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"What do policy makers think about health system and health inequalities in Asia"?

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Abstract

In recent years, a number of Asian countries have witnessed significant changes to their health care system both in terms of financing and delivery of health care. To some extent health sector reforms and its impact on equity and efficiency have been addressed, the views of the policy makers has not been studied. Policy makers are important actors in both formulation and implementation of health policies and hence assessing their views on health systems and health inequalities is crucial. This paper presents the comparative results of a survey conducted using a standardised questionnaire among 184 policy makers of 10 Asian countries namely: Hong Kong, Taiwan, Sri Lanka; China, Mongolia, Thailand; Bangladesh, India, Indonesia, Nepal. Flexibility was built-in the design of the questionnaire to allow collecting data using approaches (mail questionnaire, face-to face interviews, convenient sampling) suitable to individual countries. The design of the questionnaire was aimed at capturing both policy maker's knowledge on health inequalities and their opinion on specific health system issues including eliciting equity efficiency trade-offs. The results show that policymakers have a positive attitude towards equity, and a good understanding on health determinants outside health sector, especially socio-economic development, income distribution in favour the rich than the poor, etc. which could have a large impact on health inequities. With respect to equity-efficiency trade offs, up to a cut off point, policymakers have preference for programs benefiting the poor than the rich, given equivalent cost and effectiveness. To ensure comparability the results of these studies are presented for groups of countries and to some extent results vary among the groups depending upon the level of democratization and bureaucratic systems of each countries and how policy agenda was formulated. Policy implications of the study findings are discussed.

Key words: Policy makers, health systems, equity, health inequalities, developing countries, Asia.

1.0 Introduction

Over the years, a number of Asian countries have witnessed significant changes to their health care system both in terms of financing and delivery of health care. Severe economic hardship in a number of economies and ideological shifts in favour of new forms of public management have resulted in introducing market mechanisms within the health sector with the aim of improving the efficiency of the health system (Twaddle 1996). Following the World Bank's publication "Financing Health Services in Developing Countries" (World Bank, 1987), equity and pro-poor policies were neglected and the emphasis was placed in many countries on efficiency as measured in terms of cost–effectiveness, a direction which was reinforced by the World Bank's World Development Report 1993. Common reforms in the health sector include introduction of user charges in government facilities, explicit reliance on a public-private mix, decentralisation, hospital autonomy, etc. Although health sector reforms and their impact on equity and efficiency have been evaluated to some extent, the views of the policy makers on these approaches and on health inequalities in particular have not been assessed.

In recent years, addressing health inequalities and pro-poor policies have returned to the international agenda. The World Bank recognized this in its 2001-2002 World Development Report "Attacking Poverty" (World Bank, 2000), and the World Health Organization in its 2003 report highlights equity as key to health development (WHO, 2003). The recent millennium development goals (MDGs) set by the UN Millennium Summit in September 2000 reflect commitment by the international community to pro-poor policies, which reinforces earlier commitments to use such tools as poverty-reduction strategy papers (PRSPs) in structuring and monitoring international donor assistance. With this renewed concern for equity and poverty reduction on the international agenda the issue is whether this commitment to reducing health inequalities is also reflected at the national level?

The policy component of the EQUITAP project aims to address some of these issues. This study complements the other two studies undertaken within the policy component of the project using the policy analysis framework in Figure 1. For example, the limitation of the content analysis of the policy documents with respect to reducing health inequalities is that these are statements of intent and that there could be serious gaps between the stated intent and actual implementation (Bhatia et al. 2005a). Are the policies on health inequalities as mentioned in the national policy documents a serious commitment or just rhetoric? This paper reports on an attempt to elicit views of the policy makers on health systems issues focussing on health inequalities in ten Asian countries using a standardised approach. By eliciting views from the policy makers who are responsible for both formulation and implementation of the policies, this study complements the study on "Content analysis of policy documents", and helps to provide some policy context within which to evaluate the other policy and quantitative analyses conducted by the Equitap project. In addition, this study also makes an attempt to elicit policy-makers' preferences with respect to the equity efficiency trade-offs in the Asia context.

There have been few attempts in the past to assess the views of the policymakers in number of countries on health related issues. Within the developed world there have

been studies, which elicit views of policy makers with respect to health inequalities. For example, Exworthy et al. (2003) interviewed policy makers with the aim to assess the progress and pitfalls of current United Kingdom (U.K.) policies to reduce health inequalities. However, there were no studies that attempted to systematically assess the views of policy makers with respect to health systems issues including health inequalities in Asia.

Attempts have been made to assess the views of policy makers on dengue fever (DeRoeck, et al. 2003) and the need for new generation vaccines for cholera, shigellosis and typhoid in Asian countries (DeRoeck, et al. 2005). Similarly, views of health care policy makers were elicited to assess the gate-keeping role of general practitioners in Israel (Tabekin and Gross, 2000). To the best of our knowledge, this study is the first to attempt understanding of policymakers' views on these issues, and specifically to attempt eliciting the equity efficiency trade-off from policy makers' perspective in ten countries in Asia. The paper is structured as follows: country profiles are presented in the next section followed by the survey methodology in Section 3. Country results are presented in Section 4. Finally, this paper concludes with some policy implications.

2.0 Country profiles in a comparative context

Ten of the 15 Equitap territories participated in this study: Bangladesh, China, Hong Kong SAR, India, Indonesia, Mongolia, Nepal, Sri Lanka, Taiwan and Thailand.[1] The ten countries that were involved in the survey of policy-maker opinions comprise a wide range of diversity, not only in levels of economic development (Annex Table 1), but also in terms of health systems financing and policy (Annex Table 2). As other components of the Equitap study have shown these are associated with substantial variations in performance with respect to different dimensions of equity.

