HEALTH CARE COST SHARING IN DISTRICT HOSPITALS OF BANGLADESH: ATTITUDES OF PATIENTS AND OPINIONS OF SERVICE PROVIDERS - AN EMPIRICAL STUDY

DOCTOR OF PHILOSOPHY

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This Thesis Is Submitted To The University Of Dhaka, Bangladesh
For The Degree Of
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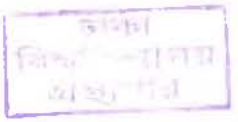

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CERTIFICATE OF SUPERVISORS

This is our immense pleasure to certify that **MD. AMIRUL HASSN**, Associate Professor of Public Health and Hospital Administration at the National Institute of Preventive and Social Medicine (NIPSOM) is a regular Ph.D. researcher entitled "**HEALTH CARE COST SHARING IN DISTRICT HOSPITALS OF BANGLADESH: ATTITUDES OF PATIENTS AND OPINIONS OF SERVICE PROVIDERS – AN EMPIRICAL STUDY**" in the Faculty of Post Graduate Medical Science and Research under the University of Dhaka. His registration number and session is 17/ 2003-2004. **Md. Amirul Hassan** has very generously and successfully presented 2 (two) seminars upon his Ph.D. thesis; on dated 02/8/2004 at 10.00am and 25/3/2007 at 10.00am in the NIPSOM. We found him profoundly sincere, innovative and philosophically hard working during our supervision of his work. He has conducted this research work under our supervision and that neither of this thesis nor any part of it has been submitted for the award of any degree or diploma anywhere.

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This work presented in this thesis is an original and has not been submitted by me to any University or Institution for the award of any degree or Diploma. The thesis entitled **"HEALTH CARE COST SHARING IN DISTRICT HOSPITALS OF BANGLADESH: ATTITUDES OF PATIENTS AND OPINIONS OF SERVICE PROVIDERS – AN EMPIRICAL STUDY"** is submitted by me for the award of the Degree of Doctor of Philosophy at the University of Dhaka, Bangladesh is based upon my own work. This work is carried out under the supervision of Professor Abdul Wadud Khan, department of community medicine, NIPSOM as Principal Supervisor and Professor Haripada Bhattacharjee, department of Marketing of Dhaka University as Co-supervisor. That neither of this thesis nor any part of it has been submitted for the award of any degree or diploma anywhere.

MD. AMIRUL HASSAN

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MD. AMIRUL HASSAN

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ABSTRACT

This was a descriptive cross sectional analytical study conducted to find out the attitudes of patients and opinions of service providing doctors and nurses about cost sharing for services by patients in district hospitals of Bangladesh and Dhaka Communality Medical College Hospitals in Dhaka city. The study was conducted since January 2004 to May 2007. Randomly selected 10 district hospitals from five divisions were taken as study sites. The studied populations were patients, nurses and doctors from whom 782(62%) patients, 305(24.0%) nurses and 170(14.0%) doctors were taken as sample for the study. Among the patients, 553(71.0%) were taken from the OPD and 229(29.0%) patients from the IPD. From the Community Medical College Hospital 148 sample were taken of whom 68 service providers and patients 80. A pre-tested structures and open-ended questionnaire were used as research instrument for data collection. Data analysis was done using SPSS11.5 and 12.0 packages.

Results of the study showed that highest 232(42.0%) of the patients from the OPD and 92(40.0%) patients from IPD were belonged to age group 21-30 years with mean (±SD) age were 34.8(±14.6) years. Service providers showed that highest 73(43.0%) doctors and 196(64.0%) nurses were belonged to age group 31- 40 years with mean (±SD) age of doctors and nurses respectively were 36.51(±7.9) and 34.01(±5.9) years (Table-1.1). Majority of the patients 527(71.0%) was male, majority of the nurses 284(93.0%) were female and majority of the doctors 167(98.0%) were male (Table-1.2). Highest 187(34.0%) patients from OPD and 75(33.0%) patients from IPD were secondary level educated (Table-1.3). Maximum 152(27.0%) patients from OPD were unemployed and 57(25.0%) from IPD were housewives (Table-1.4). Maximum 282(93.0%) nurses, 96(57.0%) doctors and 575(74.0%) patients were married (Table-1.5). Majority of the OPD patients 329(60.0%) and IPD patients 145(63.0%) have showed monthly family income taka ≤5000/- with mean (±SD) taka 5451.7(±3172.3). Overall highest 157(33.0%) service providers' belonged length of service <5 years with mean (±SD) of doctors and nurses were respectively 8.5(±8.1) and 12.09(±6.7) years (Table-1.8). Highest 319(41.0%) patients from OPD, 142(18.0%) patients from IPD, 180(59.0%) nurses and

94(55.0%) doctors were partially satisfied with currently provided services in the district hospitals were significant. The overall satisfaction level of both service providers and patients are more in Dhaka community hospital than the non-cost sharing district hospitals (Table-1.9). It was found that overall 595(86.0%) of Patients, 228(75.0%) of nurses and 138(83.0%) of doctors had opined that currently at OPD taka >5/- were the patients' registration fees (Table-3.1). At most 550(99.0%) of patients from OPD and 228(99.0%) from IPD and maximum 298(98.0%) of nurses and 138(81.0%) of doctors had opined that taka ≤10/- were the patients registration fees in IPD (Table-3.2). Overall, 487(62.0%) of patients have showed the attitudes that current registration fees were adequate which was opined not adequate by 238(78.0%) nurses and 159(93.0%) doctors (Table-3.3). Maximum 130(65.0%) and 56(60.0%) patients respectively from OPD and IPD have showed the attitudes that registration fees should be taka ≥21/-, majority of nurses 134(56.0%) and 87(55.0%) doctor had opined that it should be taka ≤20/- with mean (±SD) amount taka 37.3(±20.8) by nurses, 24.3(±10.8) by doctors and taka 35.5(±16.5) by patients (Graph-1). were significant ($p<.001$) (Table-3.4). Maximum 125(60.0%) patients from OPD and 63(60.0%) patients from IPD, 85(50.0%) nurses and 98(81.0%) doctors had showed the attitude and had opined that taka ≤50/- should be prescription fees for first visit at OPD with the mean (±SD) amount taka 66.9(±44.0) by patients, taka 73.0 (±31.0) by nurses and taka 50.5 (±28.0) by doctors were showed significantly difference between doctors and nurses ($p<.001$), doctors and OPD patients ($p<.001$) and doctors and IPD patients ($p<.001$) but opinions of nurses, OPD patients and IPD patients showed no difference ($p<.001$) (Table-4.2). Mean (±SD) amount prescription fees for second visit found taka 38.1(±25.5) by patients, taka 38.8(±15.6) by nurses and taka 26.5(±18.9) doctors were also showed significant difference between doctors and nurses ($p<.001$), doctors and OPD patients ($p<.001$) and doctors and IPD patients ($p<.001$) but opinions of nurses, OPD patients and IPD patients showed no difference. Respectively 702(90.0%) patients, 239(78.0%) nurse and 167(98.0%) doctor were opined that currently patients are paying for some medical investigation tests (Table-5.1 & Figure-6). At most 528(93.0%) and 214(93.0%) patients each respectively from OPD and IPD showed the attitude and 180(59.0%) nurses and 127(75.0%) doctors

had opined that patients should share cost for medical investigations tests (Table-5.2). Maximum 40(41.0%) doctors, 245(47.9%) OPD patients and 99(46.3%) IPD patients showed that amount of medical investigation test's costs should be shared by the patients based on their economic status and highest 53(43.4%) of nurses were opined that 26% to 50% of medical investigation costs should be shared by the patients were significant ($p<.001$) (Table-5.3 & Table-5.4 &Table-5.6). Maximum 264(48.0%) and 122(53.0%) patients respectively from OPD and IPD and respectively 233(80.0%) nurse and 132(78.0%) doctors has the attitude and were opinioned that patients can purchase medicine by cheap price supplied from hospitals (Table-6.1). At most 205(78.0%) patients from OPD and 93(76.0%) patients from IPD and respectively 127(96.0%) doctors and 218(94.0%) nurses had showed their attitude and opined that patients should pay partially for supplied medicine costs (Table-6.2). Maximum 152(74.0%) patients from OPD and 67(72.0%) patients from IPD and respectively 109(86.0%) nurses and 104(47.0%) doctors were opined that the patients should share costs of supplied medicines based on the economic conditions of the patients were significant ($p<.001$) (Table-6.3 & Table-6.5). Respectively 354(64.0%) and 152(66.0%) patients from OPD and IPD, 90(53.0%) doctors had opined that the patients need to spend pocket money in most of cases and 252(83.0%) of nurses had opined that the patients need to spend some pocket money for their surgical operations were significant ($p=.001$) (Table-7.1, Table-7.2 & Table-7.4). Maximum 622(87.0%) patients had opined that the main reasons of spending pocket money for surgical operations were for the hospital staffs and for buying materials from outside both. Only buying materials from outside hospitals was the reasons of spending pocket money by the patients were opined by 154(91.0%) doctors and 251(82.0%) nurses were significant ($p<.001$) (Table-7.6, Table-7.7 & Table-7.8). Maximum 241(31.0%) patients has positive attitude, 116(68.0%) doctors and another 207(68.0%) nurses has positive opinions that patient should share costs of surgical operations in the district hospitals were significant ($p<.001$) (Table-7.9 & Table-7.10). Maximum 153(63.0%) the patients and 90(44.0%) nurses have the favorable attitude for sharing ≤25% of actual charge and based on the economic status of the patients they should share surgical operations cost had opined by 108(93.0%) doctors were also

significant (p<.001) (Table-7.11 & Table-7.12). Overall 604(77.0%) patients have opined that they need to spend pocket money mostly for delivery service. Maximum 86(51.0%) doctors and 243(80.0%) nurses had pined that patients need to spend some pocket money were significant (p<.001) (Table-8.1, Table-8.2 & Table-8.4). Maximum 423(77.0%) patients from OPD and 181(79.0%) patients from IPD had opined that they need to spend pocket money for delivery service due to giving money to hospital staff and buying materials from outside. All the nurses 305(100.0%) and all the doctors 170(100.0%) doctors have opined that the patients need to spend pocket money for their delivery service due to buy materials from outside (Table-8.5). Overall, 203(26.0%) patients had showed the attitudes, 135(79.0%) nurses and 235(77.0%) had opined that patients should share the cost of delivery service (p<.001) (Table-8.7 & Table-8.8). Overall 146(72.0%) patients have showed the attitude, 74(55.0%) doctors and 111(47.0%) nurses have opined that patients should share ≤25% of actual charge of delivery service were significant (p<.001) (Table-8.9, Table-8.10 & Table-8.11). At most 749(96.0%) patients, 153(90.0%) doctors and 247(81.0%) nurses' have opined that the payment system of service costs should be the direct payment of actual costs (Table-9.1). Overall 67(9.0%) patients and 46(8.0%) patients from OPD and 22(10.0%) patients from IPD have favorable attitudes for giving incentives to the service providers from the patient's costs sharing money. Highest 290(95.0%) nurses and 120(71.0%) doctors have opined that they should receive incentives from the patient's costs sharing money (Table-9.2). Most of the patients in this study were very significantly (p<.001) showed favorable attitudes of cost sharing for different hospital services and most of the service providers' also were significantly (p<.001) opined patient should share service cost in the district hospitals. Cost sharing by patients could be addressed in the district hospitals.

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CHAPTER 1

1. INTRODUCTION

1.1. Over View of Bangladesh: Bangladesh has an area of 147,570 squires KM[1] and is divided in to six administrative divisions, which again sub divided in to 64 districts. There are 6districts under Barisal division, 11 in Chittagong division, 4 in Sylhet divisions, 17 in Dhaka division, 10 in Khulna division and 16 in Rajshahi division[2,1]. Total population of the country was 128,200,000 of whom male 65846,000 and female 62354,000 and average population of a district are 2003,125. Adult literacy rate and GDP is 51% and taka-6.04 millions respectively in the year 2001, per capita income US$ 387[1]. Till the year 1998, maternal mortality rate 3/1000 live births and infant mortality rate 57/1000 live births, Crude Death Rate (CDR) 4.8/1000 population, Crude Birth Rate (CBR) 19.8/ 1000 live births[3].

1.2. District Hospitals And Its Services: There are 59 district hospitals in Bangladesh of which 3 hospitals of 150 beds of each, 29 hospitals of 100 beds each and 27 hospitals of 50 beds each. These hospitals are providing both curative and preventive services through inpatients, Outpatient care and limited number of specialized services such as medical, surgical, gynecological, pediatrics, ENT and obstetrics services. These hospitals are serving as secondary level referral hospitals[1-3]. The pattern of admission of patients in the district hospitals were

Year of service	Out Patient Department	Inpatient Department
1996	3070, 208	370,890
1997	3080, 557	387,552
1998	2928,476	418915
1999	3391,490	427,801

Bed occupancy rate in the district hospitals were 119.58 in 1996, 107.90 in 1997, 117.94 in 1998 and 106.46 in the year 1999. There is also, utilization of diagnostic, operative and diet services in these hospitals[3]. By the year 2000 in Bangladesh, the top twenty causes of deaths amounts 62.38% of total deaths. These top twenty causes of deaths are old age complications (senility) 12.09%, bronchial asthma 6.04%, stroke and paralysis 5.71%, fever 4.99%, heart disease 4.89%, pneumonia 4.18%, diarrhea 3.35% hypertension 2.91%, gastritis and peptic ulcer 2.42%, diabetes 2.36%, drowning 2.02%, hepatitis B 1.81%, tuberculosis 1.70%, malnutrition 1.65%, typhoid 1.48%, tetanus (after delivery) 1.21%, accidents and injuries 1.15%, cancer (all types) 1.10%, tetanus 1.10%

and anemia 1.04%[1]. Percentage distribution of **treatment expenditures** in taka by the year 2000 are shown in the following table[1]:

Table-1.1: Distribution Of Treatment Expenditure According To Treatment Type.

Types of treatment expenditure	Types of treatment facilities				
	Facilities	Government	Private	NGOs	Foreign
Total	100.0	100.0	100.0	100.0	100.0
General expenditure	53.4	12.4	64.7	67.2	58.6
Medicine	42.7	0.6	55.2	57.2	2.2
Doctor's fee	5.4	4.9	5.5	4.1	9.4
Travel	5.3	6.9	4.0	6.0	47.0
Medical tests	10.0	10.8	5.0	11.5	13.8
Surgical expenditure	3.8	6.2	1.2	2.4	1.2
Hospital/clinic rent	2.2	3.4	1.8	0.7	4.4
Attendant's expenditure	35.5	67.2	27.4	18.2	22.0

The **average expenditure in taka per treatment** recipient by type of treatment till August 2000 in public, private, NGOs, foreign and others has shows in the following tables[2]:

Table-1.2: Distribution Of Treatment Facilities According To Type Of Treatment.

Types of treatment expenditure	Types of treatment facilities				
	All facilities	Government	Private	Non-Government Organization	Foreign
Total	519.92	508.8	512.4	687.9	3938.46
General expenditure	277.43	63.2	331.4	462.6	2306.92
Medicine	221.82	3.3	282.6	393.2	86.54
Allopathic	209.88	280.43	191.21	177.32	86.54
Hakims /Ayurvedic	6.46	4.66	7.04	079	0.00
Homeopathic	5.47	3.23	6.15	1.41	0.00
Doctor's fee	28.32	24.86	28.40	27.95	369.62
Travel	27.30	35.08	20.37	41.41	1850.77
Medical tests	52.0	55.1	25.37	792.35	542.31
X-ray	11.41	18.03	8.69	9.81	372.12
Urine	3.45	5.76	2.48	27.97	27.88
Stool	2.27	4.37	1.58	5.13	37.50
Blood	7.45	12.62	5.79	12.39	79.81
Other	9.75	19.63	6.84	23.80	25.00
Surgical expenditure	19.9	31.6	5.90	16.24	48.08
Hospital	3.75	16.91	0.19	0.00	0.00
Other	1.03	1.93	0.76	1.28	9.62
Hospital/clinic rent	11.26	17.06	9.33	5.13	173.08
Attendant's expenditure	184.59	341.81	140.40	124.91	868.08

The public expenditure on health and related activities of government of Bangladesh since the fiscal year 1989-1990 till date has delineated in the following table[3]:

Table-1.3: Distribution Of Revenue According To Fiscal Year.

Fiscal Year	Total revenue expenditure	Total ADP expenditure	Grand Total	Index	Total expenditure as % of ADP	Per capita expenditure (in current prices)
1989-1990	3599790,000	2310261,000	5910051,000	93	0.90	54.17
1990-1991	3950265,000	3027721,000	6977986,000	118	0.95	62.47
1991-1921	4349734,000	2486981,000	6836715,000	98	0.82	61.37
1992-1993	5164541,000	6118500,000	11283041,000	165	1.25	99.67
1993-1994	5995791,000	7303480,000	13299271,000	117	1.51	115.40
1994-1995	6663774,000	4569428,000	11233202,000	84	0.95	93.68
1995-1996	7105611,000	8248918,000	15354523,000	136	1.17	125.75
1996-1997	7686610,000	10624600,000	18311210,000	119	1.30	147.31

1.3. Cost and Cost Sharing: Cost is the value of resources used to produce something including specific health services or a set of services. Cost sharing is a method of financing healthcare, which require some direct payments for services by the patients. Co-payment is the amount paid by the insurance beneficiary as a result of co-insurance and deductibles[4].

1.4. Users Fees Initiatives In Bangladesh: The government of Bangladesh has been trying to introduce patient's cost sharing in the hospitals since year 1987 so far. Initiative also was taken in various times like in the year 1990, 1993, 1997, and 2003. Some provisions of fees for paying beds, private room, diet charge and investigation fees are taking in various levels of hospitals, which are very much uninformed. Clear policies are not yet formulated from the government in this regard. Key actors in the health service system are consumers who receive services and benefited, service providers who render and sell services to the consumers and government who play an intermediate role in providing service to the patients and clients at the end point[5]. The most recent monitoring of Health for All (HFA) strategies in World Health Organization (WHO)'s member states has revealed inequalities continue to persist and that the benefits of health development have not percolated uniformly through all sections of the population. Profound political and economic changes are taking place at the national, regional and global levels, affecting social system, the environment and the epidemiological situation. These changes and transitions are further compounded by a rapid population growth in some countries such as Bangladesh[6]. Due to epidemiological transitions, countries of the region have double burden of diseases. The main changes took place in EPI-target disease and declining both incidence and prevalence of other diseases like leprosy, infectious disease.

1.5. Users Fees In Public Sector Hospitals In Bangladesh: To improve the services in the government hospitals, Ministry of Health and Family Welfare (MOHFW) has taken a decision to introduce user fees system al at all level hospitals like Upazila Health Complexes (UHCs), District Hospitals (DH), Medical College Hospitals (MCH), Specialized Hospitals in the country. In UHCs, DHs, and MCHs, respectively 60%, 50% and 40% of beds will be reserved free for poor patients. Patients admitted in poor beds will get all service free except registration fees at OPD and IPD. Following Table-1.4 are the rate users' fees in different hospitals in Bangladesh:

Table-1.4. Users fees provisions in different hospitals in Bangladesh.

Type of Services	UHC	DH	MCH
1. OPD registration fees	3.0	4.0	5.0
2. Investigation Test fee at OPD:			
2.1. Stool/ Urine fees	5.0	5.0	5.0
2.2. X-ray fees	30.0	30.0	30.0
2.3. Blood TC, DC, ESR, Hb%	5.0	5.0	5.0
3. IPD registration	5.0	7.0	10.0
4. Bed charge/ day	25.0	30.0	35.0
5. Cabin charge	100.0	100.0	100.0
6. Diet Charge from paying bed patients/ day	16.0	20.0	30.0
7. Diet charge for cabin	35.0	35.0	35.0
8. Supplied Medicine cost	3.0	5.0	7.0
9. Investigation test fees at IPD			
9.1. X-ray fees	20.	30.	40.0
9.2. Blood, stool and Urine (together)	10.0	10.0	20.0
9.3. Blood, stool and Urine (each test)	4.0	6.0	8.0

[Source: Md. Matiur Rahman, Joint Secretary, Medical Education and Hospital section, MOHFW, Govt. of Bangladesh, 2p-3/89(part)/403 Dated 25/6/1990]

Keeping all the principles guidelines for poor patients, freedom fighters and government employees the users' fees in the hospitals has been revised as following:

Sl. No.	Service Area	Fees rate
1.	Shared cabin bed non-A/C in District Hospitals	100/-
2.	Full cabin bed with diet in District Hospitals	300/-
3.	Shared cabin bed non-A/C with diet in Medical College Hospitals	200/-
4.	Full cabin bed with diet non-A/C in Medical College Hospitals	400/-
5.	A/C cabin without diet in Medical College Hospital	700/-
6.	A/C cabin with diet in Medical College Hospital	800/-
7.	14x14 X-ray	70/-
9.	15x12 X-ray	70/-
10.	12x10 X-ray	55/-
11.	8x10 X-ray	55/-
12.	Electro Convulsive Therapy (ECT)	300/-
13.	Fogram (without medicine)	600/-
14.	Barium Meal X-ray without medicine	250/-
15	Barium enema without medicine	350/-
16	IVU/IVP without medicine	430/-
17	Myelogram with out medicine	400/-
18	Oral Cholecystography (OCG) with out medicine	200/-

[Source: Md. Mokabbir Hossain, Sr. Assistant Secretary, Hospital Section-2, MOHFW, Govt. of Bangladesh, No. Hosp-2/misc-35/2002/(part-2)/668, Dated 18/10/2006]

1.6. User fees System in BIRDEM Hospital, Dhaka: Every patient has to pay BDT 50/- as registration fees at OPD. This registration fees provides all general medical services. Any specialized consultancy patients required paying additional BDT 50/-. No free medicine is supplied from hospitals. Selected Tests are done free of cost but others tests are done with charge which is for profit. Every patient required paying BDT 100/- admission fees in the IPD. There are 30% of total beds are free of charge including diet, medicine and all kinds of tests. The other beds are charged minimum BDT 375/- per day with free diet, free consultancy but medicine require to by in non-profit system and they also require to pay for investigation test services having the privileged with free tests as with Diabetic Guide Book (DGB). There are model ward with bed charge taka 500/- per day, Shared cabin taka 600/- to 800/- per day single cabin taka 1200/- to 1600/- per day and deluxe cabin taka 2500/- and each day charge for ICU or CCU taka 1200/-.

1.7. User fees System in Apollo Hospital, Dhaka: Attending every patient require to registrar by paying taka 200/-. A health card will provide this with ID Number. Once a patient is registered in the Apollo Hospital he/she need not to register any more through out subsequent visits. In The OPD the consultancy fees varies with the specialty required for patients. These consultancy fees are taka 400/- for physical medicine, taka 600/- for general medicine and taka 1000/- for neuro-medicine. In the emergency, for first hour the patient requires to pay taka 500/- and subsequent every hour taka 200/-, which brings taka 200/- maximum for 12 hours. An additional taka 800/- requires paying by patients if he needed specialist consultancy. The IPD bed charge ranges minimum taka 2000/- to 12000/- per day with diet, Tests service and medicine require to by patients separately. For surgical services patients require to pay for D&C fees taka 7000/- to maximum for LAP APR 82700/-. For normal Delivery a two days package charges taka 23510/.

1.8. Disease Burden And Cost Sharing In Some Asian Countries: The regional countries e.g. Bangladesh Bhutan, most of the states of India, Indonesia, Maldives, Myanmar, Nepal are characterized by high incidence and prevalence of new emerging and reemerging diseases and sporadic epidemic outbreaks. Increasing of life expectancy and non-communicable diseases emerged as major public health problems[6-7]. Due to rapid development of medical sciences and technologies, their applications in health and

biomedical sciences have made the health system more costly. The new high cost low volume technologies e.g. CT SCAN, open-heart surgery, organ transplantation; genetic engineering would become available and accessible by adopting users fees. Many regional and extra regional countries have significant experiences of improvement of service facilities as well as quality of care through adopting user fees[8].

Sources of health care finance are public or government finance, private non-profit or private for profit and a mixture of these e.g. health insurance[9]. Direct payments or user fees may be made for a wide range of health care provided by various health care agencies. Despite a policy of "free health care", a private out-of-pocket payment provision have had made in many countries for medicine, diagnostic service, laundry services, private room charge and dietary charge etc. In South East Asian Region (SEAR), most countries have implemented some form of user fees collected either in outpatient (OPD) or inpatient (IPD) wards. In Indonesia in year 1985-86 revenue from user charges totaled about 10% of recurrent expenditure for health. **Myanmar** has introduced private pay wards or private beds in government hospitals. In Thailand all users of health care in all government facilities have to make payments from a small nominal amount to higher costs depending on the type and level of care. In Myanmar and Nepal community cost sharing scheme have been introduced on a pilot basis. The drug cooperative scheme with revolving drug fund in Thailand collects funds given by members to provide essential drugs at low cost to its members[8-10]. Various health insurance schemes have been introduced in some of the SEAR countries. In Indonesia about 22 million beneficiaries (13% of total population) have been brought under compulsory health insurance, including civil servants, armed forces personnel and employees of state enterprises. Insurance for state sector employees were introduced in India and other countries. Thailand has introduced health card scheme, social security scheme and medical benefit scheme for civil servants all covering about 70% of its population[5,11].

1.9. In South African country Swaziland, health service users fees readjusted and established a unified fee structure across all missions and government health facilities that equalize fees for all special services such as X-ray and dental care. Create a safety net system for those who are unable to pay. Implement the new fee structure over a 2-3 years period. Approaches made in 3 options. Option-1: Nurses would screen patients.

Those nurse referred to a doctor would pay more than those who saw only the nurses, but who saw the doctor without screening would pay even more. Option-2: Nurses would screen the patients and those referred to doctor would pay the same as those who saw the nurses only. Those who wanted to go for screening and see a doctor only would be charged at the same rate as private patients. Option-3: Patients attending health clinics would pay less than those who are attending health centers that would pay less than hospital patients. The Ministry of Health (MOH) adopted option-2 and set the price for a consultation at E 1(about $ 0.20). Cost recover rate in 1988/89 increased 4.6% from 2.2% in 182/83. Equity and sustainability was cared, exemption of very poor from fees, less vulnerable to abuse and more dignified for the patient was cared[12].

1.10. User Fees For Health Services In African Countries: A few countries in Anglophone Africa have had national user fee systems for a couple of years e.g. Ethiopia, Namibia and South Africa while in many others changes have historically been applied in both government and non-government facilities. Most African countries (about 42 out of 52 countries) have now introduced some form of health service user fees for government facilities. User fees not only produce resources but also offer efficiency and equity benefits. Efficiency benefit results in appropriate use of referral system. Equity benefit the poorest and exemptions of fees to protect the poor from their full burden[13]. **Kenyan user fee experience** indicates that in 1991-1992 the level of fee revenue generated by provincial hospital is triple and that of generated by district and sub-district hospitals are double[14-15]. A Kenya-based study suggests that the evaluation in welfare gains from the introduction of fees should take in to account the use of additional revenues to improve government services[16]. In 1988, Nigeria adopted the Bamako Initiative (BI) as a strategy for strengthening primary health care at the community and local government level. One of the strategies was financial sustainability which is promoted through community financing encompassing fees for drugs, health cards and laboratory tests. It was started in small-scale taking 11 Local governments Area (LGA) in 1991 and on the basis of success it increased up to 69 LGA by 1995 out of 589 LGA. There has been considerable evidence of ability to pay, willingness to pay and actual payment of user fee cost among the rich and poor alike in Africa. Empirical evidence from studies in Africa indicates that the increased fees were accompanied by visible improvements in the quality of care, service utilization increased specially for the poorest

segments of the population[17-19]. In Kenya Ministry of Health (MOH) introduced a new cost-sharing program in December 1989. The program was part of a comprehensive health care financing strategy, which also included social insurance, efficiency measures and private sector Development. The Out Patient registration fee led to an average reduction in utilization of 27% at provincial hospitals, 45% at district hospitals and 33% at health centers. In contrast, phased introduction of the out patient treatment fee beginning in 1992 combined with somewhat broader exemptions, was associated with much smaller decrease in out patient utilization. Quality of care measures, though in some respects improve with cost sharing were in general somewhat mixed and inconsistent. Suggestions was made that implementing users fees in phases by level of health care facility is important to gain patient acceptance, to develop the requisite management system[20-23]. **Kenya** addressed user's fee in their health system in 1989. Observation was made on the impact on finances and service and revenue generation. Revenue fell significantly and consistently during 10 months. Following the new management system revenue began to climb steadily. Later it increased 3-folds in provincial hospitals and double in district and sub-district hospitals. Much of the increase in revenue resulted from improvements in NHIF claiming, in particular at provincial and district hospitals. In the period January to June 1993, inpatient revenue from NHIF claims and cash fees totaled 62% of the revenue at provincial hospitals and 48% at district hospitals. Out patient treatment fees, by contrast only represented 21% of total revenue at provincial hospitals and 28% at district hospitals[21, 24-27]. Users fees and quality reported in 1993 that a pre-post controlled experiment in **Cameroon** of introducing user fees simultaneously with improve drugs supply. Utilization of service was increased significantly, especially among the poorest quintiles as a result of the intervention. The people will be prepared to pay according to their ability when drugs are available and that they will not bother to visit clinics without drugs even if no charges is made is not really surprising [28-29].

