OECD Health Technical Papers No. 8

SHA-Based Health Accounts in 13 OECD Countries - Country Studies - Mexico: National Health Accounts 2001

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SHA-BASED HEALTH ACCOUNTS IN THIRTEEN OECD COUNTRIES COUNTRY STUDIES: MEXICO NATIONAL HEALTH ACCOUNTS 2001

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OECD HEALTH TECHNICAL PAPERS

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FOREWORD

1. A project aimed at presenting initial results from the implementation of the System of Health Accounts has been carried by the Health Policy Unit at the OECD and experts from thirteen member countries. The results are presented in the form of a comparative study (OECD Health Working Papers No. 16) and a set of OECD Health Technical Papers presenting individual country studies. This volume is the eighth in this series, presenting the Mexican SHA-based health accounts.

2. 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.

3. The Secretariat considers as a key task to disseminate the SHA-based health accounts of OECD member countries and their comparative analysis. In the series of Health Technical Papers - that are also available via the internet - the key results are presented on a country-by-country basis, supported by detailed methodological documentation. They – together with the comparative study - will provide a unique source of health expenditure data with interpretation of SHA-based health accounts. In particular, the results describe in a systematic and comparable way that how, and for what purposes, money is spent in the health systems of the participating countries. These papers are also important in a methodological sense: the analysis of data availability and comparability shows where further harmonisation of national classifications with the International Classification for Health Accounts (SHA-ICHA) would be desirable.

4. Thirteen countries participated in this project: Australia, Canada, Denmark, Germany, Hungary, Japan, Korea, Mexico, the Netherlands, Poland, Spain, Switzerland and Turkey. The next edition of the comparative study to be published in 2006, is expected to include several additional countries. Meanwhile, new country studies will be presented on the OECD SHA web page and in the Health Technical Papers when they become available.

5. The OECD Secretariat invites readers to comment on the series of Health Technical Papers on SHA-based health accounts and to make suggestions on possible improvements to the contents and presentation for future editions.

AVANT-PROPOS

6. L'Unité des politiques de santé de l'OCDE et des experts originaires de treize pays Membres ont mené un projet visant à rendre compte des premiers résultats de la mise en œuvre du Système de comptes de la santé (SCS). Ces résultats se présentent sous la forme d'une étude comparative (document de travail sur la santé n° 16 de l'OCDE) et d'un ensemble de rapports techniques sur la santé contenant des études par pays. Ce volume est le huitième de la série, il examine les comptes de la santé fondés sur le SCS au Mexique.

7. Face à la nécessité croissance de disposer de statistiques fiables et comparables sur les dépenses et le financement des systèmes de santé, l'OCDE, en collaboration avec des experts des pays Membres, a élaboré un manuel intitulé *Système des comptes de la santé* (SCS), dont la version 1.0 a été publiée en 2000. Depuis sa publication, une grande expérience a été accumulée dans plusieurs pays de l'OCDE au cours du processus d'application du SCS, et plusieurs publications nationales sont déjà parues dans ce domaine. En outre, le Communiqué des ministres de la santé, diffusé lors de la première réunion des ministres de la santé de l'OCDE qui s'est tenue les 13 et 14 mai 2004, qualifie l'application du *Système des comptes de la santé* dans plusieurs pays Membres d'élément clé du futur programme de travail de l'OCDE sur la santé.

8. Le Secrétariat juge essentiel de diffuser les comptes de la santé fondés sur le SCS des pays Membres de l'OCDE ainsi que leur analyse comparative. Dans la série des rapports techniques sur la santé, également disponibles sur internet, les principaux résultats sont présentés pays par pays et s'accompagnent de documents détaillés sur la méthodologie employée. Ces rapports, conjugués à l'étude comparative, constituent une source unique de données sur les dépenses de santé et fournissent une interprétation des comptes de la santé fondés sur le SCS. Ils décrivent en particulier de manière systématique et comparable la façon dont les dépenses de santé des pays participants s'effectuent ainsi que leur objet. Ces documents sont également importants d'un point de vue méthodologique : l'analyse de la disponibilité et de la comparabilité des données révèle les domaines dans lesquels il serait souhaitable de poursuivre l'harmonisation des systèmes de classification nationaux avec la classification internationale pour les comptes de la santé (ICHA).

9. Treize pays ont participé à ce projet : l'Allemagne, l'Australie, le Canada, la Corée, le Danemark, l'Espagne, la Hongrie, le Japon, le Mexique, les Pays-Bas, la Pologne, la Suisse et la Turquie. La prochaine version de l'étude comparative, à paraître en 2006, devrait inclure plusieurs pays supplémentaires. Pendant ce temps, de nouvelles études par pays seront présentées sur la page web du SCS de l'OCDE et dans les rapports techniques sur la santé dès qu'elles seront disponibles.

10. Le Secrétariat de l'OCDE invite les lecteurs à faire part de leurs commentaires sur la série des rapports techniques sur la santé relatifs aux comptes de la santé fondés sur le SCS, ainsi que de leurs suggestions sur la façon dont le contenu et la présentation des prochaines éditions pourraient être améliorés.

INTRODUCTION

11. Mexico's *National Health Programme 2001 – 2006* establishes the challenge of creating a health system that provides financial equity. The development of an information system particular to the resources spent in health, the flow of funds, the providers and functions supplies the evidence not only to determine the magnitude of the problem to be solved but also allows the evaluation of corrective measures.

12. The institutionalization of a System of National and State Health Accounts is proposed as a strategy to strengthen the stewardship function of the federal and state Ministries of Health (MOH). Although Mexico was a pioneer in the use of National Health Accounts,[1] gathering information from 1992 to 1998, the tool was not widely used by planning offices in the country.

13. The aim is to meet the challenge of producing information on financial resources spent on health as well as the flow of funds within the institutions of the health sector and the states which contribute to the policy-making process and thus increase accountability. The objective is not only to use the SHA methodology, but to institutionalize the System of Health Accounts as part of the National Health Information System.

Current organisation of the health system

14. The health system in Mexico is fragmented. The first group comprises those working in the formal sector of the economy and covered by social security institutions. The second is formed by urban middle and upper income level groups, who may contribute to social security but who also seek care in the private sector, either through out-of-pocket payments or through pre-paid medical insurance. The third group consists of the unemployed or self-employed, both urban and rural, who are left without the benefit of social security.

15. This organisation came about in a casual and cumulative manner, and is clearly linked to production. The provision of care for the above mentioned groups is provided by different institutions as follows:

A. The Social Security System consisting of a number of different institutions depending on type of employer. The financing of social security depends on contributions from the employer, the employee and the federal government. The Mexican Institute for Social Security (IMSS) provides care to workers in the formal economy, the Institute of Health and Social Security for State Workers (ISSSTE) provides care to government workers and PEMEX to oil company workers. Workers in the armed forces are also covered by a specific social security system. The Social Security System covers around 51%[2] of the population.

1. Hernández P, Cruz C, Zurita B, Frenk J, Ramírez R, Álvarez F. El Sistema de Cuentas Nacionales de Salud en México: documento para el análisis y la convergencia. FUNSALUD, Cuaderno 15, México, 1997.

2. Population estimates at the end of each year. General Direction for Health Information, Ministry of Health, Mexico.

B. Public services provided by the federal and state ministries of health (MOH) provide care to the uninsured population. Included here is the health component of the poverty alleviation programmes run by the government. Mexico has a decentralised health system and therefore States are responsible for public provision of care. Funding for the public sector is from general revenues.

C. The private sector, which is financed mainly by out-of-pocket expenditure and private insurance schemes.

16. How health expenditure is reported is a reflection of the fragmentation of the health system. Public health expenditure includes funding for the federal government and is allocated in the national budget to the federal MOH, decentralised organisations and deconcentrated organisations. The budget for the health component of the poverty alleviation programmes is also included here. States receive federal funding through the national budget through the Fund for Health Services (FASSA). Allocation of these resources is done in a historical manner. However, states also contribute to the financing of health by allocating state funds.

17. Social security is financed by contributions from the government, the employer and the employees. Funds from the government are allocated through a component in the national budget.

18. This means that reporting on public health expenditure is done differently by federal government, state governments and social security institutions. Reporting follows the requirements set by federal and local Ministries of Finance, presidential goals and indicators. It is generally done in a way that incorporates three "p´s" in each category: problems, populations and programmes, making it difficult to separate the flow of funds between financing agents, functions and providers of care. Although some categories of reporting apply to both social security institutions and the federal government, the states have no mandate to report in the same way. Also, knowledge of the total amount of state contributions to health was not officially recorded prior to 1999.