Two of the territories, Taiwan and Hong Kong SAR, are high-income developed economies. However, despite their common Chinese cultural heritage, their health systems are financed and organised quite differently. Hong Kong's health care system consist of a dominant general revenue-financed, hospital dominated public sector, which provides most inpatient care, alongside a largely ambulatory-based private sector which dominates in outpatient care provision. Although user charges are levied in the public sector, these are quite minimal in relation to average incomes, and empirical findings elsewhere in the Equitap study indicate that no households experience catastrophic medical expenses, and that government spending is the most targeted to the poor of any of the systems examined. Whilst Taiwan also does well in terms of equity in financing, protection against catastrophic medical expenses and health care use, it achieves this through a predominantly privately-provided health sector, which is funded through a national health insurance system operated by the government.

[1] The overall Equitap project involved research teams from Bangladesh, China, Hong Kong SAR, India, Indonesia, Japan, Korea, Kyrgyz Republic, Malaysia, Mongolia, Nepal, Philippines, Sri Lanka, Taiwan and Thailand.

Of the other countries in this analysis, social health insurance financing is found only in Mongolia, China, Thailand and Indonesia. Of these, only in Mongolia and Thailand can these insurance systems be described as being universal in coverage of all income groups. In both these countries, public sector facilities charge user fees, but the public insurance system covers most of these costs, and a higher proportion in the case of inpatient services. In China and Indonesia on the other hand, social insurance systems cover only a small proportion of the population, essentially in urban areas only. In rural areas, public facilities are the main source of health care provision in these two countries, and such facilities rely to varying extent on user fees, for which most of the rural population do not have insurance coverage. In general, amongst these social insurance-dominated countries, only Mongolia and Thailand are found to do well in actual equity performance, achieving high levels of protection of households against catastrophic expenses, and a less skewed targeting of government health care spending to the rich than occurs in China and Indonesia. Interestingly, it should be noted in passing that of this group of countries, China and Mongolia both share a common history of communist rule, although Mongolia switched to multiparty democracy in 1990.

The remaining countries of Bangladesh, India, Nepal and Sri Lanka have no significant social or private insurance financing. This has much to do with their common history of exposure to British imperialism (Nepal was not a colony but was a protectorate, and their generally low income. These countries rely essentially on general-revenue financing of public sector health services, with a parallel private sector funded by out-of-pocket payments. Sri Lanka has essentially no user charges in its public sector, Punjab (India) has modest levels and Nepal has substantial charges in its public hospital sector. Of this group of countries, only Sri Lanka does well in terms of effective targeting of government health spending to the poor (even though official policy does not explicitly target), and protection of households against catastrophic medical expenditures. Bangladesh and Nepal do quite poorly in these respects, and Punjab (India) somewhere in between. It should be noted that this variation in health systems equity is associated with significant health status outcomes, with Sri Lanka doing significantly better than the global average in terms of population health status with respect to its income level, whilst the others are only average performers.

3.0 Methods

To ensure comparability across countries, a standardised instrument was developed which was used across the countries with minor changes to adapt to the local context and interests of national collaborators. In addition, standard guidelines were developed and circulated to national collaborators to ensure comparability in study methodology across countries. The guidelines included definition of policy makers, issues of confidentiality, sampling design and size, issues around translation of the instrument, etc. For example, policy makers were broadly defined to include politicians at central and state levels, senior officials working with the MOH responsible for implementing health policy, senior bureaucrats and administrators from the health insurance sector at central and state level, and senior bureaucrats and administrators from other related ministries or health care organisations (e.g., Finance Ministry, Social Security, etc.) at central and state level.

Although a standardised instrument was used in all the countries, there was flexibility in the method of administering the survey. The advantages and disadvantages of each of the approaches namely telephonic interviews, mail surveys, one-to-one interviews, and opportunistic surveys was discussed, and it was left to the individual country researchers to identify the most appropriate strategy for this study. Telephonic interviews are less used in Asia and are more likely to have a poor response rate even if pre-arranged. Telephonic surveys are both time and labour intensive and it was not surprising to observe that none of the countries preferred this approach, particularly given the length of the questionnaire[2]. Even the more developed territories like Hong Kong and Taiwan preferred to rely on mail surveys instead. Self-addressed envelopes were provided to ensure that respondents post back the completed questionnaires. The Sri Lankan collaborator also used electronic mail to supplement postal collection of the completed survey forms, although only a small fraction or responses were received in this manner. One-to-one interviews with policy makers can be extremely time consuming and costly and needs a dedicated research staff for this. The strength of this approach is that it would ensure good response rate and also the quality of response. Examples of countries that used one-to-one surveys with policy makers included India, Nepal and Indonesia. Finally, opportunistic surveys of policy makers meeting at a workshop organised for other purposes were conducted in Thailand and in Indonesia, but only for district-level policy makers. The benefit of an opportunistic survey is being able to contact large number of policy makers at one point in time at least cost. A major problem with this approach is the selection bias as a result of convenience sampling. To over come this problem, both Thailand and Indonesia arranged a workshop for this purpose wherein a representative sample of policy makers were invited. At the end of the workshop policy makers were asked to complete the questionnaire.

Irrespective of the choice of survey method, country collaborators were provided guidelines to ensure that adequate representation was given to different types of policy makers, geographical representation and levels of decision making from centre to district (except Hong Kong). The questionnaire was designed to be self-completing and so could be posted to policy makers, if necessary. It would take about 25 minutes to complete the questionnaire.

The questionnaire had the following 5 sections:

I. Respondent's background
II. Views on health systems and health inequalities
III. Views on financing health care
IV. Views on delivery of health care
V. Views of public opinion

Finally, in most countries, the English instrument was used. However, where translation was necessary (e.g., Thailand, China), necessary safe guards were put in place using back translation. All the questionnaires were checked by country collaborators for accuracy and completeness, before being sent to the principle investigator (MB) based at London School of Economics (LSE), where all the data was entered centrally. Data was analysed using SPSS and Stata software. In reporting

[2] It is possible that as policy makers are less harassed by phone surveys, these may work in some countries.

aggregate results for groups of countries, each country sample was weighted to ensure that each country had equal weight.

To summarise, the aim of this methodology was to ensure flexibility to country collaborators but at the same time attempt to bring about standardisation in some aspects so that the individual country results obtained are still comparable within the constraints.

