

Health Care Expenditure and Financing in Latin America and the Caribbean [Fact sheet]

December 2012



Overview of Health Expenditure and Financing

Current Situation and Trends

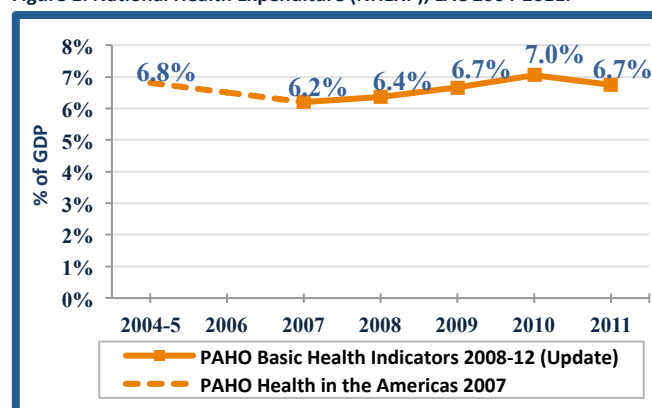
In 2011, the national or total expenditures in health care related goods and services (public and private) in Latin America and the Caribbean (LAC) represented 6.7% of the region's gross domestic product (GDP) and an average per capita expenditure of US\$ 661. The public/private mix of health expenditure in the region was of 52/48.

As expected, variations in the levels of per capita expenditures among countries are relatively large. National per capita expenditures on health varied from less than US\$ 200 in some countries of Central America and the Andean region (Bolivia, Honduras and Nicaragua), to around US\$ 530 in Mexico and US\$ 900 in Brazil. Total per capital expenditures on health was even higher in some countries of the Southern Cone (Argentina, Chile and Uruguay) and the non-Latin Caribbean (Anguilla and Trinidad and Tobago) where figures reached around US\$ 1,000 and up to more than US\$ 2,500 in Aruba and the now-dissolved Netherlands Antilles. Bermuda is the country with the highest level of per capita expenditures in health in the Americas, around US\$ 10,830, even higher than Canada (US\$ 5,656) and the United States of America (US\$ 7,491); see *Annex: Table 1*.

During the period 2004-2005 to 2008, a 3 to 4 year period of relatively rapid economic growth in the LAC region, national (total) health expenditures (NHEXP) grew at a slightly slower pace than the region's rate of economic growth.

The share of NHEXP as percentage of GDP decreased from 6.8% in 2004-05 to 6.4% in 2008. During the global economic crisis, from 2008 to 2010, increases in public expenditures to lessen the impact of the recession and/or to respond to the H1N1 pandemic, resulted in an overall increase in health expenditures. The share of NHEXP as a percentage of GDP increased from 6.4% in 2008 to 7.0% in 2010 (Figure 1). However, the increases in public expenditures could not be sustained after 2010 and in 2011 NHEXP declined to 6.7% of GDP (Figure 1).

Figure 1. National Health Expenditure (NHEXP), LAC 2004-2011.



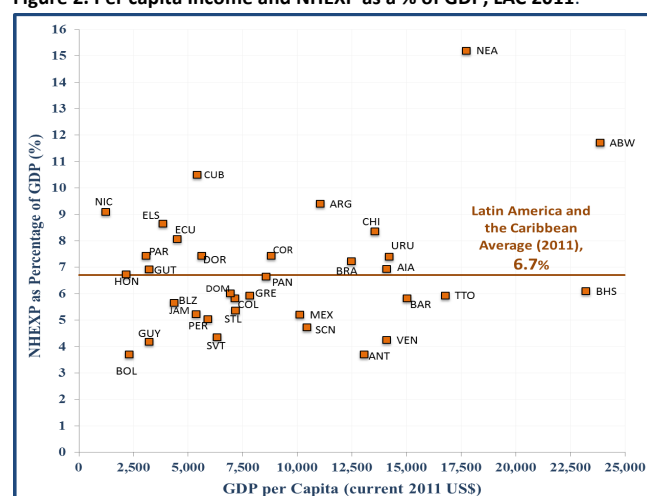
Source: Own elaboration based on updated data from PAHO Basic Health Indicators 2007-2012 and PAHO Health in the Americas 2007 and 2012.

Health Expenditures and income per capita

While at the global level there seems to be a positive correlation between the income per capita and the share of health expenditures as percentage of GDP, data from the LAC region shows a weak association between these two variables (Figure 2). The lack of correlation between these two variables over a relatively large range of country income data suggests that factors other than income determine the share of

national health expenditure as percentage of GDP. This implies that public policies (or the lack of) on the role of government in the provision of health care services, and regulation of the functioning of health care markets¹ are of greater importance than the level of income in a country when determining the amount of national resources that a country devotes to health care services.

