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

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Household Healthcare Expenditure in Bangladesh
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Household Demand for Employer-based Health Insurance
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Health Systems Performance Assessment
Household Health Expenditure in Two States
The Healthcare Imperative
Revised edition

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SALAZAR DESHAWN

Quantifying Fairness, Catastrophe, and Impoverishment, with Applications to Vietnam, 1993-98 OECD Publishing
Two key policy goals in the health sector are equity and financial protection. New methods, data and powerful computers have led to a surge of interest in quantitative analysis that permits monitoring progress toward these objectives, and comparisons across countries. ADePT is a new computer program that streamlines and automates such work, ensuring that results are genuinely comparable and allowing them to be produced with a minimum of programming skills. This book provides a step-by-step guide to the use of ADePT for quantitative analysis of equity and financial protection in the health sect
She's on the Money World Health Organization
Health care costs represent a nearly 18% of U.S. gross domestic product and 20% of government spending. While there is detailed information on where these health care dollars are spent, there is much less evidence on how this spending affects health. The research in Measuring and Modeling Health Care Costs seeks to connect our knowledge of expenditures with what we are able to measure of results, probing questions of methodology, changes in the pharmaceutical industry, and the shifting landscape of physician practice. The research in this volume investigates, for example, obesity’s effect on health care spending, the effect of generic pharmaceutical releases on the market, and the disparity between disease-based and population-based spending measures. This vast and varied volume applies a range of economic tools to the analysis of health care and health outcomes. Practical and descriptive, this new volume in the Studies in Income and Wealth series is full of insights relevant to health policy students and specialists alike.
A Guide to Improving Performance and Equity OECD Publishing
Understanding how households make health insurance choices is of critical importance in evaluating issues of equity and efficiency

in health care markets. We consider a largely neglected aspect of such decision making: the decision of families with two working spouses to obtain double coverage. Using data from the 1987 National Medical Expenditure Survey, we find that household decisions to obtain double coverage are especially sensitive to the wife's out-of-pocket premium costs. Our analysis reveals that households with double coverage have more generous insurance, as reflected in their higher coverage rates for specific types of benefits. Moreover, our evidence suggests that the presence of duplicate health benefits in double-covered households may reflect a conscious attempt by working spouses to obtain more extensive coverage.

A Comparative Study of Districts in Maharashtra and Madhya Pradesh OECD Publishing

A Brookings Institution Press and the National University of Singapore Press publication This is the story of the Singapore healthcare system: how it works, how it is financed, its history, where it is going, and what lessons it may hold for national health systems around the world. Singapore ranks sixth in the world in healthcare outcomes, yet spends proportionally less on healthcare than any other high-income country. This is the first book to set out a comprehensive system-level description of healthcare in Singapore, with a view to understanding what can be learned from its unique system design and development path. The lessons from Singapore will be of interest to those currently planning the future of healthcare in emerging economies, as well as those engaged in the urgent debates on healthcare in the wealthier countries faced with serious long-term challenges in healthcare financing. Policymakers, legislators, public health officials responsible for healthcare systems planning, finance and operations, as well as those working on healthcare issues in universities and think tanks should understand how the Singapore system works to achieve affordable excellence.

