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SHA-Based Health Accounts in the Asia/Pacific Region
: China 1990-2006

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8

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ABSTRACT

With assistance from the World Bank, China first initiated work developing its own NHA system and methodology in the early 1980s. To provide a standardized, quantitative evidence platform for national policy analysis as well as for international benchmarking, China's NHA system has since evolved to dual OECD SHA compatible classifications from 1999. Estimates have been largely consistent across both classification systems. However, heterogeneity of health financing and health services provision in China precluded producing complete three dimensional NHA based on available survey data at sub-national level. Currently, China has completed nationwide spending estimates classified by financing source and by provider for 1990 through 2006 while health accounts with all three dimensional classifications (financing source, provider and function) are only available for Tianjin municipality for the year 2005. It should be noted that as many of the characteristics of the Tianjin municipality's health system differ significantly from those of the national health system it is often not appropriate to draw national implications from Tianjin data.

Data sources include the Ministry of Finance, Ministry of Labor and Social Security, National Bureau of Statistics and Ministry of Health. In addition, the results of household surveys and field surveys of providers were used as sources of additional data for estimation and triangulation purposes.

Total Health Expenditure (THE) by source was 984.3 billion RMB ($US123.5 billion/$US 284.4 billion PPP) in 2006, equivalent to 4.7% of GDP. THE as a percentage of GDP gradually increased from 3.0% in 1978 to 4.9% in 2003, before declining to 4.7% in 2006. Per capita health expenditure grew at an average annual rate of 10.2% in real terms during the reporting period, from 11.5 RMB to 172.7 RMB at constant 1978 prices.

The general government sector financed 62.3% of THE in 1990 but the proportion declined to 35.8% by 2001, before increasing to 40.7% by 2006. The local and central government sectors respectively accounted for 90.1% and 9.9% of health spending funded through general government in 2006. At the same time private expenditure (mostly consisted of households OOP payments) as a share of THE increased from 37.7% in 1990 to 59.3% in 2006.

Hospitals have accounted for the largest, and a progressively increasing, share of health expenditure - reaching 67.6% in 2006. Retail sales and other providers of medical goods increased rapidly during the reporting period and accounted for almost 10% in 2006. The share of providers of ambulatory health care decreased from 25.0% in 1990 to 15.1% in 2006, while provision and administration of public health programs also decreased from 7.7% to 6.4%.

Data for the Tianjin municipality indicate that in 2005, the share of curative and rehabilitative care was the largest at 39.5% of total health spending in Tianjin (28.9% by in-patient care, 10.6% by out-patient care). The share of medical goods dispensed to out-patients accounted for 38.7%, while prevention and public health services accounted for 5.4%.

ABBREVIATIONS

BMI	Basic Medical Insurance Scheme
CHEI	China Health Economic Institute
CMS	Cooperative Medical System
GDP	Gross Domestic Product
GIS	Government Insurance Scheme
GRP	Gross Regional Product
ICHA	International Classification for Health Accounts
LIS	Labor Insurance Scheme
MOH	Ministry of Health
MSA	Medical Savings Account
NHA	National Health Accounts
NRCMS	New Rural Cooperative Medical System
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-pocket
OTC	Over-the-Counter
SHA	System of Health Accounts
TCHE	Total Current Health Expenditure
THE	Total Health Expenditure
UEBMI	Urban Employee Basic Medical Insurance Scheme
URBMI	Urban Resident Basic Medical Insurance Scheme
URMA	Urban & Rural Medical Assistance
VCE	Village Collective Economy
WB	World Bank
WHO	World Health Organization

TABLE OF CONTENTS

INTRODUCTION

Health financing system

1. Before the economic reforms beginning in the late 1970s, China was a planned economy and virtually all health services were publicly financed, through either tax-funded support of nationalized health facilities or contributions to one or other health insurance schemes. However, there were significant differences between urban and rural areas. Urban health insurance included the Government Insurance Scheme (GIS) for civil servants and the Labor Insurance Scheme (LIS) for workers in state-owned enterprises and their families, while rural health insurance operated through the Cooperative Medical System (CMS). The GIS, LIS and CMS all involved low co-payments at the point of care.

2. With the transition from a planned to market-based economy commencing in the late 1970s, reforms were implemented in the health services sector which resulted in health facilities having to increasingly rely on private funds (mostly household OOP payments) as government subsidies for public health facilities were reduced. With reduced government subsidies, the GIS and LIS came under severe financial strain and the rural CMS all but collapsed in most areas.

3. To achieve the Chinese government's ultimate goal of "universal coverage" and to improve the fairness of financial contributions and access to health services, government agencies at all levels have been increasing their support for health - particularly since 2000. A notable example is the central government's earmarked subsidies for public health care. To promote reform of the health insurance system, the government established the Urban Employee Basic Medical Insurance Scheme (UEBMI) in 1998 and the New Rural Cooperative Medical Scheme (NRCMS) in 2003. The Urban Resident Basic Medical Insurance Scheme (URBMI) and the Urban & Rural Medical Assistance Scheme (URMA) have also been trialed and expanded recently.

4. The Government's fiscal revenue base draws mainly on indirect taxes, with these taxes accounting for around 80% of total revenue, most of which are valued-added tax and business tax[1]. Direct taxes, mainly consisting of corporate and personal income taxes account for the remaining 20% of total revenue. Government subsidies take the form of direct allocations to public health facilities, as well as contributions made through the health insurance schemes.

5. The various health insurance schemes have different coverage and financing arrangements. NRCMS covers the rural population and primarily pays for hospitalization expenditure. It is financed through a tripartite arrangement by government (at county, city provincial and national levels), collectives and individuals. UEBMI covers urban employees and combines social insurance and personal medical savings accounts (MSAs), to which both employers and the employees contribute. UEBMI funds both inpatient and outpatient care. URBMI covers children, students, and unemployed urban residents, who are not covered by UEBMI, is jointly financed by government and individuals, and mainly pays for inpatient services. URMA is largely funded by government to ensure access to health services for the indigent.

[1] Business tax refers to tax paid by units and individuals on the income they received from the provision of taxable services, the transfer of intangible assets or the sales of immovable properties.

6. Personal OOP payments account for most of private health expenditure. Most, in absolute terms, of such payments go towards public hospitals and township health centers as opposed to private facilities. Private health insurance has only been introduced recently but has been growing rapidly.

Tables 1 & 2 summarize China's health financing statistics and arrangements.

Table 1: Health financing overview, China, 2006

Population (million)	1314.5
of which	
Urban	577.1
Rural	737.4
Gross domestic product (GDP) per capita (RMB)	16042.2
Total health spending per capita (RMB)	748.8
funded by	
Government	130.3
Social security	174.4
Private health insurance	28.7
Out-of-pocket	369.2
Total health spending as % of GDP	4.7

Table 2: Health financing arrangements

Health care coverage	Urban social health insurance (i.e. UEBMI) covers employees in the formal sector. Participation is mandatory, but not strictly enforced. The employed and dependents, mostly the aged and young, are starting to be covered by URBMI. Rural health insurance (NRCMS) is mostly voluntary. Geographical coverage remains limited but is being expanded rapidly. In both urban and rural areas, private complementary insurance is available to increase the level of maximum benefit. For those outside formal health insurance schemes, government subsidies to health care providers constitute another form of implicit insurance. However, due to the declining share of these subsidies in overall financing, the implied price subsidy is falling over time.
Risk pool structure / fragmentation	Risk pooling in the BMI schemes is at city-level (county or municipality); in NRCMS, it is at county level. In neither case is there risk-equalization across risk pools, although there are targeted central government subsidies in the NRCMS.
Health insurance contributions	In UEBMI and URBMI, both employers and employees make contributions that are a fixed percentage of income. In many localities, individuals can make voluntary payments for complementary coverage. Part of the contributions goes into a personal MSA, and the other part to a social pooling account. In NRCMS, individual contributions are fixed for all beneficiaries within risk pools, but vary across risk pools (counties). MSA model is also used in some counties.
Benefits package and co-payments	Both BMI schemes cover a certain percentage of eligible expenditures (after deductible), up to a ceiling. In most localities, MSAs are used to finance outpatient care and social pooling

	accounts finance inpatient care. In other localities, the social pooling account is only accessed when an individual's personal account is exhausted. Eligible expenditures and benefit caps vary across risk pools. NRCMS arrangements operate similarly to BMI schemes. However, due to lower levels of financing, the range of eligible services is much more limited, and co-insurance rates are often high. As with the BMI schemes, benefits packages vary across risk pools.
Special arrangements for the poor	The new Urban and Rural Medical Assistance program is intended to provide benefits to the poorest segments of the population, and to those facing "very high" health expenditures. Program details and implementation arrangements, including the extent to which the URMA scheme is integrated with health insurance schemes, vary considerably across localities. In addition, some localities require hospitals to provide health care to the poor for free or at reduced prices, but this requirement is variably enforced.

