	HC.7 Health admin. and insurance	HC.9 Other/non-classified	**CURRENT EXPENDITURE ON HEALTH**	HC.R.1 Gross capital formation	**TOTAL EXPENDITURE ON HEALTH**
Australia	58.5	6.9	6.0	71.4	17.8	14.0	3.8	89.2	1.5	3.3	-	94.0	6.0	100.0
Canada	46.3	13.8	8.2	68.3	18.1	15.5	2.5	86.4	6.9	1.9	0.8	96.1	3.9	100.0
Denmark	49.4	27.4	4.1	80.9	14.7	9.3	5.4	95.6	2.4	2.0	-	100.0	-	100.0
Germany	50.6	10.7	6.3	67.6	19.7	14.3	5.4	87.2	4.5	5.4	-	97.2	2.8	100.0
Hungary	48.7	1.6	5.5	55.9	32.9	28.5	4.3	88.7	4.9	1.7	0.4	95.7	3.9	99.6
Japan	60.7	10.4	0.6	71.7	19.5	18.7	0.9	91.2	3.0	2.2	-	96.4	3.6	100.0
Korea	62.4	-	-	62.4	26.4	24.0	2.5	88.8	1.4	4.2	-	94.4	5.6	100.0
Mexico	66.2	-	0.1	66.3	19.9	-	-	86.2	2.9	9.1	-	98.1	0.9	99.1
Netherlands	55.9	11.9	2.3	70.1	18.1	-	-	88.2	5.1	4.8	-	98.1	1.9	100.0
Poland	51.2	6.0	3.0	62.4	26.1	24.4	1.7	88.5	3.6	4.1	2.2	96.3	3.7	100.0
Spain	62.8	2.1	3.2	68.1	25.0	21.4	3.5	93.1	1.4	2.3	-	96.8	3.2	100.0
Switzerland	57.4	19.6	3.2	80.1	12.6	10.6	2.0	92.8	2.3	4.9	-		-	100.0
Turkey	48.3	-	3.3	51.6	27.8	24.8	1.2	79.4	2.3	2.2	11.7	95.6	4.4	100.0

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 4, 5, 8 and 9 in Notes to Tables.

Table 3.1a. Current health expenditure per capita, by function (mode of production) (US$ PPP per capita) - latest year available

	Current expenditure on health care	HC.1-HC.4 Personal medical services	HC.1.1; 2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2;3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health	HC.7 Health admin. and insurance	HC.9 Other/Non-classified
Australia	2,212	1,682	796	633	163	-	745	445	122	0	178	(0)	142	419	329	89	35	77	-
Canada	2,311	1,643	722	435	287	69	608	96	187	207	71	48	197	434	373	61	167	47	20
Denmark	2,205	1,785	1,155	644	511	34	411	78	106	158	67	84	91	324	205	119	52	44	-
Germany	2,648	1,841	982	811	172	-	567	140	216	137	74	120	172	536	390	146	124	147	-
Hungary	920	538	268	255	14	11	206	38	78	73	17	1	52	316	274	42	47	16	4
Japan	1,887	1,403	752	555	197	13	619	492	127	-	-	8	12	383	365	17	59	43	-
Korea	869	574	206	-	-	-	368	-	-	-	-	-	-	243	220	23	13	39	-
Mexico	526	355	223	-	-	-	130	-	-	-	-	1	1	106	-	-	16	49	-
Netherlands	2,329	1,664	-	-	-	-	-	-	-	-	-	-	55	430	-	-	122	114	-
Poland	550	356	172	170	3	1	121	74	22	24	-	32	17	149	139	10	21	24	13
Spain	1,514	1,066	443	411	32	14	551	-	-	-	-	6	51	391	336	55	22	35	-
Switzerland	3,289	2,636	1,555	977	578	-	910	635	209	55	11	67	105	416	349	67	76	162	-
Turkey	426	230	89	89	-	-	127	123	19	-	-	-	15	124	110	5	10	10	52

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 3.1b. Current health expenditure per capita, by function (mode of production) (US$ PPP per capita) - 1999

	Current expenditure on health care	HC.1-HC.4 Personal medical services	HC.1.1; 2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2;3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health	HC.7 Health admin. and insurance	HC.9 Other/Non-classified
Australia	2,095	1,619	790	623	167	-	690	328	113	0	250	-	139	363	285	78	35	78	-
Canada	2,311	1,643	722	435	287	69	608	96	187	207	71	48	197	434	373	61	167	47	20
Denmark	2,205	1,785	1,155	644	511	34	411	78	106	158	67	84	91	324	205	119	52	44	-
Germany	2,507	1,759	943	781	163	-	536	135	199	131	71	116	164	492	349	143	116	140	-
Hungary	781	455	241	225	15	9	165	37	59	60	8	1	40	269	-	127	40	17	1
Japan	1,751	1,310	703	534	169	-	592	470	122	-	-	5	10	351	336	15	54	36	-
Korea	641	441	194	-	-	-	247	-	-	-	-	-	-	156	141	15	12	32	-
Mexico	454	277	166	-	-		110	-	-	-	-	-	-	86	-	-	3	39	49
Netherlands	2,006	1,424	-	-	-	-	-	-	-	-	-	-	49	367	-	-	108	108	-
Poland	550	356	172	170	3	1	121	74	22	24	-	32	17	149	139	10	21	24	13
Spain	1,314	934	392	364	28	13	480	-	-	-	-	6	44	334	290	44	17	29	-
Switzerland	2,993	2,390	1,400	888	512	-	828	433	197	50	148	61	100	374	314	60	73	155	-
Turkey	376	213	83	83	-	-	117	109	17	-	-	-	13	107	95	4	11	7	38

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 3.2. Current health expenditure by function (mode of production) (Current health expenditure = 100)

	Current expenditure on health care	**HC.1.1; 2.1; 3.1** ***In-patient care***	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	**HC.1.2;2.2 ;3.2** ***Day-care***	**HC.1.3; 2.3** ***Out-patient care***	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	**HC.1.4; 2.4; 3.3** ***Home care***	**HC.4** ***Ancillary services***	**HC.5** ***Medical goods***	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	**HC.6** Prevention and public health	**HC.7** Health admin. and insurance	**HC.9** Other/Non-classified
Australia	100.0	36.0	28.6	7.3	-	33.7	20.1	5.5	0.0	8.0	(0.0)	6.4	18.9	14.9	4.0	1.6	3.5	-
Canada	100.0	31.2	18.8	12.4	3.0	26.3	4.1	8.1	8.9	3.1	2.1	8.5	18.8	16.2	2.6	7.2	2.0	0.9
Denmark	100.0	52.4	29.2	23.2	1.5	18.6	3.6	4.8	7.2	3.1	3.8	4.1	14.7	9.3	5.4	2.4	2.0	-
Germany	100.0	37.1	30.6	6.5	-	21.4	5.3	8.2	5.2	2.8	4.5	6.5	20.2	14.7	5.5	4.7	5.5	-
Hungary	100.0	29.2	27.7	1.5	1.2	22.4	4.1	8.5	7.9	1.9	0.1	5.6	34.3	29.8	4.5	5.1	1.7	0.4
Japan	100.0	39.8	29.4	10.4	0.7	32.8	26.1	6.7	-	-	0.4	0.7	20.3	19.4	0.9	3.1	2.3	-
Korea	100.0	23.7	-	-	-	42.4	-	-	-	-	-	-	28.0	25.4	2.6	1.5	4.5	-
Mexico	100.0	42.4	-	-	-	24.8	-	-	-	-	0.2	0.1	20.2	-	-	2.9	9.3	-
Netherlands	100.0	-	-	-	-	-	-	-	-	-	-	2.3	18.4	-	-	5.2	4.9	-
Poland	100.0	31.3	30.8	0.5	0.2	22.1	13.5	4.0	4.4	-	5.7	3.1	27.1	25.3	1.8	3.8	4.3	2.3
Spain	100.0	29.3	27.2	2.1	0.9	36.4	-	-	-	-	0.4	3.4	25.8	22.2	3.7	1.4	2.3	-
Switzerland	100.0	47.3	29.7	17.6	-	27.7	19.3	6.4	1.7	0.3	2.0	3.2	12.6	10.6	2.0	2.3	4.9	-
Turkey	100.0	20.8	20.8	-	-	29.7	28.8	4.4	-	-	-	3.5	29.1	25.9	1.3	2.4	2.3	12.3

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 3.3. Current expenditure on personal health services by function (mode of production) (Current expenditure on personal health services = 100)

	Current expenditure on personal medical services	**HC.1.1; 2.1; 3.1**	HC.1.1;2.1	HC.3.1	**HC.1.2;2.2 ;3.2**	**HC.1.3; 2.3**	HC.1.3.1	HC.1.3.2	HC.1.3.3	HC.1.3.9; 2.3	**HC.1.4; 2.4; 3.3**	**HC.4**
		In-patient care	Curative and rehabilitative care (inpatient)	Long-term nursing care (inpatient)	***Day-care***	***Out-patient care***	Basic medical and diagnostic services	Dental care	All other specialised health care	All other out-patient care	***Home care***	***Ancillary services***
Australia	100.0	47.3	37.6	9.7	-	44.3	26.5	7.2	0.0	10.6	(0.0)	8.4
Canada	100.0	43.9	26.5	17.5	4.2	37.0	5.8	11.4	12.6	4.3	2.9	12.0
Denmark	100.0	64.7	36.1	28.6	1.9	23.0	4.4	6.0	8.9	3.8	4.7	5.1
Germany	100.0	53.3	44.0	9.3	-	30.8	7.6	11.8	7.4	4.0	6.5	9.3
Hungary	100.0	49.9	47.4	2.6	2.0	38.3	7.0	14.6	13.6	3.2	0.2	9.6
Japan	100.0	53.6	39.5	14.0	0.9	44.1	35.1	9.0	-	-	0.5	0.9
Korea	100.0	35.8	-	-	-	64.2	-	-	-	-	-	-
Mexico	100.0	62.8	-	-	-	36.7	-	-	-	-	0.3	0.2
Netherlands	100.0	-	-	-	-	-	-	-	-	-	-	3.3
Poland	100.0	48.3	47.6	0.8	0.4	34.1	20.8	6.2	6.8	-	8.9	4.8
Spain	100.0	41.6	38.6	3.0	1.3	51.7	-	-	-	-	0.6	4.8
Switzerland	100.0	59.0	37.1	21.9	-	34.5	24.1	7.9	2.1	0.4	2.5	4.0
Turkey	100.0	38.5	38.5	-	-	55.1	53.3	8.1	-	-	-	6.5

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 4.1a. Current health expenditure per capita, by provider (US$ PPP per capita) - latest year available

	Current expenditure on health care	HP.1 Hospitals	HP.2 Nursing and residential facilities	HP.3 Providers of ambulatory care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	HP.4 Retail of medical goods	HP.5 Providers of public health programmes	HP.6 Health admin. and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds admin	HP.6.3, 6.4 Private insurance admin	HP.7 All other industries	HP.9 Rest of the world
Australia	2,212	790	154	756	313	108	96	102	91	(0)	46	401	30	81	48	-	32	-	-
Canada	2,311	745	230	673	338	187	71	-	-	45	32	434	155	47	11	-	36	7	-
Denmark	2,205	844	521	422	76	106	148	10	-	53	28	324	3	44	-	-	3	44	3
Germany	2,648	828	195	738	377	181	66	-	-	74	40	578	49	158	0	121	38	97	5
Hungary	920	321	3	216	37	74	-	75	3	1	27	316	46	16	4	12	-	-	2
Japan	1,887	954	55	545	399	130	-	-	-	5	12	231	59	43	-	36	6	-	-
Korea	869	261	-	349	215	83	47	4	-	-	-	191	10	42	19	23	-	16	-
Mexico	526	223	-	132	121	-	-	9	1	1	-	106	16	49	18	26	5	-	-
Netherlands	2,329	858	267	562	-	-	-	-	-	-	-	408	37	110	-	-	-	70	17
Poland	595	177	11	153	80	24	2	26	3	1	17	161	16	26	9	17	0	37	1
Spain	1,514	641	-	429	228	1	1	181	5	4	10	387	13	40	19	11	9	5	0
Switzerland	3,289	1,150	578	1,007	578	209	66	-	44	67	44	309	-	210	66	71	72	36	-
Turkey	426	162	-	101	38	15	0	33	13	-	1	121	2	9	1	4	5	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

Table 4.1b. Current health expenditure per capita, by provider (US$ PPP per capita) - 1999

	Current expenditure on health care	HP.1 Hospitals	HP.2 Nursing and residential facilities	HP.3 Providers of ambulatory care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	HP.4 Retail of medical goods	HP.5 Providers of public health programmes	HP.6 Health admin. and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds admin	HP.6.3, 6.4 Private insurance admin	HP.7 All other industries	HP.9 Rest of the world
Australia	2,095	808	152	709	305	808	78	84	89	(0)	47	314	34	78	49	-	29	-	-
Canada	2,311	745	230	673	338	187	71	-	-	45	32	434	155	47	11	-	36	7	-
Denmark	2,205	844	521	422	76	106	148	10	-	53	28	324	3	44	-	-	3	44	3
Germany	2,480	789	183	694	358	169	63	-	-	68	37	522	45	149	0	112	36	93	5
Hungary	781	288	4	163	35	55	-	54	3	1	15	269	39	17	5	11	-	-	1
Japan	1,751	903	46	511	377	124	-	-	-	-	10	202	54	36	-	30	5	-	-
Korea	641	277	-	249	161	52	30	6	-	-	-	62	5	38	13	25	-	10	-
Mexico	454	166	-	110	103	-	-	8	-	-	-	86	3	39	-	39	39	-	-
Netherlands	2,006	719	221	509	-	-	-	-	-	-	-	349	32	104	-	-	-	60	12
Poland	595	177	11	153	80	24	2	26	3	1	17	161	16	26	9	17	0	37	1
Spain	1,314	566	-	369	194	1					174	331	10	32	16	10	6	7	0
Switzerland	2,993	1,027	512	930	529	197	60	-	40	61	44	287	-	203	63	68	72	34	-
Turkey	376	148	-	90	33	13	0	31	11	-	1	104	0	7	1	3	4	-	-

Table 4.2. Current health expenditure by provider (Current health expenditure = 100)

	Current expenditure on health care	HP.1 Hospitals	HP.2 Nursing and residential facilities	HP.3 Providers of ambulatory care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	HP.4 Retail of medical goods	HP.5 Providers of public health programmes	HP.6 Health admin. and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds admin	HP.6.3, 6.4 Private insurance admin	HP.7 All other industries	HP.9 Rest of the world
Australia	100.0	35.7	6.9	34.2	14.1	4.9	4.3	4.6	4.1	(0.0)	2.1	18.1	1.4	3.6	2.2	-	1.5	-	-
Canada	100.0	32.3	10.0	29.1	14.6	8.1	3.1	-	-	2.0	1.4	18.8	6.7	2.0	0.5	-	1.6	0.3	-
Denmark	100.0	38.3	23.6	19.1	3.4	4.8	6.7	0.5	-	2.4	1.3	14.7	0.1	2.0	-	-	0.2	2.0	0.1
Germany	100.0	31.3	7.4	27.9	14.2	6.9	2.5	-	-	2.8	1.5	21.8	1.8	6.0	0.0	4.6	1.4	3.7	0.2
Hungary	100.0	34.9	0.4	23.5	4.0	8.0	-	8.1	0.3	0.1	2.9	34.3	5.0	1.8	0.4	1.3	-	-	0.3
Japan	100.0	50.6	2.9	28.9	21.1	6.9	-	-	-	0.2	0.7	12.2	3.1	2.3	-	1.9	0.3	-	-
Korea	100.0	30.0	-	40.2	24.7	9.5	5.5	0.5	-	-	-	22.0	1.1	4.8	2.1	2.7	-	1.9	-
Mexico	100.0	42.4	-	25.2	23.1	-	-	1.7	0.1	0.2	-	20.2	2.9	9.3	3.4	5.0	0.9	-	-
Netherlands	100.0	36.8	11.5	24.1	-	-	-	-	-	-	-	17.5	1.6	4.7	-	-	-	3.0	0.7
Poland	100.0	29.8	1.8	25.7	13.4	4.0	0.3	4.4	0.5	0.2	2.9	27.1	2.6	4.3	1.5	2.8	0.0	6.3	0.1
Spain	100.0	42.3	-	28.3	15.0	0.0	0.1	11.9	0.3	0.3	0.6	25.6	0.9	2.6	1.3	0.7	0.6	0.3	0.0
Switzerland	100.0	35.0	17.6	30.6	17.6	6.4	2.0	-	1.3	2.0	1.3	9.4	-	6.4	2.0	2.2	2.2	1.1	-
Turkey	100.0	38.0	-	23.7	8.8	3.5	0.0	7.7	3.0	-	0.3	28.4	0.4	2.1	0.2	0.9	1.1	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

Table 5. Expenditure on medical services by financing agent (Current expenditure on medical services = 100)

	Current expenditure on medical services	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**73.5**	73.5	-	-	-	**26.5**	7.9	-	7.9	15.3	-	3.3	**-**
Canada	100.0	**78.2**	77.3	1.3	76.0	1.0	**21.8**	8.4	7.6	0.8	11.3	-	-	**-**
Denmark	100.0	**89.8**	89.8	0.0	58.7	-	**10.2**	0.9	-	0.9	9.2	-	-	**-**
Germany	100.0	**81.7**	8.2	-	-	73.5	**18.3**	8.7	-	8.7	8.2	1.4	-	**-**
Hungary	100.0	**73.0**	8.1	-	-	64.9	**27.0**	0.1	0.1	-	25.1	0.9	0.8	**-**
Japan	100.0	**86.3**	16.4	-	-	69.9	**13.7**	-	-	-	13.7	-	-	**-**
Korea	100.0	**55.4**	7.3	-	-	48.2	**44.6**	3.6	3.6	-	38.2	0.7	2.1	**-**
Mexico	100.0	**47.8**	11.7	9.7	2.1	36.1	**52.2**	2.7	-	2.7	49.5	-	-	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**82.8**	8.7	-	-	74.1	**17.2**	0.7	0.6	0.1	16.5	-	-	**-**
Spain	100.0	**72.9**	-	-	-	-	**27.1**	4.9	-	4.9	20.9	1.3	-	**-**
Switzerland	100.0	**56.1**	19.2	-	-	36.9	**43.9**	9.8	4.0	5.9	33.4	0.7	-	**-**
Turkey	100.0	**58.9**	27.2	26.5	0.7	31.7	**41.1**	3.5	0.9	2.6	31.6	0.4	5.6	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3 and 5 in Notes to Tables.

Table 6. Expenditure on curative-rehabilitative care by financing agent (Current expenditure on C&R care = 100)

	Current expenditure on C & R care	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**71.8**	71.8	-	-	-	**28.2**	9.3	-	9.3	15.0	-	3.9	**-**
Canada	100.0	**74.7**	73.5	1.0	72.5	1.2	**25.3**	12.0	10.9	1.1	10.9	-	-	**-**
Denmark	100.0	**87.2**	87.2	-	87.2	-	**12.8**	1.6	-	1.6	11.2	-	-	**-**
Germany	100.0	**81.3**	7.3	-	-	74.0	**18.7**	9.6	-	9.6	7.3	1.9	-	**-**
Hungary	100.0	**69.6**	4.9	-	-	64.7	**30.4**	0.2	0.2	-	28.4	1.0	0.9	**-**
Japan	100.0	**85.4**	10.7	-	-	74.8	**14.6**	-	-	-	14.6	-	-	**-**
Korea	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Mexico	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**81.6**	4.0	-	-	77.6	**18.4**	0.8	0.7	0.1	17.6	-	-	**-**
Spain	100.0	**71.1**	-	-	-	-	**28.9**	-	-	-	-	-	-	**-**
Switzerland	100.0	**61.6**	21.5	-	-	40.1	**38.4**	13.2	5.5	7.7	25.2	-	-	**-**
Turkey	100.0	**61.7**	28.0	27.3	0.8	33.6	**38.3**	3.5	1.0	2.6	28.8	0.2	5.8	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3, 5, 8 and 9 in Notes to Tables.

