

Differences In Attitude Of Urban And Rural Residents In Accepting National Health Insurance

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Abstract

This paper is aimed to demonstrate the differences of urban and rural resident's attitude as well as to know the factors influencing the resident acceptance to the national health insurance (NHI) in Indonesia. The research was conducted through a survey in household heads by applying cross sectional design. The sample is collected through purposive cluster quota for 1,289 samples from three provinces. A structured questionnaire was used as instrument. A logic regression model was used to analyze the factors influencing willingness to pay NHI between rural and urban resident. The findings of the study revealed that the rural resident has higher level of acceptance to the government's plan to obligate NHI than the urban resident ($p < 0,001$). The willingness of urban resident to pay the premium is significantly influenced by education level (high), the condition of family health (unhealthy), household head's occupation (formal), and the level of family wealth (high). While the willingness of rural resident to pay the premium is significantly influenced by the level of family wealth (high), the presence of toddler and geriatric in the family (unpresent), and the health condition of the household heads (healthy). To increase public participation in NHI program, the government will need to consider urban and rural residents difference.

Keywords: National Health Insurance, the acceptance, urban, rural

1. Background of the Study

Many countries, including South-East Asia countries, have their resident health finance reformed by reducing out-of-pocket health finance dependence (WHO, 2010).

It is reported that on 2011 there were 87 million (36.88%) of Indonesian people have no health insurance (Mukti et al., 2011, Kementrian Kesehatan RI, 2011). The resident obtains health insurance through various schema such as Jamkesmas (government's fund for poor and almost poor resident), Askes (for public officers and military workers), Jamsostek (formal employees), Jamkesda (regional-level scheme), and private insurance (mainly for urban resident). Based on Household Survey, >80% of households in Indonesia spend 60% of their income for food, which means >40% out-of-pocket money is allocated for medical fund. When it happens for some times, it will threaten the fulfillment of the basic needs (Thabarani, 2011, Kementrian Kesehatan Republik Indonesia, 2010).

On 2004, the government issued UU No. 40/2004 on the System of National Social Insurance (SJSN), which one of its purposes is to increase the participants of health insurance. The membership of this health insurance is obligatory. Therefore, all resident in Indonesia has to join this health insurance program. It is expected that this health insurance has achieved a Universal Health Coverage (UHC) at least by 2019.

Regardless its obligation, it is technically challenging to collect the premium from worker groups who are non-wage receiver and non-assessable. Indonesia demography with its 17.504 islands and 33 provinces, makes it rich with various cultures and region capabilities (Subdirektorat Layanan dan Promosi Statistik, 2011). Most of the regions in Indonesia (79.53%) are village/rural areas and the rest (20.47%) is urban area (Badan Pusat Statistik, 2010).

In many developed countries, poverty is related to living area, in which urban households tend to concentrate on the wealthy while rural households tend to concentrate on the poor (AUSAID, 2011). Some research show different health attitude between the rural and urban resident; economic as well as education factors are assumed to be the cause of this difference (AUSAID, 2011, Wang et al., 2010). In Indonesia, rural area is contrasted to the urban in term of its less dense population, and its major occupation (farmer), and its limited health access. Study of urban and rural differences on willingness to participate in the National Health Insurance needs to be done, especially for developing countries with high rural area.

The theories on demand highly contribute in analyzing public decision making (Lee, 2009, Russell et al., 1995)

and understanding the factors which encourage resident who has no health insurance to pay the premium is crucial. Therefore, it is needed to analyze the factors which may influence the demand of health insurance. This research aims to discern the difference of urban and rural resident acceptance to the national health insurance as well as the factors which may influence it.

2. Methodology

2.1. Sample

This research employs cross-sectional method and uses the research data from the Ministry of Health of the Republic of Indonesia in 2008. The population of this research is the households in Indonesia which respondent is the head of the household.

