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Views of General Public on Health System issues in four Asian Countries.

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Abstract

In recent years number of Asian countries have witnessed significant changes to their health care system both in terms of financing and delivery of health care. While health sector reforms and their impact on equity and efficiency have been addressed to some extent, the views of the general public have rarely been examined. One of the ways to assess public views is by conducting opinion polls. Public opinion polls are commonly conducted in the developed countries to inform policy makers of the public's views on health systems issues but such surveys have hardly been conducted in a developing country context. This paper presents the comparative results of a opinion poll survey conducted among the general population of 4 Asian countries: Bangladesh, Nepal, Sri Lanka and Mongolia. Data was collected from a nationally representative sample of 1014 respondents in Bangladesh, 1001 in Mongolia, 1500 in Nepal and 2002 in Sri Lanka, through personal interviews using a standardised questionnaire. The design of the survey questionnaire was aimed at capturing both respondents' knowledge and their opinion on specific health system issues including access to government health services. The results show high level of dissatisfaction with government health services in all the countries. Majority of the respondents felt that major changes were needed to improve the working of the health system. Access to government health services, especially for the poor, was an important concern among the respondents. One in every two respondents in these countries expressed that their governments did not consider their views at all in shaping health care services. Policy implications of the study findings are discussed.

Key words: Opinion polls, health systems, access, health sector reforms, health inequalities, developing countries, Asia.

1.0 Introduction

In recent years, number of Asian countries have witnessed significant changes to their health care system both in terms of financing and delivery of health care. A combination of factors including new public management ideology, lack of resources, devaluation of currency, pressures from international donors, and national government policies have been responsible for introduction of the reforms in the health sector in the region. Common reforms in the health sector include introduction of user charges in government facilities, public private mix, decentralisation, hospital autonomy, etc. Although health sector reforms and their impact on equity and efficiency have been addressed to some extent, the views of the general public to these changes and the health system in general have not been assessed in a systematic manner.

Public consultation and involvement in health policy process is the current "mantra" in number of developed countries. There is a growing consensus that obtaining views and feedback from users and general public is an essential part of the public policy process (Knox and Mcalister, 1995). For health care systems to be effective in 21st century, and that the citizens support it, it is imperative that public involvement is ensured. Although the level of participation and involvement may vary from consultation (seeking their views) to partnership (fully decision making by public/citizen control), majority of the health systems are engaged in involving the public in some way or the other. It is not surprising therefore that there are calls for increased public involvement in health care planning and decision making and terms such as responsiveness, accountability, public participation, etc. have been frequently cited (Suanders et al. 2002). For example, in the UK, recent government policies aim at promoting public involvement in health care (Florin and Dixon, 2004). Similarly, citizens' juries have been set up in Western Australia (Mooney and Blackwell, 2004).

Eliciting views of the general public is a first step in engaging and involving the public in decision-making process. Views of the public are essential for any effective policy decision as the general public plays important roles as taxpayers, collective community decision makers and as users. Therefore, it can be argued that the public should have a say. In addition, involving the public will ensure that health policy decisions better reflect the values of the community (Florin and Dixon, 2004). As end users, their views are important in assessing the quality of services (Donabedian, 1988); and the responsiveness of the services (WHO, 2000). Involving the public is also likely to make the services more responsive[1] to the public who use them as they are the ones to use it and judge it. Besides, involving the public brings legitimacy to the policy process and makes the process more transparent and accountable (WDR 2004).

[1] One of the measures considered in analysing health systems performance in WHO (2000) report was responsiveness and has given impetus to this measure.

It may also be noted that the views of the experts may not necessarily represent that of the general public. A study by Bowling et al. (1993) showed that the views of the GPs and that of the general public with respect to ranking priorities across public services in the UK were significantly different from each other. The conditions that were ranked as top priorities by GPs were on the bottom list of the general public. Hence it is essential that instead of relying on the expert opinion, it may be best to also seek the views of the general public.

Having established the need to consult the public, the next question then is what are the approaches to consult the public? There are number of ways by which public can be consulted or involved in general: by the use of citizens juries (Lenaghan et al. 1996), use of panels (Dowswell et al. 1995), Delphi technique, public opinion polls, deliberative democracy, focus groups (Dolan et al. 1999), conjoint analysis (Ryan et al. 2001), willingness to pay and other approaches. Jordean et al (1998) presents some of these approaches using in a 2x2 contingency table based on whether the respondents were provided with any information and whether opportunity for deliberation was made available to the respondents. Citizens juries and panels usually have informed respondents who have an opportunity to deliberate the issue at hand whereas in case of opinion poll surveys, data is collected from uninformed public who have no opportunity to deliberate. The remaining two cells have either informed respondents or deliberation is possible **(See Table 1**). All these approaches have their own strengths and limitations[2].

Although opinion poll surveys involve uninformed participants and offers no scope for deliberation, it is yet the most familiar means of consulting the public. According to Blendon (1991), "public opinion polls play an increasingly important role in informing policy makers of the public's views on reform strategies". In the developed countries, opinion polls are frequently conducted to inform policy makers of the public's views on various health systems issues including satisfaction (WESH survey, 1994); Euro barometer survey No. 49, 1998). For example, number of opinion polls were conducted in Australia to assess community attitudes to assisted reproductive technology (Kovacs et al. 2003). Similarly, number of papers have been published reporting results of access and satisfaction with health systems in European countries (Blendon et al. 1990, 1991,1994, 2002; Donelan et al. 1999). Wilson and Rosenberg (2004) use opinion polls data to compare the perceptions and realities with respect to accessibility to health care in the Canada. Bowling et al. (1996) presents the views of UK citizens on priority setting and rationing by conducting opinion poll survey. Mossialos & King[3] and King & Walter use the Eurobarometer survey results to assess the views of the respondents for setting health care priorities in Europe and in UK. Recently, methodological development in terms of measuring responsiveness (Darby et al.); and eliciting public preferences with respect to health inequalities by assessing strength of preferences to different sorts of

[2] See Jordan et al. (1998) and Ryan et al. (2001) for further details. For opinion polls see Altman and Brodie (2002).

[3] Mossialos and King used the Eurobarometer (1998) survey data to analyse the views of the general public with respect to priority setting.

reduction in health inequalities through eliciting trade-offs has also been attempted (Shaw et al. 2001).