Table 7. Expenditure on long-term care by financing agent (Current expenditure on LTC = 100)

	Current expenditure on LTC	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**81.5**	81.5	-	-	-	**18.5**	(0.0)	-	(0.0)	18.5	-	-	**-**
Canada	100.0	**80.1**	79.7	1.2	78.5	0.4	**19.9**	0.4	0.3	0.1	18.7	-	-	**-**
Denmark	100.0	**93.4**	93.4	-	1.6	-	**6.6**	-	-	-	6.6	-	-	**-**
Germany	100.0	**82.4**	13.1	-	-	69.3	**17.6**	1.9	-	1.9	15.7	-	-	**-**
Hungary	100.0	**100.0**	32.0	-	-	68.0	**-**	-	-	-	-	-	-	**-**
Japan	100.0	**90.5**	45.1	-	-	45.5	**9.5**	-	-	-	9.5	-	-	**-**
Korea	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Mexico	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**99.2**	51.5	-	-	47.8	**0.8**	-	-	-	0.8	-	-	**-**
Spain	100.0	**84.7**	-	-	-	-	**15.3**	-	-	-	-	-	-	**-**
Switzerland	100.0	**39.9**	13.2	-	-	26.7	**60.1**	0.3	0.0	0.3	57.3	2.5	-	**-**
Turkey	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3 and 9 in Notes to Tables.

Table 8.1. Expenditure on in-patient care by financing agent (Current expenditure on in-patient care = 100)

	Current expenditure on inpatient services	**HF.1** General government	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2** Private sector	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	100.0	**74.4**	74.4	-	-	-	**25.6**	12.5	-	12.5	8.3	-	4.9	**-**
Canada	100.0	**85.9**	85.5	0.9	84.6	0.4	**14.1**	1.3	1.0	0.3	9.8	-	-	**-**
Denmark	100.0	**96.6**	96.6	-	96.6	-	**3.4**	-	-	-	3.4	-	-	**-**
Germany	100.0	**83.0**	9.2	-	-	73.9	**17.0**	6.9	-	6.9	7.5	2.6	-	**-**
Hungary	100.0	**88.3**	7.3	-	-	81.0	**11.7**	-	-	-	10.3	0.9	0.5	**-**
Japan	100.0	**89.8**	25.8	-	-	64.0	**10.2**	-	-	-	10.2	-	-	**-**
Korea	100.0	**66.4**	11.3	-	-	55.1	**33.6**	9.4	9.4	-	23.7	0.5	-	**-**
Mexico	100.0	**72.1**	14.6	11.3	3.3	57.6	**27.9**	3.4	-	3.4	24.5	-	-	**-**
Netherlands	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Poland	100.0	**97.2**	6.9	-	-	90.2	**2.8**	0.2	0.1	0.1	2.7	-	-	**-**
Spain	100.0	**87.5**	-	-	-	-	**12.5**	1.7	-	1.7	8.2	2.6	-	**-**
Switzerland	100.0	**59.9**	30.0	-	-	29.9	**40.1**	12.7	5.4	7.3	26.6	0.8	-	**-**
Turkey	100.0	**85.1**	39.4	38.3	1.1	45.8	**14.9**	4.3	1.2	3.1	8.6	0.1	1.8	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3, 5, 6 and 7 in Notes to Tables.

Table 8.2. Expenditure on curative-rehabilitative in-patient care by financing agent (Current expenditure on C & R in-patient care = 100)

	Current expenditure on C&R inpatient services	**HF.1** General government	HF.1.1 General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	HF.1.2 Social security funds	**HF.2** Private sector	HF.2.1 + HF.2.2 Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	HF.2.3 Private household out-of-pocket payments	HF.2.4 Non-profit organisations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	**HF.3 Rest of the world**
Australia	100.0	**72.5**	72.5	-	-	-	**27.5**	15.6	-	15.6	5.7	-	6.1	**-**
Canada	100.0	**91.8**	91.2	0.8	90.5	0.6	**8.2**	1.9	1.5	0.4	2.0	-	-	**-**
Denmark	100.0	**100.0**	100.0	-	100.0	-	**-**	-	-	-	-	-	-	**-**
Germany	100.0	**84.3**	6.9	-	-	77.4	**15.7**	8.0	-	8.0	4.6	3.2	-	**-**
Hungary	100.0	**87.8**	6.2	-	-	81.6	**12.2**	-	-	-	10.7	1.0	0.5	**-**
Japan	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Korea	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Mexico	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Netherlands	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Poland	100.0	**97.3**	6.3	-	-	91.0	**2.7**	0.2	0.1	0.1	2.6	-	-	**-**
Spain	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Switzerland	100.0	**74.4**	41.5	-	-	32.9	**25.6**	20.2	8.5	11.7	5.4	-	-	**-**
Turkey	100.0	**85.1**	39.4	38.3	1.1	45.8	**14.9**	4.3	1.2	3.1	8.6	0.1	1.8	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3, 5, 6 and 7 in Notes to Tables.

Table 9. Expenditure on out-patient care by financing agent (Current expenditure on out-patient care = 100)

	Current expenditure on outpatient services	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**71.2**	71.2	-	-	-	**28.8**	3.9	-	3.9	22.9	-	2.0	**-**
Canada	100.0	**60.3**	58.5	1.3	57.2	1.7	**39.7**	20.4	18.8	1.6	18.4	-	-	**-**
Denmark	100.0	**66.3**	66.3	-	66.3	-	**33.7**	4.1	-	4.1	29.5	-	-	**-**
Germany	100.0	**77.0**	7.8	-	-	69.2	**23.0**	11.9	-	11.9	11.1	-	-	**-**
Hungary	100.0	**45.0**	3.5	-	-	41.5	**55.0**	0.4	0.4	-	52.2	1.0	1.4	**-**
Japan	100.0	**81.7**	2.6	-	-	79.1	**18.3**	-	-	-	18.3	-	-	**-**
Korea	100.0	**49.3**	5.0	-	-	44.4	**50.7**	0.3	0.3	-	46.3	0.8	3.3	**-**
Mexico	100.0	**7.1**	7.1	7.1	-	-	**92.9**	-	-	-	92.9	-	-	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**59.7**	0.8	-	-	58.9	**40.3**	1.7	1.5	0.2	38.5	-	-	**-**
Spain	100.0	**57.5**	-	-	-	-	**42.5**	8.1	-	8.1	33.9	0.4	-	**-**
Switzerland	100.0	**47.9**	-	-	-	47.9	**52.1**	5.7	2.2	3.5	46.4	-	-	**-**
Turkey	100.0	**45.2**	20.1	19.6	0.5	25.2	**54.8**	3.0	0.8	2.2	42.8	0.3	8.6	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3, 6 and 7 in Notes to Tables.

Table 10. Expenditure on medical goods by financing agent (Current expenditure on medical goods = 100)

	Current expenditure on medical goods	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**47.1**	47.1	-	-	-	**52.9**	2.0	-	2.0	49.7	-	1.1	**-**
Canada	100.0	**32.4**	29.9	2.2	27.8	2.4	**67.6**	21.8	19.8	2.1	45.8	-	-	**-**
Denmark	100.0	**52.8**	52.8	-	52.8	-	**47.2**	0.8	-	0.8	46.4	-	-	**-**
Germany	100.0	**68.9**	3.9	-	-	65.0	**31.1**	5.3	-	5.3	25.8	-	-	**-**
Hungary	100.0	**60.1**	3.2	-	-	56.9	**39.9**	0.5	0.5	-	39.4	-	-	**-**
Japan	100.0	**63.9**	0.9	-	-	63.0	**36.1**	-	-	-	36.1	-	-	**-**
Korea	100.0	**50.0**	4.8	-	-	45.3	**50.0**	0.1	0.1	-	49.9	-	-	**-**
Mexico	100.0	**0.4**	0.4	0.4	-	-	**99.6**	0.4	-	0.4	99.1	-	-	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**34.3**	0.1	-	-	34.3	**65.7**	-	-	-	64.1	1.6	-	**-**
Spain	100.0	**63.7**	-	-	-	-	**36.3**	-	-	-	36.3	-	-	**-**
Switzerland	100.0	**60.4**	-	-	-	60.4	**39.6**	5.4	2.1	3.2	34.2	-	-	**-**
Turkey	100.0	**61.9**	15.1	14.3	0.8	46.8	**38.1**	1.4	0.9	0.5	32.9	1.4	2.4	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2, 3 and 5 in Notes to Tables.

Table 11. Expenditure on pharmaceuticals by financing agent (Current expenditure on pharmaceuticals = 100)

	Current expenditure on pharmaceuticals	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**55.8**	55.8	-	-	-	**44.2**	0.4	-	0.4	42.9	-	0.9	**-**
Canada	100.0	**33.9**	31.5	2.4	29.1	2.3	**66.1**	25.1	22.8	2.3	41.1	-	-	**-**
Denmark	100.0	**53.1**	53.1	-	53.1	-	**46.9**	-	-	-	46.9	-	-	**-**
Germany	100.0	**73.9**	4.1	-	-	69.7	**26.1**	5.6	-	5.6	20.6	-	-	**-**
Hungary	100.0	**61.2**	3.7	-	-	57.5	**38.8**	0.5	0.5	-	38.2	-	-	**-**
Japan	100.0	**66.0**	-	-	-	66.0	**34.0**	-	-	-	34.0	-	-	**-**
Korea	100.0	**55.1**	5.2	-	-	49.9	**44.9**	0.1	0.1	-	44.8	-	-	**-**
Mexico	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**35.0**	0.1	-	-	34.9	**65.0**	-	-	-	63.3	1.7	-	**-**
Spain	100.0	**72.9**	-	-	-	-	**27.1**	-	-	-	27.1	-	-	**-**
Switzerland	100.0	**62.6**	-	-	-	62.6	**37.4**	3.0	1.1	1.9	34.4	-	-	**-**
Turkey	100.0	**62.6**	16.9	16.0	0.9	45.7	**37.4**	1.5	0.9	0.6	33.5	0.8	1.6	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3 and 5 in Notes to Tables.

Table 12. Expenditure on prevention and public health by financing agent (Current expenditure on prevention and public health = 100)

	Current expenditure on prevention and public health	**HF.1**		HF.1.1		HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of the world**
Australia	100.0	**99.9**	99.9	-	-	-	**0.1**	0.1	-	0.1	-	-	-	**-**
Canada	100.0	**99.7**	97.5	20.2	77.3	2.2	**0.3**	0.1	0.1	0.0	0.1	-	-	**-**
Denmark	100.0	**98.7**	98.7	4.5	94.1	-	**1.3**	-	-	-	1.3	-	-	**-**
Germany	100.0	**67.2**	18.2	-	-	49.0	**32.8**	0.3	-	0.3	0.1	20.6	11.8	**-**
Hungary	100.0	**51.3**	33.0	-	-	18.4	**48.7**	1.2	1.2	-	13.4	1.1	32.9	**-**
Japan	100.0	**48.8**	11.6	-	-	37.2	**51.2**	-	-	-	-	-	51.2	**-**
Korea	100.0	**98.1**	76.0	-	-	22.1	**1.9**	-	-	-	-	-	1.9	**-**
Mexico	100.0	**100.0**	100.0	90.0	10.0	-	**-**	-	-	-	-	-	-	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**86.2**	84.8	-	-	1.4	**13.7**	-	-	-	-	-	13.7	**0.1**
Spain	100.0	**100.0**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Switzerland	100.0	**65.7**	39.9	-	-	25.8	**34.3**	-	-	-	15.2	19.2	-	**-**
Turkey	100.0	**96.1**	96.1	95.8	0.3	-	**3.9**	0.1	-	0.1	-	3.1	0.7	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 3 in Notes to Tables.

Table 13. Total public expenditure on health by function (Total public expenditure on health = 100)

	HC.1;HC.2	HC.3	HC.4	HC.5	HC.5.1	HC.5.2	HC.1-5	HC.6	HC.7		HC.R.1	
	Curative and rehabilitative care	Long-term nursing care	Ancillary services to health care	Medical goods dispensed to out-patients	Pharmaceut. and other medical non-durables	Therap. appliances and other med. durables	**Personal medical services and goods**	Prevention and public health services	Health administration and health insurance	**CURRENT PUBLIC EXPENDITURE ON HEALTH**	Gross capital formation	**TOTAL PUBLIC EXPENDITURE ON HEALTH**
Australia	61.1	8.2	7.1	12.2	11.4	0.8	**88.6**	2.1	3.4	**94.1**	5.9	**100.0**
Canada	49.2	15.7	11.0	8.3	7.5	0.8	**84.3**	9.9	0.6	**95.4**	4.6	**100.0**
Denmark	50.4	30.2	4.7	9.2	5.8	3.3	**95.1**	2.8	2.2	**100.0**	-	**100.0**
Germany	52.3	11.2	6.7	17.3	13.5	3.8	**87.5**	3.9	5.1	**96.5**	3.5	**100.0**
Hungary	52.8	1.8	8.2	30.3	26.8	3.5	**93.0**	3.8	2.5	**99.4**	-	**100.0**
Japan	63.8	11.5	0.8	15.4	15.1	0.2	**91.5**	1.8	2.3	**95.6**	4.4	**100.0**
Korea	63.2	-	-	24.1	24.1	0.0	**87.3**	2.5	7.7	**97.5**	2.5	**100.0**
Mexico	70.9	-	-	0.2	-	-	**71.0**	6.5	18.3	**95.8**	2.1	**100.0**
Netherlands	-	-	-	-	-	-	-	-	-	**-**	-	**-**
Poland	58.8	8.3	3.0	12.6	12.0	0.6	**84.6**	4.4	5.8	**94.8**	5.2	**100.0**
Spain	62.3	2.4	4.5	22.2	21.8	0.4	**91.5**	1.9	2.3	**95.7**	3.9	**100.0**
Switzerland	61.9	13.7	3.1	13.4	11.6	1.7	**92.0**	2.6	5.3	**100.0**	-	**100.0**
Turkey	47.3	-	1.0	27.3	24.6	1.9	**75.7**	3.5	1.7	**93.7**	6.3	**100.0**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 4, 5, 8, 9 and 10 in Notes to Tables.

Table 14.1 Current public expenditure on health by function (mode of production) (Current public expenditure on health = 100)

	Current public expenditure on health care	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health services	HC.7 Health administration and health insurance
Australia	100.0	**38.8**	30.1	8.7	**-**	**34.8**	-	-	-	-	**-**	**7.6**	**12.9**	12.1	0.9	**2.3**	**3.6**
Canada	100.0	**38.4**	24.7	13.7	**4.0**	**22.7**	5.9	0.7	12.2	1.3	**3.0**	**11.6**	**8.7**	7.8	0.9	**10.3**	**0.7**
Denmark	100.0	**60.3**	34.5	25.2	**1.8**	**14.6**	0.4	1.3	8.5	4.4	**4.5**	**4.7**	**9.2**	5.8	3.3	**2.8**	**2.2**
Germany	100.0	**39.5**	33.1	6.4	**-**	**21.2**	-	-	-	-	**5.2**	**6.9**	**17.9**	14.0	3.9	**4.0**	**5.3**
Hungary	100.0	**37.8**	36.1	1.8	**1.7**	**14.8**	5.9	1.9	4.4	2.6	**0.2**	**8.2**	**30.3**	26.8	3.5	**3.8**	**2.5**
Japan	100.0	**44.4**	-	-	**0.7**	**33.3**	-	6.7	-	-	**0.4**	**0.8**	**16.1**	15.8	0.2	**1.9**	**2.4**
Korea	100.0	**27.8**	-	-	**-**	**37.0**	-	-	-	-	**-**	**-**	**24.7**	24.7	0.0	**2.5**	**7.9**
Mexico	100.0	**69.9**	-	-	**-**	**4.0**	-	-	-	-	**-**	**-**	**0.2**	-	-	**6.7**	**19.1**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**43.5**	43.2	0.6	**0.3**	**18.8**	-	-	-	-	**8.1**	**3.2**	**13.3**	12.7	0.6	**4.6**	**6.1**
Spain	100.0	**36.2**	33.6	2.5	**1.3**	**29.5**	-	-	-	-	**0.6**	**4.7**	**23.2**	22.8	0.4	**2.0**	**2.4**
Switzerland	100.0	**49.5**	38.7	10.9	**-**	**23.2**	-	-	-	-	**2.8**	**3.1**	**13.4**	11.6	1.7	**2.6**	**5.3**
Turkey	100.0	**28.7**	28.7	-	**-**	**21.8**	-	-	-	-	**-**	**1.1**	**29.2**	26.3	2.0	**3.8**	**1.8**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 14.2 Public expenditure on personal health services by function (mode of production) (Public expenditure on personal health services = 100)

	Current public expenditure on personal health services	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*
Australia	100.0	**47.8**	**37.1**	**10.7**	**-**	**42.8**	**-**	**-**	**-**	**-**	**-**	**9.3**
Canada	100.0	**48.2**	**31.1**	**17.2**	**5.0**	**28.5**	**7.4**	**0.9**	**15.3**	**1.6**	**3.7**	**14.5**
Denmark	100.0	**70.2**	**40.2**	**29.4**	**2.1**	**17.0**	**0.4**	**1.5**	**9.9**	**5.2**	**5.2**	**5.4**
Germany	100.0	**54.2**	**45.4**	**8.8**	**-**	**29.1**	**-**	**-**	**-**	**-**	**7.2**	**9.5**
Hungary	100.0	**60.3**	**57.5**	**2.8**	**2.7**	**23.6**	**9.5**	**3.0**	**7.1**	**4.1**	**0.3**	**13.1**
Japan	100.0	**55.7**	**-**	**-**	**0.9**	**41.7**	**-**	**8.4**	**-**	**-**	**0.6**	**1.0**
Korea	100.0	**42.9**	**-**	**-**	**-**	**57.1**	**-**	**-**	**-**	**-**	**-**	**-**
Mexico	100.0	**94.6**	**-**	**-**	**-**	**5.4**	**-**	**-**	**-**	**-**	**-**	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**58.8**	**58.4**	**0.9**	**0.5**	**25.5**	**-**	**-**	**-**	**-**	**11.0**	**4.3**
Spain	100.0	**50.0**	**46.5**	**3.5**	**1.8**	**40.8**	**-**	**-**	**-**	**-**	**0.8**	**6.5**
Switzerland	100.0	**63.0**	**49.2**	**13.8**	**-**	**29.5**	**-**	**-**	**-**	**-**	**3.6**	**3.9**
Turkey	100.0	**55.6**	**55.6**	**-**	**-**	**42.3**	**-**	**-**	**-**	**-**	**-**	**2.1**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 15. Current government/social security health expenditure by function (mode of production) (Current govt./social security health exp. = 100)

		Current government/social security expenditure on health care	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health services	HC.7 Health administration and health insurance
AUS	HF.1.1	100.0	38.8	30.1	8.7	-	34.8	-	-	-	-	-	7.6	12.9	12.1	0.9	2.3	3.6
	HF.1.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CAN	HF.1.1	100.0	39.0	25.1	13.9	4.0	22.5	6.0	0.7	12.4	0.9	3.0	11.7	8.2	7.4	0.8	10.3	0.7
	HF.1.2	100.0	9.5	8.2	1.2	1.1	32.7	-	0.6	2.4	17.2	2.6	2.8	32.9	27.2	5.6	11.4	-
DNK	HF.1.1	100.0	60.3	34.5	25.2	1.8	14.6	0.4	1.3	-	12.9	4.5	4.7	9.2	5.8	3.3	2.8	2.2
	HF.1.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
DEU	HF.1.1	100.0	46.2	28.7	17.5	-	22.8	-	-	-	-	2.1	6.4	10.9	8.3	2.6	11.6	0.0
	HF.1.2	100.0	38.8	33.5	5.3	-	21.0	-	-	-	-	5.5	7.0	18.6	14.5	4.1	3.2	5.8
HUN	HF.1.1	100.0	25.9	21.3	4.7	0.0	9.6	1.4	1.3	0.8	6.0	0.0	22.2	13.4	13.4	-	20.4	6.1
	HF.1.2	100.0	39.5	38.1	1.4	1.9	15.5	6.6	1.9	4.9	2.1	0.2	6.3	32.6	28.6	4.0	1.6	2.0
JPN	HF.1.1	100.0	80.4	-	-	2.4	6.7	-	0.7	-	-	1.1	5.2	1.5	-	1.5	2.8	-
	HF.1.2	100.0	37.6	-	-	0.4	38.3	-	7.8	-	-	0.3	0.0	18.8	18.8	-	1.7	2.8
KOR	HF.1.1	100.0	28.6	-	-	-	22.6	-	-	-	-	-	-	14.2	14.1	0.1	11.9	22.7
	HF.1.2	100.0	27.6	-	-	-	39.9	-	-	-	-	-	-	26.8	26.8	-	0.7	5.0
MEX	HF.1.1	100.0	43.0	-	-	-	12.2	-	-	-	-	-	-	0.6	-	-	20.6	23.6
	HF.1.2	100.0	83.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	16.9
NLD	HF.1.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	HF.1.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
POL	HF.1.1	100.0	21.1	19.1	2.1	-	1.8	-	-	-	-	28.9	1.2	0.2	0.2	-	31.0	14.5
	HF.1.2	100.0	47.3	47.3	0.4	0.4	21.8	-	-	-	-	4.5	3.5	15.5	14.8	0.7	0.1	4.7
ESP	HF.1.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	HF.1.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CHE	HF.1.1	100.0	83.8	72.9	10.9	-	-	-	-	-	-	4.4	2.8	-	-	-	5.4	3.6
	HF.1.2	100.0	35.1	24.3	10.9	-	33.0	-	-	-	-	2.2	3.2	19.0	16.5	2.5	1.5	6.0
TUR	HF.1.1	100.0	31.6	31.6	-	-	23.1	-	-	-	-	-	2.1	16.9	16.9	-	8.9	1.0
	HF.1.2	100.0	26.6	26.6	-	-	20.9	-	-	-	-	-	0.4	38.0	33.1	3.5	-	2.4

