Ipsos Social Research Institute

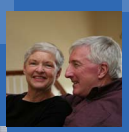














National Health?

CITIZENS' VIEWS OF HEALTH SERVICES AROUND THE WORLD

Authors: Bobby Duffy, Anna Quigley & Kate Duxbury

www.ipsos.com/public-affairs

Ipsos

Acknowledgements

We would like to thank colleagues from across the global Ipsos Social Research Institute for their invaluable input into this report – including: Mike Colledge, Ben Barnes, Nando Pagnoncelli and Olof Frensborg.

We would like to particularly thank the Accenture Institute for Health and Public Service Value for permission to reproduce international findings from the Accenture Citizen Experience Survey 2009. For further findings, please see the Institute's website at www.accenture.com/publicservicevalue

Foreword

Healthcare is one of the biggest social policy challenges facing the world. Costs are inexorably rising, due to some of the biggest global trends – in particular, an ageing population and technological advances that are making ever more sophisticated treatments the norm rather than the exception. When we combine this with faltering economic growth off the back of a severe global recession, and the sovereign debt crisis that many countries are facing, it is clear that governments face some very tough decisions in how to look after the health of their citizens.

This Ipsos Social Research Institute report looks at this major theme, and in particular how perceptions of healthcare vary across a wide range of countries. We explore what drives these perceptions and what can be done to maintain trust on this issue, which is vital to any government's reputation.

The main conclusions chime with two very current themes that have been seen across other work on healthcare and social issues more generally – citizen engagement and behaviour change/social marketing.

Firstly, informing and engaging citizens are central to trust. When difficult decisions need to be made, the temptation is to shy away from the debate with our populations, as we expect contradictory views and we may feel that people want strong, decisive leadership. Both of these points are true to an extent – but neither are incompatible with talking more to citizens and getting their views on what should be done. Those that engage successfully with the public are better rated.

Secondly, people increasingly recognise that individuals themselves have a responsibility to change their own behaviour and take some of the pressure off the system. More importantly, they believe that government has a role to play in encouraging this change, through social marketing interventions. This is not to say that people are crying out for government interference in

their lifestyle choices, but rather that they are willing to accept this can be an important tool, and better than the alternative of even more thinly spread resources.

Of course, as always with this type of international comparison, these generalities hide huge variation between countries, and it is one of the key aims of this report to highlight just how different perceptions are across the world. Understanding local cultural, historical and system contexts is central to what we do in the Ipsos Social Research Institute - and we hope this report helps provide some pointers to the key issues across different national health services.

Bobby Duffy
Director, Ipsos Social Research Institute

Executive Summary

At a time of unprecedented challenges to the delivery of high quality healthcare, it is crucial that governments understand citizens' perceptions of these services. This report explores these perceptions and the factors that underlie them. It draws on data from Ipsos' Global @dvisor survey[1] across 24 countries and the Accenture Citizen Experience Survey[2] in 14 countries.[3]

- Globally, citizens do worry about healthcare; it rates as **the fifth most important national concern** after unemployment, poverty and social inequality, corruption and crime and violence. While the extent of concern varies greatly by country, it is not necessarily higher in countries that provide the worst healthcare (according to the World Health Organisation (WHO) ranking)[4]. In fact, in countries with a poor ranking, people worry relatively less about it compared with those in countries with the best performing health systems[5]. This will be because the countries where healthcare systems are judged to be poorest tend to be less developed; as a result they are facing a range of more pressing problems, particularly economic. In more developed countries, citizens are free to worry more about healthcare; it is only within this group of richer countries that concern varies according to the WHO's assessment of performance of the healthcare system. **So, developed countries that achieve a good rank, such as France or Italy, show lower levels of concern than countries achieving a poorer rank, such as the US.**

- Generally, the majority of people are positive about the quality of healthcare in their country; over half say it is good in ten of 14 countries. **There are substantial differences between countries** though; in Singapore, as many as nine in ten rate the quality of healthcare as good, falling to under three in ten in Hong Kong. Again, objective measures of the quality of healthcare (such as WHO rank) only partly account for these differences in perceptions. For example, Italy and Singapore both figure among the best performing healthcare systems in the world according to the WHO (ranked second and sixth respectively), yet citizens in Singapore are twice as likely to rate the quality of their healthcare system as good than in Italy (87% compared to 43%). This may partly be accounted for by cultural factors, for example strong consensual support for Government and a reluctance to criticise public authorities in Singapore (in addition to a very efficient healthcare system).[6]

- Citizens are also **more likely to rate the quality of healthcare in their country as good than they are to say it would be easy for them to get quality, affordable healthcare services.** For example, while 48% of Japanese citizens believe healthcare to be good, only 15% say it would be easy to get quality, affordable healthcare services. This demonstrates the different dimensions of public perceptions that we need to consider when looking at how services are rated.

- There is little relationship between public assessments of the quality of healthcare services though and trust in the government to improve healthcare. In most cases, **current ratings of services are much higher than trust in the government to improve them.** For example, in Canada, over three quarters think the quality of healthcare is good, yet only slightly over half trust the government to improve the quality of services.

