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Domestic health expenditure in Hong Kong: 1989/90 to 2001/02

1989/90至2001/02年度香港本地醫療衛生開支

Objective. To estimate the total domestic health expenditure in Hong Kong between fiscal years 1989/90 and 2001/02, with breakdown by financing source, provider, and function over time.

Methods. The standard health accounting methods as per the Organisation for Economic Co-operation and Development System of Health Accounts guidelines of 2000 were adopted.

Results. Total domestic health expenditure was $68 620 million in the fiscal year 2001/02. In real terms, expenditure grew at an average rate of 7% while gross domestic product increased by 4% during the same period. This indicates a growing share of health spending relative to gross domestic product, from 3.8% in 1989/90 to 5.5% in 2001/02. This upward trend was largely driven by increased public spending that rose 208% in real terms over the period, compared with 76% for private spending. Out-of-pocket payments by households accounted for about 70% of private spending while employers and insurance accounted for 28%. Private insurance plays an increasingly important role in financing private spending whereas household expenditure has shown a corresponding decrease during the period. Expenditure incurred at providers of ambulatory services and hospitals accounted for more than 70% of total health expenditure during the observed period. Hospitals' share of total spending increased by 18%, reaching 45% of total expenditure in 2001/02, whilst the share of providers of ambulatory services reduced to 30% in 2001/02. The two largest functional components of total health expenditure were ambulatory care (35-41%) and in-patient curative care (20-27%). Public spending generally financed in-patient curative care and ambulatory services; private spending was concentrated on ambulatory services and medical goods outside the patient care setting.

Conclusion. These data provide important information for the public, policymakers, and researchers to assess the performance of the health care system longitudinally, and to evaluate health expenditure-related policies.

目的：估算1989/90至2001/02財政年度香港醫療衛生開支，並提供融資來源、服務提供單位及服務功能等細項資料。

方法：採用經濟合作及發展組織2000年「醫療衛生會計制度指引」作為計算標準。

結果：2001/02財政年度香港本地醫療衛生開支為686億2千萬元。以實質計算，在同一段時間本地醫療衛生開支的平均增幅為7%，而本地生產總值平均增長4%，顯示醫療衛生開支佔本地生產總值的比例上升，由1989/90年度佔3.8%，增至2001/02年度的5.5%。這是因為在上述時期公共開支實質上升208%，而私人開支則增加76%。私人開支中，家庭使用者自付的支出佔70%，而僱主及保險機構負擔的支出則佔28%。同時，私人保險在私人開支上越見重要，而家庭自付支出所佔的比例則相應減少。門診及住院服務提供單位佔整體醫療衛生開支的70%，其中醫院開支增加了18%，於2001/02年度達到整體開支的45%。門診服務開支則在同年度跌至佔整體開支的30%。兩種比例最大的開支類別是門診護理（35-41%）和住院醫療護理（20-27%）。一般來說，公共開支支付住院醫療護理服務和門診服務；而私人開支則集中支付門診開支及醫療物品費用。

結論：這些數據為公眾、政府官員及研究人士提供重要資料，縱向評估醫療系統的表現，和評估醫療衛生開支有關的政策。

Key words:
Delivery of health care;
Health expenditures;
Hong Kong

關鍵詞：
醫療護理服務；
醫療衛生開支；
香港

Hong Kong Med J 2006;12:47-55

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Introduction

An understanding of the financial dimensions of health care systems is increas-

ingly recognised as an important contribution to health policy development. In the developed world, especially those belonging to the Organisation for Economic Co-operation and Development (OECD), systematic accounting of national health expenditures has been carried out for several decades, albeit in non-standardised ways until the publication of consensus guidelines in 2000.[1] This is a relatively new area of intense focus in Hong Kong.

The creation of standardised definitions and accounting methods across countries and the routine collection of data have provided the means for informative and productive inquiry into the financial and health implications of macro patterns of health care financing. Health accounts are an important tool that demonstrates how a territory's health resources are spent, on what services, and who pays for them.

National or domestic health accounts (NHA/DHA) describe systematically and accurately the totality of health care expenditure flows in both government and non-government sectors. National or domestic health accounts achieve this by identifying the sources of all funds utilised in the sector, ascertaining the uses of these funds, and demonstrating how they are spent. Overall, NHA/DHA provide essential data for health sector planning and management, in the same way that national income accounts and vital statistics provide essential data for macro-economic planning, and population and social service planning respectively.[1,2]

Properly constructed NHA/DHA that conform to international standards can achieve the following:

(1) Track secular changes in health resource inflow and outflow and provide time-series estimates.
(2) Provide national, international, and cross-regional comparisons and benchmarking so that best practices can be learned and adopted.
(3) Serve as a baseline before any major reforms are made to health financing infrastructure and allow evaluation and monitoring of new macro financing policies and instruments, such as those Hong Kong is currently facing.
(4) Support and promote good governance and stewardship of the health system as Hong Kong moves forward in its health system reforms.
(5) Provide the necessary fiscal data infrastructure to study and examine condition-specific (eg for major disease groups) health accounting and resource allocation.
(6) Strengthen the research-policy link and reinforce the importance of integrating research and development in the policy formulation process.