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 16. Total public and private expenditure on health by function (Total public and private expenditure on health = 100)

		HC.1;HC.2	HC.3	HC.4	HC.5	HC.5.1	HC.5.2	HC.1-5	HC.6	HC.7		HC.R.1	
		Curative and rehabilitative care	Long-term nursing care	Ancillary services to health care	Medical goods dispensed to out-patients	Pharmaceut. and other medical non-durables	Therap. appliances and other med. durables	**Personal medical services and goods**	Prevention and public health services	Health administration and health insurance	**Current Public/Private Expenditure on Health**	Gross capital formation	**Total Public/Private Expenditure on Health**
AUS	Public	61.1	8.2	7.1	12.2	11.4	0.8	**88.6**	2.1	3.4	**94.1**	5.9	100.0
	Private	52.9	4.1	3.6	30.1	19.8	10.3	**90.7**	0.0	3.0	**93.7**	6.3	100.0
CAN	Public	49.2	15.7	11.0	8.3	7.5	0.8	**84.3**	9.9	0.6	**95.4**	4.6	100.0
	Private	39.5	9.3	1.4	41.2	34.6	6.6	**91.3**	0.1	5.0	**97.7**	2.3	100.0
DNK	Public	50.4	30.2	4.7	9.2	5.8	3.3	**95.1**	2.8	2.2	**100.0**	-	100.0
	Private	40.8	11.8	1.1	45.1	28.4	16.7	**98.8**	0.2	1.0	**100.0**	-	100.0
DEU	Public	52.3	11.2	6.7	17.3	13.5	3.8	**87.5**	3.9	5.1	**96.5**	3.5	100.0
	Private	44.2	8.8	4.8	28.5	17.4	11.1	**86.2**	6.9	6.4	**99.6**	0.4	100.0
HUN	Public	52.8	1.8	8.2	30.3	26.8	3.5	**93.0**	3.8	2.5	**99.4**	-	100.0
	Private	49.2	-	0.2	42.8	36.1	6.7	**92.3**	7.7	-	**100.0**	-	100.0
JPN	Public	63.8	11.5	0.8	15.4	15.1	0.2	**91.5**	1.8	2.3	**95.6**	4.4	100.0
	Private	47.2	5.2	-	37.7	33.9	3.8	**90.1**	8.2	1.7	**100.0**	-	100.0
KOR	Public	63.2	-	-	24.1	24.1	0.0	**87.3**	2.5	7.7	**97.5**	2.5	100.0
	Private	61.4	-	-	29.2	23.8	5.4	**90.6**	0.1	-	**90.7**	9.3	100.0
MEX	Public	70.9	-	-	0.2	-	-	**71.0**	6.5	18.3	**95.8**	2.1	100.0
	Private	62.4	-	-	35.8	-	-	**98.2**	-	1.6	**99.8**	-	100.0
NLD	Public	-	-	-	-	-	-	**-**	-	-	**-**	-	-
	Private	-	-	-	-	-	-	**-**	-	-	**-**	-	-
POL	Public	58.8	8.3	3.0	12.6	12.0	0.6	**84.6**	4.4	5.8	**94.8**	5.2	100.0
	Private	32.7	0.2	3.0	59.4	55.0	4.5	**98.2**	1.7	0.0	**100.0**	-	100.0
ESP	Public	62.3	2.4	4.5	22.2	21.8	0.4	**91.5**	1.9	2.3	**95.7**	3.9	100.0
	Private	63.7	1.1	-	31.8	20.4	11.4	**96.5**	-	2.0	**98.6**	1.4	100.0
CHE	Public	61.9	13.7	3.1	13.4	11.6	1.7	**92.0**	2.6	5.3	**100.0**	-	100.0
	Private	51.3	27.5	3.3	11.7	9.3	2.4	**93.8**	1.8	4.4	**100.0**	-	100.0
TUR	Public	47.3	-	1.0	27.3	24.6	1.9	**75.7**	3.5	1.7	**93.7**	6.3	100.0
	Private	50.0	-	7.2	28.6	25.0	0.1	**85.8**	0.2	2.9	**98.9**	1.1	100.0

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.
See additional notes 3, 4, 5, 8, 9 and 10 in Notes to Tables.

Table 17.1 Current private expenditure on health by function (mode of production) (Current private expenditure on health = 100)

	Current private expenditure on health care	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health services	HC.7 Health administration and health insurance
Australia	100.0	**29.6**	25.2	4.4	**-**	**31.2**	-	-	-	-	**(0.0)**	**3.9**	**32.1**	21.1	11.0	**0.0**	**3.2**
Canada	100.0	**14.6**	5.1	9.5	**0.7**	**34.6**	-	25.3	1.4	7.3	**0.0**	**1.4**	**42.1**	35.4	6.7	**0.1**	**5.1**
Denmark	100.0	**11.8**	-	11.8	**-**	**40.8**	-	24.2	-	16.5	**-**	**1.1**	**45.1**	28.4	16.7	**0.2**	**1.0**
Germany	100.0	**28.6**	21.9	6.7	**-**	**22.4**	-	-	-	-	**2.1**	**4.9**	**28.6**	17.5	11.1	**7.0**	**6.4**
Hungary	100.0	**10.7**	-	-	**-**	**38.6**	0.1	22.7	15.4	0.4	**-**	**0.2**	**42.8**	36.1	6.7	**7.7**	**-**
Japan	100.0	**20.9**	-	-	**0.3**	**30.9**	-	7.6	-	-	**0.2**	**-**	**37.7**	33.9	3.8	**8.2**	**1.7**
Korea	100.0	**18.3**	-	-	**-**	**49.5**	-	-	-	-	**-**	**-**	**32.2**	26.2	6.0	**0.1**	**-**
Mexico	100.0	**21.0**	-	-	**-**	**41.0**	-	-	-	-	**0.4**	**0.2**	**35.8**	-	-	**-**	**1.6**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**3.0**	2.8	0.2	**0.0**	**29.7**	-	-	-	-	**0.2**	**3.0**	**59.4**	55.0	4.5	**1.7**	**0.0**
Spain	100.0	**12.5**	11.4	1.1	**-**	**53.2**	-	-	-	-	**-**	**-**	**32.2**	20.7	11.6	**-**	**2.1**
Switzerland	100.0	**44.2**	17.7	26.5	**-**	**33.6**	-	-	-	-	**1.0**	**3.3**	**11.7**	9.3	2.4	**1.8**	**4.4**
Turkey	100.0	**8.1**	8.1	-	**-**	**42.5**	-	-	-	-	**-**	**7.3**	**28.9**	25.3	0.1	**0.2**	**3.0**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 17.2 Private expenditure on personal health services by function (mode of production) (Private expenditure on personal health services= 100)

	Current private expenditure on personal medical services	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*
Australia	100.0	**45.8**	**39.0**	**6.7**	**-**	**48.2**	**-**	**-**	**-**	**-**	**(0.0)**	**6.0**
Canada	100.0	**28.4**	**9.9**	**18.5**	**1.3**	**67.5**	**-**	**49.2**	**2.8**	**14.2**	**0.1**	**2.8**
Denmark	100.0	**22.0**	**-**	**22.0**	**-**	**75.9**	**-**	**45.2**	**-**	**30.8**	**-**	**2.0**
Germany	100.0	**49.4**	**37.8**	**11.6**	**-**	**38.7**	**-**	**-**	**-**	**-**	**3.6**	**8.4**
Hungary	100.0	**21.6**	**-**	**-**	**-**	**78.0**	**0.2**	**46.0**	**31.1**	**0.8**	**-**	**0.3**
Japan	100.0	**39.9**	**-**	**-**	**0.7**	**59.0**	**-**	**14.6**	**-**	**-**	**0.4**	**-**
Korea	100.0	**27.0**	**-**	**-**	**-**	**73.0**	**-**	**-**	**-**	**-**	**-**	**-**
Mexico	100.0	**33.9**	**-**	**-**	**-**	**66.1**	**-**	**-**	**-**	**-**	**0.7**	**0.4**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**8.3**	**7.9**	**0.4**	**0.1**	**82.8**	**-**	**-**	**-**	**-**	**0.4**	**8.4**
Spain	100.0	**19.1**	**17.4**	**1.7**	**-**	**80.9**	**-**	**-**	**-**	**-**	**-**	**-**
Switzerland	100.0	**53.9**	**21.6**	**32.3**	**-**	**40.9**	**-**	**-**	**-**	**-**	**1.2**	**4.1**
Turkey	100.0	**13.9**	**13.9**	**-**	**-**	**73.4**	**-**	**-**	**-**	**-**	**-**	**12.6**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 18. Current private insurance health expenditure by function (mode of production) (Current private insurance health expenditure = 100)

	Current households' expenditure on health care	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health services	HC.7 Health administration and health insurance
Australia	100.0	**60.4**	60.4	-	**-**	**17.9**	-	-	-	-	**-**	**2.9**	**5.2**	0.9	4.3	**0.0**	**13.6**
Canada	100.0	**3.6**	3.1	0.5	**0.4**	**46.0**	-	35.9	0.9	9.2	**0.0**	**0.9**	**35.1**	34.6	0.5	**0.0**	**13.3**
Denmark	100.0	**-**	-	-	**-**	**86.6**	-	61.6	-	25.0	**-**	**-**	**13.4**	-	13.4	**-**	**-**
Germany	100.0	**29.9**	28.6	1.3	**-**	**29.8**	-	-	-	-	**1.1**	**10.0**	**12.5**	9.6	2.9	**0.1**	**16.6**
Hungary	100.0	**-**	-	-	**-**	**27.7**	-	16.9	10.8	-	**-**	**-**	**51.9**	51.9	-	**20.4**	**-**
Japan	-	**-**	-	-	**-**	**-**	-	-	-	-	**-**	**-**	**-**	-	-	**-**	**-**
Korea	100.0	**94.1**	-	-	**-**	**5.3**	-	-	-	-	**-**	**-**	**0.6**	0.6	-	**-**	**-**
Mexico	100.0	**51.8**	-	-	**-**	**-**	-	-	-	-	**-**	**-**	**3.1**	-	-	**-**	**32.0**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**10.5**	10.5	**-**	**-**	**83.9**	-	-	-	-	**-**	**3.3**	**-**	-	-	**-**	**2.3**
Spain	100.0	**12.2**	-	-	**-**	**72.9**	-	-	-	-	**-**	**-**	**-**	-	-	**-**	**14.9**
Switzerland	100.0	**59.0**	59.0	-	**-**	**15.4**	-	-	-	-	**0.5**	**2.3**	**6.7**	3.1	3.5	**-**	**16.1**
Turkey	100.0	**20.0**	20.0	-	**-**	**19.9**	-	-	-	-	**-**	**2.2**	**9.3**	8.7	0.5	**0.0**	**23.9**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 19. Current households' health expenditure by function (mode of production) (Current households' health expenditure = 100)

	Current households' expenditure on health care	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 *Day-care*	HC.1.3; 2.3 *Out-patient care*	HC.1.3.1 Basic medical and diagnostic services	HC.1.3.2 Dental care	HC.1.3.3 All other specialised health care	HC.1.3.9; 2.3 All other out-patient care	HC.1.4; 2.4; 3.3 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.5.1 Pharmaceut. and other medical non-durables	HC.5.2 Therap. appliances and other med. durables	HC.6 Prevention and public health services	HC.7 Health administration and health insurance
Australia	100.0	**14.2**	7.7	6.5	**-**	**36.7**	-	-	-	-	**-**	**4.3**	**44.8**	30.4	14.4	**-**	**-**
Canada	100.0	**18.1**	2.2	15.8	**0.3**	**28.5**	-	20.2	0.6	6.7	**0.0**	**0.6**	**50.6**	39.0	11.6	**0.0**	**-**
Denmark	100.0	**12.6**	-	12.6	**-**	**37.9**	-	22.0	-	16.0	**-**	**1.1**	**47.1**	30.1	17.0	**0.2**	**1.1**
Germany	100.0	**25.3**	12.8	12.5	**-**	**21.8**	-	-	-	-	**3.3**	**1.9**	**47.7**	27.7	20.0	**0.0**	**0.0**
Hungary	100.0	**10.4**	-	-	**-**	**40.4**	0.0	24.8	15.5	0.0	**-**	**0.1**	**46.8**	39.4	7.4	**2.4**	**-**
Japan	100.0	**23.2**	-	-	**0.4**	**34.3**	-	8.5	-	-	**0.2**	**-**	**41.8**	37.6	4.2	**-**	**-**
Korea	100.0	**14.3**	-	-	**-**	**50.1**	-	-	-	-	**-**	**-**	**35.6**	29.0	6.6	**-**	**-**
Mexico	100.0	**19.4**	-	-	**-**	**43.1**	-	-	-	-	**-**	**-**	**37.5**	-	-	**-**	**-**
Netherlands	-	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Poland	100.0	**3.0**	2.9	0.2	**0.0**	**30.8**	-	-	-	-	**0.2**	**3.2**	**62.8**	58.0	4.8	**-**	**-**
Spain	100.0	**9.9**	-	-	**-**	**51.2**	-	-	-	-	**-**	**-**	**38.9**	24.9	13.9	**-**	**-**
Switzerland	100.0	**39.6**	5.0	34.6	**-**	**40.5**	-	-	-	-	**0.8**	**3.5**	**13.6**	11.5	2.1	**1.1**	**0.8**
Turkey	100.0	**6.3**	6.3	-	**-**	**44.5**	-	-	-	-	**-**	**8.9**	**33.5**	30.4	-	**-**	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8, 9 and 10 in Notes to Tables.

Table 20. Current hospitals' expenditure by function (mode of production) (Current expenditure on hospitals' service = 100)

	Current expenditure on hospitals' services	HC.1.1;2.1; 3.1 *In-patient care*	HC.1.1;2.1 Curative and rehabilitative care (inpatient)	HC.3.1 Long-term nursing care (inpatient)	HC.1.2;2.2; 3.2 Day-care	HC.1.3; 2.3 *Out-patient care*	HC.1.4; 2.4; 3.4 *Home care*	HC.4 *Ancillary services*	HC.5 *Medical goods dispensed to out-patients*	HC.6 Prevention and public health services	HC.7 All other industries
Australia	100.0	77.2	76.1	1.1	-	21.4	-	-	1.3	0.0	0.0
Canada	100.0	61.2	53.2	8.0	7.0	15.4	0.3	15.3	0.0	0.7	-
Denmark	100.0	77.2	76.4	-	2.8	17.4	-	2.6	-	-	-
Germany	-	-	-	-	-	-	-	-	-	-	-
Hungary	100.0	81.8	79.3	2.5	0.5	10.3	0.0	6.9	-	0.3	0.1
Japan	100.0	70.7	55.2	15.5	0.5	18.9	0.2	0.0	9.7	-	-
Korea	100.0	68.1	-	-	-	27.0	-	-	4.9	-	-
Mexico	100.0	100.0	-	-	-	-	-	-	-	-	-
Netherlands	-	-	-	-	-	-	-	-	-	-	-
Poland	100.0	99.2	99.2	-	0.8	-	-	-	-	-	-
Spain	100.0	69.2	64.2	5.0	1.2	24.8	0.3	4.5	-	-	-
Switzerland	100.0	84.9	84.9	-	-	15.1	-	-	-	-	-
Turkey	100.0	55.6	55.6	-	-	40.5	-	0.1	0.0	0.0	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7, 8 and 9 in Notes to Tables.

Table 21.1 Current expenditure on in-patient care by provider (Current in-patient expenditure = 100)

	CURRENT EXPENDITURE ON INPATIENT CARE	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	**HP.5?** Provision and administration of public health programmes	**HP.7** All other industries	**HP.9** Rest of the world
Australia	100.0	76.6	19.3	4.0	-	-	-
Canada	100.0	63.2	31.9	4.9	-	-	-
Denmark	100.0	55.9	43.8	-	-	-	0.3
Germany	-	-	-	-	-	-	-
Hungary	100.0	97.2	0.1	0.3	0.0	2.3	-
Japan	100.0	89.8	6.4	3.8	-	-	-
Korea	100.0	86.4	-	13.0	-	0.5	-
Mexico	100.0	100.0	-	-	-	-	-
Netherlands	-	-	-	-	-	-	-
Poland	100.0	94.3	5.6	-	-	-	0.1
Spain	100.0	100.0	-	-	-	-	-
Switzerland	100.0	62.8	37.2	-	-	-	-
Turkey	100.0	100.0	-	0.0	-	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 5, 6, 7 and 8 in Notes to Tables.

Table 21.2 Current expenditure on in-patient long-term care by provider (Current in-patient LTC expenditure = 100)

	CURRENT EXPENDITURE ON INPATIENT LONG TERMCARE	HP.1 Hospitals	HP.2 Nursing and residential care facilities	HP.3 Providers of ambulatory health care	HP.5? Provision and administration of public health programmes	HP.7 All other industries	HP.9 Rest of the world
Australia	100.0	5.5	94.5	-	-	-	-
Canada	100.0	20.7	79.2	0.1	-	-	-
Denmark	100.0	-	100.0	-	-	-	-
Germany	-	-	-	-	-	-	-
Hungary	100.0	55.9	1.8	2.4	0.7	39.2	-
Japan	100.0	75.1	24.4	0.5	-	-	-
Korea	-	-	-	-	-	-	-
Mexico	-	-	-	-	-	-	-
Netherlands	-	-	-	-	-	-	-
Poland	100.0	-	100.0	-	-	-	-
Spain	100.0	100.0	-	-	-	-	-
Switzerland	100.0	-	100.0	-	-	-	-
Turkey	-	-	-	-	-	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 5, 6, 7 and 8 in Notes to Tables.

Table 22 Current expenditure on out-patient care by provider (Current out-patient expenditure = 100)

	CURRENT EXPENDITURE ON OUT-PATIENT CARE	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	**HP.4** Retail sale of medical goods	**HP.5** Provision and administration of public health programmes	**HP.6** Prevention and public health services	**HP.7** All other industries
Australia	100.0	22.7	-	77.3	37.1	14.5	12.1	13.6	-	-	0.0	-	-	-	-
Canada	100.0	18.9	-	81.1	38.6	30.8	11.7	-	-	-	-	-	-	-	-
Denmark	100.0	35.7	-	64.3	17.4	25.9	18.1	2.5	-	-	-	-	-	-	-
Germany	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Hungary	100.0	16.3	0.1	76.9	15.1	35.7	-	25.6	0.0	0.0	0.5	-	1.5	0.4	4.9
Japan	100.0	29.1	-	63.3	42.8	20.5	-	-	-	-	-	7.6	-	-	-
Korea	100.0	19.1	-	76.8	49.4	22.1	4.1	1.2	-	-	-	-	-	-	4.1
Mexico	100.0	-	-	100.0	92.9	-	-	7.1	-	-	-	-	-	-	-
Netherlands	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Poland	100.0	-	-	99.8	60.7	18.3	-	19.9	-	-	0.8	-	-	-	-
Spain	100.0	28.8	-	70.8	41.3	0.1	0.1	29.3	-	-	-	-	-	-	0.3
Switzerland	100.0	19.1	-	80.9	50.8	23.0	7.2	-	-	-	-	-	-	-	-
Turkey	100.0	47.1	-	52.9	26.7	10.6	0.0	15.6	-	-	-	-	-	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3, 6 and 7 in Notes to Tables.

