

Depressive symptoms were significantly decreased among case group ($p=0.007$).

Conclusion: Although the mechanism of influence of oral function training on mental health is unclear, oral function training were related to declining the depressive symptoms. For further study, longer period intervention and examination of association between oral function and mental health will be needed.

FP-046

The Association between the Mental Health and the Oral Functions

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Introduction: The mastication for enjoyment of food and the speaking for communication with other people are the important oral functions. Hence, the disability of these factors could be associated with impaired health outcome, especially mental health problems. This study investigated whether disabilities of mastication and speaking are associated with mental health problems. **Methods:** The data were derived from National Health and Nutrition Examination Survey (KNHANES, 2007) conducted in Korea. Only subjects from the KNHANES's over 20- years of age (3335 persons, 72%) were included in this study. The multiple logistic regression models were used to examine the associations between mental health outcomes and oral functions, adjusted for the confounders such as gender, age, TMD (Temporomandibular Disorder), and household income. **Results:** In the multiple logistic regression models, the disability of mastication was significantly associated with high stress (OR=1.33, 95% CI 1.09-1.62), depression during recent two weeks (OR=1.64, CI 1.21-2.24), and impulse of suicide during recent a year (OR=1.82, CI 1.37-2.42), respectively. In addition, disability of speaking was significantly associated with mental health problems (OR for high stress=1.54, CI 1.19-1.98; OR for depression during recent two weeks=2.17, CI 1.65-2.86; and OR for impulse of suicide during recent a year=1.87, CI 1.38-2.55). **Discussion:** The disabilities of oral functions such as mastication and speaking could be related to mental health problems.

FP-047

Policy Analysis on Health Care Inequality among Internal Migrants in Ulaanbaatar, Mongolia

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Rationale: As it is stated in the New Constitution, approved in 1992, a Mongolian citizen is entitled to enjoy the right to choose the place to live. This right of citizens led to rapid migration flow to Ulaanbaatar city

from the rural provinces which had influences, overburdening of the health care service and precipitation of health care inequalities in the urban areas. **Methodology:** "Eight Step Path of Policy Analysis" was used. Incidence of some health indicators, health care service accessibility, legal acts, government policies, survey reports and articles from scientific journals were consulted. **Objective:** To reduce inequality of health care service among in-migrants from rural area to capital city of Ulaanbaatar with proper policy. **Result:** There is more morbidity rate in Ulaanbaatar since burden internal migration. Poverty, lack of awareness, lack of knowledge of migrants is the main issues of health care inequality in Ulaanbaatar. On the other hand, structural or bureaucratic procedures, poor infrastructure, and informal payments are influencing in it. As seen the findings, there is no efficient method to reduce health inequalities among migrants in Mongolia. Certain policy options were selected from international experience. Those policy options were evaluated by the criteria as accessibility, costliness, effectiveness, and implementation. By projecting the outcomes National Health Inequality Report is the best option for initiating to reduce health care access inequality. **Conclusion:** Hence, we suggest that the first priority should be given to solidifying the National Health Inequality Report, based on the analysis of policy options conducted in the paper.

FP-048

Analysis of Equity Deployment Policy on Practitioner and Dentist in Indonesia Year 2009

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Since 1992, the temporary placement policy of general practitioner and dentist (PTT) has been applied albeit its distribution is not satisfying yet. Approximately 25 - 40% of local health centers do not have general practitioner, especially those in eastern part of Indonesia and regional conflict. Within it ideal ratio where 40 general practitioners served 100,000 inhabitants, only 3 provinces could fulfill it.

This is a qualitative approach research aim of analyzing the central government policies on equity distribution of general practitioners and dentists in Indonesia. In this research, data used consists of primary obtained through in-depth interview and secondary data obtained through the document assessment. Primary data gathered from various competent informants, namely the Bureau Employee Affair of Health Department, Bureau of Legal and Organization Affairs of Health Department, The Center of Human Resource Planning and Utility of Health, PPSDM Agency of Health Department, Medical Council of Indonesia, the General Directorate of High Education Ministry, the Indonesian Association of medical doctor, and the Dentist Association of Indonesia.

The results of research showed that this policies fall into a dilemma in the middle issue of human rights violations, while in the other side people need a health care without distinction on economic status. Coordination between stakeholders at the central level is not optimal yet, particularly in the policies preparation and monitoring on the policy implementation.

FP-049

Inequities in Health and the Concept of Structural Violence

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Social inequities in health are systematic, man-made, unjust and changeable. They constitute a violation of human rights - a discrimination of people with regard to income, education, and/or professional status. Peace science has formed the concept of structural violence. It is defined as socio-economic and political structures violating basic human needs. Structural violence kills, injures and halts development on a much larger scale than direct violence does. Any society where structural violence is predominant will therefore not be a peaceful one. Structural violence has also the potential of turning into social conflicts with the risk of escalation. This paper discusses the relationship between health inequities and structural violence on three different levels: Health inequities as symptom and indicator for structural violence, inequitable access to health care as one form of structural violence, and health deficits caused by violent structures as irreconcilable with health workers' values and ethics. The paper will reflect on the special role and responsibility of health professionals in the documentation and diagnosis of structural violence, in the reduction of social inequities within the health system, and in advocacy for social welfare and human rights protection. Furthermore, it will be explored how useful it is to introduce the concept of structural violence into the domain of public health.

FP-050

Access to Health Care

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Especially addressing a fair access to health care, both on national and on international level, with the aim of reducing social inequality, national legislatures must break with the tendency to go no further than declarations of intention, stipulation of national targets or, at best, statements of commitment on government level. When it comes to the application or enforcement of the law, or to any hypothetical legal claims based on the declaration of a fundamental human right to health, it is essential that this right be transposed into the law of the individual country, just as it will be necessary, as a next

step, to equip the right to health at national level with the appropriate legal mechanisms that enable the individual to assert his or her rights. At the moment, this means that neither experts working in the health care system, for whom a fundamental national right to health would be a highly significant institution with a view to the concretisation of health care provisions on the level of simple law, nor persons who wish or are compelled to take advantage of the services of the health care system, are in a position to appeal to 'hard law'. The in-depth structure of the society or of the individual state has to be adequately decrypted, modified or further developed. Currently, it is impossible for actions to be conceived in their process-related character. Everything circles around access to health care institutions.

FP-051

Health Promotion and Health Equity: The Role of Higher Education

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Ottawa Charter in 1986 has stated that health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing. One of the five major strategies is healthy public policy that establishes the environment that makes the other four possible. Therefore, healthy public policy is a pre-requisite for successful health promotion. A Healthy Public Policy is characterized by a concern for health and equity and accountability for health impact. Health should be made a priority item on the agenda of policy-makers in all sectors. Policy-makers should be made aware of the health consequences of their decisions. They should create pro-health policies, whether in the area of development, legislation, taxation etc. Consequently, the fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites. The paper discuss about the role of higher education in enhancing health promotion practice to reach health equity for community at large.