In June 2002 the China National Health Accounts Task Force of the China Health Economics Institute, Ministry of Health in Beijing released their first set of NHA for the years 1990 to 1999. In Hong Kong, the first set of DHA was developed as part of the Harvard consultancy published in 1999. Since then, the University of Hong Kong School of Public Health has been commissioned to undertake an updating exercise with estimates up to fiscal year 2001/02.

Methods

Development process

In 2002, 5 years after the first set of DHA was constructed in 1997, we sought to update the conceptual framework and classification system based on the latest OECD guidelines—A System of Health Accounts v1.0 released in 2000.[1] In reconfiguring the structure and compilation process of the DHA to be in line with the latest international guidelines, vis-à-vis OECD standards, subsequent national, and cross-territorial comparisons and benchmarking became possible.

The conceptual framework involves the definition of what constitutes health expenditure, the institutional entities involved, the specification of the types of disaggregation involved, and the standard reporting formats. The structure includes the classifications and nomenclature used to identify and disaggregate expenditures, either by function or purpose, type or ultimate beneficiary, and the temporal reference period.

The conceptual framework and classification structure for Hong Kong's DHA was developed through a Delphi-like process of consultation with various stakeholders in health and health care and members of the Hong Kong Domestic Health Account Steering Committee. The following criteria were applied:

(1) Policy relevance and easy comprehension;
(2) Reproducibility;
(3) Categories used in classifications should be mutually exclusive;
(4) Timeliness of reporting given secondary data availability, or with limited primary data collection; and
(5) Compatibility with international practice and norms to the extent possible.

Definition of health expenditure

Health spending consists of health and health-related expenditures. Expenditures are defined on the basis of their primary or predominant purpose of improving health, regardless of the primary function or activity of the entity providing or paying for the associated health services. Health includes both the health of individuals and of groups of individuals or populations. Health expenditure consists of all expenditure or outlay for medical care, prevention, promotion, rehabilitation, community health activities, health administration and regulation, and capital formation with the predominant objective of improving health. Health-related expenditure includes expenditure on health-related functions such as medical education and training, and research and development.[1,3]

Domestic health expenditure for the Hong Kong DHA is defined as all health expenditure for the benefit of individuals resident in Hong Kong. Expenditure for the benefit

of Hong Kong citizens living abroad is excluded, although expenditure in other countries for the benefit of Hong Kong residents is included, as well as expenditure for the benefit of expatriates residing in Hong Kong.

Total domestic expenditure on health includes all direct health expenditure, plus gross capital formation in health care provider industries, ie institutions where health care is the predominant activity.

Classification system

Hong Kong's DHA has adopted the International Classification for Health Accounts (ICHA) developed by the OECD.[1] The ICHA was designed to be compatible with a number of existing classification schemes and practices in international economic statistics, eg national income accounts. It is a comprehensive classification system with three important dimensions—financing sources, health providers and functions, and health-related functions. Domestic health expenditure is measured and organised on the basis of the entities making the expenditure, and those entities passing or using the expenditure. In terms of the three key dimensions:

(1) Financing sources are defined as entities that directly incur the expenditure and hence control and finance the amount of such expenditure;
(2) Health providers are defined as institutional entities that produce and provide health care goods and services that benefit individuals, groups of individuals or whole populations; and
(3) All health expenditure is divided into two categories, core health functions or health-related functions. Hong Kong's DHA makes a distinction between in-patient and out-patient care and also recognises separately rehabilitative care, long-term nursing care, ancillary services, and medical goods dispensed to out-patients. In the subcategory of over-the-counter medicines, a further distinction is made between 'western' and 'traditional (including Chinese medicine) and others'.

Continuity with previous domestic health accounts estimates and compatibility with international norms

The first compilation of the DHA for the years 1989/90 through 1996/97 resulted in a provisional functional classification system for Hong Kong, with reference to a 1998 pre-publication draft of the OECD guidelines. The present update made substantial revisions to that earlier framework in accordance with 2000 guidelines and subsequent revisions. We offered a harmonisation of the revised definitions and those used in the first DHA exercise in 1998 by mapping the previous set of classification codes to those used in the present exercise. Additionally, we constructed a system to link the detailed Hong Kong–specific classification system with the more generic, standard OECD reporting system so that international comparisons were possible. A full version of the conceptual framework and classification system can be found online at the website: www.hwfb.gov.hk.