Table 23 Current expenditure on ancillary services by provider (Current expenditure on ancillary services = 100)

	CURRENT EXPENDITURE ON ANCILLARY SERVICES	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	**HP.3.1-3.4;3.9** Offices of physicians	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	**HP.5** Provision and administration of public health programmes	**HP.7** All other industries	**HP.9** Rest of the world
Australia	100.0	-	-	100.0	35.6	64.4	-	-	-	-
Canada	100.0	58.1	-	41.9	41.9	-	-	-	-	-
Denmark	100.0	23.7	-	76.3	76.3	-	-	-	-	-
Germany	-	-	-	-	-	-	-	-	-	-
Hungary	100.0	41.7	0.0	58.3	53.2	5.2	-	-	0.0	-
Japan	100.0	0.0	-	100.0	100.0	-	-	-	-	-
Korea	-	-	-	-	-	-	-	-	-	-
Mexico	100.0	-	-	100.0	-	100.0	-	-	-	-
Netherlands	100.0	0.9	-	58.8	-	-	-	16.4	24.0	-
Poland	100.0	-	-	99.5	82.4	17.1	-	-	0.0	0.5
Spain	100.0	57.1	-	36.9	27.8	9.1	-	-	6.0	-
Switzerland	100.0	-	-	92.6	50.8	41.8	-	-	7.4	-
Turkey	100.0	1.1	-	98.9	18.3	80.6	-	-	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 3 and 8 in Notes to Tables.

Table 24 Current expenditure on hospitals' services by source of funding (Current expenditure on hospitals = 100)

	Current expenditure on hospitals	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of world**
Australia	100.0	**78.5**	78.5	-	-	-	**21.5**	10.9	-	10.9	5.4	-	5.3	**-**
Canada	100.0	**91.3**	90.6	0.8	89.8	0.7	**8.7**	2.1	1.7	0.5	2.0	-	-	**-**
Denmark	100.0	**99.6**	99.6	-	-	-	**0.4**	-	-	-	0.4	-	-	**-**
Germany	100.0	**87.0**	6.0	-	-	81.0	**13.0**	8.9	-	8.9	2.2	2.0	-	**-**
Hungary	100.0	**90.2**	5.6	2.3	3.3	84.6	**9.8**	-	-	-	-	-	-	**-**
Japan	100.0	**88.0**	18.6	-	-	69.4	**12.0**	-	-	-	12.0	-	-	**-**
Korea	100.0	**58.5**	11.5	-	-	47.0	**41.5**	4.7	4.7	-	36.8	-	-	**-**
Mexico	100.0	**72.1**	14.6	11.3	3.3	57.6	**27.9**	3.4	-	3.4	24.5	-	-	**-**
Netherlands	100.0	**72.1**	0.9	-	-	70.6	**28.1**	20.0	9.9	10.1	1.7	-	-	**-**
Poland	100.0	**98.8**	6.5	-	-	92.3	**1.2**	0.1	0.1	-	1.2	-	-	**-**
Spain	100.0	**88.0**	-	-	-	-	**12.0**	1.8	-	1.8	8.4	1.8	-	**-**
Switzerland	100.0	**73.6**	35.3	-	-	38.3	**26.4**	17.2	7.3	9.9	9.3	-	-	**-**
Turkey	100.0	**82.9**	32.2	30.9	1.3	50.8	**17.1**	2.8	0.6	2.2	12.5	0.2	1.6	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional note 3 in Notes to Tables.

Table 25 Current expenditure on nursing & residential facilities by source of funding (Current expenditure on nursing & residential facilities = 100)

	Current expenditure on nursing & resid. facilities	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of world**
Australia	100.0	**81.1**	81.1	-	-	-	**18.9**	(0.0)	-	(0.0)	18.9	-	-	**-**
Canada	100.0	**73.2**	73.2	1.1	72.1	0.0	**26.8**	-	-	-	26.8	-	-	**-**
Denmark	100.0	**92.3**	92.3	-	-	-	**7.7**	-	-	-	7.7	-	-	**-**
Germany	100.0	**69.8**	19.1	-	-	50.7	**30.2**	1.5	-	1.5	28.8	-	-	**-**
Hungary	100.0	**100.0**	86.6	-	86.6	13.4	**-**	-	-	-	-	-	-	**-**
Japan	100.0	**86.4**	43.2	-	-	43.2	**13.6**	-	-	-	13.6	-	-	**-**
Korea	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Mexico	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Netherlands	100.0	**92.2**	0.4	-	-	91.7	**9.5**	-	-	-	2.6	-	-	**-**
Poland	100.0	**71.7**	13.9	-	-	57.8	**28.3**	-	-	-	28.3	-	-	**-**
Spain	-	**-**	-	-	-	-	**-**	-	-	-	-	-	-	**-**
Switzerland	100.0	**35.3**	10.5	-	-	24.8	**64.7**	-	-	-	62.4	2.3	-	**-**
Turkey	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 3 in Notes to Tables.

Table 26 Current expenditure on ambulatory health care providers by source of funding (Current exp. on ambulatory health care providers = 100)

	Total expenditure on ambulatory health care providers	**HF.1**	HF.1.1			HF.1.2	**HF.2**	HF.2.1 + HF.2.2			HF.2.3	HF.2.4	HF.2.5	**HF.3**
		General government	General government (excl. social security)	HF.1.1.1 Central government	1.1.2;1.1.3 Local government	Social security funds	**Private sector**	Private insurance	HF.2.1 Private social insurance	HF.2.2 Other private insurance	Private household out-of-pocket payments	Non-profit organisations (other than social ins.)	Corporations (other than health insurance)	**Rest of world**
Australia	**100.0**	65.6	65.6	-	-	-	**34.4**	6.0	-	6.0	24.3	-	4.1	**-**
Canada	**100.0**	65.6	64.0	1.9	62.1	1.6	**34.4**	18.1	16.7	1.4	16.3	-	-	**-**
Denmark	**100.0**	67.2	67.2	-	-	-	**32.8**	4.0	-	4.0	28.7	-	-	**-**
Germany	**100.0**	80.5	7.6	-	-	72.9	**19.5**	10.3	-	10.3	8.0	1.2	-	**-**
Hungary	**100.0**	47.3	9.5	7.7	1.8	37.8	**52.7**	-	-	-	-	-	-	**-**
Japan	**100.0**	82.3	5.6	-	-	76.7	**17.7**	-	-	-	17.7	-	-	**-**
Korea	**100.0**	51.2	3.9	-	-	47.4	**48.8**	2.4	2.4	-	46.4	-	-	**-**
Mexico	**100.0**	6.9	6.9	6.9	-	-	**93.1**	1.5	-	1.5	91.6	-	-	**-**
Netherlands	**100.0**	63.2	1.7	-	-	61.3	**36.8**	17.0	6.2	10.8	15.0	-	-	**-**
Poland	**100.0**	62.0	3.2	-	-	58.8	**38.0**	1.3	1.3	-	36.7	-	-	**-**
Spain	**100.0**	50.4	-	-	-	-	**49.6**	9.5	-	9.5	39.5	0.6	-	**-**
Switzerland	**100.0**	50.2	4.0	-	-	46.2	**49.8**	6.1	2.1	4.0	43.4	0.3	-	**-**
Turkey	**100.0**	24.3	21.2	21.2	-	3.2	**75.7**	3.0	1.0	2.0	60.0	1.0	11.7	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 3 in Notes to Tables.

Table 27 Current public expenditure on health by provider (Current public expenditure on health = 100)

	Current public expenditure	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	**HP.4** Retail sale and other providers of medical goods	**HP.5** Provision and administration of public health programmes	**HP.6** General health administration and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds	HP.6.3; 6.4 Private insurance	**HP.7** All other industries	**HP.9** Rest of the world
Australia	100.0	**38.3**	**7.5**	**30.0**	14.5	0.8	1.2	6.1	5.5	0.0	1.9	**10.9**	**1.8**	**11.6**	-	-	-	**-**	**-**
Canada	100.0	**42.2**	**10.4**	**27.3**	20.7	0.7	1.3	-	-	2.8	2.0	**8.7**	**9.6**	**0.7**	0.7	-	-	**0.4**	**-**
Denmark	100.0	**45.0**	**25.7**	**15.2**	1.4	1.3	7.8	0.5	-	2.8	1.3	**9.2**	**0.1**	**2.2**	-	-	-	**2.4**	**0.2**
Germany	100.0	**34.8**	**6.6**	**28.8**	15.5	6.7	2.2	-	-	2.9	1.4	**18.7**	**1.1**	**5.8**	0.0	5.8	-	**3.9**	**0.2**
Hungary	100.0	**46.2**	**0.5**	**16.3**	5.8	1.2	-	4.6	0.4	0.2	4.0	**30.3**	**3.7**	**2.6**	0.6	1.9	-	**-**	**0.4**
Japan	100.0	**55.2**	**3.1**	**29.5**	21.8	6.7	-	-	-	0.3	0.8	**7.8**	**1.9**	**2.4**	-	2.4	-	**-**	**-**
Korea	100.0	**31.1**	**-**	**36.4**	28.9	3.9	2.9	0.7	-	-	-	**22.1**	**2.5**	**7.9**	3.8	4.2	-	**-**	**-**
Mexico	100.0	**69.9**	**-**	**4.0**	-	-	-	4.0	-	-	-	**0.2**	**6.7**	**19.1**	7.8	11.4	-	**-**	**-**
Netherlands	100.0	**40.5**	**15.9**	**22.9**	-	-	-	-	-	-	-	**12.6**	**1.8**	**3.6**	-	-	-	**2.0**	**0.7**
Poland	100.0	**42.0**	**1.8**	**22.8**	12.3	-	-	6.3	-	0.2	4.0	**13.3**	**3.8**	**6.1**	2.1	4.0	-	**8.3**	**-**
Spain	100.0	**52.5**	**-**	**20.1**	1.4	0.1	0.1	16.8	0.4	0.4	0.9	**22.8**	**1.2**	**2.8**	1.8	1.0	-	**0.5**	**0.0**
Switzerland	100.0	**45.0**	**10.9**	**26.9**	18.2	0.8	2.4	-	1.5	2.8	1.2	**9.3**	**-**	**7.4**	2.7	3.8	1.0	**0.5**	**-**
Turkey	100.0	**47.9**	**-**	**8.8**	0.0	0.3	0.0	7.5	0.4	-	0.5	**27.4**	**0.5**	**1.6**	0.3	1.3	-	**-**	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 3 in Notes to Tables.

Table 28. Current private expenditure on health by provider (Current private expenditure on health = 100)

	Current private expenditure	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	**HP.4** Retail sale and other providers of medical goods	**HP.5** Provision and administration of public health programmes	**HP.6** General health administration and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds	HP.6.3; 6.4 Private insurance	**HP.7** All other industries	**HP.9** Rest of the world
Australia	**100.0**	**23.4**	**3.9**	**34.9**	9.8	12.8	10.1	0.0	-	(0.0)	2.1	**29.7**	**0.0**	**8.1**	-	-	-	**-**	**-**
Canada	**100.0**	**9.3**	**8.9**	**33.2**	0.6	25.3	7.3	-	-	-	-	**42.1**	**-**	**5.1**	-	-	5.1	**-**	**-**
Denmark	**100.0**	**1.0**	**11.8**	**40.8**	14.8	24.2	0.7	-	-	-	1.1	**45.1**	**0.2**	**1.0**	-	-	1.0	**-**	**-**
Germany	**100.0**	**18.5**	**10.1**	**24.7**	9.5	7.4	3.5	-	-	2.4	1.9	**32.9**	**4.4**	**6.4**	-	-	6.4	**2.9**	**0.1**
Hungary	**100.0**	**10.7**	**-**	**38.7**	0.1	22.6	-	15.5	-	-	0.5	**42.8**	**7.7**	**-**	-	-	-	**-**	**-**
Japan	**100.0**	**31.2**	**2.0**	**26.3**	18.5	7.6	-	-	-	0.1	-	**30.5**	**8.2**	**1.7**	-	-	1.7	**-**	**-**
Korea	**100.0**	**28.7**	**-**	**45.1**	19.3	16.8	8.7	0.3	-	-	-	**21.9**	**-**	**-**	-	-	-	**4.3**	**-**
Mexico	**100.0**	**21.0**	**-**	**41.6**	41.0	-	-	-	0.2	0.4	-	**35.8**	**-**	**1.6**	-	-	1.6	**-**	**-**
Netherlands	**100.0**	**30.0**	**3.1**	**25.4**	-	-	-	-	-	-	-	**26.5**	**1.2**	**6.7**	-	-	-	**6.4**	**0.8**
Poland	**100.0**	**1.2**	**1.7**	**32.7**	16.0	13.5	1.1	-	1.8	0.2	0.1	**59.4**	**-**	**0.0**	-	-	0.0	**1.7**	**0.3**
Spain	**100.0**	**17.5**	**-**	**48.2**	48.2	-	-	-	-	-	-	**32.2**	**-**	**2.1**	-	-	2.1	**-**	**-**
Switzerland	**100.0**	**21.6**	**26.5**	**35.6**	16.8	13.8	1.5	-	1.0	1.0	1.5	**9.6**	**-**	**5.0**	1.1	-	3.8	**1.8**	**-**
Turkey	**100.0**	**16.8**	**-**	**46.3**	22.8	8.6	-	7.2	7.1	-	0.0	**26.7**	**0.3**	**2.8**	-	-	2.8	**-**	**-**

Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional note 3 in Notes to Tables.

Table 29. Current households' health expenditure by provider (Current households' health expenditure = 100)

	Current expenditure by households	**HP.1** Hospitals	**HP.2** Nursing and residential care facilities	**HP.3** Providers of ambulatory health care	HP.3.1 Offices of physicians	HP.3.2 Offices of dentists	HP.3.3 Offices of other health practitioners	HP.3.4 Out-patient care centres	HP.3.5 Medical and diagnostic laboratories	HP.3.6 Providers of home health care services	HP.3.9 All other providers of ambulatory health care	**HP.4** Retail sale and other providers of medical goods	**HP.5** Provision and administration of public health programmes	**HP.6** General health administration and insurance	HP.6.1 Government administration of health	HP.6.2 Social security funds	HP.6.3; 6.4 Private insurance	**HP.7** All other industries	**HP.9** Rest of the world
Australia	**100.0**	**9.4**	**6.3**	**39.6**	9.1	16.1	12.4	-	-	-	2.0	**44.8**	**-**	**-**	-	-	-	**-**	**-**
Canada	**100.0**	**3.8**	**15.7**	**27.9**	1.1	20.2	6.7	-	-	-	-	**50.6**	**-**	**-**	-	-	-	**-**	**-**
Denmark	**100.0**	**1.1**	**12.6**	**38.0**	14.9	22.0	-	-	-	-	1.1	**47.1**	**0.2**	**1.1**	-	-	1.1	**-**	**-**
Germany	**100.0**	**6.2**	**19.3**	**20.4**	3.1	7.7	4.9	-	-	4.4	0.3	**53.9**	**-**	**0.0**	-	-	-	**0.2**	**-**
Hungary	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Japan	**100.0**	**34.7**	**2.3**	**29.2**	20.6	8.5	-	-	-	0.2	-	**33.9**	**-**	**-**	-	-	-	**-**	**-**
Korea	**100.0**	**28.2**	**-**	**47.5**	18.9	18.6	9.7	0.3	-	-	-	**24.2**	**-**	**-**	-	-	-	**-**	**-**
Mexico	**100.0**	**19.4**	**-**	**43.1**	43.1	-	-	-	-	-	-	**37.5**	**-**	**-**	-	-	-	**-**	**-**
Netherlands	**100.0**	**6.4**	**3.0**	**36.6**	-	-	-	-	-	-	-	**51.7**	**1.1**	**-**	-	-	-	**1.0**	**0.2**
Poland	**100.0**	**1.3**	**1.8**	**34.1**	16.2	14.6	1.2	-	1.9	0.2	0.1	**62.8**	**-**	**-**	-	-	-	**-**	**-**
Spain	**100.0**	**14.7**	**-**	**46.4**	46.4	-	-	-	-	-	-	**38.9**	**-**	**-**	-	-	-	**-**	**-**
Switzerland	**100.0**	**10.2**	**34.6**	**42.0**	18.7	17.7	2.0	-	1.4	0.8	1.3	**10.8**	**-**	**1.5**	1.5	-	-	**0.9**	**-**
Turkey	**100.0**	**16.5**	**-**	**49.2**	29.0	11.4	-	0.0	8.8	-	-	**33.1**	**-**	**-**	-	-	-	**-**	**-**

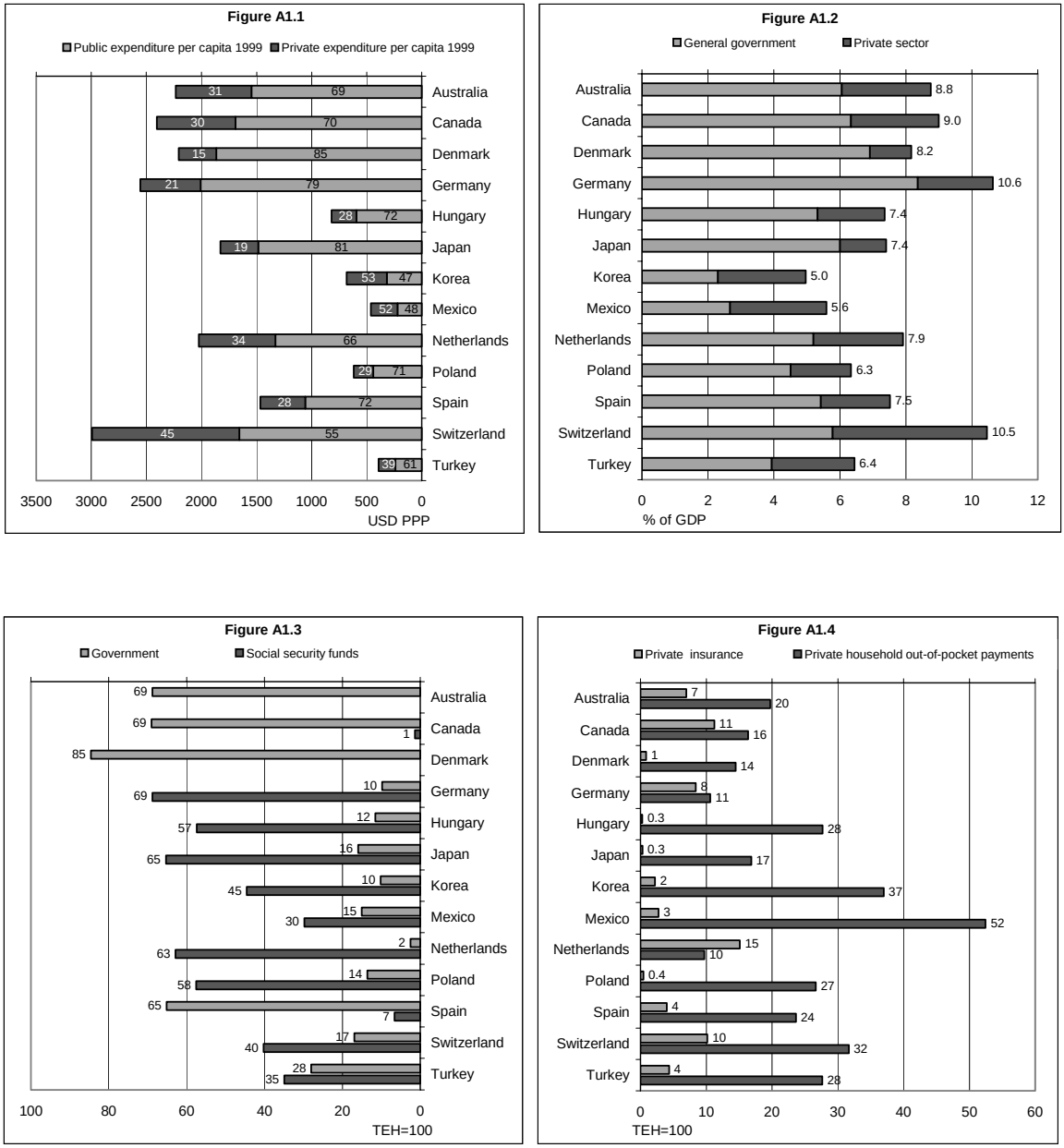
Canada, Denmark, Poland: 1999; Australia, Japan, Turkey: 2000; Germany, Hungary, Korea, Mexico, Netherlands, Spain, Switzerland: 2001.

See additional notes 2 and 3 in Notes to Tables.