4.0 Results

For the purpose of preliminary cross-country comparison, we classified the ten participating countries into three groups, based on levels of socio-economic and health development. The classification was as follows: Hong Kong SAR and Taiwan were classified as group 1 countries based on their high per capita income, similar to that in OECD nations; China, Mongolia, Sri Lanka and Thailand were placed into group 2 based on their low to middle-income economies and their generally medium to high level of health indicators, and finally Bangladesh, India, Indonesia and Nepal were classified as group 3 countries, based on their low income status and poor health indicators.

A total of 184 policy makers from 10 countries participated in the survey, however, not all participants responded to every question (**See Table 1**). The mean age of the respondents was 48.7 years, and they represented province, state and district levels of decision-making.

4.1 Health systems issues

What is wrong with your health system?

The policy makers were presented with a list of key issues that might face health systems, and were asked how important they considered each to be. The eight most important problems facing health systems in these countries were ranked, according to the percentage of respondents' stating them to be problems, and the results are presented in **Table 2**.

Policy makers from all countries with a wide range of socio-economic development, had a consensus view (99% of respondents) that improving efficiency of the system is an important pressing problem facing them. Ensuring access to healthcare by the poor was the second most mentioned important problem overall, but was the most mentioned in Group 3 countries. This indicated a high degree of awareness that the poor had problems in access to care, and a greater perception that this is important in the poorer countries. The need for improving overall quality of services came third overall, but only fourth in Group 3 countries. Ensuring universal coverage was voiced most by poorer countries in Group 3, and less so by policy makers in groups 1 and 2, which is consistent with the empirical finding that inequalities in access tend to be least in higher income countries. Reducing health status inequalities was mostly perceived as an important issue in countries in Group 3 and less so in Group 1 and 2. This was ranked fifth overall. Controlling costs of health care and generating revenue for health sector were less universally important problems, and were mentioned more

often in the high-income Group 1 countries than in the other two groups. Finally, promoting traditional medicine was universally less important, with a trend for the frequency of it being cited as an important issue to increase with lower income level.

Policymakers view on efficiency and equity

Six key statements, presented in **Table 3**, on efficiency and equity were used as tracers to solicit policy makers' attitudes. A positive opinion that emerged was that the current policies of the government in respective countries are more likely to reduce health inequalities compared to those of 5 years ago. Out of 178 policymakers, who responded to this question, 65% agreed with the above statement. However, this opinion should be interpreted with caution given that many of the policy makers were not disinterested individuals, as by implication such a question asks about the impact of their own policies. Nevertheless, there was a convergence of opinion on this issue in all three groups of countries. The statement that reducing income inequalities would narrow health inequalities was agreed with by 65% of respondents. This indicated a broader perspective of determinants of health inequity outside health sector, especially on income distribution.

When opinion on whether the goal of improving effectiveness and efficiency of health services is a greater priority than reducing health inequalities was probed, there was lack of consensus: 51% agreed and 44% disagreed across the three groups. Sub-group analysis indicated that more support (two-thirds of respondents) of efficiency over equity among policy makers in Group 1 (59%) and 3 (68%), but more support of equitable health status (63%) among Group 2. With respect to whether health inequalities are largely due to different life-style choices, divided opinions emerged across the countries: 45% agreed and 48% did not.

The statement that increasing levels of health spending, without changing its distribution, would reduce health inequalities, was rejected by two-thirds or more of respondents in all groups: 72% disagreed. However, there this disagreement was modestly weaker in Group 3. This indicated that policy makers did not believe that health spending alone matters, and that most also accept that how funds are used is more important. Similarly, the statement that improving the efficiency of health services generally conflicts with fair access to those services was not supported by most respondents. Interestingly, policy makers did not agree with this notion of an efficiency equity trade-off: a majority 67% disagreed with this statement, but 23% agreed. This indicated either the two policy goals can be achieved at the same time for those who did not agree, or policymakers did not agree to trade-off efficiency with equity (fair access).

4.2 Financing of Health Care

Notions of fairness in financing

Attitudes to the notion of fairness of financial contribution were solicited from policy makers, and are presented in **Table 4.** It can be observed from Table 4 that a large majority (>80%) of the policy makers in all the country groups either agree or agree strongly with the statements that payment for health care should be based on ability to pay and disagree that payments should be linked with ability to benefit or use of services. Similarly, almost three-quarters or more of the policy makers in each group

agree or agree strongly that health care financing system should ensure that no household is driven into poverty by payments for health care. From this it is clear that the policy makers generally hold the consensus that financing of health care should be based on this notion of fairness and that equity in financing health care should be ensured. Similarly, views on health care payments in terms of contribution according to ability to pay were solicited. Majority of the respondents (85%) preferred that payments should increase with ability to pay, but a significant proportion of these (49% overall) also preferred a higher than proportionate level of payment. In other words, a majority favoured a progressive approach, with the rich required to pay more than the poor.

Who should be exempted?

Exemption from user fees for some groups of the population is a potentially important mechanism to ensure more equal access to services. Opinions on which groups should be exempted if user fees should be charged were solicited from the policy makers. This was to elicit in what dimensions they believed inequity should be addressed. An almost universal consensus emerged that socio-economic status (such as income in case of the poor) was the most important criterion for exemption. This was followed by geographical location such as being resident in remote and hard to reach areas. Religion and gender were not considered important criteria (**Table 5**) in respective countries.

Views were also sought on which target groups of a population should be exempted from user charges. Households below the poverty line were the first priority, with a consensus on this point in all groups of countries (90% overall). This was followed by children and pregnant women, who are targets of the Millennium Development - 37%, and disabled persons, followed this. The unemployed, the retiree and elderly were generally considered across all countries less important targets for exemption.

Financing healthcare: Government vs. households

Overall, a clear majority (73%) of the policy makers believed, as reported in **Table 6**, that their government spent too little on health, and 16% reported that spending was about right. Less than 1 in 10 respondents felt that the governments in their countries were spending too much money on health care. However, there is clear distinction between group 1 countries and the rest of the countries. A larger minority of policy makers (38%) in rich countries reported their spending was about right as compared to the Groups 2 and 3, where only 13% of the policy makers felt the same.