19. Therefore, reporting of health expenditure became an accounting process done to satisfy the requirements of the Ministry of Finance, and was seldom used for planning and evaluation purposes. Furthermore, the way of reporting funds tends to change with each new administration, thus reducing the possibilities of comparing expenditure across time.

20. The process of institutionalizing a System of National and State Health Accounts included preliminary work with social security institutions, states, and the budgeting office of the federal MOH in order to adapt the SHA methodology to the reality of our Health System. This means that there are slight differences in classification between 1999 and 2001 and with the International Classification of Health Accounts. These differences will be highlighted throughout this document

Summary data on health expenditure

21. As mentioned in the previous section, the Mexican Health Foundation (Funsalud) carried out the first estimates of health expenditure using the System of National Accounts. The most relevant finding of this study was that private out-of-pocket expenditure in Mexico accounted for around 52% of total health expenditure. Even though it was known that private expenditure existed, the magnitude of the amount was unknown.

22. The use of SHA established the grounds for an in-depth reconsideration of the way the system is financed. One of the main findings so far is the contribution of state governments to health. In the years 1999 to 2001, states contributed around 14% of the health expenditure on the uninsured population, with marked differences across states.

23. Another impact of the use of SHA on health expenditure data is that health insurance premiums were only estimated but not currently reported. Therefore, the use of a standardised methodology for registering health expenditure, mainly the OECD SHA methodology, has increased the figures on health expenditure by more than 50%.

Health expenditure by financing source

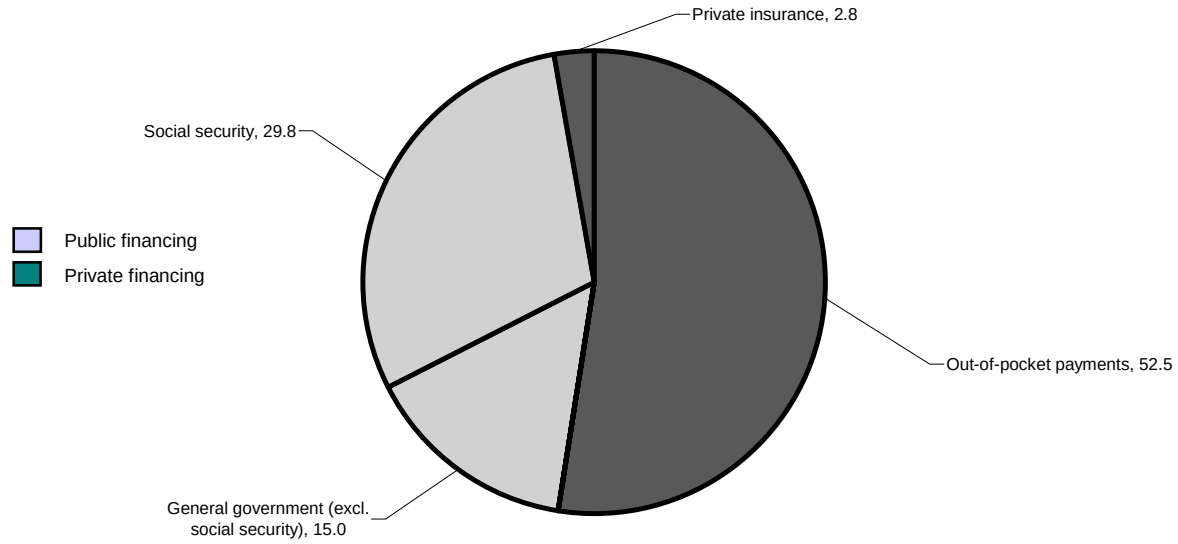
24. The public financing sources in Mexico include the federal Ministry of Health, the regional (states) Ministries of Health and Social Security Institutions (IMSS, ISSSTE, PEMEX). Although there is preliminary evidence of the contribution of municipal governments to the financing of health, the amount is currently being studied and is therefore not included as part of the total expenditure on health. Private financing sources include households and employers (companies) who pay insurance premiums for their employees. Increasingly, philanthropic organisations of certain companies have contributed to special health programmes such as rehabilitative centres, cancer equipment and nutritional supplements. It is expected that these contributions will be accounted for in the NHA reports for 2003.

25. The new Guide to Producing National Health Accounts[3] defines the category of financing agents, who, to summarise, have the decision on what the funds are spent on. The use of this new category means that for future reporting, the financing sources will be: Ministry of Finance, State Ministries of Finance, Ministry of Health, State Ministries of Health, households and employers. The financing agents will be reported as follows: Ministry of Health, State Ministries of Health, Social Security Institutions, Insurance companies and households.

26. In contrast to high-income countries, health in Mexico is financed mainly by private sources (55%) (Figure 1 and Table A1). Table 1 shows the per capita total, public and private expenditure. It can be seen that in all the three years presented, private expenditure exceeds public expenditure. This relationship is maintained when the analysis is carried out at state level. Table 3 provides further evidence that private expenditure is greater than public expenditure. It is important to note that the private expenditure presented here does not include expenditure from foreign sources nor does it include Non-governmental Organisations´ contributions to health.

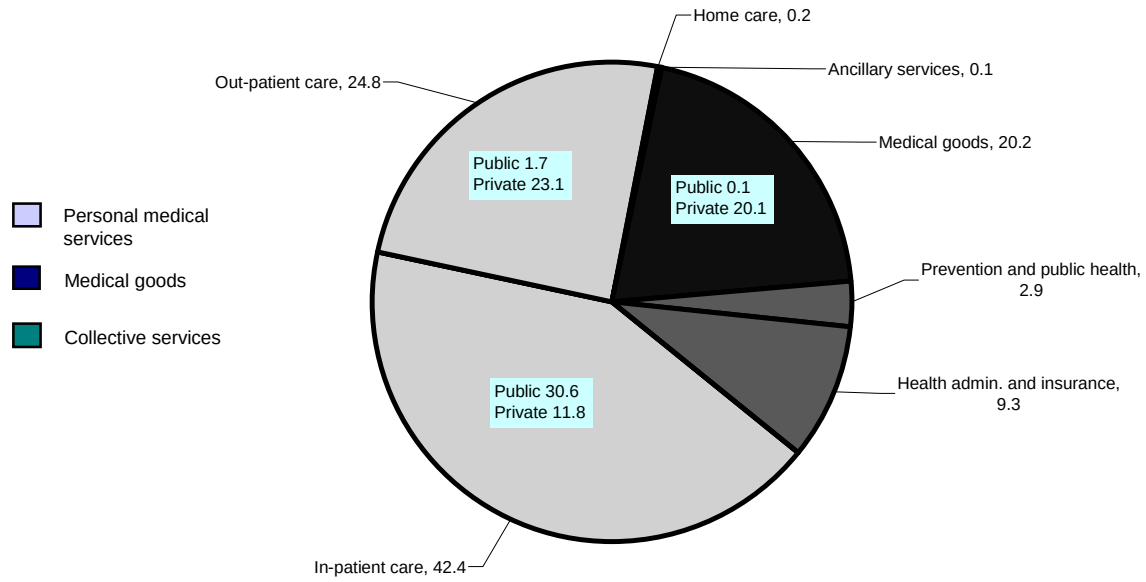
3. Guide to Producing NHA with special applications for low-income and middle-income countries. World Bank, WHO, USAID 2002.

Figure 1**: Total health expenditure by financing agent** (Total health expenditure = 100)
Mexico, 2001



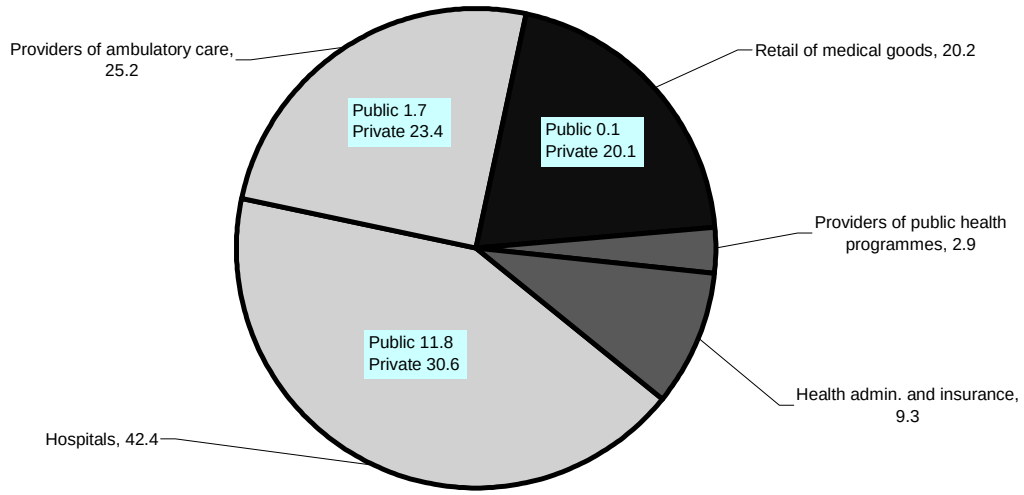
Note: Four standard figures are to be presented and numbered in the same way in each country chapter. **Figure 2**: Total health expenditure by function in not presented in this chapter due to lack of separation of long-term care (HC.3) and curative-rehabilitative expenditure in the Mexican National Health Accounts.