Model Rules of Professional Conduct World Bank Publications

Health systems financing aims at providing adequate services, ensuring sufficient providers' incentives, and protecting individuals and families from financial catastrophe. Health services are financed through government funding, taxation, out-of-pocket payments, insurance, donations and voluntary aid. Low-income countries mostly rely on out-of-pocket payments. In South East Asia region, the latter accounted for 84.0% of private expenditure on health, and over 60.0% of total health expenditure. Bangladesh health systems financing are characterized by high out-of-pocket payments (63.3%) that show an increasing trend, and a lack of prepayment mechanisms. We hypothesize that an inequity prevails, and that households face high catastrophic payments and poverty. Although, a limited number of studies exists on these issues, there were studies conducted in some pocket areas making it difficult to generalize. Thus, we aim to analyze the progressivity, incidence, and intensity of catastrophic payment and poverty using a nationally representative dataset. We use data from Bangladesh Household Income and Expenditure Survey, 2010. This is a cross sectional survey with a sample of 12,240 households consisting of 55,580 individuals. The ethical foundation of this research is based on the "ability to pay" principle, proposed by Adam Wagstaff (2002) and of John Rawls (1971) concept of distributive justice. For quantification of progressivity, we adopted the theoretical framework developed by O'Donnell, van Doorslaer, Wagstaff, and Lindelow (2008). The Kakwani index and the Gini coefficient are used to measure progressivity and redistributive effects respectively. We use Stata 14.0 and ADePT 5.0 software for data analysis. Our findings show that an inequality exists in health systems financing between the poor and the rich. All sources of healthcare financing are regressive in nature, meaning that health payments comprise a decreasing share of households' income/consumption as it rises. The gross household consumption for the poorest quintile is 0.22 times the richest quintile. However, the healthcare financing share for the poorest is 0.56 times the richest. The differences between Gini coefficient and Kakwani index for all sources of finance are negative, indicating regressivity. Health financing is more concentrated among the poor. For the poorest quintile, post-payment disposable income is less than the pre-payment. However, it is opposite for the rich. Thus, income inequality increases among the quintiles. Both incidence and intensity of catastrophic payments vary from two to five times for the lowest and the highest quintiles respectively. In case of nonfood consumption, both incidence and intensity of catastrophic payments are much higher than gross consumption. Concentration indices are negative in all thresholds indicating that the poor mostly bear the burden. Both rank-weighted headcount and overshoot are higher for all threshold levels. We found that using the conventional poverty measure, 3.0% of the population is not counted as living in extreme poverty. Our findings substantially add evidence of health systems financing impact on inequitable financial burden of healthcare and disposable income. The heavy reliance on out-of-pocket payments affect household living standards. If the government and the people of Bangladesh are concerned about inequitable financing burden, our study suggests that Bangladesh needs to reform the health systems financing scheme. The poor households need protections from catastrophic health expenditures by reducing reliance on out-of-pocket payments. Risk protection policies including finding alternative sources of health systems financing is inevitable to overcome the present situation. We recommend longitudinal monitoring of progressivity and poverty status.

Paying for Health Care

University of Chicago Press

The impacts of the two variables of population and income growth on resources and the environment are transmitted through their effects on the demands for goods and services. To enrich our understanding of the impacts of population and income on consumer demand, Philip Musgrove, with the assistance of Adele Shapanka, undertook the research in this volume, which was first published in 1982. This book will be of interest to students of economics and environmental studies.

Household Healthcare Expenditure in Bangladesh World Bank Publications

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.
The World Health Report 2000 World Health Organization
The World Health Report 2000 has generated considerable media attention, controversy in some countries, and debate in academic journals. This volume brings together in one place the substance of many of these key debates and reports, methodological advances, and new empiricism reflecting the evolution of the WHO approach since the year 2000. Specifically, the volume presents many differing regional and technical perspectives on key issues, major new methodological developments, and a quantum increase in the empirical basis for cross-country performance assessment. It also gives the full report of the Scientific Peer Review Group's exhaustive assessment of these new approaches.

Household Demand for Employer-based Health Insurance

University of Chicago Press
The burden of poor maternal, neonatal and child health (MNCH) remains unacceptably high in many developing member countries (DMCs). To understand the barriers facing households in accessing MNCH care, the ADB technical assistance project RETA-6515 analyzed data from routine national household expenditure surveys in six DMCs: Bangladesh, Cambodia, the Lao People's Democratic Republic (Lao PDR),Pakistan, Papua New Guinea, and Timor-Leste. The findings reveal not only the rich evidence base available in these surveys, but also show how healthcare costs, quality, and physical barriers play differing roles in different countries in preventing access, and how families are often impoverished by accessing needed care.
Analyses of Progressivity and Impacts on Poverty Random House Australia
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.