Accounting basis

All estimates are based on a fiscal year (1 April to 31 March) cycle, in line with much of the data available. Ideally, expenditure should be measured on an accrual basis. Nonetheless public expenditure is reported on a cash basis, thus domestic health expenditure was estimated based on cash accounting principles.

Temporal scope

This report presents estimates of domestic health expenditure in Hong Kong between fiscal years 1989/90 and 2001/02, with retrospective updating and revision of the previous 1989/90 to 1996/97 estimates based on the current conceptual framework and classification system. This facilitates time trend analysis. Both gross domestic product (GDP) and DHA estimates are standardised for the fiscal year 1 April through 31 March.

Sources of data

The estimates of Hong Kong's DHA were compiled from many sources of information. Most public expenditure data were obtained from government financial accounts, whilst private sector expenditure was based largely on estimates from surveys that are likely to be less accurate. Total domestic health expenditure (TDHE) is considered to be accurate to within 0.25% of GDP.

This final set of estimates of domestic health expenditure has been endorsed by the Hong Kong DHA Steering Committee.

Results

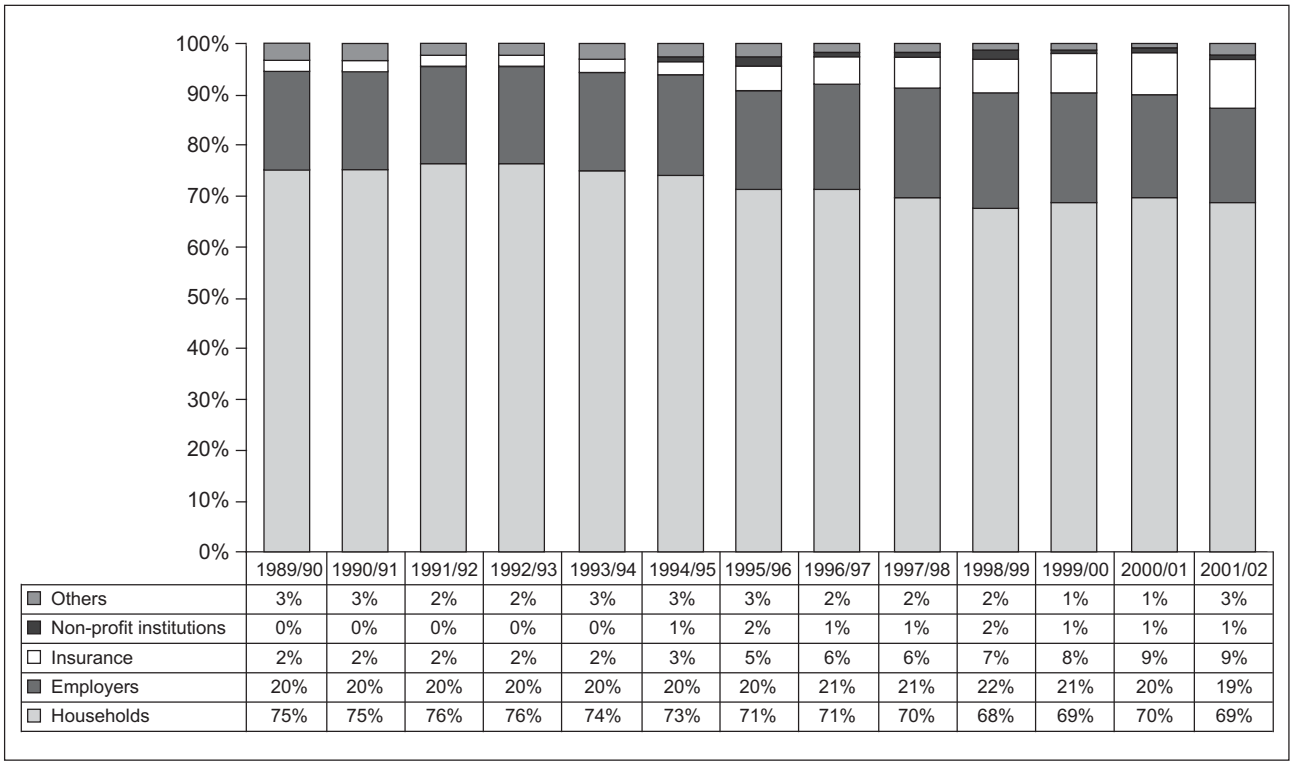
Total domestic health expenditure was estimated to be $68 620 million in the fiscal year 2001/02, with annual per capita spending at $10 204. In real terms, after removal of the impact of inflation, TDHE grew at an average annual rate of 7% from $30 284 million in 1989/90 to $70 424 million in 2001/02 at constant 2000 prices (Table 1). Real GDP grew at a lower rate of 4%. Consequently, total health spending as a share of GDP increased from 3.8% in 1989/90 to 5.5% in 2001/02 (Table 1). On a per capita basis, TDHE grew at 6% per annum on average over the period 1989/90 through 2000/01 in real terms, while GDP grew at a rate of only 3% during the same period (a mixed trend of sustained robust economic growth from 1989/90 until the Asian financial crisis in 1997/98).

