Segundo Informe sobre Desarrollo Humano en Centroamérica y Panamá

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Capítulo I
Desafío de la equidad social

Inversión en salud para el desarrollo humano: gasto y financiamiento del sector

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Section on:
The State of the Region Report:

Investing in Health for Human Development: Health Sector Expenditures and Financing in Countries of the Region[1]

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Investing in Health for Human Development: Health Sector Expenditures and Financing in Countries of the Region

A. Investments in health: National health expenditures in countries of the region: Absolute and relative levels and its composition

Investment in health: National health expenditures across countries

The countries of the Region are heterogeneous in terms of the living standard of the population; as measured by the level of income per capita, HDI, levels of education, health status and other socioeconomic indicators. They are even more heterogeneous in terms of the amount of resources invested in health; as measured by the level of national health expenditures, and in the Public/Private composition of those expenditures. Large variations in the level national health care expenditures (NHE), in the importance of NHE as percentage of the Gross Domestic Product (GDP) and in the public-private composition of national health expenditures are closely related to different ways in which national health care systems are organized and financed.

Countries with better health outcomes – life expectancy, maternal mortality and infant mortality rates and HDI are those in which there is a larger participation of the public sector in organizing and financing national health care systems. These are countries in which public expenditures as percentage of the GDP is significant higher than that of other countries of the region and/or countries with extended social insurance schemes (coverage of population and services).

Table 1 summarizes the main indicators of national health expenditures in health care related goods and services (NHE) in countries of the Region. It presents the population, income per capita, the importance of NHE as percentage of GDP, the level of NHE per capita, and the ratio of private household out of pocket

expenditures per dollar of expenditures in public health programs and health care services by public sector institutions.

Table 1. National expenditures in health care goods and services, selected indicators, 2000 (US$ PPP dollars of 2000; and percentages)

Countries	Population 2000 (000)	Income Per Capita, In $ PPP	NHE % of GDP	NH, Per capita in US$	Private/Private US$
Belice	260	5,240	4.8	252	0.92
Costa Rica	4,023	8,250	9.1	750	0.33
El Salvador	6,276	4,390	8.2	360	1.52
Guatemala	11,385	3,770	5.4	204	2.60
Honduras	6,485	2,390	7.2	172	1.67
Nicaragua	5,071	2,100	11.3	237	1.09
Panama	2,856	5,700	7.3	416	0.35
Region	36,200	4,047	7.6	306	0.9
LAC Region	518,700	7,035	7.3	506	0.9

Source: PAHO – HDP/HDD Database on NHEA-Americas. Health in the Americas 2002 Edition; Volume I. PAHO Scientific and Technical Publications, No. 587; Washington, DC. September 2002.

The Region of Central America and Panama (the Region) accounts for around 7 percent of the population of the Latin America and Caribbean Region (LAC Region) ant its income per capita of US$ 4,047 dollars is little more than half of that of the LAC Region (US$ 7,035). The level of income of the country with the highest income per capita of the region, Costa Rica with US$ 8250 dollars, is 3.9 times the level of income per capita of Nicaragua, the country with the lowest income per capita, US$ 2100 dollars.

Country's policy decisions about how to organize and finance national health care systems, and government decision about investments in human capital are reflected in the level and composition of national health care expenditures. The average NHE per capita for countries of the Region is of US$ 306 dollars. The difference between the country with the highest and lowest level of NHE per

capita; Costa Rica with a NHE per capita of around US$ 750 dollars, is 4.4 time the country with the lowest level of NHE per capita; Honduras with a NHE per capita of US$ 172 dollars.

The NHE as a proportion of the Gross Domestic Product (GDP) and the public-private composition are indicators of government commitments to address health related human capital development issues. The NHE/GDP ratio of the Central America Region is similar to that of the overall LAC region: around 7.6 percent of the GDP. But this regional average is heavily influenced by the low level of NHE/GDP of Guatemala, the largest country of the Region in terms of population and economic significance. With the exception of Belize and Guatemala, in all other countries of the region the NHE/GDP ratio is around or above the Region's average. However, among the countries of the Region, there are substantial differences in the public-private mix of government expenditures.