In many developing countries, health care policies are made by Ministry of Health usually without any inputs from the public and are not necessarily accountable to the public. According to Paul (1992), public accountability can be augmented if the system uses "exit" or "voice" i.e. the extent to which the public can vote with their feet or the degree to which they can influence services through some form of participation or articulation with their voice. In absence of choice (alternative providers) for many, especially the poor in developing countries, the exit option is not realistic. Hence assessing their views (giving the people voice) is crucial. In addition, popular support for proposed health care reforms is quite critical for ensuring that the reforms are actually implemented. Finally, such an approach could be crucial in not only understanding publics views and concerns about the health sector reforms but also provide inputs/feedback to policy makers for future direction of health sector reforms.

This paper aims to elicit views of the general public on health systems issues focussing on health inequalities in four Asian countries using opinion polls survey. To the best of our knowledge this is the first paper to provide a comparative cross-country perspective from nationally represented sample from four Asia countries namely Bangladesh, Nepal, Sri Lanka and Mongolia. The paper is structure 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

The four Asian countries included in this study are Mongolia, Bangladesh, Nepal and Sri Lanka, all low-income developing countries. All these countries place government financed care, with public provision of medical services, at the centre of overall national policy. Mongolia introduced social health insurance in 1994. The health insurance scheme in Mongolia is compulsory for all public and private sector employees, the low-income and vulnerable population. The remaining three countries have health systems in which the predominant sources of financing are taxes and direct out-of-pocket payments by households. Unlike Mongolia, presence of social health insurance is negligible in these countries. However, despite the overall similarity in financing and provision systems in Bangladesh, Nepal and Sri Lanka, there are significant differences observed in terms of their health and socio-economic indicators. **Table 2** presents the comparative summary for the four countries.

Health conditions are relatively poor in Bangladesh and Nepal, with high infant mortality rate and a life expectancy of less than 60 years at birth in 1997. Gender and regional differentials in disease prevalence and incidence are significant. By contrast, Sri Lanka has achieved both low mortality and low fertility rates. In fact, Sri Lanka has health

indicators, which are more akin to an upper-middle income economy than to a developing country. With an income level of just less than US$800 per capita, Sri Lanka has infant mortality rate of 15, and female life expectancy of 75 and 71 years at birth. Mongolia is somewhere in between with female life expectancy of 66.5 years at birth and an infant mortality rate of 23 per l000 live births. In contrast to Sri Lanka where variations in health status between different subgroups of the population are not great, with minimal differences between urban and rural populations, there are significant variations between urban and rural areas in rest of the countries, especially Nepal and Bangladesh. Maternal and child health are one of the important priorities in these countries.

The private sector is still insignificant in terms of size, number of beds and service range in Mongolia. In all remaining three countries, there is a growing private sector, which accounts for a substantial share of overall ambulatory provision, plus a smaller share of inpatient provision. In general, both Mongolia and Sri Lanka are characterised by a greater degree of state involvement in both financing and provision than in Bangladesh and Nepal. **Table 3** provides a brief overview of each of the countries' health systems.

With respect to financing of health care, in case of Bangladesh, the total national health care spending was estimated to be about 4 percent of GDP in 1997 (Data International, 1998). In 1996-97, approximately 34 percent of health financing came from public sources, 64 percent from private, out-of-pocket household expenditures, and 1 percent from NGOs. Sri Lanka's National Health Accounts (SLNHA) estimates that total national health expenditures were Rs. 25,068 Millions in1996, equivalent to 3.3 percent of GDP. Of total financing, 50% was estimated to come from government sources and 50 percent from private sources (Institute of Policy Studies, 2003). Most private sector services are paid for out-of-pocket, including private hospital services. In case of Nepal, the total health expenditure is estimated at 4% of the GDP, with less than 1% from government sources. More than 70% of the total health expenditure is from private sources, mainly out of pocket payments. Finally, Mongolia spends 6% of its GDP on health, of which, government was reported to be responsible for 43% of National Health Expenditure (NHE), social health insurance, 29%, and the rest 28% was borne by the household direct payment (Bayarsaikhan, 2005).

In terms of health spending, Sri Lanka is a low health spender when compared to the rest of the countries with health indicators much better than the rest.

3.0 Survey Methodology

The data for this study was obtained from nationally representative sample of adults over the age of 18 years using a standardised questionnaire in each of the four countries. Sampling methodology used to identify respondents varied among these countries. For example, stratified cluster sampling was used in Bangladesh. In the first step, the country was divided on the basis of divisions and rural-urban areas into 16 strata. A sample of

1000 adults was allocated to these strata according to proportional allocation method. Finally, respondents were selected randomly using the concept of defined primary Sampling Units (PSUs) as used by the Bangladesh Bureau of Statistics (BBS). In case of Mongolia, multi-stage sample design was used. In the first stage, regions were selected using geographical areas (western, central, eastern region) followed by selection of 1 aimag (provinces) from each region and 2 soums (rural areas) from each aimag using simple random sampling. Lastly a random sample of individuals was selected from the selected soums. In case of Nepal, 30 districts were selected based on the probability proportional to the size using 2001 census data. From each district 50 interviews were conducted giving a total of 1500 interviews. It may be noted that although the sampling approach varied among the countries, based on the availability of sampling frames, nevertheless nationally representative sample was obtained from each country.

Although a standardised questionnaire was developed and used in each of these countries, flexibility was built-in to permit variation across countries with respect to certain socio-demographic and system specific variables. The design of the survey questionnaire was aimed at capturing both respondent's knowledge and their opinion on health inequalities and health systems issues in all these countries. The questionnaire had 5 sections. Section I sought respondent's socio-economic information like age, sex, religion, place of residence, schooling, household size, family income, etc. Section II, III and IV sought both extent of knowledge and views on health systems issues and health inequalities. These included number of topics like access to government health services, satisfaction with govt health services, who benefits most from govt health services, government spending for health services, views on raising additional revenue for health services, view on user fees, and health system reform priorities. The final section sought views on whether government considers their views in shaping health services. To ensure that respondents are not forced to take a specific stand, most questions had don't know option.

Unlike in OECD countries where interviews over telephone are commonly used (Blendon et al. 1999), in our case personal interviews were carried out in all the four countries. Personal interviews were held with 1014 respondents in Bangladesh, 1001 in Mongolia, 1500 in Nepal and 2002 in Sri Lanka. The interviews were conducted by field researchers who were provided necessary training with respect to the aim of the survey, content of the questionnaire, and interviewing technique. The original questionnaire in English was translated into local language using standard translation safeguards. Supervision during data collection phase was ensured in all countries. Data was collected between September, 2004 and March, 2005. Data was cleaned and edited to minimise errors and inconsistencies before entering into database. SPSS was used to analyse the data. Multi nominal regression was used where appropriate.