Figure 2. Per capita Income and NHEXP as a % of GDP, LAC 2011.²



Source: Own elaboration based on updated data from PAHO Basic Health Indicators 2012.

Health Care Systems, the Role of Governments and Income Per capita

The type of national health care system found among countries in the Americas and among countries of Latin America and the Caribbean, measured by the share of public expenditures in relation to the total national health care costs, also varies significantly (Figure 3). Low income countries are characterized by a low participation of the public sector in the provision of health care services. Middle- and high-income countries mask a mix picture as there are large variations among them on the

¹ Health care markets for health care services, pharmaceutical products (and other health care inputs), health insurance and pre-paid medical plans.

² Country codes can be found in *Annex: Table 1*.

relative importance of the public sector in the provision of health care services.

Figure 3. Classification of national health care systems in the Americas (type of system and income level), 2011.

Type of Health System	Income level: Low (Under \$8,000 PPP)	Income level: Middle (Over \$8,000 PPP; Under \$20,000 PPP)	Income level: High (Over \$20,000 PPP)
Predominately public system (public health expenditure exceeds 66% of national health care costs)		Antigua & Barb. (b) Argentina (a) Colombia (a) Cuba (b) Montserrat (b) St. Vincent & the Gren.	Aruba (a) Canada (a) Netherlands Antilles (a)
Mixed system (public health expenditure exceeds 50%, but is under 66% of national health care costs)	Bolivia Guyana Honduras Nicaragua Paraguay	Anguilla Chile (a) Costa Rica (a) Dominica Mexico Panama (a) Peru Uruguay (a)	Barbados Trinidad & Tobago USA
Predominately private, market oriented system (public health expenditure is less than 50% of national health care costs)	El Salvador Guatemala Haiti	Belize Brazil Dom. Republic Ecuador Grenada Jamaica St. Kitts & Nevis St. Lucia Venezuela	The Bahamas

a/ Countries with extensive social security or compulsive medical care insurance systems that cover 50% or more of the population can be classified as having a **universal social health insurance (SHI)** system.

b/ Can be classified as a **national health services system**.

Source: Own calculations and elaboration based on updated data from PAHO Basic Health Indicators 2012 and income data from the IMF World Economic Outlook (Oct) 2012.

Tracking Progress towards Universal Health Coverage

The share of public expenditure in health as percentage of GDP, and the relative importance of private out-of-pocket expenditures in health (OOP-HEXP) as a percentage of the overall national health expenditures have been included as benchmark indicators in the PAHO Strategic Plan 2008-2012 (PAHO, 2009). They were included as indicators to assess a country's progress in the extension of social protection and equitable and sustainable financing. Similar indicators were also included in WHO's 2010 World Health Report titled "Financing Health Systems: The Path to Universal Coverage" (WHO, 2011): "[long term goal] lowering the level of direct payments (out-of-pocket) to below 15–20% of total health expenditure and to

increase the proportion of combined government and compulsory insurance expenditure (public expenditures) in GDP to about 5–6%” (pp. XIV, 42, and 53)³.

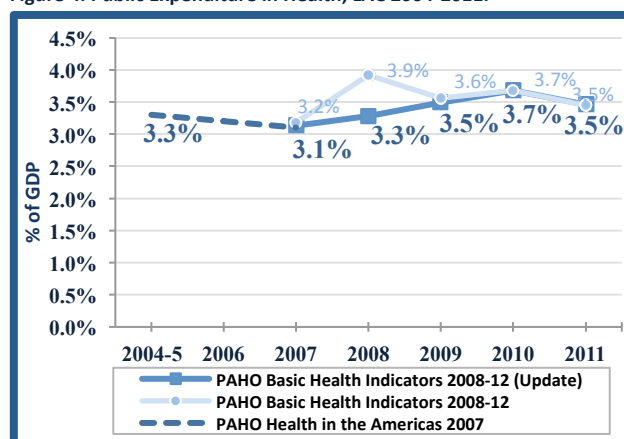
The share of household out-of-pocket expenditure as percentage of overall national health expenditures is an indicator of underutilization of risk pooling mechanisms⁴ to satisfy the population’s health care needs. Furthermore, when out-of-pocket expenditure is relatively large in relation to overall national health expenditures it implies that access to health care services depends on household ability to pay.