1.11. Health Care Financing in Central and Eastern European Countries: The central and eastern Europe countries like Hungary, Czech Republic, Latvia, Albania, Bulgaria, Croatia, Lithuania, Moldavia, Slovenia and Ukraine etc faces major challenges as they seek to reform their health system by moving from a centrally planned system driven by planning to a pluralistic model, increasingly funded by social insurance

package. The reform issues are structural, financing system, deterioration of population health, health personnel concerning[30-31].

1.12. Users Fees as Social Security Scheme in Most Latin American Countries: The social security institutes direct providers of medical care services to their beneficiaries. Many of the institutes have developed serious financial problems over the course of time and they have come under increasing attack for exacerbating inequalities in access to and use of health care, further heightening the geographic over concentration of services, and focusing a disproportionate amount of resources of high technologies, curative care to the near total exclusion of primary health care and being administratively top heavy and more generally inefficient. In the past few years, many Latin American countries have begun searching for methods for ameliorate those problems. El Salvador's partial privatization of specialty physician's out patient consultations. Peru's minor surgery and its decentralized ambulatory care program and Nicaragua's administrative services only approach wherein social security beneficiaries choose to join a certified public or private provider organization for one year and on behalf of the individual, social security pays the organization fixed, annual per capita fees to provide all health care for the enrollee. The most radical changes in Chile were municipalization project (1993), development of special program in Brazil, Ecuador, Mexico and Costa Rica to develop primary health care service coverage forpoor[32-33].

1.13. User Fees in Some Countries of Former Soviet Union: Informal payments for health care in the **Kazakhstan** in former Soviet Union provides evidence that 30% expenditure for medicine as user fees can be add in national health budget. Payments for staff are likely to add substantially to this same figure. Patient's payments for health care are increasing as official and unofficial payments. Many local administrations in Central and Eastern Europe and some central Asian countries of former Soviet Union now permits health facilities to establish charge departments in order to obtain additional revenue. The extent of income varies considerably around the countries. In rural areas few official charges are made, although even relatively small charged policlinics that provides charged services such as dentistry, IUD fitting and removal and abortion. In Almaty around 10% of income was obtained from charged services in 1996 and this proportion is likely to rise. One hospital in the city center has assigned more than 100 beds around 14% to charged services. At present all the income is retained by the

hospital, although it is possible that local administration may reduce the state budget if these charges continue to rise. In Turkmenistan the government has recently introduced a 50: 50 split whereby providers retain 50% of charged service income while the remainder supplements the national health budget for payment of salary. In 1996 health budget, user fee contributed 25%-30%for material items. In Almaty charged hospital on average more than $100 per patient for drugs in addition to other charges is collecting as user fees. Payments to practitioners made 47% for getting better quality treatment, 30% for getting a medical report to support a job application and 12% for getting sick notes from doctors[34-37].

1.14. World Bank Policy and Medical Reform in China: Since 1987 the **World Bank** has promoted a health finance policy package consisting of user fees, health insurance, privatization and decentralization. China implemented a medical reform in the1980s much in line with the World Bank Policy recommendations. It is generally accepted that the economic level of a society, along side female education and well-designed public health interventions, is one of the strongest determinants of health status of the population. It could have been expected that the health indicators of China would improve over the same period. It has improved in the big cities of China, but in the countryside, housing the vast majority of the population signs of improvements is few[38]. **In China,** in terms of equity and in the utilization of health services has achieved a very wide distribution of clinics and other services and that they are widely used by those who identify needs for them[39-42]. China has an impressive network of health service extended over the country. Up to the end of the 1970s, most health services were provided free or at a small cost and until recently the income difference were small. Starting from around 1986 Chinese health care went under a medical reform, the prime feature of which was increased emphasis on cost recovery. The health care system in China has now become extremely dependent on fee-for- services (FFS) revenue, mainly from drugs sale. Bonus payments to physicians provide an incentive to raise service revenue as much as possible[43]. Health care expenditure and provisions in rural China, the rural health care system in China is organized in 3-tier in the counties, county hospitals, township hospital / health center and village health station. There was 45.5% of the total health care revenue collection from fees for service. The county government provided on average 24.8% and provincial and prefecture governments contributed average 3.7%. Sales of drugs collected about 53.1%, surgery 2.0% and other clinical fees about 7.0% of total

health care revenue. Maternal preventive care earned 93.0% of total revenue as user fees of which 57.5% from selling of drugs. Children health care earned 95.0% of total revenue as user fees in which 56.3% from selling of drugs. Fees for service charge generated 84.2% of total revenue at township and village level health stations in which 56.3% collected from selling of drugs[44]. Like other developing countries, double burden of diseases and scarcity of resources afflict Bangladesh. Unprecedented population growth and the emergence of new and chronic illness have placed extra demands on health care services. Despite massive efforts to combat such problems in Bangladesh but the resources base are sufficient to neither meet the future needs nor the planned services at present[45-48].

2. RATIONALE: The scenarios of government health budget has magnificently visualized that in every fiscal year beginning from 1989-1990, there is a gradual increase in total revenue expenditure, total annual development program (ADP) expenditure, expenditure index, total expenditure as percentage of ADP and per capita expenditure (in current prices). But, this increase of budget could not meet the unmet needs and demands of the people as a whole and the patients in the district hospitals in particular. Therefore, these increments of health budget are not capable to compete with the changing modern scientific medical and biomedical technology based health service and requires private funding to reduce pressure on health expenditure on government budget. User charges would be an important source of revenue in the health system of the country where services cannot be cut and taxes are not imposed. User charges in public hospitals would curtail over utilization and reduce inefficient use of resources by providing an link between financial responsibility and the provision of services. The financial implication facing patients would encouraged to limit practices such as over prescribing drugs and the use of highly specialized diagnostic procedures for routine investigation or minor illness. Lack of economic incentives has lead to lack of concern for the cost of medical care. User charges would not only encourage both consumers and providers to be cost conscious, but would raise revenue to ease pressure on the health budget, combat moral hazards and assert priorities. However, to be effective and in order to make a serious impact on health system, user charges must be adopted and extended to all government sectors and specialist hospitals in particular and chargers must be high enough to discourage inappropriate use of resources. In Bangladesh the government budget is very limited and hence it cannot provide all required facilities for patients to provide good quality service. From a study on service delivery system in a tertiary level hospital at emergency department found that along with the consumer's dissatisfaction; care providers also dissatisfied with inadequate equipment, diagnostic facilities, medicines, manpower facilities and others. As a result quality of services provided is very unsatisfactory and no patient is satisfied. From another study it is found that due to lack of skilled manpower, laboratory facilities for the consumers were not utilized for long time due to lack of government budget and patients suffer. Due to inadequate supply of medicine, investigations facilities, lack of sitting facilities in the waiting room people are become very dissatisfied with hospital services, which lie in the limitation of budget. The wide spread uncontrolled introduction of user fees in any developing country like Bangladeshis likely to have a disastrous impact on poorer patients.

Furthermore, traditional targeting schemes aimed at their exemptions are often expensive, difficult to administer and ineffective in reaching those in greatest needs. This study wishes to examine the attitude of patients through taking their willingness and degree of payment of fees in registration, prescription, medicine, diagnostic services bed or room charge, linen and laundry charge, diet charge at OPD and IPD in the district hospitals. On other side, opinion of service providers in the same for revenue or resources generation for improving services in respect to quantity and quality to meet the needs and demands of patients with a cautious consideration to those unable to pay.

3. RESEARCH QUESTIONS:

3.1. Do the patients have favorable attitude towards cost sharing for getting better services in the district hospitals?

3.2. Are the services providers in favor costs sharing by patients for getting better services in district hospitals?

3.3 Do the respondents have attitudes and opinions about amount of costs should be share by the patients for getting better services in hospitals?

4.4. Are there difference of opinions of respondents of public sector district hospitals and users' fees system private hospital?

4. HYPOTHESIS:

4.1. Respondents service satisfactions are related with their characteristics e.g. age, gender, education, occupation, monthly family income, marital status, religion, length of service.

4.2. Patients attitudes of cost sharing for services and their socio-demographic characteristics are related.

4.3. Service providers opinions of about service cost sharing by patients and their characteristics are related.

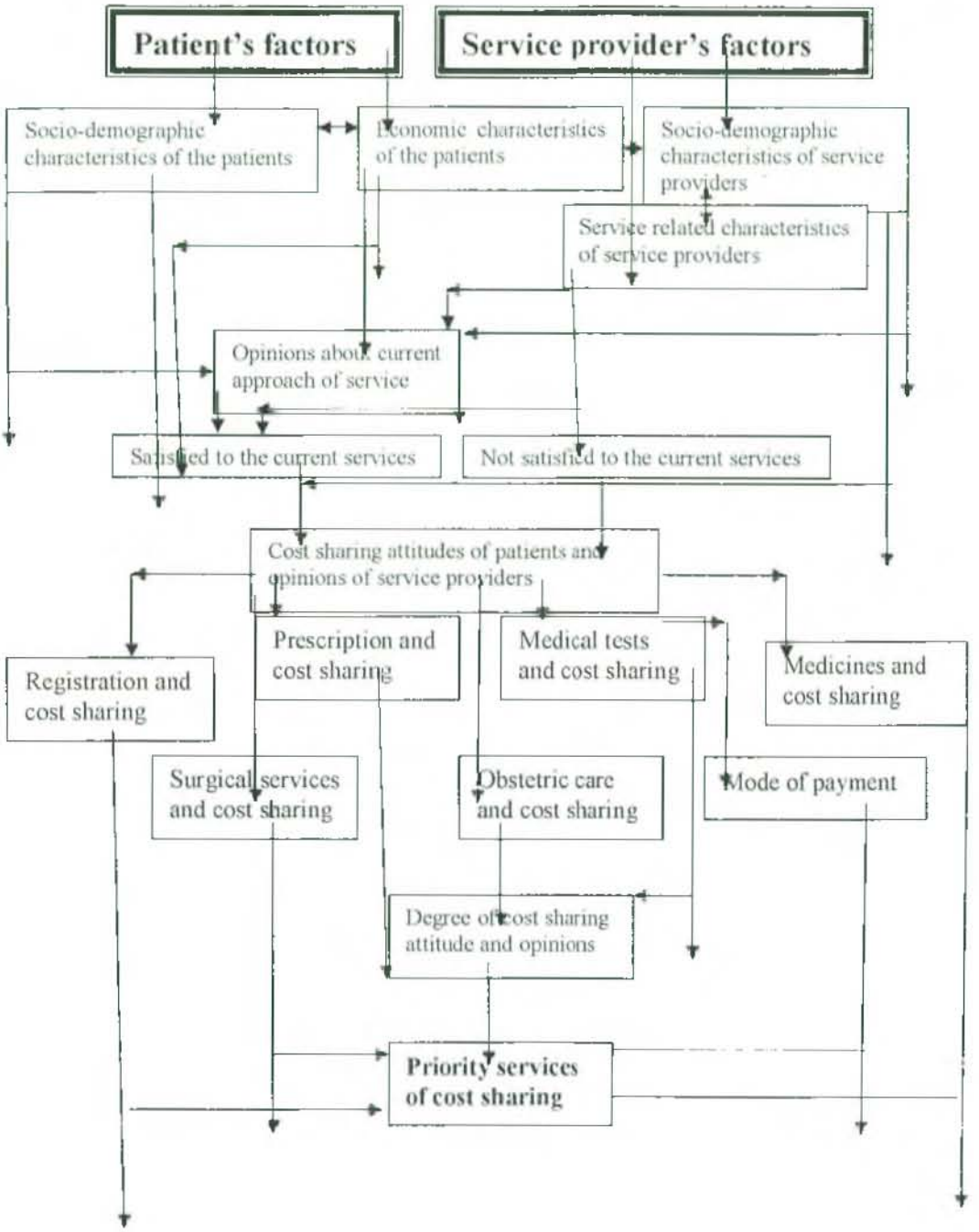
5. OBJECTIVES:

5.1. General Objective: To find out attitudes of patients and opinions of service providing doctors and nurses and ascertain the degree of cost sharing by patients for different services in district hospitals of Bangladesh

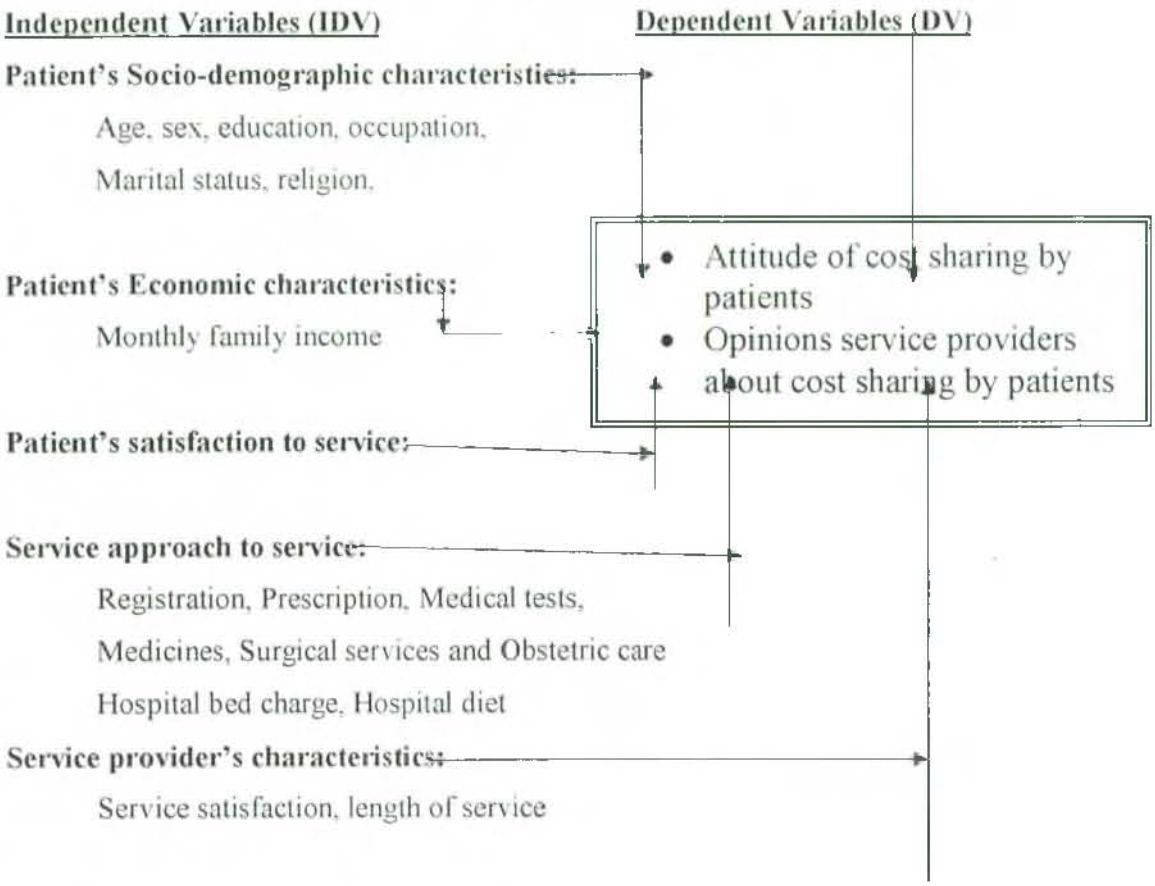
5.2. Specific Objectives:

1. To find out socio demographic and economic characteristics of patient and service providers in the district hospitals.
2. To find out the satisfaction of the patients and service providers about currently provided services in the district hospitals.
3. To find out and estimate the cost sharing attitudes of patients and opinions of service providers about **registration and prescription services** in district hospitals.
4. To measure the **degree of willingness** of cost sharing by patients for services in hospitals.
5. To ascertain cost sharing attitudes of patients and opinions of service providers about **medical tests** and **medicine** in the district hospitals.
6. To estimate cost sharing attitudes of patients and opinions of service providers about **surgical operations and delivery service** in the district hospital.
7. To identify the expected **mode of payment** and giving incentives to the service providers in district hospitals.
8. To find out the difference of opinions of respondents of public sector district hospitals and users fees system private hospital.

6. CONCEPTUAL FRAMEWORK OF THE STUDY:



7. VARIABLES FRAMEWORK OF THE STUDSY:



8. OPERATIONAL DEFINITIONS:

Cost and Cost Sharing: Cost is the value of resources used to produce something including specific health services or a set of services. Cost sharing is a method of financing healthcare, which require some direct payments for services by the patients. Co-payment is the amount paid by the insurance beneficiary as a result of co-insurance and deductibles.

District Hospitals: Government Hospitals that are established in the District level for providing mostly curative service of various specialty discipline, which ranges from 50 bed to 150 beds.

Attitudes of patients: The way that the patients think Voluntary and feel about hospital services and willingness of payment for it that the patients behave towards hospital services and payment for it that how they think and feel.

Patients: Sick or ill persons attending in district hospitals for seeking their treatment either in the OPD or in the IPD.

Opinions of service providers: Voluntary expression of service providing doctors and nurse in the district hospitals about cost sharing for received services.

Respondents: Both patients and service providing nurse and doctors together are considered respondents

Service providers: Doctors and nurse in the district hospitals who are mainly responsible for giving medical and nursing services tot he patients either attending in OPD or admitted in the IPD.

Empirical study: This is a category of research in which approaches to a research is philosophical rather theoretical. Health system research mostly follows the empirical approach. An empirical research based upon 3 (three) related numerical procedures firstly, measurement of variables, secondly, estimation of population parameters e.g. determination and comparison of rate, ratio and proportion etc. and thirdly, statistical testing of hypothesis or estimating the extent to which chance alone may account for findings.

Characteristics of the respondents: It is the socio-demographic and economic characteristics of the patients and the service providing doctors and nurses like age, sex, education, occupation, monthly family income, marital status and religion and the service characteristics of the nurses and the doctors like service satisfaction and length of service.

Monthly Family Income (MFI): It is the total of all income of every family member of a particular family of the patients under the study.

Satisfaction: It is the extent of saturation of expectation of patients and service providers about received and provided services from the district hospital..

Mismanagement: No on job training, no promotion, misbehave of outsiders, administrative complicacy, doctors and staff has illegal and bad connections with private commercial health facilities outsides, insufficient salary, inadequate manpower which creates ineffective administration leading to misuse and abuse of all resources.

Multiple responses: Three responses are called multiple responses

Multiple responses: Four or more responses, Patients are poor and uneducated, delayed treatment, misbehave of staff and tests outsides are called multiple responses.

Employed and earning: Respondents in the study whose occupations are Agriculture, Laborer, and Rickshaw puller, Business of any kind and Employed in job are together called employed and earning.

Doctors: Medical doctors who are appointed in the district Hospitals for providing medical service, diagnostic service, and consultants and or in administration in the district hospital.

Need to Spend Money Partly: It means the combination of answer of currently need to spend some money and need to spend money mostly for hospital services except need to spend money fully

Social Health Insurance (SHI): It usually forms part of a broader ***social security*** framework, covering all contingencies, which need financial protection and risk sharing. SHI is not merely a new method to collect money to co-finance services rather it is a method that is able to achieve a stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care among the population.

CHAPTER 2

REVIEWED LITERATURES

This study highlights the prospects and the potentials of User fees in the name of cost sharing by patients not simply as a way of raising more money but as a tool to help improving and increasing service facilities both in qualitatively and quantitatively, efficiency, equity and sustainability in District Hospitals in particular and the National Health System at large. Some of the important literature relevant to this study conducted else where are delineated below:

User Fees for Health Care in Developing Countries[51]: Stanton, Bonita, Clemens and John in their study, User Fees for Health Care in Developing Countries: A Case Study In Bangladesh, revealed that this country is one of the potential candidate countries for introduction of Users fees. They have suggested that additional questions should be asked to health care providers (nurse and doctors).

User Fees In Sub-Saharan Africa[52]: Shaw in his article, User Fees In Sub-Saharan Africa: Aims, Findings, Policy Implications. He stated that a nationally representative survey in the Central African Republic has determined that 64%-81% of respondents were willing to pay the estimated cost of seven quality improvements in public health services. Rural respondents were willing to pay considerably more, than the urban residents. This is presumably because the gaps are large between "demands" and existing services in rural areas. He also stated that prior to implementing user fees in Tanzaina, opinion polls revealed that 87% of respondents agreed with the statement. People will pay, provided they are assured of good service. He also mentioned that even the most optimistic studies on "Willingness And Ability To Pay" find some proportion of the population will require assistance through exemptions for the poor.

Cost Recovery Can Help Rationalize The Health Care System[53]: Hecht, Robert, Over host and Catherine et al. in their study, "How Cost Recovery Can Help Rationalize The Health Care System: Lesson From Zimbabwe" stated that cost recovery from user fees thus seen as one of several options for ensuring the financial sustainability of Zimbabwe's health sector and for improving the range and quality of service over time. They also argue that cost recovery can help to achieve Zimbabwe's health objectives, but only in conjunction with other measures to redirect public spending to essential public health and clinical care and to improve efficiency of government services. This study

finds that during 1980s the fee schedule became badly misaligned with actual medical care costs thus creating distortions in patient referral patterns. Billing and collections were also weak because of deficiencies in personnel and information system and lack of incentives for revenue generation. The study concludes that if key steps were taken to raise the collections to billing ratio. Recover fees from privately insured patients and adjust fees in line with medical cost inflation. Revenues could increase four fold, from 5 percent to 20 percent of government spending for clinical care. At the same time, access to government health services for the poor could be maintained by improving exemptions procedure.

User Fees Reduce The Demand For Health Card[54]: Matjl and Ts'qene et. in their study, "Do User Fees Reduce The Demand For Health Card?" Insight and limitations of service statistics in Lesotho" stated that in July 1988, the government of Lesotho raised fees for out-patient consultations in all public health facilities to accommodate three specific objectives :

i. Raising cost recovery for health services:
ii. Reducing over utilization of government hospitals and encouraging use of health centers:
iii. Inducing patients to switch from government to PHAL facilities.

It appears that revenue-generating objective has been fulfilled gradually. Since fee increases, user fee revenue in the health sector has doubled as a share of total recurrent expenditure. Over the same period, overall out-patient utilization declined in two districts examined here. The number of out-patient attendances declined in government hospitals as well as in government health centers. There is no evidence that the functioning of the referral system improved in terms of the number of out-patients seen at health centers, although this issue was difficult to examine with the available data.

While this study has succeed in documenting some of the rends in out- patient utilization. It is not possible to attribute them, conclusively, to an increase in fees. When the price of government services rises, the expected decline in attendances in government facilities and an increase in attendances in competitive sources appears to result. It would be tempting to attribute all of this change to the increase in user fees. However, there are many factors affecting the use of out-patient services in rural Lesotho, of which user fees are only one. They have noted that several other factors not controlled for could have

produced the same qualitative result individually or in combination, such as declining household incomes, reduced morbidity, a 50 percent increase in bus fares, natural disasters between 1988 and 1989 that inhibited travel and a decline in the quality of health care in government facilities. Further, changes in the accuracy and completeness of reporting by health units may also have been a factor.

In theory, if fees are raised and the resulting revenues are used to raise the quality of health services at the same facilities, the net-effect on out-patient utilization could be neutral. However, it is unlikely that this occurred in government facilities during the 1988 fee increased. Since all fee revenues were past on to the national treasury and none were retained by the facilities. When this is the case, there is **limited incentive for health workers** to enforce fee collection. Which has an adverse effect on the overall level of cost recovery that can be achieved.

Quality And Accessibility In Utilization Of Health Facilities[55]**:** Victor and German in their study, "Trade Offs In Cost, Quality And Accessibility In Utilization Of Health Facilities: Insight From Ghana" stated that to design effective policy reforms in the public health sector, reliable estimates are required of the effects of improvements in the quality of and access to health services, as well as the extent to which these improvements can be financed by raising user fees. They have utilized household data from a nationally representative sample in Ghana in order to estimate the effect of these policy changes. Improving basic services such as vaccinations, child care and the availability of drugs is likely to have a significant effect on demand for health care. The trade off between improvements in quality and increase in cost suggests that there is a wide scope for financing quality improvements in the public health sector through raising user fees.

Impact Of Raising Fees And Service Quality[56]**:** Litvack and Bodart in their study, "The Impact Of Raising Fees And Service Quality: A Field Experiment In Cameroon" stated that when user fees are introduced or increased, without improvements in quality, utilization drops. People are asked to pay more, yet receive the same service; thus they are receiving less for their money. But when fees are accompanied by improvements in quality, utilization rises.

Poor May Benefit More From The Users Fees In Health Service[57]**:** A controlled experiment at five public health facilities in Cameroon demonstrated that the poor may benefit more than the relatively better-off population from the introduction of cost recovery and quality improvements. In a pre and post-test experiment, three health centers introduced a user fee and quality improvement like reliable drug supply was compared with two similar facilities without such changes. Two rounds of household surveys were conducted in 25 villages, each with about 800 households, to measure the percentage of ill people seeking care before and after the changes. Conducting monthly observations at each study sites tightly controlled the experiment. Results indicate that the probability of using the health center increased significantly for people in the" treatment" areas compared to those in the "control" area, Contrary to previous studies, which have found that the poorest groups are most hurt by user fees, this study found that the probability of the poorest groups seeking care increased at a rate proportionality greater than the rest of the population. Travel and time costs involved in seeking alternative sources of care are too high for the poorest people and thus they appear to benefit from local availability of drugs more than others.

Welfare Effects of User Fees[58]**:** Meabu and Mwanoi in their study, "Health Care financing in Kenya: A Simulation of Welfare Effects of User Fees" stated that their paper examines the efficiency and equity effects of introducing user fees in public health facilities in Kenya. They found that through their favorable effects on quality of medical services, the user fees in public clinics would yield welfare gains. However, these gains might involve unacceptable equity trade offs. Thus, in general, the net welfare effects of user charges in medical services in ambiguous. More specifically, if the user fees were imposed across the board in government health facilities, the equity trade-offs would be large and for that reason, the user fees would be sociality and politically unacceptable.. But if the user charges are restricted to government hospitals, the attendant equity problem would not be too difficult to manage.

The Bamako Initiative: Rebuilding Health Systems: stated that the Bamako Initiative is a series of policy reforms formulated in response to the rapid deterioration of Public health system in developing countries during the 1970s and 1980s. It was launched in 1987 by African Ministers of health at a meeting sponsored by WHO and UNICEF in Bamako, Mali. Thirty three countries in Africa, Asia and Latin America had adopted the

initiative by the end of 1994 and it continues to gain momentum. It is interestingly being recognized as one of the most cost effective sustainable approach to revitalizing health system in the countries with poor primary health care structures.

In the World Development Report 1993[59]: Investing in Health, the World Bank endorses the initiative strategy. In fact one of the policies advocated by the report as crucial for improving health in low income countries increased community control and community financing of essential health care is the core element of the initiative. The Bamako Initiative aims at ensuring access to affordable essential health services for the majority of the populations, while containing costs. It also aims at restoring consumers' confidence in the public health system by improving the quality of services and delegating greater decision-making power. In addition, it seeks to foster better health by promoting behavioral change at household level. By late 1994, the initiative had been implemented in 33 countries of these, 28 were in Sub-Saharan Africa: Benin, Burkina Faso, Burundi, Cameroon, Zaire, and Zambia etc. The remaining five were outside Africa; Cambodia, Myanmar, Peru, Vietnam and Yemen, Preparatory action was under way in Bangladesh, Comoros, Eritrea, Ethiopia, Mongolia, Morocco, Nepal, Tunisia and several other countries, while policy dialogue had begun in Eastern Europe, and some countries of the former Soviet Union.