4.0 Results

The survey gathered data on the respondent's socio-demographic variables like age, gender, education, occupation, place of residence, marital status. In addition, information was also sought about their family size and household income. The results are presented in **Table 4.** The table shows that there is a pro male bias observed in the sample mainly

as a result of high proportion of males interviewed in Nepal (64%). Except for Sri Lanka, in the rest of the countries, more than 70% of the respondents were below the age of 45 years. As expected, more than 70% of the respondents were from rural areas in Nepal and Bangladesh, reflecting predominantly rural nature of these countries. Both Mongolia and Sri Lanka have high urban respondents. Given that Mongolia is more urbanised, higher urban respondents is expected in case of Mongolia. However urban bias in the Sri Lankan sample appears to be the case, given that as a nation it has (14.6%) of urban population[4]. Muslims and Hindus were the dominant religion in Bangladesh, and Nepal whereas Buddhist were a majority in case of Mongolia and Sri Lanka. With respect to education, 48% of the respondents overall had secondary level schooling and 17% were educated up to university level. While 48% have secondary education on average, this is largely driven by high rates of secondary schooling in Sri Lanka and Mongolia. The share of respondents with secondary schooling is much lower in Bangladesh and Nepal. The mean family size was 5.3 overall, being high in Bangladesh (5.5) and Nepal (6.5) as compared to Mongolia(4.3) and Sri Lanka (4.9). Based on the household income[5], the respondent's in each country were divided into three income groups: poor, middle and rich. **Table 5** presents the mean family size and household income for the study countries.

Health inequalities

Equity in access to and use of health services is commonly an important goal for policy-makers in these countries. The views of the respondents with respect to some of these issues are presented below.

Table 6 presents summary of their views on questions relating to health inequalities. It is interesting to note that on average, 40% of all respondents in the four countries felt that the better-off contributed most to the financing of government health services; only 12% felt that the poor contributed most. In contrast, with regard to the delivery of services, the poor are regarded as making the most use of government health services (overall 36%) as compared to the rich (23%). However, almost 1 in every 2 respondents agreed that on an average it's the rich who are in better health as compared to the poor (8%). Hence, based on the views of the respondents, it appears that both in terms of financing and delivery of care, the health systems in these countries are progressive.

Public opinion with regard to the distribution of public subsidies is interesting, because it reflects the actual distribution of subsidies as shown by empirical findings. In Nepal and Bangladesh where the rich actually capture a large share of public subsides, public opinion reflects this – especially in Nepal. In Sri Lanka and Mongolia, where public subsidies benefit the poor, public opinion reflects this also.

Use of government health services

Respondents from Mongolia, Nepal and Sri Lanka are significantly more likely to use government health facilities as compared with Bangladesh where only 31% of the

[4] Urban bias is present in the case of Sri Lanka as the survey was conducted post Tsunami and hence excluded some of the affected rural areas resulting in urban areas.

[5] One US $ = 63.7(30/3/2005) Bangladeshi takas, 1120 (30/3/2005) Mongolian tugrug,74.26 (30/11/2004) nepali rupees, and 99.43 (30/3/2005) Sri Lankan rupees.

respondents reported using government hospitals or clinics. Instead a significant percentage in Bangladesh uses private facilities and pharmacies. Sri Lankans and to a lesser extent Nepali's, in addition to the government health services, also make significant use of the private facilities **(See Figure 1**). Less than 1 in 10 Mongolian's uses the private sector and are more likely to make use of pharmacies (22%). In fact, next to Bangladesh, the highest use of Pharmacies is in Mongolia.

High utilisation of both government and private health facilities in case of Sri Lanka can be explained by its high overall utilisation rates. Sri Lankan's are highly health conscious and make frequent and early use of medical services when sick. with 4.5 physician contacts per capita annually, and an inpatient admission rate of 20 percent per annum. Surveys show that per capita utilisation rates of formal medical services are equal across all income quintiles. Poorer households use predominantly government services, while richer households are more likely to use private services (Institute of Policy Studies, 2003).

Given the significant high coverage through SHI, it is not surprising that the private drs/clinics are not much used in case of Mongolia. Those not insured tend to visit the pharmacies and shops to get the drugs (Bayarsaikhan, 2005). In all the countries, private sector services, including pharmaceutical outlets, are concentrated in the major cities. Private ambulatory care by qualified modern providers is provided mostly by small clinics and hospitals. Pharmacies and shops are responsible for most of the distribution of pharmaceutical goods, which is mainly paid for by household out-of-pocket spending.

Utilization of government health services is related to satisfaction with these services. Low utilisation of government health services in Bangladesh can also be explained by the fact that almost 2 in every 3 respondents were not satisfied with these services. In contrast, in rest of the countries, about 1 in every 3 respondents were not satisfied with government services, the lowest being in Sri Lanka. In addition, utilisation is also directly related with access to health services, results of which are presented below.

However, caution is advised in making a direct link between satisfaction as expressed in the poll and utilisation rates reported above. Access is a critical factor in determining which services people use. When "private" health care is sought in Bangladesh, it's largely at unqualified or traditional providers. Reasons for which include lack of knowledge and an inability to distinguish between qualified, modern providers and others, fewer physical barriers to access, lower costs.

Access to health services

Respondents were asked how easy it was for them to access government facilities **(See Figure 2)**. Overall, 42% of the respondents found it difficult/very difficult in obtaining health care from government services. In Bangladesh and Mongolia about 1 in every 2 respondents found difficulty in getting health care whereas it was significantly lower in case of Nepal (25%) and Sri Lanka (36%).

Subsequently, similar question about how easy it was for poor/ rich to access government services was posed to all respondents. High percentage of respondents from each of the study country were of the view that it was easy for rich to obtain health care from government services **(See Table 7).** The overall response with respect to the poor for the same was 42%, with significant variation between Nepal (61%) and Sri Lanka (58%) as compared to Bangladesh (25%) and Mongolia(26%)

A recent report on equity in health in Bangladesh concluded that the level of service remains inadequate: 60 percent of the population lack access to basic health, over 70 percent pregnant women do not receive ante-natal care, and over 90 percent of them do not receive post-natal care (Ahmed and Karim, 1998). The health care delivery system in Mongolia is facing three major problems, which include poor quality of care, inefficient provision and utilization at all referral levels, and health inequity mainly between urban and rural areas (Knowles, 2004). Geographical distance also affects transportation cost for accessing to health services specially, from remote rural areas to the provincial centre and capital city. The high response in case of Nepal can be explained by the fact that there have been increase in the establishment of healthcare facilities during the past decade in order to improve access of the rural poor population to basic health care. Primary healthcare services are provided at district level through Sub Health Posts (SHP), Health Posts (HP), Primary Healthcare Centres (PHC) and District Hospitals (DH). During the period of 1992 to 1996, the number of sub health posts increased almost twelve times, from 200 facilities to 2,597 (HMG/MOF, 1996, *Economic Survey Fiscal Year 1995-96*).