Public expenditure at constant 2000 prices grew 208% from $13 013 million in 1989/90 to $40 105 million in 2001/02, compared with a corresponding increase of 76% (from $17 270 million to $30 818 million) for private expenditure. This represents a growing share of public spending from 43% to 57% of TDHE during the period (Table 1). Public spending also accounted for an increasing share of GDP, from 1.6% in 1989/90 to 3.1% in 2001/02, whereas private spending was maintained at a relatively stable level of between 2.2% and 2.3%. Figure 1 shows the mix of pri-

Table 1. Total domestic health expenditures, 1989/90 to 2001/02

	1989/90	1990/91	1991/92	1992/93	1993/94
At current market prices					
TDHE* (HK$ million)	20 450	24 730	30 200	34 247	40 047
Annual increase in TDHE	-	21%	22%	13%	17%
GDP† (HK$ million)	539 908	605 590	704 905	820 225	943 611
Annual increase in GDP	-	12%	16%	16%	15%
At constant 2000 prices					
TDHE (HK$ million)	30 284	34 224	38 002	39 486	42 705
Annual increase in TDHE	-	13%	11%	4%	8%
GDP (HK$ million)	799 539	838 098	887 000	945 714	1 006 224
Annual increase in GDP	-	5%	6%	7%	6%
Public share	43%	46%	48%	47%	49%
TDHE as a proportion of GDP	3.8%	4.1%	4.3%	4.2%	4.2%

* TDHE total domestic health expenditures
† GDP gross domestic product
‡ CW change within 0.5%



	1989/90	1990/91	1991/92	1992/93	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
Others	3%	3%	2%	2%	3%	3%	3%	2%	2%	2%	1%	1%	3%
Non-profit institutions	0%	0%	0%	0%	0%	1%	2%	1%	1%	2%	1%	1%	1%
Insurance	2%	2%	2%	2%	2%	3%	5%	6%	6%	7%	8%	9%	9%
Employers	20%	20%	20%	20%	20%	20%	20%	21%	21%	22%	21%	20%	19%
Households	75%	75%	76%	76%	74%	73%	71%	71%	70%	68%	69%	70%	69%

Fig 1. Mix of private health expenditures, 1989/90 to 2001/02

vate health spending between 1989/90 and 2001/02. Private spending, mostly financed directly through households, accounted for 30% of total spending in 2001/02. Employer and insurance contributions were the other major sources, making up about 12% of total health expenditure. Insurance has played an increasingly important role in financing private spending, and can be explained by the decrease in share of household expenditures over the period while employer expenditures stayed at a relative constant level of private spending.

Stratified by provider categories, the largest share of expenditure in 1989/90 was incurred at providers of ambulatory services (42%) and the second largest at hospitals (27%). However, as a result of a gradual decrease in spending at providers of ambulatory services and a corresponding increase in the number of service spectrum and quality at hospitals during the period, hospitals accounted for the largest (45%) and providers of ambulatory services the second largest (30%) share of total spending in 2001/02 (Fig 2). Public expenditures were mostly incurred at hospitals and accounted for 70% in 2001/02, whilst private expenditures were mostly incurred at providers of ambulatory services (56% in 2001/02) [Table 2]. Other industries,

Fiscal year							
1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
45 382 13%	52 187 15%	58 521 12%	63 534 9%	67 184 6%	66 061 -2%	67 128 2%	68 620 2%
1 046 936 11%	1 116 430 7%	1 244 508 11%	1 346 815 8%	1 260 829 -6%	1 264 066 CW‡	1 287 306 2%	1 258 246 -2%
45 925 8%	51 077 11%	53 962 6%	55 799 3%	58 880 7%	63 019 5%	67 538 7%	70 424 4%
1 059 461 5%	1 092 676 3%	1 147 569 5%	1 182 853 3%	1 123 753 -5%	1 205 855 7%	1 295 174 7%	1 291 330 CW
49%	50%	52%	52%	55%	55%	56%	57%
4.3%	4.7%	4.7%	4.7%	5.3%	5.2%	5.2%	5.5%