Chinese National Health Accounts

7. With the technical assistance from the World Bank, the Department of Planning and Finance of MOH initially estimated China's total health expenditure by source for 1980 and 1985. By the early 1990s, the government and the World Bank Economic Development Institute had jointly established the China NHA team. The team conducted a series of comprehensive studies on NHA theory and methodology, and drew up a preliminary China NHA classification system as appropriate to the country's contextual circumstances.

8. Currently, NHA compilation is commissioned by the Department of Planning and Finance of MOH and undertaken by the China Health Economics Institute. In order to meet the needs of international communication and comparison, the health accounts have been dually coded since 1999. One set of codes is based on OECD ICHA, the other is China-specific. Estimates by financing source with the national classification codes are available from 1978 to 2006, whilst those also with SHA coding are available from 1990 to 2006; results by provider are available from 1990 to 2006. Revisions where necessary are made annually according to changes in macro-economic data.

9. The NHA team has actively explored two- and three-dimensional cross-tabulations as well as sub-NHA analyses. Sub-national NHA research, including public health expenditure in certain geographic areas and HIV/AIDS accounts, has been trialed. Full three-dimensional (source, provider and function) analysis in the municipality of Tianjin has been completed. However, the non-availability of national disaggregated data has precluded this being done for the country as a whole at this stage.

10. China has promoted the institutionalization of NHA. NHA data are formally incorporated into the national routine information release system and published by the National Bureau of Statistics in "China statistics yearbook" annually. MOH will be establishing a coordination commission for a nationwide NHA network, in order to improve NHA development and its application to health policy at the sub-national level, as well as to promote further development of three dimensional NHA analysis in regions with sufficient technical capacity.

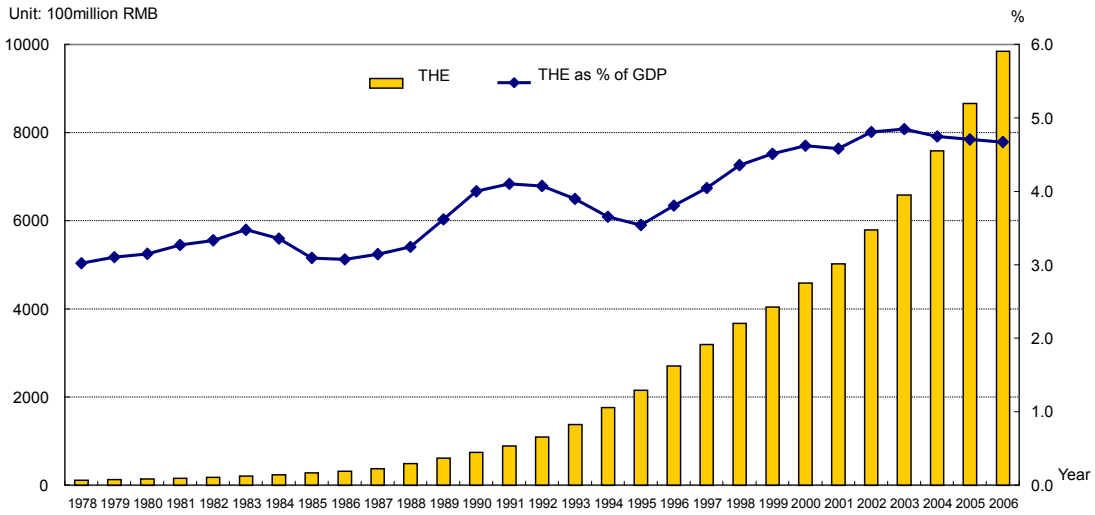
Structure and Trends of Health Expenditure

A.1. National health expenditure

11. Total health expenditure (THE) increased from 11.0 billion RMB in 1978 to 984.3 billion RMB ($US123.5 billion/$US 284.4 billion PPP) in 2006. The average annual growth rate was 11.4% from 1978 to 2006 at constant prices, which was higher than that of GDP (9.7%). The average elasticity ratio of health consumption to GDP was 1.2, meaning that THE increases on average at a rate 20% greater than GDP in China. (Figure 1)

12. THE as a proportion of GDP grew from 3.0% in 1978 to 4.9% in 2003 (an increase of 1.9 percentage points), then declined for three years and was 4.7% in 2006. This decline since 2003 was due to THE growing at a lower rate than the overall economy - with average annual growth rates of 9.8% for THE compared to GDP growth of 10.8%.

Figure 1: Total Health Expenditure as % of GDP, 1978-2006

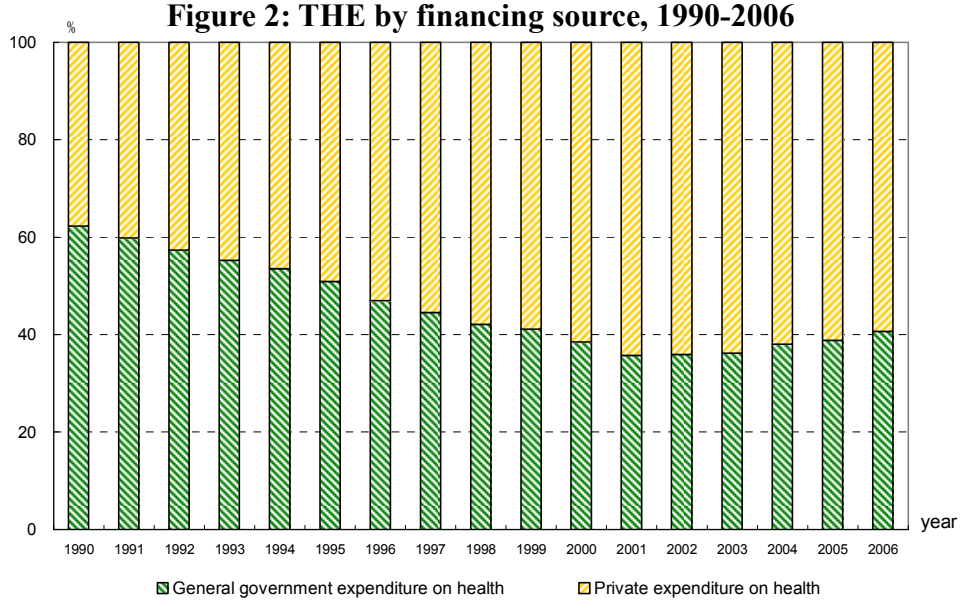


13. Per capita health expenditure increased from 11.5 RMB in 1978 to 748.8 RMB ($US 93.9/$US216 PPP) in 2006 and grew at an average annual rate of 10.2% in real terms, from 11.5 RMB to 172.7 RMB at constant 1978 prices. China's per capita health expenditure ranked 35th among 50 low-middle income WHO member states in 2004, and was below the average level of low-middle income countries ($US125.9) but higher than that of some other countries at a similar stage of economic development, such as Indonesia ($US33) and the Philippines ($US36).

A.2. Total health expenditure by financing source

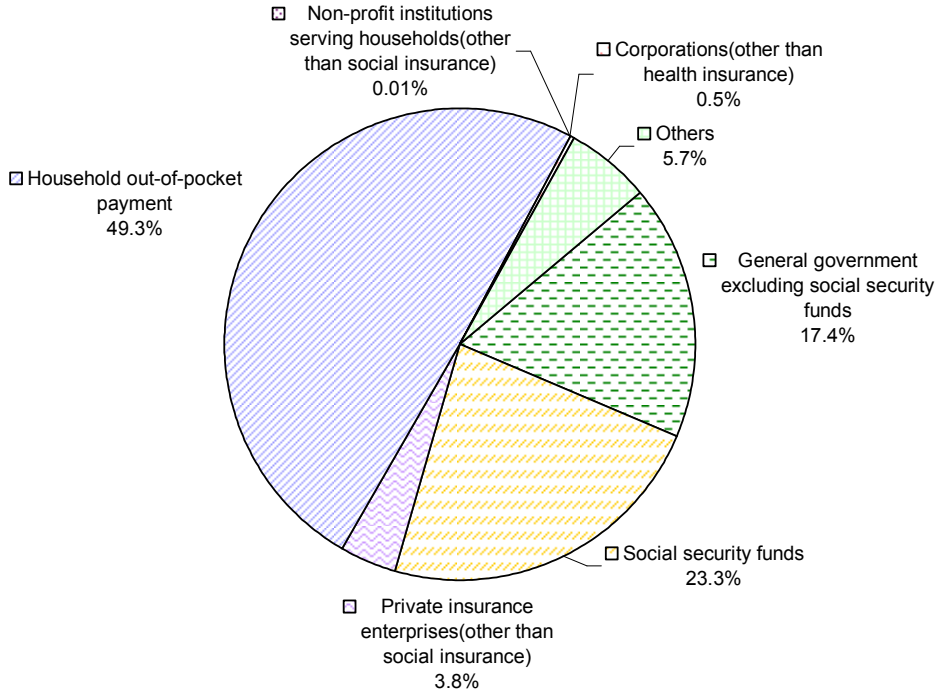
14. General government spending accounted for 62.3% of THE in 1990. However, the share steadily decreased to 35.8% by 2001 before rebounding slightly to 40.7% by 2006 as a result of decreasing shares of both local and central governments' expenditure and social security funds over the period (Figure 2). The former decreased from 24.0% to 17.4%, while the latter from 38.3% to 23.3%. (see Table A1 & Figure 3)

Figure 2: THE by financing source, 1990-2006



15. Private spending became the predominant health financing source over the past decade. Its share increased from 37.7% of THE in 1990 to 64.2% of THE in 2001, before decreasing to 59.3% of THE in 2006. OOP payments which made up the largest proportion of private health expenditure also increased from 35.7% of THE in 1990 to 49.3% of THE in 2006.