Figure 3: **Current health expenditure by mode of production** (Current health expenditure = 100)
Mexico, 2001



Note: SHA definition of current health expenditure, i.e. excludes all expenditure on health related functions.

Figure 4: **Current health expenditure by provider** (Current health expenditure = 100)
Mexico, 2001



Note: SHA definition of current health expenditure, i.e. excludes all expenditure on health-related functions.

Table 1. Per capita total, public and private health expenditure, Mexico 1999-2001

YEAR	Per capita expenditure					
	Public		Private		Total	
	NCU	USD PPP	NCU	USD PPP	NCU	USD PPP
1999	1,241	220	1,357	241	2,598	461
2000	1,402	230	1,613	264	3,015	494
2001	1,524	241	1,880	297	3,403	538

Table 2. Public share in total expenditure and structure of public expenditure, Mexico 1999-2001 (NCU)

YEAR	Public share in total expenditure	Total expenditure on health	Public expenditure		
			Total public expenditure	General Government	Social Security
1999	47.8	256,791	122,668	37,743	84,925
2000	46.5	305,096	141,881	45,834	96,047
2001	44.8	348,611	156,085	52,282	103,803

Table 3. Private share in total expenditure; and structure of private expenditure, Mexico 1999-2001

			Private expenditure		
YEAR	Private share in total expenditure	Total expenditure on health	Total private expenditure	Other private insurance	Private Household out-of-pocket payments
1999	52.2	256,791	134,123	5,559	128,565
2000	53.5	305,096	163,215	7,621	155,594
2001	55.2	348,611	192,525	9,589	182,936

27. Within public expenditure, the per capita expenditure from social security institutions tends to be greater than that of the MOH, as seen in Table 2. In 2001, social security institutions contributed to 66% of the total public expenditure on health.

28. Private expenditure includes private household out-of-pocket expenditure (HF.2.3) and private insurance (HF.2.2), which accounted for 52.5% and 2.8% respectively of the total expenditure on health in 2001.

29. Public expenditure on health had a share of 45% of the total health expenditure in 2001. Central government (HF.1.1.1) contributed 13%, state governments (HF.1.1.2) contributed 2% and social security funds (HF.1.2) contributed 30% of the total expenditure on health.

30. In 1999 and 2000, Mexico's total health expenditure represented 5.6% of the GDP; In 2001 this percentage increased to 6% of GDP.

Health expenditure by function

31. As was mentioned previously, reporting on health expenditure in Mexico follows the guidelines provided by the Ministry of Finance. In national accounting terms, this means that the reporting is done by category or chapter.[4] Health expenditure is also reported corresponding to what is known as institutional activity that describes health expenditure according to functions and programmes. However, the institutional activities, and therefore the functions are not the ones described in the International Classification of Health Accounts. This means that a "translator" must be constructed in order to represent the expenditure figures according to the ICHA classification (Table 4).

32. The expenditure on investment only relates to public investments in infrastructure. Public investments accounted for 0.9% of total expenditure in 2001. The investment expenditure share of public expenditure was 2.1% in 2001; a low figure.

33. In 1999 and 2000 almost 10% of the total expenditure in health could not be disaggregated by function because the translators developed implied too many estimations. We therefore included a category for "non-distributable expenditure" which includes state contributions, federal contribution (FASSA) and the expenditure of the national oil company (PEMEX).

4. The chapters are the following: personal services (wages), services and materials, general services, transfers, capital formation, public works, financial investments and other transactions.

Table 4. Expenditure classified by Institutional activity and ICHA, Mexico 2002

Institutional Activity	ICHA
Formulate and implement public policies Provide legal assistance Provide logistical support Communicate and disseminate activities of federal government Coordinate links between federal govt. and other levels of govt. Promote application of sector wide policies Coordinate and promote international relations Promote public participation Regulate and supervise economic agents Establish the basis for national health statistics framework Audit the public administration Administration of human, physical and financial resources Administration of technological resources Transfer of public funds	**HC. 7 General government administration of health** HC.7.1 General government administration of health HC.7.1.3 General government administration of health (except social security) HC.7.1.2 Administration, operation and support activities of social security funds
Conduct prevention and public health promotion campaigns Provide health services (poverty alleviation program OPPORTUNIDADES) Provide health services (poverty alleviation program PAC) Conduct epidemiologic surveillance Admin. of human, physical & financial resources of National Health Program	**HC.6 Prevention and public health services**
Provide medical care Administration of human, physical and financial resources of medical care	**HC.1-HC.3 Personal health care services** In-patient and out-patient services
Production of primary chemical and laboratory inputs, pharmaceuticals	**HC.5 Medical goods dispensed to out- patients** HC.5.1 Pharmaceuticals and other medical non- durables
Construct basic infrastructure Maintenance of basic infrastructure	**HC.R.1 Capital formation of health care providers institutions**
Training of health personnel	**HC.R.2 Education formation of health care provider instits.**
Conduct scientific and technological research	**HC.R.3 Research and development in health**
Conduct environmental regulation	**HC.R.4 Food, hygiene and drinking water control**

Current health expenditure by mode of production

34. Medical services include inpatient and outpatient care (Figure 3 and Table A3). Inpatient includes curative care, rehabilitative services, ancillary services and long-term care, but we cannot separate these categories. Outpatient services include curative and rehabilitative care.

Current health expenditure by provider

35. The main providers of care in terms of a percentage in the share of total health expenditure are hospitals, as reported in the National Health Information System (Figure 4 and Table A4). This is partly due to the fact that expenditure on some outpatient physicians' services is accounted for as part of hospital expenditure. At this point it is not possible to separate the outpatient care within hospitals.

36. Therefore we have made some assumptions when estimating the expenditure on outpatient care. In terms of the poverty alleviation programmes, for example, although they do provide hospital care, the majority of the health funds are spent on outpatient care and we have therefore included this expenditure as outpatient.

37. Mexico does have centres for the provision of long-term care such as asylums and elderly care centres. However, the expenditure from these providers has not yet been included as part of the total health expenditure. We are currently in the process of establishing a census of these establishments so that their health expenses can be accounted for. Psychiatric hospitals are included as part of inpatient care.

Table 5. Structure of health expenditure by major types of providers, Mexico 1999-2001

Health expenditure by major types of providers	1999	2000	2001
Health care goods and services by provider industry	100.00	100.00	100.00
Hospitals HP.1	35.99	37.30	41.61
Nursing and residential care facilities HP.2	n/a	n/a	n/a
Providers of ambulatory health care HP.3	23.84	23.48	24.70
Retail sale and other providers of medical goods HP.4	18.60	19.48	19.85
Provision and administration of public health programmes HP.5	0.70	0.58	2.89
General health administration and insurance HP.6	8.45	7.01	9.08
Other industries (rest of economy) HP.7	n/a	n/a	n/a
Rest of the world HP.9	n/a	n/a	n/a
Health Related Expenditures HC.R.1-HC.R.5	1.86	2.46	1.87
Investment (gross capital formation) in healthHC.R.1	1.17	1.77	0.94
Non distributable expenditure	10.56	9.69	0.00

Current health expenditure by function and provider

38. Expenditure of medical care providers (providers of personal health care services) cannot be disaggregated by function. This is only possible for public health services and health administration/stewardship functions. Therefore, the categories H.C.1 to H.C.4 are reported jointly as medical services and the providers of these functions are hospitals and outpatient care centres.

Current health expenditure by provider and financing agent

Spending structure of financing agents by provider (SHA Table 3.3)

39. General government expenditure is primarily directed to hospitals (more than 50% for the period from 1999 to 2001) and has increased over this period. The major increase of 66.8% in 2001 is partly due to the distribution of the amount that was reported as non-distributable expenditure for the previous years (see Table A4). This also applies to expenditure on public health programmes. (Note: Tables 6-9 refer to Total Health Expenditure rather than Current and so have different figures from SHA tables.)