Private households and government investments in health

The average household per capita expenditure in health related goods and services for the Region is estimated in US$ 143 dollars. The average per capita expenditures in health throughout public sector institutions is of US$ 157. Households spent US$ 0.91 dollars per dollar spent by public sector institutions.

The ratio private/public health expenditure ratio is an indicator of the dollars invested in health care related goods and services, pre-paid health plans and private health insurance schemes by private households per dollar spent or invested by public sector institutions in government financed health programs and health care services. A regional average of around one (0.96) indicates that households as well as government share the burden of the financing of health sector in more or less equal proportions. However, there are large variations among countries in the relative importance of public sector involvement in the provision of health care services. In Costa Rica and Panama the private/public

ratio is around 0.35 indicates that households spent only US$ 0.33 per dollar spent by dollar spent by public sector institutions. In Belize and Nicaragua, this ratio is around one. This private/public ratio contrast with ratios of around 1.5 in El Salvador and Nicaragua, and with a ratio of US$ 2.6 of private household expenditures in health services per dollar of public expenditure in health by public sector institutions in the case of Guatemala.

The external financing of health projects and programs and services

The high visibility of health sector projects financed by the World Bank and the IDB contrasts with the relative importance of resources managed throughout these projects. The total lending for health sector projects amounted in the year 2001 to a US$ 170 millions. The amount of resources channeled by these projects; of around 30 millions per year, represents less than 0.43 percent the annual amount of resources managed by public sector institutions of the Region (US$ 5,700 millions). The magnitude of resources mobilized throughout Official Development Assistance for health sector projects and programs is of a greater importance. In per capita terms, the external financing of health sector projects represents around one dollar per capita per year (US$ 0.75). The average amount of ODA resources, during 1998-200, amounted to US$ 110 millions per year; around US$ 3.8 dollars per capita. The estimated annual public expenditure per capita is of around US$ 157 dollars (See Table 2).

Lending from international organizations grew substantially during the nineties. By the end of the year 2001 the portfolio of World Bank and Inter American Development Bank (IDB) included 7 health sector projects (health, nutrition and population projects) in 4 countries of the Region (Costa Rica, Honduras, Nicaragua and Panama) amounted to around US $ 170 millions of dollars. The World Bank portfolio includes a health sector reform project in Costa Rica, nutrition and health projects in Honduras and Nicaragua, and a rural health and health sector pilot project in Panama. The IDB portfolio includes a Panama

accounted for one third of health sector lending (US$ 64.3 millions; two World Bank projects totaling around US$ 30 millions, and IDB project of US$ 35 millions).

Table 2. Lending for Health Sector Projects financed and Official Development Assistance for Health Projects/Programs; 2000

Countries	World Bank US$ Millions	IDB US$ Millions*	Total Lending US$ a/	Lending Per capita per year US$ b/	ODA Health US$ Millions c/	ODA Per Capita US$
Belice	-	-	-	-	0.5	1.92
Costa Rica	22.0	-	22.0	0.78	2.2	0.55
El Salvador	-	-	-	-	16.7	2.66
Guatemala	-	-	-	-	26.4	2.32
Honduras	35.4	-	35.4	0.78	37.1	5.72
Nicaragua	24.0	25.0	49.0	1.38	56.3	11.10
Panamá	29.3 (2)	35.0	64.3	6.43	0.7	0.25
Total	**110.7**	**60.0**	**170.7**	**0.94**	**139.9**	**1.30**

Source: World Bank and IDB web pages on portfolio of Health, Nutrition and Population projects.
*/ Projects approved during 2001, only.
a/ Most of the projects were of a duration of seven years. Two IDB projects in Panama are of duration of 5 years one and of 3.5 years the other. It does not include time delays in the implementation of projects.
b/ Annualized rate assuming a life of the projects of five years.
c/ Average 1998-2000.