This underlines the contextual nature of these responses. Access to health services in Nepal is well below par compared to Sri Lanka or even Bangladesh. So, if more Nepalese than Bangladeshi's felt that they had good access to services, it was because the access situation had improved relative to what they had before and not necessarily because they had better access to services than the Bangladeshis.

Access to health services is a problem for number of reasons but important factors include financial and geographical access. Lack of money being an important factor was also confirmed when overall, 1 in 4 (25%) respondents confirmed that they had to borrow money over last year to raise money to pay for health care for family members. In addition, 8% of the respondents confirmed selling household items to pay for health care **(See Table 8).** As one would expect, both borrowing and selling household items were significantly higher in respondents from low-income group. In the high-income groups, use of savings to pay for health care was commonly observed. Between countries, respondents from Bangladesh (40%) were more likely to borrow money and sell household items (13%) and in case of Mongolia least likely to do so. This to some extent can be explained by high utilisation of the private sector and low utilisation of government services in Bangladesh.

Financing of health care

Government spending and sources for additional revenue

When asked their view of government spending on health care, 1 in every 2 respondents in Bangladesh (49%) and Sri Lanka (54%) were of the opinion that government spending is too little, while in rest of the countries it was 1 in every 3 respondents. Only 1in 10 respondents (11%) overall were of the opinion that governments spend too much on health care. There was no significant variation with respect to income of the respondents. Across the countries, it was consistently mentioned that governments should increase spending (**See Table 9**).

Given the issue of inadequate government spending on health care, question was asked about the sources and preferred options for raising additional money for health care. The most preferred option overall was to increase taxes on tobacco and alcohol (overall 1 in 2 respondents (52%) followed by increased taxes on incomes/profits (overall, 29%). Significant variation was observed across countries. For example, increased taxes on tobacco and alcohol is preferred by 74%% of the respondents in Nepal whereas it is 23% in Bangladesh. This high preference in case of Nepal can partly be explained as Nepal has successfully implemented sin taxes. Similarly, although 1 in every 2 respondents in Bangladesh preferred taxes on incomes/profits (54%), this was as low as 1 in 10 (9%) in Mongolia. The least preferred option for raising revenue was increasing user fees in government facilities (overall, 2%). This was observed consistently across all the countries **(See Figure 3**).

Who should pay more?

Majority of the respondents agree to the statements that rich should pay more than the poor (62%) and that rich should pay proportionately more in relation to their income (58%). In contrast, majority of the respondents disagreed to the statement that those who use health care should pay more (71%). **Figure 4** presents the views of the respondents on "fair" financing of health care system**.**

Sources of funding: Current vs. should be

Respondents were asked proportion of current health care funding vs. what it should be with respect to various sources like taxation, social health insurance (SHI) and out of pocket payments. As expected, respondents in Bangladesh and Nepal confirmed that current funding from social health insurance was negligible, although this was surprisingly high in Sri Lanka (25%). In case of Mongolia, respondents were of the opinion that the contribution by SHI was 34%. With regards to taxes, all the countries would like to see an increase in tax (government spending) as a source of funding from the current levels. Most significant was the case of Bangladesh, where the respondents felt taxes (government spending) as a source of funding health care should increase from 23% to 60%. Similarly, in all countries, except Sri Lanka, there was a clear view expressed that out of pocket payments as a proportion of total health spending should be reduced form their current levels. For example, in case of Bangladesh, respondents felt that out of pocket payments should reduce from 56% to 29%. Only in case of Sri Lanka, it was observed that out of pocket payments should increase to 25% form the current

level of 29%. This may partly be as Sri Lanka is the only country, which has no user fee policy for curative care!

User fees in government facilities

Given the low acceptance of user charges in government facilities to raise revenue, respondents were asked their approval either to introduction (in case of Sri Lanka) or increase (others) of user charges in government facilities for out patient visit, inpatient admission and for drugs in order to improve the quality of services **(See Figure 5)**. It can be seen that overall about 1 in every 4 respondents is willing to pay for these services in government facilities provided it improves quality of services. However, variation both across countries and services are observed. Respondents from Nepal are significantly more willing to pay for each of the services (2 of every 3 respondents) as compared to the rest. For example, in Bangladesh only 1 in every 5 respondents is willing to pay for either drugs (22%) or in patient admission (18%) and less so for out patient visit (9%). Similarly, in Mongolia, approval for payment of user charges varies from less than 10% (9%) for drugs to 16% for out patient visits. In Sri Lanka, only 1 in 10 respondent is willing to pay for any of these services, which to some extent appears to be inconsistent with the earlier findings.

This low approval for user charges in case of Sri Lanka could be explained by the fact that the government health system is almost wholly funded from general revenues (> 98 percent). And virtually all government services are free with no user charges, with the exception of family planning services for which there are nominal charges. Thus Sri Lanka is currently able to offer good government health care facilities with equitable access, free at the point of use. In case of Mongolia where citizens have been having free access to health services until recently, had to pay a 10% co-payment for inpatient care since 1997. However, from 2003 a new graded co-payment system for the inpatient service has been introduced: a 5% co-payment for inpatient care in soum hospitals, a 10% co-payment for aimag, district, Regional diagnostic and treatment center and a 15% co-payment for tertiary level. The co-payment introduced in the public hospital system was accepted with some resistance among the population (Bayarsaikhan, 2005). Hence, it is not surprising that the respondents are resistant to any further increases. Given the low satisfaction and utilization of government health facilities in case of Bangladesh, the respondents have little confidence that things would improve and hence are less willing to pay additional user fees. Except in case of Mongolia where drugs are provided in the government facilities, in all other countries, patients currently have to purchase drugs from out of pocket.