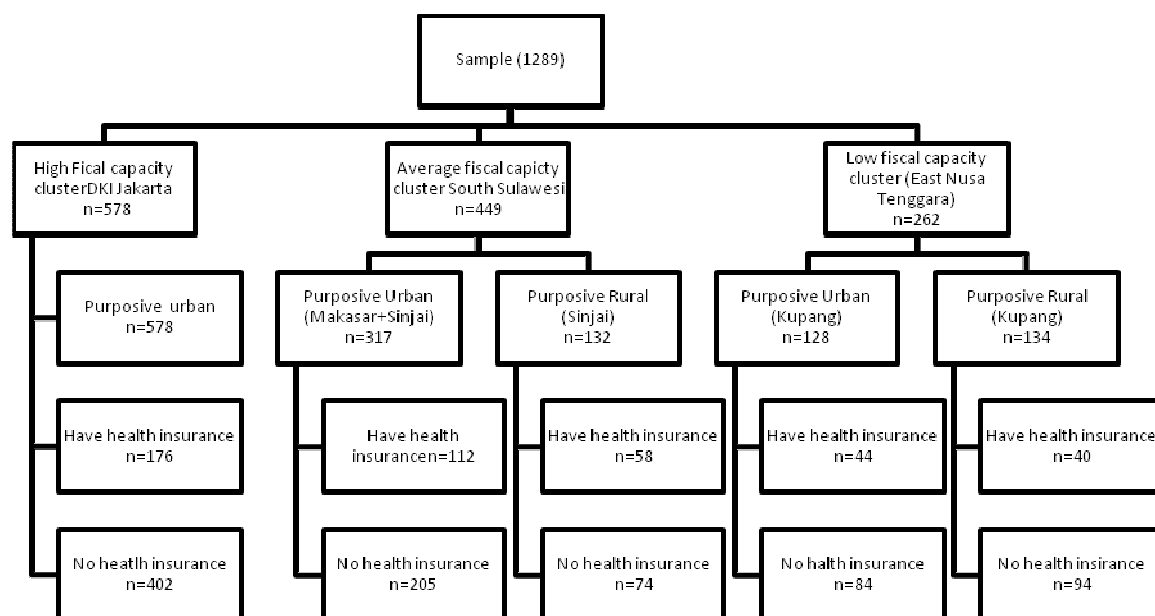


Figure 1

Figure 1: Research Sample

Figure 1 : the sample of this research is obtained through purposive sampling quota. The data are taken from three provinces in which each province represents a high fiscal capacity: DKI Jakarta (n=578), average fiscal capacity: South Sulawesi (n=449), and low fiscal capacity: East Nusa Tenggara (n=262). The number of sample in each location is taken proportionally according to the population number in the province. A city level representative is then selected to represent each province. Purposively, one city which is considered to have several urban areas and rural areas are chosen (except DKI Jakarta which has no rural areas). The total samples are 1023 for urban residents and 266 for rural residents. The final step is to select households in each city which have health insurance (33%) and do not have health insurance (67%).

2.2. Data Analysis

Chi-square is used to test the proportion of the agreement (is coded as 1) and disagreement (is coded as 0) in both rural and urban residents. They agree and disagree on: (a) government's plan to implement the NHI system; (b) government's plan to obligate the resident to join the NHI system; (c) pay the premium; (d) pay the cost sharing

Multiple logistic regressions examined to assess factors that affect a household heads choose to agree (1) or disagree (0) to pay the premium. Variable dependent model is used to get the best (fit) and simplest (parsimony) prediction model which may describe the relation of independent and dependent variable. There are factors influencing the head of households to agree and disagree to pay the premium of national health insurance (variable dependent).

The model is specified as follows:

$$\log(p/1-p) = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \beta_6 X_6 + \beta_7 X_7 + \beta_8 X_8 \quad (1)$$

Where X_1 denotes the level of family's wealth (high=1), X_2 denotes educational status of household head (\geq high school=1), X_3 denotes occupation of household head (formal=1), X_4 denotes health condition of household head (not healthy=1), X_5 denotes health condition of family member (not healthy=1), X_6 denotes the number of family member (numeric), X_7 denotes the present of under five year in family (present=1), X_8 denotes the present of elderly in family (present=1)

3. Result and Discussions

3.1. The Characteristics of Respondents in Rural and Urban Residents

Table 1 shows there is no difference of both demographic characteristics and health status of household heads and the member of the family ($p > 0.05$), yet there is a significant different ($p < 0.001$) on the socio-economic status between rural and urban resident. The household heads in urban resident mostly work in formal sector and have higher expenditure per capita rather than in rural.