B. The structure of health care markets, market failures and inequalities in access to health care services: Public policy challenges

Structure of health care markets: Scope of market and government failures

A relatively large participation of private expenditures in countries characterized by large income-expenditure inequalities is likely to replicate existing socioeconomic inequalities. The public good nature of several health care

services, the existence of externalities, economies of scale and information asymmetries suggest that market solution will lead to a level and composition of expenditures that are sub optimal from a social welfare perspective (Market failures). Contrary to the case of the health care markets in more developed countries, where public expenditures is the main component of national expenditures, in most countries of the Region there is relatively large private markets. The lack of public policies addressing market failures suggests large inefficiencies in the observed level and composition of national health care expenditures.

Table 3 shows the large heterogeneity of the market structures and public policy challenges faced by policy makers in addressing efficiency and inequality issues. This table presents a description of the structure of health care markets in terms of the expenditures in health care related goods and services by central and local governments, the expenditures in maternal and health programs throughout social insurance schemes; non-market transactions (public), and private out-pocket expenditures in health related goods and services and their expenditures in pre-paid health plans and health insurance schemes; market transactions (private).

Table 3. The structure of health care markets in countries of the region: Market and non-market transactions (composition; in percentages)

Country	*TOTAL*	Non-Market Transactions (Public)		Market Transactions (Private)	
		Government	Social Insurance	Direct out-of-pocket	Health Plans & Health Insurance
Belice	100.0	49.0	0.0	46.8	..
Costa Rica	100.0	7.9	67.6	24.5	..
El Salvador	100.0	22.0	18.3	58.1	1.6
Guatemala	100.0	14.3	12.6	73.0	..
Honduras	100.0	31.7	5.3	63.1	..
Nicaragua	100.0	43.2	16.4	40.4	..
Panamá	100.0	25.7	48.4	25.9	..
Regional Average	**100.0**	**20.6**	**26.4**	**52.6**	**0.3**

Not available estimates.
Source: Table A.2; Annex.

For the region as whole the direct participation of the government in the provision of health care services is relatively minor, it represents around one fifths of overall national health expenditures in health related goods and services (20.6 percent). More significant is the amount of resources channeled throughout social insurance schemes managed by national social security institutions. NHE throughout public health insurance schemes represents one fourth of national health expenditures (26.4 percent). Direct out-of-pocket expenditures are the main components of national health care expenditures in all countries of the Region; it represents more than half of the total (52.6 percent). The two exceptions are the cases of Costa Rica and Panama. In all other countries direct out-of pocket expenditures accounts for at least 40 percent of national health care expenditures

Private markets are relatively larger in countries with relatively low levels of income: El Salvador, Guatemala and Honduras. They accounts for more than 60 percent on NHE. Household direct out-of-pocket expenditures in health related

goods and services are the single most important component of total health expenditure. Significance of resources spent in pre-paid health plans and private health insurance schemes is relatively minor. The relatively low significance of central government expenditures in health and the lack of regulatory policies to deal with market failures affecting the market transactions suggest that there is ample room for implementing public policies to correct inefficiencies associated to the type of market failures characterizing this markets.

Inequalities in Access to Health Care Services

Inequalities in access to health care services can be measured by the differences in the level of expenditures in health related goods and services by different socio economic group and by the relative importance of household expenditures in health related goods and services and private health insurance. Table 4 summarizes the inequalities in private out-of-pocket expenditures in selected countries of the Region. The table presents the share of household out-of-pocket expenditures as percentage of total household resources (income or level of consumption) by different income groups.

