Household Health Expenditure In Two States A Comparative Study Of Districts In Maharashtra And Madhy

National Medical Expenditure Survey, 1987
The Willingness to Pay for Medical Care
Healthcare Expenditure in China
The Concentration in Health Expenditures Over a Two Year Time Interval, Estimates for the U.S. Population, 2005-2006
Good Practices in Health Financing
How Does Family Health Care Use Respond to Economic Shocks?
The Economics of New Health Technologies: Incentives, organization, and financing
assessing asset indices
Household Health Expenditure in Yanam Region, India
Expenditures on a Child by Families
Heterogeneous Effect of Health Insurance on Financial Risk
How Useful Are Benefit Incidence Analyses of Public Education and Health Spending
Household Health Expenditure in Two States
National Medical Expenditure Survey, 1987
Analyzing Health Equity Using Household Survey Data
Short But Not Sweet: New Evidence on Short Duration Morbidities from India
The Bumpy Road to Universal Health Coverage
Catastrophic and Impoverishing Effects of Health Expenditure
The Economics of Tax and Social Security in Japan
National Health Account Implementation in Viet Nam
Twenty Years of Health System Reform in Brazil
Health Expenditure in India - Private and Public Dynamics
Essays on Household Saving Rates
Household Healthcare Expenditure in Bangladesh
The Impact of National Health Insurance Program on Household Health Expenditures and Utilization of Health Services in Indonesia
Health Care Policy In East Asia: A World Scientific Reference (In 4 Volumes)
China
Benefit Incidence of Public Education, Health and Welfare spending in Thailand
Issues on Health and Healthcare in India
Health Care Use and Financial Burden of Out-of-Pocket Spending in Argentina
The Role of Health Insurance, Borrowing and Aids to Pay for Health Care on Reducing Catastrophic Health Expenditure in Indonesia
Modelling Household Expenditure on Health Care in Greece
Vulnerability in Consumption, Education, and Health
Disease, Human Health, and Regional Growth and Development in Asia
National Health Accounts for Uganda
Short But Not Sweet
Measuring Financial Protection in Health
Paying Out-of-Pocket for Drugs, Diagnostics and Medical Services
A Summary of Expenditures and Sources of Payment for Personal Health Services from the National Medical Care Expenditure Survey