Streamlined Analysis with ADePT Software

World Bank Publications
Egalitarian concepts of fairness in health care payments (requiring that payments be linked to ability to pay) are compared with minimum standards approaches (requiring that payments not exceed a prescribed share of prepayment income or not drive households into poverty). The arguments and methods are illustrated using data and out-of-pocket health spending in Vietnam in 1993 and 1998.
Health Equity and Financial Protection World Health Organization
This data collection contains two fichiers derived from information gathered in the initial screening interview and Rounds 1-4 of the Household Survey component of the 1987 NATIONAL MEDICAL EXPENDITURE SURVEY (NMES). The Person File supplies data on each sampled person who reported coverage by Medicare at any time in 1987 and who responded to all rounds of the Household Survey for which he or she was eligible to respond. Data in this file include age, sex, race, marital status, education, employment status, personal and family income, coverage under private health insurance and public programs such as Medicaid and CAMPUS/CAMPVA, and the total number and cost of all prescriptions purchased in 1987 while under Medicare coverage. In addition, there are indicators of general health and specific medical conditions : stroke, cancer, heart disease, gallbladder disease, high blood pressure, hardening of the arteries, rheumatism, emphysema, arthritis and diabetes. The Prescribed Medicines Event File presents data pertaining to every instance a prescribed medicine was purchased or otherwise obtained by these Medicare beneficiaries during 1987. For respondents who were covered by Medicare for part of the year, only prescribed medicines acquired during the Medicare coverage period are included. This file gives the trade and generic name of each prescribed medication and reports the cost of the prescription and the medical condition for which it was prescribed ... Cf. : http://webapp.icpsr.umich.edu/cocoon/ICPSR-STUDY/09340.xml.
The Economics of Social Determinants of Health and Health Inequalities Brookings Institution Press
A System of Health Accounts 2011: Revised Edition provides an updated and systematic description of the financial flows related to the consumption of health care goods and services.
U.S. Household Consumption, Income, and Demographic Changes World Health Organization
Collects together data compiled from 177 World Health Organization Member States/Countries on mental health care. Coverage includes policies, plans and laws for mental health, human and financial resources available, what types of facilities providing care, and mental health programmes for prevention and promotion.
New Evidence from the Western Balkans World Bank Publications
The objectives of this study are to describe experiences in price setting and how pricing has been used to attain better coverage, quality, financial protection, and health outcomes. It builds on newly commissioned case studies and lessons learned in calculating prices, negotiating with providers, and monitoring changes. Recognising that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings. The report and the case studies were jointly developed by the OECD and the WHO Centre for Health Development in Kobe (Japan).
Impact of out-of-pocket expenditures on families and barriers to

use of maternal and child health services in Asia and the Pacific: Evidence from national household surveys of healthcare use and expenditures—summary technical report Oxford University Press Comprehensive and informative document on the design, implementation, and use of household surveys in developing countries.

Measuring Financial Protection in Health PublicAffairs Vietnam's Health Care Fund for the Poor (HCFP) uses government revenues to finance health care for the poor, ethnic minorities living in selected mountainous provinces designated as difficult, and all households living in communes officially designated as highly disadvantaged. The program, which started in 2003, did not as of 2004 include all these groups, but those who were included (about 15 percent of the population) were disproportionately poor. Estimates of the program's impact-obtained using single differences and propensity score matching on a trimmed sample-suggest that HCFP has substantially increased service utilization, especially in-patient care, and has reduced the risk of catastrophic spending. It has not, however, reduced average out-of-pocket spending, and appears to have had negligible impacts on utilization among the poorest decile.

Health Systems Performance Assessment American Bar Association

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.

Household Health Expenditure in Two States National Academies Press

The recent recession has brought fiscal policy back to the forefront, with economists and policy makers struggling to reach a consensus on highly political issues like tax rates and government spending. At the heart of the debate are fiscal multipliers, whose size and sensitivity determine the power of such policies to influence economic growth. Fiscal Policy after the Financial Crisis focuses on the effects of fiscal stimuli and increased government spending, with contributions that consider the measurement of the multiplier effect and its size. In the face of uncertainty over the sustainability of recent economic policies, further contributions to this volume discuss the merits of alternate means of debt reduction through decreased government spending or increased taxes. A final section examines how the short-term political forces driving fiscal policy might be balanced with aspects of the long-term planning governing monetary policy. A direct intervention in timely debates, Fiscal Policy after the Financial Crisis offers invaluable insights about various responses to the recent financial crisis.

The Healthcare Imperative Routledge

Abstract: " The substantial increase in health expenditure and heavy health financial burden for residentsare two of the major challenges faced by the health system in China. It is crucial to identifythe main drivers of health expenditure growth, and also the main drivers of catastrophichealth expenditure at function level and disease level, so that cost containment policies can befocussed in the right areas and targeted measures can be taken to reduce residents' financialrisks. It is also important to project China's current health expenditure by age, disease

