THE WORLD BANK

IMPACT EVALUATION

Evaluating Impact: Turning Promises into Evidence

Evaluating the Impact of Medical Assistance System (MAS) on Hospitalization of Poor People in Rural Areas

Group 8

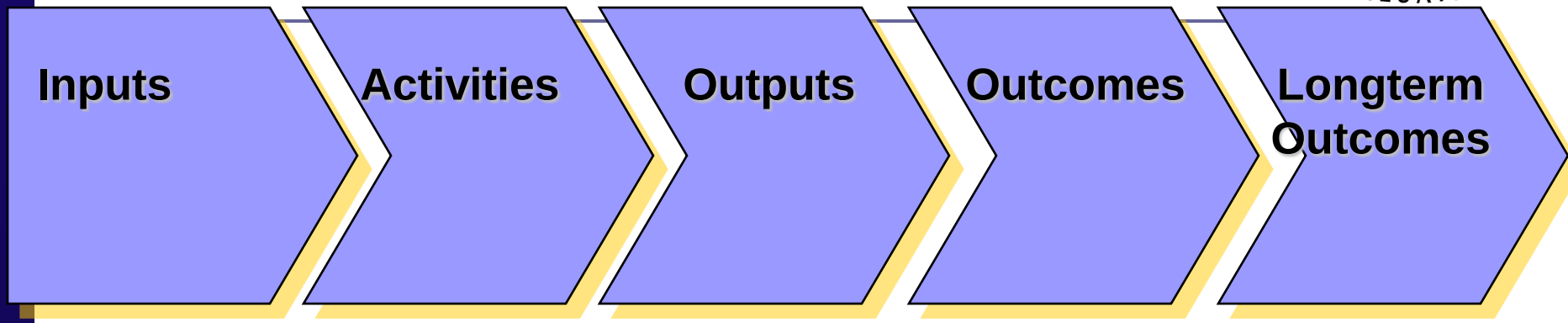
Beijing, China

July 2009

1. Background

- MAS was established in 2003 in rural China. The aim of the system was to increase the hospitalization utilization and to reduce the economic burden caused by the medical expenses of the poor population in rural China.
- The MAS provides money to the rural poor population to participate in the rural New Cooperative Medical System (NCMS) and, along with the NCMS, reimburse a proportion of the total medical expenses.
- A pilot was implemented in rich, middle and poor counties within certain provinces.

2. Results Chain



Inputs	Activities	Outputs	Outcomes	Longterm Outcomes
•Human resource •Money •Technical resource	•Design of the assistance system •Training the people who operate the system •Make the people aware of the system, communication campaign	•Provide money to participate in NCMS to a certain number of poor people in rural areas, and pay a % of their medical expenses •Medical services are provided in time	•Increase of the hospitalization of the poor people in rural areas •Decrease of economic burden caused by medical expenditures of poor people in rural areas	•Poverty reduction in rural areas caused by illness •Improvement of the living standard of the poor population

3. Primary Research Questions

Does the MAS increase the hospitalization rate of the poor population in rural China (without increasing the economic burden caused by medical expenses)?

4. Outcome Indicators

1. Hospitalization rate of rural poor people
   (1) Number of poor people (from Department of Civil Affairs)
   (2) Number of poor people who received hospitalization services (from HH survey and hospital data)

2. The proportion of the income that is due to out-of-pocket medical expenses in the poor households in rural areas
   (1) Out-of-pocket medical expenditure (from HH survey)
   (2) Household income (from HH survey)

5. Identification Strategy/Method

- Within each province, the counties were divided into three groups regarding their level of income: rich, middle and poor
- The MAS was implemented in some counties in each of these groups (treatment group)
- How the treatment counties were chosen?
  - In each of these income level groups, x "typical" counties were chosen randomly ("typical" counties are those that are around the average in the income distribution)
- How the control counties were chosen?
  - In each group, we randomely choose x "typical" counties (rest of the counties whose income is at middle level)
- POSSIBLE METHODOLOGIES:
  - Difference-in-difference (data from 2003 and 2008)
  - Regression Discontinuity (people around the Dibao line) NOTE: each county has a different Dibao line.

6. Sample and data

- Medical Service Survey and data from hospitals on hospitalization rates in 2003 and 2008
  - counties (treatment group)
    - All the households included in the Medical Service Survey
  - counties (control group)
    - All the households included in the Medical Service Survey

7. Time Frame/Work Plan

- 2009.08-09: data cleaning and collection of data from hospitals
- 2009.10-12: data analysis
- 2010.01-04: writing of the report

8. Sources of Financing

- The central and local governments
- International organizations (for example, the World Bank)