BELTRAN HUERTA

National Medical Expenditure Survey, 1987 World Bank Publications
It has been more than 20 years since Brazil's 1988 Constitution formally established the Unified Health System (Sistema Unico de Saude, SUS). Building on reforms that started in the 1980s, the SUS represented a significant break with the past, establishing health care as a fundamental right and duty of the state and initiating a process of fundamentally transforming Brazil's health system to achieve this goal. This report aims to answer two main questions. First is have the SUS reforms transformed the health system as envisaged 20 years ago? Second, have the reforms led to improvements with regard to access to services, financial protection, and health outcomes? In addressing these questions, the report revisits ground covered in previous assessments, but also brings to bear additional or more recent data and places Brazil's health system in an international context. The report shows that the health system reforms can be credited with significant achievements. The report points to some promising directions for health system reforms that will allow Brazil to continue building on the achievements made to date. Although it is possible to reach some broad conclusions, there are many gaps and caveats in the story. A secondary aim of the report is to consider how some of these gaps can be filled through improved monitoring of health system performance and future research. The introduction presents a short review of the history of the SUS, describes the core principles that underpinned the reform, and offers a brief description of the evaluation framework used in the report. Chapter two presents findings on the extent to which the SUS reforms have transformed the health system, focusing on delivery, financing, and governance. Chapter three asks whether the reforms have resulted in improved outcomes with regard to access to services, financial protection, quality, health outcomes, and efficiency. The con
The Willingness to Pay for Medical Care World Bank Publications
This book addresses health and healthcare issues in India with a special focus on the Northeast region. Pursuing a multidisciplinary approach, it highlights key issues in health and healthcare and outlines the actions needed to achieve the desired results in these areas as laid out in the UN Millennium Development Goals. In addition to introducing some new questions on health and healthcare development, it presents cross-country analyses, and examines the convergence of healthcare across Indian states, as well as mortality and morbidity in the Northeast. The book also explores the regional complexities involved in the discussion of these topics. It presents a number of specific techniques, such as two-level logistic regression, analysis of mental health, probabilistic and predictive analysis of nutritional deficit, and generalized linear mixed models, that can be used to analyze mortality and morbidity and factors affecting out-of-pocket expenses in the healthcare context. Lastly, it presents concrete case studies substantiating the theoretical models discussed. As such, the book offers a valuable resource for health researchers, professionals and policymakers alike.
Healthcare Expenditure in China World Bank Publications
This book integrates the fundamentals of quantitative significance, using existing estimates of the elasticities of demand for tax, health insurance, and medical services in a static microsimulation model. It serves as a guide to the financial and social basics of health insurance and provides the reader with the intellectual groundwork indispensable for understanding the incorrect assumptions about the elasticities of demand and pattern of tax and health insurance. Most countries feel constant pressure because expenditure is increasing and resources are scarce. The topics addressed in this book including several frameworks leading to over-insurance, excess demand for medical care, and rapid expenditure growth in the medical care sector. Illustrated by carefully chosen examples and supported by extensive data analyses, this book is highly recommended to readers who seek an in-depth and up-to-date integrated overview of the ever-expanding theoretical and quantitative fields of containing costs, increasing funding for health services, or both.
The Concentration in Health Expenditures Over a Two Year Time Interval, Estimates for the U.S. Population, 2005-2006 World Scientific
Have gaps in health outcomes between the poor and better off grown? Are they larger in one country than another? Are health sector subsidies more equally distributed in some countries than others? Are health care payments more progressive in one health care financing system than another? What are catastrophic payments and how can they be measured? How far do health care payments impoverish households? Answering questions such as these requires quantitative analysis. This in turn depends on a clear understanding of how to measure key variables in the analysis, such as health outcomes, health expenditures, need, and living standards. It also requires set quantitative methods for measuring inequality and inequity, progressivity, catastrophic expenditures, poverty impact, and so on. This book provides an overview of the key issues that arise in the measurement of health variables and living standards, outlines and explains essential tools and methods for distributional analysis, and, using worked examples, shows how these tools and methods can be applied in the health sector. The book seeks to provide the reader with both a solid grasp of the principles underpinning distributional analysis, while at the same time offering hands-on guidance on how to move from principles to practice.
Good Practices in Health Financing International Monetary Fund
This dissertation is devoted to understanding household saving rates of the two largest countries in the world - China and the United States. The first two chapters explain why the Chinese elderly save at extraordinarily high rates and the third chapter explains why the U.S. personal saving rate has been falling since 1980's. Chapter 1 explores the potential explanation of the high saving rates of the Chinese elderly. The high saving rate of China has attracted global attention. Furthermore, the saving rates of the Chinese elderly are especially high. Understanding why the elderly in China save at high rates is important for two reasons: (1) it partially explains the high aggregate saving rate in China, and (2) the fact that the elderly save more than the middle-aged contradicts the predictions of the life-cycle model. In this chapter, I present evidence that pension income is the primary explanation for the high saving rates of elderly Chinese households. I provide this evidence in two steps. First, I document three stylized facts that are consistent with this hypothesis: (1) saving rates are higher in years with higher pensions, (2) saving rates are higher for those with more generous pension plans, and (3) policy reforms that exogenously increase pensions also increase saving rates. However, a higher pension income on its own cannot explain the entire pattern because a household can simultaneously adjust its consumption. Therefore, in the second step, I demonstrate that concerns regarding future medical expenditures and bequest motives can explain why households do not increase their consumption commensurate with increases in pension income. In Chapter 2, I build and estimate a dynamic life cycle model for two purposes. The first is to quantify the effect of pension income. The second purpose is to carry out counterfactual policy simulations. The model is a standard life-cycle model with three main components. First, pension income is properly modeled to capture the increase observed in the data. The second part of the model is about uncertainty. In the model, I cover income uncertainty, health status and medical expenditures as the main source of uncertainty for the elderly. Finally, individuals have bequest motives. I estimate the model using the method of simulated moments. The estimation results show that it is possible to match the data with reasonable parameters. It is noteworthy that the estimated degree of relative risk aversion for the