FIGURES

Note: The following are intended to provide additional information to the main figures contained in Part I of this Working Paper, although in some cases there may be a degree of overlap.

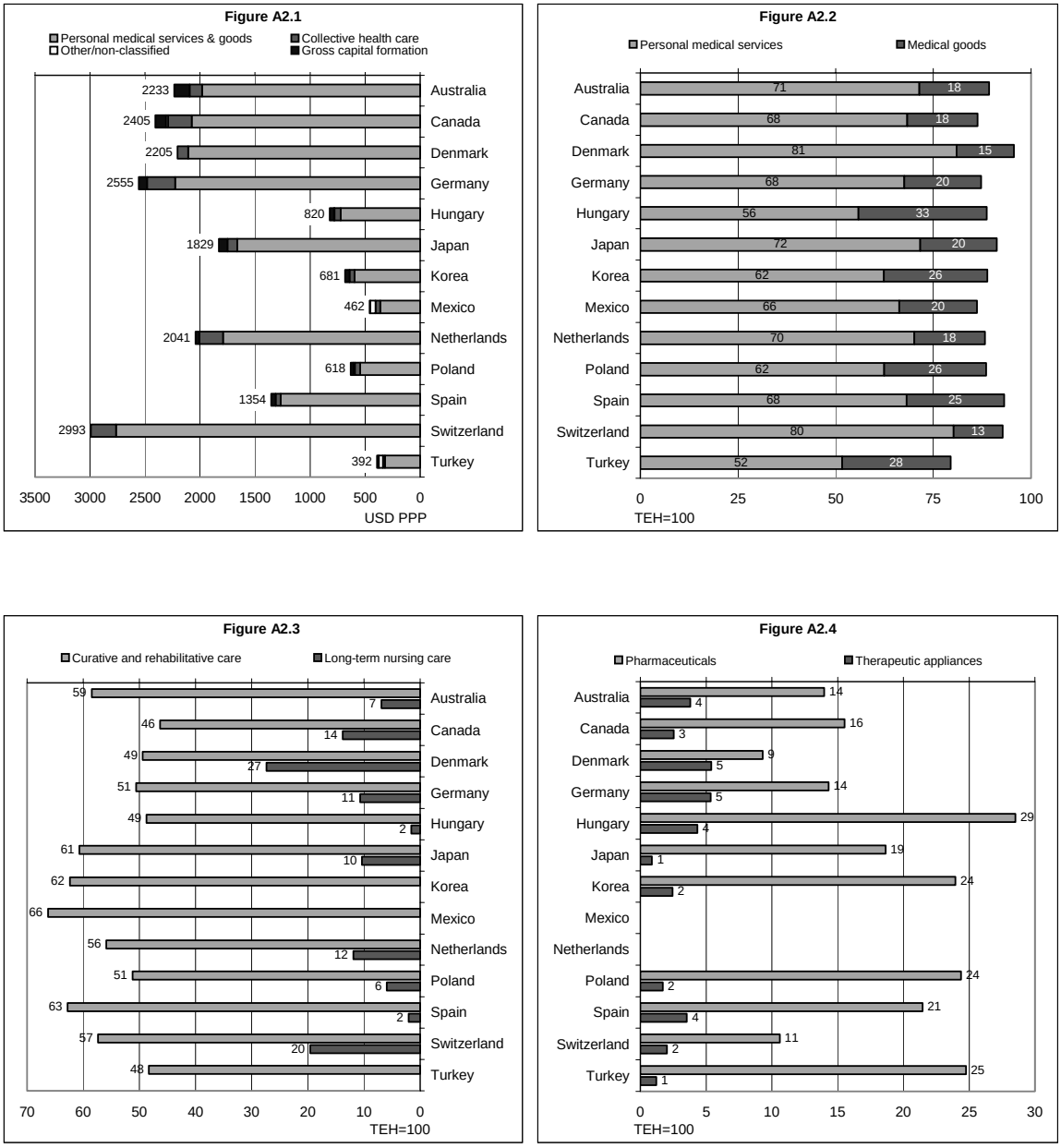
Figure A1. Total expenditure on health by financing agent



TEH = Total Expenditure on Health
General government (HF.1) = Public sector
Government (HF.1.1) = General government excluding social security funds.

Source: Table 1.

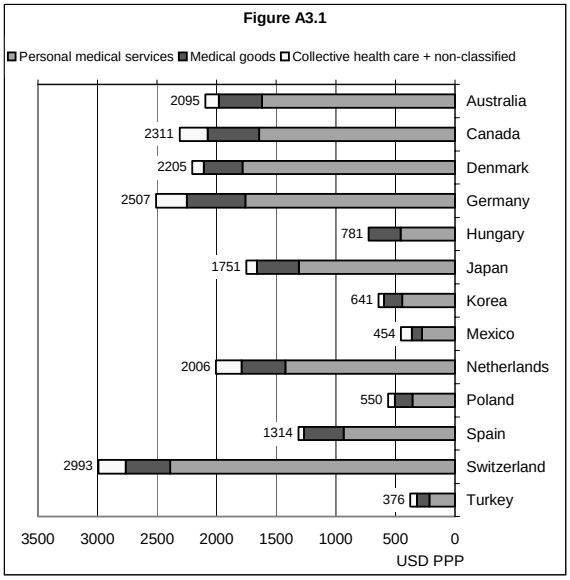
Figure A2. Total Health Expenditure by function of care

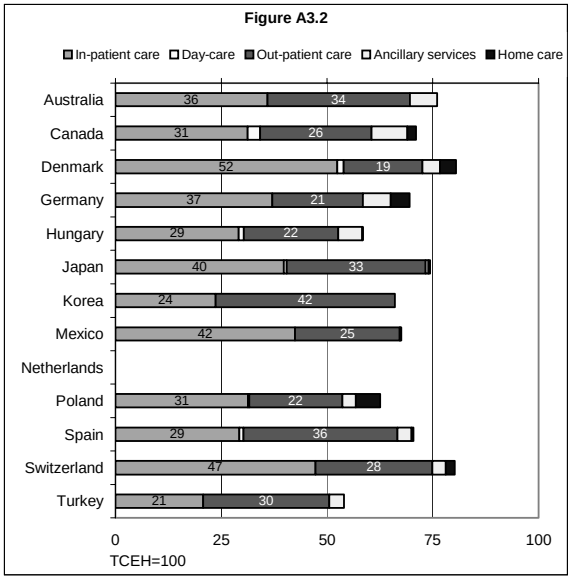


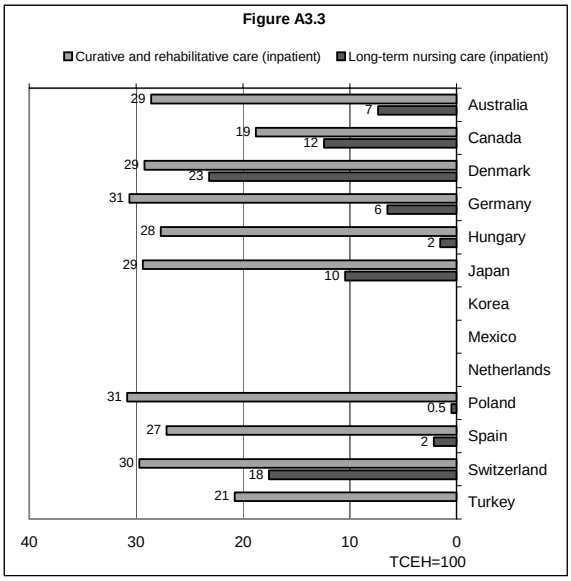
TEH = Total Expenditure on Health

Source: Table 2.

Figure A3. Current Health Expenditure by mode of production



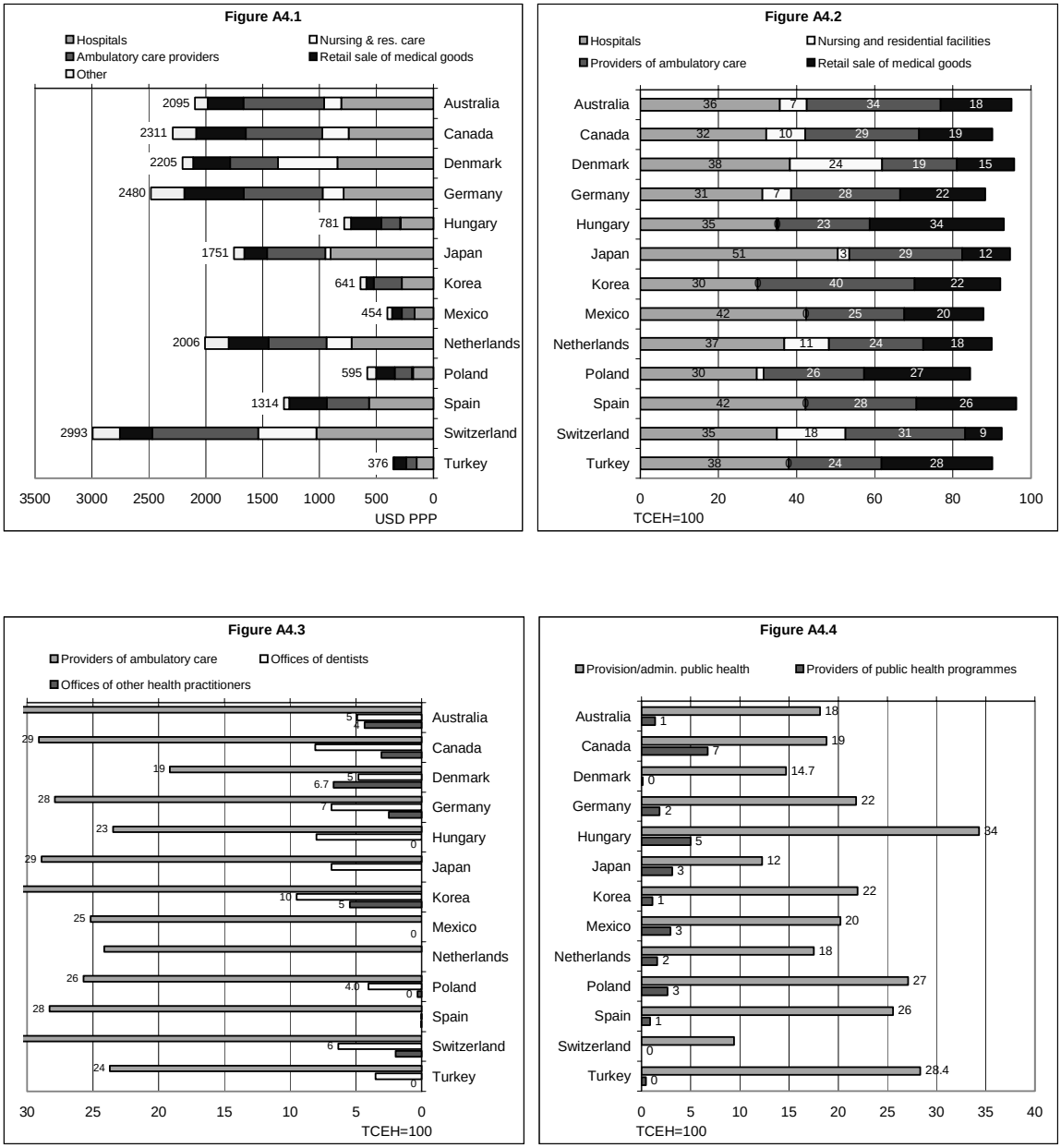




TCEH = Total Current Expenditure on Health

Source: Table 3.

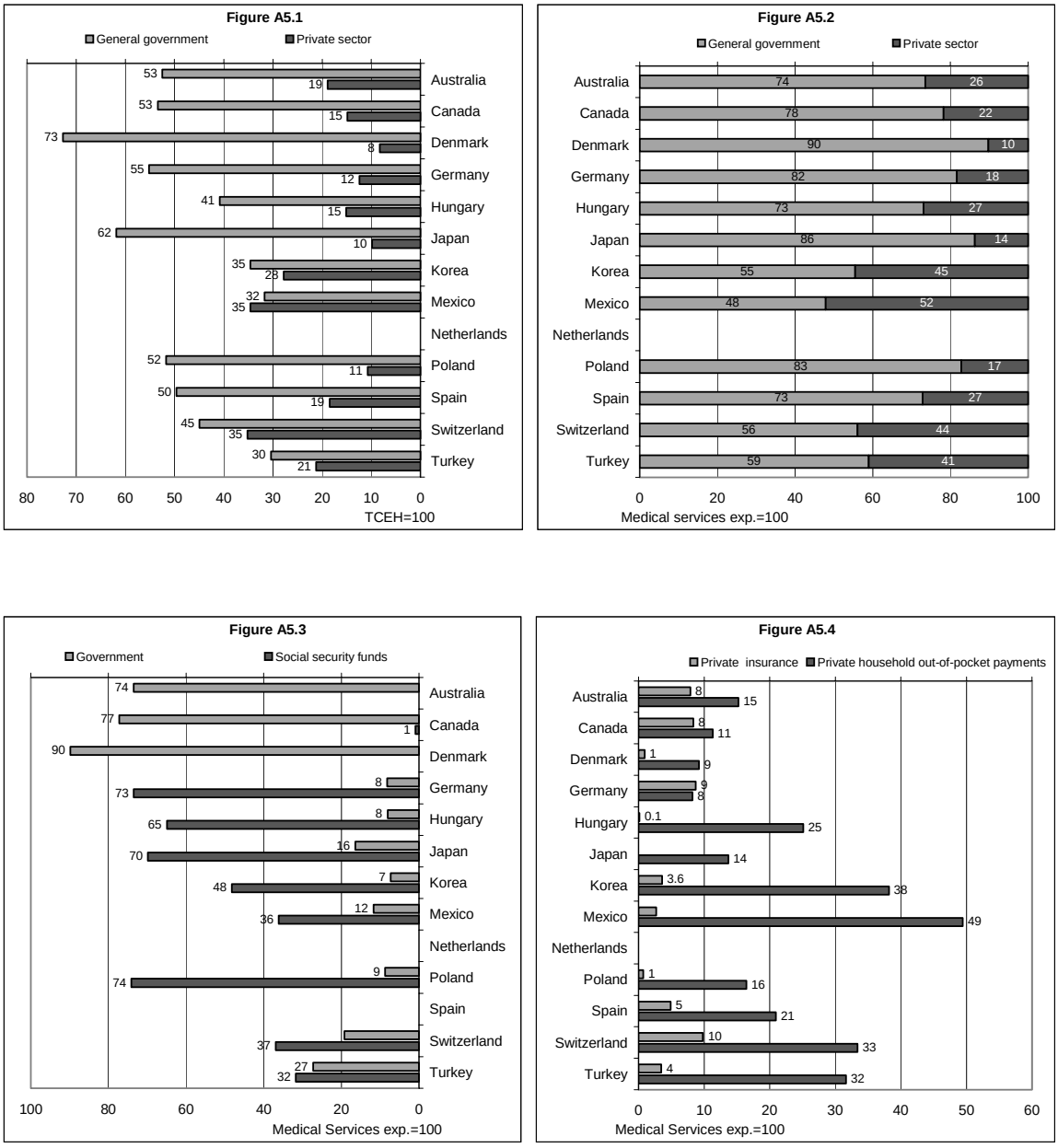
Figure A4. Current Health Expenditure by provider



TCEH = Total Current Expenditure on Health

Source: Table 4.

Figure A5. Medical Services Expenditure by financing agent

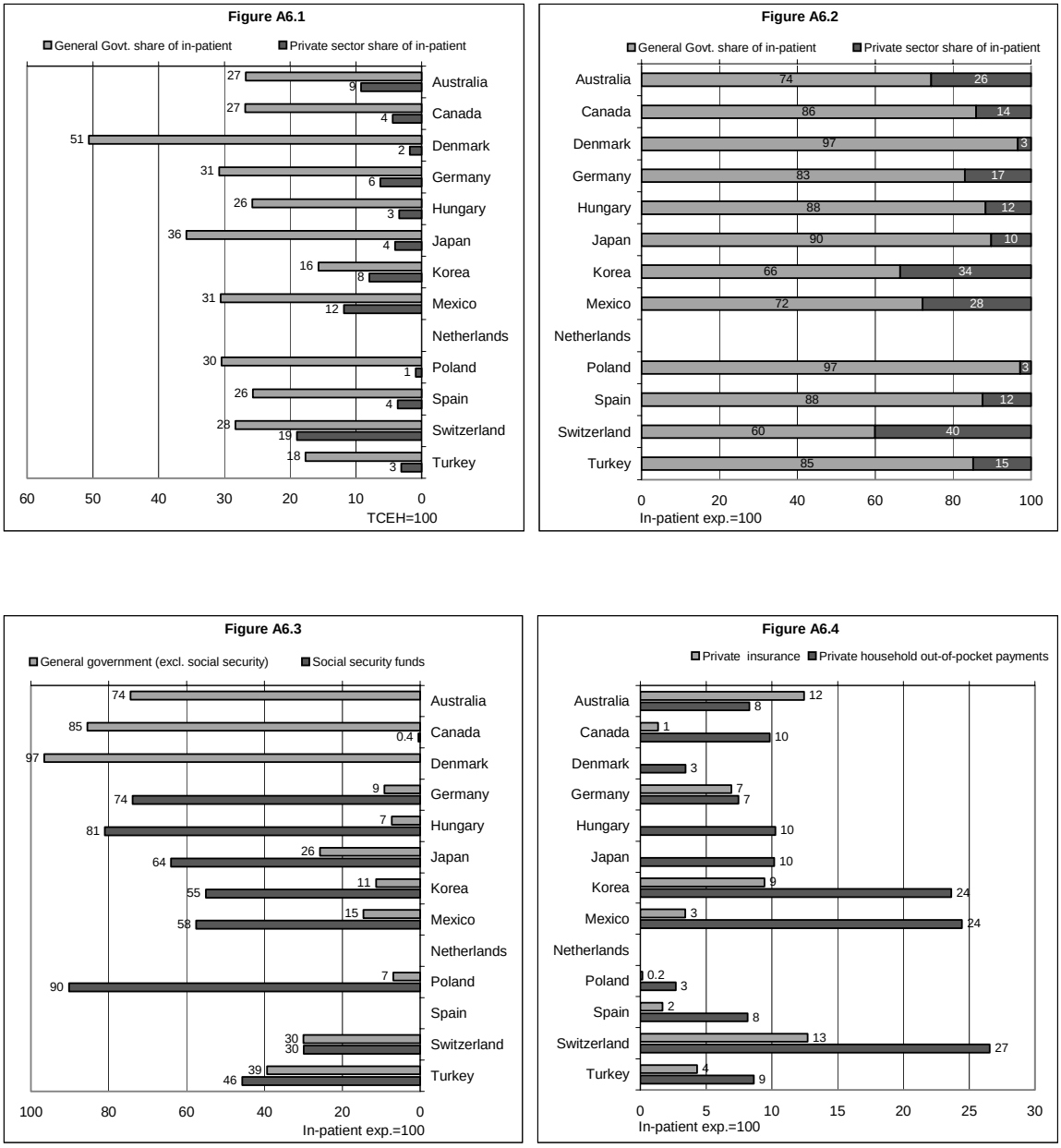


TCEH = Total Current Expenditure on Health

Government (HF.1.1) = General government excluding social security funds.

Source: Table 5.