Table 1. The Characteristics of Respondents (Household Heads) and Their Family between Rural and Urban Residents

Variable	Rural & Urban	Rural n=266 (20.64%)	Urban n=1,023 (79.36%)
The level of family's wealth***			
High	877 (69.71)	146(57.71)	731(72.74)
Low	381 (30.29)	107(42.29)	274 (27.26)
Educational status of respondent			
\geq high school	1122 (87.25)	221(84.03)	901(88.07)
\leq middle school	164 (12.75)	42(15.97)	122(11.93)
Occupation of respondent***			
Informal	884(68.7)	206(77.15)	678(66.53)
Formal	402(31.2)	61(22.8)	341(33.47)
Respondent health condition			
Healthy	1157(89.76%)	244(90.71)	913(89.51)
Not-healthy	132(10.24%)	25(9.29)	107(10.49)
Family health condition			
Healthy	1161(90.14)	240(89.22)	921(90.38%)
Not-healthy	127(9.86)	29(10.78)	98(9.62%)
Family member	4.187 (1.79)	4.04 (1.61)	4.23 (1.83)
Under five year in family			
Present	834(64.85)	178 (66.9)	656(64.8)
No	452(35.15)	88 (33.1)	364(35.7)
Elderly in family			
Present	1146(88.98)	244(91.7)	902(88.2)
No	142(11.02)	22(8.3)	120(11.8)

For numeric variable, mean and standard deviation (in the brackets) are obtained from significance test using t-test.

For categories variable, frequency and percentage (in the brackets) are obtained from significance test using Chi-square.*** $P < 0,001$

3.2. Resident's Attitude Towards National Health Insurance (NHI)

Most of the resident agrees with the plan to implement NHI system (96,64%) and the government's plan that requires the resident to mandatory participate in NHI (76,54%). Although generally the resident agrees (50,43%) to pay health insurance premium, there is a different attitude between people living in urban or rural area (Table 2).

Table 2. The Different Attitude towards National Health Insurance between Rural and Urban Residents

	Total		Rural		Urban	
	Agree	Disagree	Agree	Disagree	Agree	Disagree
Attitude towards the implementation of JKN**	1.236 (96.64)	43 (3.36)	267 (99.26)	2 (0.74)	969 (95.94)	41 (4.06)
Attitude towards government's requirement to participate in JKN***	979 (76.54)	300 (23.46)	227 (84.39)	42 (15.61)	752 (74.46)	258 (25.54)
Attitude to pay the premium***	645 (50.43)	634 (49.57)	166 (61.71)	103 (38.29)	479 (47.43)	531 (52.57)
Attitude to pay the cost sharing***	424 (33.12)	856 (66.88)	119 (44.24)	150 (55.76)	305 (30.16)	706 (69.84)

Reported as *n* and percentage (in brackets)

Chi-square test used for *Significance test* **p* <.05; ***p*<.01; ****p* <.001.

Rural resident has higher level attitude to agree than urban resident in response to government plan that requires them to NHI (rural 99.26% vs. urban 95.94%), to mandatory participant (rural 84.39% vs. 74.46%) and to pay NHI's premium (rural 61.71% vs. urban 47.43%) (Table 2). However, both communities have the same attitude — mostly disagree — towards the planning to participate in cost sharing (rural 55.76% and urban 69.84%).

The bivariate analysis using Chi-square test shows that there is a different attitude to agree in response to the program of future health insurance between urban and rural. Rural resident has higher level attitude to agree than urban resident in response to government plan that requires them to NHI (*p*<0,01), to mandatory participant (*p*<0,001), to pay premium (*p*<0,001), and to participate in paying the cost sharing (Table 2).

Living in a rural area was associated with a higher number of visits to a health clinic (van der Hoeven et al., 2012).