The revised data on the evolution of the share of public expenditure in health as percentage of GDP in the LAC region shows that progress has been slower than previously estimated (Figure 4). It increased from 3.1% in 2006–2007 to around 3.7% in 2010 and 3.5% in 2011. The public/private mix reversed from a 48/52 ratio in 2004 to a 52/48 ratio in 2011; as shown in Figure 4. Despite the progress made, the LAC region is still far from the health expenditure targets stated in PAHO’s Strategic Plan 2008–2012, and even further from the more ambitious long term expenditure goals that characterize countries with universal health coverage and which were suggested in WHO’s 2010 World Health Report.

³ The PAHO Strategic Plan 2008–2012 targets were: to increase public expenditures from 3.1% of GDP in 2006 to 5.0% of GDP in 2013; and to reduce the share of out-of-pocket expenditures as percentage of total health expenditures from 52% in 2006 to 40% in 2013; pp. 84.

⁴ Risk pooling mechanisms are considered to be a more efficient mechanism to ensure access to health care services.

Figure 4. Public Expenditure in Health, LAC 2004–2011.

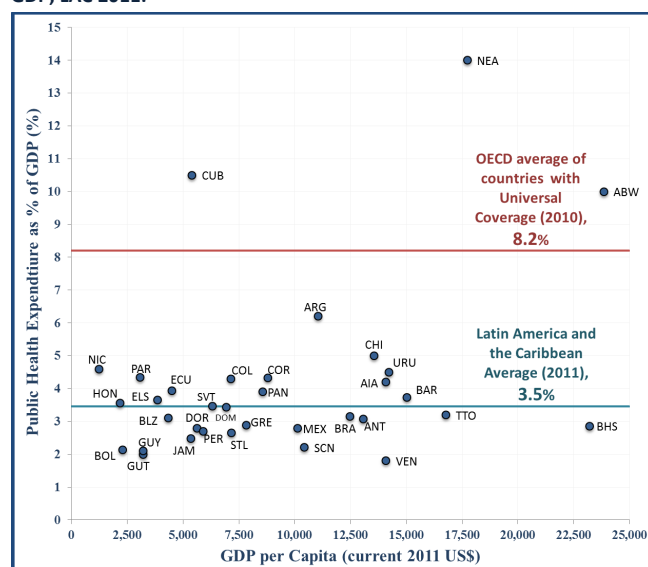


Source: Own elaboration based on updated data from PAHO Basic Health Indicators 2012 and PAHO Health in the Americas 2007 and 2012.

When analyzing the share of public expenditure in health as percentage of GDP in the LAC it is important to recognize that, once again, regional aggregates hide significant differences among countries. Indeed, countries such as Aruba, Cuba, and the now-dissolved Netherland Antilles reported shares of public expenditures in health as percentage of GDP of 10%, or more, which is well above the 5–6% public expenditure in health benchmark stated in the WHO’s World Health Report of 2010. All three of these countries are characterized as having health care systems providing universal health coverage.

Moreover, while several countries in LAC may claim to have achieved universal health coverage, their shares of *public expenditure in health as % of GDP* and *out-of-pocket expenditure in health (OOPHEXP) as a % of NHEXP* are not in line with the average values observed in OECD countries characterized as having universal health coverage (Figures 5 and 6) or with the long term benchmark indicators stated in the WHO World Health Report of 2010.

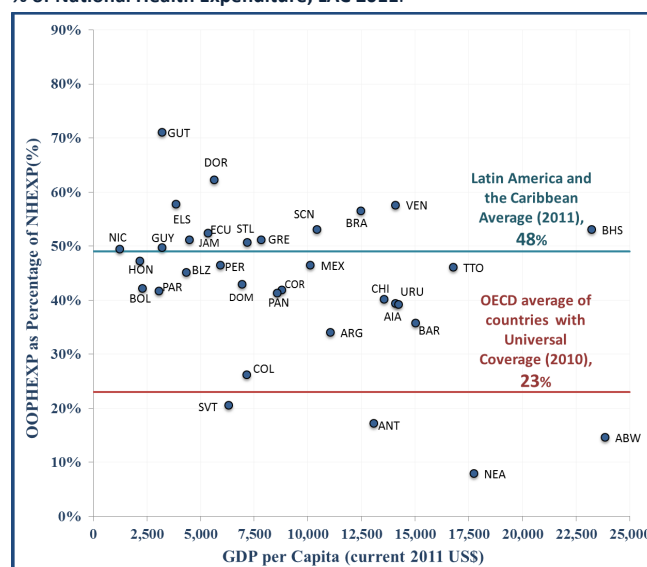
Figure 5. Per capita Income and Public Expenditure in Health as % of GDP, LAC 2011.