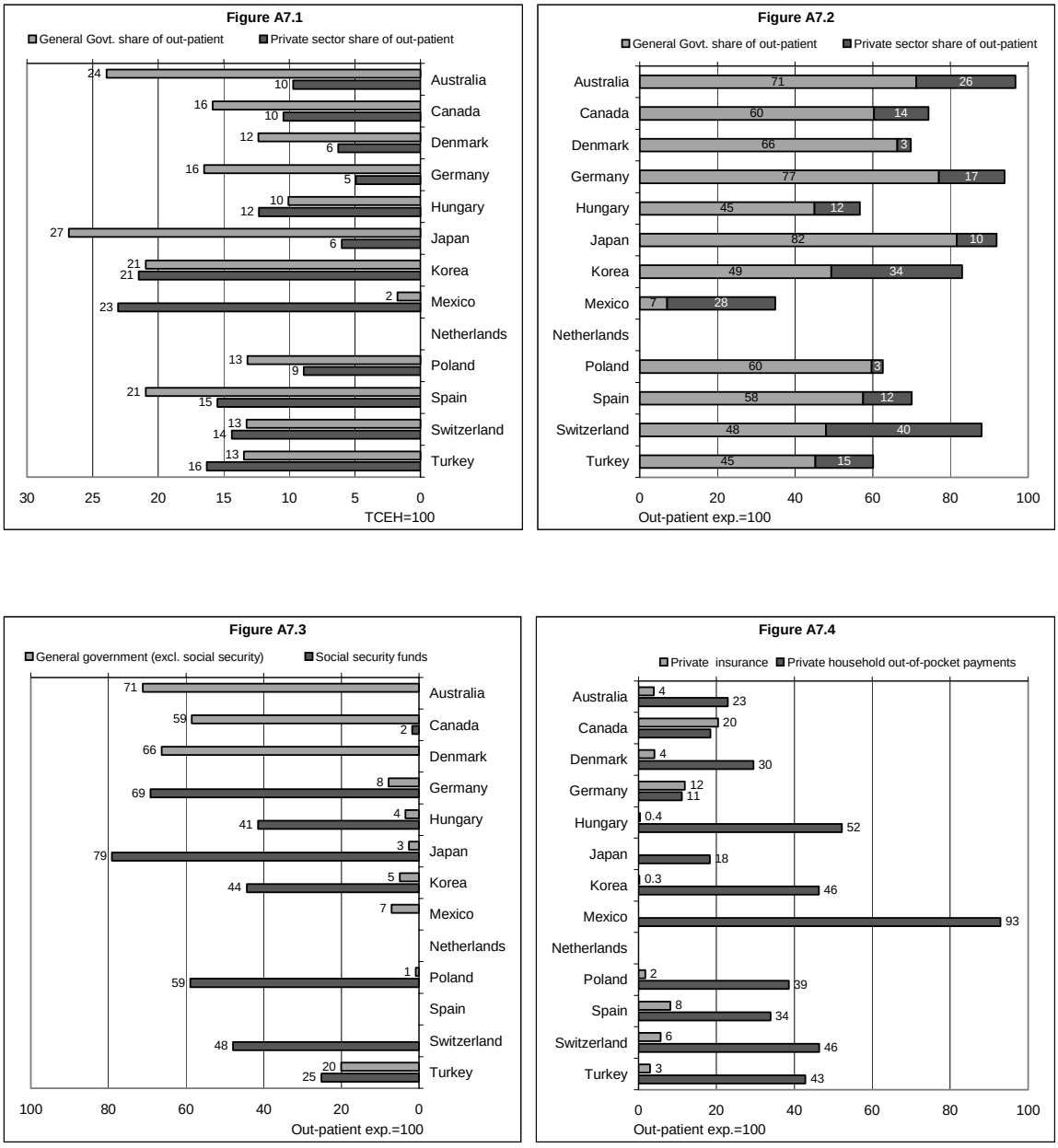
Figure A6. In-patient Expenditure by financing agent



TCEH = Total Current Expenditure on Health

Source: Table 8.

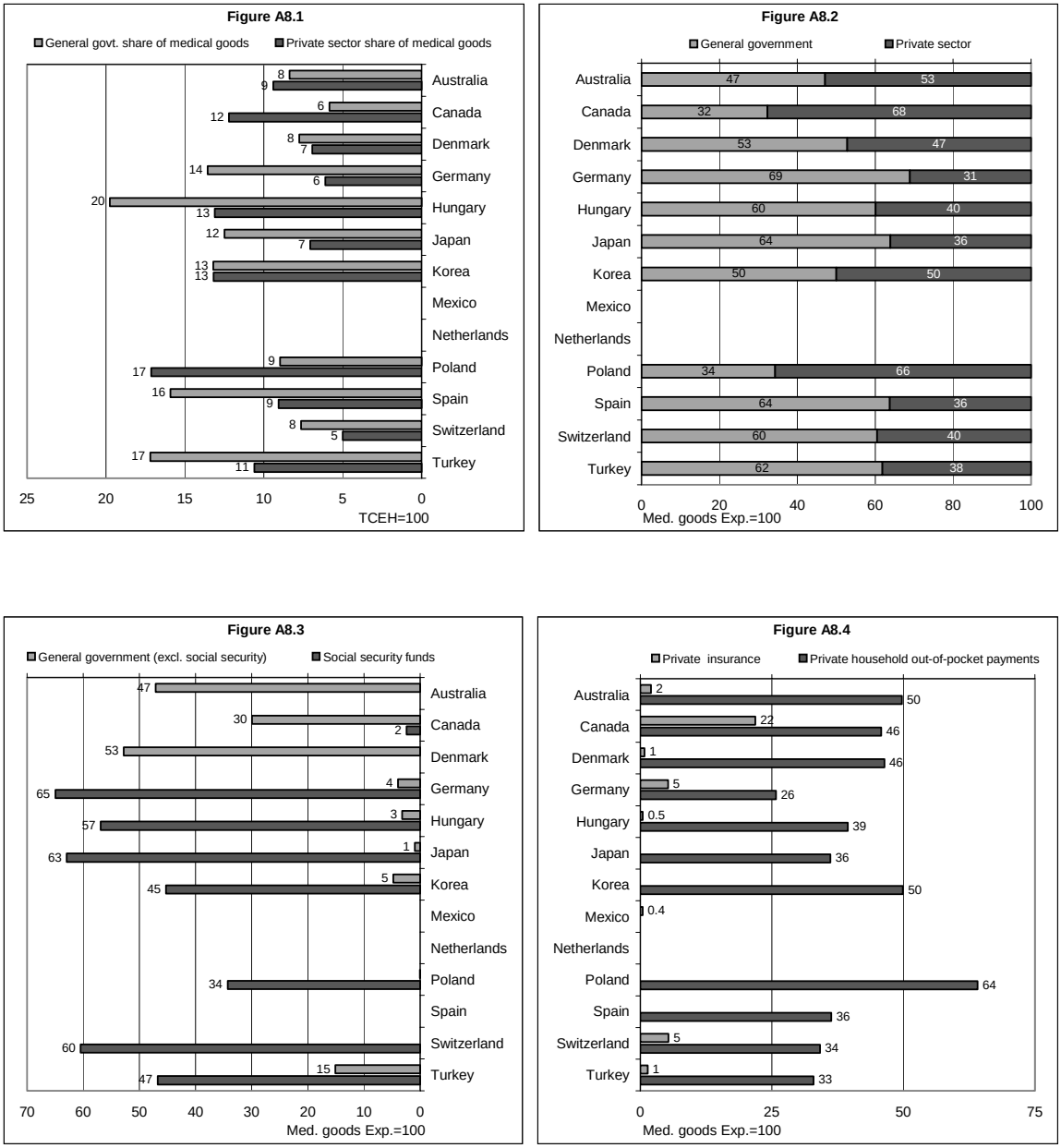
Figure A7. Out-patient Expenditure by financing agent



TCEH = Total Current Expenditure on Health

Source: Table 9.

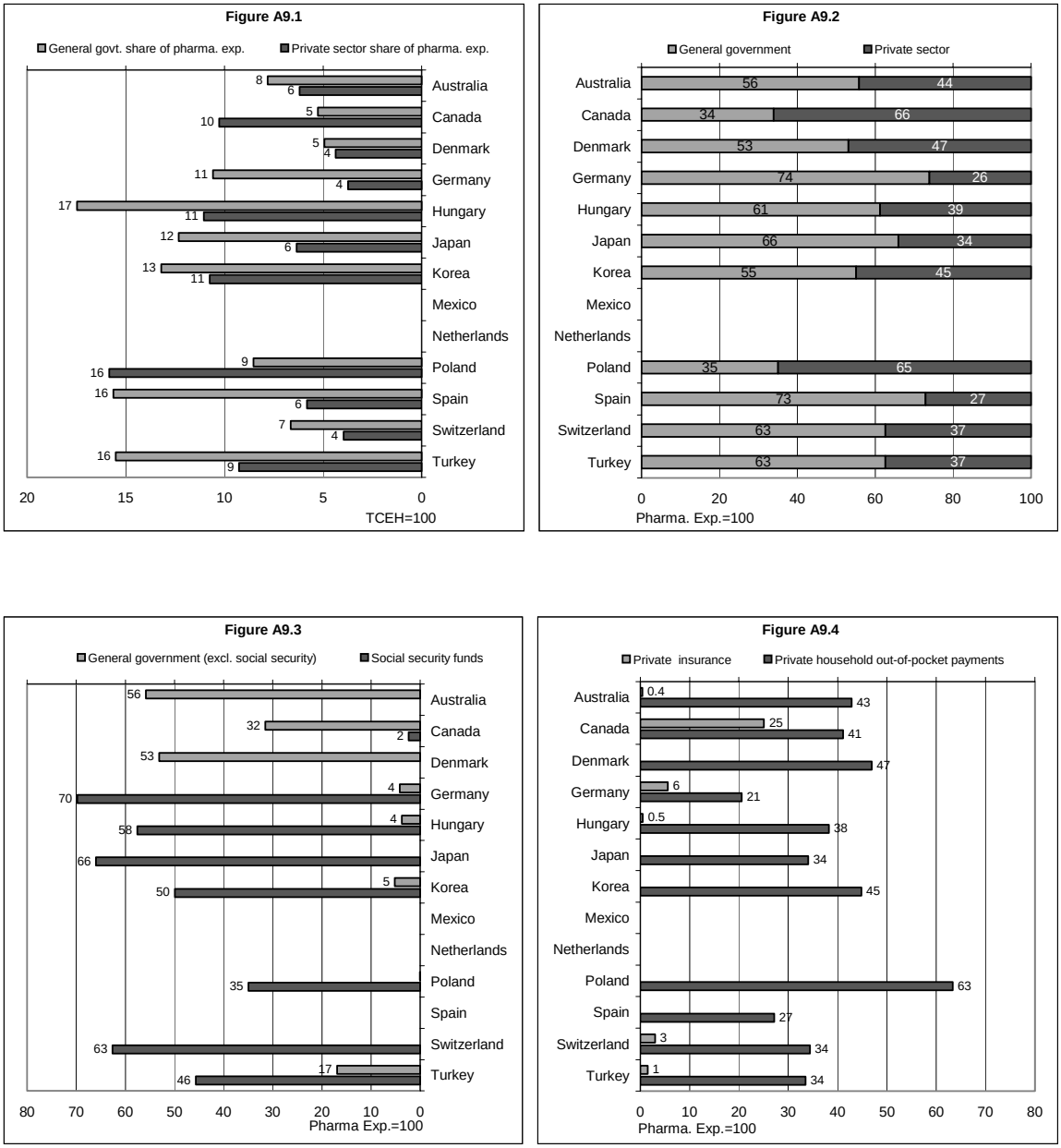
Figure A8. Medical goods Expenditure by financing agent



TCEH = Total Current Expenditure on Health

Source: Table 10.

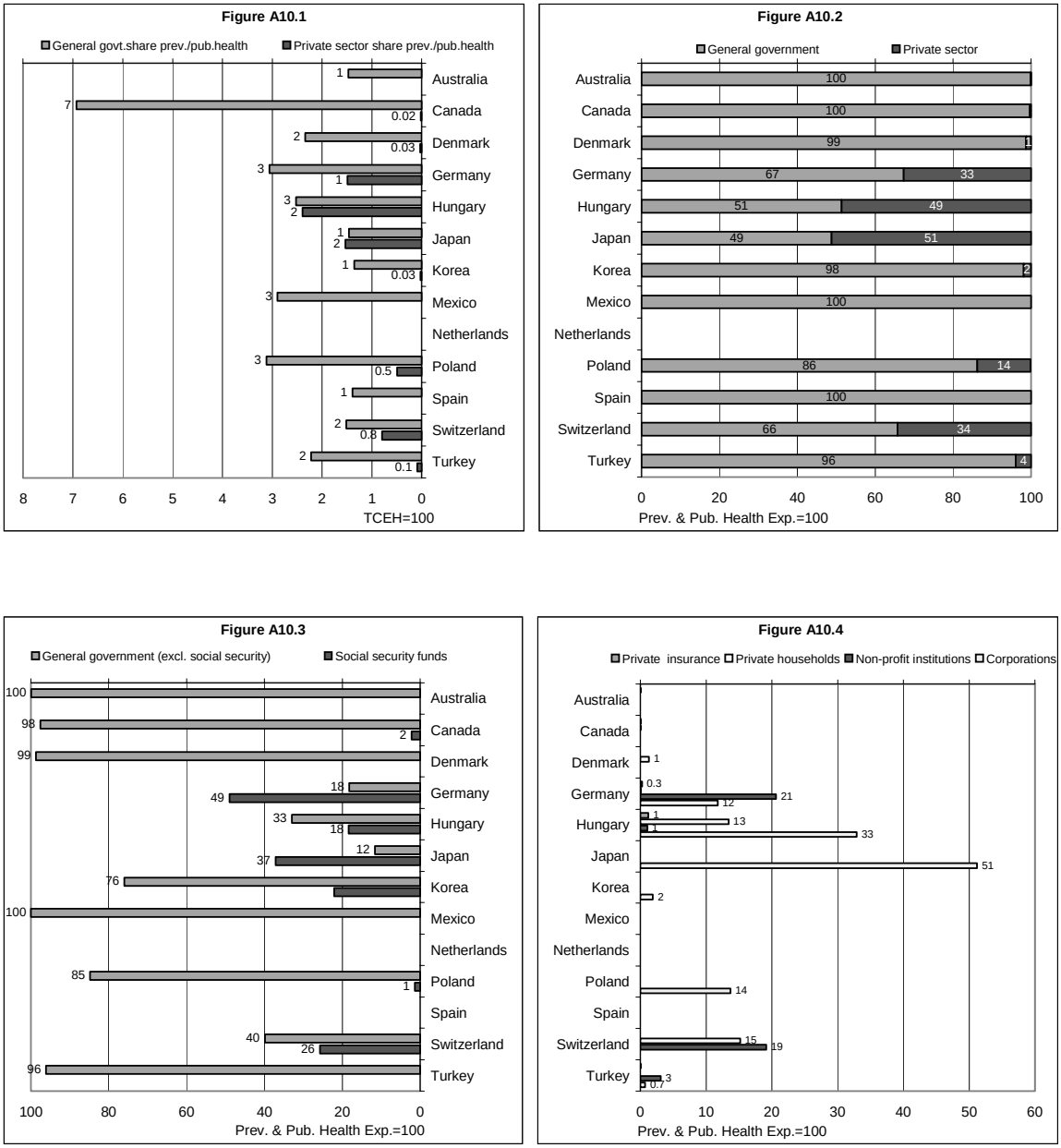
Figure A9. Pharmaceutical Expenditure by financing agent



TCEH = Total Current Expenditure on Health

Source: Table 11.

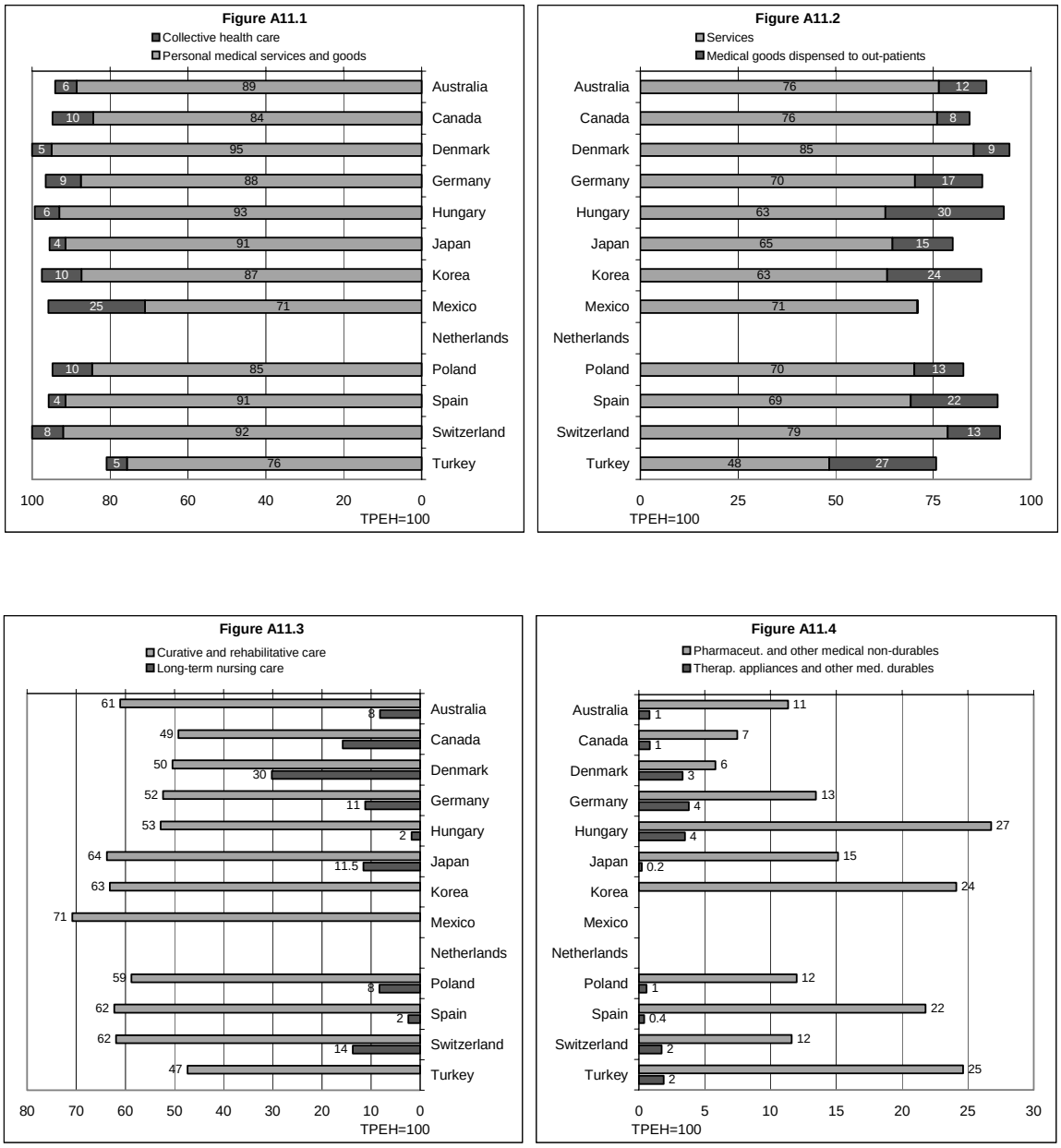
Figure A10. Prevention and Public Health Expenditure by financing agent



TCEH = Total Current Expenditure on Health

Source: Table 12.

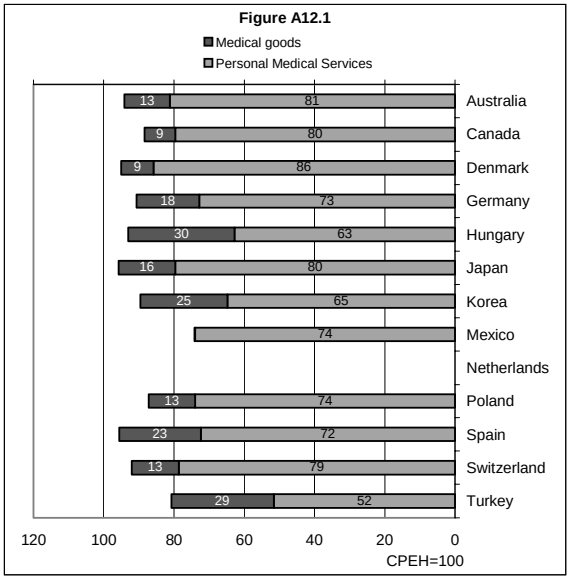
Figure A11. Total Public Expenditure on Health by function of care

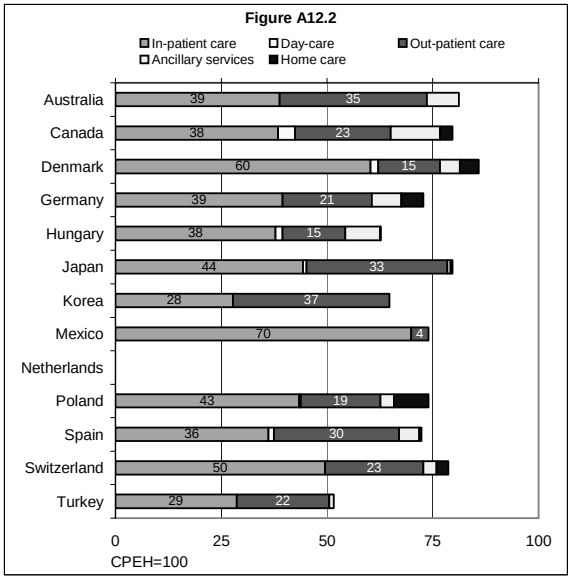


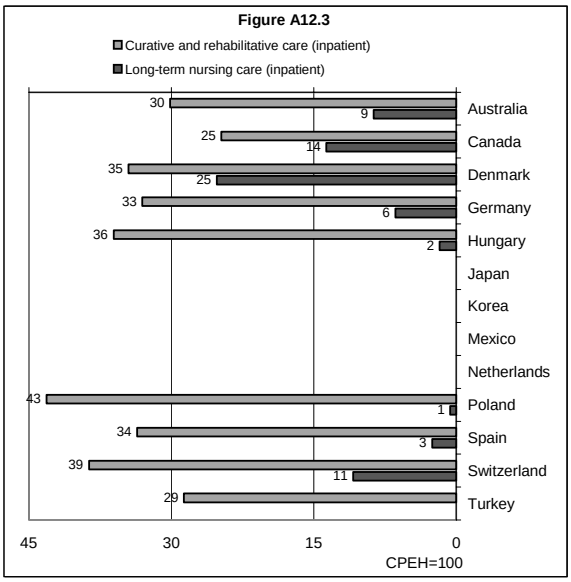
TPEH = Total Public Expenditure on Health

Source: Table 13.

