A wide range of demographic, social and economic factors, as well as the financing and organisational arrangements of the health system can explain the level and changes over time of health spending in a country, covering both individual needs and population health as a whole.

The average OECD current health spending per capita in 2017 was around four times that of the countries in LAC (USD PPP 3 994 versus 1 025). Much variation in per capita health care spending levels can be observed in LAC countries (Figure 6.1), ranging from Haiti health spending per capita of only 83 international dollars (current USD PPP) to Cuba's 2 484 international dollars (current USD PPP). In average, LAC countries devote 59% to government and compulsory insurance schemes, and the remaining 41% goes to out-of-pocket payments, voluntary payment schemes and external resources.

On average, between 2010 and 2017, the growth rate in per capita health spending was 3.6% per year in LAC, higher than the 3% observed for gross domestic product (GDP) (Figure 6.2). The growth in health spending was more rapid in Nicaragua, Bolivia and Paraguay – more than twice the average rate for the region. Venezuela reported decreasing rates in current health spending between 2010-17.

Health spending growth and GDP growth are positively associated, meaning that in general terms an increase or decrease in one of them follows the other. In many LAC countries, health spending has exceeded economic growth over the past five years, resulting in an increasing share of the economy devoted to health. All countries above the diagonal line in Figure 6.2 report that health expenditure has grown faster than income. This means that the share of health care expenditure in total expenditure has continued to increase. In all countries below the line, the increase in health spending – on average – was lower than the increase in GDP. Hence, the share of health spending in total spending declined in those countries.

Overall health spending growth and economic performance can explain how much countries spend on health care over time. Current health expenditure accounted for 6.6% of GDP in the LAC region in 2017, an increase of around 0.09 percentage points from 2010. The OECD countries averaged a current health expenditure of 8.8% of the GDP in 2018. This indicator varied from 1.1% in Venezuela to up to 11.7% in Cuba and 9.2% in Uruguay (Figure 6.3). Generally, the richer a country is, the more it spends on health. Between 2010 and 2017, the share of health in relation to GDP declined almost 6 percentage points in Venezuela, whereas it increased more than 2 percentage points in Paraguay and Chile.

Capital has been an increasingly important factor of production of health services over recent decades, as reflected for example by the growing importance of diagnostic and therapeutic equipment or the expansion of information and communications technology (ICT) in health care. Capital investments in health tends to fluctuate more with economic cycles than current spending on health care. However, slowing down investments in health infrastructure and equipment will affect service delivery. As a proportion of GDP, Panama and Saint Vincent and the Grenadines were the highest spenders on capital investment in 2017 with more than 0.7% of their GDP going on construction, equipment and technology in the health and social sector (Figure 6.4). However, capital spending can be significantly lower: in Venezuela, Argentina and Antigua and Barbuda accounted for less than 0.002% in 2017. On average, it represents 0.2% of GDP across LAC compared to 0.5% in OECD countries in 2015.

Definition and comparability

Health expenditure is given by the sum of expenditure on all the core health care functions – that is total health care services, medical goods dispensed to outpatient, prevention and public health services, and health administration and health insurance. Expenditure on these functions is included as long as it is borne by final use of resident units i.e. as long as it is final consumption by nationals in the country or abroad. For this reason, imports for final use are included and exports for final use are excluded.

Health care financing can be analysed from the point of view of financing schemes (financing arrangements through which health services are paid for and obtained by people, e.g. social health insurance), financing agents (organisations managing the financing schemes, e.g. social insurance agency), and types of revenues (e.g. social insurance contributions). Here "financing" is used in the sense of financing schemes as defined in the System of Health Accounts (OECD, Eurostat and WHO, 2011) and includes government schemes, compulsory health insurance as well as voluntary health insurance and private funds such as households' out-of-pocket payments, NGOs and private corporations. Out-of-pocket payments are expenditures borne directly by patients and include cost-sharing arrangements and any informal payments to health care providers.

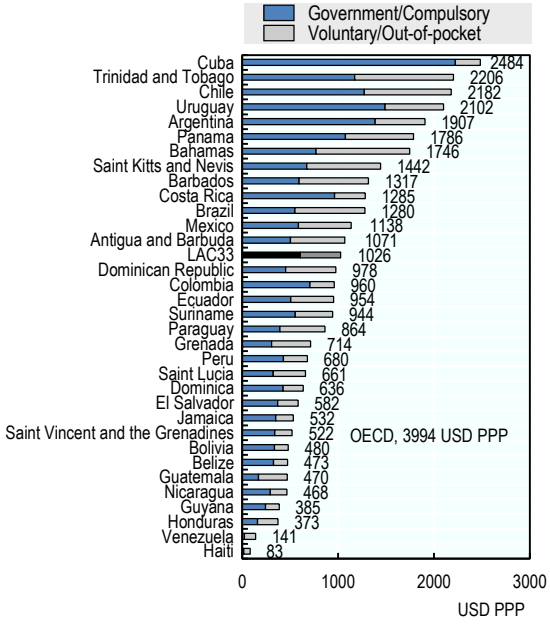
The economy-wide (GDP) PPPs are used as the most available conversion rates. These are based on a broad basket of goods and services, chosen to be representative of all economic activity. The use of economy-wide PPPs means that the resulting variations in health expenditure across countries might reflect not only variations in the volume of health services, but also any variations in the prices of health services relative to prices in the rest of the economy.