The countries of the Region are characterized for having relatively large income distribution inequalities. In almost all the countries of the Region the top 20 percent of the income distribution, the richest quintile, concentrates more than 46 percent of national income. Data on the share of household expenditure in health related goods represents between 3.0 percent in the case of Panama (in 1983-84) to 5.4 in the case of El Salvador (in 1999). No time series data exists on changes over time in the share of households out-of-pocket expenditures.

Empirical evidence from both, developed and developing countries, suggest that private household expenditures may have been increasing over time. An income elasticity of health expenditures greater than one, and greater availability and newly introduced medical services and medicines may be contributing to a greater percentage of household resources spent in health related goods and

services. The increase in private out-of-pocket expenditures may be more significant in which public sector play a minor role in the provision of health care services. The case of Guatemala may be an example. In the period between the early eighties and the late nineties, the share of expenditures in health related goods and services increased from 1.64 percent in 1979/81, to 4.5 percent in 1998/99. Similar trends have been observed in other countries of the LAC Region.

Table 4. Inequalities in access to health service indicators: Household out-of-pocket expenditures by income quartiles; selected countries and years.

Countries	Year	National Average (%)	Quartiles of income/expenditure			
			Q1	Q2	Q3	Q4
Belize						
Costa Rica a/	1987-88	3.70	2.15	2.56	3.22	4.54
El Salvador a/	1999	5.37	n.a.	n.a.	n.a.	n.a.
b/	1999	1.00	0.22	0.56	1.37	3.45
Guatemala a/	1979-81	1.64	1.32	1.71	2.24	1.32
	1998-99	4.50	3.76	4.40	4.70	5.80
Nicaragua a/	1998-99	4.41	5.75	4.98	4.75	4.04
Panama a/	1983-84	3.04	0.86	0.89	2.32	3.54
Region c/		3.9	3.2	3.2	3.7	4.5
LAC Region c/		4.3	3.6	3.9	4.3	4.9

a/ Household out-of-pocket-expenditures as percentage of household income/expenditures.
b/ Index of household per capita expenditures in health related goods and services, national average = 1.00 (C$ 159).
c/ Average of latest available years.

Sources: Elaborated from: Las Condiciones de Salud en las Américas. Edición de 1994, Organización Panamericana de la Salud, Volumen 1; p. 412. Washington D.C. 1994. Ministerio de Salud Pública y Asistencia Social de El Salvador, Dirección de Planificación, Unidad de Economía de la Salud. Cuentas Nacionales en Salud: Estimación del Gasto Nacional en Salud de El Salvador, 1999 (Borrador Preliminar, Noviembre 2002). Hernandez Samuel, Desigualdades en la provisión de los servicios de salud de la red MSPAS durante 1998 (mimeo). Instituto Nacional de Estadística, Encuesta Nacional de Ingresos y Gastos Familiares 1998-1999, Guatemala, CA. (http://www.segeplan.gob.gt/ine/index.htm). Estimación del Gasto de los Hogares en Desarrollo Humano, Informe de Consultaría, GSD Asociados; Programa de Naciones Unidas para el Desarrollo – PNUD. Encuesta Nacional de Ingresos y Gastos de los Hogares 1998-1999, Banco Central de Nicaragua. (www.bcn.gob.ni/economia/indicadores/encuesta/default.htm).

Inequalities in access to health care services are more pronounced than income inequalities. In most countries of the Region the share of household expenditures in health related goods and services increase as income increases (income elasticity of household expenditures in health is greater than one). For the Region it increased from 3.2 percent of the income of the poorest quartile, to 4.5 percent of the household income of the richest quartile. The index of household per capita expenditures in health related goods and services from El Salvador illustrate the large inequalities in the levels of expenditures between the bottom and top quartile of the income distribution. The average per capita expenditure of the top quartile is more than three times the national average. The lowest quartile is approximately one fifth the national average. The average level of expenditure of the top quartile is more than 15 times the average level of expenditures of the lowest quartile, the 25 percent poorest (The average expenditure of the top decile is more than 20 times the one of the bottom decile).