- However, there are a clear set of factors that are key to citizens' trust in the system and their belief that the government will improve services. For example, providing the public with the **information they need to exercise choice about their healthcare,** and control over it, is **strongly related to trust** in the government to improve services. Citizens also place importance on tailoring services to the needs of those who use them – but they also ask for equal access to services for everyone. This illustrates the complexities in understanding what the public demand from their services.

- Clearly it will be difficult for governments to balance these competing demands, but perhaps the answer is **involving the public in decisions about services** – this is also related to trust in the government to improve services. If people are able to see how decisions are made (and have the opportunity to influence those decisions) they are much more likely to accept them.

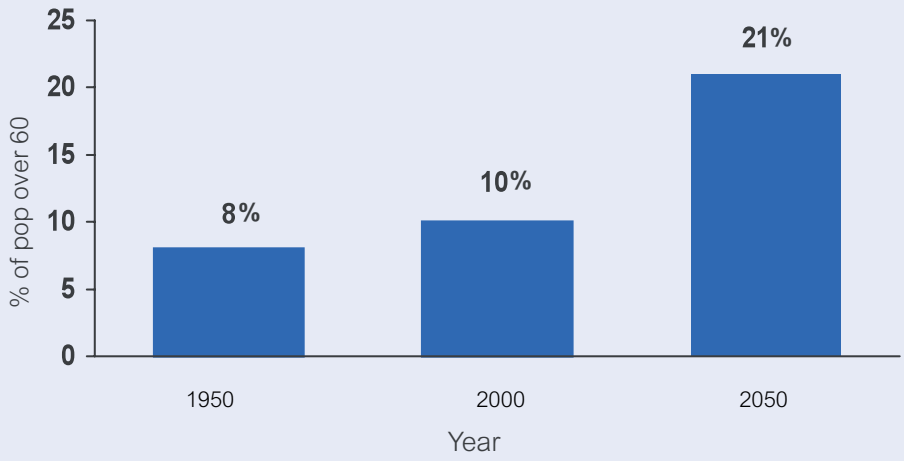
- Of course, governments also need to consider how to deliver the quality that their citizens are asking for within tighter budgets. This will inevitably entail some difficult decisions so it is important to understand what is likely to play best to their populations. **Most popular is lowering the burden placed on the system – either by making use of alternative methods of healthcare delivery or by changing citizens' own behaviours.** Eight of 14 countries thought that requiring patients to change their lifestyle before being treated was one of the most acceptable ways of lowering costs. They also believe that governments have a role to play in encouraging healthier lifestyles. In fact, it is only Germany where a majority believe that government should not interfere in individual lifestyle decisions.

- Overall then, the role of government in this increasingly challenging context has two key themes. As a first step, governments need to **understand what their populations are asking for** from healthcare services, and provide the right information and level of control. This will vary between countries, depending on the cultural and healthcare system context. However, the research also highlights that, in most countries, citizens will also accept that there is a **role for government to lead the way in encouraging behaviour change** to reduce pressures on services.

1. A changing world for healthcare provision?

Health services are facing unprecedented challenges. Many countries are now in uncharted territory, needing to provide services in a different way to meet the growing demands and cost of healthcare. In many countries (particularly in Western Europe and North America), the proportion of people aged over 60 years is growing faster than any other age group, as a result of both longer life expectancy and declining fertility rates. This may be a success story for public health policies and for socioeconomic development, but it will also place unprecedented pressure on a country's public services – particularly its health system.[7]

Proportion of world population 60 years or over: 1950-2050

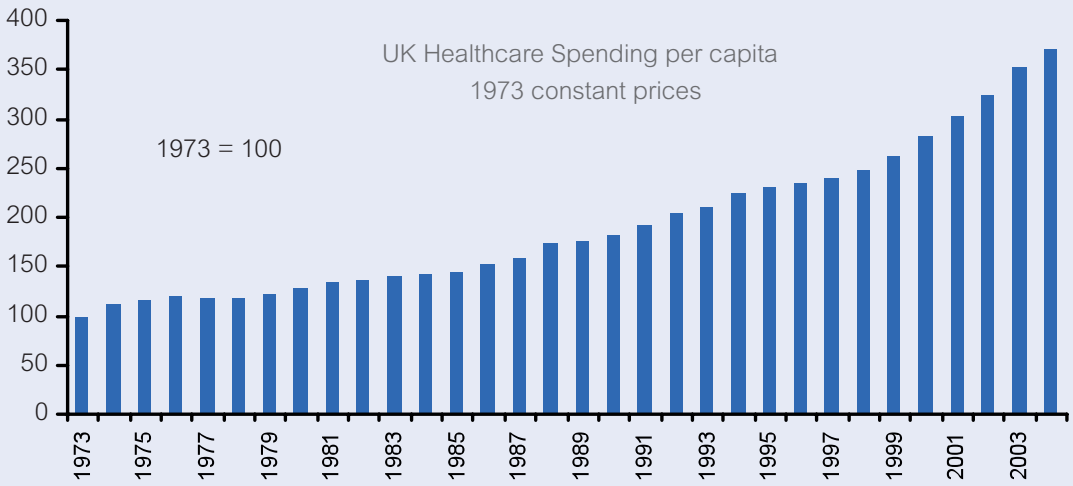


Source: UN Department of Economic and Social Affairs, World Population Ageing 1950-2050, (2002), http://www.un.org/esa/population/publications/worldageing19502050/