Figure A12. Current Public Expenditure on Health by mode of production



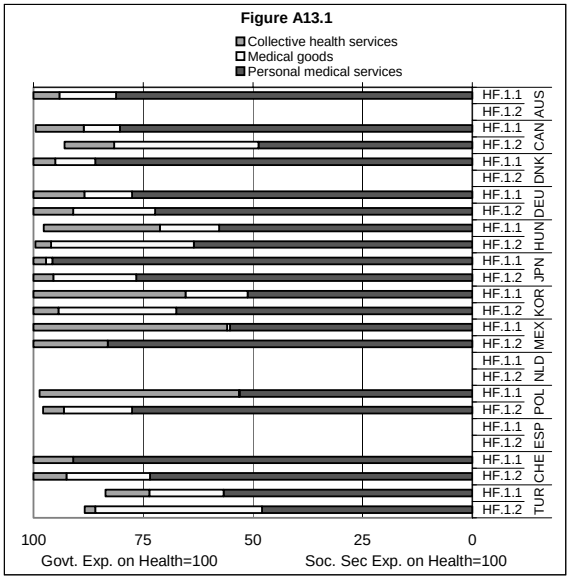


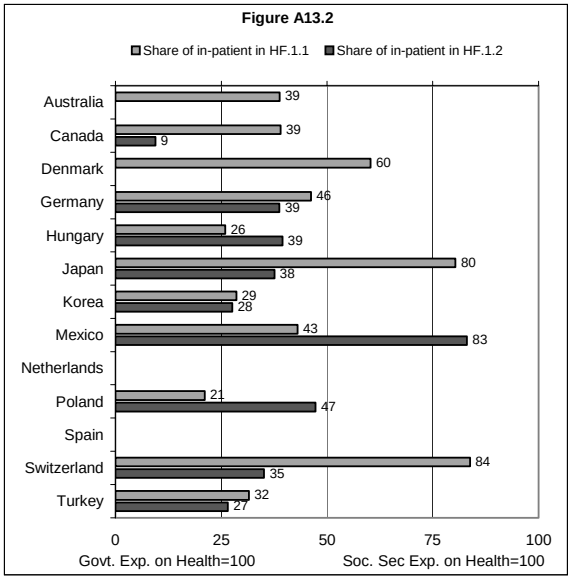


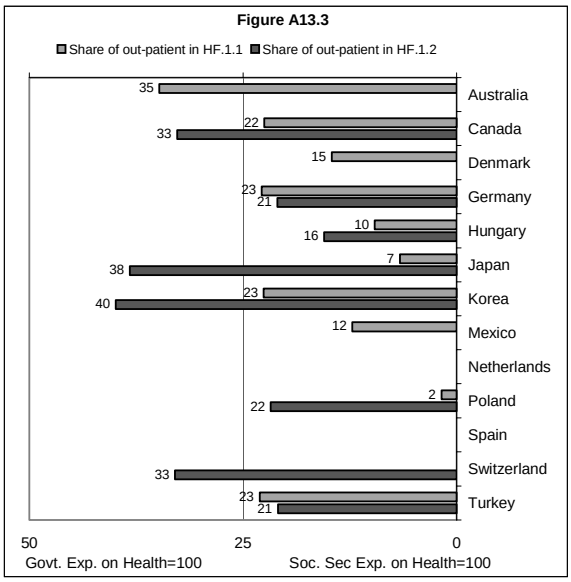
CPEH = Current Public Expenditure on Health

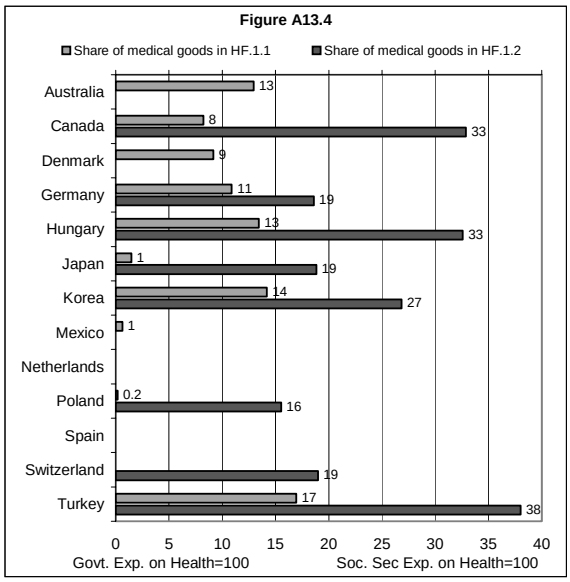
Source: Table 14.

Figure A13. Current Government and Social Security Health Expenditure by mode of production



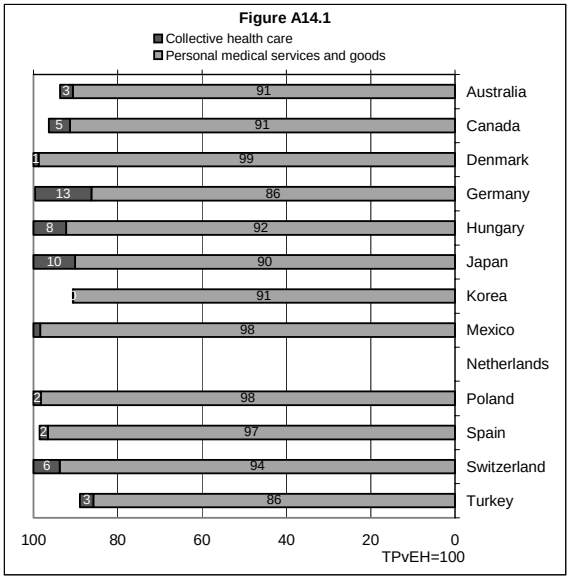


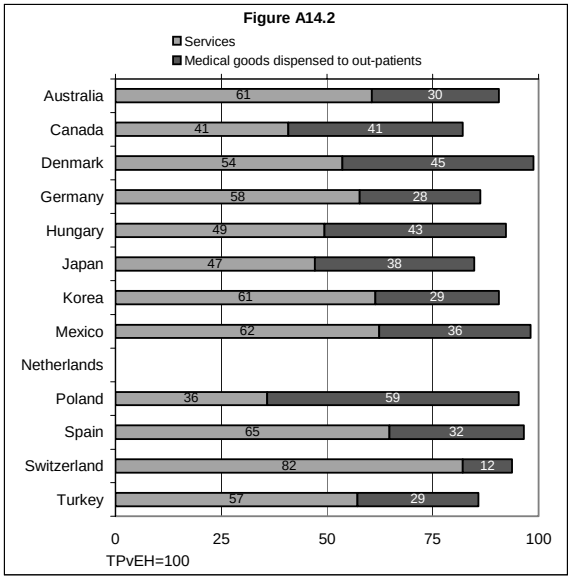


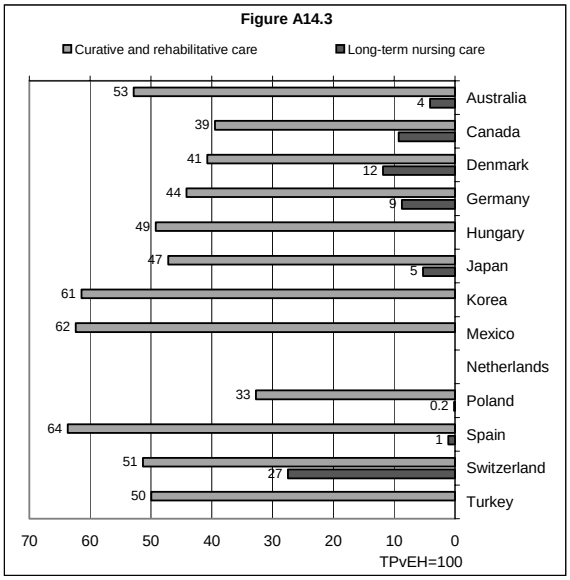


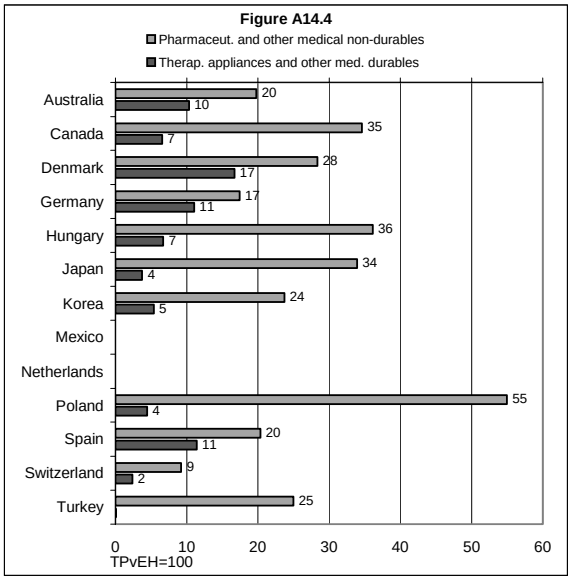
Source: Table 15.

Figure A14. Total Private Health Expenditure by function of care





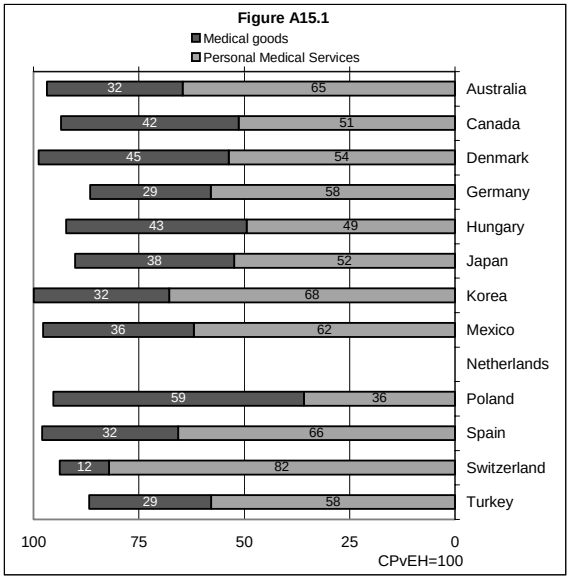


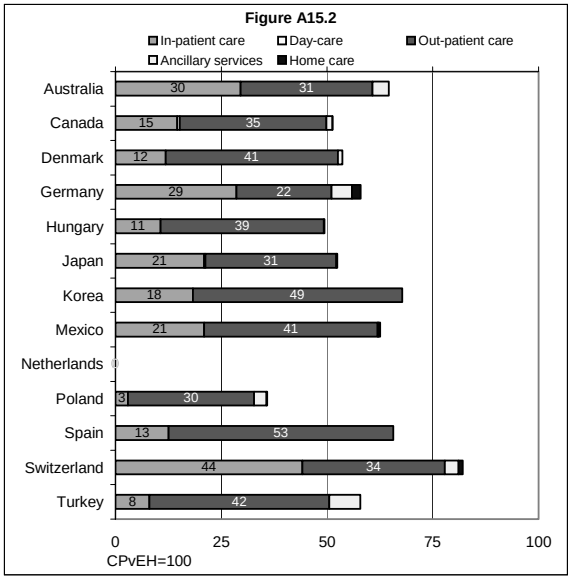


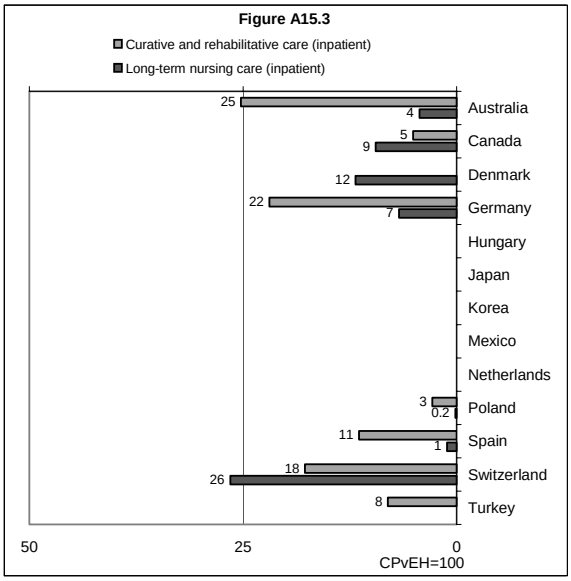
TPvEH = Total Private Expenditure on Health

Source: Table 16.

Figure A15. Current Private Health Expenditure by mode of production



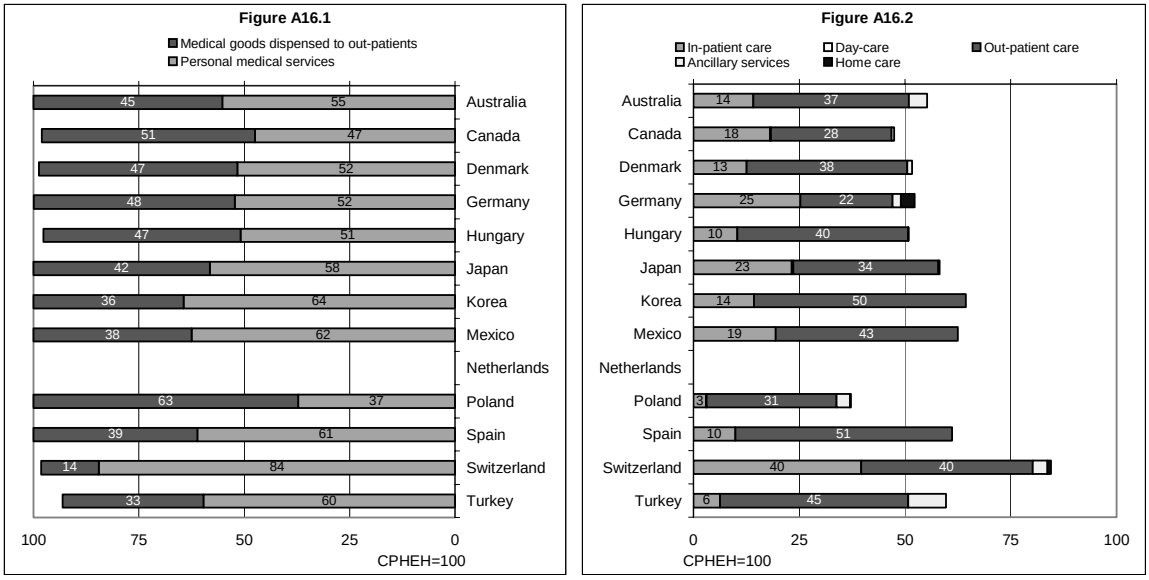




CPvEH = Current Private Expenditure on Health

Source: Table 17.

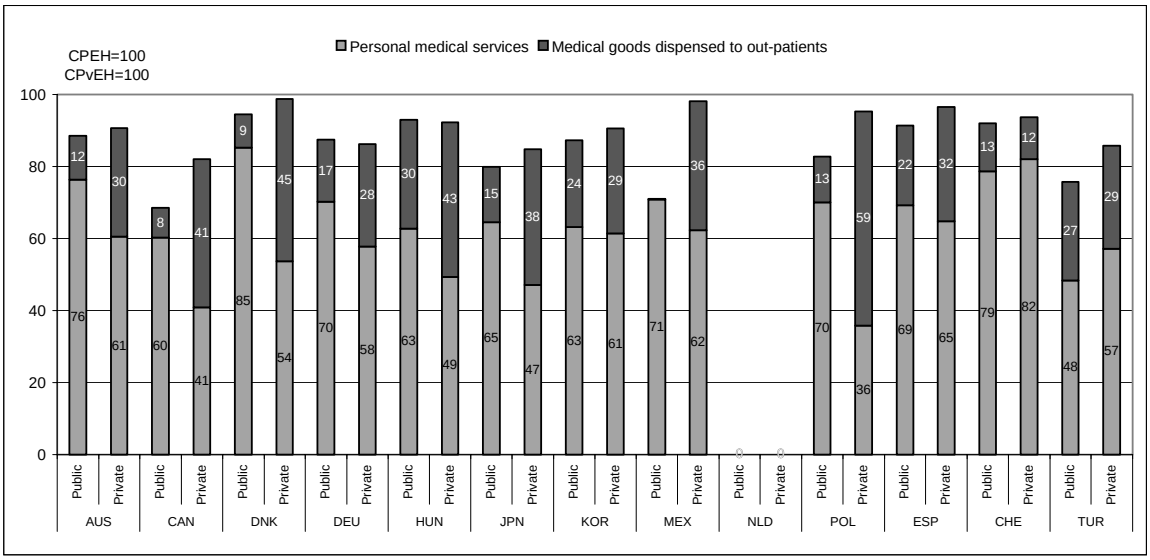
Figure A16. Private Households' Expenditure by mode of production



CPHEH = Current Private Households Expenditure on Health

Source: Table 19.

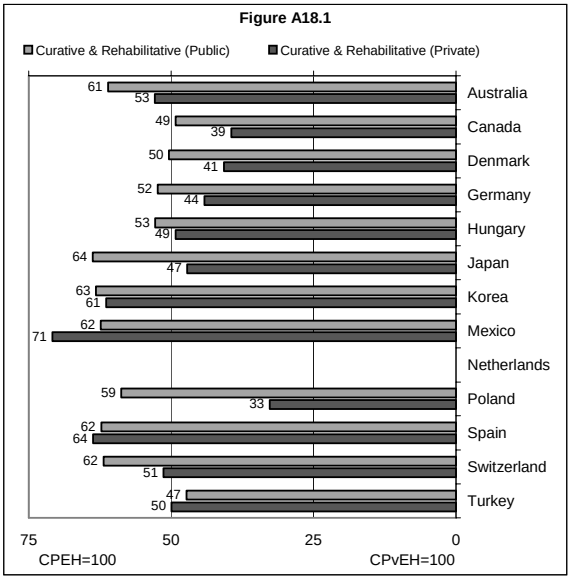
Figure A17. Share of personal medical services and goods in Public and Private Health Expenditure

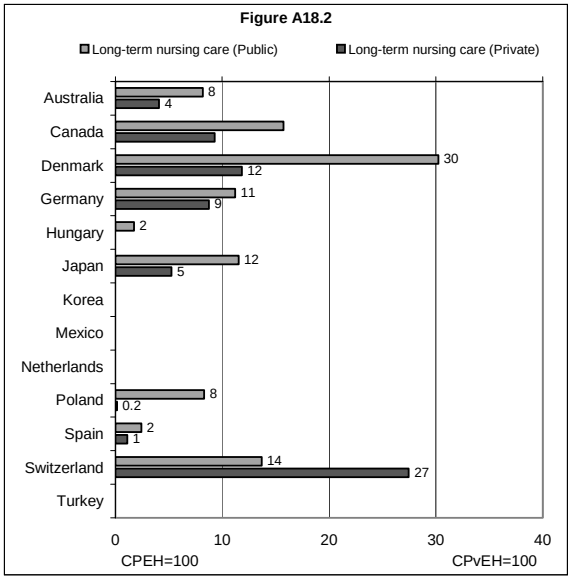


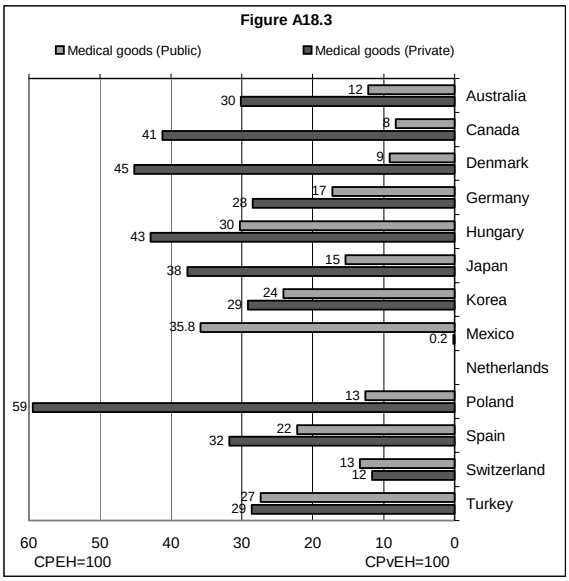
CPEH = Current Public Expenditure on Health
CPvEH = Current Private Expenditure on Health

Source: Table 16.