C. Organization and financing of national public health systems and social protection in health:

The organization and financing of national public health systems

The structure of health care markets in countries of the Region, and the inequalities in access just described are due, in a large part, to the degree of government involvement in organizing the provision and financing of national health care systems. Governments may intervene directly; throughout the organization and financing of national health care systems, and indirectly; through the setting up of statutory public health insurance schemes and the regulation of the private markets (goods and services and health insurance markets). The countries of the Region are rather heterogeneous in terms of the configuration of their national health care systems and in the importance of the public health care systems in financing the access to health care services.

In the Region there are the three types of systems commonly used in typifying the organization and financing of health care systems. The health care system of Belize may be characterized as a national health care service system (NHS); a system in which the government plays a dominant role in the financing and provision of health care services, directly. Costa Rica and Panama can be characterized as national health insurance systems (NHIS), systems in which financing and access to health care services is throughout a national health insurance systems. The health care systems of El Salvador, Honduras, Guatemala and Nicaragua can be characterized as market oriented or mixed national health care systems (MNHS). Access to health care services is financed by direct out-of-pocket expenditures. The amounts of resources (expenditures) managed by government institutions (Ministries of Health) and the expenditure and coverage of social (public) health insurance schemes is relatively minor.

Social protection in health: Coverage and expenditures of public health insurance programs

Degree of government involvement in the provision of social services may be assessed by the absolute and relative amount of resources spent in health care services and by the percentage of population covered. Table shows the large variations in the importance of the public sector in the provision of health care services in countries of the Region and in the scope of social protection throughout public health insurance schemes managed by social security institutions.

Table 5. Social protection in health: Coverage and expenditures throughout public health insurance programs; 2000-2001

Countries	Population Covered by Public Health insurance (000)	Coverage: % of the Total Population	Health Expenditures Social Health Insurance Systems % of GDP	Health Expenditure Per capita; (Per beneficiary) US$ PPP	Government Health Expenditure % of GDP	Government Health Expenditure Per capita (Total Population) US$ PPP
Belice	n.a.	n.a.	n.a	n.a	2.5	131.1
Costa Rica	2,810.0	73.6	6.1	720.5	0.6	49.5
El Salvador	941.4	15.0	1.5	439.2	1.8	79.1
Guatemala	1,646.0	14.0	0.7	182.5	0.8	30.2
Honduras	607.0	9.4	0.4	102.1	2.3	54.9
Nicaragua b/	402.5	7.7	1.8	476.8	3.6	75.6
Panama	1770.0	60.0	3.6	331.1	1.9	108.3
Region	8176.0	22.6	2.4	437.6	1.4	58.3

n.a.: Not applicable
a/ Estimates for 2000; includes insured and beneficiaries (dependents)
b/ Estimates for 2001; includes insured and beneficiaries (dependents)

Source: PAHO – HDP/HDD Database on NHEA-Americas. Health in the Americas 2002 Edition; Volume I. PAHO Scientific and Technical Publications, No. 587; Washington, DC. September 2002. Ministerio de Salud, República de Nicaragua, Cuentas Nacionales en Salud, Informe 1995-2001, División General de Planificación y Desarrollo, Managua, Nicaragua, Diciembre 2002.

Around 8.2 millions of persons; out of the 36.2 millions of inhabitants of the Region, are beneficiaries of health insurance programs managed by social security institutions. It represents less than one fourth of the total population (22.6 percent). More than 50 percent of the beneficiaries are concentrated in the two countries, Costa Rica and Panama, the countries of the Region with most comprehensive social insurance systems.

