Introduction

This is an interim report based on the first year of a two-year research program (FY2006-2007) “Health Service and Poverty: Making Health Services More Accessible to the Poor”, conducted by the Institute of Developing Economies, IDE-JETRO, Japan.

Health is increasingly a critical concern in the context of poverty reduction. Poor people suffer most from ill health and disease; by the same token, people are more likely to fall into poverty because of ill health. Reflecting this vicious cycle of poverty and ill health, health is a focal issue in development. In fact, three of the eight Millennium Development Goals (MDGs) require substantial improvements in the health sector by 2015: reducing child mortality, improving maternal health, and combating HIV/ADIS, malaria and other diseases. Health is a priority goal in its own right, as well as a central input into economic development. The Commission on Macroeconomics and Health (CMH) focused on the link between health and economic development, and stressed the additional investment in health as well as the world commitment to improve the health of the poor.

Although international concern about health is increasing, health outcomes do not appear to be improving at a steady rate. Recent evidence shows that the MDGs relating to health are unlikely to be accomplished in many developing countries. A fundamental problem is that necessary and affordable services do not reach those in need. The most vulnerable are the least protected. What factors hinder the poor from accessing the health care services they need? Family characteristics, such as education level, have an effect on the behavior of the poor when they are seeking health care services, which is an issue on the demand side. Other issues are on the supply side, for instance in the provision of health goods and services, or in the financing of health systems. A limited capacity to provide health services in developing countries is a critical concern in the health sector and a major bottleneck for improving the access of the poor to health care services. This supply side issue is our underlying focus in this study.

A weak health system and inadequate health resources substantially reduce the capacity to provide health services in developing countries. The ability to raise adequate funds for health and to manage these appropriately is fundamental to the provision of

necessary and affordable health care services. It is an essential but tough challenge for developing countries to mobilize enough resources for health and to control financial risks against unpredictable health expenses. One important step is to establish a health insurance system. With a health insurance system, financial risks become predictable and will be spread among all the people covered by the insurance system. The key challenge is how to include the poor, who are often not employed in the formal sector of the economy, in an insurance system.

Chapter 1 retraces the experiences of Japan, which attained universal coverage with social health insurance in 1961. The origin of a health insurance system in Japan dates back to the early 20th century, when there was a form of community-based insurance in manufacturing factories. Fifty years later, Japan had achieved universal coverage with its social health insurance. A feature of the Japanese social health insurance system was its ability to include people who were not employed in the formal sector, since these people comprised a relatively large proportion of the total population. This feature distinguishes the Japanese experience with social health insurance from that of other developed countries, and it has important implications for developing countries.

In addition to an insurance system, other features of health financing also have a strong impact on the accessibility of services for the poor. Chapter 2 analyzes the financial barriers in accessing health care services based on the structural framework of the health financing system. The health financing system is composed of revenue collection, risk pooling, and purchasing. In particular, payment methods in purchasing create powerful incentives that influence the behaviors of sellers or buyers of health care services. Providers (sellers) will have strong incentives to provide excessive health care services under certain payment methods, whereas they tend to provide less care under other payment methods. Using a structural framework, this chapter examines the financial barriers in the Philippines, a country that has been implementing health financing reforms in recent years.

Together with insurance, governments and individuals are the major sources of health funding. Since private resources are very limited in developing countries, public resources (government) are supposed to provide the basis of health service funding. Local governments as well as central governments have important responsibilities for financing health systems. Chapter 3 sheds light on the intergovernmental alignment of

fiscal responsibility, in particular fiscal decentralization, which has become a major trend in developing countries. This chapter examines its impact on health as a case of China, where fiscal decentralization below the province level varies across provinces. The clue for improved health outcomes is to transfer adequate fiscal resources to the lower tiers of government as well as to strengthen their own fiscal capacity.

External resources provide additional funding for health services. In addition to official development assistance (ODA), the Global Health Partnership (GHP) has been increasing its importance as an external resource for health in recent decades. For instance, the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (The Global Fund/GFATM) raise substantial amounts of finance and play critical roles in improving health in developing countries. GHPs should have a significant impact on the attainment of health in targeted countries or the control over targeted disease; however, little study has examined their practical deployment across developing countries. Chapter 4 focuses on the recent activities of GHPs. One of the striking features is the high contribution of the Gates Foundation to the funds of GHPs. GHPs appear to concentrate on countries t hat bear a heavy burden of disease, but not necessarily on countries with better public governance.

Many GHPs actively work for the provision of necessary drugs and treatment in developing countries. The Global Fund, for instance, concentrates on financing the interventions against three focal diseases: AIDS, tuberculosis, and malaria. HIV/AIDS has become a devastating burden for developing countries. The Global Fund contributes to providing the most important treatment for HIV/AIDS, i.e., antiretrovirals (ARVs), for those in need in developing countries. This has a strong impact on procurement procedures and prices of ARVs. ARV procurement prices vary between countries (developing countries), but the mechanisms or major factors determining prices are not clear. Chapter 5 throws light on this issue by investigating the major determinants of ARV procurement prices. These prices and procedures will determine who can access ARVs. Appropriate procurement prices as well as efficient procedures will be crucial to improve the access of patients, especially poor patients, to this important treatment.

Medical personnel are another essential factor to ensure the provision of adequate health care services, but many developing countries face serious shortages of medical personnel. The emigration of health professionals from developing countries to

developed countries exacerbates the shortage. Emigration also appears to create a chain reaction between developing countries or within a developing country. Developing origin countries that lose medical personnel through emigration in turn become destination countries by receiving medical personnel migrating from 'less developed' developing countries. Within a developing country, medical personnel tend to move to urban areas and cities from rural areas where, in general, poor people suffer severely from the shortage of medical personnel.

When we consider the current world trend to expand trade in services and the increasing demand for medical personnel in aging developed countries, the issue of the migration of medical personnel will become increasingly important in the context of health service availability in developing countries. There is a need to emphasize policy coherence in line with pro-poor development. As a first step, Chapter 6 investigates the momentum for the migration of medical personnel and the forces driving this momentum in both origin and destination countries by focusing on the Philippines, South Africa, Saudi Arabia, and the United Kingdom. The first two are major origin countries, whereas the latter are major destination countries.

Chapter 7 presents methods for evaluating policy programs. It is essential to evaluate policy programs in order to modify these programs or apply other programs for the ultimate objective of improved health. In particular, it is important to evaluate programs empirically in order to provide conclusive evidence. This chapter will guide policy makers or researchers in selecting the appropriate methods for evaluating their programs.

February 28, 2007

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