Table 6. Percentage distribution of general government expenditure (HF.1) between providers, Mexico 1999-2001

General Government expenditure	1999	2000	2001
Health care goods and services by provider industry	100.00	100.00	100.00
Hospitals HP.1	51.35	54.64	67.02
Nursing and residential care facilities HP.2	n/a	n/a	n/a
Providers of ambulatory health care HP.3	3.47	2.81	3.83
Retail sale and other providers of medical goods HP.4	0.02	0.12	0.20
Provision and administration of public health programmes HP.5	1.47	1.24	6.46
General health administration and insurance HP.6	17.69	15.07	18.32
Other industries (rest of economy) HP.7	n/a	n/a	n/a
Rest of the world HP.9	n/a	n/a	n/a
Health Related Expenditures HC.R.1-HC.R.5	3.89	5.28	4.17
Investment (gross capital formation) in health HC.R.1	2.45	3.80	2.10
Non distributable expenditure	22.11	20.84	0.00

40. Also, as seen in Table 6, general government expenditure on stewardship is 6 times greater than the expenditure on ambulatory care. This is due to the fact that it is not possible to separate the ambulatory care provided by hospitals and therefore, hospital care includes a portion of ambulatory care services.

41. Expenditure on pharmaceuticals may seem incredibly low, but once again, it is because at this point, it is not possible to separate pharmaceuticals used in hospitals from the total hospital expenditure.

Table 7. Percentage distribution of general government (excluding social security) expenditure (HF.1.1) between providers, Mexico 1999-2001

General Government (excluding social security) expenditure	1999	2000	2001
Health care goods and services by provider industry	100.00	100.00	100.00
Hospitals HP.1	10.78	11.22	40.41
Nursing and residential care facilities HP.2	n/a	n/a	n/a
Providers of ambulatory health care HP.3	11.28	8.68	11.45
Retail sale and other providers of medical goods HP.4	0.07	0.36	0.58
Provision and administration of public health programmes HP.5	4.76	3.84	19.30
General health administration and insurance HP.6	10.53	11.16	22.18
Other industries (rest of economy) HP.7	n/a	n/a	n/a
Rest of the world HP.9	n/a	n/a	n/a
Health Related Expenditures HC.R.1-HC.R.5	0.22	0.20	6.08
Investment (gross capital formation) in health HC.R.1	0.00	0.00	3.91
Non distributable expenditure	62.36	64.52	0.00

42. Table 7 shows that once social security is excluded, the percentage of expenditure on public health activities increases. There are two reasons for this. On the one hand, social security primarily focuses on personal care services while the MOH and State MOH are responsible for providing public health services considered as public goods and are also responsible, as head of the health sector, for the stewardship function. Secondly, it is possible to better separate the MOH expenditure by function.

43. The System of National Accounts produced by the National Institute of Statistics, Geography and Informatics (INEGI) provides information on private expenditure by the following components: hospital services, ambulatory services and pharmaceuticals. Ambulatory care includes expenditure on laboratories, physicians' offices, dental practices and diagnostic services, but these cannot be separated. In 2001, ambulatory care represented 37% of private expenditure. Hospital care represented 19.4% and pharmaceuticals 43.1% of private expenditure excluding pre-payment of private insurance. If insurance premiums are attributed to hospital services, the total expenditure for hospital care would increase to 21%.

***How different providers are financed* (SHA Table 3.2)**

44. The main source of hospital funding is the government, as seen in Table 8. However, caution is needed when analysing this data since hospital expenditure includes outpatient and inpatient care provided in the hospitals. Nevertheless, inpatient care in hospitals tends to consume the majority of resources.

45. For 1999 and 2000 the general government contribution, excluding social security, towards the financing of hospitals is around 6%. This share increased in 2001 to 20%. The increase was due to the possibility that state government expenditure and federal funds transferred to states and used for hospital services could be included, whereas previously it was reported as non-distributable.

46. As mentioned previously, although the amount reported as private insurance includes administrative costs and pharmaceuticals distributed to patients, it is not possible to disaggregate the data. Once again, the assumption is that most of the expenditure is for hospital services.

Table 8. Expenditure on hospitals' services by sources of funding, Mexico1999-2001

Hospitals' services	1999	2000	2001
Total expenditure on health	100.0	100.0	100.0
General Government HF.1.	68.1	68.1	72.1
General Government (excluding social security) HF1.1	6.5	6.6	20.2
Social security funds HF.1.2	93.5	93.4	79.8
Private sector HF.2.	31.9	31.9	27.9
Private insurance (HF.2.1+2.2)	18.9	21.0	12.3
Out-of-pocket payments HF.2.3	81.1	79.0	87.7

Current expenditure by function and financing agent

Functional structure of spending by financing agent (SHA Table 4.3)

47. General government expenditure is directed primarily to personal-health services and goods. This is true even if it is not possible to disaggregate the total share of pharmaceuticals dispensed to patients. If it were possible, the share would increase.

48. Expenditure on health administration, which includes expenditure on the stewardship functions of the MOH, represents almost 20% of total government health expenditure in 2001. This high share is partly due to the fact that some public health functions are provided by federal and state MOHs, but until 2001 it was not possible to separate this proportion from the total expenditure. Efforts have been made to change the way reporting is done at federal level. This means that for 2002, the share of government expenditure on public health functions will increase and consequently the share of health administration will decrease. General government, excluding social security, spends 19% on public health functions.

49. In the case of social security institutions, it has not been possible to separate the expenditure on public health functions from that of personal services. Although the proportion tends to be small, social security institutions do provide public health services such as vaccination campaigns.

Table 9. Percentage of general government expenditure on health by functions. Mexico 1999-2001

General Government expenditure	1999	2000	2001
Total expenditure on health	100.00	100.00	100.00
Current expenditure on health care	97.55	96.20	97.90
Curative & rehabilitative& LTC HC.1-Hc.3	54.82	57.45	70.85
Curative & rehabilitative care	100.00	100.00	100.00
Long-term care	n/a	n/a	n/a
Ancillary services to health care HC.4	n/a	n/a	n/a
Medical goods dispensed to out- patients HC.5	0.02	0.12	0.20
Personal health care services and goodsHC.1-HC.5	54.84	57.56	71.05
Prevention and public health services HC.6	1.47	1.24	6.46
Health administration and health insurance HC.7	17.69	15.07	18.32
Health Related Expenditures HC.R.1-HC.R.5	3.89	5.28	4.17
Investment (gross capital formation) in health HC.R.1	2.45	3.80	2.10
Non distributable expenditure	22.11	20.84	0.00

50. Information regarding private expenditure by function is aggregated. It is not possible to separate curative from rehabilitative and long-term care. Furthermore, information on expenditure for ancillary services is not available either, except for private insurance for 2001. However distribution during the three years presented tended to be constant: about 64% was spent on personal medical services and 36% on medical goods.

How the different functions are financed *(SHA Table 4.2)*

51. The private sector is the main financing agent for medical services. Medical services as presented in Table 10 do not include pharmaceuticals dispensed to outpatients.

Table 10. Percentage distribution medical services by financing agent. Mexico 1999-2001

Medical services	1999	2000	2001
Total expenditure on health	100.0	100.0	100.0
General Government HF.1.	43.8	44.0	47.9
General Government (excluding social security) HF1.1	12.4	11.2	24.5
Social security funds HF.1.2	87.6	88.8	75.5
Private sector HF.2.	56.2	56.0	52.1
Private insurance (HF.2.1+2.2)	6.4	7.3	4.8
Out-of-pocket payments HF.2.3	93.6	92.7	95.2

Conclusions

52. The challenge faced is to correct the failures and transform the system from one based on administrative records for programmes to one that privileges the health of the individual.

53. The purpose is to generate a system of financial resources that provides information for decision-makers, but also one that is useful when conducting follow-up programmes and processes for improving the management of health services.

54. For this reason, the implementation of a System of National Accounts envisions the incorporation of states. This means that work is in progress so that each of the 32 states will have a system of state health accounts, following a standardized methodology. Furthermore, some states are now working towards including municipal expenditure on health into their system of health accounts.

55. The work has now led to the 2003 expenditure reporting being more closely linked to the care functions of the health system, as expressed in the International Classification of Health Accounts.

56. Although the basic SHA methodology is used, some variations were necessary. For example, in 1999, it was not possible to distinguish between the federal fund expenditure transferred to States and the state contributions by provider. We therefore had to add a line in SHA Table 3: Non-distributable expenditure. For 2001 it was possible to separate this amount and therefore care should be taken when comparing this category across time.

57. One of the major achievements in the process of institutionalizing health accounts has been the adoption by the Ministry of Finance of a system of reporting health expenditure that is in accordance with the functions of the health system. This will allow for further comparability.

58. There is also difficulty in separating expenditure by level of care. Certain assumptions have been made. However, for 2002 information by level of care is available. It is important to note that when

"information is not available" is provided in the tables, this does not mean that the function/provider does not exist.