Chinese elderly is similar to that of U.S. population in other studies. This implies when factors including pension income, medical expenditures and bequest motives are properly taken into account, it is not necessary to assume Chinese elderly to be highly risk averse to explain their high saving rates. With the model, I am able to carry out various policy simulations. The most interesting simulation is if the Chinese pension and economy growth rate becomes similar to those in the United States, the saving rates of the Chinese elderly will fall to the level of the U.S. Chapter 3 is a joint work with Maurizio Mazzocco and Bela Szemely. In this chapter we provide evidence that most of the decline in the U.S. personal saving rate from 9 percent in the early eighties to 2 percent in 2007 can be explained by the steep increase in health expenditure experienced by the U.S. economy during the same period. The most convincing evidence is provided using the FDA approval of new drugs as a source of exogenous variation in medical expenses. Employing this source of variation, we find that a 1 percentage point increase in health expenditure generates a decline in the U.S. saving rate that is between 0.58 and 0.67 percentage points. Using this result, we calculate that the rise in health expenditure explains about 83 percent of the drop in the U.S. saving rate. To evaluate whether households changed their consumption decisions to mitigate the effect of higher medical expenses, we develop a stylized model of household's and government's decisions. Using the model jointly with our empirical results, we find that the households' response to the rise in health expenses was negligible. This is why the saving rate dropped by a significant amount. Finally, with the objective of better understanding why households did not respond, we provide evidence on how the increase in medical expenditure was funded. We find that it was paid almost exclusively by an increase in government debt, a reduction in other government expenses, and an increase in employer contributions to health funds. The main implication of these findings is that the households were barely affected by the rise in health expenditure. The households' negligible response was, therefore, rational.

How Does Family Health Care Use Respond to Economic Shocks? World Bank Publications

One of the major challenges for health systems is to ensure that everybody has access to needed care without facing catastrophic payments or impoverishment. Argentina is middle income country that has experienced remarkable transformations in income distribution and inequality in the last decade. The health sector as the rest of the economy has suffered from the deterioration of the living conditions during the last years of the 1990s, ending up in an economic crisis at the end of 2001. Objectives: This paper aims at identifying the impact of these changes, mainly between 1997 and 2002, on access to health services and on financial risk protection across population, in particular of vulnerable groups. Methodology: Data used in this study come from three different surveys, namely National Survey on Household Expenditure 1996/1997, Conditions of Life Survey 1997 and World Bank Survey 2002. All surveys are nationally representative. Multinomial Logit regression model has been used to explore the determinants of health service utilization and Logit regression model for determinants of catastrophic health expenditure. Financial catastrophe is defined as out-of-pocket expenditure for health equal to or exceeding 40% of total household non-subsistence spending. Results: Insurance coverage decreased from 63% in 1997 to 56% in 2002. Health care utilization is clearly linked to income. Richer individuals are more likely to use both social health insurance and private health facilities and are less likely to use public facilities, which may indicate that the perception of poor quality of care in public health facilities leads people to turn to private health care as soon as they can afford it. For those who had used health services, the required out-of-pocket payments placed a heavy burden to households. The level of catastrophic expenditure has diminished from 1997 (5.5%) to 2002 (3.6%). One reason could be the reduction in the use of health care for low and low-middle income households. The study identifies good reasons to believe that households with elderly members are the most likely to face financial difficulties due to out-of-pocket payments. Neither in 1997 nor in 2002 there is evidence that households covered by social health insurance are less likely to face catastrophic expenditure. The low-middle income groups appears to have high proportion of household with catastrophic expenditure in both years. Conclusions: In summary, the required out-of-pocket payments for health care in Argentina result in some household facing financial catastrophe, some household being pushed into poverty and some others forwent needed care. Therefore, special attention should be paid to the elderly population and to improvements in the quality of public facilities and in the extension of the social health insurance coverage and its degree of financial protection, specially for low and middle-low income groups.