Similarly, the policy makers were asked their views on household spending on health. As reported in **Table 7**, overall about 34% of the respondents were of the opinion that households spend too much money on health care. As seen in Table 7, there is a divide in opinion between Group 1 and the rest of the countries, in that no respondent (0%) in Group 1 country felt that households spend too much money on health as compared to Groups 2 and 3 where the response was almost 50%. Sixty three per cent of the Group 1 country respondents reported that households spent too little on health, as compared to about 25% in Groups 2 and 3. This answer might be related to the empirical fact of high out of pocket spending in the poorer countries of Groups 2 and 3, but such expenditures are minimal in most developed economies, except that Hong

Kong SAR which has an unusually high level of out-of-pocket spending for a high income economy.

Generating additional revenue and financing role of the government

Potential sources of generating revenues were probed in the responses summarised in **Table 8.** Introducing "Sin taxes" for example on harmful products such as tobacco and alcohol was seen as a very important potential source (45% of policy makers), but less so among policy makers in Group 3. Increasing sin taxes was in fact much more preferred than increasing general revenue taxes. This was followed by increases in health insurance contributions, with a varying opinion among three groups of country. There was no consistent trend of whether increased general taxes and user fees in government health facilities play important roles across the three groups of country. Resources from international donors had no role according to policy-makers in Groups 1 and 2, but quite a significant potential role (very important 30% and important 56%) in the resource poor Group 3.

In event of resource constraints, two-thirds of respondents across all countries agreed that the government should provide only essential or basic care services for the whole population, which implies that households have to finance services outside this package (**Table 9**). Policy makers have a liberal view that private sector should provide care to those who can afford to pay. This attitude implies they prefer to leave the public provision for the poor.

Divergent views emerge in **Table 10**, which presents respondents' responses when asked in view of fiscal constraint, what should the governments do? The richer Group 1 and poorer Group 3 of countries preferred to limit user fees than subsidize more to general services. Whereas the middle-income countries indicated that government should subsidize the expensive treatment, which they cannot leave to the household as they are potentially catastrophic. There is no right or wrong answer to this type of question, but they indicate a stronger perception amongst middle-income countries of the desirability of protecting populations against catastrophic or expensive treatment costs than is the case in other countries.

4.3 Healthcare delivery

The goal of minimum standards of healthcare delivery was the favoured priority national policy goal in all groups of countries, rather than ensuring equal treatment (**Table 11**). This implicitly implied that policy makers across three groups gave priority to quality of care than to equitable access by all.

4.4 Efficiency equity trade-off

To what level of tolerance, policy makers would agree to a trade-off between efficiency and equity was solicited by a several hypothetical questions of a gradient reduction in program efficiency, which benefits more the poor than the rich.

The question posed was as follows. Suppose that government has to choose between two programs; Program A reduces deaths from diseases mainly affecting the rich, whereas Program B reduces deaths from diseases mainly affecting the poor people. Given that both Programs were equivalent in program cost and outcome in term of number of lives saved, which would you prefer? Majority of policy makers in the three groups (67%) chose Program B in favour of the poor. However, policy makers in Group 1 were less supportive of program B than Group 2 and Group 3, see **Table 12.1**, implying a lower prioritization to preferentially benefiting the poor.

Further hypothetical questions were probed and are presented in **Table 12.2**, for those who preferred program B or were indifferent to the above question. When Program B had less effectiveness in term of lives saved (e.g. 90% and 80%), while Program A maintained same level of effectiveness (at 100 throughout), both A and B were equivalent in program cost. In this scenario, a trend of decreasing support of Program B (equity), in favour of Program A (efficiency) was observed amongst policy makers in all countries. For example, when Program B effectiveness was 90%, 22% of policy makers supported Program A, and at 80% effectiveness, this increased to 31%. This indicates the level of tolerance to trade off efficiency with equity. When program B, which favors the poor, had far little effectiveness, less policy makers would support it.

4.5. Who should have a say?

Opinion was solicited on who should be involved in making decisions about resource allocation (**Table 13**). Policy-makers across all groups had a consensus that they themselves had a legitimate role and should have most say (67% supported this). This was followed by general public and health experts who are the constituency and major stakeholders, more than 25% support that they should have most say. Doctor should have some say, 70% of policy makers supported this.

Policy-makers across the three groups of country had doubts on the sound judgment of the general public on the direction of healthcare: only 18% felt they had sound judgment to a large extent, but a majority (60%) felt the public had some extent of good judgment (See **Table 14**). Looking across the groups, trust in public judgment tends to increase with income level.

Policy-makers were also asked who in practice had influence on shaping health policy in their countries. As indicated in **Table 15**, in all the groups, policy makers believed that the general public did have some role in shaping the healthcare system, but in the richer countries of Group 1, policy-makers felt the public had a larger role in shaping the system.

4.6. Assessment of health systems

Policymakers were asked to assess their own health systems performance. It can be observed from **Table 16** that only 9% were satisfied that it was working well, 54% reported the need for major changes and 36% minor changes. A convergence in opinion emerged across countries. Assessment of healthcare delivery systems confirmed the previous opinion, that the large majority across all three groups,

especially Group 3, desired major changes (78% of respondents), and 17% desired minor reforms. Similarly, a majority of respondents (54%) across three groups of countries had a consensus that health financing systems required major reform, 36% required minor changes, only 9% satisfied that the systems was working well.

Comparing our results with that of the World Health Report (2000) on health systems performance, one would expect that policy makers from health systems ranked high on the WHO ranking would be more satisfied with their health systems when compared with those with a lower ranking. However, no such clear correlation was observed. For example, Bangladesh and Indonesia ranked relatively high (88 and 92[3] respectively) on the WHO health systems performance ranking compared to Monglia and China (142 and 144). However, in terms of satisfaction with health systems performance, more than 50% of policy makers from Bangladesh and Indonesia were of the opinion that their health systems needed major change whereas this number was less than 50% in case of Mongolia and China. Hence there was a clear lack of correlation between our findings and those obtained by WHO ranking. This could partly be explained by the fact that our results reflect the views of the policy makers whereas the methodology used for ranking by the WHO resulted in imputed figures on health systems performance.