59. The inclusion of state contributions in total health expenditure in 2001, which amount to 14.3% of public expenditure for the uninsured population, has been very important in for policy-making. For example, information from national and state health accounts contributed to financial imbalances in the health system. The first imbalance refers to an insufficient level of spending: 6% of GDP in 2001 and 6.1% in 2002. The second imbalance refers to the financing source: in 2001, 52% of total health expenditure was household out-of-pocket expenditure. The third imbalance refers to the distribution of resources: the per capita expenditure on the insured population is almost two times higher than on the uninsured population, and the federal per capita expenditure is 8 times higher in the state that receives more federal funding. Finally, the state contributing the most to health expenditure contributes 119 times more than the state contributing the lowest amount.

60. Institutionalizing a system which records the financial flows of the health system has been an incremental process. The main issue that makes such an institutionalization viable is the adaptation of SHA methodology. For this reason, working with state planning and administration offices has been vital.

61. Although progress has been made, some of the future challenges include:

- Expenditure on hospital care which needs to be shared out among the different functions or services within the hospital. However, the creation of cost centres as part of the NHA exercise is not envisioned.

- Further disaggregation of insurance premiums according to function.

- Disaggregation of personal services by level of care.

- Inclusion of other funding agents such as NGOs

62. In technical terms, the OECD/WHO methodology has been adapted to better reflect the reality of the Mexican health system while still maintaining the comparability of information produced. The Mexican System of National and State Health Accounts has produced valuable evidence for the formulation of the financial architecture needed for the creation of the System of Social Protection in Health.

ANNEX 1: METHODOLOGY

Current state of applying the ICHA

Health Expenditure by Financing Agent

ICHA	SHA Manual	Categories used in national practice and / or departures from the ICHA as to the content of the category
HF 1	General government	The sum of expenditure on insured population and uninsured population. For the three years, we do not have information on municipal contributions to the financing of health.
HF 1.1	General government excluding social security funds	The sum of central and state contributions to health.
HF 1.1.1	Central government	OECD definition
HF 1.1.2	State/provincial government	OECD definition
HF 1.1.3	Local/municipal government	information not available
HF 1.2	Social security funds	Includes health expenditure from the social security institutions (IMSS, ISSSTE and PEMEX)
HF 2	Private sector	Includes private household out-of-pocket expenditure and prepayment of private insurance. And for 2001, also includes the out of pocket expenditure in public (MOH) institutions.
HF 2.1	Private social insurance	Information not available
HF 2.2	Private insurance enterprises (other than social insurance)	Includes prepayment of private insurance.
HF 2.3	Private household out-pocket expenditure	OECD definition
HF 2.3.1	Out-of-pocket expenditure excluding cost-sharing	Information not available
HF 2.3.2	Cost sharing: central government	Information not available
HF 2.3.3	Cost sharing: state/provincial government	Information not available
HF 2.3.4	Cost sharing: local/municipal government	Information not available
HF 2.3.5	Cost sharing: social security funds	Information not available
HF 2.3.6	Cost sharing: private social insurance	Information not available
HF 2.3.7	Cost sharing: other private insurance	Information not available
HF 2.3.9	All other cost-sharing	Information not available
HF 2.4	Non-profit institutions serving households (other than social insurance)	Information not available
HF 2.5	Corporations (other than health insurance)	Information not available
HF 3	Rest of the world	Information not available

Health Expenditure by Function

ICHA	SHA Manual	Categories used in national practice and / or departures from the ICHA as to the content of the category
HC.1	Services of curative care	Includes inpatient care and outpatient care only, without further disaggregation.
HC 1.1	Inpatient curative care	It is not possible to separate the day cases of curative care. Includes medical goods dispensed in the three levels of care since we cannot separate them. The expenditure on medical care of social security, federal and state institutions is included in this category because we cannot separate inpatient and outpatient level of care. And includes the private insurance.
HC 1.2	Day cases of curative care	Information not available
HC 1.3	Outpatient curative care	Only able to include ambulatory care of the poverty alleviation programs. The rest of ambulatory care is included in inpatient care because it is not possible to separate the two types of care. The assumption here is that, since expenditure on inpatient care is higher, everything is allocated in this category.
HC 1.3.1	Basic medical and diagnostic services	Information not available
HC 1.3.2	Outpatient dental care	Information not available
HC 1.3.3	All other specialised health care	Information not available
HC 1.3.9	All other outpatient curative care	Information not available
HC 1.4	Services of curative home care	Included in HC 1.3, except the expenditure of private insurance, which also includes the HC.2.4 Services of rehabilitative home care
HC.2	Services of rehabilitative care	Information not available
HC 2.1	Inpatient rehabilitative care	Information not available
HC 2.2	Day cases of rehabilitative care	Information not available
HC 2.3	Outpatient rehabilitative care	Included in HC 1.3. This information cannot be disaggregated.
HC 2.4	Services of rehabilitative home care	Included in HC 1.3. This information cannot be disaggregated, except the private insurance expenditure, which is included in HC.1.4
HC 3	Services of long-term nursing care	Information not available
HC 3.1	Inpatient long-term nursing care	Information not available
HC 3.2	Day cases of long-term nursing care	Information not available
HC 3.3	Long-term nursing care: home care	Information not available
HC 4	Ancillary services to health care	Only includes private insurance
HC 4.1	Clinical laboratory	Information not available
HC 4.2	Diagnostic imaging	Information not available
HC 4.3	Patient transport and emergency rescue	Information not available
HC 4.9	All other miscellaneous ancillary services	Information not available
HC 5	Medical goods dispensed to outpatients	Since we cannot disaggregate the information by two or three digit codes, we include everything in this category. Includes medical goods dispensed through poverty alleviation programs and vaccines, the private expenditure (out of pocket payment and private insurance) in pharmaceuticals and therapeutic appliances. The rest of medical goods dispensed to patients is included in HC1.1 since we cannot separate this concept by type of care.
HC 5.1	Pharmaceuticals and other medicals non-durables	Information not available
HC 5.1.1	Prescribed medicines	Information not available
HC 5.1.2	Over-the-counter medicines	Information not available

HC 5.1.3	Other medical non-durables	Information not available
HC 5.2	Therapeutic appliances and other medical durables	Information not available
HC 5.2.1	Glasses and other vision products	Information not available
HC 5.2.2	Orthopaedic appliances and other prosthetics	Information not available
HC 5.2.3	Hearing aids	Information not available
HC 5.2.4	Medico-technical devices, including wheelchairs	Information not available
HC 5.2.9	All other miscellaneous medical durables	Information not available
HC 6	Prevention and public health services	Includes central offices, deconcentrated organisations and the decentralised organisations with functions of public health for 1999-2000. For 2001, includes central and state governments. Does not include private information and social security institutions for the three years.
HC 6.1	Maternal and child health; family planning and counselling	Information not available
HC 6.2	School heath services	Information not available
HC 6.3	Prevention of communicable diseases	Information not available
HC 6.4	Prevention of non-communicable diseases	Information not available
HC 6.5	Occupational health care	Information not available
HC 6.9	All other miscellaneous public health services	Information not available
HC 7	Health administration and health insurance	OECD definition
HC 7.1	General government administration of health	OECD definition
HC 7.1.1	General government administration of health (except social security)	OECD definition
HC 7.1.2	Administration, operation and support activities of social security funds	OECD definition
HC 7.2	Health administration and health insurance: private	OECD definition
HC 7.2.1	Health administration and health insurance: social insurance	Information not available
HC 7.2.2	Health administration and health insurance: other private	OECD definition
INCLUDES	NON DISTRIBUTABLE EXPENDITURE	For 1999 corresponds to ramo 33 (FASSA: Federal transfers to the states), PEMEX and state contributions that cannot be distributed by functions of care. For 2000 corresponds to ramo 33 (FASSA: Federal transfers to the states) and state contributions that cannot be distributed by functions of care.
Health Related Expenditures		
HC.R 1	Capital formation of health care provider institutions	OECD definition. For 1999 and 2000, only includes social security. For 2001, includes federal and state government as well.
HC.R 2	Education and training of health personnel	OECD definition. For 1999 and 2000, only includes social security. For 2001, includes federal and state government as well.
HC.R 3	Research and development in health	OECD definition. For 1999 and 2000, only includes social security. For 2001, includes federal and state government as well.
HC.R 4	Food, hygiene and drinking water control	OECD definition. For 1999 and 2000, only includes federal government. For 2001, includes federal and state government.
HC.R 5	Environmental health	OECD definition. Only includes central government
HC.R 6	Administration and provision of social services in kind to assist living with disease and impairment	information not available
HC.R 7	Administration and provision of health-related cash-benefits	information not available