Paying For Health Services[60-62]: De Ferraanti in his article, "Paying For Health Services In Developing Countries: A Call for Realism" stated that user charges are viewed with disfavor in many countries. Until very recently there was a trend towards reducing or elimination them in public facilities, and some government have reaffirmed that a free health service should be a basic right for all their citizens. Nevertheless, user charges are still widespread in the developing world. Most private spending on health is through user charges, and private expenditure accounts for a large fraction of total health expenditure larger, often, than in the developed countries, Furthermore, public services, despite rhetoric to the contrary, do have charges in many instances, although the revenue usually represents a small proportion of total expenditure. As countries assess possible policies on user charges, their planners should be aware of three points. The **first** is that different strategies will often be appropriate for different types of service. Health services are extremely heterogeneous with respect to the arguments for and against user charges. For instance, services like environmental intervention have very little in

common, in terms of attributes relating to user charges, with services like out-patient consultations, drug sales, or elective somatic surgery. Lump together these diverse activities when user charges are discussed and be misleading. **Second,** there is a difference between (a) user chargers that are nominal amounts intended principally to deter unnecessary utilization of services by households and that are not expected to generate large revenues and (b) user charges that are more substantial, reflecting additional objectives (e.g. greater cost recovery and/or marginal cost pricing). Many of the charges made at public facilities are of the nominal sort. **Third,** while discussions of user charges tend to focus chiefly on public facilities because governments have less control over private providers, it should be remembered that substantial fees exist already in the private sector, accounting for a significant portion of total health expenditure. Policies on charges for public services should be designed with an awareness of the opportunities that households have on the private side and of how they react to them.

Taking district types of service one at a time, planners will normally need to ask themselves several key questions before reaching decisions about charges. Although the choice made will understandably vary markedly from one set of circumstances to another, some services will frequently be suitable for expanded application of user charges, while others will be candidates for exemption from chargers.

This nominal fee might be determined in relation to the daily agricultural wage, the aim being to promote the more efficient use of resources, e.g. where too little is currently spent on essential and cost effective activities because valuable staff and supplies are over burdened with treating minor cases. Concerns about whether households would be able and willing to pay an access fee may have been exaggerated, given the accumulating evidence that they are not easily dissuaded by price from seeking essential medical care. Abel-Smith in his article, "Paying for Health for All." Stated that if rich countries cannot afford to provide wholly free service to everyone, how poor countries go on trying to do so? It is clearly inequitable to provide urban population with a full range of health services without any charges, while there are no services at all within reasonable reach of large sections of rural population. It is a challenge to finalize separating those who can afford to pay from these who cannot. Giving people the right to apply to village leaders for certificates that they are poor may work only imperfectly. So many attempts to identify those who can afford to pay when they actually come to use the services.

Das and Shahidullah etal[63] in their study on, "Patient Attendance And Cost Recovery In Chandina And Debidwar Upazilla Of Comilla District In Bangladesh" stated that 82.5% in Chandina and 82.7% in Debidwar have positive opinion about the "Cost Recovery scheme

Akhter and Hafiz[64] in their article, "Opinion Of A Rural Community About Cost Sharing In The Health Service Delivery System" stated that opinions of 73% of rural people were positive in respect of sharing cost in health service delivery system in public sector at THC level. Higher educated and members from higher monthly income groups were in favor of sharing cost.

Hussain[65] in his article, "Health Care System in Bangladesh" stated that introduction of selective pricing of health carte is none of the strategies that are to be adopted for the attainment of goal of health for all (HFA) by the year 2000. He specifically recommends that a charge will be made for out patient tickets in hospitals and clinics. This founds could be utilized locally for the development of health facilities.

User Fees May Reduce Out-Of-Pocket Expenditure[66]**:** Suhaila H Khan. in her study, Free Does Not Mean Affordable: Maternity Patient Expenditures In A Public Hospital In Bangladesh. found all interviewees incurred substantial out-of-pocket expenditures for travel, hospital admission fees, medicine, tests, food, and tips. Only two of the expenditures, travel expenses and admission fees, were not supposed to be provided free of charge by the hospital. The median total per-patient expenditure was $65 (range $2–$350), equivalent to 7% (range 0.04%–225%) of annual household income. Half of all patients reported that their families had to borrow to pay for care at interest rates of 5%–30% per month. A third of these families reported selling jewelry, land or household items to moneylenders. The rural patients reported more difficulty in paying for care than the urban patients. Factors increasing the expenditures were duration of hospitalization, rural residence, and necessary (e.g. C-section, hysterectomy) and unnecessary (e.g. episiotomy) medical procedures. They have concluded as free maternity services in Bangladesh impose large **out-of-pocket expenditures** on patients. They have recommended that users fee for service could reduce unofficial expenditures if the fee were lower than and replaced typical unofficial expenditures, otherwise adding service

fees without reform of current hospital practices would lead to even more burdensome expenditures and inequities

Child Immunization Cost:[67] Khan MM, Khan SH, Walker D, Fox-Rushby J, Cutts F, Akramuzzaman SM. in their study, Cost Of Delivering Child Immunization Services In Urban Bangladesh has conducted to estimate the costs of providing child immunization services in Bangladesh, from the perspective of healthcare providers and revealed that about 25% of all immunization (EPI) delivery sites in Dhaka city were surveyed. About 77% of the EPI delivery sites in Dhaka were under the management of NGOs, and 62% of all vaccinations were provided through these sites. The outreach facilities (both GoB and NGO) provided immunization services at a much lower cost than the permanent static facilities. The average cost per measles-vaccinated child (MVC), an indirect measure of number of children fully immunized (FIC-the number of children immunized by first year of life), was 11.61 U.S. dollars. If all the immunization doses delivered by the facilities were administered to children who were supposed to be immunized (FVC), the cost per child would have been 6.91 U.S. dollars. The wide gap between the cost per MVC and the cost per FVC implies that the cost of immunizing children can be reduced significantly through better targeting of children. The incremental cost of adding new services or interventions with current EPI was quite low, not significantly higher than the actual cost of new vaccines or drugs to be added. NGOs in Dhaka mobilized about 15,000 U.S. dollars from the local community to support the immunization activities. Involving local community with EPI activities not only will improve the sustainability of the program but will also increase the immunization coverage.

Satisfaction of In-Patients[68]**:** Bhattacharya A, Menon P, Koushal V, Rao K.L.N. Studied Patient Satisfaction in a Tertiary Referral Hospital. Patients admitted in the ward, neonatal surgical intensive care unit (NSICU) and private wards managed by the Pediatric Surgery department in the Advanced Pediatric Center (APC) of Post Graduate Institute of Medical Education and Research (PGIMER) were taken up for the study. Attendants of 252 patients discharged between September and December 2001. Two hundred fifty two in-patients admitted in the wards and intensive care units of a teaching department of a public sector tertiary referral hospital were interviewed at the time of discharge. The perceptions and expectations of attendants regarding the quality of medical care, general satisfaction and infrastructure were assessed. Very high levels of

satisfaction were expressed on doctors' work. The technical aspects of nursing care were satisfactory to 88% of patients. Moderate levels of satisfaction were recorded regarding the general attitude of nurses and ward servants. Thirty seven percent of patients felt the treatment facilities could be better. The consumers recorded many suggestions.

Table-1: Assessment of hospital services by patient's attendant; Summary of questionnaire and Percentage distribution of responses

(1)	**Technical Delivery Of Doctors Care:**	
1.	Have explained the disease to me and I have completely understood the diseases and treatment	89.3%
2.	Have spent enough time with my child to evaluate the disease	98.8%
3.	Attended to problems immediately or at the earliest	98.8%
4.	Showed concern to child and family	98.2%
5.	Treated my child with love and affection	99.6%
(2) (A) Technical Delivery Of Nursing Care:		
6.	Treated my child with love and affection	98.8%
7.	Attended to problems immediately or at the earliest	96.4%
8.	Are approachable to my personal problems	91.3%
9.	Showed concern to child and family	96.8%
10.	Advised to my satisfaction at the time of discharge	90.5%
(2) (b) Nurses general behavior with the attendants		
11.	Pleasant	54.4%
12.	Indifferent	21.4%
13.	Rude	24.2%
(3)	**Food**	
14.	Very good	0.8%
15.	Always good	42.1%
16.	Occasionally good	49.2%
17.	Worst	0.8%
18.	Not applicable	7.1%
(4)	**OPD Services:**	
19.	Satisfactory	98.0%

In-Patients Care Satisfaction In a Tertiary Care Hospital[69]: Verma A, Sarma R.K. in their study, Evaluation of the "Exit Proformas" in use at Special Wards of a Public Sector

Tertiary Care Hospital Health care scenario is fast changing all over the world. Economic, political, social, environ-mental, and cultural factors influence the people's need for health care and the delivery of health service. Providing quality services at the lowest possible cost, leading to a variety of alternatives to hospital care was evaluated. This change in health care scene presents both opportunity and challenge for health care professionals and the administrators. Consumerism is also affecting the health care sector. It can help authorities to advance from considering individual members of their public (patients) as passive clients or recipients of service - who get what they are given for which they must be thankful-to thinking of them as customers with legitimate rights and preference as well as responsibilities. Presently, with the phase of globalization in India, upcoming corporate hospitals in tertiary care have further compounded still competition in the delivery of health care in terms of patients' perception and satisfaction vis-a-vis the value for money. Further, the latest concept in customer delight has added a new dimension to health care industry. Also the Supreme Court verdict of bringing Government hospitals under the purview of Consumer Protection Act has further necessitated considering the patient as a consumer. The approach to choice by the patients was special (paying) wards type A and B with or with our having air-conditioned and in Gen. wards. Patients' views about various aspects of hospital services in special wards as elicited by the pro-forma were analyzed. Overall, a very high level of satisfaction was observed with the various aspects of hospital services. All 100% patients were satisfied with the services of Consultants, Nurses and Physiotherapists and some dissatisfaction was observed with the Quality of Food (19.8%), supplies in private ward rooms (17%), Radiology Services (12%), Patient's were generally satisfied with "Comfort" and "Cleanliness of the room", "Nursing Orderlies", "Sweepers", "Laboratory Services" and "Radiology Services".

Table – II: Percentage of patients satisfied with various aspects of hospital services in special wards

Issue of concern	Percentage Satisfied
Admission Procedure	95.0%
Cleanliness of rooms	94.0%
Room Comfort	95.0%
Supplies	83.0%
Services of consultants	100.0%

Services of nursing staff	100.0%
Services of Dietician	95.8%
Quality of food	80.2%

Generally, it was observed that patients' who were satisfied with the hospital services stayed longer than the dissatisfied patients.

Household Health Expenditure In India[70]: Alex George, Ila Shah, Sunil Nandraj in their study of Household Health Expenditure in Madhya Pradesh. An estimate of household expenditures on health as a proportion of total consumption expenditure and household level expenditures on health care and its differentials by variables such as class, social geography, etc was conducted in two districts of Madhya Pradesh i.e. in Sagar and Morena among 770 households covering a population of 5202, (62.08% from rural areas and 37.92% from urban areas) in India. The acute prevalence rate was 162.16/ 1000, and the chronic prevalence rate 128.33 / 1000. The annual per capita health expenditure was Rs.299.16, which formed 8.44% of overall consumption expenditure. There was a steady increase in the annual per capita health expenditure between the classes. It was Rs.28.16 in the lowest class, which went as high as Rs. 563.94 in the highest class. The difference between the lowest and the highest class was as high as 339.79%. The per episode cost for health care was much higher than the per capita figures. It was as high as Rs.134.23. The corresponding figures for the lowest class were Rs.71.91, and for the highest class was Rs.243.60. The intra-rural and intra-urban difference in per capita and per episode expenditures was wide. Within the rural areas, the annual per capita expenditure was the highest (Rs.314.16) in the PHC villages, but monthly per episode expenditure was the lowest, as against remote villages, where it was the opposite (viz. Rs. 219.96 and Rs. 145.63). Within urban areas, the annual per capita and monthly per episode costs were higher in district headquarters (Rs.322.448, Rs. 134.7) than in small towns (Rs.280.92 and Rs. 116.86). The utilization of the private sector for health care was found to be as high as 69.05%. Only 15.52% of the episodes sought public health care, out of which 6.14% utilized government /civil hospitals, and 6.88% utilized the PHC / government dispensaries, while Sub Centers were used only by 1.73%.

Costs And Prices Of Services, Quality Of Care[71]**:** Bharti Ramkishan conducted a study of the State of Medicare Facilities in Agra. The study focuses on the infrastructural facilities available at nursing homes, qualifications and experiences of service providers. A survey of a few nursing homes in Agra city in India was conducted. About 30% of the professionals have 15 to 20 years practice, followed by another 25% with 10-15 years, 25% of them have 5-15 years and 20% of them have only 0-5 years of experience. The consultancy charges range between Rs. 25/- to Rs. 50/- per patient and the bed charges range from Rs. 50/- to 150/- per bed. The private room charges lie between Rs. 100/- to Rs. 200/- per day excluding the additional nursing charges. The average number of patients admitted to these nursing homes are 171 in private rooms as compared to 240 patients in general wards. The average income of nursing homes in Agra city around is Rs. 53,000/- per month.

Prices and Costs of Medical Care[72]**:** Pandey, Baidya Nath Kumar conducted a study of the State of Medicare Facilities in Agra City **N**ature of private practice and the cost effectiveness of their services provided was evaluated in this study, **in** selected private clinics in Agra, India. **M**ajority of these practitioners belong to the 30-40 year age group and are engaged mainly in private practice. A majority of them have five years of experience and prefer to practice privately. Doctors are found to charge additionally for these facilities and the consultation Rs. 30- 35 for each alternate visit and their daily earnings are between RS- 300-500. Most of the patients who use these services are from the upper middle class. A majority of the practitioners opined that services have become commercial as a result of increased competition. This study shows that there is a trend towards specializations rather than general care. Here, the emphasis is solely on curative services with minimal preventive inputs. The earning of these doctors ranges from Rs. 10,000 to 15,000 a month. This trend requires regulation of medical practice in both government and private institutions. Some process needs to be initiated at the state level, which at the moment is lacking.

Organization Of Private Care (Pathology Labs), Subsides Form Government, Referrals To Labs Cost Of Services[73]**:** Omar Vishal Singh studied the State of Medicare Facilities in Agra City **P**athology labs towards medical care and health services provided in all the wards of Agra city were assessed **in** 12 selected pathology labs. The study was identified forty-eight pathology labs in the city and of these twelve were

economically weaker households scattered across 65 locations in and around Bangalore city. Households with incomes below Rs.3500/- per month were considered for the study. The inpatient sample covered 108 users of government hospitals, 46 users of Municipal Corporation Hospitals, 63 users of Mission and Charity Hospitals, and 63 users of Private Hospitals. The study covered 81 outpatients, of which 47 were from government hospitals and 34 from Mission and Charity hospitals. At most, 31% of patients from government hospitals gave clear positive ratings, while only 20% from Corporation hospitals did so. In contrast 57% of the users in Mission and private hospitals gave positive ratings. Only 30% of the users of government and corporation hospitals made the choice primarily for inexpensive treatment. But only 10% of the users of government hospitals reported satisfaction with free treatment. Around 50% of users in government hospitals and 80% of those in corporation hospitals reported spending amounts from Rs.100/- to Rs.800/- for treatment. Costs of treatment in Mission and Private Hospitals were much higher. But a significant portion of what the poor spent was on **speed money (un-billed charges)**. Around 51% of users in government hospitals and 87% of users in corporation hospitals reported paying speed money. In contrast, this figure was 29% in Mission hospitals and 22% in private hospitals. The public hospitals may be cheap but the poor have to pay extra in terms of speed money and still cope with poor quality of services. Such problems are not because of lack of facilities.

Utilization Of Health Services, Costs Of Care, Household Expenditure[76]: Kunhikannan K T and K P.Aravindan, studied the changes in the Health Status of Kerala, A sample of 8.53% (about 5000 households) of the original households (of 1987) were resurveyed in 1996. The study design was identical to the 1987 study, because the chief objective of this study was to make a comparison of morbidity and health expenditure between these two study periods. The study also accounted for inflation in prices over the 10-year period, at a compound rate of 10% per year. In 1996 were Rs.236, Rs.448, and Rs.590, compared to Rs.100, Rs.190 and Rs.250, respectively, in 1987. Cardiovascular events, cancer, accidents, and suicides continue to be the leading causes of death (as in 1987). About 63% of the people seek care from the private health sector, 30% seek care from the government sector. In government hospitals, accounted for only 39% (in 1996). Caesarean deliveries went up from 12% in 1987 to 21.4% in 1996. The average expenses for a delivery in a government hospital were Rs.2025. It was Rs.2870 in a private hospital. In private hospitals, the average expense for a normal

delivery was Rs.2456, while for a caesarean delivery it was Rs.4944. In the case of a government hospital, it was Rs1670 and Rs.2864, respectively. Surprisingly, c-sections form a greater proportion of total deliveries in government hospitals (30%) than in private hospitals (17%). The medical expenditure per morbid person per episode increased from Rs.16.5 to R.165.2 during the decade, an increase of nearly 900%. The per capita medical expenditure rose from Rs.88.92 to R.548.8 during the period, an increase of about 520%

Financing, Costs, Expenditure On Health[77]**:** Duggal R, Amin S conducted a study on Cost of Health Care. Foundation for Research in Community Health (FRCH), **H**ousehold health expenditure and health expenditure was studied in six villages of Jalgaon district in Maharashtra and six wards (including two slums) of Jalgaon city. **O**verall monthly prevalence rate was 148.89 illness episodes per 1,000 populations, and the incidence rate was 96.56 per 1000 population. Of the acute illnesses 83.45% were treated by the private practitioner / hospital, whereas public facility utilization was only 9.07%. The per capita annual expenditure incurred by the household on health worked out to Rs.182.49. This was 7.64% of the total consumption expenditure, and 9.78% of the reported income.

Cost And Willingness To Pay For Voluntary Counseling And Testing (VCT)[78]**:** Forsythe S, Arthur G, Ngatia G, Mutemi R, Odhiambo J, Gilks C studied for Assessing the cost and willingness to pay for voluntary HIV counselling and testing in Kenya, An economic evaluation was performed of VCT services in two rural health centers in Thika District and an urban health centre in Nairobi, Kenya. VCT added US dollars 6800 per year to the average cost of providing services at each of these three health centers. The incremental cost, from the government's perspective, of adding VCT is approximately 16 dollars per client. The cost of VCT services might be further reduced to as little as 8 dollars per client if a government health worker could perform the counseling. Most VCT clients would be willing to pay at least 2 dollars for the service. Full cost of service was charged to client, less than 5% of clients indicated they were willing and able to pay for the service. Strategies For Financial Self-Sufficiency[79]: While taking care not to compromise its social mission, AKHS encourages an entrepreneurial approach by national service companies in all of their operations. All AKHS community health programs and services have strategies to achieve financial self-sufficiency. For poorer communities, this may require a timeframe of 15 years or more, but a strategy is

percent spent between $2,000 and $5,000, and 4 percent spent more than $5,000. For those with private health insurance, 24 percent indicated that what they paid in premiums had risen "a lot" in the past twelve months, and 29 percent reported an increase of "a little." Perhaps most importantly, slightly more than two-thirds said that they are very or somewhat concerned about how much their family must pay for health care. **Managed care cost containment strategies[82]:** American adults perceive four different cost containment strategies commonly used by health plans: requiring a referral from one's regular physician to see a specialist; requiring substitution of a similar but less costly drug for one prescribed by their physician (known as therapeutic substitution); requiring approval to have a new or costly medical procedure recommended by one's doctor; and paying an income bonus to doctors who keep their patients' health care costs under control. With respect to the first two strategies, a slight majority of adults thought that the practice was a very good or good idea. When asked about requiring approval for a new or costly procedure, the proportion in favor dropped to 43 percent, with a slight majority indicating they thought it was either a bad or a very bad idea. The response was even less enthusiastic with respect to paying doctors a bonus for controlling health care costs. Perceptions of these cost containment strategies vary by personal characteristics, including health spending and attitudes. In terms of basic demographic characteristics, people in the youngest age group (ages 18–34) are most likely to think that these strategies are a very good or good idea. With respect to referrals and bonuses, men are more favorably inclined than women. Income has little effect on the level of support in general, but it has a marked influence for those with fair or poor health status. For people reporting that they are in fair or poor health, support is much higher across all four practices among those with annual incomes less than $25,000 per year than among those earning $75,000 or more. The burden of health care spending has a strong impact on perceptions about these practices. People with higher health care expenses—either higher out-of-pocket costs or premiums that have risen more, or those who are most concerned about health care costs—are generally less likely to approve of the three directly restrictive measures. In contrast to those reporting fair or poor health status, the uninsured—who are also vulnerable to high health care costs—are, in fact, more inclined to support three of the four measures than those with private or Medicaid coverage[83].

The trade-off between cost sharing and restrictions on use[84-85]: Willing to accept a higher deductible or a higher premium in exchange for fewer restrictions on their use of health care services. Only 27 percent responded that they would be willing to do so. A

slightly higher proportion (35 percent) indicated willingness to pay a higher premium for fewer restrictions. Although these proportions may seem quite low, it may be that because consumers are not strongly opposed to these strategies, their willingness to pay more in increased cost sharing to avoid these restrictions is not higher.

User Fees For Health Care In Bangladesh[86]: Stanton B, Clemens J studied User Fees For Health Care In Developing Countries: A Case Study Of Bangladesh, In designing country health care programs to achieve the goals of the Alma Alta declaration of 'Health for All', developing countries including Bangladesh have been confronted with the problem of increased health care needs and decreased available resources. Health economists have preferred several possible solutions to this fiscal shortfall, including cost-recovery measures through the imposition of user fees for curative services at government health facilities. Health care providers have been noticeably absent from discussions of the many possible implications of these fees; consequently, resultant programs and policies may be economically sound but may fail to place a sufficient emphasis on features designed to maintain and improve the health of the population. The possible impact of user fees on health of individuals residing in Bangladesh is potential candidate country for user fees. Existing government health care system appears already to be providing care to two of the most medically vulnerable groups in Bangladesh, the poor and women, and provide evidence that such fees may seriously interfere with maintaining this patient profile. Curative care provides for the individuals, their families and the wider community. Institution of user fees in the government system and those measures should first be introduced in an experimental format with a rigorous and comprehensive impact evaluation.

Alternative Financing Of Health Care[87-91]: Resolution, Agenda and Working Paper Of WHO Stated in The 48th session of the WHO Regional Committee for South-East Asia, in September 1995, debated the topic of "Alternative financing of health care". The Committee urged Member States to undertake various alternative financing reforms, within the framework of solidarity, equity and expanding essential coverage[87-89]. A follow-up regional consultative meeting, held in Bangkok in October 1995, reviewed the regional experience of health care financing reforms, including **D**evelopment of **S**ocial **H**ealth **I**nsurance, and noted the importance of careful studies on various policy options and adoption of appropriate policy decisions[90]. The Health Ministers agreed on the need

to assess the consequences of health care financing reforms[91]. Several countries of the Region initiated reforms of health systems, including those for health care financing, especially in attempting to expand the coverage of social health insurance or similar social protection for the poor. Subsequently, the 55th session of the WHO Regional Committee, in September 2002, having expressed its concern at the high level of **out-of-pocket health expenditure by patients** and the **low level of public spending on health** in almost all countries, lead on "Social Health Insurance (SHI).

Revenue Collection[92-94]: IMF study "*Public spending on health care and the poor*", 2001 Resources for health care financing come mainly from the government's general revenue, accumulated through various forms of taxation, social health insurance contribution, and other collections. Even though health policy-makers realized that the increase in the level of funding to the health sector depends largely on the rate of economic growth and the efficiency of taxation, which are outside their immediate control. **Purchasing:** In order to have an effective and efficient health insurance, the essential health care packages should be available to the consumers literally free-of-cost, rather than fee-for-services and arrangement for reimbursement, in addition to having a large amount of co-payment.

Current Status Of Social Health Insurance[95-97]: Basic Concept Social health insurance is a mechanism for financing and managing health care through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other. SHI is generally perceived as a financial protection mechanism for health care, through health risk sharing and fund pooling for a larger section of the population[95]. It usually forms part of a broader ***social security*** framework, covering all contingencies, which need financial protection and risk sharing. SHI is not merely a new method to collect money to co-finance services. It is a method that is able to achieve a stable financing for a package of health services (health insurance benefits), while at the same time achieving greater access to health care among the population. SHI must have certain characteristics to be used with the terms "social" and "insurance". Countries, which implement various SHI schemes on a national scale usually, adopt broad social security policies and legislative framework, within the policy framework stipulated under the national constitution. In some cases, the policy

framework is determined by society consensus. The major characteristics of SHI schemes are[96]:

- Compulsory or mandatory membership of individuals and/or groups or households, initially targeted to cover civil servants, and other formally employed people, from public and private, commercial, semi-commercial, industrial and agricultural establishments and their dependents; and, usually expanding coverage to informally employed people, non-working people, retirees and even students (inclusion of target population does not necessarily depend on the structure of the economy);
- Responsibility for contributions by members (employees) with proper organizational arrangement to collect regular income-related contributions or flat-rate contributions from individuals/groups, with added contribution from employers and the government (earmarked deduction as insurance contribution from regular pay-roll or pre-set collection amount from individuals or groups)[97];
- Contribution according to the ability to pay (based on economic means) and not related to health risks of individuals, households or employment groups;
- Choice of health care according to the health needs (Basic benefit packages usually set by many countries, which also allow the members to make co-payment or purchasing supplementary health care services in addition to basic packages);
- Solidarity across the population; risk equalization and cross subsidization;
- Arrangement for social assistance to cover vulnerable populations (young and old aged, disabled, pregnant women). Contributions by these groups may be partially or totally subsidized by the government through general revenue;
- Covering a large segment of the population, and funds collected from contributions are pooled into single or multiple fund arrangements administered by a quasi-independent public body that would act as a purchaser of health care.

Bismarck Model Of Health Care Financing[98]: This model is applied in most EU countries like Germany, Belgium, Austria and Netherlands (based on a system of entitlement to health insurance on employment status and payment of contributions[98]. There is some fundamental difference of "prepaid" or "prepayment" for insurance with other "prepaid" services like "prepaid telephone card" or "prepaid goods". The money

spent for the goods or services by the consumers in such cases is limited to the amount prepaid, whereas, in health insurance, the goods /services received by the consumer might get will be costing many times the actual value prepaid. The term "insurance contribution" may be better used than "prepaid".

Social Insurance In India[99]**:** Introduction of Employees' State Insurance Scheme (ESIS) in **1948,** as part of the mandatory social security benefit to workers in the formal employed sectors The scheme now covers more than 33 million employees and retirees. The pre-payment contribution are based on the proportion of pay-roll tax by employees (1.75 per cent), employers (4.75 per cent) and state government (12.5 per cent). ESIS provides health care from its own network of health establishments, and if not accessible, the members are entitled for reimbursement for fee-for-services. India also established a Central Government Health Scheme (CGHS) in **1954,** providing comprehensive health care to employees of the Central Government (Civil Servants) and their families. The premium is progressive with salary scales ranging from Rupees 15/- to 150/- per month. The beneficiaries include nearly 4.5 million central government civil servants and their families. Since 1986, the General Insurance Corporation (GIC) of India, a public sector undertaking, along with its subsidiaries, has offered various voluntary health insurance schemes (Mediclaim Plan and others). Since 1995, a series of private insurance companies, as major parts of larger insurance corporations or financial institutions, have introduced specialized private health insurance schemes. Some state governments have established a multitude of community-based health insurance schemes with an estimated coverage of 30-50 million people.

Social Insurance In Indonesia[100]**:** Introduced the Civil Servant Welfare Scheme where health care expenses are reimbursed to civil servants, since its independence. The formal/national social health insurance for civil servants was started in 1968 by mandating all civil servants paying a contribution of 5 per cent of monthly basic salary. **Askes** in 1992, to manage mandatory social health insurance of all civil servants beneficiaries and military personnel, the contribution is 100 per cent payment by the civil servants and is reduced to about 2 per cent of monthly basic salary. From 2003, the central government contributes 0.5% of basic salary as counterpart funding, and it is expected to increase to 2%. The beneficiaries include about 14 million civil servants,

their spouses and two children less than 21 years old. In 1992, Indonesia introduced the social health insurance scheme for **formal employees**, called **Jamsostek.**

The Ministry of Health, through the Health Act of 1992, introduced a nation-wide, "Managed Health Care Scheme" called Jaminan Pemeliharaan Kesehatan Masyuarakat (JPKM), using the model of the United States Voluntary Health Maintenance Organizations (HMO). It is strictly not a social health insurance, but promoted as a socially-oriented scheme. The main purpose is to provide comprehensive health benefits through a network of health care providers managed by public and private health maintenance organizations. By the end of 2002, there were 24 licensed JPKM *bapels* (Indonesian HMOs), which are basically health insurance carriers, mandated to provide comprehensive health benefits through public and private health care providers and to make payment to providers on capitation. Current implementation needs improvement in expansion strategies as well as other areas such as benefit packages, premiums, management, and payment to providers.

Social Insurance in Myanmar[101]: Introduced a nation-wide SHI scheme in 1956, within the stipulation of the National Social Security Act of 1954. The benefits of SHI include free medical care, and payment of partial or full salary for some period based on illness and injuries. The scheme covers around 765000 workers from around 25000 establishments. It established its own health care facilities (3 hospitals and 89 dispensaries). Benefits include lump sum reimbursement for hospitalization, major surgery, disability, delivery and death. Since the early 1990s, Myanmar has introduced various community-based health finance options in order to reduce the financial burden on the poor.