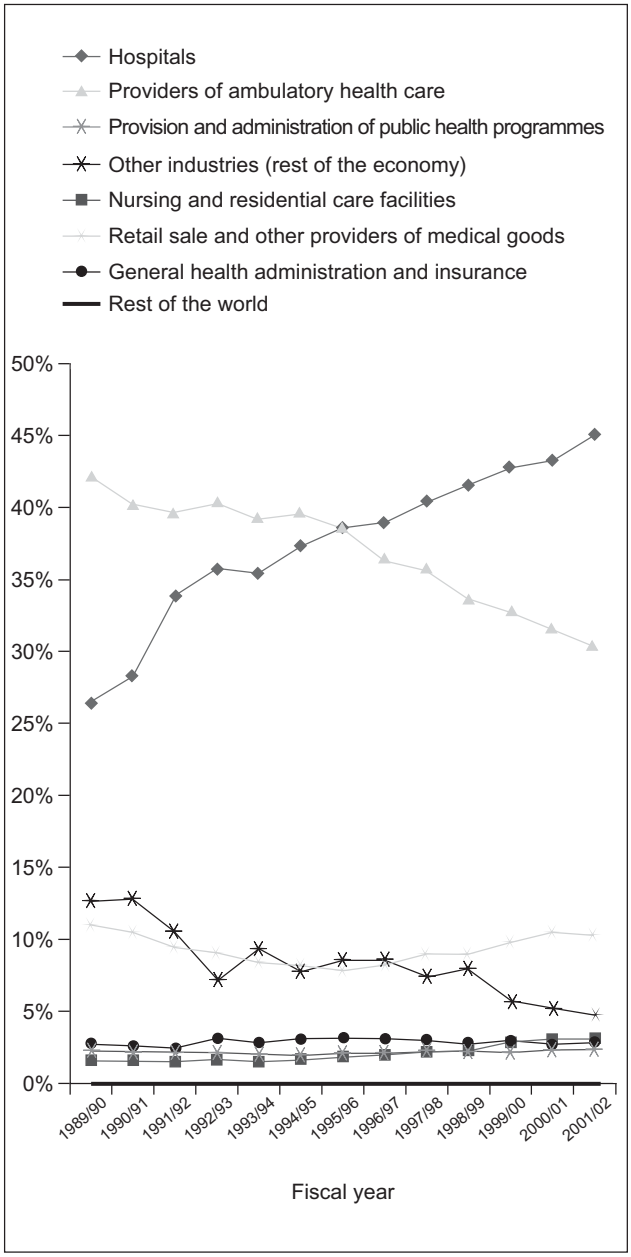


Fig 2. Total health expenditure by provider, 1989/90 to 2001/02

which represent providers of investment in capital formation and medical facilities, constituted between 7% and 26% of total public expenditure. For private expenditure, the other significant element was retail sales and other providers of medical goods that made up between 16% and 24% of total private spending.

In terms of health and health-related expenditure by function, services of curative care maintained the largest share of total health spending during 1989/90 to 2001/02, of which in-patient curative care and ambulatory services accounted for about 60% of the total. Medical goods outside the patient care setting and investment in medical facilities constituted about one fifth of total spending and prevention and public health services remained at 3% share. Other health-related functions that do not fall under TDHE accounted for 5% to 9% of total health and health-related expenditures. Of these, education and training of health personnel remained at 2% to 3% while research and development in health, and environmental health grew 1 percentage point and 3 percentage points during the period, respectively. Figure 3 compares the various functions as a share of total spending for the year 1989/90 with 2001/02. In-patient curative care increased 7 percentage points as a share of total spending, while ambulatory services and investment in medical facilities decreased 5 and 8 percentage points, respectively. Table 3 shows public and private expenditures by function during the period. Public spending mostly financed in-patient curative care and ambulatory services, whilst most private spending contributed towards ambulatory services and medical goods outside the patient care setting. Table 3 also shows that day-patient hospital services, home care, rehabilitative and extended care, long-term care, prevention and public health services, and investment in medical facilities were predominately financed by public sources. Public and private spending both accounted for an increasing share of in-patient curative care during 1989/90 to 2001/02, from 33% to 38% for public and from 11% to 13% for private. Ambulatory services as a share of government spending increased from 15% to 24% while the share

Table 2. Public versus private health expenditure by provider, 1989/90 to 2001/02

Provider	1989/90	1990/91	1991/92	1992/93
Public				
Hospitals	52%	53%	61%	65%
Nursing and residential care facilities	2%	2%	2%	2%
Providers of ambulatory health care	13%	13%	11%	11%
Retail sale and other providers of medical goods	0%	0%	0%	0%
Provision and administration of public health programmes	5%	5%	5%	4%
General health administration and insurance	2%	2%	1%	3%
Other industries (rest of the economy)	26%	26%	20%	14%
Rest of the world	0%	0%	0%	0%
Public expenditures (HK$ million)	8788	11 256	14 569	16 250
Private				
Hospitals	8%	9%	9%	10%
Nursing and residential care facilities	1%	1%	1%	1%
Providers of ambulatory health care	64%	64%	66%	66%
Retail sale and other providers of medical goods	20%	20%	19%	18%
Provision and administration of public health programmes	0%	0%	0%	0%
General health administration and insurance	3%	3%	3%	3%
Other industries (rest of the economy)	3%	3%	2%	2%
Rest of the world	0%	0%	0%	0%
Private expenditures (HK$ million)	11 662	13 473	15 632	17 997