Health Expenditure by Provider

ICHA	SHA Manual	Categories used in national practice and / or departures from the ICHA as to the content of the category
HP 1	Hospitals	Includes the cost of medical goods dispensed by hospitals and outpatient providers since we cannot disaggregate the information. The expenditure of hospitals of social security, federal and state institutions is included in this category because we cannot separate hospitals from providers of outpatient care.
HP 1.1	General hospitals	Information not available
HP 1.2	Mental health and substance abuse hospitals	Information not available
HP 1.3	Speciality (other than mental health and substance abuse) hospitals	Information not available
HP 2	Nursing and residential care facilities	Information not available
HP 2.1	Nursing care facilities	Information not available
HP 2.2	Residential mental retardation, mental health and substance abuse facilities	Information not available
HP 2.3	Community care facilities for the elderly	Information not available
HP 2.9	All other residential care facilities	Information not available
HP 3	Providers of ambulatory health care	Includes outpatient care centers in the poverty alleviation programs and private expenditure
HP 3.1	Offices of physicians	Includes the out of pocket expenditure
HP 3.2	Offices of dentists	Information not available
HP 3.3	Offices of other health practitioners	Information not available
HP 3.4	Outpatient care centers	OECD definition
HP 3.4.1	Family planning centres	Information not available
HP 3.4.2	Outpatient mental health an substance abuse centers	Information not available
HP 3.4.3	Free-standing ambulatory surgery centers	Information not available
HP 3.4.4	Dialysis care centers	Information not available
HP 3.4.5	All other outpatient multi-speciality and cooperative services centers	Information not available
HP 3.4.9	All other outpatient community and other integrated care centers	Information not available
HP 3.5	Medical and diagnostic laboratories	Includes the private insurance expenditure
HP 3.6	Providers of home health care services	Includes the private insurance expenditure
HP 3.9	Other providers of ambulatory health care	Information not available
HP 3.9.1	Ambulance services	Information not available
HP 3.9.2	Blood and organ banks	Information not available
HP 3.9.9	Providers of all other ambulatory health care services	Information not available
INCLUDES	NON DISTRIBUTABLE EXPENDITURE	For 1999 corresponds to ramo 33 (FASSA: Federal transfers to the states), PEMEX and state contributions that cannot be distributed by functions of care. For 2000 corresponds to ramo 33 (FASSA: Federal transfers to the states) and state contributions that cannot be distributed by functions of care.
HP 4	Retail sale and other providers of medical goods	Only includes a share of central government expenditure (poverty alleviation programs) and private expenditure. Includes medical goods dispensed through poverty alleviation programs and vaccines and private expenditure (out of pocket payment and private insurance) in pharmaceuticals and therapeutic appliances. The rest of medical goods dispensed to patients is included in HP.1 since we cannot separate this concept by level of care.

HP 4.1	Dispensing chemist	
HP 4.2	Retail sale and other suppliers of optical glasses and other visions products	Information not available
HP 4.3	Retail sale and other suppliers of hearing aids	Information not available
HP 4.4	Retail sale and other suppliers of medical appliances (other than optical glasses and hearing ads)	Information not available
HP 4.9	All other miscellaneous sale and other suppliers of pharmaceuticals and medical goods	
HP 5	Provision and administration of public health programmes	Includes central offices, deconcentrated organisations and the decentralised organisations with functions of public health for 1999-2000. For 2001, includes central and state governments. Does not include private information and social security institutions for the three years.
HP 6	General health administration and insurance	OECD definition
HP 6.1	Government administration of health	OECD definition
HP 6.2	Social security funds	OECD definition but does not include administration of PEMEX because the data is not available.
HP 6.3	Other social insurance	Does not apply
HP 6.4	Other (private) insurance	OECD definition
HP 6.9	All other providers of health administration	Information not available
HP 7	Other industries (rest of the economy)	Information not available
HP 7.1	Establishment as providers of occupational health care services	Information not available
HP 7.2	Private households as providers of home care	Information not available
HP 7.9	All other industries as secondary producers of health care	Information not available
HP 9	Rest of the world	Information not available

ANNEX 2: TABLES

Table A1
Total health expenditure by financing agents

		First available year		Last available year	
		1999		2001	
		MXN million	percent	MXN million	percent
HF.1	General government	122,668	47.8%	156,085	44.8%
HF.1.1	General government excluding social security funds	37,743	14.7%	52,282	15.0%
HF.1.1.1	Central government	32,397	12.6%	44,775	12.8%
HF.1.1.2;1.1.3	Provincial/local government	5,346	2.1%	7,507	2.2%
HF.1.2	Social security funds	84,925	33.1%	103,803	29.8%
HF.2	Private sector	134,123	52.2%	192,525	55.2%
HF.2.1	Private social insurance	-	-	-	-
HF.2.2	Private insurance enterprises (other than social insurance)	5,559	2.2%	9,589	2.8%
HF.2.3	Private household out-of-pocket expenditure	128,565	50.1%	182,936	52.5%
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	-	-	-	-
	Total health expenditure (Mexican NHA)	**256,791**	**100.0%**	**348,611**	**100.0%**

Notes:

(1) According to the Mexican Health Accounts total health expenditure includes all Health Related Expenditures (HC.R.1-5). Figure 1 and relevant tables presented in this country chapter and the comparative chapter use the Mexican definition of total health expenditure. [Total Health Expenditure for 2001, according to the SHA definition, was 345 379 million pesos.]

Table A2

Total health expenditure by function of care

Note: Four standard tables are to be presented and numbered in the same way in each country chapter. This table cannot be presented due to lack of separation of long-term care (HC.3) and curative-rehabilitative expenditure in the Mexican National Health accounts.

Table A3
Current health expenditure by mode of production

		First available year		Last available year	
		1999		2001	
		MXN million	percent	MXN million	percent
	Inpatient care	92,428	36.7%	145,039	42.4%
HC.1.1;2.1	Curative & rehabilitative care	-	-	-	-
HC.3.1	Long-term nursing care	-	-	-	-
	Services of day-care	-	-	-	-
HC.1.2;2.2	Day cases of curative & rehabilitative care	-	-	-	-
HC.3.2	Day cases of long-term nursing care	-	-	-	-
	Outpatient care	61,209	24.3%	84,840	24.8%
HC.1.3;2.3	Outpatient curative & rehabilitative care	-	-	-	-
HC.1.3.1	Basic medical and diagnostic services	-	-	-	-
HC.1.3.2	Outpatient dental care	-	-	-	-
HC.1.3.3	All other specialised health care	-	-	-	-
HC.1.3.9;2.3	All other outpatient curative care	-	-	-	-
	Home care	-	-	787	0.2%
HC.1.4;2.4	Home care (curative & rehabilitative)	-	-	-	-
HC.3.3	Home care (long term nursing care)	-	-	-	-
HC.4	*Ancillary services to health care*	-	-	471	0.1%
HC.5	*Medical goods dispensed to outpatients*	47,758	19.0%	69,211	20.2%
HC.5.1	Pharmaceuticals and other medical non-durables	-	-	-	-
HC.5.2	Therapeutic appliances and other medical durables	-	-	-	-
	Total expenditure on personal health care	**201,394**	**79.9%**	**300,348**	**87.8%**
HC.6	*Prevention and public health services*	1,798	0.7%	10,091	2.9%
HC.7	*Health administration and health insurance*	21,701	8.6%	31,669	9.3%
	Non-distributable expenditure	*27,126*	*10.8%*	-	-
	Total current expenditure on health (SHA definition)	**252,019**	**100.0%**	**342,109**	**100.0%**
	Health related functions	4,773	1.9%	6,502	1.9%
	Total current expenditure on health (Mexican NHA)	256,791	101.9%	348,611	101.9%

Notes:

(1) Non distributable expenditure includes Federal transfers to the states, PEMEX and state contributions that cannot be distributed by functions of care. For 1999 it was not possible to distribute by function care because of the way expenditure was reported to the Ministry of Finance.

