Findings from the first SHA implementations in Asia

What this tells us about
developing Asia and how it differs
or not from the OECD

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SHA development in Asia

- 1990-2000
  - Expanding national efforts to compile health accounts (China, Philippines, Thailand, Sri Lanka)
  - Regional interest in common databases
- 2000
  - Publication of OECD SHA
- 2000-2005
  - Independent implementations of OECD SHA in 15+ Asian territories, including first two (Korea, Sri Lanka)

The Seoul 2005 Agenda

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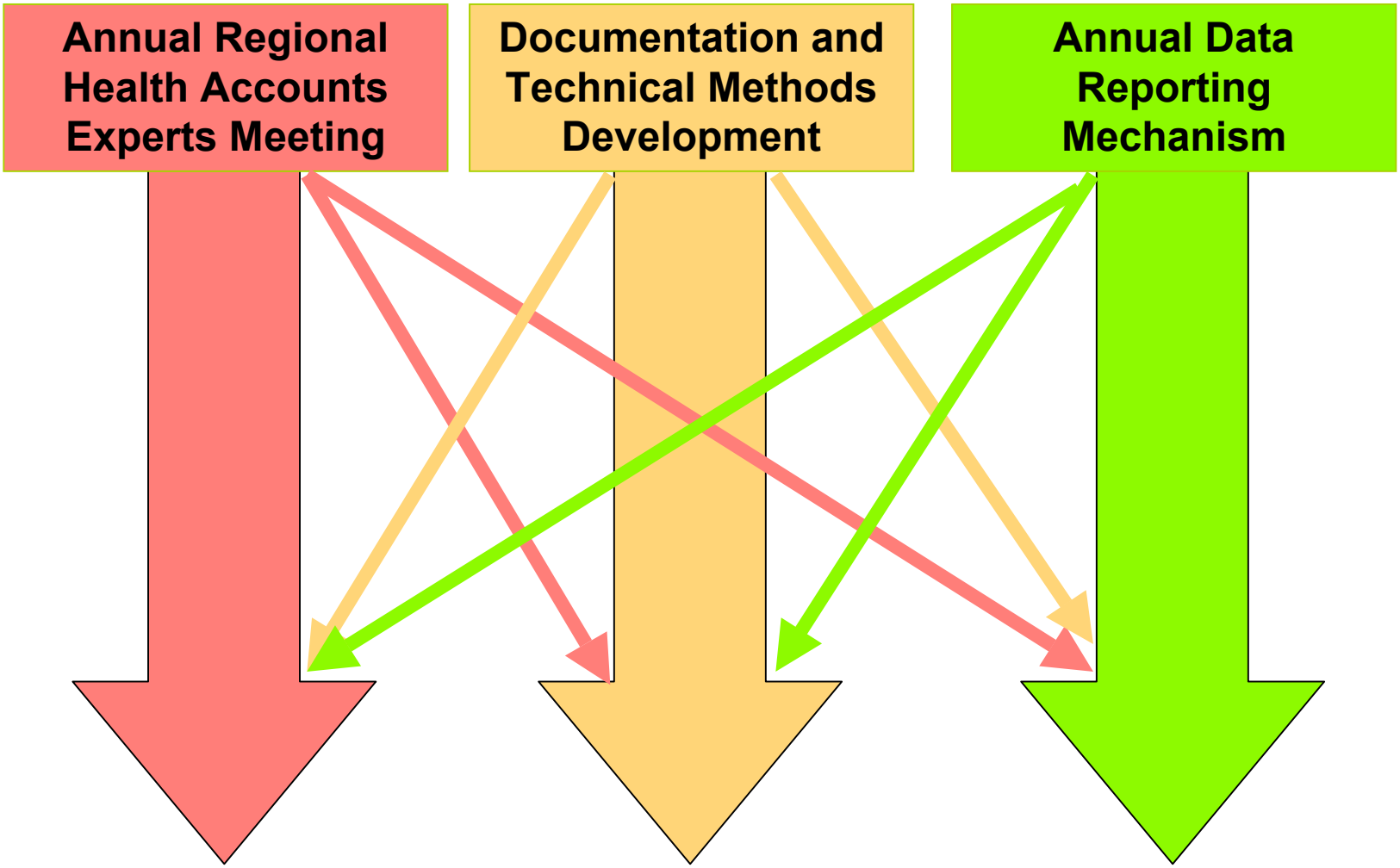
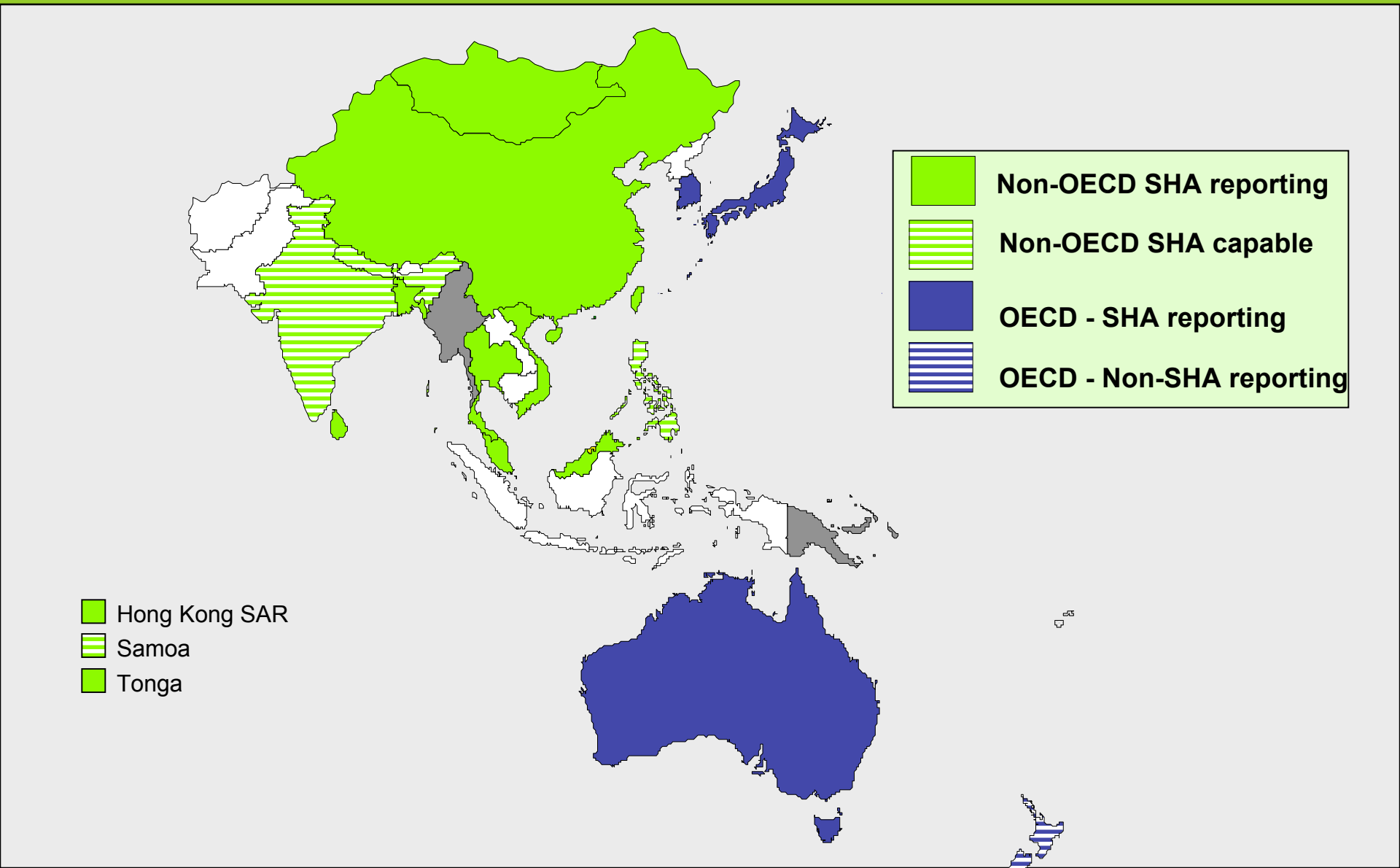