Surprising, that the people in rural areas have a higher attitude to agree to follow the government's plan to require national health insurance, to pay premiums and cost sharing, rather than people in urban areas. There are two (2) terms of an explanation for this. First, in terms of the conditions of urban society, higher education factors and access to extensive information causes urban communities have more options in terms of health insurance and health centers. Urban people prefer private health care than rural (Hoeven *et al.*, 2012, van der Hoeven *et al.*, 2012). On the other hand, a rural resident with limited information makes them not have many options for health insurance, so they prefer to follow the government's program. Living in a rural resident was associated with a higher number of visits to a health clinic (van der Hoeven *et al.*, 2012).

Second, urban communities have higher income levels than rural. The higher level of wealth of a person will lead him to the need of high health expenditures, thus requiring insurance with the higher level (Wang et al., 2010b). Health care quality is an important factor in choosing a health insurance provider (kyei-Nimakoh et al., 2012). Health insurance program for the class of this group connotes insurance program for the poor. This is one factor why urban accept less than rural communities to the plan of a national health insurance program.

The results of the study of van der Hoeven, et al (2012) on health care-seeking behavior differences between rural and urban communities in South Africa, said that the health care-seeking behavior on these two societies, distinguished by socioeconomic characteristics, health status, and utilization of health services. Rural communities have lower weekly availability of funds is significantly, not only for the health service itself but also for transportation to health care facilities. One important difference is the selection of health care providers. Urban resident prefer private practice physicians and rural resident prefer health clinics. Private health facilities were most patronized Regardless of socio-economic class (kyei-Nimakoh *et al.*, 2012). The

articles of this study support the results of this study that the lack of consumer response to the Government's plan to develop urban NHI, because urban people have a tendency to choose better health care. In Table 3 are shown the choice of health care outpatient physician practices 28.5% (urban) and 8.5% (rural), 48.9% at the health center (urban) and 80.5% (rural). Choices of inpatient in health centers 17.1% (urban) and 45.3% (rural), private hospitals 18.5% (urban) and 1.4 (rural).

Table 3. Place of Health Services most Frequently Used

Health services	Rural (%)	Urban (%)
Outpatient :		
Primary health center	80.5	48.9
Doctor	8.5	28.5
Nurse/Midwife	4.9	5.1
Alternative medicine	0.6	0.8
Hospital	5.5	11.9
Inpatient :		
Primary health center	45.3	17.1
Government hospital 3 rd class (in province)	45.3	38
Government hospital 3 rd class (out province)	0	1.2
Government hospital above 3 rd class (in province)	6.8	6.2
Government hospital above 3 rd class (out province)	0	0.4
Private hospital 3 rd class	0.7	15.2
Private hospital above 3 rd class	0.7	3.3
Others	1.4	18.7

3.3.

3.4. Factors Influencing Rural vs Urban Residents to Agree to Pay Premium

Indonesia's rural and urban areas are categorized based on the score obtained from three (3) conditions: (1) population density—the more densely populated, the lower the score is; (2) percentage of farm household—the higher the percentage, the lower the score is; (3) the availability of access to city facilities (10 facilities such as schools, hospitals, households with telephone and electricity)—the further the location of the facility or the fewer its availability, the lower the score is. It is called urban area if the total score is ≥ 10 (Badan Pusat Statistik, 2010).

Table 4. Factors Influencing the Willingness to Pay Premium between Rural and Urban Residents*

	p	OR	95% CI for OR	
			Lower limit	Upper limit
Urban (n=691)				
Education 1 \geq high school	0.002	2.56	1.42	4.62
Condition of family's health 1= not healthy	0.019	1.97	1.12	3.48
Occupation 1=formal	0.029	1.47	1.04	2.07
#Level of wealth 1=high	0.04	1.47	1.01	2.14
Rural (n=168)				
#Level of wealth 1=high	0.000..1	4.60	1.96	10
Under 5 years old in family 1= present	0.001	0.24	0.10	0.56
Elderly in family 1= present	0.039	0.1 9	0.04	0.92
Condition of respondent's health 1= not healthy	0.024	0.07	.,007	0.71