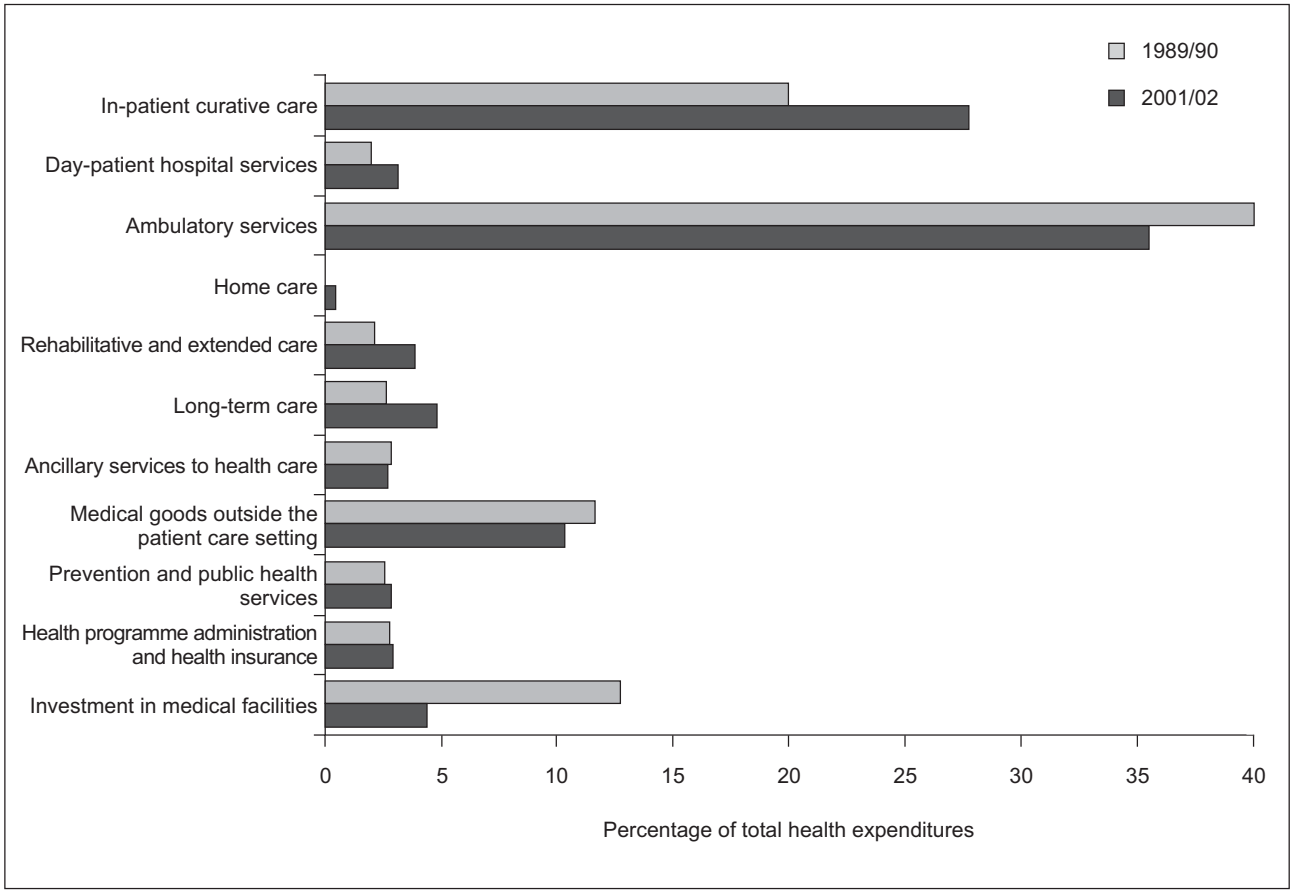


Fig 3. Total health expenditures by function, 1989/90 and 2001/02

of private spending decreased from 58% to 51%.