Health Accounts Status in Asia-Pacific 2007



2006-2007 SHA Collections

- WHO-APNHAN
  - Bangladesh
  - China
  - Malaysia
  - Mongolia
  - Nepal
  - Philippines
  - Sri Lanka
  - Thailand
  - Tonga
  - Vietnam
- OECD RCHSP-APNHAN
  - Hong Kong SAR
  - Taiwan
  - Australia
  - Japan
  - Korea

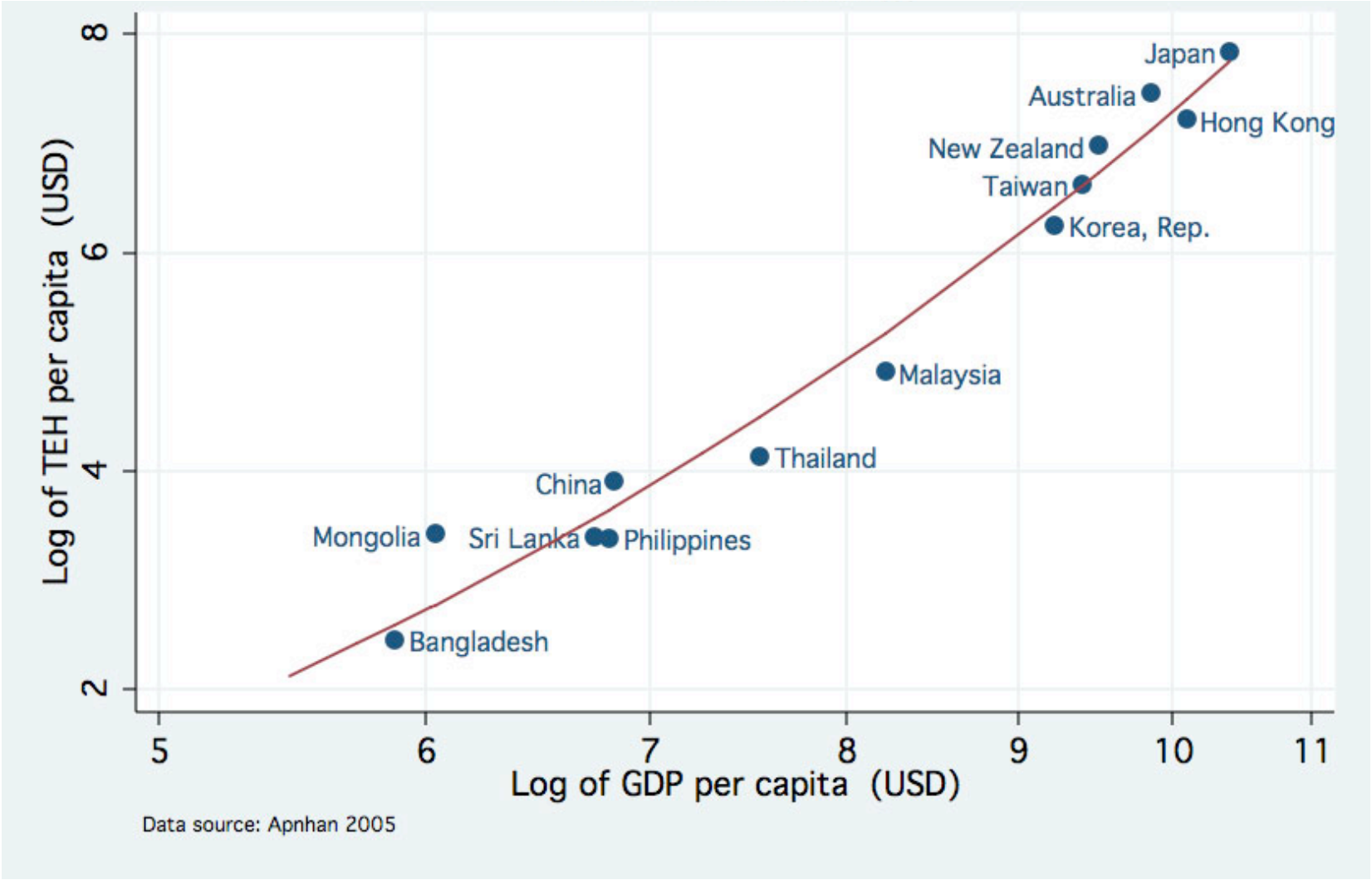
Regional SHA estimates

- Source: WHO, APNHAN and RCHSP NHA and Joint SHA data collections in 2006-2007, RCHSP Green Papers
- First consistent, comparable estimates of health expenditure for a non-OECD region
- Standardization of what is being measured
- Comparability still has limits owing to differences in measurement methods