5.0 Discussion

This study provides invaluable insights among key policymakers who, to a large extent govern the direction of health systems development. It is imperative to understand their perception, especially on the diagnosis of health systems problem, and ideology towards equity in health systems.

Three major problems facing them were identified: inefficiency of health systems, inability of access to healthcare by the poor and overall problems on quality of services. These problems are along the line of health systems reform throughout the world, especially when a country aims to achieve the Millennium Development Goal, a major reform would include improving systems efficiency, ensuring the poor, who harbours most of the burden of disease, have adequate access to care and ensuring a decent quality of care.

Policymakers have positive attitude towards equity, and a good understanding on health determinants outside health sector, especially socio-economic development, income distribution in favour the rich than the poor, have a large influence on health inequities. For example, increased level of health expenditure must be guided by policy instrument, which would ensure better access by the poor, otherwise additional resources would be enjoyed by the urban rich. Majority of policymakers did not agree that the increase in health spending without changing in its distribution would reduce health inequalities. It indicated that they do not believe in the conventional trickle-down effects of economic growth.

They also had a positive view on financial payment according to ability to pay in a moderate way (not extremely pro-poor), at least the rich should pay proportional to the poor and at most should pay more. On who should be exempted from user

[3] Figures obtained from World Health Report (WHO, 2000) in Annex Table 1.

charges, socio-economic status should be the major criteria, such as the poor, those who resided in remote and hard to reach areas. However, there is no gap in relation to gender and religious belief in these countries that warrant special exemption.

Introducing "sin taxes" on harmful products such as tobacco and alcohol was seen as the very important sources, except poorer countries in Group 3 whereby sin tax has a lesser role. Increase in health insurance contribution is limited to countries with larger proportion of formal sector. Increasing user fees in government facilities were seen as important source among poorer countries. High level of out-of-pocket by households would result in catastrophic or inability to access to care, that might violate equity principle, but in real life, this is important source of financing healthcare in poorer countries.

Perception towards the trade-off between efficiency and equity trade-off was carefully solicited. Policymakers had preferential favour of program benefiting the poor than the rich, given equivalent cost and effectiveness. When program effectiveness benefiting the poor reduced with equivalent cost to program benefiting the rich but having high effectiveness, policymakers can tolerate inefficient program that benefit the poor to some extent. When the program effectiveness becomes unacceptable low, they would sacrifice equity and take efficiency as priority. This confirmed the notion that resource is finite and should maximize its effectiveness.

Who should have a major or minor role, policy makers, general public, experts or doctors in the direction of health systems development and resource allocation, a divide opinion emerged, according to the level of democratization and bureaucratic systems of each countries and how policy agenda was formulated. In general, policymakers viewed their role as crucial and except in more developed societies viewed the role of the general public as minimal. It would be interesting to compare the views of the policy makers with that of the general public on some of these issues[4].

A very frank assessment was provided on the health systems in general, and in particular financing and healthcare delivery. There is an urgent need for a major change throughout these countries.

7.0 Conclusion

This companion study to solicit policymakers' diagnosis of the current health systems, their ideology towards equity, their willingness to trade-off between equity and efficiency and priority target population for exemption from user fee are important inputs for the re-design of the current health systems and in particular, health financing to be more sustainable and equitable. It helps to explain the main part of the EQUITAP study, which provided the magnitude, profile, causes and nature of inequity in term of financial contribution, utilization of public health services and in public subsidies.

[4] See Bhatia et al. (2005b) on views of the general public on some of these issues.

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Table 1 Number of respondents in participating territories

Territory	No. of respondents
Group 1	
Hong Kong	27
Taiwan	8
Sub-total	*35*
Group 2	
China	18
Mongolia	3
Sri Lanka	14
Thailand	45
Sub-total	*80*
Group 3	
Bangladesh	10
India	13
Indonesia	27
Nepal	19
Sub-total	*69*
Total	184

Table 2 Relative important problem facing health systems

Health system issues	**Group 1**	**Group 2**	**Group 3**	**Overall**
	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)
1. Improving efficiency of the system	(100%) (0%) (0%) (N=37)	(100%) (0%) (0%) (N=51)	(98%) (0%) (2%) (N=60)	(99%) (0%) (1%) (N=148)
2. Ensuring access to health care for the poor	(95%) (5%) (0%) (N=37)	(85%) (0%) (14%) (N=74)	(99%) (1%) (0%) (N=72)	(92%) (2%) (5%) (N=183)
3. Improving overall quality of services	(97%) (3%) (0%) (N=37)	(82%) (3%) (14%) (N=74)	(93%) (6%) (1%) (N=72)	(90%) (4%) (6%) (N=183)
4. Ensuring universal coverage	(78%) (19%) (3%) (N=37)	(65%) (21%) (14%) (N=63)	(95%) (0%) (5%) (N=64)	(80%) (12%) (8%) (N=164)
5. Reducing health status inequalities	(83%) (17%) (0%) (N=37)	(81%) (4%) (15%) (N=66)	(90%) (7%) (3%) (N=72)	(85%) (8%) (17%) (N=175)
6. Controlling costs of health care	(94%) (6%) (0%) (N=36)	(66%) (20%) (14%) (N=68)	(79%) (15%) (6%) (N=72)	(77%) (15%) (8%) (N=176)
7. Generating revenue	(95%) (5%) (0%) (N=37)	(50%) (21%) (29%) (N=48)	(63%) (23%) (14%) (N=72)	(67%) (18%) (15%) (N=156)
8. Promoting traditional medicine	(49%) (43%) (8%) (N=37)	(53%) (7%) (39%) (N=44)	(62%) (29%) (9%) (N=58)	(56%) (26%) (18%) (N=139)

Note: Issues ranked according to overall ranking, and not according to order in questionnaire. Shades of grey used to indicate the first, second and third most mentioned issue in each group of countries.
NI= Not important
NO= No opinion

Table 3 Opinion on equity and efficiency, ranked by percent of agreement across all countries

