related ambulatory care visits over a 6 year period. Although all age groups demonstrated an increase in stroke-related visit rates during the study period, the 55–64 year age group had the most significant rise. Among persons aged 55–64 years, stroke-related visit rates increased from 9.1/1000 persons to 39.1/1000 persons (P Trend=0.0001), resulting in a 428% rise. After adjustment, greater odds of stroke visits were found in persons ≥55 years (55–64 years OR = 3.4, 95% CI: 2.3–5.0; ≥75 years OR = 4.1, 95% CI: 2.7–6.2; ≥75 years OR = 5.4, 95% CI: 3.6–8.2; age 45–54 referent), blacks (OR = 1.4, 95% CI: 1.0–2.0), men (OR = 1.5, 95% CI: 1.2–1.9), or persons in the South (OR = 1.6, 95% CI: 1.2–2.1). CONCLUSION: From 2000 to 2005, stroke-related ambulatory visits increased significantly in the United States, particularly among the near-elderly, Southern residents, and blacks. These age, regional, and racial disparities in outpatient stroke utilization are not explained by stroke risk factor prevalence. Health care resource allocation needs to target these high-risk groups.

DOES COMMUNITY-BASED HEALTH INSURANCE IMPROVE ACCESS TO DRUGS AND HEALTH CARE FOR THE POOREST IN AFRICA?

Souares A1, Savadogo G2, Gnawali DP, Sauerborn R1
1Heidelberg University, Heidelberg, Baden-Württemberg, Germany, 2Centre de Recherche en Santé de Nouna, Nouna, Kossi, Burkina Faso

OBJECTIVES: Health care utilization in Burkina Faso is far below the average level in OECD countries (0.15 and eight contacts per capita and year respectively). Worse still, there is a pronounced income elasticity of demand. Hence, much of the potential benefit of effective drugs remains elusive for most of the sick poor. This paper reports on the enrollment of the poorest quintile in CBI and the change in health care utilization of the insured households. Further more, the effect of a targeted subsidy on enrollment of the poorest 5th of household was assessed.

METHODS: Community-based insurance has been offered to a district in Burkina Faso, comprising 74,000 people who lived in 53 villages and the district capital of Nouna since 2004. Community self assessment of poverty was used in 2007 to identify the poorest quintile of households who were subsequently offered insurance at half the usual premium rate. RESULTS: Overall enrollment in health insurance was 5.2% in 2006 and 8.3% in 2007. However, only 1.1% of the poorest quintile of household chose to enroll. In 2007, with the targeted subsidy on enrollment of poorest households, this rate reached 11.1%. Once enrolled, household increased their utilization of health care substantially (from 0.15 to 0.64 contacts per capita and year). This increase in utilization given enrollment held also for the poorest quintile. CONCLUSION: The authors discuss the covariates influencing household decisions to enroll and to use health care subsequently. They stress the need to enhance the access of the poor to drugs and health care in general through the combined effect of community-based insurance and targeted subsidies to the poor.

PRESCRIPTION DRUG UTILIZATION AMONG A NATIONALY REPRESENTATIVE SAMPLE OF MEDICARE BENEFICIARIES WITH HEART FAILURE

Bain KT1, Richardson D2, Liao D3, Diamond J4, Novielli KD5, Goldfarb N6
1excelRx, Inc, Philadelphia, PA, USA, 2Jefferson Medical College, Philadelphia, PA, USA, 3Thomas Jefferson University, Philadelphia, PA, USA

OBJECTIVE: The efficacy of angiotensin converting enzyme inhibitors (ACEI), angiotensin II receptor blockers (ARB), beta-blockers (BB), aldosterone antagonists (AA), digoxin (DG), and diuretics (DU) in reducing morbidity and mortality among persons with heart failure (HF) has been well established in clinical trials. Using the 2002 Medicare Current Beneficiary Survey, we determined utilization of these drugs in the real-world setting among community-dwelling older adults with HF.

METHODS: Community-dwelling, non-hospice beneficiaries >65 years of age with a diagnosis code for HF (428.xx) were included. Medication use was determined by beneficiary self-report, documentation of prescription fills, and computer-assisted personal interviews. Diagnosis codes were used to identify beneficiaries without medical contraindications for each drug, who were eligible to receive them. We further classified beneficiaries into groups based on concomitant use of more than one drug: ACEI or ARB and BB (group 1); ACEI or ARB, BB, and AA (group 2); and ACEI or ARB, BB, AA, DG, and DU (group 3).

RESULTS: We estimated that 1038, 590, 821, 1059, and 926 survey respondents were eligible to use an ACEI or ARB, BB, AA, DG, or DU, respectively. Among those eligible, 55.9%, 44.1%, 23.8%, 19.4%, and 13.4% were using each, respectively.