Analysing the response in different income groups it is observed that there was no significant difference across groups with respect to paying for these services. For the poor, access to government health care services is crucial as there are financial barriers to seeking private care. Hence they have little choice but to pay. However, for the rich who have a choice of seeking health care in private, improved quality of government facilities provides them with an alternative to private sector and that too at much lower costs. Hence both the poor out of no choice and rich as a result of increasing choice are both likely to be willing to pay for health care. Those not willing to pay for health services

must have experienced the barriers they pose in seeking health care. In addition, given that historically, health care was provided free at the point of use in these countries, it is possible that number of those not willing to pay, irrespective of the income group they belong to, firmly believe that the government should ensure that health care is provided free to all its citizens. Irrespective of income group, protest responses as a result of negative attitude to user charges in general cannot be ruled out. Hence, no difference was observed with respect to paying for health services across income groups.

Health system

Priority health system issues

The respondents were asked to rank health systems issues in order of priority. In all the countries, improving quality of services, improving access to government health facilities were top priorities. Although improving drug availability in govt hospitals was ranked as a third priority in Bangladesh and Mongolia, reducing waiting time in govt hospitals and reducing payments in govt facilities was a priority in Nepal and Mongolia respectively **(See Table 10)**. Improving staff motivation and moral was low on the priority list in all countries.

Satisfaction with health care system

Similar to question asked by Blendon et al. (1999) in developed countries, we asked respondents if they thought that their health care systems were working well, needed minor changes or needed major changes. **Figure 6** presents the response to this question. It is clear that overall a high degree of dissatisfaction with their existing health care system is observed across all countries and a major change in their health care system is necessary. Overall only 1 in every 10 respondents felt that the health care system was working well overall (9%) and was highest in case of Mongolia (17 %). Similarly, 39% of the respondents expressed desire for a major change in their health care system in Mongolia, followed by Bangladesh (44%) and Sri Lanka (46%). This figure was highest in case of Nepal (58%). The good news is that overall, 1 in every 2 respondents was of the opinion that over the last 5 years the health system in their respective countries has been improving. It may be noted that responses about system satisfaction are highly context specific. i.e. in some cultures, citizens are more critical and more demanding than others.

Multi Nominal Regression was used to understand the factors explaining the view that major changes in the health system are necessary. In Bangladesh, those respondents who were more educated, not satisfied with government health services and who were of the opinion that their health systems were getting worse over time were significantly more likely to suggest major changes were needed. In Mongolia besides the variables that also explain minor changes like age, education, income, those who had difficulty in getting govt health services, not satisfied with govt services, and that the system was getting worse, another important factor was those respondents who felt that their views were not considered by the govt were significantly more likely to suggest major changes in the health system.

Higher satisfaction with the health care system in Mongolia can be attributed to high government commitment and targeted subsidies under the social health insurance scheme

which has ensured near universal coverage in a very short period of time (Bayarsaikhan, 2005). Currently, the entire population entitled to access to outpatient and selected curative cares offered at public health facilities without or with minimal co-payments. As it regards to hospital care, equity access is supported by health insurance. The insured patients are entitled to necessary health care according to their needs regardless of the amount of premium contribution and co-payments.

Public opinion

When asked who should have most say in setting priorities in their countries, majority of the respondents preferred doctors and health experts in all the countries. Except in case of Sri Lanka (44%), in all other countries majority of the respondents were of the opinion that politicians should not have a say in setting priorities. This was consistently observed across countries reflecting a general lack of trust the public has in the politicians. In spite of the fact that significant proportion of respondents across all countries are of the opinion that general public should have a major say in shaping health services in their countries, less than 5% (4.8%) of the respondents overall were of the opinion that governments in their countries considers their views in shaping health care services **(See Table 11**). Hence it appears that public's voice is not considered in health policy decisions in any of these countries.

5.0 Conclusion

Despite the emphasis in recent years on public involvement in health care issues, there has hardly been any effort expanded towards assessing the views of the public on important health systems issues including health inequalities in Asian countries. To the best of our knowledge, this is the first opinion poll survey study being reported across four low-income countries in Asia.

Conducting opinion poll surveys was extremely helpful in understanding the views expressed by the public with respect to health sector reform and health inequalities. In all the countries, majority of the respondents were not satisfied with their health care systems and only a major change was the only way forward. This is not surprising given the low level of government spending on health care in these countries. High OPPs, user fee policy; HSRs, difficulties in access to care, etc result in dissatisfaction. Given the relatively good health care indicators, well performing health care system and lack of user fee policy, it is surprising to note a comparatively similar level of dissatisfaction in case of Sri Lanka as compared to Bangladesh.

Unlike most developed countries, where out of pocket payments for health care are negligible to the total health spending, these assume significant proportion in Asian country context (WHO, 2003). For example, out of pocket payments are as high as 70% of the total health expenditure in Nepal and are about 50% in Sri Lanka. Only in case of Mongolia, out of pocket payment is below 30% (Bayarsaikhan, 2005). There is sufficient evidence to show that out-of-pocket financing is extremely inequitable and inefficient method of financing health care. High out of pocket payments are likely to push low-

income families into poverty and are strongly associated with catastrophic illness (Owen et al. 2005). Given the high out of pocket payments in these countries, it is not surprising that respondents are in favour of increasing government health spending and reducing out of pocket payments in government health facilities.

There are a number of policy implications emerging from the results of this study. Increasing govt spending on health and reducing out of pocket spending should be given a top priority. "Sin taxes" are one of the ways by which additional revenue could be raised for health care. Surprisingly SHI is not much in favour – possibly due to lack of awareness in countries like Nepal, Bangladesh. There is general lack of confidence in politicians and that people would like to be involved in the health care decision making process. It's interesting to note that public opinion appears to be cognizant of distributional outcomes observed in the empirical findings as their views reflect the actual distribution of subsidies. Policy makers in developing countries must understand that public are aware of the health systems issues in the countries and as consumers feel the implications of policy changes.

The results should be interpreted in the light of the limitations of the study. It may be noted that as in any other survey, it is feasible that respondents in this study too could have responded in a way that was thought socially desirable or likely to be more acceptable. Opinion poll surveys provide little opportunity for in-depth probing of the responses and like other surveys wording of the questions, etc. can influence the responses. The surveys in all the countries are cross sectional and have assessed public view at a given point in time. In case of Nepal, although nationally representative sample was use, the final selection of respondents for the study was based on proximity to health institutions. This could result in potential bias and could explain the relatively high utilisation of government health facilities in Nepal. Although valid responses varied, generally there was high response rate to most questions. In addition, opinion polling requires more specialised skill and sensitivity on the part of the interviewer than an ordinary survey. Differences in interviewer quality would have implications for how the poll was carried and the extent to which responses were not biased by the interviewers themselves. Lastly, caution is advised in interpreting the results from this study as these could be context specific.