The Economics of New Health Technologies: Incentives, organization, and financing Household Health Expenditure in Two StatesHealth Expenditure in India - Private and Public Dynamics

This paper provides a primer on benefit incidence analysis (BIA) for macroeconomists and a new data set on the benefit incidence of education and health spending covering 56 countries over 1960-2000, representing a significant improvement in quality and coverage over existing compilations. The paper demonstrates the usefulness of BIA in two dimensions. First, the paper finds, among other things, that overall education and health spending are poorly targeted; benefits from primary education and primary health care go disproportionately to the middle class, particularly in sub-Saharan Africa, HIPCs and transition economies; but targeting has improved in the 1990s. Second, simple measures of association show that countries with a more propoor incidence of education and health spending tend to have better education and health outcomes, good governance, high per capita income, and wider accessibility to information. The paper explores policy implications of these findings.

assessing asset indices Archers & Elevators Publishing House

Families in constrained economic circumstances resulting from economic shocks face difficult choices regarding how best to spend their diminished resources. As families strive to preserve their living standards, decisions regarding health care use and its allocation among family members may become more discretionary and complex. Using two-year panel data from the Medical Expenditure Panel Survey for 2004 to 2011, we examine how the intra-family allocation of health care spending responds to realized and anticipated changes in family economic status. We focus on the share of total family health care spending allocated to children, and measure realized economic shocks based on changes in the family's income, employment, and health insurance status. We account for anticipated economic shocks by differentiating families by whether they are observed prior to, at the onset of, or during the Great Recession, or in the post-recession period. Our findings suggest that both types of economic shocks affect the share of family health care spending allocated to children, with findings more pronounced for single-mother families. We also find that realized economic shocks have a greater impact on children's spending share than the anticipated change in economic status associated with the Great Recession and its recovery.

Household Health Expenditure in Yanam Region, India World Bank Publications

During the past three decades, health care systems in the East Asian regions of China, Japan, South Korea, and Taiwan have undergone major changes. Each system has its unique achievements and challenges. Global health care policymakers are increasingly interested in understanding the changes that have taken place in these four systems. This four-volume reference set is designed to help health care professionals, academics, policymakers, and general readers gain a good grasp of the background and latest developments in the health care systems of China, Japan, South Korea, and Taiwan. This reference set provides an in-depth comparative health policy analysis and discussion of health care reform strategies in each of these systems. One unique feature of this set is that each volume has been edited by a leading scholar who has been deeply involved in the development of the health care system in that particular region. Each of these editors also has invited both scholars and practitioners to provide a first-hand description and analysis of key health care reform issues in that system. The many examples provided in each volume demonstrate how findings of evidence-based policy research can be implemented into policy practice.Volume 1 describes and discusses China's ambitious and complex journey of health care reform since 2009. The Chinese government has achieved universal health insurance coverage and has embarked on reforms of the service delivery system and provider payment methods that are aimed at controlling health expenditure growth and improving efficiency. This volume includes pilot and social experiments initiated by the government and researchers and their evaluations that have guided the formulation of health reform policies. It provides information on how to make reforms work at the local and provincial levels. The findings detailed in this volume will contribute to a global knowledge base in health care reforms.Volume 2 provides a comprehensive review and evaluation of the Japanese health care system. Japan has a long history of health care system development and provision of universal health coverage, with a mature and well-developed health care system among East Asian countries. However, due to increases in health care costs, economic stagnation and the country's rapidly aging population, Japan has undergone significant health care reform during the last two decades, both in the delivery as well as financing of health services in its hospital sector, medical technology sector and long-term care insurance. Despite these challenges and reforms, health outcomes among the Japanese population have been progressively among the best in the world. This volume shows how policy research can lead to policy analysis, implementation and assessment. It also provides valuable lessons learnt for mutual learning among other health care systems.Volume 3 offers a comprehensive review of the developments in South Korea's national health insurance system since 1989 in terms of financing, delivery systems, and outcomes. The volume analyzes the efficiency of cost and service delivery by public sectors versus private sectors. It points out areas of challenge to future Korean health care reform. Chapter authors in this volume are leading experts involved in Korean health care policy implementation.Volume 4 reviews the development and achievements of Taiwan Health Insurance since 1995. Because of its continuous reform in payment, services delivery, and pharmaceutical technology, Taiwan has been considered a model example of universal health insurance among global health systems. This volume shows the processes used to translate policy research findings into policy changes. While the health care reform in Taiwan is ongoing, the Taiwan example provides a real-world and practical understanding of health care system changes.In summary, this four-volume set makes an outstanding contribution to health care system reform and policy research, based on solid scholarly work. It also introduces policy researchers and academic communities to current debates about health systems, health financing, and universal health coverage. This reference volume is a must for anyone keen on East Asia's health care system reform dynamics and changing scene.