Among countries of the region there are large variations in the percentage of population covered by public health insurance programs as well as in the benefits received, measured by the level of per capita health expenditure per beneficiary. In El Salvador, Honduras, Guatemala and Nicaragua, less than 15 percent of the

population is covered by social health insurance schemes. In Nicaragua, only 7.7 percent of the total population is cover. It contrasts with the coverage of 60 and more than 70 percent of the population in the cases of Panama and Costa Rica. Variations across countries in the significance of expenditures as percentage of the GDP and in the level of expenditures per beneficiary indicates the variations of the benefits received by the beneficiaries of social insurance programs in different countries of the Region. The share of health expenditures by social insurance programs varies from a high level of 6.1 percent of the GDP in the case of Costa Rica, to less than 0.4 percent in the case of Honduras. The level of expenditure per beneficiary in Honduras is of around US$ 102 dollars with an average expenditure per beneficiary of US$ 720 dollars in the case of Costa Rica.

The distributive impact of public expenditures in health care services

The Distribution of the benefits of government expenditures in health care related goods and services is pro-poor in the case of Costa Rica; around 27 percent of the benefits of public expenditures is received by the 20 percent poorest quintile of the income distribution. Government expenditures in health were found to be pro-rich in the cases of Guatemala and Nicaragua. The richest 20 percent of the population received 25 percent of the benefits in the case of Nicaragua and 31 percent in the case of Guatemala. In the case of Honduras the distribution of the benefits of government expenditures is neutral (Table 6).

Table 6. Distribution of benefits of government expenditures on health indicators: Countries of region and average for the Latin America and the Caribbean

	Q1	Q2	Q3	Q4	Q5
Costa Rica; 1986*	27.7	23.6	24.1	13.9	10.7
Costa Rica, 1990 ***	27.0	-	-	-	13.0
Costa Rica, 2000	29.9	25.2	19.8	14.8	11.1
****	12.8	12.7	16.9	26.3	31.3
Guatemala;	22.0	-	-	-	15.0
1998/99*	10.0	-	-	-	25.0
Honduras, 1990 ***					
Nicaragua, 1990 ***	26.9	23.3	22.0	16.7	11.1
Average LAC a/**					

Sources: Suarez-Berenguela, R. *Health Systems Inequalities in Latin America and the Caribbean*, in Investment in Health: Social and Economic Returns; Scientific and Technical Publications No. 582. Pan American Health Organization, 2001. CEPAL. Equidad, desarrollo y ciudadanía; Versión definitiva; Comisión Económica para América Latina -CEPAL; Santiago, Chile, Agosto, 2000; Panorama Social de América Latina, 2000-2001; CEPAL, Santiago, Chile, 2001. Corbacho, A. and Davoodi, H. Expenditure Issues and Governance in Central America; IMF Working Paper (WP/02/187); Internacional Monetary Fund, Washington DC, November 2002.

* Estimates reported in Suarez-Berenguela, R. (2001) p. 142.
* * Estimates from CEPAL (CEPAL, 2000; CEPAL 2001). Quintiles, by level of income per capita. It includes government expenditures in Health and Nutrition.
*** Estimates reported in Corbacho and Davoodi (2002). P.21.
**** Estimates from Trejos (2000) reported in Picado, G. Gasto y Financiamiento de la Salud en Costa Rica: Situación actual, tendencies y retos (Versión Preliminar; 20/12/2002). Ministerio de Salud, Organización Panamericana de la Salud.

a/ Unweighted average using CEPAL estimates for 8 countries of the LAC region.
- : Data not available.

Large variations in the distributive impact of government expenditures in health care services and public health programs suggest that there in most countries of the region there is an ample room for improving the use of government expenditure as a tool for achieving a more equitable access to health care services. Data presented in this paper suggest that governments of countries of the Region, particularly those in low- income countries, have the potential to use more effectively existing fiscal tools to address health and equity issues:

Increasing the level of expenditures in health programs and health care services throughout public sector institutions, and improving the distributive impact of those expenditures.