Figure 3: THE by financing source, 2006



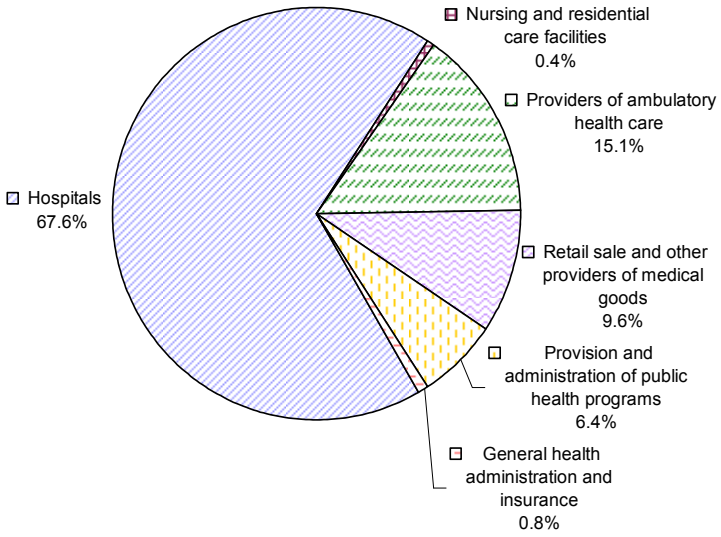
16. Private health insurance has been offered in China only since the early 1980s with the resumption of life insurance operations. This has quickly expanded along with the

development of UEBMI since 1998 as a result of the low benefit level of UEBMI. However, data on private health insurance have only been available since 1997. Its share of THE increased from 0.4% in 1997 to 3.8% in 2006.

A.3. Current health expenditure by provider

17. Hospitals have been the recipients of the largest share of health expenditure, accounting for 67.6% of total current health expenditure (CHE) in 2006. The second largest share was incurred at providers of ambulatory health care (15.1% of CHE), followed by retail sales and other providers of medical goods (9.6% of CHE). The remaining share was attributed to provision and administration of public health (6.4% of CHE), general health administration and insurance (0.8% of CHE), and nursing and residential care facilities (0.4% of CHE). (see Table A2 & Figure 4)

Figure 4: Current health expenditures by provider, 2006



18. Throughout the reporting period, hospital expenditure constituted an increasing percentage of THE, as did spending on retail sales and other providers of medical goods (which quadrupled from 2.5% to 9.6% of THE). Conversely the share of ambulatory health care providers dropped from 25.0% of THE in 1990 to 15.1% of THE in 2006, and the provision and administration of public health programs declined from 7.7% of THE to 6.4% of THE.

B. Health expenditure in Tianjin municipality

19. Tianjin is one of the Chinese administrative regions (provinces, autonomous regions and municipalities). Tianjin and the other three municipalities (Beijing, Shanghai and Chongqing) have mainly urban populations and are characterized by some of the fastest economic development in China. Tianjin's gross regional product (GRP) per capita was RMB 35234 in 2005, which was ranked the third amongst the Chinese administrative regions in mainland China.

20. Tianjin municipality has completed its three dimensional health accounts for the year 2005. The results are presented in this article for illustrative purposes and in order to provide readers with insights into the financing arrangements in China. It should be noted, however, that as many of the characteristics of the Tianjin municipality's health system differ significantly from those of the national health system it would often not be appropriate to draw national implications from Tianjin data.

21. Its THE was estimated to be RMB 16214 million in 2005, which was equivalent to 4.4% of GRP and compared to the national figure of 4.7% of GDP. However per capita health expenditure was RMB 1554.6 (Table 3), compared to the national figure of RMB 748.8.

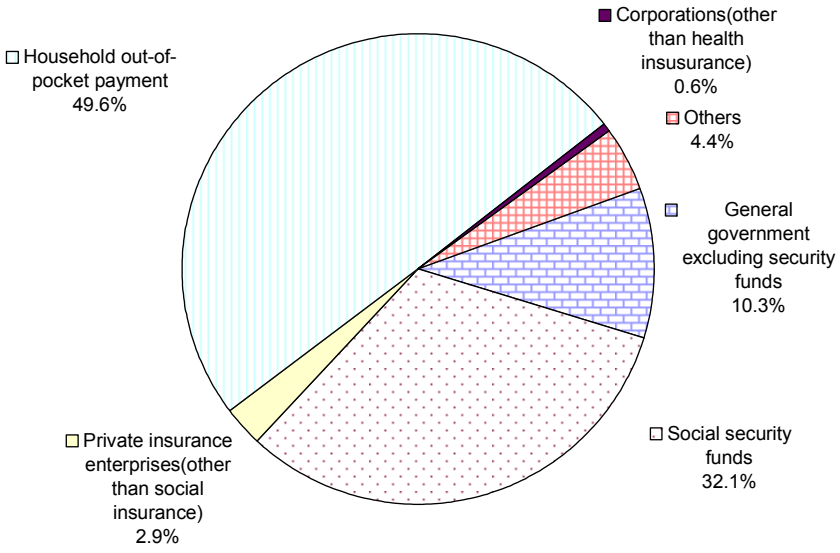
Table 3: Health financing overview, Tianjin, 2005

Population (million)	10.4
of which	
Urban	7.8
Rural	2.6
Gross regional product (GRP) per capita (RMB)	35234
Total health spending per capita (RMB)	1554.6
funded by	
Government	160.3
Social security	499.5
Private health insurance	45.0
Out-of-pocket	771.3
Total health spending as % of GRP	4.4

B.1. Total health expenditure by financing source

22. General government expenditure accounted for 42.4% of THE in Tianjin, 2005, of which social security was 32.1 percentage points of THE and general government expenditure excluding social security was 10.3 percentage points of THE. Private expenditure accounted for 57.6% of THE, of which household out-of-pocket was 49.6 percentage points of THE. (see Table B1 & Figure 5)

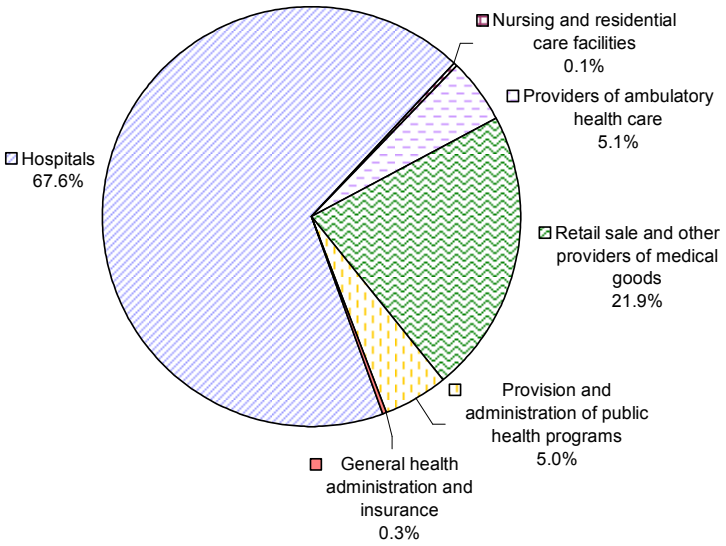
Figure 5: THE by financing source, Tianjin, 2005



B.2. Current health expenditure by provider

23. Hospitals have accounted for the largest share of current health expenditure, making up 67.6% of current health expenditure in Tianjin in 2005. The second largest share was incurred at retail sales and other providers of medical goods (21.9% of CHE), followed by providers of ambulatory health care (5.1% of CHE). The remaining share was attributed to provision and management of public health programs (5.0% of CHE), health administration and insurance administration (0.3% of CHE), and nursing and residential facilities (0.1% of CHE). (see Table B2 & Figure 6)