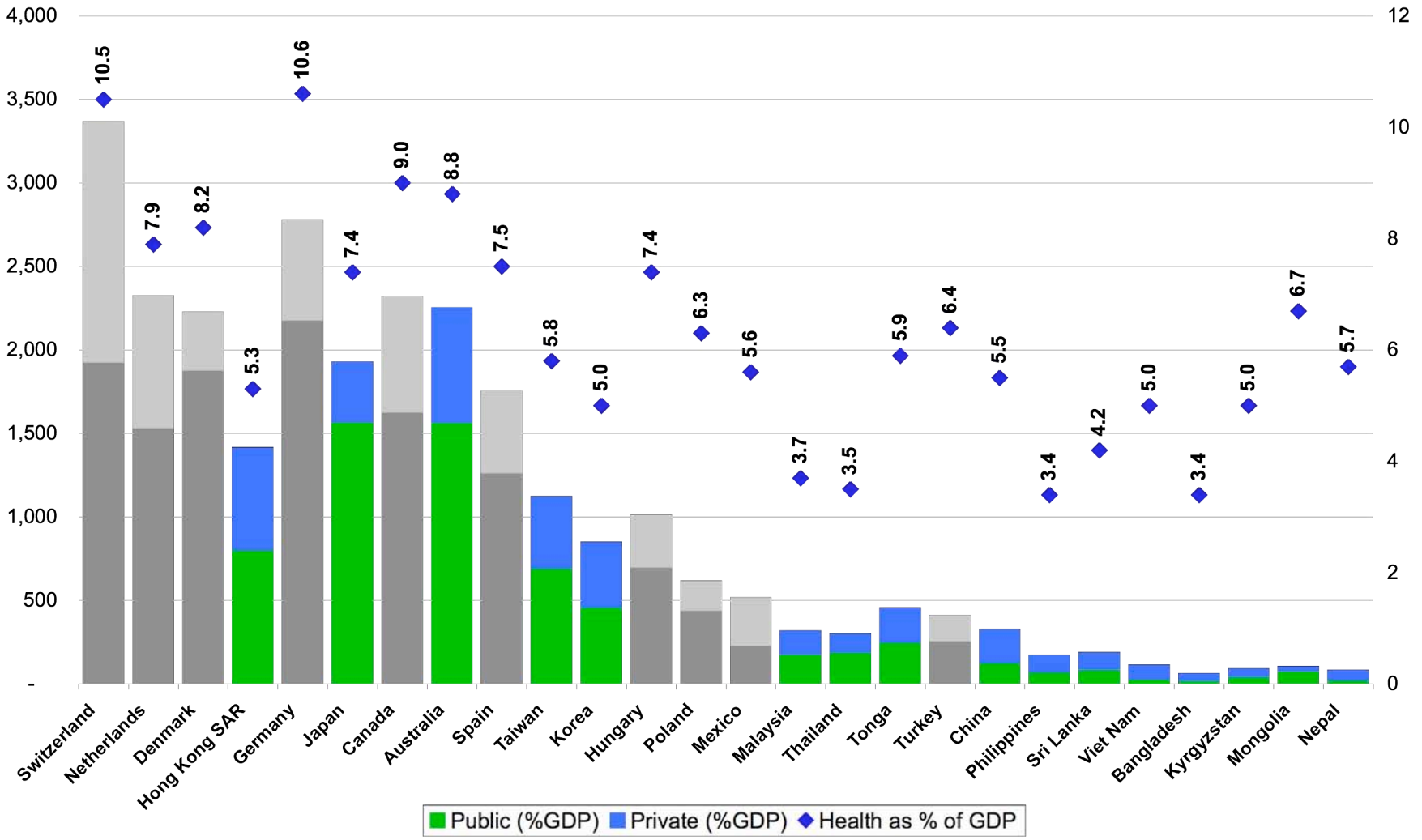
Experience of Asian SHA implementers

- Feasibility and difficulties similar to those reported in OECD countries. Most implementing countries able to complete OECD-WHO-Eurostat Joint SHA Questionnaire.
- Foreign trade, nursing home, long-term care spending not systematically measured in many countries.
- Capital formation continues to be handled differently by countries.