Source: Own elaboration based on updated data from PAHO Basic Health Indicators 2012.

In terms of private out-of-pocket expenditure in health (OOP-HEXP) as a share of NHEXP, the LAC regional average of around 48% in 2011 is still far from the target of 40% for 2013 stated in PAHO's Strategic Plan, and even further from the "15–20% benchmark" suggested in WHO's World Health Report of 2010 (Figure 6).

Figure 6. Per capita Income and Out-of-Pocket Expenditure in Health as % of National Health Expenditure, LAC 2011.



Source: Own elaboration based on updated data from PAHO Basic Health Indicators 2012.

Only Antigua and Barbuda, the now-dissolved Netherlands Antilles and Aruba are below the 15–20% benchmark. Likewise, only these three countries, together with St. Vincent and the Grenadines, are at the same level, or below, the 23% OOP-HEXP as percentage of GDP average of OECD countries characterized as having universal coverage (Figure 6).

Health Care Expenditure and Financing in Latin America and the Caribbean [Fact sheet]
prepared by Rubén M. Suárez-Berenguela and William Vigil-Oliver.

Area of Health Systems Based on Primary Health Care
Pan America Health Organization/World Health Organization (PAHO/WHO).
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For correspondence and inquiries: suarezru@paho.org

ANNEX

Table 1. Selected Income and National Health Expenditure Indicators, the Americas 2011.

Code	Country	GDP per Capita (Current US\$)	Public Expenditure in Health % of GDP (%)	Private Expenditure in Health % of GDP (%)	NHEXP per Capita (Current US\$)
AIA	Anguilla b/	14,080	4.2	2.7	976
ANT	Antigua and Barbuda	13,067	3.1	0.6	485
ARG	Argentina a/	11,042	6.2	3.2	1,038
ABW	Aruba	23,848	10.0	1.7	2,794
BAR	Barbados	15,023	3.7	2.1	874
BLZ	Belize b/	4,348	3.1	2.6	246
BMU	Bermuda	91,780	5.9	5.9	10,830
BOL	Bolivia	2,295	2.1	1.6	85
BRA	Brazil	12,467	3.1	4.1 *	902
CAN	Canada	50,496	7.9	3.3	5,656
CHI	Chile	13,559	5.0	3.4 *	1,133
COL	Colombia	7,152	4.3	1.5	417
COR	Costa Rica	8,794	4.3	3.1	654
CUB	Cuba b/	5,405	10.5	N/A	N/A
DOM	Dominica	6,941	3.4	2.6	418
DOR	Dominican Republic	5,633	2.8	4.6 *	418
ECU	Ecuador	4,492	3.9	4.1	362
ELS	El Salvador	3,855	3.7	5.0	334
GRE	Grenada	7,826	2.9	3.0	464
GUT	Guatemala	3,205	2.0	4.9 *	222
GUY	Guyana	3,212	2.1	2.1	134
HON	Honduras	2,171	3.6	3.2 *	146
JAM	Jamaica	5,357	2.5	2.7	280
MEX	Mexico	10,122	2.8	2.4 *	527
MNT	Montserrat	N/A	10.2	1.0	N/A
NEA	Netherlands Antilles a/	17,730	14.0	1.2	2,695
NIC	Nicaragua	1,232	4.6	4.5 *	112
PAN	Panama a/	8,575	3.9	2.7 *	570
PAR	Paraguay	3,068	4.3	3.1	228
PER	Peru	5,913	2.7	2.3 *	298
STL	St. Lucia	7,176	2.6	2.7	385
SVT	St. Vincent and the Grenadines	6,316	3.5	0.9	275
SCN	St. Kitts and Nevis	10,432	2.2	2.5	493
BHS	The Bahamas	23,216	2.9	3.2	1,415
TTO	Trinidad and Tobago	16,767	3.2	2.7	995
USA	United States c/	48,328	9.9	5.6	7,491
URU	Uruguay b/	14,214	4.5	2.9	1,052
VEN	Venezuela d/	14,087	1.8	2.4	598

a/ Public Expenditure in Health data from 2010.

b/ Public Expenditure in Health data from 2009.

c/ Public and Private Expenditure in Health data from 2010.

d/ Public Expenditure in Health data for 2012 (Budgeted).

(*) Includes expenditure on private health insurance.

Source: Own calculations, based on updated information of data presented in PAHO Basic Health Indicators 2012.