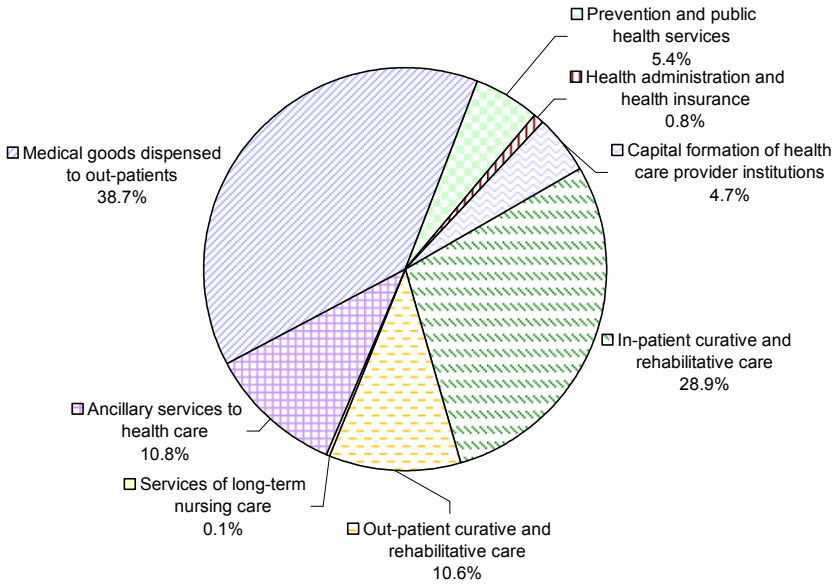
Figure 6: Current health expenditures by provider, Tianjin, 2005



B.3. Total health expenditure by function

24. In 2005, curative and rehabilitative care accounted for the largest share of THE at 39.5%, of which 28.9 percentage points of THE and 10.6 percentage points of THE were spent on in-patient and out-patient care respectively. Spending on medical goods dispensed to out-patients include those incurred in retail sale and other providers of medical goods as well as others dispensed to out-patients at health facilities. Together these components accounted for 38.7% of THE. Ancillary services accounted for 10.8% of THE with 5.4% of THE spent on prevention and public health services. Capital formation accounted for 4.7% of THE (see Table B3 & Figure 7).

Figure 7: Total health expenditure by function, Tianjin, 2005



25. Comparing to other cities and provinces, the share of expenditure on medical goods was higher whereas the share of out-patient curative and rehabilitative care was lower in Tianjin. It may be because Tianjin is an autonomous city in China, where the urbanization level is high and its residents are inclined to self-treat for non-serious illnesses.

B.4. Current health expenditure by function and provider (SHA Tables 2.1, 2.2 and 2.3)

Provider structure of different functions

26. Hospitals, and provision and administration of public health programs accounted for 98.6% and 1.4% of in-patient expenditure respectively. (Figure 8)

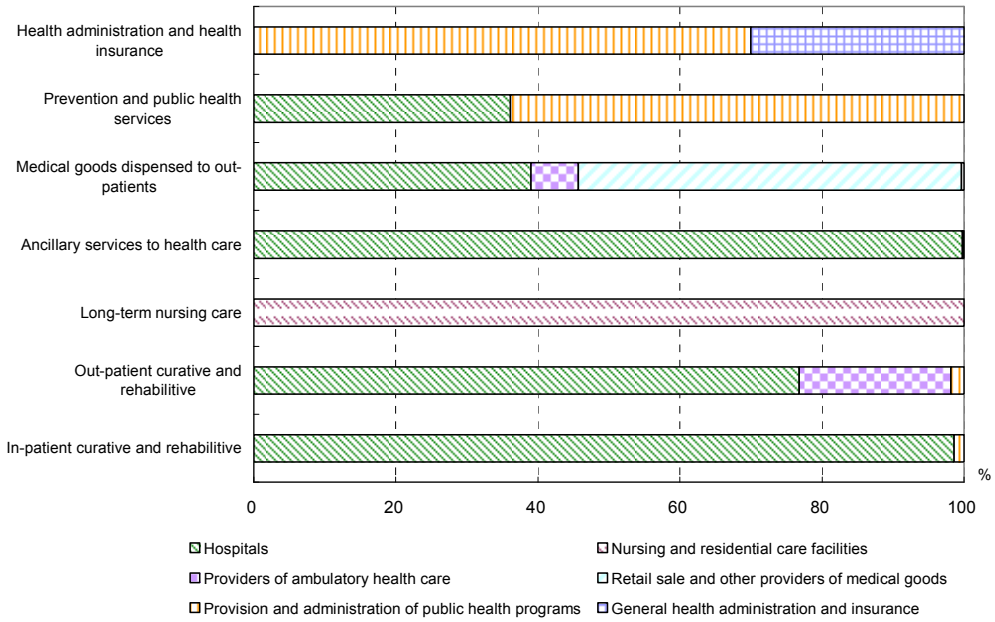
27. Spending on out-patient care was variously dispersed to hospitals (76.8%), ambulatory health care providers (21.4%), and for provision and administration of public health programs (1.9%).

28. Most of the expenditure on medical goods dispensed to out-patients was via retail sales and other providers of medical goods (54.0%), followed by hospitals (39.0%) and providers of ambulatory health care (6.7%).

29. The vast majority of expenditure in ancillary services to health care was through hospitals.

30. Spending on prevention and public health services was shared between provision and administration of public health programs (63.9%) and hospitals (36.1%). The latter included expenditure on diseases prevention and control as well as maternal and child health services.

Figure 8: Provider structure of different services, Tianjin, 2005



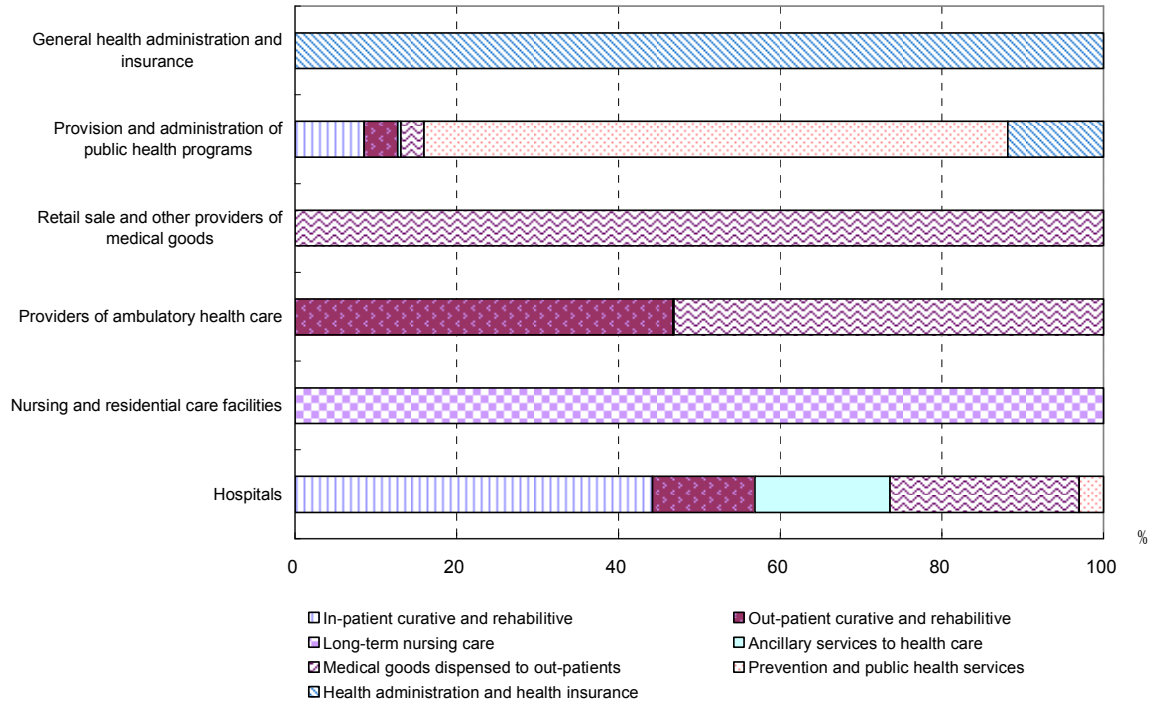
Functional structure of different providers

31. In 2005, 97.0% of current expenditure at hospitals in Tianjin (10,448 million RMB) was taken up by personal health care services and goods (44.2 percentage points for in-patient services; 12.7 percentage points for out-patient services; 16.7 percentage points for ancillary services to health care; 23.4 percentage points for medical goods dispensed to out-patients), and 3.0% for collective health services (prevention and public health services). (Figure 9)

32. Expenditure at providers of ambulatory health care was 789 million RMB, of which 53.1% paid for medical goods, 46.8% for out-patient curative and rehabilitative care and 0.1% for ancillary services to health care.

33. Provision and administration of public health programs (768 million RMB) mostly provided collective health services (84.0%), and the remaining 16.0% was accounted for by personal health care services and goods (8.5 percentage points for in-patient services; 4.1 percentage points for out-patient services; 2.9 percentage points for medical goods dispensed to out-patients; and 0.4 percentage points for ancillary services to health care).