- Significant differences in methods used to measure private spending, may be leading substantial errors in comparability.
- Need to revise SHA to incorporate mandatory, government-operated personal savings accounts which can be used for health, as in Singapore, Malaysia and Sri Lanka

Expenditures (TEH) versus per capita GDP



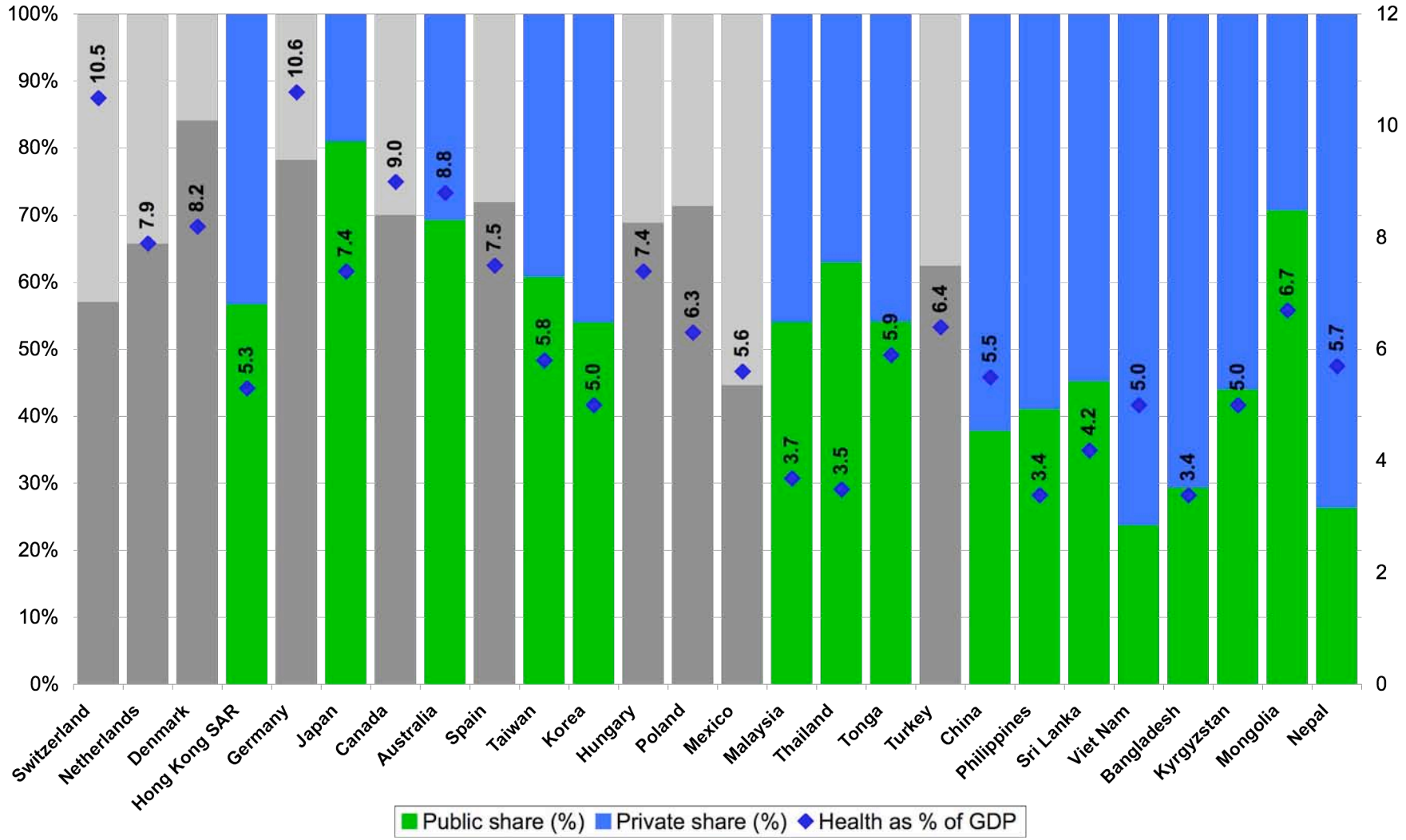
Total health expenditure per capita in PPP$ and % GDP



