

Health at a Glance - OECD Indicators 2003
Country Notes (Mexico)

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Health spending

Total health expenditure (public and private) in 2001 represented 6.6% of **Mexico's** GDP as compared to the OECD average of 8.4% (Chart 3.4). Between 1990 and 2001, health expenditure as a share of GDP in **Mexico** increased by 2 percentage points, narrowing the gap with the OECD average (Chart 3.5).

Health spending tends to rise with income. In general, OECD countries with higher GDP per capita spend more on health (Chart 3.7). It is not surprising therefore to observe that health spending per capita in **Mexico** is less than one third of the average in OECD countries and eight times lower than the United States, which spent by far the most on health in 2001 (Chart 3.1 and Table 3.1).

Public and private financing

Public spending is the main source of health financing in all OECD countries except for **Mexico**, the US and Korea. On average across OECD countries, 72% of health spending was paid for by public sources in 2001. In **Mexico**, the public share stood at 46% (Table 3.8).

Private funds, therefore, remained the main source of health care financing in **Mexico** in 2001 of which nearly all came from out-of-pocket payments (Table 3.10). This is in contrast with the US where private insurance covers a large part of health spending and out-of-pocket payments accounts for only 15% of total health spending. The burden of out-of-pocket spending on households can be measured alternatively by its share of final household consumption. The percentage of household consumption on health in **Mexico** stood at 4 % in 2000, compared with the OECD average of less than 2%. According to a Mexican study of the National Household Income-Expenditure survey (1998), 7 percent of families in the lowest income decile incurred catastrophic health expenditures in the previous three months compared with only 3 percent of those in the highest income decile¹.

Resources and activities in the health sector

Mexico had 1.1 doctors per 1000 population in 2000 compared to the OECD average of 2.9 doctors per 1000 population. The number of nurses per 1000 population was also lower, with 2.2 nurses per 1000 population, compared to the OECD average of 8.2 nurses per 1000 population (Chart 2.1 and 2.5)².

While the number of doctors in **Mexico** remains low compared to the OECD average, it has increased significantly over the past decade. In tandem with the rise in the number of doctors, **Mexico** has also

¹ Barraza-Llorens, M et al., Addressing Inequity in Health and Health Care in Mexico, *Health Affairs*, May/June 2002.

² It must be noted, however, that for both doctors and nurses, **Mexico** reports full-time equivalents instead of head counts, which results in an under-estimation.

reported one of the largest increases in doctor consultations per capita between 1990 and 2000, although the average number of doctor consultations per person per year still is only about half the OECD average (Charts 2.17 and 2.18).

The number of acute care hospital beds in **Mexico** was 1 per 1 000 population in 2000, four times lower than the OECD average. The average length of stay for acute care in hospitals was also relatively low, at 3.6 days, the lowest among OECD countries (Chart 2.29). Focussing on specific conditions leading to hospitalisation, the average length of stay following a normal delivery was less than 2 days in **Mexico**, also the lowest among OECD countries (Chart 2.32).

Income is an important factor influencing also the adoption and subsequent diffusion of health technologies throughout health systems. The diffusion of leading edge cardiovascular procedures to treat heart diseases provides a striking example. In 2000, only one coronary artery bypass graft surgery and one coronary angioplasty per 100,000 population was performed in **Mexico** (Table 2.13). In no other OECD country was this figure less than 15 per 100,000 population in 2000. This variation cannot be explained by the much smaller differences in the incidence of heart disease (as measured by mortality rates) between Mexico and other OECD countries.

Similarly, **Mexico** has among the lowest number per capita of leading edge diagnostic technologies such as magnetic resonance imaging (MRI) and computed tomography (CT) scanners (Charts 2.13 and 2.14).

Childhood immunisation remains a cornerstone of a country's disease prevention programme. **Mexico** has achieved great progress in childhood immunisation coverage over the past decade. By 2001, the measles immunisation rate was more than 95%. Similarly, diphtheria, tetanus, and pertussis (DTP) vaccine coverage increased from 50% in 1990 to 97% in 2001 (Chart 2.21 and 2.22). These figures contrast with the relatively low immunisation coverage in the United States, which reports 91% coverage for measles and 82% for DTP coverage.

Health status of the population

Life expectancy has risen markedly in all OECD countries over the past 40 years and **Mexico** is no exception. Gains in life expectancy in **Mexico** between 1960 and 2000 reached 16.6 years, rapidly narrowing the gap with the OECD average. In 2000, life expectancy at birth in **Mexico** was 76.5 years for females and 71.6 years for males, compared with the OECD average of 80.1 years for females and 74.2 years for males (Tables 1.2 and 1.3).

Although infant mortality rates in **Mexico** (23.3 deaths per 1000 live births in 2000) are still significantly higher than the OECD average (6.5 deaths per 1000 live births), there have been substantial reductions over the past few decades (Table 1.6). However, there remain wide variations in infant mortality rates between income levels and states in **Mexico**³.

Risk factors

Obesity in adults is increasing in all OECD countries. **Mexico** ranks only second to the United States among OECD countries in terms of adult obesity rates. The percentage of the adult population (15+) considered obese in **Mexico** was 24% in 2000, compared with 31% in the United States. The proportion of

³ Infant mortality rates have been reported to range from 9 deaths per 1000 live births in the richest municipalities to 103 in the poorest areas (Barraza-Llorens, M et al., Addressing Inequity in Health and Health Care in Mexico, *Health Affairs*, May/June 2002).

males and females defined as obese was 19% and 29% respectively (Chart 4.9 and 4.10). By comparison, adult obesity rates are much lower in Japan, Korea and Continental European countries, although they are also on the rise. A recent review of the literature on the cost of obesity to health care systems in the United States and other countries suggests that obesity in the late 1990s accounted for about 5.5% to 7% of total health expenditure in the United States, and 2% to 3.5% in other countries such as Canada, Australia and New Zealand⁴. The time lag between the onset of obesity and increases in related chronic diseases (such as diabetes and asthma) also suggest that the rise in obesity that has occurred in **Mexico** and most OECD countries will have substantial implications for future incidence of health problems and related spending.

By contrast with most other OECD countries which have seen tobacco smoking come down over time, **Mexico** is also reporting a rise in the proportion of adults who smoke during the 1990s. The overall proportion of daily smokers among adults increased from 26% in 1990 to 28% in 1998. It went up for both males and females. There remains however a marked gender gap in smoking rates in **Mexico**: 16% of females reported smoking on a daily basis in 1998 as opposed to 43% of males (Table 4.1 and Chart 4.2).

⁴ Thompson, D and Wolf, A., The medical-care cost burden of obesity, *Obesity Reviews* (2001) 2, 189-197.