It appears that the general public in developing countries are able to understand health system issues, have strong views on these issues in their countries and are able to clearly express them. As the study shows, the public are clear about what the priority health systems issues are, ways of raising revenue for the health care, improving access to government health services, etc. They have much to offer with respect to improving the health systems and reducing health inequalities. They are critical that their views are currently not considered by the policy makers but are optimistic that policy makers will give greater emphasis to their involvement in health care decision-making process in future.

It should be noted that opinion poll surveys are a first step in seeking public's views on health systems issues. However, given the importance of eliciting public views, it is recommended that further work be undertaken in this direction. Qualitative approaches may be useful in providing more in-depth information on the reasons for the views held by the respondents on particular issues. Hence, it is recommended that emphasis is given for both empirical and methodological future in future and includes role of various approaches in assessing public views on health system issues. Views of the general public may be one input into the policy process but understanding the views of the policy makers too may prove to be crucial.

The public have expressed their views on the health system issues and direction that needs to be taken. As it is the public who bear the brunt of health sector reforms, it is necessary that policy makers move in the direction that will ensure both accountability and support of the people. Listening to the voice of the public will be a first step in this direction.

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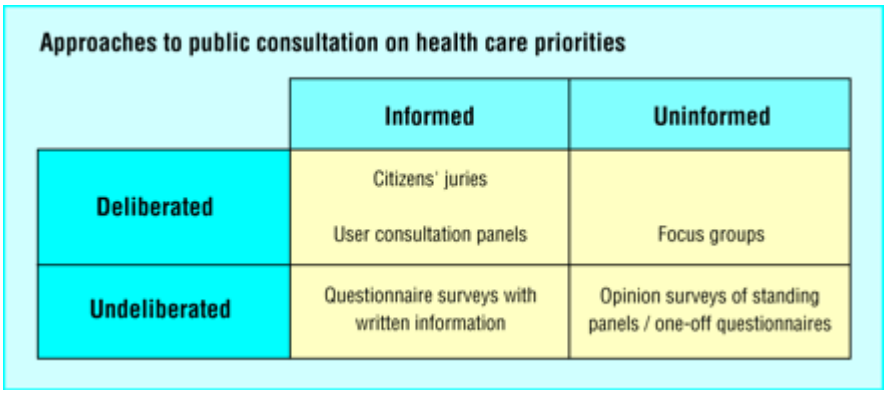
Table 1: Approaches to public consultation on health care priorities



Source: Jordan et al. (1998); 316: 1668-1670.

Table 2: Summary of socio-economic and health status indicators

Indicators	Bangladesh	Mongolia	Nepal	Sri Lanka
Population (in millions)	124	2.5	23	18
GDP per capital (US$)	265	450	213	773
Rural population (%)	81	43	88	78
% population living below poverty line	43		42	25
Adult illiteracy (%)				
Female Life Expectancy (in years)	59	66.5	57	75
IMR/1000 live births	90		93	15
MMR/1000 live births	35		54	8

Source: Institute of Policy Studies, Sri Lanka (2003)

Table 3: Summary information on Health systems in four study countries

	Bangladesh	Mongolia	Nepal	Sri Lanka
Total Health expenditure as % of GDP	3.9	6	5.45	3.19
Total expenditure on health per capita (US $)	10.6		11.5	26
% of total expenditure on health				
Public	34		23	50
Private	64		77	50
Public sector beds per 1000 capita	0.24			3.08
Private sector beds per 1000 capita	0.06		.07	0.13
Admissions per 1000 capita in public sector	<1		<1	18
Physician contacts per capita per year	2		<2	4.5

Source: Institute of Policy Studies, Sri Lanka (2003)

Table 4: Summary of the socio-economic variables of the respondents

Respondent's details	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Male	52	49	64	54	55
Rural	74	59	73	60	66
Religion	87 (M)	79 (B)	88 (H)	69 (B)	
Age group (in years) 18-29 30-44 45-59 60+	 36 46 15 3	 43 38 15 3	 31 39 22 8	 27 37 27 9	 34 40 20 6
Educational status No Schooling Primary Secondary University +	 20 28 30 22	 2 29 51 18	 28 24 27 21	 2 5 86 7	 13 21 48 17
Occupational status Student Unemployed Self employed Skilled+Unskilled worker Professional Civil Servants Employed Herdsmen Unpaid Family Workers	 11 8 19 16 23 22	 9 26 13 0 0 0 22 13 10	 10 43 23 10 9 3	 5 10 19 0 0 4 19 19 20	 9 22 19 6 8 7 10 8 8

Table 5: Household characteristics: Family size and income group

	Bangladesh	Mongolia	Nepal	Sri Lanka
Income groups	Annual HH income in Takas %	Annual HH income in Tugrug: %	Annual HH income in Quintile: %	Annual HH income in Rupees: %
Poor	<2500 : 29	<50,000: 50	1st and 2nd: 37	<5000: 22
Middle	2500-3500: 34	50,000-100,000: 29	3rd and 4th: 19	5,000-9,999: 53
Rich	>3500: 37	>100,000: 21	5th : 44	10,000 & >: 24

Mean family size	5.45	4.3	6.5	4.9

Table 6: Views on health inequalities

Views on	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Makes most use of govt services					
Better off	24	28	19	15	22%
Middle income	16	20	13	26	19%
The poor	53	23	39	36	38
All same	7	30	28	22	22
Contributes most to the finance of govt health services					
Better off	31	66	52	23	43
Middle income	30	11	10	27	20
The poor	19	6	4	20	12
All same	20	17	35	30	25
Receives most of the govt subsidies to health services					
Better off	30	14	43	6	23
Middle income	18	9	6	16	12
The poor	40	36	18	50	36
All same	12	41	33	27	28
On average, is in better health					
Better off	71	72	45	42	57
Middle income	18	9	6	29	15
The poor	8	3	12	8	8
All same	4	17	37	21	20

Table 7: Views on access to government health services

Views on	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
For you to obtain health care from govt services	39	40	75	61	54
Easy/very easy	39	44	21	30	34
Difficult	13	10	4	6	8
Quite difficult	9	6	0	3	4
Not used					
For poor to obtain health care from govt services	25	26	61	58	42
Easy/very easy	52	49	31	33	41
Difficult	23	25	8	4	16
Quite difficult					
Not used					
For rich to obtain health care from govt services	96	96	96	87	94
Easy/very easy	4	4	3	13	6
Difficult/Quite difficult					

Table 8: Access to health care: Financial constraints

Over the last year did you have to raise money to pay for health care for fly?	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Borrow money	40	12	25	21	25
Use savings	36	3	18	35	23
Sell household items	13	6	7	6	8
Others					

Table 9: View on government spending on health care

View on government spending on health care	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Too much	4	12	17	10	11
Too little	49	35	32	54	42
The right amount	21	53	47	21	35
Don't know	27	0	4	16	11

Table 10: Ranking of priority health systems issues

Priority ranking	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Reduce payments in govt facilities	6	2	3	2	4
Improve quality	1	1	2	1	1
Improve access	2	4	1	3	2
Improve drug supply	3	3	5	4	3
Improve staff motivation and morale	4	5	4	5	5
Reduce waiting time	5	6	6	6	6

Table 11: Does govt consider your views in shaping health care services?