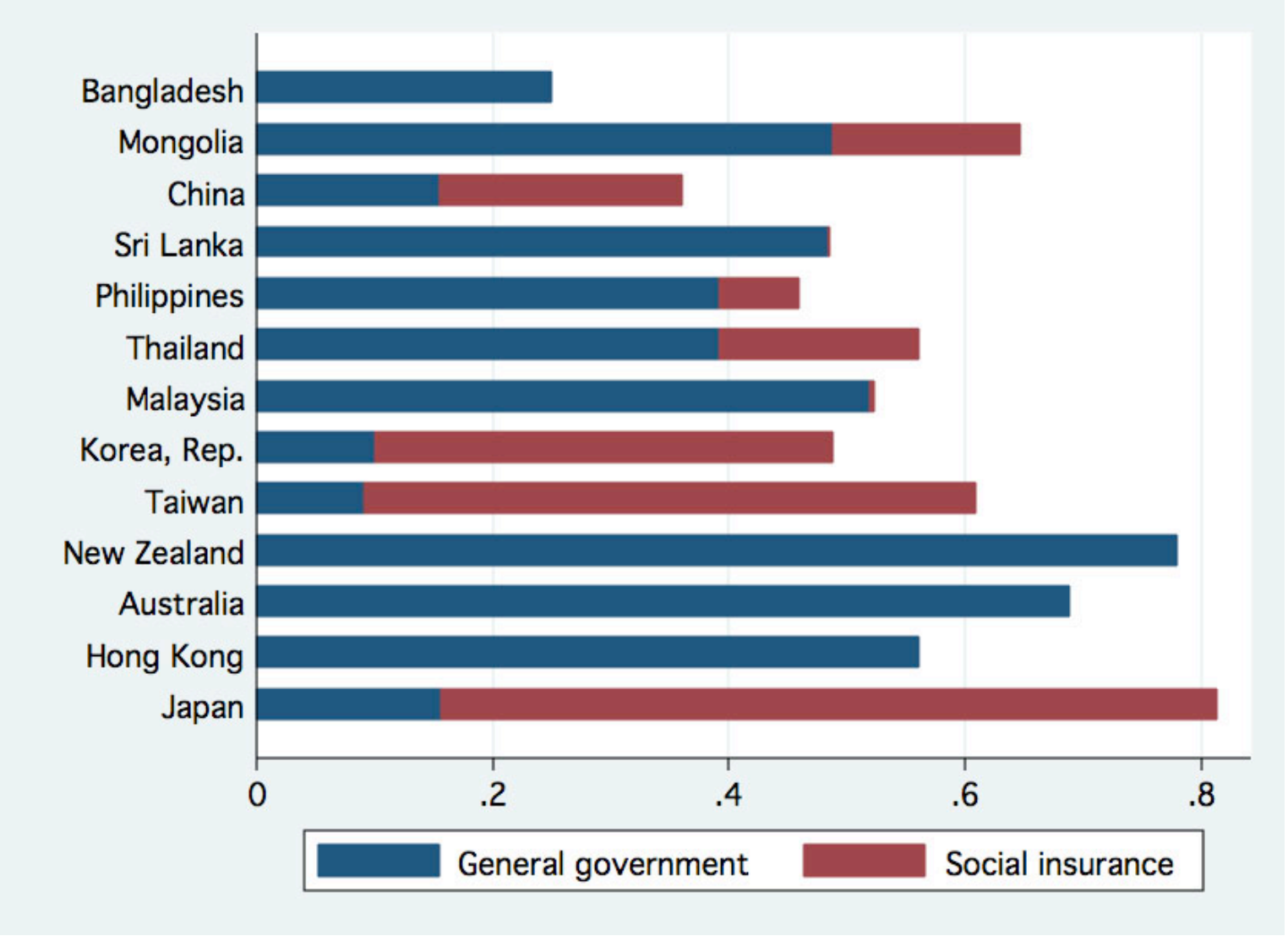
Total health spending in PPP$ and %GDP and public shares

- Expenditures in middle and low-income Asia typically 3-5% of GDP, in contrast to 7-10% in OECD
- Total expenditure increases with income in Asia as in OECD. However, income elasticity appears to be ~ 1.0 until GDP per capita reaches PPP$5,000.
- Expenditures per capita are similar to ranking in GDP per capita, but several Asian economies spend less than expected (Hong Kong, Korea, Taiwan, Malaysia, Thailand)
- Public share is not dominant in all Asian health systems, but share increases with income.

Public and private shares in financing (%)



Source of public financing (ICHA-HF)