Expenditures on a Child by Families Springer

Investment on health has a direct, positive and significant influence on the economic growth of an economy. Secondly, research on Health Economics has a recent origin and whatever the works available on it are mainly on macro aspects. Little attention has been given to the micro aspects of it by the researchers, government, policy makers and development planners. In this context the present piece of work is an attempt to study the pattern of health expenditure as a component of income and consumption expenditure across different income groups; to examine the impact of income and education on household health expenditure (HHE); and to find out the gender bias in HHE in Yanam, India. The study is based on primary data collected from Yanam. Simple random sampling method is used to select the households. To substantiate the objectives descriptive statistics and multiple regression techniques are used. Income has significant influence on household health expenditure where as the impact of education is insignificant. Both male health expenditure and female health expenditure also have significant influence on household health expenditure but female has more influence on it than male.

Heterogeneous Effect of Health Insurance on Financial Risk Springer

Health expenditure data are known to be afflicted by restricted range, zero values, skewness and kurtosis. Several methods for modelling such data have been suggested in the literature to cope with these problems. This paper compares the performance of several alternative estimators, including two-part models and generalized linear models. The dependent variable is household, not individual, expenditure on health care in Greece, a country where out-of-pocket health expenditure is higher than anywhere else in the European Union, whether as a proportion of GDP, as a share of all health spending, or in per capita terms. To facilitate comparison of model performance, household health expenditure is examined in two different specifications: expenditure on all health care (where zero values are rare) and expenditure on hospital services alone (where zero values are common). Three of the estimators performed almost equally well in terms of mean square error and mean absolute prediction error: a modified two-part model with non-linear least squares in the second part, a constant-variance generalized linear model, and a varianceproportional-to-mean generalized linear model. The findings suggest that no estimator is best under all circumstances, while most alternative estimators produce similar results. The paper concludes by discussing implications for further research.

How Useful Are Benefit Incidence Analyses of Public Education and Health Spending GRIN Verlag

Background: Indonesia has implemented social security program through Government-run health insurances through PT. ASKES for civil servants and pensioners, PT. JAMSOSTEK for private employees, provided Community Health Insurance scheme (JAMKESMAS) and Regional Health Insurance (JAMKESDA) for the poor. Since 2014 central government has implemented JKN (jaminan Kesehatan Nasional or National Health Insurance) scheme which basically merged all various government-run social security for health in a single Social Security Agency namely BPJS(Badan Penyelenggara Jaminan Sosial). This study examines the impact of JKN implementation on households health expenditure and health care utilization by comparing before and after the implementation of JKN in 2014 using IFLS (Indonesian Family Live Survey) 2007 and IFLS 2014 data. Method: This study was an analytical study based on quantitative data using two panel data from IFLS (Indonesian Family Life Survey) or IFLS-4 2007dan IFLS-5 2014, by using univariate, bivariate, multivariate regression method and fixed effects regression analysis.Result: Compared to situation in 2007, the implementation of National Health Insurance (JKN) in 2014 had impacted on improving utilization of health care facilities. On the other hand, social determinant factors such as increasing household income, education level of household heads, having family members aged 65 old and above, having children below five years old, increasing health needs in 2014, resulted in increasing household health expenditure in Indonesia. JKN also has no significant impact on reducing catastrophic health expenditure. Conclusion: Health insurance program in Indonesia had significant impacted on increasing utilization of health facilities, but had no significant impacted in reducing household health expenditure in Indonesia.

Household Health Expenditure in Two States Springer Science & Business Media

Public Use Tape 9 contains the initial release of data from two supplementary parts of the 1987