Table A4
Current health expenditure by provider

		First available year		Last available year	
		1999		2001	
		MXN million	percent	MXN million	percent
HP.1	Hospitals	92,428	36.7%	145,039	42.4%
HP.2	Nursing and residential care facilities	-	-	-	-
HP.3	Providers of ambulatory health care	61,209	24.3%	86,098	25.2%
HP.3.1	Offices of physicians	56,949	22.6%	78,856	23.1%
HP.3.2	Offices of dentists	-	-	-	-
HP.3.3-3.9	All other providers of ambulatory health care	4,259	1.7%	7,241	1.7%
HP.4	Retail sale and other providers of medical goods	47,758	19.0%	69,211	20.2%
HP.5	Provision and administration of public health	1,798	0.7%	10,091	2.9%
HP.6	General health administration and insurance	21,701	8.6%	31,669	9.3%
HP.6.1	Government administration of health	3,973	1.6%	11,597	3.4%
HP.6.2	Social security funds	17,728	7.0%	17,004	5.0%
HP.6.4	Other (private) insurance	-	-	3,069	0.9%
HP.7	Other industries (rest of the economy)	-	-	-	-
HP.7.1	Occupational health care services	-	-	-	-
HP.7.2	Private households as providers of home care	-	-	-	-
HP.7.9	All other secondary producers of health care	-	-	-	-
HP.9	Rest of the world	-	-	-	-
	Non-distributable expenditure	*27,126*	*10.8%*	-	-
	Total current expenditure on health (SHA definition)	**252,019**	**100.0%**	**342,109**	**100.0%**
	Health related functions	4,773	1.9%	6,502	1.9%
	Total current expenditure on health (Mexican NHA)	256,791	101.9%	348,611	101.9%

Notes:

(1) Non distributable expenditure includes branch 33 (FASSA: Federal transfers to the states), PEMEX and state contributions that cannot be distributed by functions of care. For 1999 it was not possible to distribute by function care because of the way expenditure was reported to the Ministry of Finance.

ANNEX 3: MEXICO 2001 SHA TABLES

SHA Table 2.1 **Current expenditure on health by function of care and provider industry** (MXN, billion)

Health care by function	ICHA-HC code	**Total current health expenditure**	**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 sale of medical goods	HP.4.1 Dispensing chemists	HP.4.2-4.9 All other sales of medical goods	**HP.5** Providers of public health programmes	**HP.6** General health admin.and insurance	HP.6.1 Government admin. 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
In-patient care		145.0	145.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
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		84.8	-	-	84.8	78.9	-	-	6.0	-	-	-	-	-	-	-	-	-	-	-	-	-
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.1.3.9, 2.3	-																				
Home care		0.8	-	-	0.8	-	-	-	-	-	0.8	-	-	-	-	-	-	-	-	-	-	-
Curative and rehabilitative care	HC.1.4; 2.4	-																				
Long-term nursing care	HC.3.3	-																				
Ancillary services	HC.4	0.5	-	-	0.5	-	-	-	-	0.5	-	-	-	-	-	-	-	-	-	-	-	-
Medical goods	HC.5	69.2	-	-	-	-	-	-	-	-	-	-	69.2	-	-	-	-	-	-	-	-	-
Pharmaceuticals / non-durables	HC.5.1	-																				
Therapeutic appliances	HC.5.2	-																				
Total expenditure on personal health care		300.3	145.0	-	86.1	78.9	-	-	6.0	0.5	0.8	-	69.2	-	-	-	-	-	-	-	-	-
Prevention and public health services	HC.6	10.1	-	-	-	-	-	-	-	-	-	-	-	-	-	10.1	-	-	-	-	-	-
Health administration and health insurance	HC.7	31.7	-	-	-	-	-	-	-	-	-	-	-	-	-	-	31.7	11.6	17.0	3.1	-	-
Total current health expenditure		342.1	145.0	-	86.1	78.9	-	-	6.0	0.5	0.8	-	69.2	-	-	10.1	31.7	11.6	17.0	3.1	-	-

SHA Table 2.2 **Current expenditure on health by function of care and provider industry** (% of expenditure on functional categories)

Health care by function	ICHA-HC code	**Total current health expenditure**	**HP.1** Hospitals	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 sale of medical goods	HP.4.1 Dispensing chemists	HP.4.2-4.9 All other sales of medical goods	**HP.5** Providers of public health programmes	**HP.6** General health admin.and insurance	HP.6.1 Government admin. 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
In-patient care		100.0	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
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		100.0	-	-	100.0	92.9	-	-	7.1	-	-	-	-	-	-	-	-	-	-	-	-	-
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.1.3.9; 2.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Home care		100.0	-	-	100.0	-	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-	-	-
Curative and rehabilitative care	HC.1.4; 2.4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Long-term nursing care	HC.3.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ancillary services	HC.4	100.0	-	-	100.0	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-	-	-	-
Medical goods	HC.5	100.0	-	-	-	-	-	-	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-
Pharmaceuticals / non-durables	HC.5.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic appliances	HC.5.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total expenditure on personal health care		100.0	48.3	-	28.7	26.3	-	-	2.0	0.2	0.3	-	23.0	-	-	-	-	-	-	-	-	-
Prevention and public health services	HC.6	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	100.0	-	-	-	-	-	-
Health administration and health insurance	HC.7	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	100.0	36.6	53.7	9.7	-	-
Total current health expenditure		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	-	-

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SHA Table 2.3 **Current expenditure on health by function of care and provider industry** (% of provider category expenditure)

Health care by function	ICHA-HC code	**Total current health expenditure**	**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 sale of medical goods	HP.4.1 Dispensing chemists	HP.4.2-4.9 All other sales of medical goods	**HP.5** Providers of public health programmes	**HP.6** General health admin.and insurance	HP.6.1 Government admin. 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
In-patient care		42.4	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
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		24.8	-	-	98.5	100.0	-	-	100.0	-	-	-	-	-	-	-	-	-	-	-	-	-
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.1.3.9; 2.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Home care		0.2	-	-	0.9	-	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-	-	-
Curative and rehabilitative care	HC.1.4; 2.4	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Long-term nursing care	HC.3.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Ancillary services	HC.4	0.1	-	-	0.5	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-	-	-	-
Medical goods	HC.5	20.2	-	-	-	-	-	-	-	-	-	-	100.0	-	-	-	-	-	-	-	-	-
Pharmaceuticals / non-durables	HC.5.1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Therapeutic appliances	HC.5.2	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total expenditure on personal health care		87.8	100.0	-	100.0	100.0	-	-	100.0	100.0	100.0	-	100.0	-	-	-	-	-	-	-	-	-
Prevention and public health services	HC.6	2.9	-	-	-	-	-	-	-	-	-	-	-	-	-	100.0	-	-	-	-	-	-
Health administration and health insurance	HC.7	9.3	-	-	-	-	-	-	-	-	-	-	-	-	-	-	100.0	100.0	100.0	100.0	-	-
Total current health expenditure		100.0	100.0	-	100.0	100.0	-	-	100.0	100.0	100.0	-	100.0	-	-	100.0	100.0	100.0	100.0	100.0	-	-

SHA Table 3.1 **Current expenditure on health by provider industry and source of funding** (MXN, billions)

Health care provider category	ICHA-HP code	**Total 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
Hospitals	HP.1	145.0	104.6	21.1	83.5	40.4	5.0	-	5.0	35.5	-	-	-
Nursing and residential care facilities	HP.2	-	-	-	-	-	-	-	-	-	-	-	-
Providers of ambulatory health care	HP.3	86.1	6.0	6.0	-	80.1	1.3	-	1.3	78.9	-	-	-
Offices of physicians	HP.3.1	78.9	-	-	-	78.9	-	-	-	78.9	-	-	-
Offices of dentists	HP.3.2	-	-	-	-	-	-	-	-	-	-	-	-
Offices of other health practitioners	HP.3.3	-	-	-	-	-	-	-	-	-	-	-	-
Out-patient care centres	HP.3.4	6.0	6.0	6.0	-	-	-	-	-	-	-	-	-
Medical and diagnostic laboratories	HP.3.5	0.5	-	-	-	0.5	0.5	-	0.5	-	-	-	-
Providers of home health care services	HP.3.6	0.8	-	-	-	0.8	0.8	-	0.8	-	-	-	-
Other providers of ambulatory health care	HP.3.9	-	-	-	-	-	-	-	-	-	-	-	-
Retail sale and other providers of medical goods	HP.4	69.2	0.3	0.3	-	68.9	0.3	-	0.3	68.6	-	-	-
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	10.1	10.1	10.1	-	-	-	-	-	-	-	-	-
General health administration and insurance	HP.6	31.7	28.6	11.6	17.0	3.1	3.1	-	3.1	-	-	-	-
Government (excluding social insurance)	HP.6.1	11.6	11.6	11.6	-	-	-	-	-	-	-	-	-
Social security funds	HP.6.2	17.0	17.0	-	17.0	-	-	-	-	-	-	-	-
Other social insurance	HP.6.3	-	-	-	-	-	-	-	-	-	-	-	-
Other (private) insurance	HP.6.4	3.1	-	-	-	3.1	3.1	-	3.1	-	-	-	-
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												
Total expenditure on health		342.1	149.6	49.1	100.5	192.5	9.6	-	9.6	182.9	-	-	-

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SHA Table 3.2 **Current expenditure on health by provider industry and source of funding** (% of provider category expenditure)