	Group 1	Group 2	Group 3	Overall
	A D DN (%) (%) (%)	A D DN (%) (%) (%)	A D DN (%) (%) (%)	A D DN (%) (%) (%)
1. Current policies of the government are more likely to reduce health inequalities compared to those of 5 years ago?	(73%) (19%) (8%) (N=37)	(55%) (19%) (26%) (N=73)	(72%) (18%) (10%) (N=69)	(65%) (19%) (16%) (N=178)
2. Reducing income inequalities would narrow health inequalities.	(65%) (32%) (3%) (N=37)	(70%) (22%) (8%) (N=67)	(63%) (34%) (3%) (N=73)	(66%) (30%) (4%) (N=177)
3. Effectiveness and efficiency of health services is a greater priority than reducing health inequalities.	(59%) (41%) (0%) (N=37)	(31%) (63%) (6%) (N=74)	(68%) (25%) (7%) (N=73)	(52%) (43%) (5%) (N=183)
4. Health inequalities are largely due to different life-style choices.	(51%) (46%) (3%) (N=37)	(35%) (51%) (14%) (N=71)	(52%) (46%) (2%) (N=71)	(45%) (48%) (7%) (N=179)
5. Increasing levels of health spending without changing its distribution, would reduce health inequalities.	(5%) (76%) (19%) (N=37)	(14%) (79%) 8%) (N=70)	(33%) (63%) (4%) (N=64)	(19%) (72%) (9%) (N=171)
6. Improving the efficiency of health services generally conflicts with fair access to those services.	(8%) (89%) (3%) (N=37)	(19%) (66%) (15%) (N=72)	(37%) (53%) (10%) (N=62)	(23%) (67%) (10%) (N=171)

A denotes agree
D denotes disagree
DN denotes don't know

Table 4 Agreement on the notion of financial contributions

	Group 1	Group 2	Group 3	Overall
	AS A D DN (%) (%) (%) (%) (N=37)	AS A D DN (%) (%) (%) (%)	AS A D DN (%) (%) (%) (%)	AS A D DN (%) (%) (%) (%)
i. Payment for health care should be based on ability to pay- i.e. those with higher income should pay more than those with lower incomes.	(38%) (54%) (8%) (0%)	(31%) (57%) (8%) (4%) (N=74)	(41%) (41%) (18%) (2%) (N=74)	(36%) (49%) (12%) (3%) (N=184)
ii. Payment for health care should be based on ability to benefit- i.e. those who use the health care more should pay more irrespective of their income.	(0%) (25%) (75%) (0%)	(1%) (18%) (73%) (7%) (N=74)	(2%) (32%) (66%) (0%) (N=71)	(2%) (25%) (72%) (3%) (N=184)
iii. Health care financing system should ensure that no household is driven into poverty by payments for health care	(57%) (38%) (3%) (3%)	(48%) (28%) (22%) (2%) (N=54)	(51%) (45%) (4%) (0%) (N=67)	(51%) (38%) (10%) (1%) (N=158)

Note:
AS denotes agree strongly
A denotes agree
D denotes disagree
DN denotes don't know

Table 5 Relative importance of exemption criteria

Basis for defining groups for exemption	**Group 1**	**Group 2**	**Group 3**	**Overall**
	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)	Imp NI NO (%) (%) (%)
Socio economic status	(97%) (3%) (0%) (N=37)	(90%) (7%) (3%) (N=62)	(94%) (4%) (2%) (N=67)	(94%) (4%) (2%) (N=165)
Geographical location	(72%) (26%) (2%) (N=36)	(85%) (10%) (5%) (N=67)	(89%) (7%) (4%) (N=67)	(84%) (12%) (4%) (N=170)
Age	(78%) (22%) (0%) (N=37)	(60%) (24%) (16%) (N=50)	(82%) (17%) (1%) (N=65)	(74%) (20%) (6%) (N=152)
Sex	(23%) (73%) (4%) (N=37)	(39%) (48%) (13%) (N=34)	(77%) (22%) (1%) (N=69)	(54%) (41%) (5%) (N=140)
Religion	(10%) (86%) (4%) (N=37)	(24%) (63%) (13%) (N=33)	(27%) (70%) (3%) (N=56)	(21%) (73%) (6%) (N=126)

Table 6 Assessment of how much does their government spend on health?

	Group 1 (N=36)	**Group 2 (N=69)**	**Group 3 (N=71)**	**Overall**
Too much	6%	13%	5%	8%
Too little	56%	77%	77%	73%
Right amount	38%	10%	11%	16%
Don't know	0%	0%	7%	3%

Table 7 Assessment of how much households spent on health?

	Group 1 (N=37)	**Group 2 (N=71)**	**Group 3 (N=68)**	**Overall (N=176)**
Too much	0%	39%	47%	34%
Too little	63%	21%	28%	32%
Right amount	33%	15%	13%	18%
Don't know	4%	25%	12%	16%

Table 8 Potential source of revenue for health sector

	Group 1	Group 2	Group 3	Overall
	VI I NI NO (%) (%) (%) (%)	VI I NI NO (%) (%) (%) (%)	VI I NI NO (%) (%) (%) (%)	VI I NI NO (%) (%) (%) (%)
Introduce "Sin taxes" on tobacco/alcohol sales	(35%) (54%) (11%) (0%) (N=37)	(61%) (29%) (6%) (4%) (N=48)	(39%) (32%) (28%) (1%) (N=72)	(45%) (36%) (17%) (2%) (N=157)
Increase Health Insurance contribution.	(50%) (45%) (4%) (1%) (N=37)	(23%) (47%) (14%) (16%) (N=62)	(48%) (40%) (8%) (4%) (N=58)	(38%) (44%) (10%) (8%) (N=157)
Increase general taxes	(25%) (28%) (39%) (8%) (N=36)	(15%) (19%) (45%) (21%) (N=62)	(25%) (41%) (23%) (11%) (N=55)	(21%) (29%) (36%) (14%) (N=149)
Increase user fees in government health facilities	(16%) (46%) (38%) (0%) (N=37)	(6%) (37%) (30%) (27%) (N=62)	(10%) (50%) (33%) (7%) (N=58)	(11%) (44%) (32%) (13%) (N=157)
Obtain money from international donors	(3%) (5%) (89%) (3%) (N=37)	(0%) (24%) (70%) (6%) (N=62)	(30%) (56%) (10%) (4%) (N=50)	(11%) (30%) (54%) (5%) (N=149)