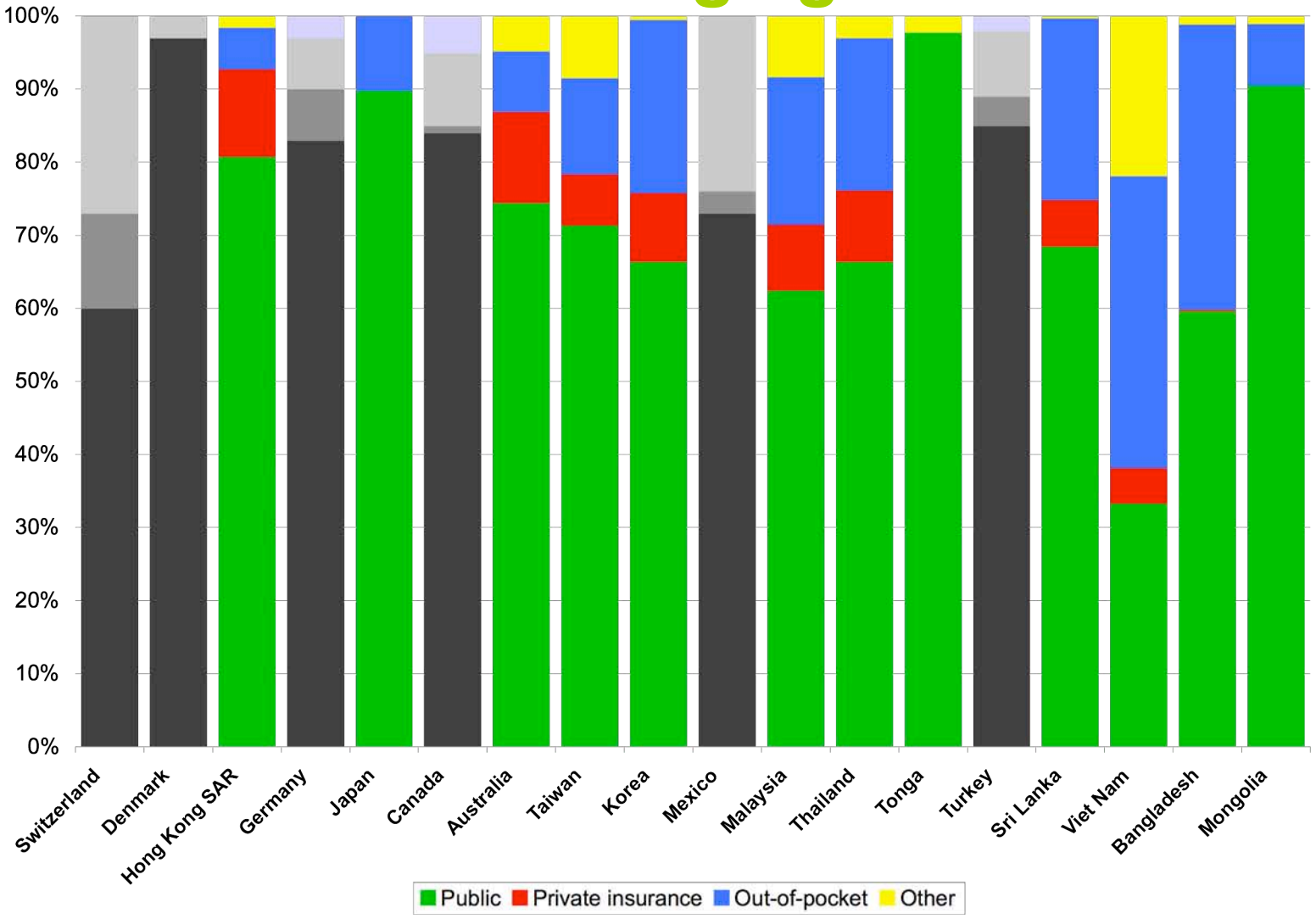
Expenditure by financing agent

- Increase in expenditure in region with income is driven by increases in public spending as share of GDP. Private expenditure as %GDP does not increase.

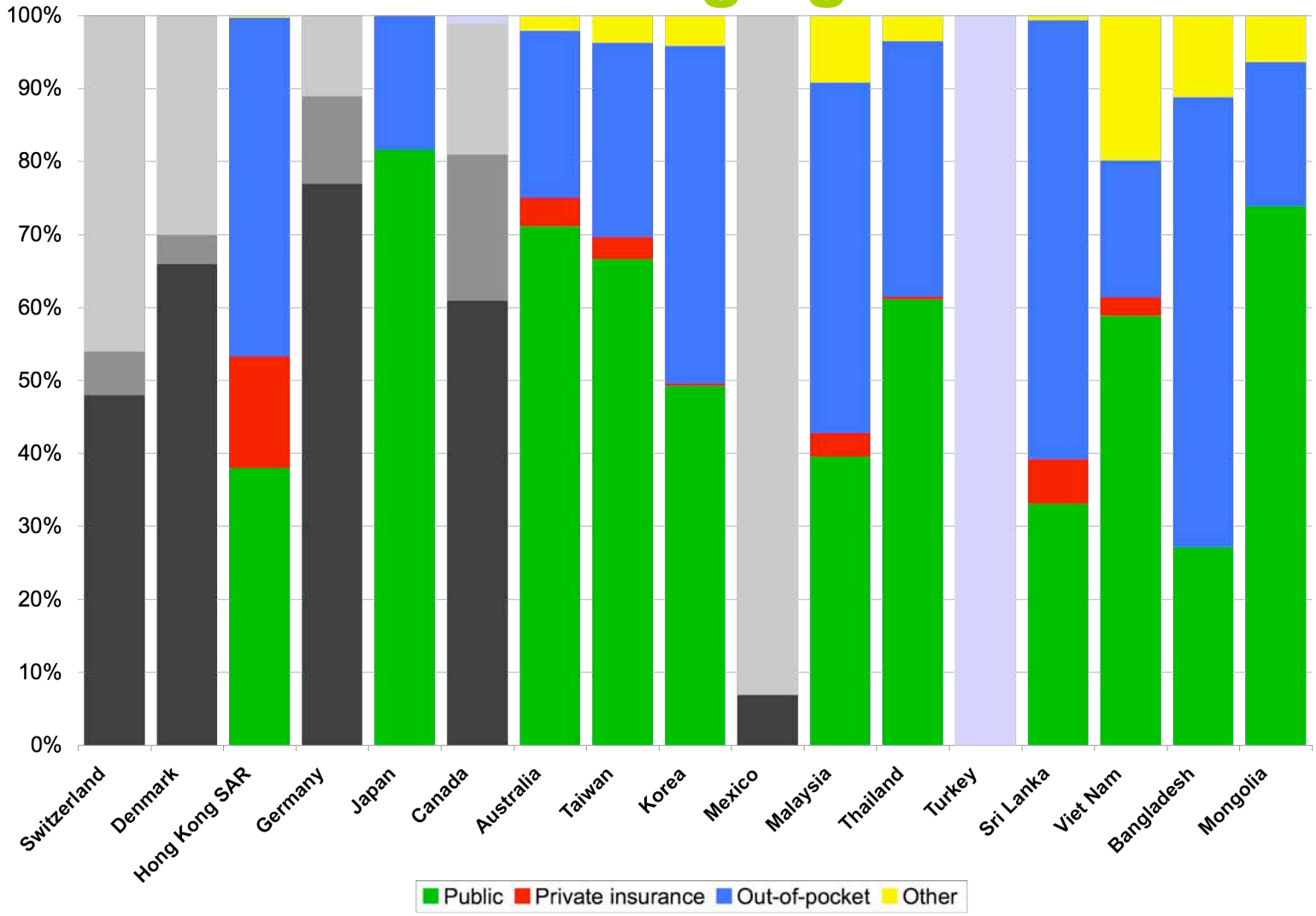
- Mix of public financing approaches seen also in Asia, with general government in some, and a mix of general government and social insurance in others.