Most say in setting priorities in your country	Bangladesh	Mongolia	Nepal	Sri Lanka	Overall
Politicians	16	16	9	44	21
Doctors	52	34	74	62	55
Health experts	58	26	66	51	50
Public	33	16	66	42	39
Does govt consider your views in shaping health care services?					
To a large extent	3	5	5	7	5
To a small extent	27	38	66	56	47
Never	70	57	30	37	48

Figure 1: Utilisation of health facilities

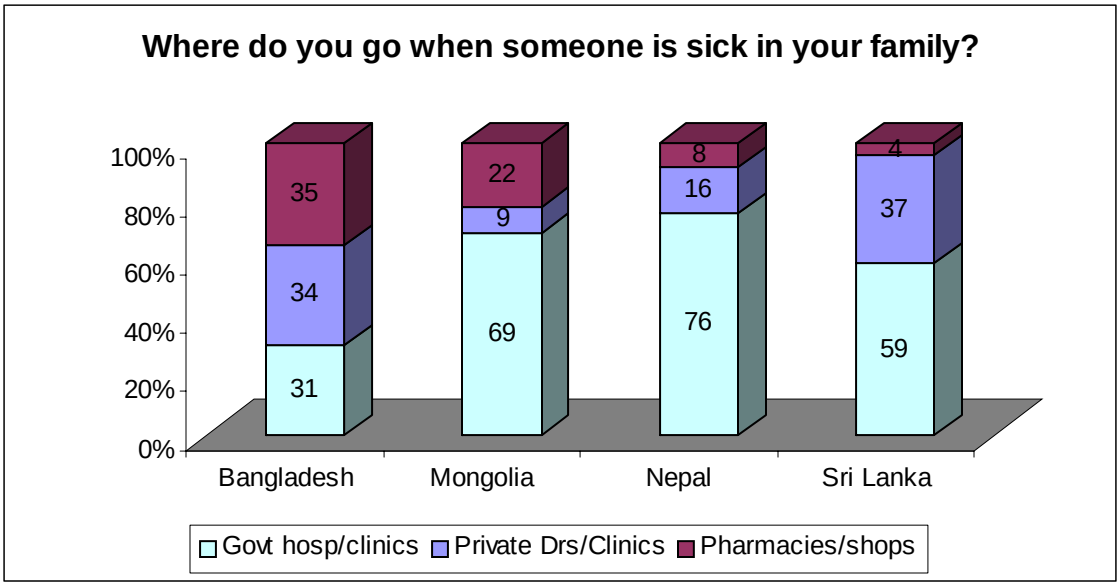


Figure 2: Views on access to government health services

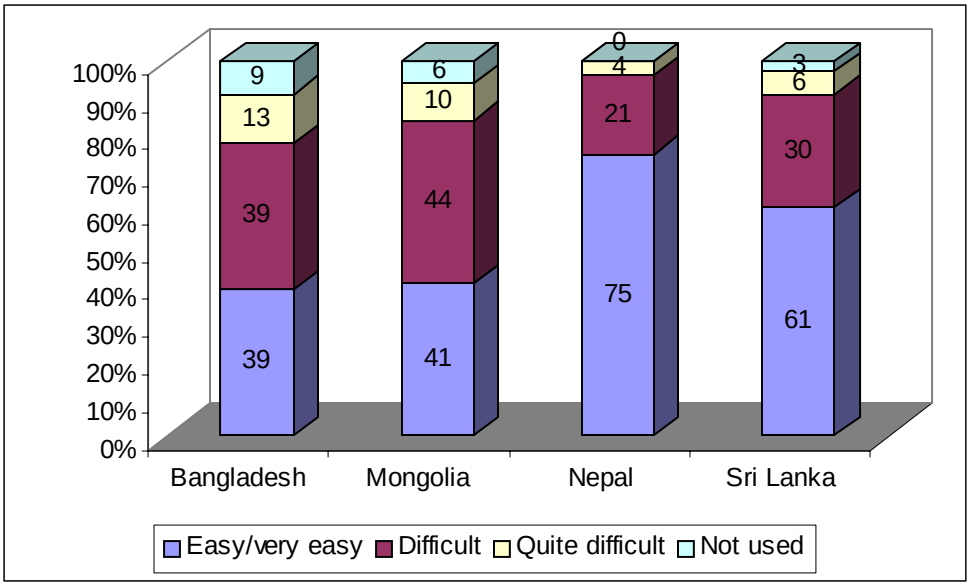