Social Insurance In Thailand And Fee-For-Service (FFS) Reimbursement Model[102]: Introduced the financial protection scheme for poor and low-income households as part of the national social welfare scheme in 1975. This low-income medical welfare scheme (MWS) was originally introduced as free medical care for poor workers from the formal sector and later extended to include the elderly, children less than 12 years, secondary school students, the disabled, veterans and monks. The service package includes free care at public facilities for ambulatory and in-patient care. By 2000, around 20 million people were covered under this scheme. The budget was allocated through global budget

and later on through capitation. Due to difficulty in the mean testing for selecting poor, the real poor households were excluded on many occasions. It has around 6 million beneficiaries. The scheme works on a **fee-for-service (FFS) reimbursement model**. This has resulted in longer hospital stay, frivolous use of drugs and diagnostics, and other charges. The source of funds was the general revenue of the government. An electronic disbursement system was introduced for inpatients. The Voluntary Health Card (VHC) project started in 1983 covering initially MCH care. Its coverage extended in 1994 to include village health volunteers and local leaders with 100 per cent government subsidy. The VHC covered around 11 million people. By mid-1990s, the program was revised with a single card for individuals or families, offering a comprehensive health benefit package. Since 1994, the government has subsidized with Baht 500/- for every Baht 500/- family card. Thailand introduced the Universal Coverage (UC) Scheme, notably known as the "30 Baht Scheme" in October 2000, with the idea of replacing the "Social Welfare Scheme" and the "Voluntary Health Card Scheme". The program was operational nation-wide by mid-2001.

Health Development and Users fees In Some Asian Countries[103-104]: Sri Lanka and DPR Korea: Does not have any formal social health insurance schemes, despite a large proportion of people working in the formal employed sectors. **Maldives**: Except some form of subsidy for medical expenses for civil servants, does not have any social welfare packages. The national social welfare policy and schemes are under consideration. As part of tourism, some private insurance companies operating in Maldives are covering a few proportions of the people as "health riders on life insurance".

In Nepal and Bangladesh: Social health insurance schemes are almost non-existent or, if present, cover a few people in limited geographical areas. Most schemes rely on external funding and are on some contributions. There are a small number of private health insurance and community-based insurance schemes with limited coverage.

China: Spent around 476.4 billion RMB on health in 2000 with average health expenditure per capita of 376 RMB (US$ 47). The government budget on health in the last decade decreased from 60% to 40%. According to the Chinese NHA, in the year 2000, Out of Pocket (OOP) expenditure was around 60%, of which only 6% was on private insurance, rest being direct payment for users' fees. Within the public

expenditure, at least 47% was accounted for by social health insurance. In 1952, China introduced the Government employees' health insurance (GHI) scheme financed from general revenue. This scheme covered all government employees, college teachers and students. The beneficiaries received free medical care at both public outpatient and inpatient facilities. The government is also planning to revive or to establish new types of rural cooperative medical and medical aid systems through a government subsidy for the benefit of poor in rural areas, and to achieve universal coverage by 2010.

Vietnam: Spends ≤1% of its GDP on government health expenditure. The government initiated SHI schemes in 1992 and rapidly expanded the coverage to the present level of around 14 million (11 per cent of the total population). The scheme presently covers employees and retirees from the formal sector and their family members. School children are also included. The SHI program is to expand coverage to include people working in the informal sector, especially in rural areas.

Philippines Out-Of-Pocket Private Expenditure: Total health spending pattern has remained unchanged for the last few decades, with around 3% of GDP. More than half of this was out-of-pocket private expenditure. Voluntary SHI for formal sector employees and their dependents under the national social security system (SSS) started in 1972. The medical benefits included reimbursement of inpatient and outpatient care provided by both public and private health facilities. There are Government Service Insurance System (GSIS) around the same time to provide medical benefits for civil servants. Both schemes are operated by a government agency, the Philippines Medicare Commission (PMC), established under the Medicare Act of 1969. It is almost self-financed with limited public subsidies. Voluntary individual membership to PhilHealth has grown from around 165000 in 1999 to 7 millions in 2002. There was an enormous workload on claim reviews, resulting in high administration costs (12% of total spending) and ineffective filtering of frauds.

Singapore: One possible approach of using savings for medical expenses is to develop an additional component to the national SHI schemes, as pioneered by famous "3M" health financing schemes, i.e. Medisave, Medishield and Medifund **of Singapore**[23]. The *Medisave* scheme is an individual saving scheme for which the savings accumulated could be used for medical care expenses. Singapore introduces *Medishield*, a back-up

health insurance program based on cross-sectional risk pooling, designed to finance the extreme catastrophic tail of risk distribution. In addition, the Government of Singapore also introduced *Medifund*, which is an endowment fund for those whose health care costs are beyond their means, even with Medisave and Medishield.

WHO-CMH Recommendations[105-107]**:** Out-of-pocket expenditures in poor communities should increasingly be channelized into 'community financing' schemes through an incentive scheme, in which each $1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government backed by donor assistanc[105-106].

Community-Based Health Insurance (CHI)[107-110]**:** This scheme have voluntary private membership using principle of pooling health risks and resources, usually known as rural health insurance, mutual health organizations or associations, medical aid societies, medical aid schemes etc. These are different from other forms of community-based health financing, like community cost-sharing and drug funds, in which risk sharing can even absent. These non-formal, community-based health insurance initiatives are usually launched on no-profit basis, to cover certain targeted groups. A few studies have shown that a smaller numbers of such schemes cover a large.

CHAPTER 3

METHODOLOGY

1. Study Design: This was a descriptive type of cross sectional analytical study. It was a quantitative study in nature and attempted to describe and analyses the cost sharing opinions by patients and services provider doctors and nurses.

2. Period Of Study And Data Collection: This research work was completed in three and a half years time since January 2004 to June 2007.

3. Place Of Study: The research work was carried out at the department of Public Health and Hospital Administration in the National Institute of Preventive and Social Medicine (NIPSOM), Dhaka, Bangladesh.

4. Sites of the Research Work: The research work was conducted in District Hospitals of Bangladesh. There were 59 district hospitals in 64 districts in the country. Of them one hospital was 250 bedded, 2 were 150 bedded 26 were 100 bedded and 30 hospitals were 50 bedded. Characteristically all these hospitals are homogenous in nature. A total of 10 such hospitals were randomly selected taking two hospitals each division except Sylhet division where formally cost-sharing program was already introduced. Data were collected from the attendant patients at the Out Patient Department (OPD) and admitted patents in the In-patient Department (IPD) at the study district hospitals. Data also was collected from the service provider doctors and nurses from the study hospital. Dhaka Community Medical College Hospital (DCMCH) was also taken to understand and compare the situation of Public sector hospital to Private sector.

5. Study Population: Study population consisted of all patients attending in OPD and admitted patients in IPD in the study hospitals and all working doctors and nurses as health care providers of the study hospitals was study population. The selection criteria were employed before employing sampling technique for data collection.

Inclusion Criteria for patients:

1. All patients at OPD and patient admitted in the hospital wards age 15 years and above.
2. Either father or mother of the children and minor patients.

Exclusion Criteria:

1. Patient who are unconscious and or unable to speak.

2. All patients <15 years of age.

6. Sample And Determination Of Sample Size: To determine the sample size from both the patients and service providers' population following formula was used.

(a). Sample Size For Patients: To determine the sample size in OPD following formula was used. $n = Z^2_{(1-\alpha/2)}pq/d^2$. Here, p= Proportion of patients having the positive attitude for cost sharing of hospital services (19%) [49], q = (1-p) = Proportion of population not having the positive attitude for cost sharing of hospital services (79%), $Z_{(1-\alpha/2)} = 1.96$ and d = precision (0.03). Therefore, the calculated minimum sample size is 657 patients. To minimize sampling error more 20% (125) of patients were added with the sample. Therefore, total estimated sample size was 782. These patients were proportionately taken 553 from OPD and 229 from IPD. From each of the hospital 56-sample patient was taken from OPD and 23-sample patient was taken from IPD. From the Dhaka Community Medical College Hospital 148 samples were taken among which 36 nurses, 32 doctors and 80 patients of which 46 patients from OPD and 32 patients from IPD were taken.

(b). Sample Size For Service Providers[50]: As the service provider populations are not homogenous, therefore stratified sampling technique was employed as in the following table:

Sl. No.	Population	Size	Sample proportion	Sample size
1.	Care providing doctors (all consultants and medical officers)	20±5	85%	17*10=170
2.	Nurse (staff nurse & supervisor)	33±8	83%	30*100 = 300
3.	**Total**			470

7. Sampling Technique: Systematic sampling technique was use for data collection from sample population at OPD of the hospital. Simple random sampling technique was used for patients in IPD and service providers

8. Research Instrument: A structured questionnaire was used for data collection. Pre-testing of the questionnaire was done and it was both open and closed ended. The questionnaire was constructed in two parts. Part-I contained socio-demographic characteristics of the patients as well as service characteristics of the providers. Part-II was constructed for collection data on attitudes on cost sharing by patients

9. Methods Of Data Collection: Permission for data collection was taken from competent authority of the respective hospitals. Prior written consent of the respondents for participating in the study was duly taken in a well-designed informed consent form, from the potential participant. Data were collected at OPD and IPD from the patients and work place of the service providers during the working hour. Data were collected through face-to-face interview of the patients by well-trained interviewer using questionnaire. Data was collected from service providers through self-administered questionnaire process.

10. Data management: Collected data were checked, verified for quality and coding was done. Finally data were entered into computer for analysis using SPSS 11.0 & 12.0 package. Both descriptive and inferential statistics were employed for analysis of data. After due analysis, results were obtained and interpretation of the data is delineated in the results and subsequently.

CHAPTER 4: RESULTS

This descriptive type of cross sectional analytical study was conducted with the objective to find out attitudes of patients and opinions of service providing doctors and nurses and to ascertain the amount of cost should sharing by patients for different services in district hospitals of Bangladesh. In this study a total 1257 (100.0%) sample were studied of whom 782(62.0%) were patients, 305(24.0%) of nurses and 170(14.0%) of respondents were doctors. A structured and open ended pre-tested questionnaire was used as research instrument for data collection. Data were analyzed suing SPSS12.0 version and results were obtained which are delineated as following.

1. CHARACTERISTICS OF RESPONDENTS:

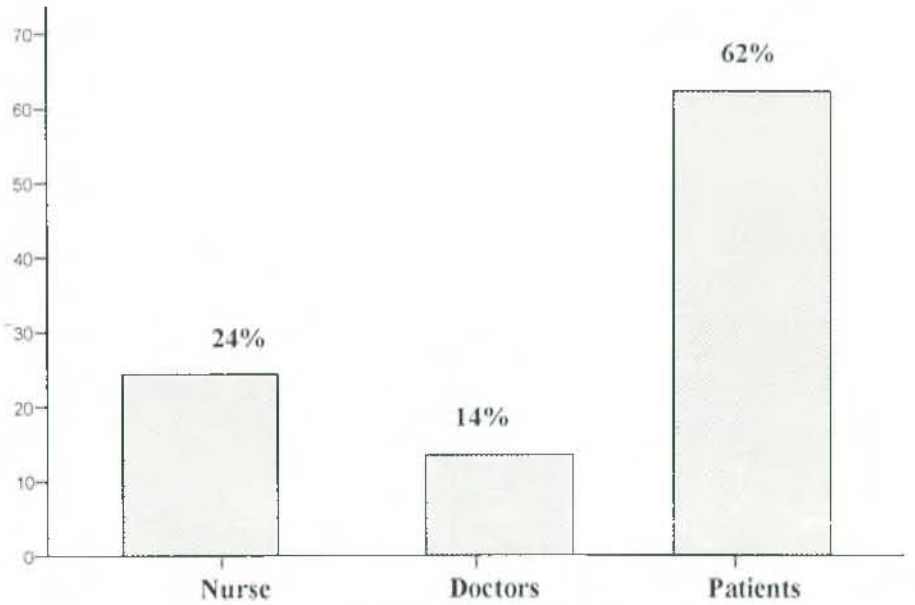


Figure-1: Category of the respondents

Figure-1 showed that maximum respondents 782(62%) were patients and 24% and 14% respectively were nurse and doctors.

Table-1.1: Distribution of the respondents according to the age group.

Age groups (year)	Category of respondents							
	District Hospitals [n=1257]				Community Medical College Hospital (n=148)			
	Service providers [n=475]		Patients (n=782)		Service providers (n=68)		Patients (n=80)	
	Nurse n=305)	Doctors (n=170)	OPD (n=553)	IPD (n=229)	Nurses (n=36)	Doctors (n=32)	OPD (n=46)	IPD (n=34)
≤20	-	1(1.0)	77(14.0)	32(14.0)	-	-	4(8.0)	2(6.0)
21-30	92(30.0)	41(24.0)	**232(42.0)**	**92(40.0)**	9(24.0)	11(34.0)	**21(47.0)**	**14(41.0)**
31 – 40	**196(64.0)**	**73(43.0)**	88(16.0)	43(19.0)	**23(64.0)**	**18(56.0)**	8(18.0)	7(21.0)
41 – 50	17(6.0)	46(27.0)	60(11.0)	25(11.0)	4(12.0)	3(10.0)	6(12.0)	5(15.0)
≥51	-	9(5.0)	70(13.0)	27(12.0)	-	-	7(15.0)	6(17.0)
Mean (±SD)	**34.0 (±5.9)**	**36.5 (±7.9)**	**34.8(±14.6)**	**33.0 (±6.0)**	**36.0 (±8.0)**	**35.0(±15.0)**	**35.8(±14.4)**	**36.0 (±6.1)**

Table-1.1 show that highest 64.0% of nurses from district hospital and Community Medical College Hospital, 43.0% of doctors from district hospital and 56.0% from Community Medical College Hospital, 42.0% OPD patients and 40.0% IPD patients from district hospitals and 47.0% from OPD and 41.0% from IPD of Community Medical College Hospital are in the age group 31-40 years age group. The mean age of nurses, doctors, OPD and IPD patients (are respectively 34.0 (±5.9), 34.8 (±14.6) and 33.0 (±6.0) years. In Medical College Hospital in district hospital it no respectively 36.0 (±8.0), 35.0(±15.0), 35.8(±14.4) and 36.0(±6.1) years. There are 30.0% nurses from age group 21-30, 27% doctors from age group 41-50 years, 16.0% patients from OPD in the age group 8/-40 years and 19.0% patients in IPD in the age group 31-40 years in the second highest in the district hospitals. In the community Medical College there are 24.0% nurses and 34.0% nurses and .4.0% doctors are in the age group 21-30 years among the patients, 18.0% from OPD and 21.0% from IPD are in the age group 31-40 years are the second highest.

Table-1.2: Distribution of the respondents according to the sex group.

Sex groups	Category of respondents							
	District Hospitals [n=1257]				Community Medical College Hospital (n=148)			
	Service providers [n=475]		Patients (n=782)		Service providers (n=68)		Patients (n=80)	
	Nurse n=305)	Doctors (n=170)	OPD (n=553)	IPD (n=229)	Nurses (n=36)	Doctors (n=32)	OPD (n=46)	IPD (n=34)
Male	167(98)	21(7.0)	378(68.0)	149(65.0)	34(95.0)	18(57.0)	16(35.0)	20(58.0)
Female	3(2.0)	284(93.0)	175(32.0)	80(35.0)	2(5.0)	14(43.0)	30(65.0)	**14(32.0)**
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**36(100.0)**	**32(100.0)**	46(100.0)	34(100.0)

Table-1.2 Show that There are 98.0% male nurse, 93.0%, female doctors, 68.0% male patients from OPD and 65.0% male patients in IPD of district hospitals on the other side, 95.0% are male nurse, 57.0% male doctors, 65.0% female patients from OPD and 58.0% male patients from IPD are found from Dhaka community hospital.

Table-1.3: Distribution of the respondents according to the educational level.

Educational level of the patients	Category of respondents			
	District Hospitals [n=1257]		Community Medical College Hospital (n=148)	
	Patients (n=782)		Patients (n=80)	
	OPD (n=553)	IPD (n=229)	OPD (n=46)	IPD (n=34)
No formal education	116(21.0)	47(21.0)	7(15.0)	4(11.0)
Up to elementary level	166(30.0)	68(30.0)	9(20.0)	5(16.0)
Secondary level	**187(34.0)**	**75(33.0)**	**23(49.0)**	**18(53.0)**
HSC level	14 (2.0)	10 (4.0)	5(12.0)	5(14.0)
Bachelor degree and above	70(13.0)	29(12.0)	2(4.0)	2(6.0)
Total	**553(100.0)**	**229(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.3. Show that height 34.0% patients in OPD are educated secondary level and 33.0% patients from IPD in the district hospitals of Bangladesh. On the opposite, 49.0% of patients from OPD and 53.0% patients from IPD are educated in secondary level in community medical college. There are 30.0% patients in OPD are educated in up to elementary level and another 30.0% are from IPD in secondary level in community hospital.

Table-1.4: Distribution of the respondents according to the Occupation.

Occupation of the patients	Category of respondents			
	District Hospitals [n=1257]		Community Medical College Hospital (n=148)	
	Patients (n=782)		Patients (n=80)	
	OPD (n=553)	IPD (n=229)	OPD (n=46)	IPD (n=34)
Unemployed	152 (27.0)	50 (22.0)	2(4.0)	2(6.0)
Day laborer	41(7.0)	19(8.0)	2(4.0)	3(8.0)
Agriculture, rickshaw puller and households	53 (10.0)	23 (10.0)	7(15.0)	5(14.0)
Business	114 (21.0)	48 (21.0)	17(37.0)	13(40.0)
Employed in job	67 (12.0)	32 (14.0)	10(23.0)	7(20.0)
Housewife	126 (23)	57 (25.0)	8(17.0)	4(12.0)
Total	**553(100.0)**	**229(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.4 Shows those 27% patients in OPD are employed and 25.0% are house wife in district hospitals. The second highest 23.0% patients are from OPD having house wife in the district hospitals. On the other there are 37.0% patients in OPD have business occupation, 40.0% in IPD of community Medical College. There are second highest 23.0% of the patients are in OPD are 20.0% are in IPD belong employed in job occupation in community medical college.

Table-1.5: Distribution of the respondents according to the marital status.

Marital Status	Category of respondents							
	District Hospitals [n=1257]				Community Medical College Hospital (n=148)			
	Service providers [n=475]		Patients (n=782)		Service providers (n=68)		Patients (n=80)	
	Nurse n=305)	Doctors (n=170)	OPD (n=553)	IPD (n=229)	Nurses (n=36)	Doctors (n=32)	OPD (n=46)	IPD (n=34)
Married	96(57.0)	282(93.0)	405(73.0)	171(75.0)	20(55.0)	22(70.0)	35(76.0)	27(78.0)
Single	74(43.0)	23(7.0)	148(27.0)	58(25.0)	16(45.0)	10(30.0)	11(24.0)	7(22.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**36(100.0)**	**32(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.5. Show that 57.0% of nurses 93.0% of doctors respectively 73.0% of patients from OPD and 75.0% from IPD are married in district hospitals. In the community Medical College, 55.0% nurse, 70.0% doctors, respectively 76.0% patients from OPD and 78.0% patients from IPD were found married.

Table-1.6: Distribution of the respondents according to the religion.

Religion of the respondents	Category of respondents							
	District Hospitals [n=1257]				Community Medical College Hospital (n=148)			
	Service providers [n=475]		Patients (n=782)		Service providers (n=68)		Patients (n=80)	
	Nurse n=305)	Doctors (n=170)	OPD (n=553)	IPD (n=229)	Nurses (n=36)	Doctors (n=32)	OPD (n=46)	IPD (n=34)
Islam	142(84.0)	148(48.0)	537(97.0)	221(96.0)	23(64.0)	23(72.0)	40(88.0)	30(90.0)
Hinduism	28(16.0)	146(48.0)	16 (3.0)	8(4.0)	11(31.0)	8(25.0)	5(11.0)	3(8.0)
Buddhism	-	11(4.0)	-	-	2(5.0)	1(3.0)	1(1.0)	1(2.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**36(100.0)**	**32(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.6 Show that 84.0% of nurses 48.0% doctors, respectively 97.0% of patients from OPD and 96.0% of patients belonged to Islam religion and 48.0% doctors from Hindu religion in the district hospitals in the community medical college hospital. There are 64.0% nurses 72.0% doctors, respectively 88.0% patients from OPD and 90.0% of patients from IPD were belonged Islam religion.

Table-1.7: Distribution of the respondents according to monthly family income of the patients.

Monthly Family Income (MFI) (in taka)	Category of respondents			
	District Hospitals		Community Medical College Hospital	
	Patients (n=782)		Patients (n=80)	
	OPD (n=553)	IPD (n=229)	OPD (n=46)	IPD (n=34)
5000/- or less	329(60.0)	145(63.0)	8(17.0)	5(16.0)
5001/- through 10,000/-	166(30.0)	65(28.0)	28(62.0)	22(64.0)
Above 10,000/-	58(11.0)	19(8.0)	10(21.0)	7(20.0)
Total	**553(100.0)**	**229(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.7 Show 60.0% of patients from OPD and 63.0% patients from have monthly family income taka 5000 or less in the district hospitals. On the other 62.0% of patients from OPD and 64.0% of patients from IPD in the community medical college hospital have monthly family income taka- 500/- through 10,000 the mean of monthly family in come respectively from OPD taka 5380.0 (± 3161), IPD taka 5481 (± 3179.0) and overall = taka 5451.66 (± 3172.31)

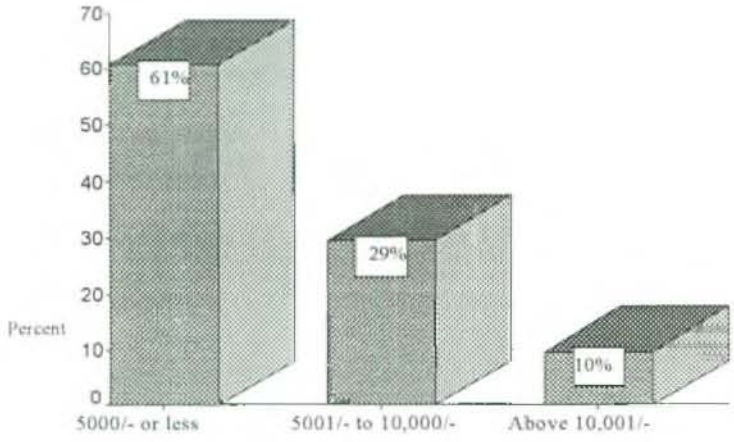


Figure-2: **Shows distribution of patients according to monthly Family Income**

Figure-2 show maximum 61% of patients has MFI taka 5000/- or less.

Table-1.9: Distribution of the respondents according to the satisfaction of the respondents.

Satisfaction To Services	Category of respondents							
	District Hospitals [n=1257]				Community Medical College Hospital (n=148)			
	Service providers [n=475]		Patients (n=782)		Service providers (n=68)		Patients (n=80)	
	Doctor (n=305)	Nurse (n=170)	OPD (n=553)	IPD (n=229)	Nurses (n=36)	Doctors (n=32)	OPD (n=46)	IPD (n=34)
Not satisfied	65(38.0)	52(17.0)	122(22.0)	44(19.0)	5(14.0)	5(16.0)	4(8.0)	4(11.0)
Partially satisfied	94(55.0)	180(59.0)	319(58.0)	142(62.0)	26(73.0)	20(64.0)	31(68.0)	24(72.0)
Fully satisfied	11(7.0)	73(24.0)	112(20.0)	43(19.0)	5(13.0)	7(20.0)	11(24.0)	6(17.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**36(100.0)**	**32(100.0)**	**46(100.0)**	**34(100.0)**

Table-1.9 Show that 55.0% of nurse, 59.0% of doctors respectively 58.0% of patients from OPD and 62.0% of patients from IPD of district hospitals are partially satisfied to the provided services. Fully satisfied to the service are 7.0% nurse, 24.0% doctors' 20.0% nurse from OPD and 19.0% nurse from IPD. There 38.0% nurses, 17.0% doctors respectively 22.0% of patients OPD and 19.0% of patients from IPD of district hospitals were not satisfied to the service provide from district hospital. There were 73.0% nurses, 64.0% doctors, respectively 68.0% patients from OPD and 72.0% patients from IPD showed their partial satisfied in to the provided services in the community medical college hospital. There were 13.0% nurse, 20.0% doctors; respectively 24.0% patients from OPD and 17.0% of patients from IPD were fully satisfied. Not satisfied to the provided 8 service of community medical college hospital were 14.0% nurse, 16.0% doctors, respective by 8.0% of patients from OPD and 11.0% from IPD.

Table-1.9A: Relationship of levels of satisfaction of both Patients and Service Provider Nurses and Doctors in district hospitals and Dhaka Community Medical College Hospital.

Category of Respondents	Levels of Satisfactions	Type of Hospitals		p-value
		District Hospital	Dhaka Community Medical College Hospital	
Nurse(n=305, n=36)	Not satisfied	52(17%)	5(14%)	.280
	Partly satisfied	180(59%)	26(72%)	
	Fully satisfied	73(24%)	5(14%)	
Doctors (n=170, n=32)	Not satisfied	65(38%)	5(16%)	.005
	Partly satisfied	94(55%)	20(64%)	
	Fully satisfied	11(7%)	7(20%)	
Patients(n=782, n=80)	Not satisfied	166(21%)	8(10%)	.056
	Partly satisfied	461(59%)	55(79%)	
	Fully satisfied	155(20%)	17(21%)	

The above Table-1.9A show that satisfaction of nurses upon providing services between the district hospitals and Dhaka Community Medical College Hospital are not significant (p=.280). Similarly, satisfaction of patients are also not significant (p=.056). But, satisfaction of doctors between the district hospitals and Dhaka Community Medical College Hospital are significant (p=.005).

2. Relationships of service satisfaction and important characteristics of service respondents.

Monthly Family Income, Educational level, Occupation of respondents is considered as strong influencing variables in choosing service as well as service satisfaction in district hospitals. The following Tables show relationships of such socio-demographic and economic characteristics and satisfactions to currently provided services in district hospitals.

Table-2.1: Relationships of patient's monthly family income and satisfaction to currently provided services according to service area in district hospitals

Patients Satisfaction To Services (n=782)					
Service area	**Monthly Family Income of patients**	**Not satisfied n(%)**	**Partially satisfied n(%)**	**Fully satisfied n(%)**	**Level of significance χ^2_{df}, p=.05**
OPD	taka ≤5000/-	35(11.0)	218(66.0)	76(23.0)	
	taka 5001/- to 10000/-	33(20.0)	98(59.0)	35(21.0)	**χ^2_4=195.7, p<.001**
	taka ≥10000/-	54(93.0)	3(5.0)	1(2.0)	
IPD	taka ≤5000/-	18(13.0)	97(66.0)	31(21.0)	**χ^2_6=44.3, p<.001**
	taka 5001/- to 10000/-	12(19.0)	42(65.0)	11(16.0)	
	taka ≥10000/-	14(74.0)	3(21.0)	1(5.0)	

Table-2.1 shows that irrespective of service area of district hospitals, patients satisfactions to the services has a very significant relationship with their monthly family income (MFI) (p<.001).

Table-2.3: Relationships Of Patients Occupations And attitudes towards provided Services In District Hospitals

Service Area	Occupations of patients	Patients attitudes towards Services (n=782)			
		Not satisfied (166)	Partially satisfied (461)	Fully satisfied (155)	χ^2_{df}, p<.05
OPD (553)	Unemployed and no occupation	56(37.0)	71(47.0)	25(16.0)	
	Daily laborer and R. puller	14(34.0)	14(34.0)	13(32.0)	
	Agriculture and households	-	51(96.0)	2(4.0)	χ^2_{10} = 92.365, p<.001
	Business any type	13(11.0)	70(61.0)	31(27.0)	
	Employed in job	26(39.0)	27(40.0)	14(21.0)	
	Housewife	13(10.0)	86(68.0)	27(21.0)	
IPD (229)	Unemployed and no occupation	16(32.0)	27(54.0)	7(7.0)	
	Daily laborer and R. puller	7(37.0)	8(42.0)	4(21.0)	
	Agriculture and households	-	23(100.0)	-	χ^2_{10} = 47.779, p<.001
	Business any type	4(8.0)	29(60.0)	15(31.0)	
	Employed in job	13(41.0)	12(38.0)	7(22.0)	
	Housewife	4(7.0)	43(75.0)	10(18.0)	

Results in the above Table-2.3 shows that irrespective of service area of the district hospitals Patients Occupations and service satisfactions in district hospitals are very significantly related (p<.001).