Discussion

These findings represent the most up-to-date health accounting information currently available in Hong Kong. They provide a resource for assessing and understanding trends and levels of health spending locally, across jurisdictions and over time. Such data provide important information for the public, policymakers, and researchers to assess the performance of the domestic health system longitudinally, and to evaluate health expenditure–related policies. These

Fiscal year								
1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
64%	66%	66%	65%	67%	66%	69%	70%	70%
2%	2%	3%	3%	4%	4%	5%	5%	5%
11%	11%	11%	10%	11%	11%	11%	11%	11%
0%	0%	0%	0%	1%	1%	1%	1%	1%
4%	4%	4%	4%	4%	4%	4%	4%	4%
2%	2%	1%	1%	1%	1%	1%	1%	1%
16%	14%	14%	15%	13%	13%	9%	8%	7%
0%	0%	0%	0%	0%	0%	0%	0%	0%
19 541	22 314	26 169	30 291	33 128	37 009	36 601	37 449	39 078
9%	10%	10%	9%	9%	9%	9%	10%	12%
1%	1%	1%	1%	1%	1%	1%	1%	1%
66%	67%	65%	66%	64%	62%	60%	58%	56%
17%	16%	16%	17%	18%	20%	22%	24%	24%
0%	0%	0%	0%	0%	0%	0%	0%	0%
3%	4%	5%	6%	5%	5%	6%	6%	6%
3%	3%	3%	2%	2%	2%	1%	1%	1%
0%	0%	0%	0%	0%	0%	0%	0%	0%
20 506	23 068	26 018	28 230	30 406	30 175	29 460	29 679	29 542

findings are a timely addition to the evidence base on which health system reform options should be formulated and evaluated. More specifically, the data provided herewith can be used to, among other analyses, (1) project future levels and trends of TDHE employing econometric and/or actuarial approaches so as to inform the medium- to long-term financial sustainability of the status quo and potential reform options; and (2) assess the equity performance of the current financial arrangements in terms of the progressivity of different forms of health payments, benefit-incidence of public subsidies, catastrophic and poverty impact of health spending, and horizontal equity of health care utilisation.

In the estimation process, we encountered several conceptual, definition, and methodological challenges that bear mention, in order to share best practice with other jurisdictions that may be facing similar difficulties and thus jointly develop solutions in future iterations of the OECD standards. First, there might have been an artefactual, albeit very small, inflation of private spending due to problems defining operating deficits, for example in the case of the Hospital Authority in recent years. Such deficits were accounted for by two extra source categories called "HFS.2.6 Non-patient care-related revenue" (expenditure financed by non-patient care-related revenue such as rental, interest or investment income) and "HFS.2.7 Provider own funds" (providers' surplus from previous years or reserve) in the Hong Kong classification scheme, both of which are considered "private" sources according to the OECD guidelines. The Hospital Authority is nonetheless clearly a public provider and as such all funds, whether they are intertemporally transferred or otherwise could also be deemed as "public" in nature. Second, in the OECD methodology, depreciation is usually booked as an expenditure item in providers' income and expenditure statements, while capital formation is booked as a change of fixed assets in providers' balance sheet. This creates a dilemma of double-counting the same item (eg construction costs of a new hospital wing) over time, and remains an unresolved issue at the most recent meeting of national health accounts experts and revision of OECD SHA 1.0 in October 2004. Third, the proper accounting of expenditure in the control of infectious diseases has yet to achieve consensus in the health accounts community. For instance, expenditure on the actual culling of poultry to control avian influenza was counted as health expenditure, but compensation to poultry operators was not included in the present estimation exercise, following guidance sought specifically from the OECD Secretariat. One could reasonably argue that both should be part of TDHE if the overriding objective of health accounts is to include all spending that has a "predominant purpose of improving health": the latter activity is a preventive intervention and thus should be covered. Fourth, notwithstanding a recent OECD document on refined definitions of long-term care, the definition remains vague and difficult to interpret. Additionally, the data required probably exceed routine data collection in most territories, including Hong Kong. This issue deserves urgent attention given the rapidly ageing population and the growing importance of elderly care. Finally, there are still limited local data on Chinese medicine practitioner episodes, medical laboratories and diagnostic imagining facilities, employer-provided group medical benefits, and medical goods outside the patient care setting. More routine data gathering exercises, as opposed to ad hoc surveys, to better inform the next round of estimations should be instituted.

Since the formal launch of the OECD System of Health Accounts in 2000, there have been significant attempts to further refine the standardisation of NHA/DHA approaches, with the ultimate objective of developing global standards that are also locally responsive and policy relevant. In the present exercise, we have maintained this delicate

Table 3. Public versus private health expenditures by function, 1989/90 to 2001/02