*Don't have health insurance

#The limit of wealth level is adjusted with the level of family's per capita expenditure and rural/urban status

using poverty standard of BPS 2007. Family's total expenditure: urban > Rp 187942,- and rural > Rp 146837,-

Table 4 shows the results of the logistic regression of multivariate analysis on the willingness to pay health insurance premium among rural resident and urban resident which is separately analyzed. The data is calculated based on the respondents that absence health insurance. In fact, the acceptance to pay premium between rural and urban resident is influenced by different variables. Among the rural resident, the high level of wealth, the presence of under five year's old and elderly (> 65 years old), and the healthy condition of household heads jointly change the willingness to pay premium, from unwilling to be willing. Whereas, the willingness among the urban resident is influenced by high level of education, high level of wealth, formal occupation and the unhealthy condition of family members.

Empirical studies have proven that the higher the family income, the higher health insurance demands will be (Lofgren et al., 2008, Ying et al., 2007, Bhat and Jain, 2006, Murti, 2005). However, most study using income as data which is obtained from independent interview or questionnaire is bias. This study uses family expenditure per capita in the last three months as the data. The total expenditure is then contrasted to the standard family expenditure in rural and urban family based on BPS. Each research subject is based on expenditure per capitals categorized into two (binary) that are the high (1) and low (0) wealth. The result of the study is in line with empirical studies that have been conducted. Family welfare level affects the willingness improvement to pay a premium SHI, both in the urban (OR 4.6, 95% CI 1.96 - 10.82) and rural communities (OR 1:47, 95% CI 1:01 to 2:14). In rural communities, the level of welfare of family being the biggest factor in affecting increasing willingness to pay SHI premium.

Education. In urban communities, the main factors' affecting the willingness to pay a premium is not wealth but the level of education. Urban communities with higher education increases the willingness to pay a premium (2:56 OR, 95% CI 1.42-4.62) This finding supports the model of the Grossman's demand for health capital (Grossman, 1972). The more educated have greater exposure to health information, and therefore the more behavior advantages of making small regular payments insurance to avoid large and sudden medically related financial catastrophes. Due in urban areas, information is more easily obtained, and then the people who are more educated are more afraid of the risk of illness costs. While in rural, although highly educated but the information obtained is still lacking. Higher levels of education will increase the willingness to pay health insurance, but does not affect the decision to purchase insurance (Lofgren *et al.*, 2008, Murti, 2005, Ying *et al.*, 2007, Dong *et al.*, 2003). Income has a significant positive correlation with insurance purchase (Bolhaar *et al.*, 2012).

Formal Sector. The study showed that the proportion of workers in the formal urban more than rural (99% confidence level). Formal employment remains assure the availability of funds to pay premiums on a regularly. In urban areas, formal employment status of the head of family influence on willingness to pay NHI (1:47 OR, 95% CI 1:04 to 2:14), but had no effect in rural areas (Table 4). The results of the study in Kentucky showed that the overall rate of health insurance of working-age adults is influenced more by employment status and income than by whether these individuals reside in rural or urban areas (Lu *et al.*, 2010)

Elderly and toddlers in family. The Presence of the elderly and toddlers who become the responsibility of the family, affect family spending. This suggests that the unit characteristics in the family is a factor influencing the decision (Bhat and Jain, 2006). Most evidence on the presence of advantageous selection in health insurances comes from older individuals in the US (Brown and Finkelstein, 2006, Cutler et al., 2008). Cost was a greater barrier to care among rural elderly people (Blazer et al., 1995). Nguyen and Knowles (2010) stated in their research that the presence of school-age children in the family affects the head of the family's decision to buy health insurance for their children. Female heads of household are generally more prone to purchase health insurance for their children, households prioritize young children, male children, and those children with more schooling in their purchase decision. The decision would be easier if they only have one child than some children. However, there is no comparison of the effect described in urban and rural areas. In Table 4 of this study indicates that the presence of the elderly in the family in the rural communities, influencing attitudes of household heads to disagree to pay a premium (OR 0.19, 95% CI 0.04 - 0.92). So also with the presence of the toddler in the family (OR 0.24, 95% CI 0.10 - 0.56).