Figure A18. Public and Private Health Expenditure by function



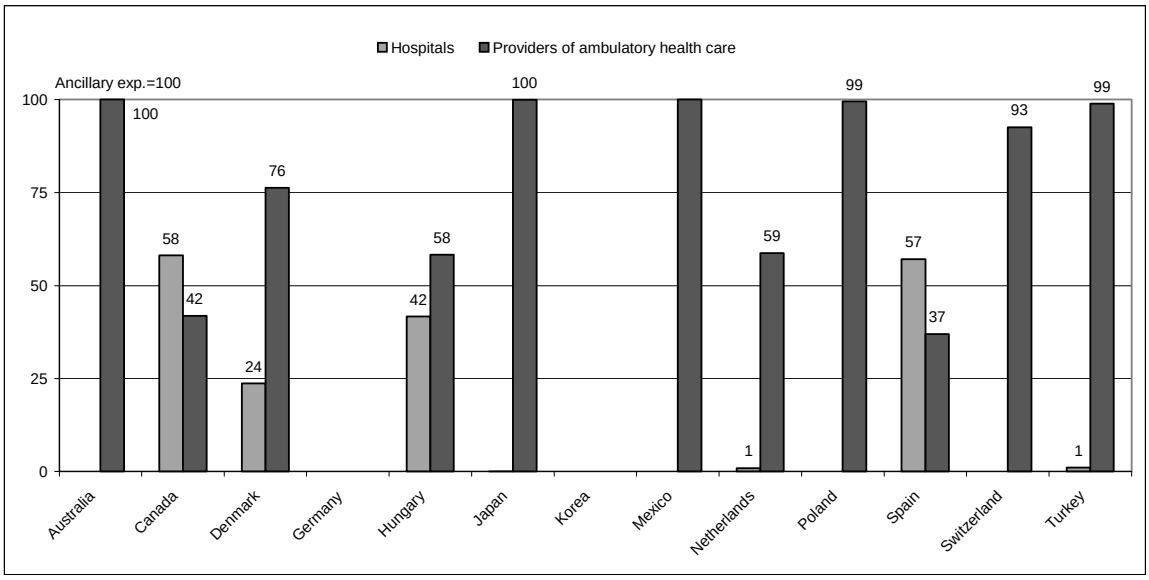




CPEH = Current Public Expenditure on Health
CPvEH = Current Private Expenditure on Health

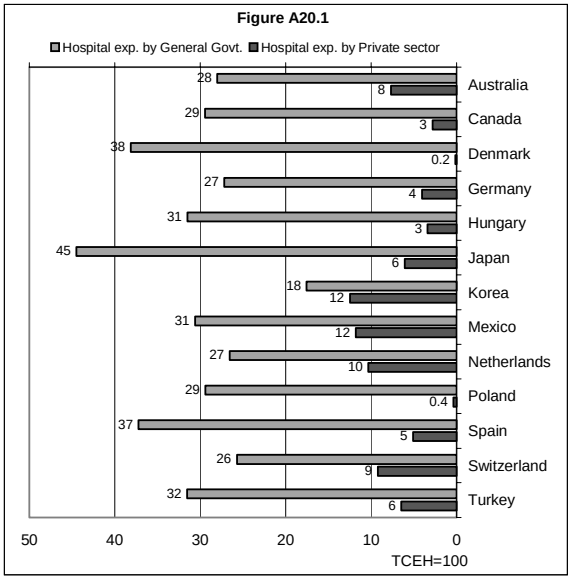
Source: Table 16.

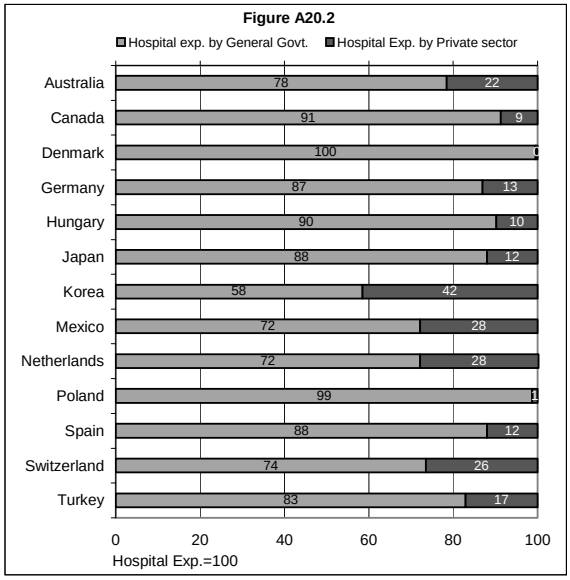
Figure A19. Provision of ancillary services

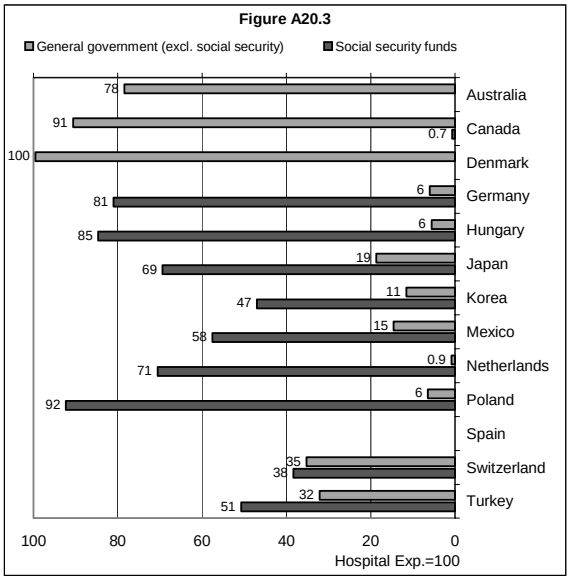


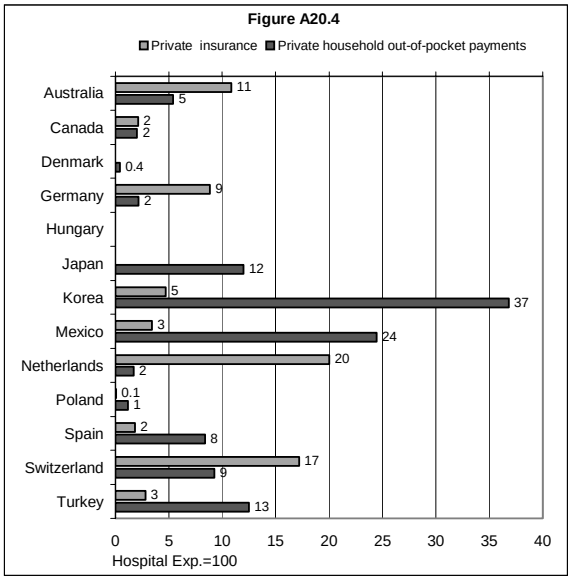
Source: Table 23.

Figure A20. Hospital services by financing agent





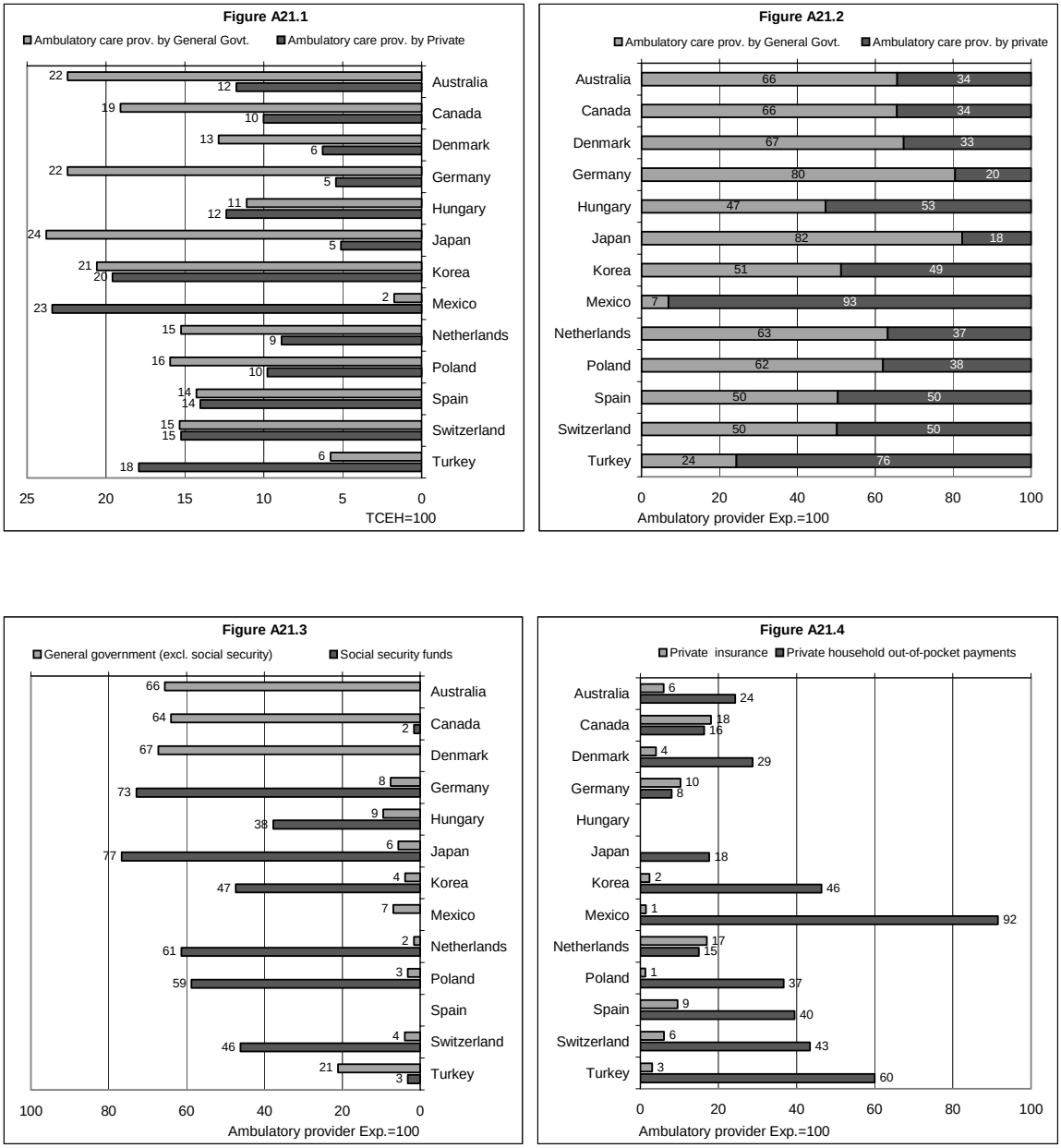




TCEH = Total Current Expenditure on Health

Source: Table 24.

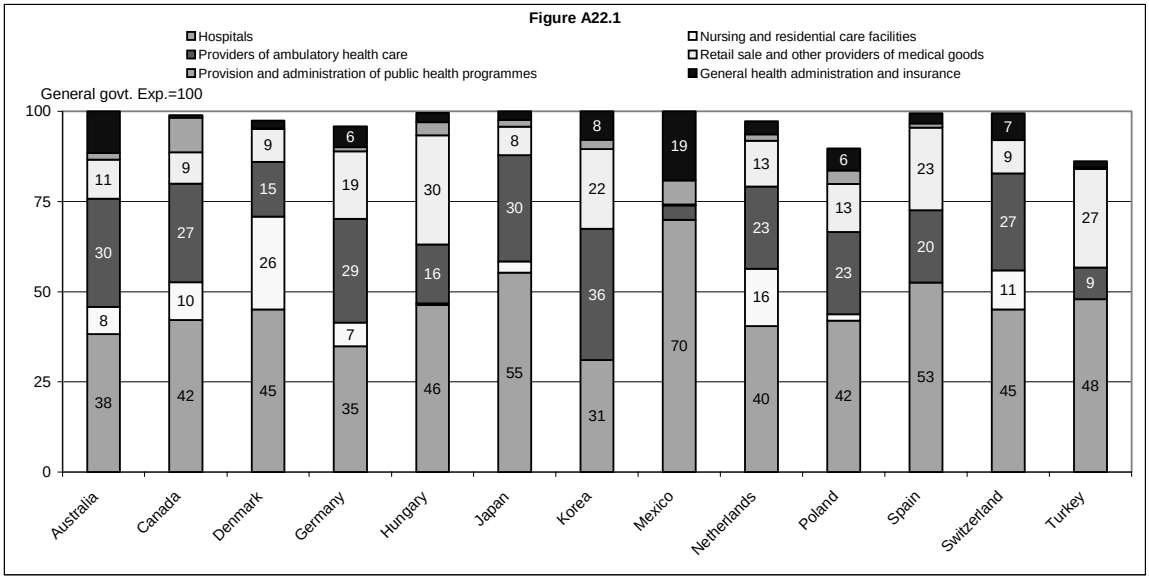
Figure A21. Ambulatory services by financing agent

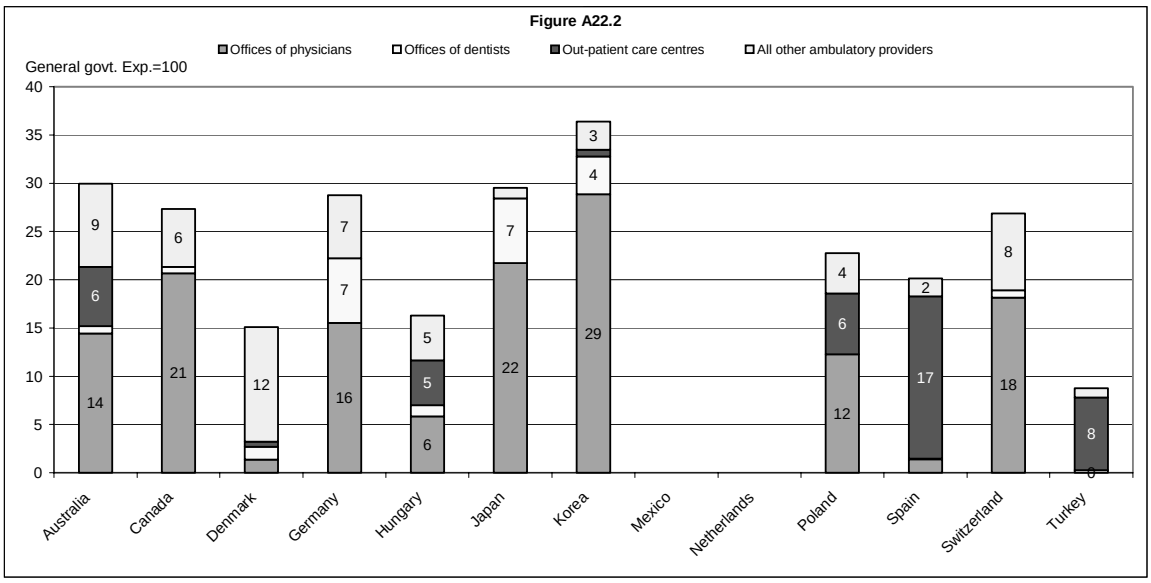


TCEH = Total Current Expenditure on Health

Source: Table 26.

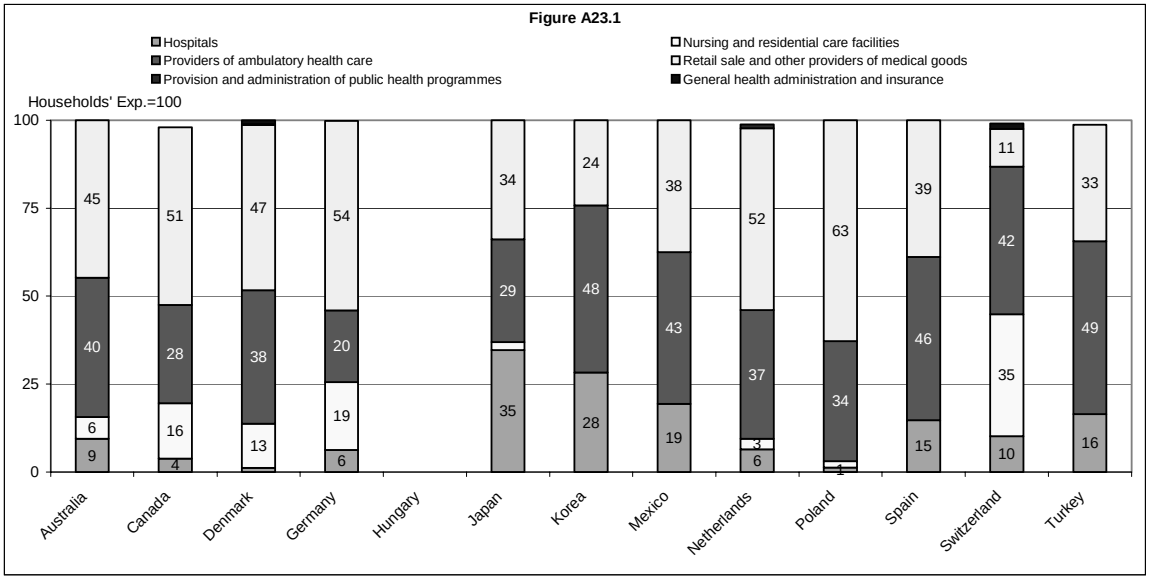
Figure A22. Spending structure of General govt. by provider

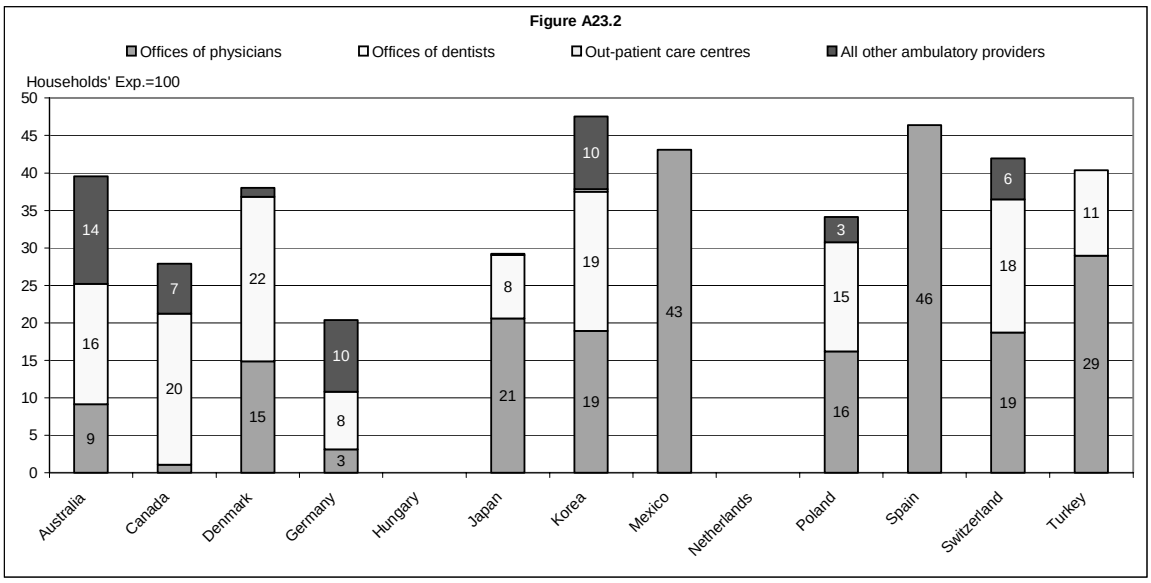




Source: Table 27.

Figure A23. Spending structure of households by provider





Source: Table 29.

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