Function	1989/90	1990/91	1991/92	1992/93
Public				
Services of curative care	53%	53%	60%	64%
In-patient curative care	33%	33%	36%	38%
Day-patient hospital services	5%	5%	5%	5%
Ambulatory services	15%	15%	18%	20%
Home care	0%	0%	0%	0%
Rehabilitative and extended care	5%	5%	5%	6%
Long-term care	5%	5%	5%	5%
Ancillary services to health care	4%	4%	3%	4%
Medical goods outside the patient care setting	0%	0%	0%	0%
Prevention and public health services	6%	6%	5%	5%
Health programme administration and health insurance	2%	2%	1%	3%
Investment in medical facilities	26%	26%	20%	14%
Public expenditures (HK$ million)	8788	11 256	14 569	16 250
Private				
Services of curative care	69%	70%	71%	72%
In-patient curative care	11%	11%	11%	12%
Day-patient hospital services	0%	0%	0%	0%
Ambulatory services	58%	59%	60%	60%
Home care	0%	0%	0%	0%
Rehabilitative and extended care	0%	0%	0%	0%
Long-term care	1%	1%	1%	1%
Ancillary services to health care	2%	2%	2%	2%
Medical goods outside the patient care setting	21%	21%	20%	19%
Prevention and public health services	0%	0%	0%	0%
Health programme administration and health insurance	3%	3%	3%	3%
Investment in medical facilities	3%	3%	2%	2%
Private expenditures (HK$ million)	11 662	13 473	15 632	17 997

balancing process between local compatibility with statistics (eg domestic income accounts) produced by the Government Treasury and Census and Statistics Department, usefulness to policy deliberations by the Health, Welfare and Food Bureau and other stakeholders, comprehensibility by the general public in addition to comparability across countries for benchmarking purposes. We believe we have achieved a sufficient degree of detail that permits further disaggregation, reconstitution, and customisation for local needs and priorities (in the form of a multi-dimensional relational database that can be queried in different ways and produce results in a multitude of formats), while simultaneously allowing for the production of summary data to meet the needs of an emerging international standard. Future work should focus on developing a web-based interactive information system for public and executive inquiry regarding domestic health expenditure, at various pre-defined levels of disaggregated details to protect privacy and confidentiality of the parties involved. Such a dissemination tool would promote further discussion and dialogue, and in turn facilitate policy design and implementation.

Acknowledgements

We thank colleagues on the Domestic Health Accounts Steering Committee, which additionally included KH Lee (Hospital Authority), John Howes (Hospital Authority), Eva Tsui (Hospital Authority), Billy Chow (Hospital Authority), Simon Yeung (Department of Health), Clora Chan (Department of Health), Shirley Cheung (Department of Health, currently Census and Statistics Department), Sarah Choi (Health, Welfare and Food Bureau, currently Department of Health), Elizabeth So (Census and Statistics Bureau) and Thomas Cheung (Census and Statistics Department). In addition, we are grateful to the following organisations for participating in the Subcommittee on Data Priorities and Management: Association of Hong Kong and Kowloon Practitioners of Chinese Medicine, Hong Kong Association of Medical Laboratories Ltd, Hong Kong Chinese Herbalists Association, Hong Kong Medical Association, Hong Kong Private Hospitals Association, IMS Asia, Medical Insurance Association of the Hong Kong Federation of Insurers, and The Hong Kong Association of the Pharmaceutical Industry. The opinions expressed here are the authors' and do not necessarily reflect those of the government or any of the participating institutions and organisations.

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	Fiscal year								
	1993/94	1994/95	1995/96	1996/97	1997/98	1998/99	1999/00	2000/01	2001/02
	62%	64%	64%	63%	65%	64%	67%	68%	68%
	37%	38%	38%	38%	39%	38%	38%	38%	38%
	5%	5%	5%	5%	5%	5%	5%	5%	6%
	20%	21%	21%	20%	21%	21%	23%	23%	24%
	0%	0%	0%	0%	1%	1%	1%	1%	1%
	6%	6%	6%	6%	6%	6%	7%	6%	7%
	5%	5%	6%	6%	7%	7%	8%	8%	8%
	4%	4%	3%	3%	3%	3%	3%	3%	3%
	0%	0%	0%	0%	1%	1%	1%	1%	1%
	5%	5%	5%	5%	5%	5%	5%	5%	5%
	2%	2%	1%	1%	1%	1%	1%	1%	1%
	16%	14%	14%	15%	13%	13%	9%	8%	7%
	19 541	22 314	26 169	30 291	33 128	37 009	36 601	37 449	39 078
	71%	72%	71%	70%	69%	68%	67%	65%	65%
	12%	12%	12%	11%	11%	11%	12%	12%	13%
	0%	0%	0%	0%	0%	0%	0%	0%	0%
	59%	60%	59%	59%	58%	56%	55%	53%	51%
	0%	0%	0%	0%	0%	0%	0%	0%	0%
	0%	0%	0%	0%	0%	0%	0%	0%	0%
	1%	1%	1%	1%	1%	1%	1%	1%	1%
	2%	2%	2%	2%	2%	2%	2%	2%	2%
	19%	18%	18%	19%	20%	21%	23%	24%	24%
	0%	0%	0%	0%	0%	0%	0%	0%	0%
	3%	4%	5%	6%	5%	5%	6%	6%	6%
	3%	3%	3%	2%	2%	2%	1%	1%	1%
	20 506	23 068	26 018	28 230	30 406	30 175	29 460	29 679	29 542