To make useful comparisons of real growth rates over time, it is necessary to deflate (i.e. remove inflation from) nominal health expenditure through the use of a suitable price index, and also to divide by the population, to derive real spending per capita. Due to the limited availability of reliable health price indices, an economy-wide (GDP) price index is used in this publication.

To take into account the timing of the government budget allocation process, comparison over time look at the latest five years for which expenditure data are available.

Gross fixed capital formation in the health sector is measured by the total value of the fixed assets that health providers have acquired during the accounting period (less the value of the disposals of assets) and that are used repeatedly or continuously for more than one year in the production of health services. The breakdown by assets includes infrastructure (e.g. hospitals, clinics, etc.), machinery and equipment (including diagnostic and surgical machinery, ambulances, and ICT equipment), as well as software and databases. Gross fixed capital formation is reported by many countries under the System of Health Accounts.

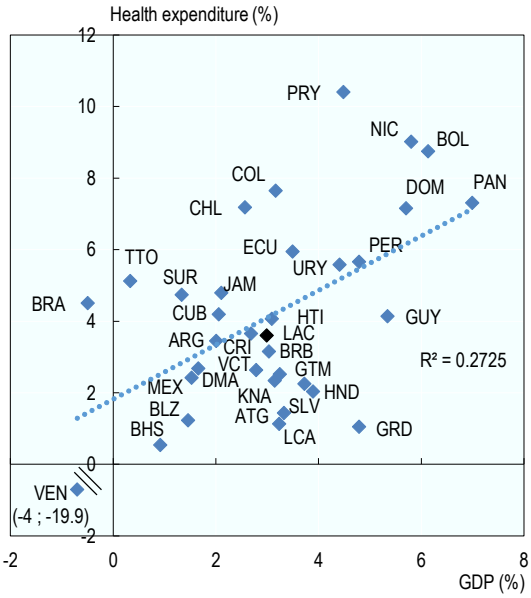
Figure 6.1. **Total health expenditure per capita (USD PPP), 2017**



Note: 2018 data for Brazil, Chile, Colombia, Costa Rica and Mexico.
Source: WHO Global Health Expenditure Database 2020; OECD Health Statistics 2019 for Brazil, Chile, Colombia, Costa Rica and Mexico.

StatLink https://stat.link/tpq71j

Figure 6.2. **Average annual growth rate in current health spending and GDP per capita, 2010-17**



Source: WHO GHED 2020; OECD Health Statistics 2019 for Brazil, Chile, Colombia, Costa Rica and Mexico.

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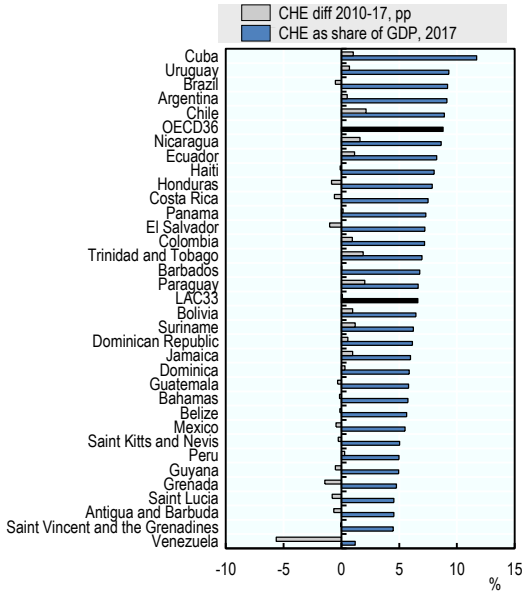
Figure 6.3. **Change in total expenditure on health as a share of GDP, 2010-17**



Note: 2018 data for Brazil, Chile, Colombia, Costa Rica and Mexico.
Source: WHO GHED 2020; OECD Health Statistics 2019 for Brazil, Chile, Colombia, Costa Rica and Mexico.

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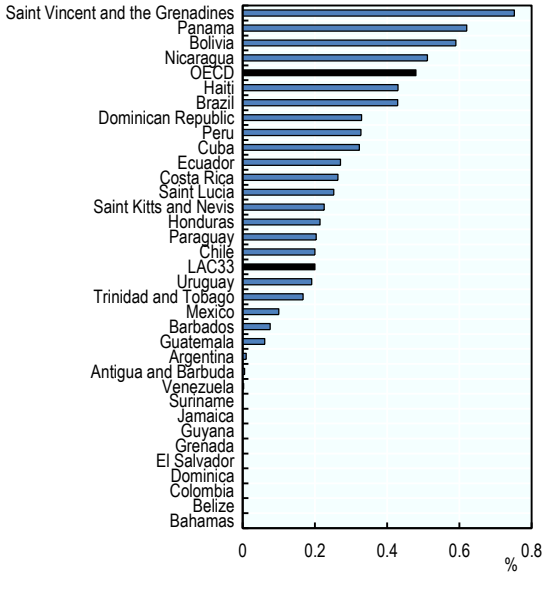
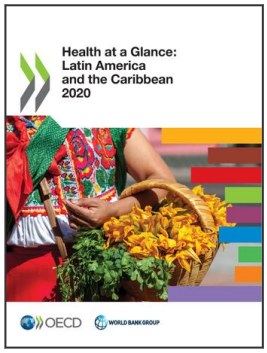
Figure 6.4. **Grossed fixed capital formation in the health care sector as a share of GDP, 2017**



Note: OECD average corresponds to 2015.
Source: WHO GHED 2020, OECD Health Statistics 2019 for Chile and Mexico.

StatLink https://stat.link/qmlewp



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