Figure 9: Service structure of different providers, Tianjin, 2005



B.5. Current health expenditure by financing source and provider (SHA Tables 3.1, 3.2 and 3.3)

Financing mix of different providers

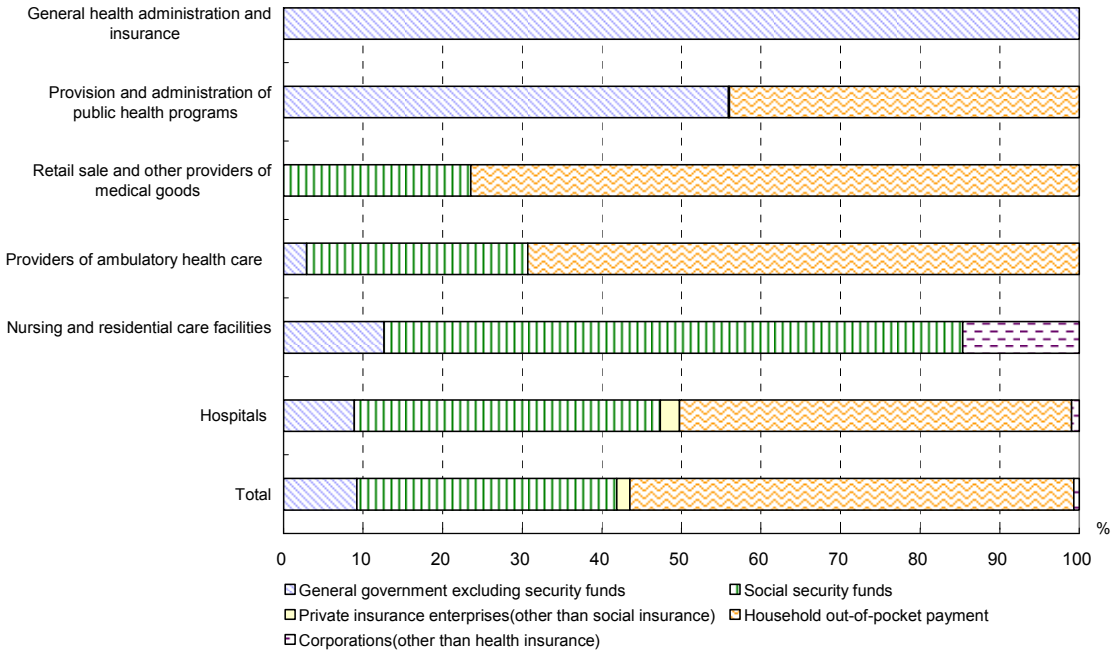
34. In 2005, current health expenditure at hospitals in Tianjin was mostly financed by household OOP payments (49.3%) and general government (47.3%) while the remainder was made up by private insurance enterprises (2.4%) and corporations (1.0%). Of the general government funding component, social security funds financed 38.4 percentage points with the remainder being financed by other general government funding. (Figure 10)

35. Households OOP payments (69.3%) accounted for the largest share of expenditure at providers of ambulatory health care, followed by general government (30.7% - 27.8 percentage points social security and 2.9 percentage points general government excluding social security).

36. Expenditure on retail sales and other providers of medical goods was shared between social security (23.5%) and household OOP payments (76.5%).

37. Of the current health expenditure on provision and administration of public health programs, 56.0% was publicly financed (55.9 percentage points by central and local governments; 0.1 percentage points by social security); and 44.0% financed by households OOP payments.

Figure 10: Financing mix of different providers, Tianjin, 2005



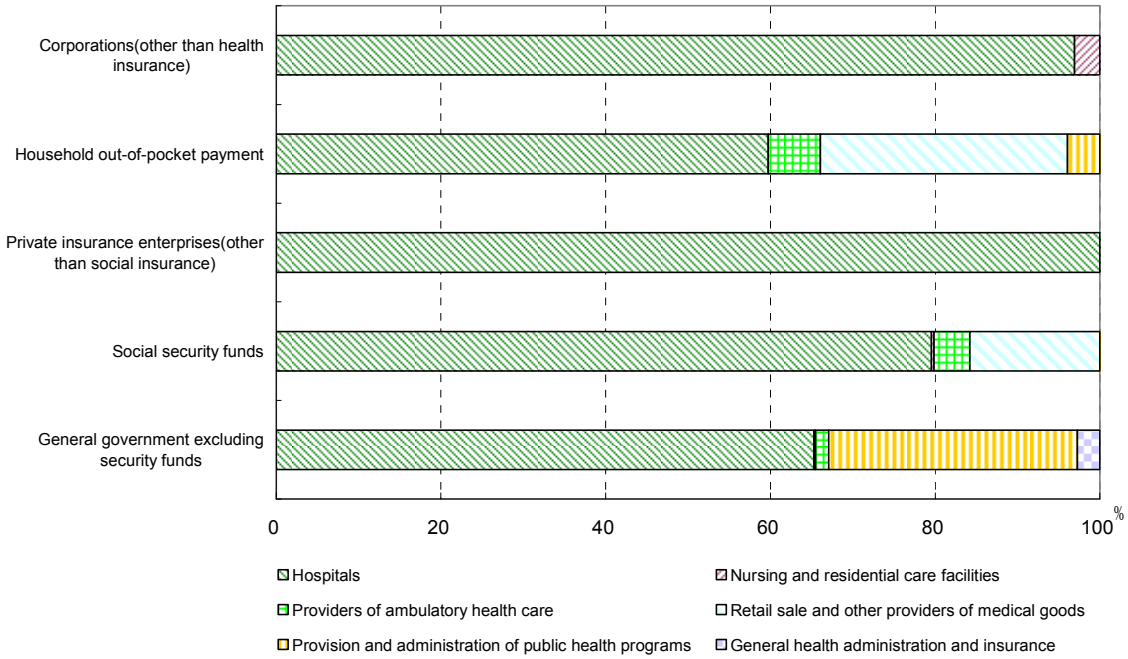
Provider allocation of different financing source

38. Most of the public funds were dispersed to hospitals (76.4%) and retail sales and other providers of medical goods (12.3%). The remaining public spending was distributed among provision and administration of public health programs (6.7%), providers of ambulatory health care (3.7%) and nursing and residential care facilities (0.3%). (Figure 11)

39. In contrast, private funds were distributed among hospitals (61.3%), retail sales and other providers of medical goods (28.8%), providers of ambulatory health care (6.1%), provision and administration of public health programs (3.8%), and nursing and residential care facilities (0.04%).

40. Of households OOP payments, 59.7% funded hospitals, 30.0% retail sales and other providers of medical goods, 6.3% providers of ambulatory health care, and 3.9% provision and administration of public health programs.

Figure 11: Provider allocation of different financing source, Tianjin, 2005



B.6. Current health expenditure by function and financing source (SHA Tables 4.1, 4.2 and 4.3)

Financing mix of different services

41. Of the expenditure on in-patient services in 2005 (4,685 million RMB), 40.6% was financed by general government revenue (of which 31.9 percentage points was by social security and 8.7 percentage points was by central and local governments), and 59.5% by private sources (of which 52.7 percentage points was by households' OOP payments, 5.4 percentage points by private insurance enterprises and 1.4 percentage points by corporations). (see Figure 12)

42. Similarly, expenditure on out-patient services (1,725 million RMB) was almost equally shared between general government and household OOP payments, in the ratio of 48.1 to 49.9, with the remaining 2.0% accounted for by corporations.

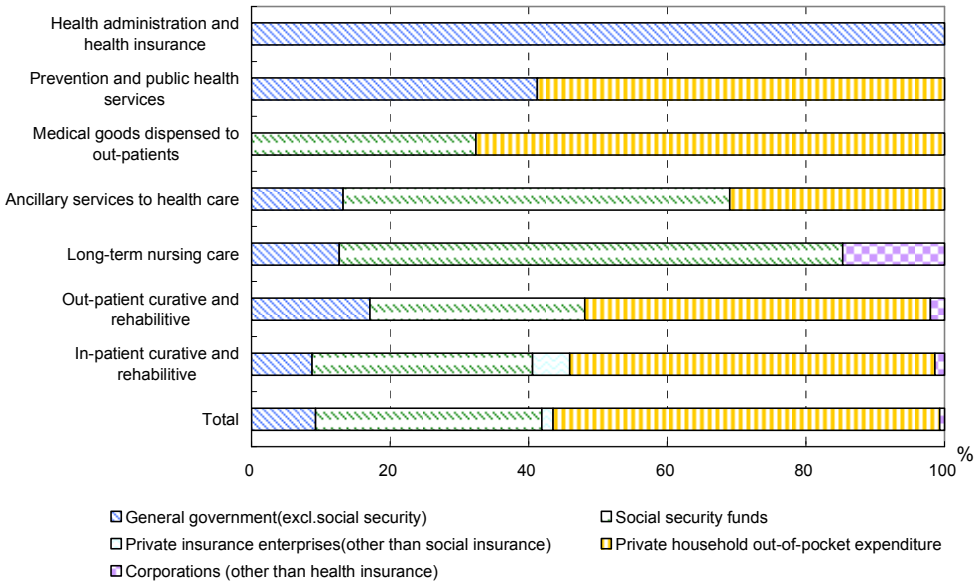
43. Of the expenditure on ancillary services to health care (1,749 million RMB), 69.0% was publicly financed (of which 55.8 percentage points was by social security and 13.2 percentage points by general government excluding social security), while the remaining 31.0% was paid for by households' OOP payments.