Health care provider category	ICHA-HP code	**Total 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
Hospitals	HP.1	100.0	72.1	14.6	57.6	27.9	3.4	-	3.4	24.5	-	-	-
Nursing and residential care facilities	HP.2	-	-	-	-	-	-	-	-	-	-	-	-
Providers of ambulatory health care	HP.3	100.0	6.9	6.9	-	93.1	1.5	-	1.5	91.6	-	-	-
Offices of physicians	HP.3.1	100.0	-	-	-	100.0	-	-	-	100.0	-	-	-
Offices of dentists	HP.3.2	-	-	-	-	-	-	-	-	-	-	-	-
Offices of other health practitioners	HP.3.3	-	-	-	-	-	-	-	-	-	-	-	-
Out-patient care centres	HP.3.4	100.0	100.0	100.0	-	-	-	-	-	-	-	-	-
Medical and diagnostic laboratories	HP.3.5	100.0	-	-	-	100.0	100.0	-	100.0	-	-	-	-
Providers of home health care services	HP.3.6	100.0	-	-	-	100.0	100.0	-	100.0	-	-	-	-
Other providers of ambulatory health care	HP.3.9	-	-	-	-	-	-	-	-	-	-	-	-
Retail sale and other providers of medical goods	HP.4	100.0	0.4	0.4	-	99.6	0.4	-	0.4	99.1	-	-	-
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	100.0	100.0	100.0	-	-	-	-	-	-	-	-	-
General health administration and insurance	HP.6	100.0	90.3	36.6	53.7	9.7	9.7	-	9.7	-	-	-	-
Government (excluding social insurance)	HP.6.1	100.0	100.0	100.0	-	-	-	-	-	-	-	-	-
Social security funds	HP.6.2	100.0	100.0	-	100.0	-	-	-	-	-	-	-	-
Other social insurance	HP.6.3	-	-	-	-	-	-	-	-	-	-	-	-
Other (private) insurance	HP.6.4	100.0	-	-	-	100.0	100.0	-	100.0	-	-	-	-
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	-	-	-	-	-	-	-	-	-	-	-	-
Total expenditure on health		100.0	43.7	14.4	29.4	56.3	2.8	-	2.8	53.5	-	-	-

SHA Table 3.3 **Current expenditure on health by provider industry and source of funding** (% of expenditure by financing agent category)

Health care provider category	ICHA-HP code	**Total 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
Hospitals	HP.1	42.4	69.9	43.0	83.1	21.0	51.8	-	51.8	19.4	-	-	-
Nursing and residential care facilities	HP.2	-	-	-	-	-	-	-	-	-	-	-	-
Providers of ambulatory health care	HP.3	25.2	4.0	12.2	-	41.6	13.1	-	13.1	43.1	-	-	-
Offices of physicians	HP.3.1	23.1	-	-	-	41.0	-	-	-	43.1	-	-	-
Offices of dentists	HP.3.2	-	-	-	-	-	-	-	-	-	-	-	-
Offices of other health practitioners	HP.3.3	-	-	-	-	-	-	-	-	-	-	-	-
Out-patient care centres	HP.3.4	1.7	4.0	12.2	-	-	-	-	-	-	-	-	-
Medical and diagnostic laboratories	HP.3.5	0.1	-	-	-	0.2	4.9	-	4.9	-	-	-	-
Providers of home health care services	HP.3.6	0.2	-	-	-	0.4	8.2	-	8.2	-	-	-	-
Other providers of ambulatory health care	HP.3.9	-	-	-	-	-	-	-	-	-	-	-	-
Retail sale and other providers of medical goods	HP.4	20.2	0.2	0.6	-	35.8	3.1	-	3.1	37.5	-	-	-
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	2.9	6.7	20.6	-	-	-	-	-	-	-	-	-
General health administration and insurance	HP.6	9.3	19.1	23.6	16.9	1.6	32.0	-	32.0	-	-	-	-
Government (excluding social insurance)	HP.6.1	3.4	7.8	23.6	-	-	-	-	-	-	-	-	-
Social security funds	HP.6.2	5.0	11.4	-	16.9	-	-	-	-	-	-	-	-
Other social insurance	HP.6.3	-	-	-	-	-	-	-	-	-	-	-	-
Other (private) insurance	HP.6.4	0.9	-	-	-	1.6	32.0	-	32.0	-	-	-	-
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	-	-	-	-	-	-	-	-	-	-	-	-
Total expenditure on health		100.0	100.0	100.0	100.0	100.0	100.0	-	100.0	100.0	-	-	-

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SHA Table 4.1 **Current expenditure on health by function of care and source of funding** (MXN, billions)

Health care function	ICHA-HC code	**Total current exp.**	**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
Personal health care services	HC.1-HC.4	231.1	110.6	27.1	83.5	120.6	6.2	-	6.2	114.3	-	-	-
In-patient services		145.0	104.6	21.1	83.5	40.4	5.0	-	5.0	35.5	-	-	-
Day care services		-	-	-	-	-	-	-	-	-	-	-	-
Out-patient services		84.8	6.0	6.0	-	78.9	-	-	-	78.9	-	-	-
Home care services		0.8	-	-	-	0.8	0.8	-	0.8	-	-	-	-
Ancillary services	HC.4	0.5	-	-	-	0.5	0.5	-	0.5	-	-	-	-
Medical goods dispensed to out-patients	HC.5	69.2	0.3	0.3	-	68.9	0.3	-	0.3	68.6	-	-	-
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	300.3	110.9	27.4	83.5	189.5	6.5	-	6.5	182.9	-	-	-
Prevention and public health services	HC.6	10.1	10.1	10.1	-	-	-	-	-	-	-	-	-
Health administration and health insurance	HC.7	31.7	28.6	11.6	17.0	3.1	3.1	-	3.1	-	-	-	-
Current expenditure on health care		342.1	149.6	49.1	100.5	192.5	9.6	-	9.6	182.9	-	-	-

SHA Table 4.2 **Current expenditure on health by function of care and source of funding** (% of expenditure on functional category (mode of production))

Health care function	ICHA-HC code	**Total current exp.**	**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
Personal health care services	HC.1-HC.4	100.0	47.8	11.7	36.1	52.2	2.7	-	2.7	49.5	-	-	-
In-patient services		100.0	72.1	14.6	57.6	27.9	3.4	-	3.4	24.5	-	-	-
Day care services		-	-	-	-	-	-	-	-	-	-	-	-
Out-patient services		100.0	7.1	7.1	-	92.9	-	-	-	92.9	-	-	-
Home care services		100.0	-	-	-	100.0	100.0	-	100.0	-	-	-	-
Ancillary services	HC.4	100.0	-	-	-	100.0	100.0	-	100.0	-	-	-	-
Medical goods dispensed to out-patients	HC.5	100.0	0.4	0.4	-	99.6	0.4	-	0.4	99.1	-	-	-
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	100.0	36.9	9.1	27.8	63.1	2.2	-	2.2	60.9	-	-	-
Prevention and public health services	HC.6	100.0	100.0	100.0	-	-	-	-	-	-	-	-	-
Health administration and health insurance	HC.7	100.0	90.3	36.6	53.7	9.7	9.7	-	9.7	-	-	-	-
Current expenditure on health care		100.0	43.7	14.4	29.4	56.3	2.8	-	2.8	53.5	-	-	-

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SHA Table 4.3 **Current expenditure on health by function of care and source of funding** (% of expenditure by financing agent category)

Health care function	ICHA-HC code	**Total current exp.**	**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
Personal health care services	HC.1-HC.4	67.6	73.9	55.2	83.1	62.6	64.9	-	64.9	62.5	-	-	-
In-patient services		42.4	69.9	43.0	83.1	21.0	51.8	-	51.8	19.4	-	-	-
Day care services		-	-	-	-	-	-	-	-	-	-	-	-
Out-patient services		24.8	4.0	12.2	-	41.0	-	-	-	43.1	-	-	-
Home care services		0.2	-	-	-	0.4	8.2	-	8.2	-	-	-	-
Ancillary services	HC.4	0.1	-	-	-	0.2	4.9	-	4.9	-	-	-	-
Medical goods dispensed to out-patients	HC.5	20.2	0.2	0.6	-	35.8	3.1	-	3.1	37.5	-	-	-
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	87.8	74.1	55.8	83.1	98.4	68.0	-	68.0	100.0	-	-	-
Prevention and public health services	HC.6	2.9	6.7	20.6	-	-	-	-	-	-	-	-	-
Health administration and health insurance	HC.7	9.3	19.1	23.6	16.9	1.6	32.0	-	32.0	-	-	-	-
Current expenditure on health care		100.0	100.0	100.0	100.0	100.0	100.0	-	100.0	100.0	-	-	-

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