- Public expenditure share in relation to income exceptionally high in Mongolia, Thailand, and low in Hong Kong.

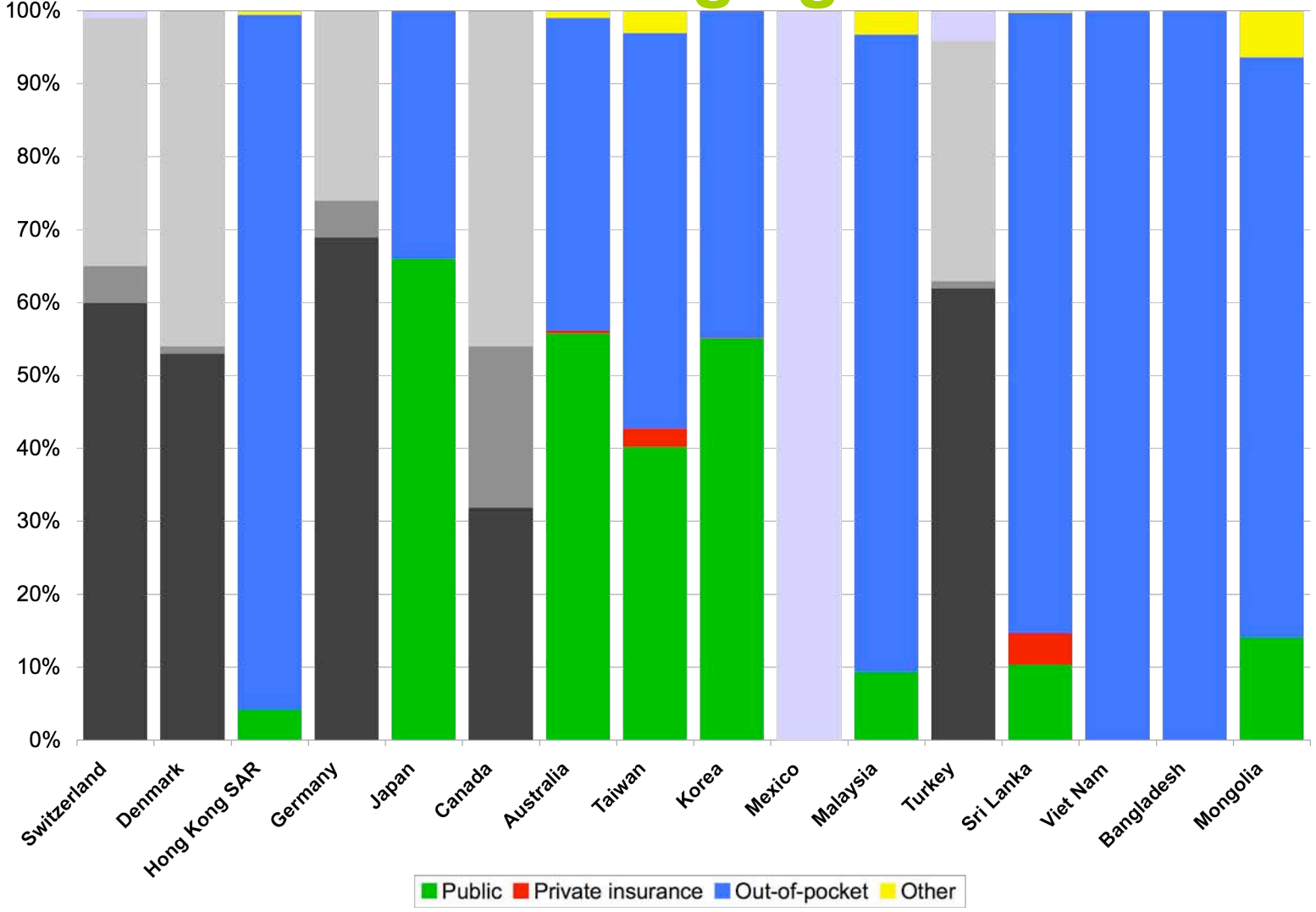
Expenditure on inpatient care by financing agent