National Medical Expenditure Survey's Household Survey : the Health Status Questionnaire, and the Access to Care Supplement. The file provides person-level data for all those respondents (other than infants less than one year of age) with both information for their entire period of 1987 survey eligibility (Rounds 1-4) and valid data on a minimum set of items in both the Health Status Questionnaire and Access to Care Supplement. The minimum items were : perceived general health status, at least one question on availability and characteristics of a usual source of medical or dental care, all items in the checklists of chronic conditions (for adults aged 18 and over), at least one question on screening for breast and cervical cancer (for adult females), and all questions on immunizations (for children aged 1-17). The Health Status Questionnaire was administered in three age-specific versions between Rounds 1 and 2 of the interviews. Adults aged 18 and over responded for themselves and for children aged 5-17 and under 5 years in their families. The Questionnaire contained items concerning self-assessments of current and past health status, acute and chronic conditions, vision and hearing, dental status, mental health and functional ability, and health-related behaviors such as care-seeking and preventive care. The Access to Care Supplement was administered to all eligible household respondents during Round 3 interviews, and covered access to and usual sources of medical and dental care. For medical providers identified as a usual source of care, information was sought on their specialty, sex, race/ethnicity, and on availability and convenience in terms of hours of practice, travel and waiting times, and related items. Other topics in the Access to Care ... Cf. : http://webapp.icpsr.umich.edu/cocoon/ICPSR-STUDY/09674.xml.

National Medical Expenditure Survey, 1987 LAP Lambert Academic Publishing

Abstract: This paper compares how results using various methods to construct asset indices match results using per capita expenditures. The analysis shows that inferences about inequalities in education, health care use, fertility, child mortality, as well as labor market outcomes are quite robust to the specific economic status measure used. The measures-most significantly per capita expenditures versus the class of asset indices-do not, however, yield identical household rankings. Two factors stand out in predicting the degree of congruence in rankings between per capita expenditures and an asset index. First is the extent to which per capita expenditures can be explained by observed household and community characteristics. In settings with small transitory shocks to expenditure, or with little measurement error in expenditure, the rankings yielded by the alternative approaches are most similar. Second is the extent to which expenditures are dominated by individually consumed goods such as food. Asset indices are typically derived from indicators of goods which are effectively public at the household level, while expenditures are often dominated by food, an almost exclusively private good. In settings where private goods such as food are the main component of expenditures, asset indices and per capita consumption yield the least similar results, although adjusting for economies of scale in household expenditures reconciles the results somewhat.

Analyzing Health Equity Using Household Survey Data Linköping University Electronic Press

Technological change in healthcare has led to huge improvements in health services and the health status of populations. It is also pinpointed as the main driver of healthcare expenditure. Although offering remarkable benefits, changes in technology are not free and often entail significant financial, as well as physical or social risks. These need to be balanced out in the setting of government regulations, insurance contracts, and individuals' decisions to use and consume certain technologies. With this in mind, this book addresses the following important objectives: to provide a detailed analysis of what technological change is; to identify drivers of innovation in several healthcare areas; to present existing mechanisms and processes for ensuring and valuing efficiency and development in the use of medical technologies; and to analyse the impact of advances in medical technology on health, healthcare expenditure, and health insurance. Each of the seventeen chapters summarizes an important issue concerning the innovation debate and contributes to a better understanding of the role innovation has both at the macro level and at the delivery (meso) and micro level in the healthcare sector. The effectiveness of innovation in improving people's welfare depends on its diffusion and inception by the relevant agents in the health production process, and this book recognizes the multi-faceted contribution of policy makers, regulators, managers, technicians, consumers and patients to this technology change. This book offers the first truly global economic analysis of healthcare technologies, taking the subject beyond simply economic evaluation, and exploring the behavioural aspects, organization and incentives for new technology developments, and the adoption and diffusion of these technologies.

Short But Not Sweet: New Evidence on Short Duration Morbidities from India World Bank Publications

Abstract: Health systems are not just about improving health: good ones also ensure that people are protected from the financial consequences of receiving medical care. Anecdotal evidence suggests health systems often perform badly in this respect, apparently with devastating consequences for households, especially poor ones and near-poor ones. Two principal methods have been used to measure financial protection in health. Both relate a household's out-of-pocket spending to a threshold defined in terms of living standards in the absence of the spending: the first defines spending as catastrophic if it exceeds a certain percentage of the living standards measure; the second defines spending as impoverishing if it makes the difference between a household being above and below the poverty line. The paper provides an overview of the methods and issues arising in each case, and presents empirical work in the area of financial protection in health, including the impacts of government policy. The paper also reviews a recent critique of the methods used to measure financial protection.