Table-2.4: Relationships Of Nurses Length Of Service And Satisfaction To Currently Provided Services In District Hospitals

Length Of Service of nurses	Nurses opinions Towards Services (n=305)			
	Not satisfied (52)	Partially satisfied (180)	Fully satisfied (73)	χ^2_{df}, p<.05
5 years or below	-	51(28.0)	13(18.0)	$\chi^2_8 = 100.076$, p<.001
6 through 10 years	19(24.0)	32(18.0)	29(40.0)	
11 through 15 years	20(71.0)	8(4.0)	-	
16 through 20 years	13(15.0)	53(29.0)	23(31.0)	
21 years and above	-	36(20.0)	8(11.0)	

Results in the above Table-2.4 shows that Nurses Length Of Service and their satisfactions to currently provided service in district hospitals are very significantly related (p<.001).

Table-2.5: Relationships Of Nurses Length Of Service And Satisfaction To Currently Provided Services In District Hospitals

Length Of Service	Doctors opinions to Services (n=170)			
	Not satisfied (65)	Partially satisfied (94)	Fully satisfied (11)	χ^2_{df}, p<.05
5 years or Below	33 (55.0)	27 (45.0)	-	χ^2_2=14.958, p<.001
6 years and above	32 (29.0)	67 (61.0)	11 (10)	

Results in the above Table-2.5 shows that Doctors Length of Service and opinions towards service in district hospitals are very significantly related (p<.001).

Table-2.6: Distribution of respondents according to their opinions about reasons of not satisfaction to services in district hospitals

Category of respondents (n=1102)					
Reasons of not satisfaction to services	**Service providers**		**Patients**		
	Doctors n(%)	**Nurses n(%)**	**OPD n(%)**	**IPD N(%)**	**Totai n(%)**
Management problems	69 (41.0)	34 (12.0)	9 (2.0)	14(7.0)	23(3.7)
Non-cooperation of service providers	30 (18.0)	7 (2.0)	280 (63.0)	130(70.0)	410(65.4)
Less medicines	28 (16.0)	50 (16.0)	57 (13.0)	9(5.0)	66(10.5)
All of above three	43 (25.0)	214 (70.0)	95 (22.0)	33(18.0)	128(20.4)
Total	**170(100.0)**	**305(100.0)**	**441(100.0)**	**186(100.0)**	**627(100.0)**

Table-2.6 shows that maximum 69(41.0%) of doctors and 214(70.0%) of nurses had opined that the reasons of unsatisfaction to services respectively due to management and combined management and less medicine and non-cooperation of service providers. Less medicines and management were the reasons had been opined respectively by 50(16.0%) and 34(12.0%) of nurse. Respectively 43(25.0%) and 30(18.0%) of doctors had opined that the reasons of unsatisfaction were combined management, non-cooperation of service providers and less medicines and non-cooperation of service providers. Maximum 280(63.0%) and 130(70.0%) of patients respectively from OPD and IPD were opined that the reasons of unsatisfaction were non-cooperation of service providers in district hospitals.

3. ATTITUDES AND OPINIONS ABOUT PATIENTS REGISTRATION FEES

Table-3.1: Distribution of the respondents according to knowledge about current patient's registration fees in OPD of district hospitals

[n=1162]

Category Of Respondents					
Knowledge about current registration fees at OPD	**Service providers**		**Patients**		
	Doctors n(%)	**Nurse n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
taka 4 or less	28(17.0)	75(25.0)	76 (15.0)	22(11.0)	98 (14.0)
taka 5 and above	138(83.0)	228(75.0)	420(85.0)	175(89.0)	595 (86.0)
Total	**166(100.0)**	**303(100.0)**	**496(100.0)**	**197(100.0)**	**693(100.0)**

[N.B: The exact registration fees at OPD are taka 4.40 per patient per visit]

Table-3.1 shows that maximum 420(85.0%) and 175(89.0) of patients respectively from OPD and IPD and 228(75.0%) of nurses and 138(83.0%) of doctors and overall, 595(86.0%) of patients opined that currently taka >5/- were the patients' registration fees in OPD of district hospitals. Rest of respondents had opined that taka <4/- were the patients' registration fees in OPD of district hospitals of Bangladesh.

Table-3.2: Distribution of respondents according to knowledge about current patient's registration fees in IPD of district hospitals

[n=1257]

Category of respondents					
Knowledge about current registration fees at IPD	**Service providers**		**Patients**		
	Doctors n(%)	**Nurse n(%)**	**OPD n(%)**	**IPD N(%)**	**Total n(%)**
taka 10/- or less	138(81.0)	298 (98.0)	550 (99.0)	228 99.0)	778(99.0)
taka 11/- and above	32(19.0)	7(2.0)	3(1.0)	1(1.0)	4(1.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

[N.B: The exact registration fees at OPD are taka 7.30 per patient per visit]

Table-3.2 shows that at most 550(99.0%) of patients from OPD and 228(99.0%) from IPD and maximum 298(98.0%) of nurse and 138(81.0%) of doctor opined taka 10/- or less registration fees by patients in IPD of district hospitals. Rest of respondents opined that taka 11/- and above registration fees in IPD.

Table-3.3: Distribution of the respondents according to opinions about adequacy of current patients' registration fees in district hospitals

Adequacy of current patients registration fees	Category of respondents (n=1257)				
	Service providers		Patients		
	Doctors n(%)	Nurse n(%)	OPD n(%)	IPD n(%)	Total n(%)
Adequate	11(7.0)	67(22.0)	351(63.0)	136(59.0)	487(62.0)
Not adequate	159(93.0)	238(78.0)	202(37.0)	93(41.0)	295(38.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

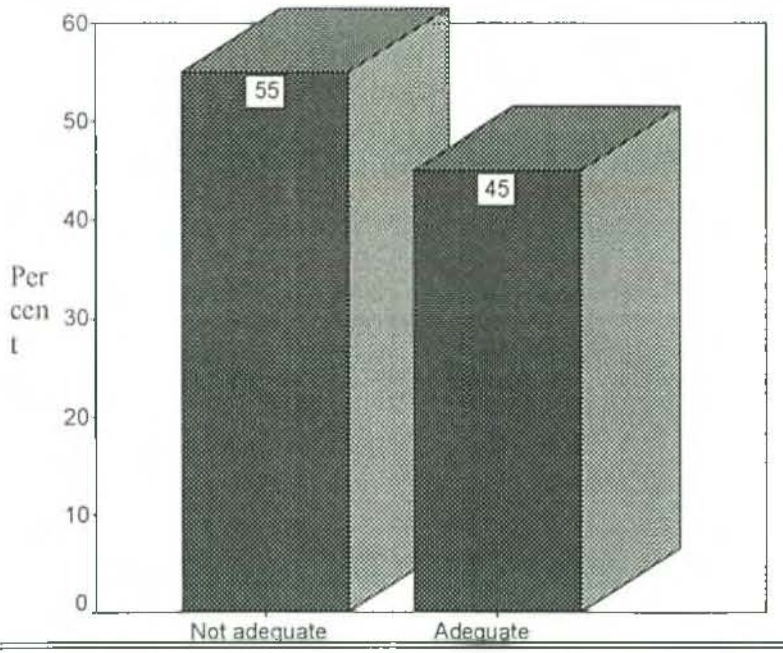


Figure-3: Distribution of respondents according to adequacy of current registration fees in the district hospitals

Table-3.3 showed that maximum 351(63.0%) of OPD patients and 136(59.0%) of IPD patients and overall 487(62.0%) of patients showed attitudes of current registration fees adequate. At most 238(78.0%) of nurse and 159(93.0%) of doctor opined registration fees not adequate. **Figure-3** show overall maximum 55% of respondents showed their attitudes and opined current registration fees were not adequate and 45% opined adequate.

Table-3.4: Distribution of respondents according to opinions about cost sharing by patients for registration fees in district hospitals.

[n=691)]

Category Of Respondents					
Attitude and opinions about cost sharing by patients for registration fees (taka)	**Service providers**		**Patients**		
	Doctors n(%)	**Nurse n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Based on economic condition of patients	6(4.0)	-	-	-	-
Based on quality of service	17(11.0)	9 (4.0)	29 (14.0)	6 (7.0)	35(12.0)
taka <20/-	87(55.0)	95 (40.0)	43 (21.0)	31 (33.0)	74(25.0)
≥21/-	48 (30.0)	134 (56.0)	130 (65.0)	56 (60.0)	186(63.0)
Total	**158(100.0)**	**238(100.0)**	**202(100.0)**	**93(100.0)**	**295(100.0)**

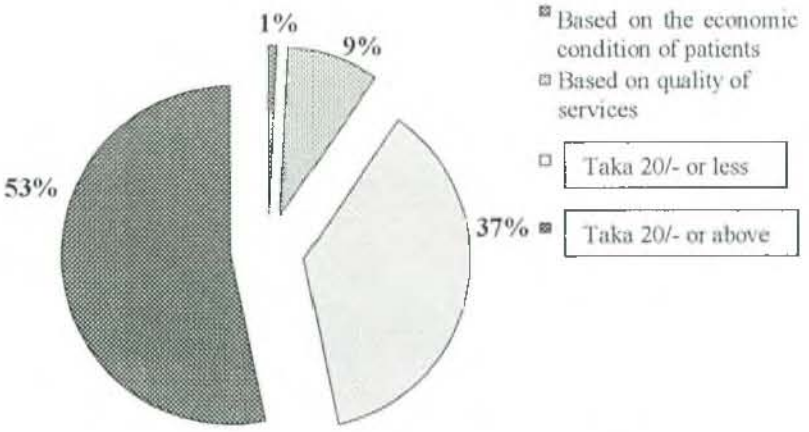


Figure-4: **Overall distribution of respondents according to attitude and opinion about amount of registration fees.**

Table-3.4 shows that maximum 130(65.0%) and 56(60.0%) of patients respectively from OPD and IPD and 134(56.0%) of nurse showed attitudes of patient registration fees should taka 21/- and above and maximum 87(55.0%) of doctor opined patients registration fees should be taka 20/- or less in district hospitals. Among others, 43(21.0%) and 31(33.0%) of patients, 95(40.0%) of nurse and 48(30.0%) of doctor showed attitude of taka 20/- or less. Eleven percent of doctor, 9(4.0%) of nurse and 29(14.0%) and 6(7.0%) of patient respectively from OPD and IPD opined patients'

registration fees should be based on quality of service in hospitals. **Figure-4** reveals overall maximum 53% of respondents showed attitudes of patients' registration fees should be taka 20/- or less in district hospitals.

Table-3.5: Relationship of patient's attitudes on cost sharing for registration fees and their socio-economic characteristics in district hospitals.

[n=295]

Patient's attitude on cost sharing for registration fees				
Socio-Demographic characteristics	**Upon quality Of service and economic conditions**	**taka 20/- or less**	**taka 21/- and above**	**χ^2_{df}, p<.05**
Age group (years):				
<30	17(11.0)	44(29.0)	92 (60.0)	χ^2_4=27.9, p<.001
31 – 50	17 (21.0)	25 (30.0)	41 (49.0)	
≥50	1 (2.0)	5 (8.0)	53 (90.0)	
Sex group:				
Male	34 (18.0)	25 (13.0)	130 (69.0)	χ^2_2=48.9, p< .001
Female	1 (1.0)	49 (46.0)	56 (53.0)	
Education:				
Elementary completed	1(1.0)	4(3.0)	113(96.0)	χ^2_4=148.5, p<.001
Secondary completed	-	43 (53.0)	38 (47.0)	
H.S.C and above	34 (35.0)	27 (28.0)	35 (37.0)	
Monthly Family Income (taka):				
<5000/-	1(1.0)	45(25.0)	130 (74.0)	χ^2_4=152.6, p< .001
5001/- to 10000/-	1 (2.0)	25 (40.0)	37 (58.0)	
>10000/-	33 (59.0)	4 (7.0)	19 (34.0)	
Occupations:				
Unemployed and H. wife	16 (15.0)	46 (44.0)	43 (41.0)	χ^2_6=158.6, p<.001
Ag., Labo. and rickshaw puller	1 (1.0)	1 (1.0)	91 (98.0)	
Business of any	17(43.0)	22 (55.0)	1 (2.0)	
Employed in job	1 (2.0)	5 (9.0)	51 (89.0)	
Satisfaction services:				
Satisfied	1 (1.0)	53 (33.0)	108 (66.0)	χ^2_2=25.7, p<.001
Not satisfied	34 (37.0)	-	59 (63.0)	
Marital status:				
Married	19 (8.0)	73 (30.0)	148 (62.0)	χ^2_2=31.9, p<.001
Single	16 (29.0)	1 (2.0)	38 (69.0)	

Table-3.5 showed that patients attitude about cost sharing willingness for IPD registration fees have significant relationships with their socio-demographic and economic characteristics like age, sex, educational, monthly family income, occupations, marital status and service satisfaction (p<.001) in district hospitals.

Table-4.3: Relationships of patient's attitudes of cost sharing willingness for prescription fees in second visit at OPD and some selected socioeconomic characteristics according to service area in district hospitals

[n=314]

Patients attitude of pay amount for prescription fees for second visit at OPD			
Socioeconomic Characteristics	**50/- or less**	**51/- and above**	**χ^2_{df}, p<. 05**
Educational level:			
Up to Elementary level	83 (81.0)	19 (19.0)	χ^2_2=11.8, p<.005
Secondary completed	109(84.0)	21(16.0)	
Higher secondary and above	80 (98.0)	2 (2.0)	
Sex group:			X^2_1=19.5, P<.001
Male	156(80.0)	39(20.0)	
Female	116(98.0)	3(2.0)	
Occupations:			χ^2_1=37.9, p<.001
Unemployed & HW	32 (60.0)	21 (40.0)	
Employed and earning	240(92.0)	21(8.0)	

Table-4.4 showed that significant relationship of patients attitude of cost sharing for prescription fees for second visit at OPD with some selected socioeconomic characteristics education (p<.005), sex (p<.001) and occupation (p<.001) in district hospitals.

4.4: Correlations of patient's attitude of pay amount of money for prescription fees at OPD and selected socioeconomic characteristics in district hospitals: It was found that patient's attitudes of giving prescription fees for first visit at the OPD of district hospitals were very significantly correlated with monthly family income (n=314, r=.137, p<.015) and with age were not significant (n=314, r= -.029, p>.05). The mean amount of giving prescription fees by patients for first visit were taka 69.9 and (±SD)= taka 52.6. The results showed that opinion of nurses about paying prescription fees for first visit should given by patients at OPD in district hospitals were not related with their length of service (n=169, r=.084, p>.05) and age (n=169, r=.061, p>.05). The mean (±SD) amount of prescription fees for first visit should be 73.0 (±31.0). It was also found that opinions of doctors about giving prescription fees by patients for first visit were very significantly related with their length of service (n=120, r=.417, p<.001) and with age (n=120, r=.435, p<.001). According to opinions of doctors, the mean (±SD) amount of prescription fees for first visit should be 50.5 (±28.0). One way ANOVA showed that comparison of the means of prescription fees for first visit that should be given by the patients at the OPD of district hospitals were significantly difference between doctors and nurses (p<.001), doctors and OPD patients (p<.001) and doctors and IPD patients (p<.001). However, opinions of nurses, OPD patients and IPD patients showed no difference.

It was found that attitudes of patients for giving prescription fees for second visit at OPD of district hospitals have a significant positive correlations with their monthly family income (n=312, r=.131, p<.025) and with age has no relation (n=312, r=-.078, p<.168). The mean (±SD) amount of taka 38.1(±25.5) they willing to pay for second visit, median was taka 30/- and mode was taka 20/- for second visit. It was showed that opinions of nurses about amount of fees should be given by the patients for second visit has no significant relationship with their length of service (n=169, r=.042, p>.05) and with age (n=169, r=.017, p>.05) in district hospitals. Though there is was a significant correlations between age and length of service of nurses (n=169,r=.823, p<.001). The mea (±SD) amount of taka 38.8(±15.6) should pay by patients for second visit, median was taka 30/- and mode was taka 50/- for second visit has opined by nurses. It was found that opinions of doctors about amount of fees should be given by the patients for second visit has a significant relationship with their length of service (n=118, r=.292, p<.001) and with age (n=118, r=.333, p<.001) in district hospitals. There was also significant correlations between age and length of service of nurses (n=118,r=.966, p<.001). The mea (±SD)

amount of taka 26.5(±18.9) should pay by patients for second visit, median was taka 20/- and mode was taka 20/- for second visit has opined by the doctors. One way ANOVA showed that the comparison of means of prescription fees for second visit that should be given by the patients at the OPD of district hospitals were significantly difference between doctors and nurses ($p<.001$), doctors and OPD patients ($p<.001$) and doctors and IPD patients ($p<.001$). However, opinions of nurses, OPD patients and IPD patients showed no difference.

5. ATTITUDES AND OPINIONS ABOUT COST SHARING FOR MEDICAL INVESTIGATION TEST

Table-5.1: Distribution Of Respondents According To Opinions About Current Cost Sharing System For Medical Investigations Tests In District Hospitals

Category Of Respondents [n=1257]					
Opinions about current cost sharing by patients for medical investigations tests	**Service providers**		**Patients**		
	Doctor n(%)	**Nurses n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Patients are paying for some tests	167(98.0)	239(78.0)	499(90.0)	204(89.0)	702(90.0)
Patients are free of charge for medical tests	3(2.0)	66(22.0)	64(10.0)	25(11.0)	80(10.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

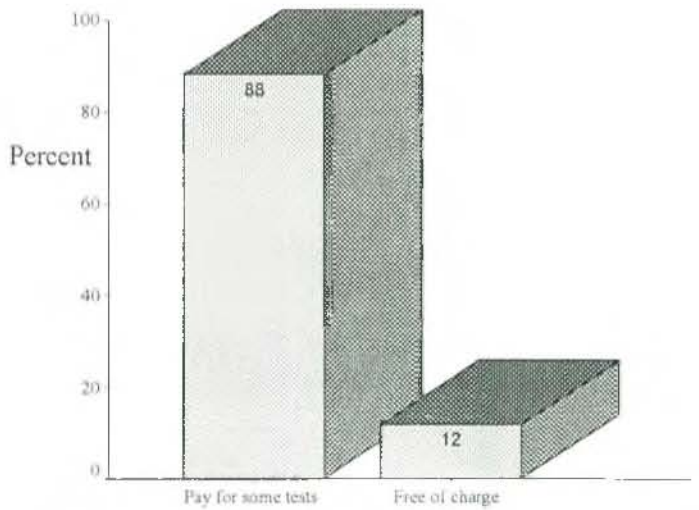


Figure-6: Distribution of respondents according to Opinions on paying medical investigation tests

Table-5.1 shows that respectively 702(90.0%) of patients, 239(78.0%) of nurse and 167(98.0%) of doctor opined currently patients are paying for some tests in district hospitals and overall 88% of respondents opined patients have to share costs for some medical tests in district hospitals (Figure-6).

Table-5.2: Distribution of respondents according to attitudes and opinions about cost sharing by patients for medical tests in district hospitals

[n=1257]

Category of respondents					
Respondents attitudes and opinions about cost sharing for tests	**Service providers**		**Patients**		
	Doctor n(%)	**Nurse n(%)**	**OPD n(%)**	**IPD n(%)**	**Total N(%)**
Not Willing to share cost	43 (25.0)	125(41.0)	41(7.0)	15(7.0)	56(7.0)
Willing to share cost	127(75.0)	180(59.0)	512 (93.0)	214(93.0)	726(93.0)
Total	**170(100.0)**	**305(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-5.2 shows that maximum 528(93.0%) and 214(93.0%)of patients each respectively from OPD and IPD showed attitude of sharing costs and maximum 180(59.0%) of nurses and 127(75.0%) of doctors had opined that patients should share cost for medical investigations. Among others, 43(25.0%) of doctors, 125(41.0%) of nurses and overall 56(7.0%) of patients had opined and showed their attitude of not sharing the cost of medical investigation tests in district hospitals of Bangladesh.

Table-5.3: Distribution of respondents according to the attitudes and opinions of about amount of cost of medical investigation tests should be share by the patients in the district hospitals

Attitudes and opinions about Amount of cost sharing for investigation tests	Category of respondents (n=943)				
	Service providers		Patients		
	Nurses n(%)	Doctors n(%)	OPD n(%)	IPD n(%)	Total n(%)
Based on economic status of patients	43 (35.0)	40(41.7)	245(47.9)	99(46.3)	344(47.5)
1% to 25%	22(18.0)	23(24.0)	105(20.5)	49(22.9)	154(21.2)
26% to 50%	53(43.4)	30(31.3)	95(18.6)	34(15.9)	129(17.8)
51% to 75%	4(3.3)	3(3.1)	46(9.0)	18(8.0)	64(8.8)
76% to 100%	0.0	0.0	20(3.9)	14(6.5)	34(4.7)
Total	**122(100.0)**	**96(100.0)**	**511(100.)**	**214(100.0)**	**725(100.0)**

Table-5.3 showed that maximum 40(41.%) of doctors, 245(47.9%) of OPD patients and 99(46.3%) of IPD patients showed that amount medical investigation costs should be shared by the patients based on their economic status. Maximum 53(43.4%) of the nurses were opined that 26% to 50% of medical investigation costs should be shared by the patients. Overall, 344(47.5%) of patients showed their attitudes that medical investigation costs should be shared by them based on the economic status.

Table-5.4: Relationships of patient's attitudes of cost sharing amount for medical investigation tests with some socio-demographic characteristics in district hospitals

[n=725)]

Patients attitudes of pay amount of money for medical investigation test				
Socio-demographic characteristics	**Based on economic condition**	**≤50% of actual cost**	**≥51% of actual cost**	**X^2_{df} p<. 05**
Age group (in years):				
≤30	184(54.0)	173(61.0)	57(58.0)	χ^2_4=43.5, p<.001
31 – 50	38(11.0)	27(10.0)	30(31.0)	
≥51	122(35.0)	83(29.0)	11(11.0)	
Sex:				χ^2_2=5.3, p<.069
Male	246(72.0)	181(64.0)	61(62.0)	
Female	98(28.0)	102(36.0)	37(38.0)	
Education:				
Up to elementary	213(62.0)	111(39.0)	51(52.0)	χ^2_4=48.6, p<.001
Secondary education	106(31.0)	115(41.0)	23(24.0)	
H.S.C. and above	25(7.0)	57(20.0)	24(24.0)	

Table-5.4 showed that significant relationship between patients attitude of cost sharing for medical investigation tests with their socio-demographic characteristics like; age (p<.001) and education (p<.001) and non-significant relationship with sex of patients (p<.05).

Table-5.5: Relationships of patient's attitude of cost sharing amount for medical investigation tests with some socio-demographic characteristics in district hospitals

Service area	Socio-demographic characteristics	Patients attitudes of pay amount of money for medical investigation tests (n=726)			
		Based on economic condition	≤50% of actual cost	≥51% of actual cost	χ^2_{df}, p<. 05
OPD	**Occupation:**				χ^2_6=35.9, p<.001
	Unemployed and H.W.	134(51.0)	109(41.0)	20(8.0)	
	Agr., Lab. and R. Puller	38(47.0)	26(32.0)	17(21.0)	
	Business of any	55(54.0)	37(37.0)	9(9.0)	
	Employed in job	18(27.0)	29(43.0)	20(30.0)	
IPD	Unemployed and H.W.	51(50.0)	41(40.0)	10(10.0)	χ^2_6=23.7, p<.001
	Agra., Lab. and R. Puller	15(42.0)	9(25.0)	12(33.0)	
	Business of any	26(59.0)	15(34.0)	3(7.0)	
	Employed in job	7(22.0)	18(56.0)	7(22.0)	
OPD	**Monthly Family Income**				
	taka ≤5000/-	180(58.0)	94(31.0)	34(11.0)	
	taka 5001/- to 10000/-	58(36.0)	73(46.0)	29(18.0)	χ^2_4=50.9, p<.001
	taka 10001/-and above	7(16.0)	34(77.0)	3(7.0)	
IPD	taka ≤5000/-	73(54.0)	41(30.0)	22(16.0)	χ^2_4=18.0, p<.001
	taka 5001/- to 10000/-	23(37.0)	30(48.0)	10(16.0)	
	taka 10001/-and above	3(20.0)	12(80.0)	-	
OPD	**Satisfaction To Services:**				
	Not Satisfied	27(28.0)	40(42.0)	29(30.0)	χ^2_2=43.3, p<.001
	Satisfied	163(53.0)	122(40.0)	20(7.0)	
IPD	Not Satisfied	7(19.0)	16(44.0)	13(36.0)	χ^2_2=20.3, p<.001
	Satisfied	71(52.0)	52(38.0)	13(10.0)	
OPD (512)	**Marital Status:**				
	Married	182(48.0)	134(36.0)	61(16.0)	χ^2_2=17.3, p<.001
	Single	63(47.0)	67(50.0)	5(3.0)	
IPD (214)	Married	79(49.0)	56(35.0)	26(16.0)	χ^2_2=4.4, p>.05
	Single	20(38.0)	27(51.0)	6(11.0)	

Table-5.5 shows that very significant relationships of patients attitude to pay amount of money for medical tests fees with some selected socio-demographic characteristics like occupations (p<.001), monthly family income (p<.001), service satisfaction (p<.001) and marital status (p<.001) irrespective of service area in hospitals.

Table-5.6: Relationships of nurse's opinion about patients cost sharing for medical investigations tests with their service satisfactions in district hospitals.

[n=180]

Nurse's opinion about cost sharing willingness for medical investigation test				
Service Satisfaction	**Based On Economic Condition**	**≤50% Of Actual Cost**	**≥51% Of Actual Cost**	$\chi^2_{df,}$ p<. 05
Not satisfied	18(25.0)	39(53.0)	16(22.0)	χ^2_2=18.6, p<.001
Satisfied	25(23.0)	78(73.0)	4(4.0)	

Table-5.6 showed that nurse's opinions about patients cost sharing amount for medical investigations tests with their service satisfaction has a significant relationship (p<.001).

6. ATTITUDES AND OPINIONS ABOUT COST SHARING FOR MEDICINES

Table-6.1: Distribution of respondents according to attitude and opinion about patients can purchase medicine by cheap price from district hospitals

[n=1257]

Attitude and opinion of respondents	Category of respondents				
	Service providers		Patients		
	Nurse n(%)	Doctor n(%)	OPD (n(%)	IPD n(%)	Total N(%)
Cannot purchase medicine by cheap rate from hospitals	72(20.0)	38(22.0)	289(52.0)	107(47.0)	396(51.0)
Can purchase medicine by cheap rate from hospitals	233(80.0)	132(78.0)	264 (48.0)	122(53.0)	386(49.0)
Total	**305(100.0)**	**170(170.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-6.1 shows that maximum 264(48.0%) and 122(53.0%) of patient respectively from OPD and IPD and respectively 233(80.0%) of nurse and 132(78.0%) of doctors has attitude and were opinioned that patients can purchase medicine by cheap price supplied from hospitals.

Table-6.2: Distribution of respondents according to their attitude and opinion about cost sharing by patients for medicine in district hospitals

[n=751]

Attitudes and opinions about pay medicine cost	Category of respondents				
	Service providers		Patients (386)		
	Nurse n(%)	Doctor n(%)	OPD n(%)	IPD n(%)	Total n(%)
Patient should pay partly for medicine	218(94.0)	127(96.0)	205 (78.0)	93 (76.0)	298(77.0)
Patient should pay fully for medicine	15(6.0)	5(4.0)	59 (22.0)	29 (24.0)	88(23.0)
Total	**233(100.00**	**132(100.0)**	**264(100.0)**	**122(100.0)**	**386(100.0)**

Table-6.2 shows that maximum 205(78.0%) of patients from OPD and 93(76.0%) of patients from IPD and respectively 127(96.0%) of doctors and 218(94.0%) of nurses had showed their attitude and opined that patients should pay medicine costs partially that will be supplied from the hospitals. Patient should pay full costs of medicines supplied from hospitals had opined by 59(22.0%) patients from OPD and 29(24.0%) patients from IPD and respectively 5(4.0%) of doctors and 15(6.0%) of nurses in the district hospitals.

Table-6.3: Respondents attitude and opinion about amount of cost should pay for medicine supplied from district hospitals.

[n=643]

Attitude and opinion about cost sharing amount for medicines	Category of respondents				
	Service providers		Patients		
	Nurse n(%)	Doctor n(%)	OPD n(%)	IPD n(%)	Total N(%)
Based on economic condition	104(47.0)	109(86.0)	152 (74.0)	67(72.0)	219(74.0)
Up to 25% of actual cost	46(21.0.0)	12(9.0)	26 (13.0)	12 (13.0)	38(12.0)
26% and above of actual cost	68(32.0)	6(5.0)	27(13.0.0)	14 (15.0)	41(14.0)
Total	**218(100.0)**	**127(100.0)**	**205(100.0)**	**93(100.0)**	**298(100.0)**

Table-6.3 showed that Maximum 152(74.0%) of patients from OPD and 67(72.0%) of patients from IPD and respectively 109(86.0%) and 104(47.0%) of nurses were opined that patients should share costs of supplied medicines based on the economic conditions of the patients.