Figure 3: Sources for raising additional revenue for health care

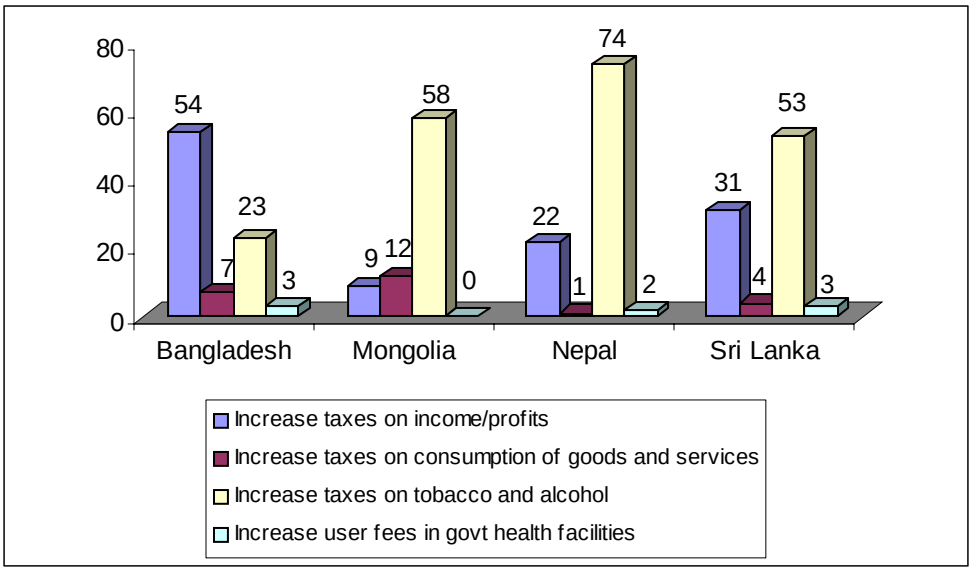


Figure 4: Views on health inequalities

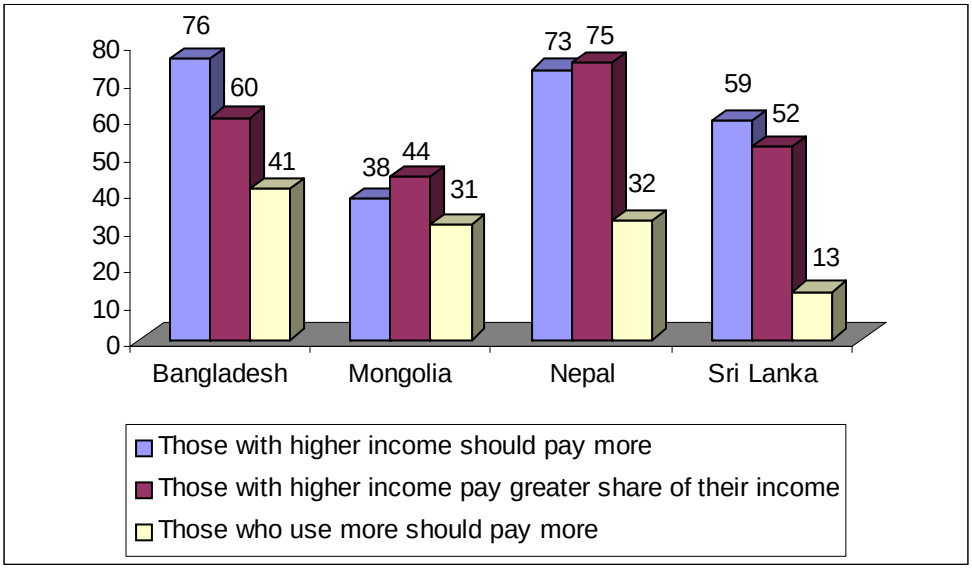


Figure 5: User fees in government facilities

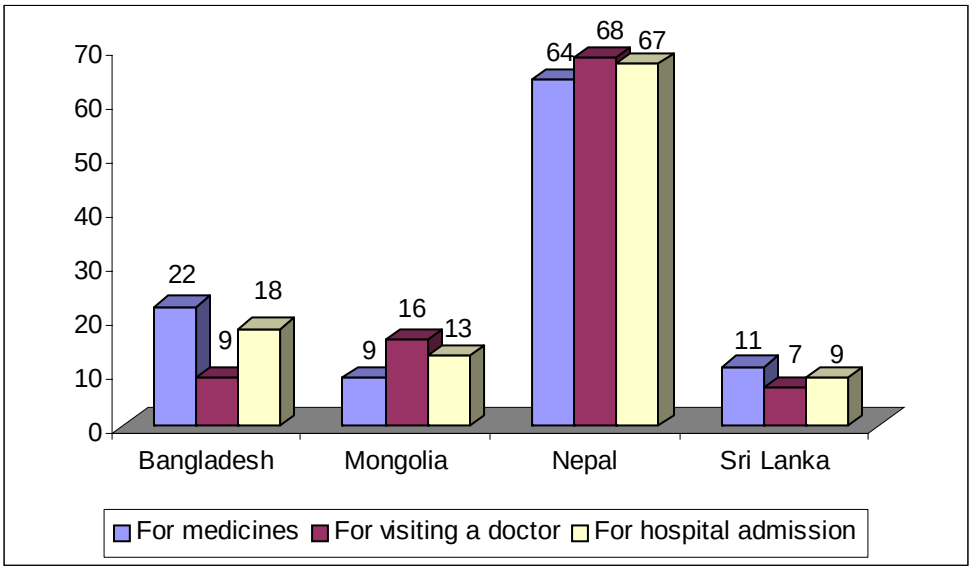
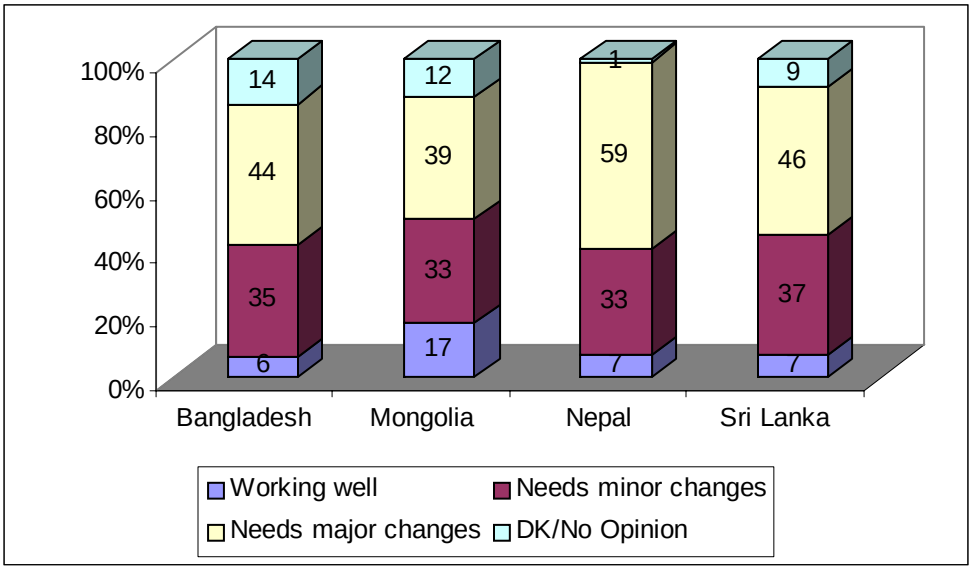


Figure 6: Respondents views on their health care system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Bangladesh
Mongolia
Nepal
Sri Lanka
Working well
Needs minor changes
Needs major changes
DK/No Opinion