Expenditure on outpatient care by financing agent



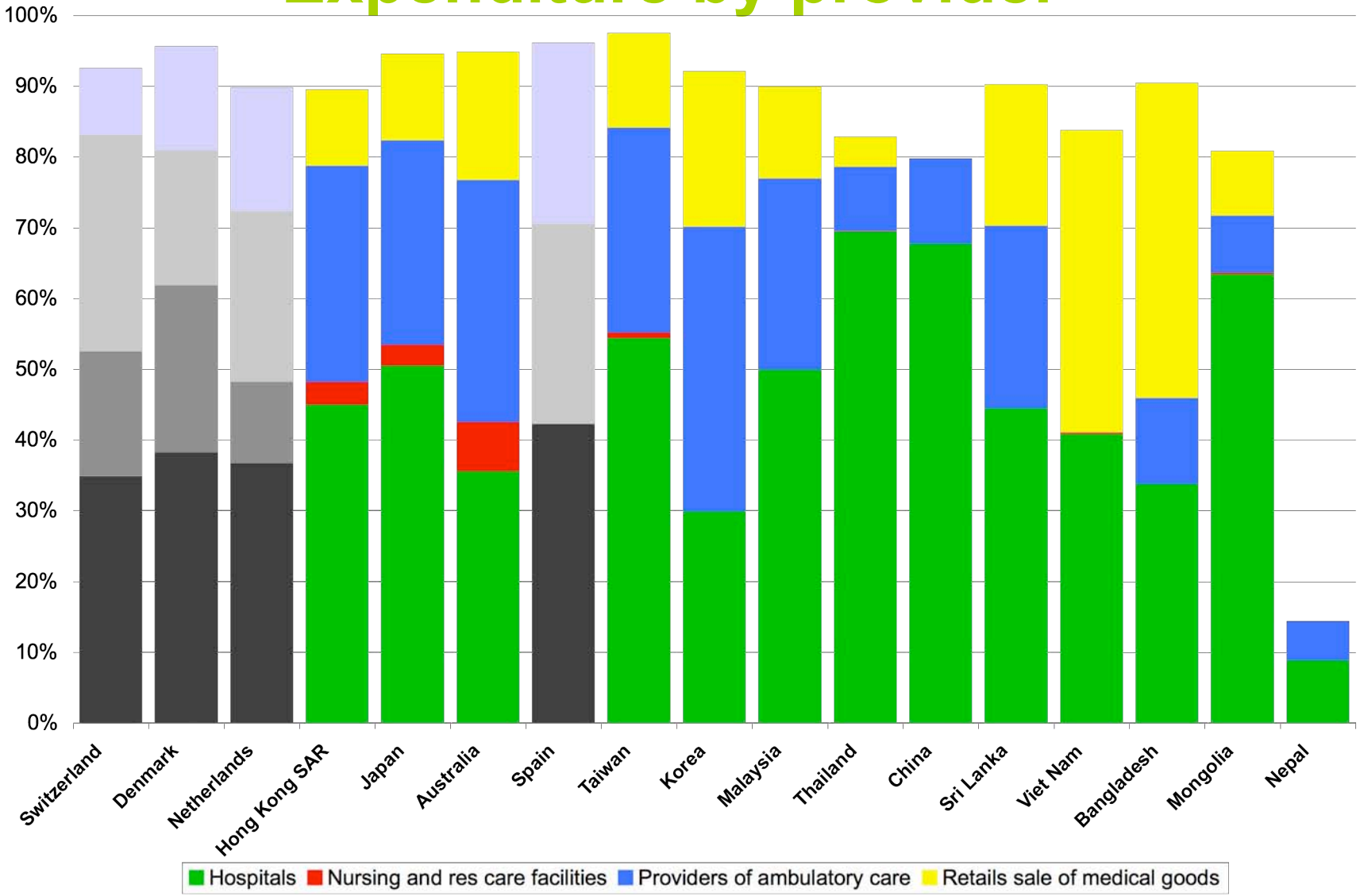
Expenditure on pharmaceuticals by financing agent



Expenditure on functions by financing agent

- Public funds dominate inpatient care (71%) to a similar extent as in OECD (~80-90%). Shares in Bangladesh and Viet Nam are exceptionally low.
- In contrast, private funds dominate outpatient care (51% versus 33%).
- Private insurance plays a marginal role in Asia, with occasional exception of inpatient care.
- Low to low-middle income Asian economies rely largely on private funds for pharmaceuticals.
- Patterns may reflect stages in development of health systems, with inpatient care being the first priority, then outpatient care, and finally pharmaceuticals.

Expenditure by provider



Expenditure by providers

- Spending through hospitals similar or higher in developing Asia than OECD. Exceptionally high in social insurance systems of Mongolia, Thailand and China
- Largest contrasts are much lower spending through ambulatory care providers in developing Asia, and in some countries much higher spending at drug retailers
- Nursing home spending noticeably absent in developing economies.

Conclusions

- SHA provides a practical and important framework that can allow new insights and analysis of health systems in Asia
- General patterns of spending are similar to OECD with total and public spending increasing with GDP per capita, public domination of inpatient care funding, and hospital shares of spending.
- Some evidence that total spending as %GDP is not related to income at GDP per capita less than PPP$5000.
- Total and public spending significantly less than expected for their income levels in Hong Kong, Korea and Taiwan.
- Significant differences in Asia are seen in (i) extent of public funding of outpatient care and pharmaceuticals, (ii) medical goods retailers tend to be larger, and ambulatory provider spending substantially less.