Notes:
VI denotes very important,
I denotes important
NI denotes not important
NO denotes no opinion

Table 9 The optimal government finance and provision role

	Group 1	Group 2	Group 3	Overall
	A D DN (%) (%) (%)	A D DN (%) (%) (%)	A D DN (%) (%) (%)	A D DN (%) (%) (%)
i. Given the resource constraints, Government should provide only the essential/basic health care services to the whole population.	(75%) (25%) (0%) (N=36)	(63%) (37%) (0%) (N=30)	(62%) (38%) (0%) (N=58)	(67%) (33%) (0%) (N=124)
ii. Government should encourage those who can afford to purchase health care to seek care from the private sector.	(54%) (41%) (5%) (N=37)	(80%) (17%) (3%) (N=30)	(80%) (17%) (3%) (N=59)	(72%) (24%) (4%) (N=125)

A denotes agree
D denotes disagree
DN denotes don't know

Table 10 The government financial role in view of fiscal constraint

	Group 1 (N=37)	Group 2 (N=30)	Group 3 (N=57)	Overall (N=124)
Limit users fee	54%	43%	67%	57%
Subsidize expensive treatments	46%	57%	33%	43%

Table 11 National priority policy goals on healthcare delivery: standards versus equity

	Group 1 (N=37)	Group 2 (N=30)	Group 3 (N=55)	Overall (N=122)
Minimal Standard	84%	70%	69%	74%
Equal Treatment	16%	30%	31%	26%

Table 12.1 Scenario 1 Program A and B had equal cost and outcome

	Group 1 (N=37)	Group 2 (N=66)	Group 3 (N=66)	Overall (N=167)
Programme A	9%	11%	5%	8%
Programme B	43%	70%	76%	67%
Indif. A & B	48%	19%	19%	25%

Table 12.2 Scenario 2: gradient of trade off between efficiency and equity.

	Group 1	Group 2	Group 3	Overall
Program effectiveness	A B Indif. (%) (%) (%)	A B Indif. (%) (%) (%)	A B Indif. (%) (%) (%)	A B Indif. (%) (%) (%)
A – 100% B – 90%	(41%) (59%) (0%) (N=32)	(34%) (54%) (12%) (N=56)	(7%) (93%) (0%) (N=49)	(22%) (72%) (6%) (N=105)
A – 100% B – 80%	(41%) (59%) (0%) (N=32)	(35%) (51%) (14%) (N=57)	(27%) (73%) (0%) (N=450)	(31%) (61%) (8%) (N=108)

Table 13 Who should be a say in resource allocation

	Group 1	Group 2	Group 3	Overall
	MS SS NS DK (%) (%) (%) (%)	MS SS NS DK (%) (%) (%) (%)	MS SS NS DK (%) (%) (%) (%)	MS SS NS DK (%) (%) (%) (%)
Policy makers	(53%) (47%) (0%) (0%) (N=36)	(78%) (17%) (5%) (0%) (N=64)	(64%) (36%) (0%) (0%) (N=69)	(67%) (31%) (2%) (0%) (N=169)
General public	(38%) (49%) (0%) (13%) (N=36)	(28%) (55%) (16%) (1%) (N=56)	(41%) (36%) (16%) (7%) (N=59)	(35%) (46%) (13%) (6%) (N=151)
Other health experts	(8%) (89%) (3%) (0%) (N=36)	(18%) (74%) (6%) (2%) (N=56)	(44%) (49%) (7%) (0%) (N=66)	(27%) (67%) (6%) (0%) (N=158)
Doctors	(14%) (86%) (0%) (0%) (N=36)	(11%) (72%) (17%) (0%) (N=58)	(30%) (59%) (9%) (2%) (N=64)	(19%) (70%) (10%) (1%) (N=158)

Notes
MS denotes most say
SS denotes some say
NS denotes no say
DK denotes don't know

Table 14 General public sound judgment on direction of healthcare

	Group 1 (N=37)	**Group 2 (N=73)**	**Group 3 (N=55)**	**Overall (N=165)**
Large Extent	29%	20%	8%	18%
Some Extent	60%	60%	61%	60%
No judgment	11%	15%	29%	19%
Don't know	0%	5%	2%	3%