Table-6.4: Relationships of patient's attitudes about cost sharing amount for medicines supplied with their socio-demographic characteristics.

[n=298]

Patients attitude of pay for medicines				
Service area	Socio-demographic characteristics	Based on economic condition	Up to 25% of actual cost	Level of significance χ^2_{df}=.05
OPD (205)	Age group (Years)			χ^2_3=9.3, P=.010
	<30	70(67.0)	34(33.0)	
	31 to 50	36(92.0)	3(8.0)	
	>50	46(74.0)	16(26.0)	
IPD (205)	<30	29(59.0)	16(26.0)	χ^2_3=9.8, P=.010
	31 to 50	17(94.0)	1(6.0)	
	>50	21(81.0)	5(19.0)	
OPD (205)	Education:			χ^2_2=72.7, P=.001
	Up to elementary	85(82.0)	19(18.0)	
	Secondary education	58(95.0)	3(5.0)	
	HSC and above	9(23.0)	31(77.0)	
IPD (205)	Up to elementary	38(81.0)	9(19.0)	χ^2_2=28.5, P=.001
	Secondary education	23(96.0)	1(4.0)	
	HSC and above	6(27.0)	16(73.0)	
OPD (205)	Occupations:			χ^2_3=32.8, P=.001
	Unemployed and H.W	71(76.0)	22(24.0)	
	Agra, Lab. And R. Puller	49(98.0)	1(2.0)	
	Business of any	20(57.0)	15(43.0)	
	Employed in job	12(47.0)	15(53.0)	
IPD (205)	Unemployed and H.W	32(76.0)	10(24.0)	χ^2_3=24.8, P=.001
	Agra, Lab. And R. Puller	23(100.0)	-	
	Business of any	11(58.0)	8(42.0)	
	Employed in job	1(11.0)	8(89.0)	

Table-6.4 showed that the patients attitudes about costs sharing amount for supplied medicines has a very significant relationship with socio-economic characteristics like age ($p<.001$), education ($p<.001$) and occupations ($p<.001$) in district hospitals.

Table-6.5: Relationships of patient's attitude about cost sharing amount for medicines with their monthly family income and service satisfaction.

Patients attitude of pay amount for medicine (n=298)				
Service Area	**Monthly family income and satisfaction**	**Based on economic condition**	**Up to 25% of actual cost**	χ^2_{df}, p<. 05
OPD (205)	**Monthly Family Income (taka):**			
	<5000/-	114(86.0)	18(14.0)	χ^2_2=44.4, p<.001
	500/- to 10000/-	18(38.0)	30(62.0)	
	≥10001/-	20(80.0)	5(20.0)	
IPD (93)	<5000/-	53(87.0)	8(13.0)	
	500/- to 10000/-	6(26.0)	17(74.0)	χ^2_2=32.6, p<.001
	≥10001/-	8(89.0)	1(11.0)	
OPD (187)	**Satisfaction to services:**			
	Not satisfied	42(86.0)	7(14.0)	χ^2_1=5.3, p<.015
	Satisfied	95(69.0)	43(31.0)	
IPD (81)	Not satisfied	17(90.0)	2(10.0)	χ^2_1=4.2, p<.034
	Satisfied	40(65.0)	22(35.0)	

Table-6.5 showed that patients attitudes about costs sharing amount for supplied medicines has a very significant relationship with their monthly family income (p<.001) and service satisfaction (p<.025) irrespective of OPD and IPD of district hospitals..

7. ATTITUDES AND OPINION ABOUT COST SHARING FOR SURGICAL OPERATIONS

Table-7.1: Distribution of respondents according to opinion about current spending pocket money for surgical operations by patients in district hospitals.

Category of respondents (n = 1257)					
Opinion of respondents	**Service providers**		**Patients**		
	Nurse n(%)	**Doctor n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Undecided	-	-	44(8.0)	25(11.0)	69(9.0)
Need to spend some money	252(83.0)	80(47.0)	87(16.0)	30(13.0)	117(15.0)
Need to spend money mostly	53(17.0)	90(53.0)	354(64.0)	152(66.0)	506(65.0)
Need to spend money fully	-	-	68(12.0)	22(10.0)	90(11.0)
Total	**305(100.0)**	**170(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-7.1 shows that maximum 354(64.0%) and 152(66.0%) of patients respectively from OPD and IPD and 90(53.0%) of doctors had opined that the patients need to spend pocket money in most of cases and 252(83.0%) of nurses had opined that the patients need to spend some pocket money for their surgical operations. Patients need to spend some pocket money for surgical operations had opined by 80(47.0%) of doctor, 87(16.0%) and 30(13.0%) of patient respectively from OPD and IPD and overall 506(65.0%) of patients' had opined that the patients need to spend pocket money mostly for their surgical operations in district hospitals.

Table-7.2: Association of patient's opinion about current spending pocket money for surgical operations with their socioeconomic characteristics.

[n=713]

Patients opinion about current spending pocket money for surgical operations					
Service area	**Socioeconomic Characteristics**	**Bear some cost**	**Bear costs mostly**	**Bear cost fully**	**χ^2_{df}, p<.05**
OPD (509)	**Age group (years):**				
	<30	215(76.0)	13(4.0)	56(20.0)	χ^2_4=50.5, p<.001
	31 to 50	11(13.0)	48(55.0)	28(32.0)	
	≥50	20(14.0)	91(66.0)	27(20.0)	
IPD (204)	<30	15(14.0)	90(82.0)	4(4.0)	χ^2_4=19.3, p<.001
	31 to 50	6(13.0)	24(60.0)	11(27.0)	
	≥50	10(18.0)	37(69.0)	7(13.0)	
OPD (509)	**Sex group:**				
	Male	240(66.0)	53(15.0)	69(19.0)	χ^2_2=6.3, p<.05
	Female	18(12.0)	114(78.0)	15(10.0)	
IPD (204)	Male	24(17.0)	99(70.0)	18(13.0)	χ^2_2=4.5, p<.105
	Female	7(10.0)	52(84.0)	4(6.0)	
OPD (509)	**Occupations:**				
	Up to elementary	178(70.0)	28(11.0)	47(19.0)	χ^2_4=13.4, p<.001
	Secondary education	33(19.0)	126(73.0)	13(8.0)	
	HSC and above	7(8.0)	50(60.0)	27(32.0)	
IPD (204)	Up to elementary	14(14.0)	77(76.0)	10(10.0)	χ^2_4=13.4, p<.005
	Secondary education	11(16.0)	52(78.0)	4(6.0)	
	HSC and above	5(14.0)	22(63.0)	8(23.0)	

Table-7.2 showed that patients opinion about current spending pocket money by the patients for their surgical operations has a very significant relationships with their socioeconomic characteristics age (p<.001), sex (p<.05) and education (p<.001) in district hospitals.

Table-7.3: Association of patient's opinion about current spending pocket money for surgical operations with their satisfaction to services.

[n=713]

Patients opinion about current spending pocket money for surgical operations					
Service area	**Satisfaction to services**	**Spend some cost**	**Spend costs mostly**	**Spend cost fully**	χ^2_{df}, p<.05
OPD (509)	Not satisfied	16(13.0)	66(54.0)	40(33.0)	χ^2_2=31.1, p<.001
	Satisfied	45(16.0)	205(74.0)	28(10.0)	
IPD (204)	Not satisfied	6(4.0)	22(51.0)	15(35.0)	χ^2_2=23.1, p<.001
	Satisfied	18(15.0)	94(79.0)	7(6.0)	

Table-7.3 showed that the opinions of patients about currently spending pocket money for their surgical operations has a very significant relationship with their service satisfaction (p<.001).

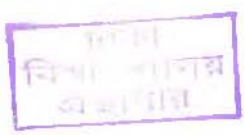


Table-7.4: Relationship of nurse's opinion about spending pocket money by patients for surgical operations and their demographic and service characteristics.

[n=305]

Nurses opinion about current spending pocket money for surgical operations by patients			
Demographic	**Need to spend some money (252)**	**Need to spend money mostly (53)**	χ^2_{df}, p<.05
Age group (years):			
≤30	83(33.0)	9(17.0)	χ^2_1=5.3,
≥31	169(67.0)	44(83.0)	**p<.025**
Sex:			
Male	13(5.0)	8(15.0)	χ^2_1=6.7,
Female	239(95.0)	45(85.0)	**p<.025**
Religion:			
Islam	100(40.0)	48(91.0)	χ^2_1=45.4,
Others	152(60.0)	5(9.0)	**p<.001**
Satisfaction to the service (n=232):			
Not satisfied	52(25.0)	-	χ^2_1=7.7,
Satisfied	156(75.0)	24(100.0)	**p<.001**
Length of Service (years):			
<5	59(92.0)	5(8.0)	χ^2_2=9.8,
6-10	70(88.0)	10(12.0)	**p<.025**
≥11	123(76.0)	38(24.0)	

Table-7.4 showed that opinion of nurses about currently patients need to spend pocket money for surgical operations has a significant relationship with their socio-demographic and service characteristics e.g. age (p<.025), sex (p<.025), religion (p<.001), service satisfaction (p<.001) and length of service (p<.025) in the district hospitals.

Table-7.5: Relationships of doctor's opinion about currently spending pocket money by the patients for their surgical operations with their age and service characteristic.

[n=170]

Opinion of doctors about current spending money for surgical operations by patient			
Demographic and service characteristics	**Need to spend some money (80)**	**Need to spend money mostly (90)**	χ^2_{df}, **p<.05**
Age groups (year):			
≤30	-	41(46.0)	χ^2_1=48.4, **p<.001**
≥31	80(100.0)	49(54.0)	
Length of services (years):			
≤5	11(14.0)	49(54.0)	χ^2_1=29.5, **p<.001**
≥6 years	69(86.0)	41(46.0)	
Satisfaction to service (159):			
Not satisfied	43(54.0)	22(28.0)	χ^2_1=11.5, **p<.001**
Satisfied	37(46.0)	57(72.0)	

Table-7.5 showed that the opinions of doctors about currently spending pocket money by the patients for their surgical operation has a very significant relationships with their age (p<.001), length of service (p<.001) and service satisfactions (p<.001) in district hospitals

Table-7.6: Respondents opinion about reasons of spending pocket money for surgical operations by patients in district hospitals

[n=1188]

Reasons of spending pocket money for surgical operations	Category of respondents				
	Service providers		Patients		
	Nurse n(%)	Doctor n(%)	OPD n(%)	IPD n(%)	Total n(%)
Giving to hospital staff	54(18.0)	16(9.0)	-	-	-
Buying materials from outside hospital	251(82.0)	154(91.0)	68(13.0)	23(11.0)	91(13.0)
Giving to hospital staff and buying materials from outside hospitals both for	-	-	441(87.0)	181(89.0)	622(87.0)
Total	**305(100.0)**	**170(100.0)**	**509(100.0)**	**204(100.0)**	**713(100.0)**

Table-7.6 showed that maximum 622(87.0%) of patients opined that the main reasons of spending pocket money for surgical operations were for the hospital staff and for buying materials from outside both and 19(13.0%) of patients had opined that buying materials from outside hospital was the main reasons for spending pocket money for surgical operations. At most 154(91.0%) of doctors and 251(82.0%) of nurses had opined that buying materials from outside hospital were the main reason for spending pocket money by the patients for their surgical operations in district hospitals.

Table-7.7: Relationships of patient's opinion about reasons of currently spending pocket money by the patients for their surgical operations with their socio-demographic characteristics.

(n=713)

Service Area	Socio-demographic characteristics	Opinions of patients about reasons		
		Buy materials from outside	Hospital staff & buy materials	χ^2_{df}, p<.05
OPD (509)	**Age group (years) (n=713):**			
	<30	31(11.0)	253(89.0)	χ^2_1=3.3,
	≥30	37(16.0)	188(84.0)	p<.046
IPD (204)	<30	9(8.0)	100(92.0)	χ^2_1=11.5,
	≥30	14(15.0)	81(85.0)	p<.108
OPD (509)	**Occupation (n=713):**			
	Unemployed and HW	40(21.0)	151(79.0)	χ^2_1=15.2
	Employed and Earning	28(9.0)	290(91.0)	p<.001
IPD (204)	Unemployed and HW	40(21.0)	151(79.0)	χ^2_1=4.1
	Employed and Earning	28(9.0)	290(91.0)	p<.05
OPD (509)	**Monthly Family Income (taka)(n=713):**			
	<5000/-	32(11.0)	268(89.0)	χ^2_2=57.4
	5001/- to 10000/-	10(7.0)	141(93.0)	p<.001
	>10,000/-	26(45.0)	32(55.0)	
IPD (509)	<5000/-	10(8.0)	118(92.0)	χ^2_2=36.1
	5001/- to 10000/-	3(5.0)	54(95.0)	p<.001
	>10,000/-	10(53.0)	9(47.0)	
OPD (400)	**Satisfaction to Service (n=563):**			
	Satisfied	28(10.0)	250(90.0)	χ^2_1=27.3
	Not Satisfied	38(31.0)	84(69.0)	p<.001
IPD (163)	Satisfied	10(8.0)	110(92.0)	χ^2_1=12.5
	Not Satisfied	13(30.0)	30(70.0)	p<.001

Table-7.7 showed that the patients opinion about reasons of spending pocket money for their surgical operations has a very significant relationships with their socio-demographic characteristics like monthly family income (p<.001), occupations (p<.001), service satisfaction (p<.001). Age of the patients shows just significant relationship (p<.05).

Table-7.8: Relationships of nurse's opinion about reasons of currently spending pocket money by the patients for their surgical operations with their age and length of service

(n=305)

Socio-demographic and service characteristics	Nurses opinion about reasons		
	Buy materials from outside	Hospital staff & buy materials	χ^2_{df}, p<.05
Age group (years):			
<30	88(35.0)	4(7.0)	χ^2_1=16.1
≥30	163(65.0)	50(93.0)	p=.001
Length of service (years):			
<5	-	64(26.0)	χ^2_2=25.5
6 to 10	10(18.0)	70(28.0)	p=.001
>10	44(82.0)	117(46.0)	
Satisfaction to service (n=232):			
Satisfied	30(100.0)	150(74.0)	χ^2_1=10.0
Not satisfied	-	52(26.0)	p=.001

Table-7.8 showed the a the opinions of the nurses about currently spending pocket money by the patients for their surgical operations has a very significant relationships with their age (p=.001), length of service (p=.010) and service satisfaction(p=.001) in district hospitals.

Table-7.9: Distribution of respondents according to attitudes and opinion about cost sharing by patients for surgical operations in district hospitals

[n=1257]

Category of respondents					
Attitude and opinion of cost sharing by patients surgical operations	**Service providers**		**Patients**		
	Nurse n(%)	**Doctor n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Patients should not share	98(32.0)	54(32.0)	378(68.0)	163(71.0)	541(69.0)
Patients should share	207(68.0)	116(68.0)	175(32.0)	66(29.0)	241(31.0)
Total	**305(100.0)**	**170(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-7.9 showed that maximum 241(31.0%) of patients has positive attitude, 116(68.0%) doctors and another 207(68.0%) of nurses has positive opinions that patient should share costs of surgical operations in the district hospitals.

Table-7.10: Relationships of patient's attitude about cost sharing by them for their surgical operations with the socio-demographic characteristics

(n=241)

Service area	Socio-demographic characteristics	Patients attitude of cost sharing for surgical operations		χ^2_{df}, p<.05
		Based on economic condition	Up to 25% of actual cost	
OPD	**Age groups (years):**			
(175)	<30	10(11.0)	79(89.0)	χ^2_1=22.5
	≥30	37(43.0)	49(57.0)	**p<.001**
IPD	<30	6(17.0)	29(83.0)	χ^2_1=2.9
(66)	≥30	10(33.0)	20(67.0)	**p<.001**
OPD	**Education level:**			
(175)	Elementary and below	47(54.0)	40(46.0)	χ^2_1=65.0
	Secondary and above	-	88(100.0)	**p<.001**
IPD	Elementary and below	14(40.0)	21(60.0)	χ^2_1=7.9
(66)	Secondary and above	2(7.0)	28(93.0)	**p<.025**
OPD	**Monthly Family Income (taka):**			
(175)	<5000/-	47(32.0)	100(68.0)	χ^2_1=12.2
	≥5,000/-	28(100.0)	-	**p<.001**
OPD	**Satisfaction to Service (203):**			
(148)	Satisfied	46(50.0)	46(50.0)	χ^2_1=40.6
	Not Satisfied	-	56(100.0)	**p<.001**
IPD	Satisfied	16(42.0)	22(58.0)	χ^2_1=10.6
(55)	Not Satisfied	-	17(100.0)	**p<.001**
OPD	**Marital status:**			
(175)	Married	47(36.0)	84(64.0)	χ^2_1=21.6
	Single	-	44(100.0)	**p<.001**
PID	Married	16(33.0)	33(67.0)	χ^2_1=7.3
(66)	Single	-	16(100.0)	**p<.025**

Table-7.10 showed that the attitudes of patients about cost sharing for by them for their surgical operations has a very significant relationship with the socio-demographic characteristics age (p<.001), education (p<.001), occupation (p<.001), monthly family income (p<.001), marital status (p<.001) and their satisfaction to services (p<.001) in district hospitals.

Table-7.11: Distributions of respondents according to their attitude and opinion about amount of actual costs for surgical operations should pay by the patients.

Category of respondents (n=564)			
Attitude and opinion of paying amount by patients for surgical operations	**Nurses n(%)**	**Doctors n(%)**	**Patients N(%)**
Based on economic status patients	54(26.0)	108(93.0)	64(27.0)
1% to 25% of actual charge	90(44.0)	2(2.0)	153(63.0)
26% to 50% of actual charge	21(10.0)	6(5.0)	20(8.0)
51% through above of actual charge	42(20.0)	-	4(2.0)
Total	**207(100.0)**	**116(100.00**	**241(100.0)**

Table-7.11 showed that maximum 153(63.0%) of the patients has the favorable attitude for sharing % to 25% of actual charge. Among the rest of the patients 64(27.0%) of them showed their favorable attitudes of sharing costs based on their economic status that was also opined by the maximum 108(93.0%) of doctors and 54(26.0%) of nurses. Maximum 90(44.0%) of nurses has opined that the patients should share 1% to 25% of actual costs of their surgical operations in the district hospitals.

Table-7.12: Relationship of patient's attitudes about cost sharing amount by them for surgical operations with their socio-demographic characteristics

(n=241)

Socio-demographic characteristics	Attitude of patients for cost sharing for surgical operations: Based on economic condition (64)	25% or less of actual cost (118)	26% to 50% of actual cost (35)	χ^2_{df}, p<.05
Monthly Family Income (241):				
<5000/-	63(98.0)	120(78.0)	21(88.0)	χ^2_2=14.1
≥5,000/-	1(2.0)	33(22.0)	3(12.0)	p<.001
Marital status (241):				
Married	64(100.0)	96(63.0)	21(88.0)	χ^2_2=35.7
Single	-	57(37.0)	3(12.0)	p<.001
Satisfaction (204):				
Satisfied	-	53(45.0)	20(83.0)	χ^2_2=63.3
Not Satisfied	63(100.0)	64(55.0)	4(17.0)	p<.001

Table-7.12 showed that the attitudes of patients for sharing amount of costs for their surgical operations has a very significant relationship with their monthly family income (p<.001), marital status (p<.001) and service satisfactions (p<.001).

8. ATTITUDES AND OPINIONS ABOUT COST SHARING FOR DELIVERY SERVICE

Table-8.1: Distribution of respondents according to opinion about currently spending amount of pocket money by patients for delivery service.

[n=1257]

Category of respondents					
Opinion on currently spending pocket money by patients for delivery service	**Service providers**		**Patients**		
	Nurse n(%)	**Doctor n(%)**	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Undecided	-	-	43(8.0)	22(10.0)	65(8.0)
Need to spend pocket money some thing	243(80.0)	86(51.0)	16(3.0)	4(2.0)	20(3.0)
Need to spend pocket money mostly	62(20.0)	84(49.0)	425(77.0)	179(78.0)	604(77.0)
Need to spend pocket money fully	-	-	69(12.0)	24(10.0)	93(12.0)
Total	**305(100.0)**	**170(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-8.1 showed that maximum 425(77.0%) and 179(78.0%) of patients respectively from OPD and IPD and overall 604(77.0%) of patients have opined that the patients need to spend pocket money in mostly for delivery service. Maximum 86(51.0%) of doctors and 243(80.0%) of nurses had pined that currently patients need to spend some pocket money for delivery service in district hospitals.

Table-8.2: Relationships of patient's attitudes on currently spending amount of pocket money for delivery services by them with the socio-demographic characteristic

(n=717)

Socio-demographic characteristics	Patients attitudes on spending pocket money for delivery: Need To spend Some money (20)	Need to spend money mostly (604)	Need to spend money fully (93)	χ^2_{df}, p<.05
Age group (years):				
<30	17(85.0)	360(60.0)	17(18.0)	χ^2_4=151.9
31 to 50	2(10.0)	69(11.0)	58(62.0)	p<.001
>50	1(5.0)	175(29.0)	18(19.0)	
Education level:				
Elementary and below	-	297(49.0)	58(62.0)	χ^2_4=90.1
Secondary completed	2(10.0)	221(37.0)	17(18.0)	p<.001
Higher secondary and above	18(90.0)	86(14.0)	18(19.0)	
Monthly family income (taka) (n=717):				
<5000/-	2(10.0)	363(60.0)	66(71.0)	χ^2_4=142.7
5001 to 10000/-	1(5.0)	198(33.0)	10(10.0)	p<.001
>10,000/-	175(85.0)	43(7.0)	17(18.0)	
Occupation (n=717):				
Unemployed and HW	16(80.0)	190(31.0)	53(57.0)	χ^2_2=39.9
Employed and Earning	4(20.0)	414(69.0)	40(43.0)	p<.001
Satisfaction (n=566):				
Satisfied	16(80.0)	95(21.0)	55(59.0)	χ^2_2=79.9
Not Satisfied	4(20.0)	358(79.0)	38(41.0)	p<.001

Table-8.2 showed that opinions of patients about currently spending amount of pocket money for delivery service has a very significant relationships with age (p<.001), education (p<.025), monthly family income (p<.001), occupation (p<.001 and satisfaction to services (p<.001) in district hospitals.

Table-8.3: Relationships nurse's opinions of about currently spending amount of pocket money by patients for delivery service with socio-demographic characteristics

Nurses opinions about spending pocket money for delivery by patients (n=305)			
Socio-demographic characteristics of nurse	**Need to pay some money**	**Need to spend money mostly**	χ^2_{df},p<.05
Age group (years):			
<30	83(34.0)	9(15.0)	χ^2_1=9.1
≥30	160(60)	53(85.0)	p<.025
Satisfaction (232):			
Not satisfied	39(20.0)	13(35.0)	χ^2_1=5.0
Satisfied	156(80.0)	24(65.0)	p<.05

Table-8.3 showed that opinions of nurses about amount of pocket money need to spend by the patients for delivery service has a very significant relationship with age (p<.025) and service satisfaction (p<.05) in district hospitals.

Table-8.4: Relationships of doctor's opinion about currently spending amount of pocket money by patients for delivery services with socio-demographic characteristics

Doctors opinions about spending pocket money by patients for delivery service (n=170)			
Socio-demographic characteristics of the doctors	**Need to spend some money**	**Need to spend money mostly**	χ^2_{df},p<.05
Age group(years) (n=170):			
<30	13(15.0)	29(34.0)	χ^2_1=8.6
≥30	73(85.0)	55(66.0)	p<.025
Satisfaction (159):			
Not satisfied	44(55.0)	21(27.0)	χ^2_1=13.8
Satisfied	36(45.0)	58(73.0)	p<.001
Length of service (years)(n=170):			
<5	12(14.0)	48(57.0)	χ^2_1=34.7
≥6	74(86.0)	36(43.0)	p<.001

Table-8.4 showed that opinions of doctors about amount of pocket money need to spend by the patients for delivery service has a very significant relationship with age (p<.025), service satisfaction (p<.001) and length of service (p<.001) in district hospitals.

Table-8.5: Distribution of patients according to reasons of spending pocket money for delivery service.

[n=782]

Patient's attitudes on reasons of spending pocket money for delivery service			
Reasons of spending pocket money	**OPD n(%)**	**IPD n(%)**	**Total n(%)**
Pay to hospital staff	41(7.0)	11(5.0)	52(7.0)
Buy materials from out side	89(16.0)	37(16.0)	126(16.0)
Pay to staff and buy materials both	423(77.0)	181(79.0)	604(77.0)
Total	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-8.5 showed that maximum 423(77.0%) of patients from OPD and 181(79.0%) of patients from IPD has opined that they need to spend pocket money for delivery service due to giving money to hospital staff and buying materials from outside. Rests of the patient's shows that 89(16.0%) of patients from OPD and 37(16.0%) of patients from IPD had opined that hey have spent money for due to buy materials from out side for delivery purpose. 41(7.0%) of respondents from OPD and 11(5.0%) of patients from IPD had opined that they have spent pocket money for pay to hospital staff. It was also found that 305(100.0%) of nurses and 170(100.0%) of doctors have opined that the patients need to spend pocket money for their delivery service due to buy materials from outside.

Table-8.6: Relationships of patient's attitudes on reasons of spending pocket money by patients for delivery service and their socio-demographic characteristics in district hospitals.

Socio-demographic characteristics	Service area	Reasons about spending money for delivery service (n=782)			χ^2_{df} p<.05
		Pay to hospital Staff	Spend to buy material outside	Spend to Staff Both & outside	
Age groups (years):					
OPD (553)	<30	13(4.0)	58(19.0)	239(77.0)	χ^2_2=13.9
	≥30	28(11.0)	13(13.0)	184(76.0)	**p<.001**
IPD (229)	<30	4(3.0)	24(20.0)	95(77.0)	χ^2_2=3.9
	≥30	7(7.0)	13(12.0)	86(81.0)	**p<.145**
Sex:					
OPD (n=553)	Male	28(7.0)	46(12.0)	304(80.0)	χ^2_2=13.9
	Female	13(7.0)	43(25.0)	119(68.0)	**p<.001**
IPD (n=229)	Male	7(5.0)	18(12.0)	124(83.0)	χ^2_2=5.9
	Female	4(5.0)	19(24.0)	57(71.0)	**p<.050**
Education level:					
OPD (n=553)	Elementary and below	15(5.0)	46(16.0)	221(78.0)	χ^2_4=24.1
	Secondary completed	13(7.0)	41(22.0)	133(71.0)	**p<.001**
	Above Secondary level	13(16.0)	2(2.0)	69(82.0)	
IPD (n=229)	Elementary and below	3(3.0)	17(15.0)	95(83.0)	χ^2_4=12.3
	Secondary completed	4(5.0)	18(24.0)	53(71.0)	**p<.025**
	Above Secondary level	4(10.0)	2(5.0)	33(85.0)	
Occupation:					
OPD (n=553)	Unemployed and HW	25(13.0)	18(9.0)	150(78.0)	χ^2_2=20.1
	Employed and Earning	16(4.0)	71(20.0)	273(76.0)	**p<.001**
IPD (n=229)	Unemployed and HW	7(10.0)	6(9.0)	56(81.0)	χ^2_2=9.0
	Employed and Earning	4(3.0)	31(19.0)	125(78.0)	**p<.011**
Monthly family income:					
OPD (n=553)	<5000/-	28(6.0)	63(13.0)	404(82.0)	χ^2_4=71.5
	≥5,000/-	13(22.0)	26(45.0)	19(33.0)	p<.001
Satisfaction (n=526):					
OPD (n=441)	Satisfied	16(5.0)	58(18.0)	245(77.0)	χ^2_2=28.1
	Not Satisfied	25(21.0)	27(22.0)	70(57.0)	**p<.001**
IPD (n=85)	Satisfied	3(2.0.0)	27(19.0)	112(79.0)	χ^2_2=16.1
	Not Satisfied	8(18.0)	9(21.0)	27(61.0)	**p<.001**

Table-8.6 showed that the opinions of patients about reasons of spending pocket money for delivery service has a very significant relationship with age (p<.001), sex (p<.001), occupation (p<.001), monthly family income (p<.001) and satisfaction to service (p<.001) in the OPD district hospitals. Significant relationships also found in the IPD.

Table-8.7: Distribution of respondents according to attitude and opinion about cost sharing by patients for delivery service in district hospitals.

[n=1257]

Respondents attitude and opinion about cost sharing for delivery service	Category of respondents				
	Service providers		Patients		
	Nurse n(%)	Doctor n(%)	OPD n(%)	IPD N(%)	Total n(%)
Should not pay for delivery service	70(23.0)	35(21.0)	407(74.0)	172 (75.0)	579(74.0)
Should pay delivery charges	235(77.0)	135(79.0)	146(26.0)	57(24.0)	203(26.0)
Total	**305(100.0)**	**170(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-8.7 showed that maximum 146(26.0%) of patients from OPD and 57(24.0%) of patients from IPD and overall, 203(26.0%) of patients had showed their attitudes that they should share the cost of delivery service. It was also found that among the service providers 135(79.0%) of doctors and 235(77.0%) of doctors have opined that the patients should share the costs of delivery service in the district hospitals.

