

Oral Track 13- Health Equity

OT13-1

Is There Income-Related Differential Access to Medical Institutions Under NHI

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Recognizing the importance of health care in enhancing human capital quality, governments around the world have been dedicated to improving the efficiency and equity aspects of the health systems and better population health. Hence, assuring an equitable access to care has become an undeniable policy objective of NHI. This study is set forth to examine whether there is income-related differential access to different levels of medical institutions under NHI. In addition to the total number of visits, total medical expenditures and drug expenditures which represent service intensity were also examined. Index of horizontal inequity was employed to assess the equity distribution of health care use and the validity of the estimation results was improved with research variables profoundly constructed from exploiting 2001 National Health Interview Survey and a well-linked 2000-2003 NHI claim data. The study found that in terms of visit number and probability of use, the wealthy seem to have better access to more sophisticated medical centers and regional hospitals, and on the contrary, a pro-poor/proportional distribution is observed at district hospitals and clinics, after adjusting differences in health care needs. However, the poor are the big users of medical resources (in terms of total medical and drug expenditures) at medical centers and regional hospitals, but no statistically significant differences observed at the district hospital. The results seem to suggest that the wealthy people have better access to more sophisticated medical institutions, but the poor who showed up at medical centers tend to be sicker and incur higher expenditures.

OT13-2

A Four-Year Follow-Up Survey on the Influences to the Health Output Equity from the New Rural Cooperative Medical System

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Objective: To study the dynamic changes of influences to the health output equity from the new -type rural cooperative medical system(CMS) through comparing the base-line investigation with the three follow-up investigations. Offer the scientific basis for improving the implementation plan of the new-type rural CMS. **Methods:** The multi-phase stratified random sampling has been adopted to select 3 sample counties, 9 townships, 27 administrative villages, about 1890 families as the study objects and carry out household investigation for four consecutive years. Put the four

surveys' results for a longitudinal comparative study. Use the concentration index (CI) , slope index of inequity (SII) to evaluate the health output equity. Results: Two weeks prevalence rate, half years chronic diseases prevalence rate, two weeks working (studying) suspended rate of four surveys all show descending tendency. The CI absolute values of two weeks prevalence rate, half years chronic diseases prevalence rate are less than 0.2 and of two weeks working (studying) suspended rate and days, two weeks bed rate and days are less than 0.3. The SII absolute values of two weeks prevalence rate 、two weeks working (studying) suspended rate and days all show descending tendency, but the CI and SII absolute values of half years chronic diseases prevalence rate show ascendant tendency. Conclusion: The peasants' health output equity is good. The implementation of the new-type rural CMS has some effect on peasants' health output equity, mainly in positive effects.

OT13-3

Catastrophic Payments and Coping Associated with Household Spending Due to Acute Coronary Syndrome in Kerala, India

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Background: India had the highest number of deaths attributed to coronary artery disease (CAD) in 2002. Out-of-pocket expenditure data related to Acute Coronary Syndrome (ACS), the major cause of deaths in CAD, are not available. We estimated out-of-pocket expenditure, catastrophic health spending (CHS) and coping strategies for the treatment of ACS. **Methods:** Using stratified random sampling 210 ACS patients (mean age 56 yrs, 83% men) were selected from six hospitals in Trivandrum district. Information on demographics, ACS-related and household consumption expenditure and financing options was collected using a pre-tested structured interview schedule. CHS was estimated using the 40% threshold methodology. Multiple linear and logistic regression analyses were conducted to identify the correlates of proportionate out-of-pocket expenditure and CHS respectively. **Findings:** Patients from low socioeconomic status (SES), treated with any intervention procedures and without any health security coverage had significantly higher proportionate out-of-pocket expenditure compared to their counterparts ($p < 0.001$). Compared to their counterparts, patients who belonged to low SES were 15 times [(odds ratio (OR) 14.51, 95% CI: 1.69-124.41)], whose jobs were adversely affected were seven times (OR: 7.21, CI: 1.54-33.80), who had no health security were six times (OR: 6.00, CI: 2.02-17.81) and who underwent any intervention were three times (OR: 3.24, CI: 1.03-10.16) more likely to have CHS. Unsecured loans, assistance/gifts, savings and mortgage of assets