andhealth care function, analyse the main drivers of health expenditure growth in the future, andtest the impact of several hypothetical policy interventions on health expenditure to identifyareas where unproductive cost escalation can be reduced, as well as to estimate the potentialbudgetary implications of government policies.Chapter 1 briefly introduces the health system and health system reforms undertaken in thepast and recently, the remaining challenges for the health system and health financing inChina, and the aims of this study.Chapter 2 reviews the literature, systematically summarises the factors determining healthexpenditure growth and catastrophic health expenditure, and compares different factorsaffecting the growth of health expenditure and catastrophic health expenditure in differentstudies. In considering previous research about determinants of health expenditure growth,residents' financial risk and future trends in health expenditure, gaps in the literature havebeen identified, so further justifying the purpose of this study. Several studies point to theimportance of disease prevalence, treatment practice and health price inflation as the maindrivers of health expenditure growth in several countries, but no single study in China haslooked at the relative contribution of all of these to the recent and rapid health expendituregrowth. A greater gap in knowledge arises because previous research did not analyse thedrivers of health expenditure growth by age group and disease group. Moreover, previousstudies in this country were also limited in that they did not analyse potential variations inexposure to catastrophic health expenditure for all types of diseases.In other countries, excess health price inflation has been identified as a major factor affectinghealth expenditure growth, but until this study there has been no health price inflation data forChina. Chapter 3 mainly uses the Laspeyres Price Index method to generate inpatient,outpatient, pharmacy pharmaceutical, preventive service, and governance and health financing administration related price indices separately. Then an aggregate health priceindex was calculated by weighting the components. Aggregate health price inflation exceededthe gross domestic product (GDP) deflator by 1.1% per annum during the period 2007 to2012.In Chapter 4, Das Gupta's decomposition method is used to decompose the changes in healthexpenditure by disease into five main components that include population growth, populationageing, disease prevalence rate, expenditure per case of disease, and excess health priceinflation. During the period from 1993 to 2012, growth in health expenditure in China wasmainly driven by a rapid increase in real expenditure per prevalent case. This factorcontributed 8.4 percentage points of the 11.6% annual average growth. Excess health priceinflation and population growth contributed 1.3% and 1.3% respectively. The effect ofpopulation ageing was relatively small, contributing only 0.8% per year. Reductions indisease prevalence rates reduced the growth rate by 0.3 percentage points.In Chapter 5, age and disease specific inpatient, outpatient, and pharmacy pharmaceuticalexpenditures are projected using a component-based projection model. Five factors affectinghealth expenditure growth are modelled: population, age structure, disease prevalence rates,services per case of disease, and unit cost. Three policy scenarios are analysed: trends inhealth expenditure if health service utilisation reaches and is held at a benchmark level, andthe effects of reduction in smoking rates and hypertension. Health expenditure in China isprojected to increase at 8.4% per annum from 2015 to 2035. This growth will mainly bedriven by rapid increases in services per case of disease and unit cost, which contributerespectively 4.3 and 2.4 percentage points. By 2035 over 60% of health expenditure isexpected to be on the population aged 60 and above. Inpatient expenditure is expected togrow at an average of 9.2% per year compared to 7.3% for outpatient expenditure.Circulatory disease expenditure is projected to increase sharply, from 18.7% to 23.4% ofhealth expenditure. Three percent of GDP is expected to be saved by slowing the growth ofinpatient health service utilisation once the benchmark level is reached. Health expenditure isexpected to be reduced by 3.5% if the smoking rate is cut in half and by 3.4% if hypertensionis cut by 25% by 2035.At the micro-level, Chapter 6 analyses the main drivers of incidence of householdcatastrophic health expenditure (CHE) in different regions that have different economicdevelopment levels using a common household health survey. The major drivers of the incidence of CHE by function and disease level are identified. The incidences of CHE causedby inpatient out-of-pocket payment (OOP), outpatient and pharmacy pharmaceutical OOPsand by different diseases were estimated under different methods. Determinants of CHE wereexamined using logistic regression in the different regions. Outpatient and pharmacypharmaceutical OOP were identified as the major drivers of household CHE. Circulatorydiseases, endocrine, nutritional and metabolic diseases, neoplasms, respiratory diseases,digestive diseases, injuries, and musculoskeletal diseases are the main diseases of thehouseholds experiencing CHE. This research also found that the incidence of CHE in aneconomically developed province is higher than that of an economically developing province.In Chapter 7, the main findings from all aspects of this research are brought together andclearly illustrate the original contribution of the study to knowledge in the area of healthexpenditure structure, components and future trends in China. A health price index isgenerated, the growth of health expenditure by disease in the past two decades and forecastsfor the next two decades are decomposed using Das Gupta's decomposition method, healthexpenditure by function, age and disease in the next two decades is projected, and drivers ofthe incidence of catastrophic health expenditure by disease are analysed for the first time. Thechapter also outlines the policy implications of the research findings, and points out futureresearch directions. "

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