Table-8.8: Relationships of patient's attitude about cost sharing for delivery service with the socio-demographic characteristics

[n=782]

Socio-demographic Characteristics	Service Area	Patients attitude of pay for delivery charge		
		Not willing to pay	willing to pay	(χ^2_{df}, p<.05)
Age group (years):				
OPD (n=553)				
<30		242(78.0)	68(22.0)	χ^2_2=6.0
31 to 50		68(77.0)	20(23.0)	p<.025
> 50		97(63.0)	58(37.0)	
OPD (n=229)				
<30		98(80.0)	25(20.0)	χ^2_2=4.1
31 to 50		35(81.0)	8(19.0)	p<.129
>50		39(62.0)	24(38.0)	
Education level:				
OPD (n=553)	Elementary and below	187(63.0)	95(34.0)	χ^2_1=3.9
	Secondary level and above	220(81.0)	51(19.0)	p<.030
IPD (n=229)	Elementary and below	79(69.0)	36(31.0)	χ^2_1=1.2
	Secondary level and above	93(82.0)	21(18.0)	p<.275

Table-8.8 showed that opinions of patients from the OPD about favorable attitudes for sharing the costs of delivery service has a significant relationships with their age ($p<.025$) and education ($p<.001$) in district hospitals. Opinions of patients from the IPD showed non-significant relationships.

Table-8.9: Distribution of respondents according to attitude and opinion about sharing amount of costs for delivery service should pay by patients.

[n=573]

Attitude and opinion of cost sharing amount by patients for delivery service	Category of respondents				
	Service providers		Patients		
	Nurse n(%)	Doctors n(%)	OPD n(%)	IPD N(%)	Total n(%)
Based on economic status of patients	71(30.0)	56(41.0)	38(26.0)	17(30.0)	57(28.0)
≤25% of actual charge	111(47.0)	74(55.0)	108(74.0)	40(70.0)	146(72.0)
≥26% of actual charge	53(23.0)	5(4.0)	-	-	-
Total	**235(100.0)**	**135(100.0)**	**146(100.0)**	**57(100.0)**	**203(100.0)**

Table-8.9 showed that overall 146(72.0%) of patients of whom 108(74.0%) of patients from OPD and 40(70.0%) of patients from IPD have showed attitude that they should share ≤25% of actual charge of delivery service. Among the service providers, maximum 74(55.0%) of doctors and 111(47.0%) of nurses have opined that the patients should share ≤25% of actual charge of delivery service in district hospitals. Among others, 57(28.0%) of patients, 56(41.0%) of doctors and 71(30.0%) of nurse have showed attitude and had opined that the patients' should share the costs of delivery service based on their economic status of patients.

Table-8.10: Relationships of patient's attitude about cost sharing amount for delivery service with the socio-demographic characteristics.

[n=203]

Socio-Demographic Characteristics	Patients aattitude of cost sharing amount for delivery service		
	Based on economic condition	≤ 25% of actual charge	χ^2_{df} p<.05
Age groups (years):			
<30	36(64.0)	58(39.0)	χ^2_1=10.0
≥30	20(36.0)	89(61.0)	p<.001
Education level:			
Elementary and below	36(63.0)	96(66.0)	χ^2_2=39.8
Secondary level completed	2(3.0)	44(30.0)	p<.001
Higher Secondary and above	19(34.0)	6(4.0)	
Occupation:			
Unemployed and HW	17(30.0)	118(80.0)	χ^2_3=55.8
Agr., Lab., R. puller house hold s	19(34.0)	15(10.0)	p<.001
Business of any	19(34.0)	8(6.0	
Employed in job	1(2.0)	6(4.0)	
Monthly Family Income (taka):			
<5000/-	36(63.0)	93(64.0)	χ^2_2=42.3
5000- to 10,000/-	3(5.0)	49(34.0)	p<.001
>10,000/-	18(32.0)	4(2.0)	
Marital status:			
Married	54(96.0)	04(71.0)	χ^2_1=17.7
Single	2(4.0)	43(29.0)	p<.001
Satisfaction:			
Satisfied	18(33.0)	10(9.0)	χ^2_1=14.1
Not Satisfied	37(67.0)	97(91.0)	p<.001

Table-8.10 showed that the attitudes of patients about amount of costs of delivery service they willing to pay has a very significant relationships with their age (p<.001), education (p<.001), occupation (p<.001), monthly family income (p<.001), marital status (p<.001) and satisfaction (p<.001) in the district hospitals.

Table-8.11: Relationships of nurse's opinion about cost sharing amount by the patients for delivery service with the service characteristics.

[n=235]

Service characteristics	Nurses opinion about cost sharing by patient for delivery service		
	Based on economic condition	≤25% of actual charge	χ^2_{df} p<.05
Length of service (years)(n=235):			
<5	17(24.0)	14(8.0)	χ^2_1=15.2, p<.001
≥5	54(76.0)	150(92.0)	
Satisfaction (n=178):			
Not satisfied	6(10.0)	33(28.0)	χ^2_1=28.6, p<.025
Satisfied	56(90.0)	83(72.0)	

Table-8.11 showed that the opinions of nurses about amount of costs of delivery service that the patients should pay has a very significant relationship with their length of service (p<.001) and satisfaction to services (p<.025) in district hospitals.

9. MODE OF PAYMENT OF SERVICES COSTS BY PATIENTS

Table-9.1: Distribution of respondents according to attitude and opinion about payment system of service cost.

Attitude and opinion about payment system	Category of respondents (n=1257)		
	Nurses n(%	Doctors n(%	Patients n(%
Actual cost direct payment	247(81.0)	153(90.0)	749(96.0)
Yearly family health card	37(12.0)	13(8.0)	33(4.0)
Family health insurance	21(7.0)	4(2.0)	-
Total	**305(100.0)**	**170(100.0)**	**782(100.0)**

Table-9.1 showed that at most 749(96.0%) of patients, 153(90.0%) of doctors and 247(81.0%) of nurses' have opined that the payment system of service costs should be the direct payment of actual costs.. Yearly payment by family health card system have opined respectively by 37(12.0%) of nurses, 13(8.0%) of doctors and 33(4.0%) of patients. Family health insurance payment system has opined by 21(7.0%) of nurses and 4(2.0%) of doctor.

Table-9.2: Distribution of respondents according to attitude and opinion of giving incentives to service providers from patients service cost.

[n=1257]

Attitude and opinion of giving incentives	Category of respondents				
	Service providers		Patients		
	Nurses n(%)	Doctors n(%)	OPD n(%)	IPD n(%)	Total
Not willing to give incentive	15(5.0)	50(29.0)	507(92.0)	207(90.0)	715(91.0)
Willing to give incentive	290(95.0)	120(71.0)	46(8.0)	22(10.0)	67(9.0)
Total	**305(100.0)**	**170(100.0)**	**553(100.0)**	**229(100.0)**	**782(100.0)**

Table-9.2 showed that overall at most 67(9.0%) of patients and 46(8.0%) of patients from OPD and 22(10.0%) of patients from IPD have favorable attitudes for giving incentives to the service providers from the patients costs sharing money. It was also found that 290(95.0%) of nurses and 120(71.0%) of doctors have opined that they should receive incentives from the patients costs sharing money.

CHAPTER 5

1. DISCUSSIONS: Bangladesh is one of the potential candidate countries for introduction of Users fees[51]. In this study, authors have suggested that additional questions should be asked to health care providers, nurses and doctors. Aims, findings, policy implications study in Sub-Saharan Africa, the Authors stated that a nationally representative survey in Central African Republic has determined that 64%-81% of respondents were willing to pay estimated cost of seven quality improvements in public health services where rural respondent were willing to pay considerably more, than urban residents. This is presumably because the gaps are large between "demands" and existing services in rural areas. He also stated that prior for implementing user fees in Tanzaina, opinion polls revealed that 87% of respondent agreed with the statement. People will pay, provided that they are assured of required good service. He also mentioned that even most optimistic studies on "Willingness And Ability To Pay" find some proportion of population will require assistance through exemptions of poor[52]. "How Cost Recovery Can Help Rationalize Health Care System: Lesson From Zimbabwe" stated that cost recovery from user fees thus seen as one of several options for ensuring financial sustainability of health sector and for improving range and quality of service over time. They also argued that cost recovery can help to achieve health objectives, but only in conjunction with other measures to redirect public spending to essential public health and clinical care and to improve efficiency of government services. They have also found that during 1980s fee schedule became badly misaligned with actual medical care costs thus creating distortions in patient referral patterns. Billing and collections were also weak because of deficiencies in personnel and information system and lack of incentives for revenue generation. The study concluded that if key steps were taken to raise collections to billing ratio, recovers fees from privately insured patients and adjusts fees in line with medical cost inflation. Revenues could increase four fold, from 5 percent to 20 percent of government spending for clinical care. At the same time, access to government health services for the poor could be maintained by improving exemptions procedure[53]. Do User Fees Reduce The Demand For Health Card?" Insight and limitations of service statistics in Lesotho" stated that in July 1988, the government of Lesotho raised fees for out-patient consultations in all public health facilities to accommodate three specific objectives viz. (1) Raising cost recovery for health services, (2) Reducing over utilization of government hospitals and encouraging use of health centers and (3) Inducing patients to switch from government to PHAL facilities. It

appears that revenue-generating objective had been fulfilled gradually. Since fee increases, user fee revenue in health sector had been doubled as a share of total recurrent expenditure. Over the same period, overall outpatient utilization declined in two districts examined here. The number of outpatient attendances declined in government hospitals as well as in government health centers. There was no evidence that functioning of the referral system improved in terms of the number of out-patients seen at health centers, although this issue was difficult to examine with the available data. While this study has succeed in documenting some of the rends in out- patient utilization. It is not possible to attribute them conclusively to an increase in fees. When the price of government services rises, the expected decline in attendances in government facilities and an increase in attendances in competitive sources appears to result. It would be tempting to attribute all of this change to the increase in user fees. However, there were many factors affecting the use of out-patient services in rural Lesotho, of which user fees was only one. They had noted that several other factors could not have controlled for producing the same qualitative result individually or in combination, such as declining household incomes, reduced morbidity, a 50 percent increase in bus fares, natural disasters between 1988 and 1989 that inhibited travel and a decline in the quality of health care in government facilities. Further, changes in the accuracy and completeness of reporting by health units may also had been a factor. In theory, if fees were raised and the resulting revenues were used to raise the quality of health services at the same facilities, the net-effect on outpatient utilization could be neutral. However, it is unlikely that this occurred in government facilities during the 1988 fee were increased. Since all fee revenues were past on to the national treasury and none were retained by the facilities. When this was the case, there was limited incentive for health workers to enforce fee collection. Which had an adverse effect on the overall level of cost recovery that could be achieved[54].

Patient Satisfaction in a Tertiary Referral Hospital where Patients admitted in the ward, neonatal surgical intensive care unit (NSICU) and private wards managed by the Pediatric Surgery department in the Advanced Pediatric Center (APC) of Post Graduate Institute of Medical Education and Research (PGIMER) were taken up for study. Attendants of 252 discharged patients were interviewed at the time of discharge. The perceptions and expectations of attendants regarding the quality of medical care, general satisfaction and infrastructure were assessed. Very high levels of satisfaction were expressed on doctors' work. The technical aspects of nursing care were satisfactory to 88% of patients. Moderate levels of satisfaction were recorded regarding the general attitude of nurses and ward servants. Thirty seven percent of

patients felt the treatment facilities could be better. The consumers recorded many suggestions[68]. Verma A, Sarma R.K. in their study, Evaluation of "Exit Proformas" in use at Special Wards of a Public Sector Tertiary Care Hospital Health care scenario is fast changing all over the world. Economic, political, social, environ-mental, and cultural factors influence the people's need for health care and the delivery of health service. Providing quality services at the lowest possible cost, leading to a variety of alternatives to hospital care was evaluated. This change in health care scene presents both opportunity and challenge for health care professionals and the administrators. Consumerism is also affecting health care sector. It can help authorities to advance from considering individual members of their patients as passive clients or recipients of service - who get what they were given for which they must be thankful-to thinking of them as customers with legitimate rights and preference as well as responsibilities. Presently, with the phase of globalization in India, upcoming corporate hospitals in tertiary care have further compounded, still competition in the delivery of health care in terms of patients' perception and satisfaction vis-a-vis value for money. Further, the latest concept in customer delight has added a new dimension to health care industry. Also the Supreme Court verdict of bringing Government hospitals under the purview of consumer protection Act has further necessitated considering the patient as a consumer. The approach to choose by the patients was special (paying) wards type A and B with or with out having air-conditioner and in Gen. ward, patients' views about various aspects of hospital services in special wards as elicited by the pro-forma were analyzed. Overall, a very high level of satisfaction was observed with the various aspects of hospital services. All 100% patients were satisfied with the services of Consultants, Nurses and Physiotherapists and some dissatisfaction was observed with the Quality of Food (19.8%), supplies in private ward rooms (17%), Radiology Services (12%), Patient's were generally satisfied with "Comfort" and "Cleanliness of the room", "Nursing Orderlies", "Sweepers", "Laboratory Services" and "Radiology Services". Generally, it was observed that patients' who were satisfied with the hospital services stayed longer than the dissatisfied patients[69].

Alex George, Ila Shah, Sunil Nandraj in their study of Household Health Expenditure in Madhya Prodesh. An estimate of household expenditures on health as a proportion of total consumption expenditure and household level expenditures on health care and its differentials by variables such as class, social geography, etc was conducted in two districts of Madhya Pradesh i.e. in Sagar and Morena among 770 households covering a population of 5202, (62.08% from rural areas and 37.92% from urban areas) in India. The acute prevalence rate was 162.16/ 1000, and the chronic prevalence rate was 128.33 / 1000. The annual per capita health expenditure was Rs.299.16, which formed 8.44% of overall consumption expenditure. There was a steady increase in the annual per capita

health expenditure between the classes. It was Rs.28.16 in the lowest class, which went as high as Rs. 563.94 in the highest class. The difference between the lowest and the highest class was as high as 339.79%. The per episode cost for health care was much higher than the per capita figures. It was as high as Rs.134.23. The corresponding figures for the lowest class were Rs.71.91, and for the highest class was Rs.243.60. The intra-rural and intra-urban difference in per capita and per episode expenditures was wide. Within the rural areas, the annual per capita expenditure was the highest (Rs.314.16) in the PHC villages, but monthly per episode expenditure was the lowest, as against remote villages, where it was the opposite (viz. Rs. 219.96 and Rs. 145.63). Within urban areas, the annual per capita and monthly per episode costs were higher in district headquarters (Rs.322.448, Rs. 134.7) than in small towns (Rs.280.92 and Rs. 116.86). The utilization of the private sector for health care was found to be as high as 69.05%. Only 15.52% of the episodes sought public health care, out of which 6.14% utilized government /civil hospitals, and 6.88% utilized the PHC / government dispensaries, while Sub Centers were used only by 1.73%[70].

Bharti Ramkishan conducted a study of the State of Medicare Facilities in Agra. The study focuses on the infrastructural facilities available at nursing homes, qualifications and experiences of service providers. A survey of a few nursing homes in Agra city in India was conducted. About 30% of the professionals have 15 to 20 years practice, followed by another 25% of them have 10-15 years, 25% of them have 5-15 years and 20% of them have only 0-5 years of experience. The consultancy charges range between Rs. 25/- to Rs. 50/- per patient and the bed charges range from Rs. 50/- to 150/- per bed. The private room charges were 100/- to Rs. 200/- per day excluding the additional nursing charges. The average number of patients admitted to these nursing homes were 171 in private rooms as compared to 240 patients in general wards. The average income of nursing homes in Agra city around is Rs. 53,000/- per month[71].

Pandey, Baidya Nath Kumar conducted a study of the State of Medicare Facilities in Agra City **N**ature of private practice and the cost effectiveness of their services provided was evaluated in this study, **in** selected private clinics in Agra, India. **M**ajority of these practitioners belong to the 30-40 year age group and are engaged mainly in private practice. A majority of them have five years of experience and prefer to practice privately. Doctors are found to charge additionally for these facilities and the

consultation Rs. 30- 35 for each alternate visit and their daily earnings are between RS-300-500. Most of the patients who use these services are from the upper middle class. A majority of the practitioners opined that services have become commercial as a result of increased competition. This study shows that there is a trend towards specializations rather than general care. Here, the emphasis is solely on curative services with minimal preventive inputs. The earning of these doctors ranges from Rs. 10,000 to 15,000 a month. This trend requires regulation of medical practice in both government and private institutions. Some process needs to be initiated at the state level, which at the moment is lacking[72].

In the above studies in different countries across the world have revealed health service customer patient want assurance to get good service, assistance and exemption of poor patients, ensuring improving quality of services, accuracy and completeness in reporting, high level of satisfaction of doctors work and nursing care and general attitudes of nurses and a supporting staffs. Moreover, economic, political, social, environ-mental, and cultural factors influence the people's need for health care and delivery of health service. Consumerism and customer delight new concept of service providers and administrators. Very high level of satisfaction demand by service customers to various aspects of hospital services like consultants, nurses and physiotherapists, quality of food supplies, radiology services, cleanliness of room, nursing orderlies, sweepers, laboratory services. In some nursing home in Agra, India study revealed consultancy charges range between Rs. 25/- to Rs. 50/- per patient and the bed charges range from Rs. 50/- to 150/- per bed. The private room charges lie between Rs. 100/- to Rs. 200/- per day excluding the additional nursing charges. The average income of nursing homes in Agra city around is Rs. 53,000/- per month. Majority of practitioners in Agra nursing homes belonged to 30-40 year age group and are engaged mainly in private practice. Majority of them have five years of experience. Doctors were found to charge additionally for facilities and consultation Rs. 30- 35 for each alternate visit. Though these are private hospitals and similar study in private sector hospitals in Bangladesh are not available

1.1. Socio-demographic and Service Characteristics of study population: In the present study with the objective to find out the opinions of doctors and nurse working in the secondary level public sector district hospitals in the country. Attitudes of patients attending in the outdoor and admitted in the inpatient wards were also studied. In this

study total 1257(100.0%) sample were studied of whom, 782 (62.0%) patients, 305 (24.0%) nurses and 170(14.0%) doctors (Figure-1) were interviewed. Interview administered and self-administered research instrument respectively for patients and service provider nurses and doctors were used. Patient's mean age and SD was 34.8(±14.6) years and near about half of the patients 232(42.0%) were from OPD and more than one third 92(40.0%) of patients from IPD were belonged respectively to the age group 21 to 30 years and second highest were below one fifth of the patients 88(16.0%) from OPD and just near about one fifth of the patients 43(19.0%) were from IPD whom were respectively belonged to the age group 31 to 40 years. The mean of age of nurses and doctors were respectively 34.0(±5.9) years and 36.5(±7.9). Near about one half of the doctors 73(43%) and about two thirds of the nurses 196(64.0%) were belonged to the age group 31 to 40 years (Table-1.1). It was also found that more than two thirds of the patients 378(68.0%) from the OPD and just near about two thirds of the patients 149(65.0%) from the IPD were male sex and overall above two thirds patients 527(71.0%) were male sex (Table-1.2). It was found that just above one third of the patients (18734.0%) from the OPD and another one third of the patients 75(33.0%) from the IPD were educated in secondary level (**Table-1.3**). There were above one fourth of the patients 152(27.0%) from the OPD and another exactly one fifth of the patients 57(25.0%) were from the IPD of district hospitals were respectively found unemployed in job and housewives. There were overall just more than one fifth of the patients 202(26.0%) were unemployed (**Table-1.4**). It was found in the study that 282(93.0%) of nurses, 96(57.0%) of doctors and 575(74.0%) of patients were married. Among the patients, maximum 405(73.0%) from OPD and 171(75.0%) from IPD were married and respectively 148(27%.0) and 58(25.0%) of patients from OPD and IPD were unmarried (Table-1.5).

It was found in the study that mean MFI of patients have found taka 5451.7(±3172.3) and majority of the patients 329(60.0%) from the OPD and near two thirds of the patients 145(63.0%) from the IPD have MFI taka ≤5000/-. It was also found here that below one third of the patients 166(30.0%) from the OPD and more than one fourth of the patients 65(28.0%) patients from the IPD have MFI taka 5001/- to 10,000/- (**Table-1.7**). Overall near about one third of patients 477(61.0%) of patients have MFI taka ≤5000/-(**Figure-2**). It was found that overall one third of the service providers 157(33.0%) providers have length of service ≤5 years and just below one fifth of the service providers 116(24.0%)

and just above one fifth of the service providers 100(21.0%) have length of service respectively 16-20 years and 6-10 years. It was found that about one third of the nurses 89(30.0%) and just above one fourth of the nurses 80(26.0%) have length of service respectively 11-15 years and 6-10 years. Majority of doctors 93(55.0%) have length of service ≤5 years and below one fifth of the doctors 27(16.0%) have length of service 16-20 years. Mean (±SD) length of service of doctors and nurses respectively were 8.5(±8.1) years and 12.1(±6.7) (Table-1.8). Near about a half of the patients 319(41.0%) from the OPD, below one fifth of the patients 142(18.0%) from the IPD and majority of the nurses 94(59.0%) and doctors 94(55.0%) have found partially satisfied with currently provided services from district hospitals **(Table-1.9).**

The findings of the present study about professional experience of doctors are similar with the findings of the study conducted in some nursing homes in Agra in India. But the level of satisfactions magnificently visualized large gap between two studies. Patients were highly satisfied with the services including doctor's work, nursing service, investigation report service found in the study conducted in India. Where as, in the present study near about one half of the patients 319(41.0%) from the OPD, below the one fifth of the patients 142(18.0%) from IPD and overall above one half of the patients 461(59.0%), majority of the nurses 180(59.0%) and majority of doctors 94(55.0%) had partially satisfied with currently provided services from district hospitals **(Table-1.9).** The reasons of high level dissatisfaction in the present study of both service providers and patients may be due to unavailability of services, inappropriate management of existing resources and service, questionable quality of provided services, approaches of services all of which demands for further investigation along with introduction of users fee system in the district hospitals. Moreover, no such study was found conducted upon the socio-demographic characteristic of both the patients and service providers in the district hospitals else where. But considering the all of the context of the present study it could be believe that the finding of the study is representing the characteristics of the patients of the district hospitals.

1.2. Patient registration Fees: In the present study, most of the patients 420(85.0%) and 175(89.0%) respectively were from OPD and IPD and overall majority 595(86.0%) of patients and the three fourth quarter 228(75.0%) of nurses and most of doctors 138(83.0%) were opined that currently taka ≥5/- was the patients' registration fees in the

OPD (Table-3.1). It was also found here in the study that almost all of patients 778(99.0%) from OPD and IPD and nurses 298(98.0%) and doctors 138(8.01%) opined taka 10/- or less registration fees by patients in IPD of district hospitals (Table-3.2). It also reveals about two thirds 351(63.0%) of OPD patients and majority of IPD patients 136(59.0%) and overall about two thirds of patients 487(62.0%) showed attitude of current registration fees are adequate. But more than three fourth of nurses 238(78.0%) and almost all of doctors 159(93.0%) opined registration fees inadequate (Table-3.3). Overall majority of respondents 691(55%) have shown their attitude and had opined that the current registration fees were inadequate (Figure-3). Near about two thirds of the patients 130(65.0%) from OPD and majority of the patients 56(60.0%) the IPD and another majority nurses 134(56.0%) had showed their attitude that the patients registration fees should taka ≥21/- and majority of the doctors 87(55.0%) were opined that patients registration fees should be taka ≤20/- in district hospitals **(Table-3.4)**. Overall, majority of respondents 666(53.0%) showed their attitude that the patients' registration fees should be taka ≤20/- in district hospitals **(Figure-4).** At present OPD patients, registration fees were taka 4.40 and in IPD were taka 7.30 (MOHFW No.-503 dated 25/6/1990). In BIRDEM Hospital, Dhaka, every patient has to pay taka 50/- for registration fee at OPD. This registration fee provides all general medical services only. Any specialized consultancy patient required paying additional taka 50/-. No free medicine supplied from hospital. Selected tests were done free of cost but other tests were done with charge of not for profit. Every patient required paying taka 100/- admission fees in the IPD. Attending every patient in Apollo hospital Dhaka, require to registration by paying taka 200/-. This will be providing only a health card with a permanent ID number only. Once a patient is registered in the Apollo Hospital he/she needs not to register any more through out subsequent visits in life time. This registration fee is taken irrespective of OPD and IPD. Registration fees were taka 5/- at OPD in Dhaka Medical College Hospital, taka 20/- and taka 100/- respectively in OPD and IPD of BSMMU Hospital. The above poor and hazy picture of patient registration fees of the district hospitals and other different level of government hospitals in contrast to either private, autonomous, or trustee hospitals in Bangladesh draw attention to concern authority for rethink and readjust the patient registration fees in the government hospitals at large and district hospitals in particular. Moreover, present study finds inadequate patient registration fees by most of the service providers, which also demands for

readjustment of current patient registration fees forecasting at least next 25 years projection of currency value change.

1.3. OPD Prescription Fess: It was found in the present study that more than one third of the patients 314(40.0%), highest majority of doctors 120(71.0%) and more than one half of the nurses 169(55.0%) had opined that the patients cant get better services by giving prescription fees at the OPD in the district hospitals (**Table-4.1**). Majority of the patients 125(60.0%) from the OPD and another majority of the patients 63(60.0%) from the IPD, a half of the nurses 85(50.0%) and the highest majority of doctors 98(81.0%) had showed their attitude and have opined that taka ≤50/- should be prescription fees for first visit at OPD. Overall, more than a half of the patients 188(60.0%) have found that they were willing to pay taka ≤50/- and more than one fourth of the patients 88(28.0%) and only just more than one tenth of the patients 38(12.0%) patients had showed the favorable attitudes of giving prescription fees respectively taka 51/- to 100/- and taka >100/- in the district hospitals (**Table-4.2**). Overall near about two third majority of respondents 779(62.0%) had showed their attitude and were opined that the prescription fees for first visit should be taka ≤50/- at OPD and mean amount of prescription fees were opined for taka 66.9 with SD=443.0 (Figure-5).

It was found in the present study that the patient's attitudes of giving prescription fees for first visit at the OPD of district hospitals were very significantly correlated with monthly family income (n=314, r=.137, p<.025) and with age were not significant (n=314, r= -.029, p>.05). The mean amount of giving prescription fees by the patients for the first visit were opined for taka 69.9 and (±SD)= taka 52.6. It was showed in the study that the opinions of the nurses about paying prescription fees for first visit should given by patients at OPD in district hospitals were not related with their length of service (n=169, r=.084, p>.05) and age (n=169, r=.061, p>.05). The mean (±SD) amount of prescription fees for first visit should be 73.0 (±31.0). It was also found that opinions of doctors about giving prescription fees by patients for first visit were very significantly related with their length of service (n=120, r=.417, p<.001) and with age (n=120, r=.435, p<.001). According to opinions of doctors, the mean (±SD) amount of prescription fees for first visit should be 50.5 (±28.0). One way ANOVA showed that comparison of the means of prescription fees for first visit that should be given by the patients at the OPD of district hospitals were significantly difference between doctors and nurses (p<.001), doctors and

OPD patients (p<.001) and doctors and IPD patients (p<.001). However, opinions of nurses, OPD patients and IPD patients showed no difference.

In the present study it was also found that the attitudes of the patients for giving prescription fees for the second visit at OPD of district hospitals have a significant positive correlations with their monthly family income (n=312, r=.131, p<.025) but with age has no relation (n=312, r=-.078, p>.05). The mean (±SD) amount of taka 38.1(±25.5) they willing to pay for second visit, median was taka 30/- and mode was taka 20/- for second visit. It was showed that opinions of nurses about amount of fees should be given by the patients for second visit has no significant relationship with their length of service (n=169, r=.042, p>.05) and with age (n=169, r=.017, p>.05) in district hospitals. Though there is was a significant correlations between age and length of service of nurses (n=169,r=.823, p<.001). The mea (±SD) amount of taka 38.8(±15.6) should pay by patients for second visit, median was taka 30/- and mode was taka 50/- for the second visit has opined by nurses. It was found that opinions of doctors about amount of fees should be given by the patients for second visit has a significant relationship with their length of service (n=118, r=.292, p<.001) and with age (n=118, r=.333, p<.001). There was also significant correlations between age and length of service of nurses (n=118, r=.966, p<.001). The mea (±SD) amount of taka 26.5(±18.9) should pay by patients for second visit, median was taka 20/- and mode was taka 20/- for second visit has opined by the doctors. One way ANOVA showed that the comparison of means of prescription fees for second visit that should be given by the patients at the OPD of district hospitals were significantly difference between doctors and nurses (p<.001), doctors and OPD patients (p<.001) and doctors and IPD patients (p<.001). However, these opinions of nurses, OPD patients and IPD patients showed no difference. Though at present there is no provision of giving prescription fees in the district hospitals but the present study have shown that the patients and service providers both have the favorable positive attitudes and they have opined that for getting better service patients should pay prescription fees.