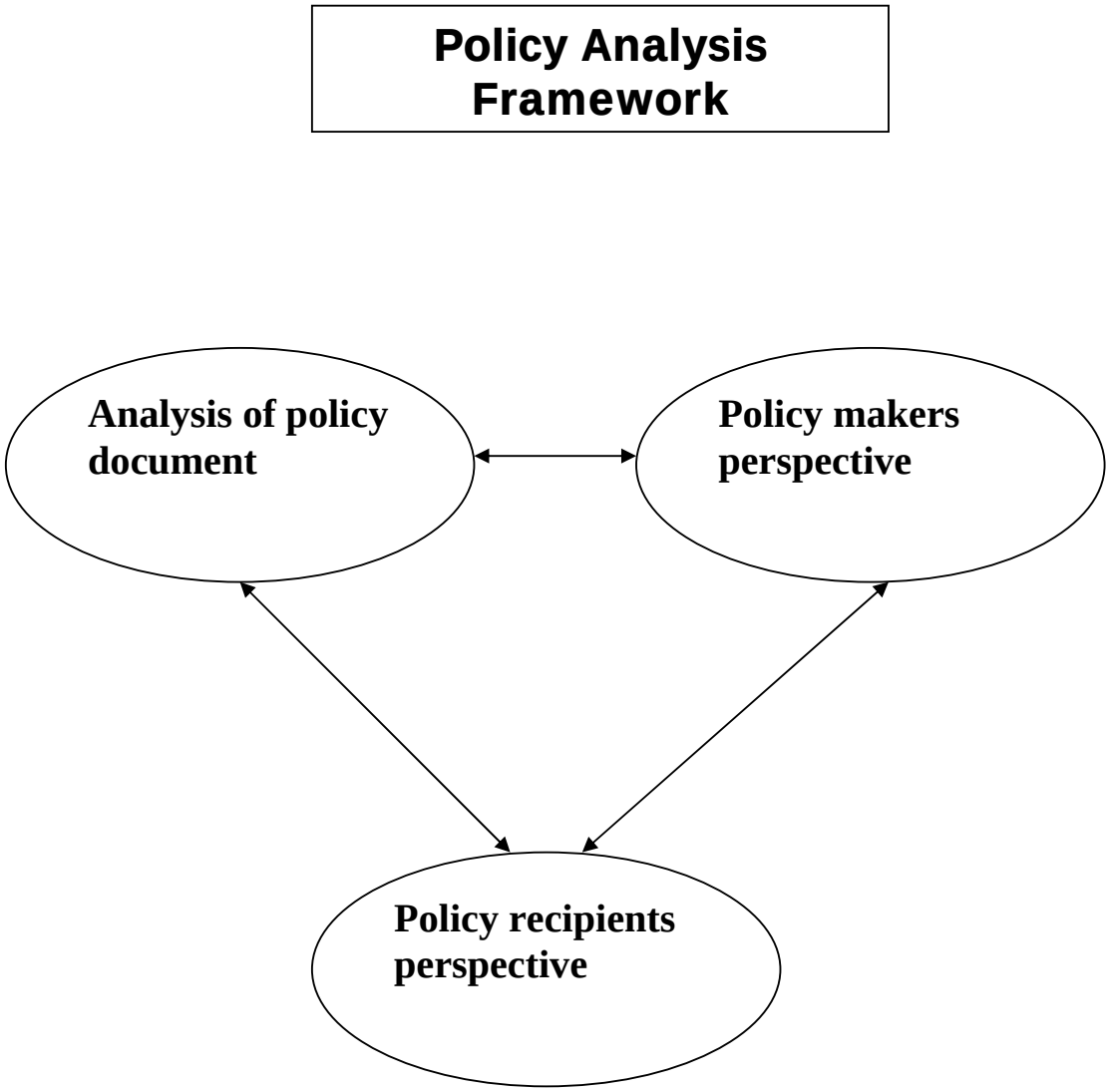
Table 15 Role of public in shaping healthcare services

	Group 1 (N=37)	**Group 2 (N=73)**	**Group 3 (N=55)**	**Overall (N=164)**
Large Extent	22%	19%	16%	32%
Some Extent	54%	75%	64%	59%
No judgment	24%	2%	18%	7%
Don't know	0%	4%	2%	2%

Table 16 Assessment of health system performance

	Group 1 (N=32)	**Group 2** (N=16)	**Group 3** (N=56)	**Overall** (N=104)
Working well	22%	3%	3%	9%
Minor changes	54%	50%	17%	36%
Major changes	24%	47%	78%	54%
Don't know	0%	0%	2%	1%

Figure 1: Framework for Policy Analysis



Annex Table 1: Development indicators, year 2000

Territory	World Bank Income Group	GNI per capita[(a)]	Population	% urban[(b)]	Life expectancy[(c)]	IMR[(d)]
Hong Kong, SAR	high	25920	6,797,000	100	79.82	2.9
Taiwan	high	14188	22,276,672	63.25	74.9	5.86
Thailand	lower-middle	2010	60,728,000	19.83	68.82	27.92
Sri Lanka	lower-middle	850	19,359,000	22.8	73.14	14.95
China	lower-middle	840	1,262,460,000	35.79	70.26	32
Indonesia	low	570	210,421,000	40.99	66.03	40.88
Mongolia	low	1,600	2,398,000	57	...	60
Punjab (India)	low	537	24,324,749	27.66	64.1	57.1
Bangladesh	low	370	131,050,000	25	61.19	60
Nepal	low	240	23,043,000	11.85	58.86	73.6

Source: World Bank, WDI Tables (http://devdata.worldbank.org/data-query/)
Notes:

a. GNI - gross national income, Atlas method (current US$).
b. % of population which is urban.
c. Life expectancy at birth (years).
d. Infant mortality rate per 1000 live births

Table 2: Health care financing mix (percentage of total health expenditure from main sources)

Territory (year)	Public Finance			Private Finance		Other
	General govt. revenue[a]	*Social Insurance*	*All public finance*	*Private Insurance*	*Direct payments*	
Bangladesh (1999)	27.23%	0.00%	27.23%	0.0%	64.64%	8.13%[b]
China (2000)	14.89%	16.52%	31.4%	0.0%	60.35%	8.24%[c]
Hong Kong, SAR (1999-2000)	55.10%	0.00%	55.10%	12.52%	30.79%	1.28%
Indonesia (2001)	23.71%	1.77%	25.48%	6.11%	68.41%	0.00%
Mongolia			71%		17%	12%
Nepal (1994-5 & 1995-6)[d]	23.50%	0.00%	23.50%	0.00%	75.00%	1.50%[e]
Punjab (India) (1995-96)	40.73%	1.30%	42.03%	0.20%	56.41%	1.28%[f]
Sri Lanka (2002)	45.0%	0.00%	45.0%	6.0%	48.0%	1.0%
Taiwan (2000)	9.17%	51.78%	60.95%	8.90%	30.15%	0.00%
Thailand (2000)	56.28%	5.11%	61.39%	5.87%	32.74%	0.00%

Source: National / Domestic / Regional Health Accounts unless stated otherwise. Row totals sum to 100%.

a. Includes revenues from donors / foreign aid.
b. Private enterprise, NGOs and community health insurance.
c. Payments by collective organisations, towns and villages through grass roots governments and rural cooperatives.
d. Public finance data for 1994-5 [HMG/Nepal, 2000 #985], private expenditure data from 1995-6 Nepal Living Standards Survey (Hotchkiss, Rous et al. 1998).
e. Private companies.
f. Revenue from private firms and NGOs for finance of own facilities.