44. Medical goods dispensed to out-patients, and prevention and public health services shared a similar financing mix. The majority of the expenditure was household OOP payments (67.6% and 58.8% respectively) while the remainder was funded by general government. The general government funding for medical goods dispensed to out-patients was totally funded through social security funds, whereas prevention and public health services was totally funded by non-social security general government sources. A characteristic of the Tianjin health system is that some public health services for individuals,

such as physical examinations and non-planned immunization programs are rarely publicly subsidized being mainly paid for through household OOP payments.

45. Expenditure on health administration and health insurance was totally financed by central and local governments. Note that administration costs in private insurance schemes were not counted due to a lack of appropriate data sources. However these costs are likely to be a very small proportion of overall health spending.

Figure 12: Financing mix of different services, Tianjin, 2005



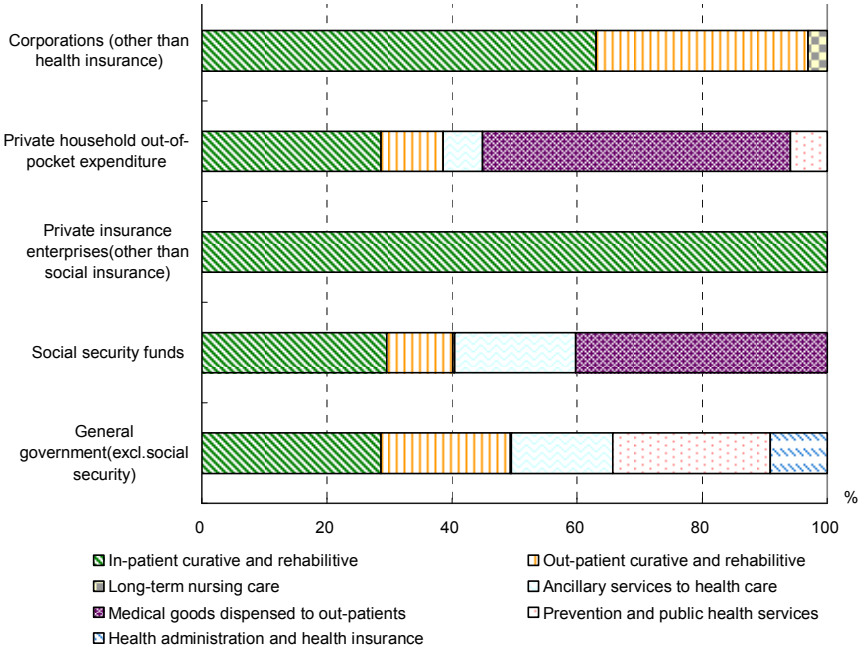
Service allocation of different financing source

46. In 2005, 92.5% of public health expenditure in Tianjin (total 6,472 million RMB) was for personal health care services and goods, of which medical goods accounted for the largest share (31.4 percentage points) and in-patient services the second largest (29.4 percentage points). The remaining 7.5% was spent on collective health services such as prevention and public health services (5.5 percentage points of total public health spending). (Figure 13)

47. The allocation patterns of central and local governments, and social security funds are largely similar (about 60% of their funds were expended on in-patient, out-patient and long-term nursing care services) except that instead of funding prevention and public health services, and health administration and health insurance, social security allocated about 40% of its funds for medical goods dispensed to out-patients.

48. As for private spending in Tianjin (total 8,980 million RMB), 94.3% of funds was for personal health care services and goods and 5.7% for public health services in 2005. Among personal health care, medical goods dispensed to out-patients and in-patients services accounted for most of the private spending (47.3 percentage points and 31.1 percentage points respectively) with out-patient services making up another 10.0 percentage points.

Figure 13: Service allocation of different financing source, Tianjin, 2005



CONCLUSIONS

Key findings

49. China's THE was 984.3 billion RMB ($US123.5 billion/$US284.4 billion PPP) or 4.7% of GDP in 2006. This percentage gradually increased between 1978 and 2003 but declined slightly in the subsequent three years. In absolute terms, per capita health expenditure increased throughout the period averaging 10.2% per annum.

50. Currently, the private sector is the predominant source of health financing in China. However, the share of general government expenditure has been increasing since 2002 as health funding from governments at all levels has increased and various social insurance schemes have been implemented and improved. General government expenditure funded 40.7% of THE in 2006 – a level which was lower than most OECD countries. Of expenditure by general government excluding social security, local level governments take on the bulk of the financing burden, accounting for 90.2% of total government spending in 2006. Private expenditure, consisting mostly of household OOP payments, accounted for the largest share (59.3%) of THE in 2006.

51. The largest share of THE was spent on hospitals – this share has been showing an increasing trend in recent years reaching 67.6% in 2006. Conversely the shares of ambulatory health providers as well as provision and administration of public health programs have both shown decreasing trends in recent years. As a result of increasing self-medications, the share of retail sales and other providers of medical goods increased rapidly during the period.

52. The subaccounts for Tianjin in 2005, with fully SHA compatible three-dimensional classification demonstrated the feasibility of implementing such in the Chinese context.

Main issues encountered in implementing SHA

53. Initially, China NHA specified its own definitional boundaries according to national policy needs. On release of OECD SHA, a new, dually compatible and coded NHA framework and classification system was developed.

54. Given the unique characteristics of China's health system, it has proven difficult to estimate and disaggregate all items of health expenditure according to ICHA, For example the village collective economy is not strictly government or social/private insurance according to the traditional definitions. There are also some functions which cannot be disaggregated, e.g., day care services, rehabilitative care, nursing care in general health facilities.

55. Due to a paucity of regular statistics, e.g., the distribution of private health insurance expenditures among different corporations, some of the data in the NHA results are imprecise estimates. An example is health facilities that are not financed and managed by MOH – as data are not routinely collected for these facilities, statistics which include these facilities are imprecise.

56. Because of significant variations in health financing and health services provision among different regions in China, some regional conditions cannot be generalized to the

whole country, therefore it is not possible to estimate the national total health expenditure by the three dimensions.

Future work

57. China's NHA work is now fully institutionalized within MOH. NHA estimates have been formally included in the national regular information release system and are reported to the National Bureau of Statistics, and published in the China Statistics Yearbook annually. The results provide important information for health policy planning and research.

58. The NHA team will promote the development of sub-national health accounts and continue to solicit further support for national health accounts.

59. To improve estimation methodology, and to encourage sub-national level compilation and use of SHA-based health accounts, wherever technical capacity allows MOH plans to set up a coordination commission for a national NHA network.

60. At the national level, the NHA team will make further refinements to the classification system and clarify boundary issues; complete the estimation procedures respectively by source and financing agent (as per the WHO's Producers' Guide distinction), and conduct feasibility studies on estimation by provider. With the availability of sub-national estimates by function in various regions, the NHA team will attempt to compile national estimation by function.

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World Health Organization (2003). *Guide to producing national health accounts*. Geneva, Switzerland: World Health Organization.

OECD (2000). *A System of health accounts: Version 1.0*. Paris: Organization for Economic Co-operation and Development.

China Health Economics Institute (2007). *China health accounts report 2007*.Beijing, China. China Health Economics Institute.

World Health Organization (2007). *World Health Report 2007: A safer future: Global public health security in the 21st century.* Geneva, Switzerland: World Health Organization.

ANNEX 1: METHODOLOGY

Data sources:

61. Main sources for public expenditure:

- Ministry of Finance
- Ministry of Labor and Social Security
- China Statistics Yearbook, National Bureau of Statistics of China
- China Health Statistics Yearbook, Center for Information Statistic, Ministry of Health
- China Labor Statistics Yearbook, Ministry of Labor and Social Security
- Health Financial Report, Department of Planning and Finance, Ministry of Health
- China Agricultural Statistics Yearbook, Ministry of Agriculture
- New Rural Cooperative Medical System Statistics Report, Center for New Rural CMS Management and Research, Ministry of Health
- Other ministries related to health

62. Main sources for private expenditure:

- China Statistics Yearbook, National Bureau of Statistics of China
- China Urban Living and Price Yearbook, Department of Urban Society and Economic Statistics, National Bureau of Statistics of China
- China Rural Households Statistics Yearbook, Department of Rural Society and Economic Statistics, National Bureau of Statistics of China
- China Health Statistics Yearbook, Center for Information Statistic, Ministry of Health
- China Labor Statistics Yearbook, Ministry of Labor and Social Security
- China Floating Population Statistics Report, Bureau of Public Security Management, Ministry of Public Security
- China Population Statistics Yearbook, National Bureau of Statistics of China
- Chinese Red Cross Foundation

63. Ad hoc surveys of health care providers supplied additional data for estimation of health expenditure by the 3 dimensions as well as compilation of SHA tables.