D. Towards a regional integration of national health care systems: Challenges

Large differences among countries of the Region in the absolute and relative levels of national health expenditures in health care related goods and services, in the public-private mix of those expenditures, and in the way in which national health care systems are organized and financed posses a enormous challenges for harmonization of social policies in countries of the Region. These differences in the characteristics of health care markets in the different countries of the Region are only a reflection of the government commitments to address health and human development issues. Regardless of the reasons, there are marked differences in health status outcomes and scope of social protection programs, and on the use of government policies to address equity concerns.

Costa Rica and Panama are the two countries with the highest level of investment in health (and other forms of human capital such as education and training), with the most extensive scope of health insurance-social protection programs are the countries with better health outcomes. Also they are the countries of the Region with the fastest rate of economic growth, the only countries in which the long term rate of economic growth is above the average of countries of the LAC region.

Table 7 summarizes the life expectancy at birth and life expectancy of the population of 25 years of age. Also, it shows the difference in life expectancy among countries at birth and at 25 years of age for the period 2000-2005. Differences in the number of years of life expectancy at birth and at 25 years of

age are indicators of well being as well as of the duration of the investments in human capital.

Table 7. Economic growth and longevity of human capital: Life expectancy at birth and life expectancy at 25 years of age (2000 -2005); 2000

Countries	Rate of Economic growth a/ 1970-2000	Life Expectancy at Birth (Years)	Life Expectancy at 25 years of Age 2000-2005		Difference in Life Expectancy b/ Years	Difference in Life Expectancy at 25 years c/ 2000-2005 Years	
			Male	Female		Male	Female
Belice		74.4	-	-	-3.6	-	-
Costa Rica	1.9	76.7	51.7	56.0	-1.3	-0.2	-0.0
El	1.1	70.3	46.8	52.2	-7.7	-5.2	-3.8
Salvador	1.1	65.6	43.8	48.9	-12.4	-8.2	-7.1
Guatemala	0.5	65.8	48.7	52.7	-12.2	-3.3	-3.3
Honduras	-1.5	69.1	48.1	51.9	-8.9	-4.0	-4.1
Nicaragua	1.9	74.5	50.4	54.6	-3.5	-1.6	-1.4
Panamá							
Region		68.1			-9.9		

a/ Average rate of growth of the income per capita of the population.
a/ Life Expectancy of 78 years used as reference.
b/ Reference of 52 years of life expectancy for men and 56 years for women.
Sources: OPS Health Indicators, 2002. CELADE; Boletin Demográfico

The large difference in the living conditions and health status of the population of countries of the Region presents a major challenge for ensuring an equitable distribution of the gains from economic growth and for harmonization of social policies. The quality and longevity of human capital is one of the most important constraints for ensuring long term sustainable economic growth. Health of the population, the quality and longevity of human capital is one of the most important constraints for ensuring long term economic growth. Differences in morbidity and mortality rates, is a proxy variable to assess the quality and longevity of human capital. Longer life expectancy allows longer periods of accumulation of physical and human capital and allows intergenerational transfers of knowledge, skills. Also, it allows longer period of time over which the rate of returns on investments in human capital can be captures and

accumulated (investments in early child development programs, education, occupational skills, etc.).

Many countries of the Region are making a limited use of public policy instruments to improve health outcomes and to achieve a more equitable access to health care services. Level of public investments in health, in absolute terms and as percentage of the GDP, is lower than one observed in countries that once had similar level of income but achieved greater level of health, human development and economic growth. Low income countries of the Region are lagging behind in terms in the rate of investments in health and human development. The level of public expenditure as percentage of GDP of the last 20 years, since 1980, have been less than half of that of the countries with the better health outcomes, and with more extensive social protection systems.

Large variations in the distributive impact of government expenditures in health care services and public health programs suggest that there is an ample room for improving the distributive impact of government expenditures in health. Government of the countries of the Region have the potential to use more effectively existing public policy (fiscal) tools for increasing the level of investment in health and human development and to improve the distributive impact of those expenditures.