In the BIRDEM hospital in Dhaka, and Bangladesh Medical College and other private medical college hospitals has already introduced prescription fees in the OPD ranging from taka 50/- to 100/- and in the Apollo hospital taka 600/- to 800/- and in BSMMU hospital taka 20/- is taking as registration fees including prescription fees. In addition to this, all the private hospitals clinics and Non-governmental Organizations (NGO)

hospitals has also introduced prescription fees in the OPD in different range of amount of fees. People are purchasing this service giving prescription fees. In the public sector hospitals at all level the government has skilled and highly technical medical consultants at large and in district hospitals in particular. Bharti Ramkishan conducted a study of State of Medicare Facilities in Agra. The study focuses on the infrastructural facilities available at nursing homes, qualifications and experiences of service providers. A survey of a few nursing homes in Agra city in India was conducted. The consultancy charges range were Rs. 25/- to Rs. 50/- per patient. The average income of nursing homes in Agra city around is Rs. 53,000/- per month[71]. In the present study there were around one third of the patients have showed significant positive attitude ($p<.001$) of giving prescription fees for better service in the OPD of the hospitals. Other than government hospital, every hospital at home and abroad has introduced OPD consultancy fees. Therefore, the circumstances demands for introduction of prescription fees in the district hospitals of Bangladesh.

1.4. Medical Investigation Tests Fees: In the present study almost all of the patients 702(90.0%), more than three quarters of nurses 239(78.0%) and almost all of the doctors 167(98.0%) had opined that currently patients are paying for some medical investigation tests in district hospitals (Table-5.1). It was found in the study that almost all the patients 528(93.0%) from the OPD and another similar number of patients 214(93.0%) from the IPD have showed the attitude of sharing costs of medical investigation tests. Majority of the nurses 180(59.0%) and highest majority of the doctors 127(75.0%) had opined that patients should share cost for medical investigation tests (Table-5.2). It was also found in the study that more than one third of the doctors 40(41.0%), near about a half of the OPD patients 245(47.9%) and similarly another half of the IPD patients 99(46.3%) have showed their attitudes that the amount of medical investigation costs should be shared by the patients based on their economic status. But near about a half of the nurses 53(43.4%) had opined that the patients should share 26% to 50% of actual medical investigation costs in on hand and on the other overall near about a half of the patients 344(47.5%) had showed their attitudes that medical investigation costs should be shared by them based on the economic status (Table-5.3). These attitudes of patients about sharing costs of medical investigation tests and the opinions of doctors and nurses about sharing costs of medical investigation tests by the patients have found very significantly related respectively with their socio-demographic and service characteristics like; age

(p<.001) and education (p<.001) and non-significant relationship with sex of patients (p<.05). (Table-5.4). Therefore the medical investigation tests fees could be reform and reorganize for efficient service and an effective sustainable cost sharing system in the district hospitals.

1.5. Attitudes And Opinions About Medicine Fees: In the present study, it was found that near about a half of the patients 264(48.0%) from the OPD and majority of the patients 122(53.0%) from the IPD and respectively a highest majority of the nurses 233(80.0%) and also another highest majority of the doctors 132(78.0%) have showed their attitudes and were opined that the patients can purchase medicine by cheap price if supplied from the hospitals (Table-6.1). It was also found in this study that a highest majority of the patients 205(78.0%) from the OPD and almost similar number of patients 93(76.0%) from the IPD and respectively almost all the doctors 127(96.0%) and near about all the nurses 218(94.0%) had showed their attitude and were opined that the patients should pay part of actual costs of medicine supplied from the hospitals. But about one fifth of the patients 59(22.0%) from the OPD and about one fourth of the patients 29(24.0%) from the IPD had showed their attitudes and were opined that the patient should pay full costs of medicines supplied from hospitals (Table-6.2). But about three quarter of the patients from the OPD 152(74.0%) and almost similar number of patients from IPD 67(72.0%) and respectively a highest majority of doctors 109(86.0%) and about a half of the nurses 104(47.0%) have showed their attitudes and were opined that the patients should share costs of supplied medicines based on the patient's economic conditions (Table-6.3). The attitudes of patients and the opinions of the service providing doctors and nurses about patient's costs sharing regarding medicines supplied from the hospitals have a very significant relationships with their respective socio-demographic and service characteristics like age (p<.001), education (p<.001) and occupations (p<.001) in district hospitals (Table-6.4).

Medicines are the very essential and very costly item in the hospital services. It is very hard to supply all medicines to all patients free of charge in the hospitals. May be that is the main reasons of popularly criticizing the hospitals about medicine service. BSMMU hospitals, BIRDEM hospitals, Apollo hospitals, all private medical college hospitals including private clinics are giving only prescription in lieu of prescription fees but no medicine. Contrararily, public sector hospitals at all level providing some medicine with prescription without charging any prescription fees. As partial length few medicines are

supplied, patients could not become happy. It could be wise providing required medicine through not for profit as majority patients willing to pay.

1.6 Attitudes And Opinions About Cost sharing for Surgical Operations: In the present study it was found that around two third majorities of the patients respectively from the OPD 354(64.0%) and similarly another majority of patients 152(66.0%) from the IPD and just more than one half of the service providing doctors 90(53.0%) had opined that the patients need to spend pocket money in most of cases and a highest majority of the nurses 252(83.0%) had opined that the patients need to spend some pocket money for their surgical operations in the district hospitals. It was found here that the patients need to spend some pocket money for surgical operations had opined by near about a half of the doctors 80(47.0%), near about one fifth of patients 87(16.0%) from the OPD and about another one fifth of patients 30(13.0%) from the IPD and overall about two third majority of patients 506(65.0%) had opined that the they need to spend pocket money mostly for their surgical operations in the district hospitals (Table-7.1). These attitudes of patients and the opinions of the service providing doctors and nurses regarding the costs sharing and the amount of costs sharing were found significantly related respectively with their socioeconomic characteristics like age ($p<.001$), sex ($p<.05$) and education ($p<.001$) (Table-7.2), service satisfaction ($p<.001$) (Table-7.3) and length of service ($p<.025$) in the district hospitals (Table-7.4) and (Table-7.5). In this study it was found that a highest majorities of patients 622(87.0%) had opined that the main reasons of spending pocket money by the patients for surgical operations were for giving money to the hospital staff and for buying operation materials from outside both. It was also found that just more than one tenth of the patients 19(13.0%) had opined that buying operation materials from outside the hospital was the main reasons for spending pocket money for surgical operations. But a difference was found from the service providers where at most about all the doctors 154(91.0%) and a highest majority of nurses 251(82.0%) had opined that only buying operation materials from outside the hospital were the main reason for spending pocket money by the patients for their surgical operations in district hospitals (Table-7.6). These opinions about reasons of spending pocket money by the patients for their surgical operations have found very significantly related with the socio-demographic characteristics of patients like monthly family income ($p<.001$), occupations ($p<.001$) and service satisfaction ($p<.001$). Age of the patients shows just significant relationship ($p<.05$) (Table-7.7 & Table-7.8) with the

length of service (p<.025) and service satisfaction (p<.001) of the doctors and nurses in district hospitals. It was found in this study that about one third of patients 241(31.0%) has positive attitude and more than two third majorities of doctors 116(68.0%) and nurses 207(68.0%) has positive opinions that the patients should share the costs of surgical operations in the district hospitals (Table-7.9). This cost sharing attitudes of patients and opinions of service providing doctors and nurses that patients should share costs for their surgical operations were found very significantly related respectively with the socio-demographic characteristics like age (p<.001), education (p<.001), occupation (p<.001), monthly family income (p<.001), marital status (p<.001) and their satisfaction to services (p<.001) in district hospitals (Table-7.10). The respondents also showed their attitudes and gave their opinions about amount of operation costs that the patients should share. It was found that near about two third majorities of the patients 153(63.0%) have shown the favorable attitude for sharing ≤25% of actual cost of surgical operations and just more than one fourth of the patients 64(27.0%) showed their favorable attitudes of sharing costs based on their economic status that was also opined by almost all the doctors 108(93.0%) and by just more one quarter of nurses 54(26.0%). Maximum 90(44.0%) of nurses has opined that the patients should share ≤25% of actual costs of their surgical operations in the district hospitals. (Table-7.11). These attitudes of patients and the opinions of service providing doctors and nurses about amount of cost sharing by the patients for surgical operations have found a very significant relationship with their monthly family income (p<.001), marital status (p<.001) and service satisfactions (p<.001) (Table-7.12).

In the results of the present study it was significantly found that the patients need to spend pocket money pocket money in most of the cases for their surgical operations whatsoever the reasons. Though the reasons were for spending pocket money by the patients for surgical operations between the patients and the service providing doctors and nurses but it was acknowledged by both the groups. These spending pocket money do not have any rate or limit and do not getting any legal authority. Therefore, a well designed system should be addressed for efficient cost sharing system for the surgical operations in the district hospitals.

1.7. Attitudes and Opinions about Cost Sharing For Delivery Service: It was found in the present study that more than three quarter majorities of the patients 425(77.0%)

from the OPD and similar number of patients 179(78.0%) from the IPD and overall similar number of patients 604(77.0%) have opined that they need to spend pocket money mostly for delivery service in the hospitals. Just more than a half of the doctors 86(51.0%) and a highest majorities of the nurses 243(80.0%) had opined that currently patients need to spend some pocket money for delivery service in district hospitals (Table-8.1). These opinions of the respondents about currently spending of pocket money for delivery service have found a very significant relationships with the age ($p<.001$), education ($p<.025$), monthly family income ($p<.001$), occupations ($p<.001$) and satisfaction to services ($p<.001$) (Table-8.2) and length of service ($p<.001$) in district hospitals (Table-8.3 & Table-8.4). It was also found that a highest majority of patients 423(77.0%) from the OPD and almost similar another highest majority of patients 181(79.0%) from the IPD has opined that they need to spend pocket money for the delivery service due to the reason of giving money to the hospital staff and for buying materials from outside both. Rests of the patients 89(16.0%) from the OPD and similar number of patients 37(16.0%) from the IPD were opined that they have to spent money for buying materials from out side the hospitals for delivery purpose. Only 41(7.0%) of respondents from the OPD and 11(5.0%) of patients from the IPD had opined that they have spent pocket money for paying to the hospital staff. It was also found that all the nurses 305(100.0%) and all the doctors 170(100.0%) have opined that the patients need to spend pocket money for their delivery service due to buying materials from outside (Table-8.5). In this study it was found that the given opinions of the patients about reasons of spending pocket money for delivery service has a very significant relationship with age ($p<.001$), sex ($p<.001$), occupations ($p<.001$), monthly family income ($p<.001$) and satisfactions to service ($p<.001$) in the OPD of district hospitals. Significant relationships regarding the same issue were also found in the case of IPD (Table-8.6)

Results of the study showed that at most just more than one quarter of patients 146(26.0%) from the OPD and just below another one quarter of patients 57(24.0%) from the IPD and overall almost similar number of patients 203(26.0%) have shown their attitudes that they should share the cost of delivery service. It was also found that among the service providers, a highest majority of doctors 135(79.0%) and about similar number of nurses 235(77.0%) had opined that the patients should share the costs of delivery service in the district hospitals (Table-8.7). These attitudes of patients and opinions of service providing doctors and nurses about cost sharing by the patients for

their delivery service have found a significant relationships with their age ($p<.025$) and education ($p<.001$) but the attitudes of patients from the IPD showed non-significant relationships.

How much the amount of costs of delivery service should share by the patients were studied and found that overall near about the three quarter of patients 146(72.0%) of whom about similar number of patients 108(74.0%) from the OPD and above two third majority of patients 40(70.0%) from the IPD have showed the attitude that they should share ≤25% of actual charge of delivery service. Among the service providers, similarly majority of doctors 74(55.0%) and just below the half of the nurses 111(47.0%) have opined that the patients should share ≤25% of actual charge of delivery service in district hospitals. Rest of the more than one quarter of patients 57(28.0%), near the half of the doctors 56(41.0%) and just below one third of nurses 71(30.0%) respectively have showed attitude and had opined that the patients' should share the costs of delivery service based on their economic status (Table-8.9). These attitudes of patients and opinions of service providing doctors regarding the costs sharing amount for delivery service have shown a very significant relationships respectively with their age ($p<.001$), education ($p<.001$), occupation ($p<.001$), monthly family income ($p<.001$), marital status ($p<.001$) and satisfaction ($p<.001$) and length of service ($p<.001$) and satisfaction to services ($p<.025$) (Table-8.10 & Table-8.11).

It could be worthy if the patients spending pocket money for delivery service in the hospitals is through official systems. Otherwise this spending money would not produce any results for getting hospital services. Moreover unofficial money giving to the hospital staff do not give good results in sustainable improvement of service. Addressing the official system of cost sharing for delivery service would bring good results and sustainable improvement in the service. In district hospitals Kunhikannan K T and K P.Aravindan, studied the changes in the Health Status of Kerala in 1996. The study accounted for inflation in prices over the 10-year period, at a compound rate of 10% per year. The average expenses for a delivery in a government hospital were Rs.2025. It was Rs.2870 in a private hospital. In private hospitals, the average expense for a normal delivery was Rs.2456, while for a caesarean delivery it was Rs.4944. In the case of a government hospital, it was Rs1670 and Rs.2864 respectively. Surprisingly, c-sections form a greater proportion of total deliveries in government hospitals (30%) than in private hospitals (17%). The medical expenditure per morbid person per episode

increased from Rs.16.5 to R.165.2 during the decade, an increase of nearly 900%. The per capita medical expenditure rose from Rs.88.92 to R.548.8 during the period, an increase of about 520%[76].

Mode Of Payment Of Services Costs By Patients: It was found in the present study that all most all the patients 749(96.0%), near about all the doctors 153(90.0%) and a highest majority of nurses 247(81.0%) have opined that the service costs payment system should be the direct payment of actual costs.. Yearly payment by family health card system have opined respectively by only 37(12.0%) of nurses, 13(8.0%) of doctors and 33(4.0%) of patients and that the family health insurance payment system has opined by only 21(7.0%) of nurses and 4(2.0%) of doctor (Table-9.1). It was found in this study that an overall at most only below one tenth of patients 67(9.0%) of patients of whom 46(8.0%) of patients from OPD and 22(10.0%) of patients from IPD have shown a favorable attitudes for giving incentives to the service providers from the patients costs sharing money. It was also found that almost all of the nurses 290(95.0%) and more than two third majority of doctors 120(71.0%) have opined that they should receive incentives from the patient's costs sharing money (Table-9.2).

Basic concept social health insurance is a mechanism for financing and managing health care through pooling of health risks of its members on the one hand, and the financial contributions of enterprises, households, and the government, on the other. SHI is generally perceived as a financial protection mechanism for health care, through health risk sharing and fund pooling for a larger section of the population[95]. It usually forms part of a broader **social security** framework[96]**.** Responsibility for contributions by members (employees) with proper organizational arrangement to collect regular income-related contributions or flat-rate contributions from individuals/groups, with added contribution from employers and the government (earmarked deduction as insurance contribution from regular pay-roll or pre-set collection amount from individuals or groups)[97].

This BISMARK model is applied in most EU countries like Germany, Belgium, Austria and Netherlands (based on a system of entitlement to health insurance on employment status and payment of contributions[98]. Introduction of Employees' State Insurance Scheme (ESIS) in **1948,** as part of the mandatory social security benefit to workers in the

formal employed sectors Some state governments have established a multitude of community-based health insurance schemes with an estimated coverage of 30-50 million people[99]. **Indonesia** introduced the Civil Servant Welfare Scheme where health care expenses are reimbursed to civil servants, since its independence. The beneficiaries include about 14 million civil servants, their spouses and two children less than 21 years old. In 1992, Indonesia introduced the social health insurance scheme for **formal employees**, called **Jamsostek.** The Ministry of Health, through the Health Act of 1992, introduced a nation-wide, "Managed Health Care Scheme" called Jaminan Pemeliharaan Kesehatan Masyuarakat (JPKM), using the model of the United States Voluntary Health Maintenance Organizations (HMO)[100].

Almost similar situation about Social Insurance to In Myanmar[101], Thailand And Fee-For-Service (FFS) Reimbursement Model[102] Since 1994, the government has subsidized with Baht 500/- for every Baht 500/- family card. Thailand introduced the Universal Coverage (UC) Scheme, notably known as the "30 Baht Scheme" in October 2000, with the idea of replacing the "Social Welfare Scheme" and the "Voluntary Health Card Scheme". The program was operational nation-wide by mid-2001. Health Development and Users fees In Some Asian Countries[103- 104], Sri Lanka and DPR Korea: Does not have any formal social health insurance schemes, despite a large proportion of people working in the formal employed sectors. **Maldives**: Except some form of subsidy for medical expenses for civil servants, does not have any social welfare packages. **In Nepal and Bangladesh:** Social health insurance schemes are almost non-existent or, if present, cover a few people in limited geographical areas. **China:** According to the Chinese NHA, in the year 2000, Out of Pocket (OOP) expenditure was around 60%, of which only 6% was on private insurance, rest being direct payment for users' fees. **Vietnam spends** ≤1% of its GDP on government health services. The government initiated SHI schemes in 1992 and rapidly expanded the coverage to the present level of around 14 million (11 per cent of the total population). **Singapore's** One possible approach of using savings for medical expenses is to develop an additional component to the national SHI schemes, as pioneered by famous "3M" health financing schemes, i.e. Medisave, Medishield and Medifund **of Singapore**[23]. The Medisave scheme is an individual saving scheme for which the savings accumulated could be used for medical care expenses. Singapore introduces Medishield, a back-up health insurance program based on cross-sectional risk pooling, designed to finance the extreme catastrophic tail of risk

distribution. In addition, the Government of Singapore also introduced Medifund, which is an endowment fund for those whose health care costs are beyond their means, even with Medisave and Medishield.

Out-of-pocket expenditures in poor communities should increasingly be channelized into 'community financing' schemes through an incentive scheme, in which each $1 that the community raises for pre-paid health coverage would be augmented, at some rate of co-financing, by the national government backed by donor assistanc[105-106]. A few studies have shown that a smaller numbers of such schemes cover a large.

In the above studies across the world, there are several systems of cost sharing for health service such as Social Health Insurance (SHI), Community Health Card and Family Health Card,. Cooperative Drug, Yearly Health Plan and direct payment of actual charge. Almost every payment system characteristically bears good and bad. In the present study Almost all of patients and most of the service provider doctors and nurse significantly ($p<.001$) showed attitudes and opined to pay in the form of actual cost direct payment. Very high percentage of patients was choosing this system may be due to almost ignorance about other payment system or their intuition. In the current study, almost all of nurses (95%) and near about three fourth of doctors (71%), only a few of patients (9%), and over all 38% of respondents were significantly $p<.001$) showed attitudes and opined to give incentives to service providers in district hospitals (Table-11.5). It could assume from the present study service provider doctors and nurses has no objection receiving money from service charge but patients almost have no attitudes to pay for incentive to service providers.

2. CONCLUSIONS: The present study was conducted upon the patients and service providing doctors and nurses to find out respectively their attitudes and opinions about cost sharing for different services by patients in 10 district hospitals from five divisions of the country. Results of this study were discussed and following conclusions were made.

1. Reasons of high percentage of patients and service providers' dissatisfaction to existing services revealed in the present study should be explored along with the introduction of users' fees in the district hospitals.

2. Currently, patient registration fees in the district hospitals are grossly unmatched with socioeconomic context and in a state of poor and hazy to every class people in the society ignoring the economically capable affluents.

3. At present no consultancy fees for prescription are taking in the district hospitals. But many hospitals other than public sector have introduced OPD prescription fees at the earliest of inauguration. Significantly ($p<.001$) about one third of patients as well as service providers revealed positive attitudes and opinions about giving prescription fees at OPD in the district hospitals.

4. Near about all of patients (93.0%) showed attitude of willingness to share costs and more than one half of nurses (59%) and three quarters of doctors (75%) were significantly ($p<.001$) opined that patients should share costs for medical investigations tests.

5. Attitudes and opinions about willingness of pay amount for investigations tests fees were also found significant.

6. Some prescribed medicines were supplied from the hospitals, which were opined by most of the patients, doctors and nurses. Most of the patients were willing to pay for medicine significantly ($p<.001$) f if medicine can buy with chief rate from the hospitals.

7. At present almost all of patients need to spend unofficially pocket money for surgical operations in district hospitals, which was opined, by patients and service provider doctors and nurses both. Significantly around half of patients showed the attitudes ($p<.001$) and opined by the nurses and the doctors ($p<.001$) that patients should share costs of surgical operations. Patients were very significantly ($p<.001$) willing to share costs and doctors and nurses were opined about amount of cost sharing by patients.

8. Patients are sharing cost of delivery service elsewhere at home and abroad in a planned package individually for normal and caesarian section. Patients are spending out

of pocket payment as un-billed speed money for delivery service revealed in the present study by patients for delivery service in the district hospitals.

9. Almost all of the patients and most of the service provider doctors and nurses were found positive attitudes and were opined significantly ($p<.001$) that mode of payment of cost sharing money should be the direct cash payment.

10. Near about all of the service providers were significantly opined that they should receive incentive from patients cost sharing money but most of the patients' were significantly showed opposite attitudes.

11. Most of the respondents in users fees system private hospitals are satisfied to provided services than that of nonuser fees public sector district hospitals.

12. The difference of satisfaction of service provider nurse and patients between the district hospitals and Dhaka Community Medical College Hospital are not significant compare to the doctor's satisfactions where the differences are significant. These results may happen due to large difference of sample size between these hospitals from which it is hard to conclude in favor or disfavor of user fee system in these hospitals. A representative sample from these hospitals could help to conclude. But considering the significant satisfaction of doctors, still there is scope to take careful decision in favor of user fees system with adequate safety net.

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3. RECOMMENDATIONS: The present research work was carried out in the secondary district hospitals in the country. Majority of the patients and service providing doctors and nurses were found that their attitudes and opinion were in favor of cost sharing by patients for services. From this study following recommendations have made to the health service policy planners and administrator.

1. Problem based research for identification of reasons of dissatisfaction of all patients, nurse and doctors should be addressed on regular basis.
2. Patient registration fees in the district hospitals should be readjusted and redetermined keeping all level economically capable patients as well as currency value change rate in consideration.
3. The OPD consultancy prescription fees could be addressed considering all economic capable groups. Consultancy prescription fees package policy should be formulated by taking meticulous.
4. User fees for medical investigation tests should be extended and test facilities should increase by both qualitatively and quantitatively in the district hospitals in Bangladesh.
5. Medicine supply from hospitals not for profit would bring more efficiency in hospital service. Required pharmacy service should be addressed in the district hospital service.
6. Patients' friendly cost sharing system for surgical operations could be addressed in the district hospitals. The cost will be variable with the size of operation and economical capability of the patients.
7. As there are high demands of cost sharing by patients for delivery service as well as similar opinion given significantly by near about one third of respondents that a planned package of cost sharing by patients for delivery service could be addressed in the district hospitals.
8. Mode of payment of cost sharing money by patients could be direct payment along with addressing in-depth study about other options.

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Questionnaire

Title: "Health care cost sharing in district hospitals of Bangladesh :Attitudes of patients and opinions of service providers-An Empirical Study"o

District Hospital:.....Area of service: 1=OPD 2=IPD

1. Socio-demographic and service characteristics:

1. Age(in complete years) : .....years

2. Sex :1=male 2=female

3. Educational level :

4. Occupations :0=unemployed 1=Labor and rickshaw puller

2= Agriculture and house holds 3=business of any 4=employed in private job

5=employed in govt. job 6=others.....

5. Marital status :1=single 2=married 3=others

6. Religion : 1= Islam

2=Hindu 3=Christian 4=Buddhist 5=others

7. Monthly income(taka) :.....

8. Professional designation :1=Nurse 2=doctor 3= patients

9. Length of services :0=Not applicable

2. Satisfaction to current service of the district hospitals:

10. Are you satisfied with present services provided from this hospitals?

11. What the reasons are of not fully satisfied with service?

1. ..... 2. ..... 3. .....

3. Cost Sharing about Patient Registration:

12. What amount of money (in taka) you paid for registration of patients in OPD? Taka.....

13. What amounts of money (in taka) need to pay for registration of patients in IPD? Taka.....

14. Do you think, amount of money for registration of patients in district hospitals adequate?

1=yes 2=No

15. (If inadequate) how much money (in taka) you proposed for registration fee in OPD?

Taka.....

16. (If inadequate) how much money (in taka) you proposed for registration fee in IPD?

Taka.....

4. Cost Sharing about Prescription Fees at OPD:

17. Are there a provision of prescription fees at OPD of district hospitals? 1= yes 2= no

18. (If No) Do you think, better service can get if fees given for prescription? 1= yes 2= no

19. (if yes) what should be the amount of money for prescription in first visit? Taka.....

20. What should be the amount of money for second visit? Taka.....

21. What should be the amount of money for second follow up visit? Taka.....

5. Cost Sharing for Medical Investigation Tests:

22. Are there provision for paying by patient for medical investigation tests?

1. Patients are free of charge for medical tests
2. Patients are paying for some tests
3. Patients are paying for all tests

23. Do you think that patient should pay for all medical tests?

1. Not willing to share cost for all tests
2. Willing to share cost for all tests

24. (If willing) How much cost should be share by the patients for medical investigation test?

1. Patients should share.....% of actual cost
2. Patient should share cost based on economic condition.

6. Cost Sharing by patients for Medicines and MSRs:

25. Whether patients have to pay for necessary medicine? 1=yes 2=no

26. Do you think medicine can purchase by chief price from hospital? 1=yes 2=no

27. Do you think that patient should share cost of medicine?

    1. Patients should share cost fully

    2. Patient should share cost partly

28. (If partly) what amount of medicine cost that patient should pay?

    1. Patients should share cost partly..... % of actual cost

    2. Patient should share cost based on economic condition.

7. Cost Sharing by Patients for Surgical Operation:

29. At present do you need to spend pocket money for surgical operations in district hospitals?

    1. Undecided 2. Need to spend some money

    3. Need to spend money mostly 4. Need to spend money fully

30. Where you spend pocket money for surgical operations?

    1. Giving to hospital staff

    2. Buying materials from outside hospital

    3. Both for hospital staff and buying materials from outside

31. Do you think patients should share cost for surgical operations? 1=yes 2=no

32. (If partly) what amount of surgical operations cost should pay by patient?

    1. Patients should share cost partly ..... % of actual cost

    2. Patient should share cost based on economic condition.

8. Cost sharing by patients for delivery service:

33. At present do you need to spend pocket money for delivery service in district hospitals?

    1. Undecided 2. Need to spend some money

3. Need to spend money mostly 4. Need to spend money fully

34. Where you spend pocket money for delivery service?

1. Giving to hospital staff

2. Buying materials from outside hospital

3. Both for hospital staff and buying materials from outside

35. Do you think patients should share cost for delivery service? 1=yes 2=no

36. (If partly) what amount of delivery service cost should pay by patient?

1. Patients should share cost partly..... % of actual cost

2. Patient should share cost based on economic condition.

9. Cost Sharing by Patients for Hospital bed:

37. Do you think patient should pay for hospital bed?

1. Patients should not pay bed charge

2. Patients should pay bed charge

38. What amount of charge patient should pay for general bed?

1. Patients should share taka.....per patient per day

2. Patient should share cost based on economic condition.

39. What amount of charge patient should pay for semi cabin in district hospitals?

1. Patients should pay taka.....per patient per day

2. Patient should share cost based on economic condition.

40. What amount of charge patient should pay for private room in district hospitals?

1. Patients should pay taka.....per patient per day

2. Patient should share cost based on economic condition.

10. Cost sharing by patients for hospital diet:

41. What is the quality of supplied hospital diet?

1. Diet as bed 2. Diet average quality 3.Diet as good quality

42. Whether patients should pay for food?

1. Undecided 2. Disagree to pay 3. Agree to pay

11. Attitudes and opinions about mode of payment:

43. Do you know the payment system for hospital service charge?

1. Actual cost direct payment
2. Yearly family health card
3. Family health insurance

44. Whether service provider should take incentive from patient's money?

1. Service provider should receive incentive
2. Service provider should not receive incentive

45. What amount of money should receive for incentive by the service providers from patients' charge?

1. Patients should share cost partly.....% of actual cost
2. Patient should share cost based on economic condition.

(Interviewer's Signature)