64. Household surveys on health services utilization supplied additional data for breakdown of OOP payments and health insurance expenditure by provider and function.

Differences between classification of health expenditure in national practice and the IHCA:

65. To accommodate national policy analysis and meet the needs of international comparison and communication, China's NHA system has been dually classified and coded since 1999. The estimates are largely the same under both classification systems.

66. General government health expenditure excluding social security includes an item named *Village Collective Economy (VCE) health expenditur*e. *VCE* in China is an autonomous organization of villagers. The council is under the guidance of, and assisted by, the township government. Although it is not a government organization, it does have some administrative function. The income of VCE includes government subsidies and land or assets rent.

67. In China, hospitals expenditure includes that of general hospitals, mental health hospitals and other specialized hospitals, but it is not possible to differentiate between them.

Of note, township health centers are also classified as general hospitals, although some of them are actually specialized health centers.

68. For ambulatory health care providers, which include private clinics, outpatient departments, and nursing facilities, detailed information is not available, thus it is not possible to provide two-digit level ICHA classifications. In addition, some nursing facilities are also classified as ambulatory health care providers because of the lack of detailed information to allow proper classification.

69. It is not possible to disaggregate the day cases of curative care services, long-term care services, home care services and rehabilitative care services to in-patient care and out-patient care services. Long-term nursing care services include services provided by sanatoria. Meanwhile, many functions cannot be further disaggregated, e.g. drug expenditure cannot be broken down into prescription drugs and OTC drugs.

70. As for estimation of social health insurance expenditures by function and provider, they (except NRCMS) are only apportioned according to data collected via household surveys undertaken in different reference years.

Other methodological issues:

71. The capital formation of public and private health facilities are estimated by the actual expenditure of that year in China, without capital depreciation.

ANNEX 2: TABLES

Table A1: Total health expenditure by source of funding in China

		First available year		Last available year	
		1990		2006	
		RMB billion	Percent	RMB billion	Percent
HF.1	General government	46.6	62.3	400.5	40.7
HF.1.1	General government excluding social security funds	18.0	24.0	171.2	17.4
HF.1.1.1	Central government	N/A	N/A	16.9	1.7
HF.1.1.2	Local governments	N/A	N/A	154.4	15.7
HF.1.2	Social security funds	28.6	38.3	229.3	23.3
HF.2	Private sector	28.2	37.7	583.8	59.3
HF.2.1	Private social insurance	–	–	–	–
HF.2.2	Private insurance enterprises(other than social insurance)	*	*	37.7	3.8
HF.2.3	Household out-of-pocket payment	26.7	35.7	485.4	49.3
HF.2.4	Non-profit institutions serving households(other than social insurance)	–	–	0.1	0.01
HF.2.5	Corporations(other than health insurance)	0.8	1.1	4.6	0.5
HF.2.9	Others	0.6	0.8	56.1	5.7
HF.3	Rest of world	–	–	–	–
	Total expenditure on health	**74.7**	**100.0**	**984.3**	**100.0**

* Data not available but very minimal

Table A2: Current health expenditure by provider in China

		First available year		Last available year	
		1990		2006	
		RMB billion	percent	RMB billion	Percent
HP.1	Hospitals	49.6	63.5	681.1	67.6
HP.2	Nursing and residential care facilities	0.8	1.0	4.5	0.4
HP.3	Providers of ambulatory health care	19.6	25.0	152.1	15.1
HP.4	Retail sale and other providers of medical goods	1.9	2.5	96.7	9.6
HP.5	Provision and administration of public health programs	6.0	7.7	64.1	6.4
HP.6	General health administration and insurance	0.3	0.4	8.5	0.8
HP.7	Other industries (rest of the economy)				
HP.9	Rest of the word				
	Total Health Expenditure	**78.2**	**100.0**	**1006.9**	**100.0**

Table B1: Total health expenditure by source of funding in Tianjin, China

		First available year		Last available year	
		1995		2005	
		RMB million	Percent	RMB million	Percent
HF.1	General government	2400.2	67.7	6881.5	42.4
HF.1.1	General government excluding security funds	508.4	14.3	1672.0	10.3
HF.1.2	Social security funds	1891.8	53.4	5209.5	32.1
HF.2	Private sector	1143.9	32.3	9332.5	57.6
HF.2.1	Private social insurance	–	–	–	–
HF.2.2	Private insurance enterprises(other than social insurance)	6.3	0.2	469.3	2.9
HF.2.3	Household out-of-pocket payment	1071.5	30.2	8044.7	49.6
HF.2.4	Non-profit institutions serving households(other than social insurance)	–	–	–	–
HF.2.5	Corporations(other than health insurance)	49.2	1.4	103.7	0.6
HF.2.9	Others	17.0	0.5	714.8	4.4
HF.3	Rest of world	–	–	–	–
	Total health expenditure	**3544.1**	**100.0**	**16214.0**	**100.0**

Table B2: Current health expenditure by provider in Tianjin, China

		First available year		Last available year	
		1995		2005	
		RMB Million	percent	RMB million	Percent
HP.1	Hospitals	2366.3	68.0	10448.0	67.6
HP.2	Nursing and residential care facilities	15.4	0.4	21.8	0.1
HP.3	Providers of ambulatory health care	386.0	11.1	789.2	5.1
HP.4	Retail sale and other providers of medical goods	436.0	12.5	3385.9	21.9
HP.5	Provision and administration of public health programs	265.7	7.6	768.3	5.0
HP.6	General health administration and insurance	8.6	0.2	39.0	0.3
HP.7	Other industries (rest of the economy)				
HP.9	Rest of the word				
	Total Current Health Expenditure	**3478.0**	**100.0**	**15452.1**	**100.0**

Table B3: Total health expenditure by function in Tianjin, China

		Last available year	
		2005	
		RMB million	percent
HC.1;HC.2	Services of curative and rehabilitative care	6409.8	39.5
HC.1.1;H.2.1	In-patient curative and rehabilitative care	4684.6	28.9
HC.1.3;HC.2.3	Out-patient curative and rehabilitative care	1725.2	10.6
HC.3	Services of long-term nursing care	21.8	0.1
HC.4	Ancillary services to health care	1748.8	10.8
HC.5	Medical goods dispensed to out-patients	6273.4	38.7
HC.6	Prevention and public health services	868.3	5.4
HC.7	Health administration and health insurance	130.0	0.8
HC.R.1	Capital formation of health care provider institutions	761.9	4.7
	Total Health Expenditure	**16214.0**	**100.0**

ANNEX 3: TIANJIN 2005 SHA TABLES

SHA Tables 2.1 Current expenditure on health by function of care and provider industry in Tianjin, China (RMB, million)

Health care by function	ICHA-HC code	**Total current health expenditure**	HP.1 Hospitals	HP.2 Nursing and residential care facilities	HP.3 Providers of ambulatory health care	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance	HP.7 All other industries	HP.9 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	6409.8	5943.5	–	369.0	–	97.4	–		
In-patient curative and rehabilitative	HC.1.1;HC.2.1	4684.6	4619.0	–	–	–	65.6	–		
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	1725.2	1324.4	–	369.0	–	31.8	–		
Long-term nursing care	HC.3	21.8	…	21.8	–	–	–	–		
Ancillary services to health care	HC.4	1748.8	1744.8	…	0.9	–	3.1	–		
Medical goods dispensed to out-patients	HC.5	6273.4	2446.1	…	419.3	3385.9	22.2	–		
Prevention and public health services	HC.6	868.3	313.7	…	…	–	554.7	–		
Health administration and health insurance	HC.7	130.0	–	–	–	–	91.0	39.0		
Total current health expenditure		**15452.1**	**10448.0**	**21.8**	**789.2**	**3385.9**	**768.3**	**39.0**		

SHA Tables 2.2 Current expenditure on health by function of care and provider industry in Tianjin, China (% of expenditure on functional category)

Health care by function	ICHA-HC code	**Total current health expenditure**	HP.1 Hospitals	HP.2 Nursing and residential care facilities	HP.3 Providers of ambulatory health care	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance	HP.7 All other industries	HP.9 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	100.0	92.7	–	5.8	–	1.5	–		
In-patient curative and rehabilitative	HC.1.1;HC.2.1	100.0	98.6	–	–	–	1.4	–		
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	100.0	76.8	–	21.4	–	1.9	–		
Long-term nursing care	HC.3	100.0	…	100.0	–	–	–	–		
Ancillary services to health care	HC.4	100.0	99.8	…	0.1	–	0.2	–		
Medical goods dispensed to out-patients	HC.5	100.0	39.0	…	6.7	54.0	0.4	–		
Prevention and public health services	HC.6	100.0	36.1	…	…	–	63.9	–		
Health administration and health insurance	HC.7	100.0	–	–	–	–	70.0	30.0		
Total current health expenditure		**100.0**	**67.6**	**0.1**	**5.1**	**21.9**	**5.0**	**0.3**		