Health status. Although health economics is a relatively young field, some literature has been contributed to the study of health and demand for medical care (Folland et al., 2007). Health as a consumption good in a consumer utility function is not purchased from the market, but rather produced in a health production function. The medical care is a factor input purchased from the market and the decisions on medical care and health production

are made after the health status is revealed, so there is perfect information under certainty. Only when health insurance is brought into the decision set does the model start to involve risk because the health status is uncertain by the time the insurance decision is made. Expected utility maximization, the typical model for decision under risk, is then used. The existence of a sick family member (chronic), history of previous hospitalization or health care also affect the increase in demand for health insurance (Bhat and Jain, 2006). Table 4 shows that, in rural areas, the health status of unhealthy household heads influences attitudes to disagree to pay a premium (OR 0.024 95 % CI 0.007-0.71). While in urban areas, the presence of a sick family member will increase the willingness to pay a premium (OR 1.97, 95 % CI 1:12 to 3:48).

Barriers (Figure 2). Rural area have more barriers in obtaining health services than urban. The biggest barrier in rural society is financial problems (39.9 %). Other barriers are the issue of access to health services (36.9 %), quality of service (18.5 %), discrimination in services (16.1) and others (2 %). In urban areas, perceived barriers is the largest of financial problems (37 %), then the quality of service (11.9 %), discrimination in services (11.3 %), access to health services (6.7 %) and others (2 %).

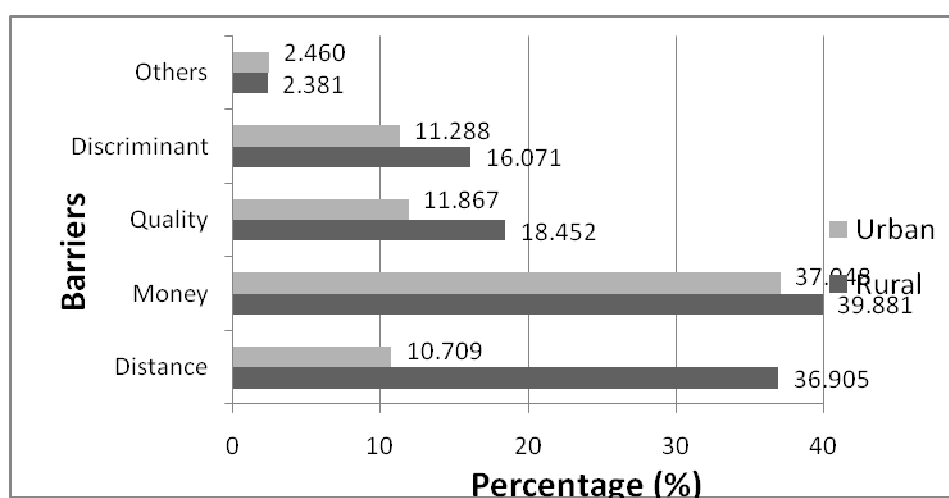


Figure 2: Barriers to Get Health Services

WHO recommends that to achieve universal health coverage in developing countries needed good quality of health services and adequate human resource (Tangcharoensathien et al., 2011).

4. Conclusion and Recommendations

The Indonesian government has a target to achieve UHC for the entire population by the end of 2019. So the government needs to pay attention to differences in attitudes that affect the willingness of urban and rural residents are willing to pay premiums for the national insurance. Although the NHI is mandatory, but the government will have difficulty to require groups of informal sector workers, who are mostly located in the rural area.

In general, rural residents have a willingness to NHI better than urban residents. This study showed that to improve the willingness to pay a premium in the rural residents, hence the need to get attention or support are people with low levels of wealth, families who have toddlers and the elderly, and families with household head in unhealthy conditions. While for the urban residents, the factors that need to be supported to increase the willingness to pay a premium NHI are families with low education household heads, informal sector, low level family wealth and families with family members who do not have a health problem.

Based on the findings in this study, therefore, the following recommendations are made with regard topolicy and practice: (1) more infrastructure investments, including public transport, should be made to improve accessibility to health care, especially in rural areas; (2) the quality of health care; (3) health financing assistance; (4) reduce or eliminate discrimination in health care.

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