The Bumpy Road to Universal Health Coverage Johns Hopkins University Press

Household Health Expenditure in Two StatesHealth Expenditure in India - Private and Public DynamicsArchers & Elevators Publishing HouseModelling Household Expenditure on Health Care in Greece

Catastrophic and Impoverishing Effects of Health Expenditure OUP Oxford

The 1987 NMES provides information on health expenditures by or on behalf of families and individuals, the financing of these expenditures, and each person's use of services. The Household Survey is one of the three major components of the 1987 National Medical Expenditure Survey (NMES). (The other two components are the Survey of American Indians and Alaska Natives [SAIAN] and the Institutional Population Component.) The Household Survey was fielded over four rounds of personal and telephone interviews at four-month intervals. Baseline data on household composition, employment, and insurance characteristics were updated each quarter, and information on all uses of and expenditures for health care services and sources of payment was obtained. Public Use Tape 14.2 provides two fichiers containing information on expenditures for formal home health care and the purchase or rental of medical equipment, supplies, and other medical items. The Home Health Care file contains information on each person in the Household Survey using these services in 1987. Each record is restricted to the set of formal services provided during the year by each type of provider sent by each unique agency furnishing home health care. This file provides person-level demographic information such as age, sex, and race, and information on household-reported medical conditions associated with the use of home health care. The Medical Equipment and Supplies file contains one record per type of medical item for each eligible person in the Household Survey who reported having purchased, rented, or otherwise obtained such items. This file also provides person-level demographic information, and medical condition and date of purchase variables ... Cf. : http://webapp.icpsr.umich.edu/cocoon/ICPSR-STUDY/09944.xml.

The Economics of Tax and Social Security in Japan International Monetary Fund

Background: Sizable out of pocket payment for health care make a hardship financing for many families and this will lead to a catastrophic expenditure. To pay health services that exceed the financial capacity of households would aggravate the economic stability of the household, which in economic terms is called catastrophic expenditure. When Households fall under the poverty line, their catastrophic spending threshold is zero. For households whose expenditures are above the poverty line, catastrophic threshold value will be difference between total household expenditure minus total minimum basic needs of the household divided by the total expenditure of the household. Based on this definition of catastrophic health expenditure, the research examines determinants of catastrophic OOP health expenditure in Indonesia.Method: This study is based on quantitative data analytic research that uses two data sources IFLS years 200 and 2007 and SUSENAS 2009 and 2010. Results: Probability of catastrophic health expenditure in such households especially being significantly influenced by economic condition. While health condition did not have significant influence to increase catastrophic health expenditure. A part of potentially catastrophic households in Indonesia (which are poor and have health problems) were not being catastrophic because they reduced health expenditure and did not use appropriate health treatment. Health cost subsidies like health insurance, borrowing money, and health care cost aids did not have influence to reduce the occurence of catastrophic health expenditure in Indonesia. Conclusion: Economic condition is the biggest factor in the occurrence of catastrophic health expenditure. Potentially catastrophic households were not being catastrophic because they reduce health expenditure and did not use health care treatment. Health cost subsidies like health insurance, borrowing money, and health cost aids have not reduced the occurence of catastrophic health expenditure in Indonesia.

National Health Account Implementation in Viet Nam World Bank Publications

Research paper from the year 2013 in the subject Politics - International Politics - Region: South Asia, National Institute of Development Administration, course: Fiscal and Monetary Policy Analysis and Management, language: English, abstract: In this paper, there is an attempt to compile evidence on the benefit incidence of public education and health spending in 2005 in Thailand. The 2005 data marks an improvement over Medhi Krongkaew’s 1979 analysis due to changes in the creation of the quintile income groups and marked improvement in the data collected on the whole. This paper is used to ascertain which income groups tend to benefit more from social spending. The paper also explores the relationship between benefit incidence on the one hand and indicators of access to education and health services and social outcomes on the other using simple measures of association. In addition, the paper explores the policy implications of these findings. In general, there is an attempt to enhance the position of the poor as the total (all) post-expenditure saw a major improvement in the Gini coefficient to record 0.2818 from 0.3056 or a rate of improvement of 2.38%. On the basis of these findings, it could be concluded that government’s interventions or subsidies on the two functional areas is pro-poor or progressive as it seeks to favor the poor. This will enhance the position of the poor as to accessing these two facilities in Thailand. We make a number of policy recommendations to enhance government’s efforts in eradicating poverty in the not distant future.