SHA Tables 2.3 Current expenditure on health by function of care and provider industry in Tianjin, China (% of provider category expenditure)

Health care by function	ICHA-HC code	**Total current health expenditure**	HP.1 Hospitals	HP.2 Nursing and residential care facilities	HP.3 Providers of ambulatory health care	HP.4 Retail sale and other providers of medical goods	HP.5 Provision and administration of public health programs	HP.6 General health administration and insurance	HP.7 All other industries	HP.9 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	41.5	56.9	–	46.8	–	12.7	–		
In-patient curative and rehabilitative	HC.1.1;HC.2.1	30.3	44.2	–	–	–	8.5	–		
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	11.2	12.7	–	46.8	–	4.1	–		
Long-term nursing care	HC.3	0.1	…	100.0	–	–	–	–		
Ancillary services to health care	HC.4	11.3	16.7	…	0.1	–	0.4	–		
Medical goods dispensed to out-patients	HC.5	40.6	23.4	…	53.1	100.0	2.9	–		
Prevention and public health services	HC.6	5.6	3.0	…	…	–	72.2	–		
Health administration and health insurance	HC.7	0.8	–	–	–	–	11.8	100.0		
Total current health expenditure		**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**		

SHA Tables 3.1 Current expenditure on health by provider industry and source of funding in Tianjin, China (RMB, million)

Health care provider category	ICHA-HP code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Hospitals	HP.1	10448.0	4945.4	928.6	4016.7	5502.7	–	251.9	5150.3	…	100.6	
Nursing and residential care facilities	HP.2	21.8	18.6	2.7	15.8	3.2	–	–	…	…	3.2	
Providers of ambulatory health care	HP.3	789.2	242.1	22.8	219.3	547.1	–	–	547.1	…	…	
Retail sale and other providers of medical goods	HP.4	3385.9	796.7	–	796.7	2589.2	–	–	2589.2	…	–	
Provision and administration of public health programs	HP.5	768.3	430.4	429.4	0.9	338.0	–	–	338.0	…	…	
General health administration and insurance	HP.6	39.0	39.0	39.0	–	0.0	–	–	–	…	–	
Other industries(rest of the economy)	HP.7											
Rest of the world	HP.9											
Total Current Expenditure on Health		**15452.1**	**6472.1**	**1422.6**	**5049.5**	**8980.1**	**–**	**251.9**	**8624.5**	**…**	**103.7**	

SHA Tables 3.2 Current expenditure on health by provider industry and source of funding in Tianjin, China (% of provider category expenditure)

Health care provider category	ICHA-HP code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Hospitals	HP.1	100.0	47.3	8.9	38.4	52.7	–	2.4	49.3	…	1.0	
Nursing and residential care facilities	HP.2	100.0	85.3	12.6	72.7	14.7	–	–	…	…	14.7	
Providers of ambulatory health care	HP.3	100.0	30.7	2.9	27.8	69.3	–	–	69.3	…	…	
Retail sale and other providers of medical goods	HP.4	100.0	23.5	–	23.5	76.5	–	–	76.5	…	–	
Provision and administration of public health programs	HP.5	100.0	56.0	55.9	0.1	44.0	–	–	44.0	…	…	
General health administration and insurance	HP.6	100.0	100.0	100.0	–	0.0	–	–	–	…	–	
Other industries(rest of the economy)	HP.7											
Rest of the world	HP.9											
Total Current Expenditure on Health		**100.0**	**41.9**	**9.2**	**32.7**	**58.1**	**–**	**1.6**	**55.8**	**…**	**0.7**	

SHA Tables 3.3 Current expenditure on health by provider industry and source of funding in Tianjin, China (% of expenditure by source of funding category)

Health care provider category	ICHA-HP code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Hospitals	HP.1	67.6	76.4	65.3	79.6	61.3	–	100.0	59.7	…	96.9	
Nursing and residential care facilities	HP.2	0.1	0.3	0.2	0.3	0.04	–	–	…	…	3.1	
Providers of ambulatory health care	HP.3	5.1	3.7	1.6	4.3	6.1	–	–	6.3	…	…	
Retail sale and other providers of medical goods	HP.4	21.9	12.3	–	15.8	28.8	–	–	30.0	…	–	
Provision and administration of public health programs	HP.5	5.0	6.7	30.2	0.02	3.8	–	–	3.9	…	…	
General health administration and insurance	HP.6	0.3	0.6	2.7	–	–	–	–	0.0	…	–	
Other industries(rest of the economy)	HP.7											
Rest of the world	HP.9											
Total Current Expenditure on Health		**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**–**	**100.0**	**100.0**	**…**	**100.0**	

SHA Tables 4.1 Current expenditure on health by function care and source of funding in Tianjin, China (RMB, million)

Health care by function	ICHA-HC code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	6409.8	2728.6	701.7	2026.9	3681.2	–	251.9	3328.8	…	100.6	
In-patient curative and rehabilitative	HC.1.1;HC.2.1	4684.6	1899.7	407.0	1492.7	2784.9	–	251.9	2467.7	…	65.4	
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	1725.2	828.9	294.8	534.2	896.3	–	…	861.1	…	35.2	
Long-term nursing care	HC.3	21.8	18.6	2.7	15.8	3.2	–	…	…	…	3.2	
Ancillary services to health care	HC.4	1748.8	1206.9	230.3	976.6	541.9	–	…	541.9	…	…	
Medical goods dispensed to out-patients	HC.5	6273.4	2030.2	–	2030.2	4243.3	–	…	4243.3	…	…	
Prevention and public health services	HC.6	868.3	357.8	357.8	…	510.5	–	–	510.5	…	…	
Health administration and health insurance	HC.7	130.0	130.0	130.0	–	–	–	–	–	–	–	
Total current health expenditure		**15452.1**	**6472.1**	**1422.6**	**5049.5**	**8980.1**	**–**	**251.9**	**8624.5**	**…**	**103.7**	

SHA Tables 4.2 Current expenditure on health by function of care and source of funding in Tianjin, China (% of expenditure on functional category)

Health care by function	ICHA-HC code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	100.0	42.6	11.0	31.6	57.4	–	3.9	51.9	…	1.6	
In-patient curative and rehabilitative	HC.1.1;HC.2.1	100.0	40.6	8.7	31.9	59.5	–	5.4	52.7	…	1.4	
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	100.0	48.1	17.1	31.0	52.0	–	**…**	49.9	…	2.0	
Long-term nursing care	HC.3	100.0	85.3	12.6	72.7	14.7	–	**…**	…	…	14.7	
Ancillary services to health care	HC.4	100.0	69.0	13.2	55.8	31.0	–	**…**	31.0	…	…	
Medical goods dispensed to out-patients	HC.5	100.0	32.4	–	32.4	67.6	–	**…**	67.6	…	…	
Prevention and public health services	HC.6	100.0	41.2	41.2	…	58.8	–	–	58.8	…	…	
Health administration and health insurance	HC.7	100.0	100.0	100.0	–	–	–	–	–	–	–	
Total current health expenditure		**100.0**	**41.9**	**9.2**	**32.7**	**58.1**	–	**1.6**	**55.8**	…	**0.7**	

SHA Tables 4.3 Current expenditure on health by function of care and source of funding in Tianjin, China (% of expenditure by source of funding category)

Health care by function	ICHA-HC code	**Total current health 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 Private social insurance	HF.2.2 Private insurance enterprises(other than social insurance)	HF.2.3 Private household out-of-pocket expenditure	HF.2.4 Nor-profit organizations (other than social ins.)	HF.2.5 Corporations (other than health insurance)	HF.3 Rest of the world
Curative and rehabilitative care	HC.1;HC.2	**41.5**	42.2	49.3	40.1	41.0	–	100.0	38.6	…	96.9	
In-patient curative and rehabilitative	HC.1.1;HC.2.1	**30.3**	29.4	28.6	29.6	31.0	–	100.0	28.6	…	63.0	
Out-patient curative and rehabilitative	HC.1.3;HC.2.3	**11.2**	12.8	20.7	10.6	10.0	–	0.0	10.0	…	33.9	
Long-term nursing care	HC.3	**0.1**	0.3	0.2	0.3	0.0	–	…	…	…	3.1	
Ancillary services to health care	HC.4	**11.3**	18.7	16.2	19.3	6.0	–	…	6.3	…	…	
Medical goods dispensed to out-patients	HC.5	**40.6**	31.4	–	40.2	47.3	–	…	49.2	…	…	
Prevention and public health services	HC.6	**5.6**	5.5	25.2	…	5.7	–	–	5.9	…	…	
Health administration and health insurance	HC.7	**0.8**	2.0	9.1	–	–	–	–	–	–	–	
Total current health expenditure		**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	–	**100.0**	**100.0**	…	**100.0**	

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