Health spending and financing

Total health spending accounted for 6.2% of GDP in Mexico in 2003, more than two percentage points lower than the average of 8.6% in OECD countries. This places Mexico among the countries with the lowest share in the OECD, after Korea (5.6%), Slovakia (5.9%), Poland (6.0%) and Luxembourg (6.1%).

Mexico also ranks below the OECD average in terms of total health spending per capita, with spending of 583 USD in 2003 (adjusted for purchasing power parity), compared with an OECD average of 2307 USD. Health spending per capita in Mexico is the second lowest across OECD countries after Turkey. Between 1998 and 2003, health spending per capita in Mexico increased in real terms by 4% per year on average, a growth rate slightly lower than the OECD average of 4.5% per year.

Pharmaceutical spending account for an increasing share of health costs in Mexico and in many other OECD countries. In 2003, spending on pharmaceuticals accounted for 21.4% of total health spending in Mexico, up from 18.6% in 1999. This is above the OECD average of 17.7%. In Mexico, most spending on pharmaceuticals is financed through private sources, especially out-of-pocket expenditures.

The public sector is the main source of health funding in all OECD countries, except the United States, Mexico and Korea. With 46.4% of health spending paid from public sources in 2003, Mexico has the second lowest public share after the United States. While the public share of health spending rose from 40.4% in 1990, it remains well below the OECD average of 72% in 2003.

Private financing in Mexico is almost entirely in the form of out-of-pocket payments, as only 3.1% of total expenditure on health is funded through private health insurance. This contrasts with the United States, where private health insurance arrangements account for 66% of total private health financing and 36.7% of total health financing.

Resources in the health sector (human, physical, technological)

Health-care supply is low in Mexico by OECD standards. In virtually all dimensions for which data are available, Mexico lies well below average.

While the number of doctors per capita increased by 50% in Mexico over the past decade or so, up from 1 practising doctor per 1 000 population in 1990 to 1.5 in 2003, the doctor-to-population ratio in Mexico was only half the OECD average of 2.9 in 2003.

There were 2.1 nurses per 1 000 population in Mexico in 2003, a much lower figure than the average of 8.2 in OECD countries. However, as in most other countries, the number of nurses per capita has increased in Mexico, up from 1.7 in 1990.

The number of acute care hospital beds in Mexico was 1 per 1 000 population in 2003, about a quarter the OECD average of 4.1 beds per 1 000 population. Unlike other OECD countries where the number of hospital beds per capita has fallen over time, in Mexico the number of beds has been stable since 1990. The average length of stays for acute care in hospitals has slightly decreased over the past decade in Mexico, from 4.4 days in 1993 to 4.1 in 2003, a downward trend observed in other OECD countries.

During the past decade, there has been rapid growth in the availability of diagnostic technologies such as computed tomography (CT) scanners and magnetic resonance imaging (MRI) units in most OECD
countries. In Mexico, the number of MRIs remains the lowest in the OECD, at 0.2 per million population in 2003. Mexico still lags well behind the OECD average of 7.6 MRI units per million population. Similarly, the number of CT scanners in Mexico stood at 1.5 per million population in 2003, below the OECD average of 17.9.

**Health status and risk factors**

Most OECD countries have enjoyed large gains in life expectancy over the past 40 years, thanks to improvements in living conditions, public health interventions and progress in medical care. Since 1960, Mexico experienced one of the largest increases in life expectancy in the OECD area. Nonetheless, life expectancy at birth in Mexico stood at 74.9 years in 2003, about three years lower than the OECD average.

Infant mortality rate in Mexico is the second highest among OECD countries, at 20.1 deaths per 1 000 live births in 2003 compared with the OECD average of 6.1. However, it has fallen greatly over the past decades, from 79.3 deaths per 1 000 live births in 1970.

The proportion of daily smokers among adults has shown a marked decline over the past two decades in most OECD countries. However, Mexico has not achieved much progress in reducing tobacco consumption, with current rates of daily smokers among adults going slightly up from 25.8% in 1988 to 26.4% in 2002, around the OECD average of 26.5%. Sweden, the United States and Canada provide examples of countries that have achieved remarkable success in reducing tobacco consumption, with current smoking rates among adults at about 17%.

Obesity rates have increased in recent decades in all OECD countries, although there remain notable differences across countries. In Mexico, the obesity rate among adults, at 24.2% in 2000, is higher than in all other OECD countries except the United States (30.6% in 2002). The cost of obesity to health care systems has been estimated to account for about 5.5% to 7% of total health expenditure in the United States in the late 1990s, and 2% to 3.5% in other countries such as Canada, Australia and New Zealand (Thompson and Wolf, 2001). There is a time lag of several years between the onset of obesity and related health problems (such as diabetes and asthma), suggesting that the rise in obesity that has occurred in most OECD countries, including Mexico, will mean higher health care costs in the future.

More information on **OECD Health Data 2005** is available at [www.oecd.org/health/healthdata](http://www.oecd.org/health/healthdata). Note that **OECD Health Data 2005** is available in Spanish in the CD-ROM and on the SourceOECD version.

For more information on OECD's work on Mexico, please visit [www.oecd.org/mexico](http://www.oecd.org/mexico).

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1 It should be noted that the data for the United States (and also for the United Kingdom and Australia) are more accurate than those from other countries since they are based on actual measures of people’s height and weight, while estimates for other countries are based on self-reported data, which generally under-estimate the real prevalence of obesity.