When we add to this the effects of a global downturn and huge increases in sovereign debt it is clear that the healthcare systems that have been sufficient in the past may not be sustainable in the future. The need to make changes in the provision of healthcare is being advocated in different countries, for a range of reasons. For example, in the US, while much of the recent debate on healthcare reform focused on the introduction of universal healthcare coverage, the challenge of meeting rising costs also featured strongly. Government spending on the Medicaid and Medicare schemes is projected to rise from 4% of GDP in 2007 to 7% in 2025 and 12% in 2050, making rising healthcare costs one of the biggest contributing factors to the US budget deficit.[8] The intention is to pay for the reforms and the rising costs of healthcare by reducing waste and containing costs in the system, for example by linking payment to quality.

In the UK too, the need for change has become increasingly clear. The country needs to find savings equivalent to a fifth of its budget over the next few years simply to keep up with the rising costs of healthcare. This is in spite of the new coalition government's promise to maintain spending on the NHS.

Healthcare inflation outstrips national inflation



Sources: Office of National Statistics, Dept of Health, Laing & Buisson

Those who are charged with running health services will inevitably have to look at the way in which they provide those services in order to assess whether the same level of healthcare can be provided in a more cost-effective manner. This may entail limiting the treatments available or even withdrawing services – something which will be seen as a denial of healthcare provision (even if better outcomes are achieved in a different way). This brings with it a real risk of reputational damage to the healthcare system and governments.

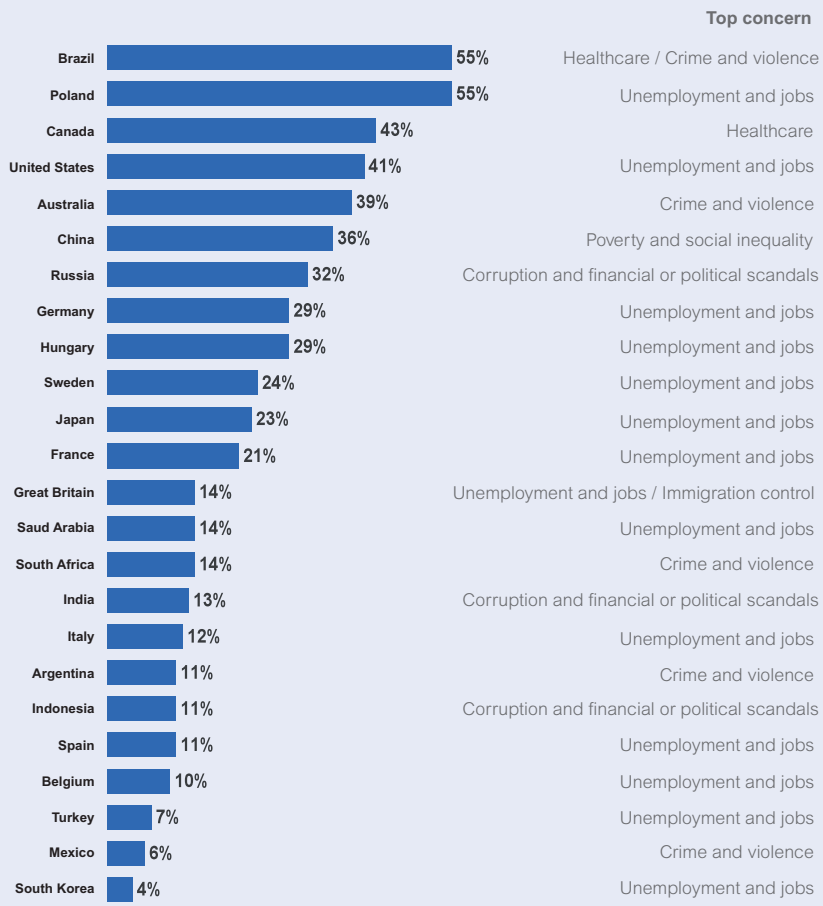
At a time of substantial shift in the way in which healthcare services around the world are provided, it is more important than ever for governments to understand their citizens' perceptions and to evaluate the impact of their health policy changes on quality and service delivery. This report looks at these perceptions and asks how citizens rate the systems available to them. We explore what drives these perceptions and what can be done to maintain trust on this key issue.

2. How concerned are citizens about healthcare?

The level of worry about healthcare provides an indication of how citizens feel about the quality of care available to them in their respective countries. Ipsos Social Research Institute data establishes the importance of healthcare as a public concern. Ipsos Global @dvisor, a monthly online survey carried out in 24 countries, shows that globally, around a quarter of citizens find healthcare to be one of the most worrying topics in their country.[9] Overall, it is the fifth most important worry (out of a list of 16 topics) after concerns over unemployment, poverty and social inequality, corruption and crime and violence.

Concern about healthcare

Which three of the following topics do you find the most worrying in your country?



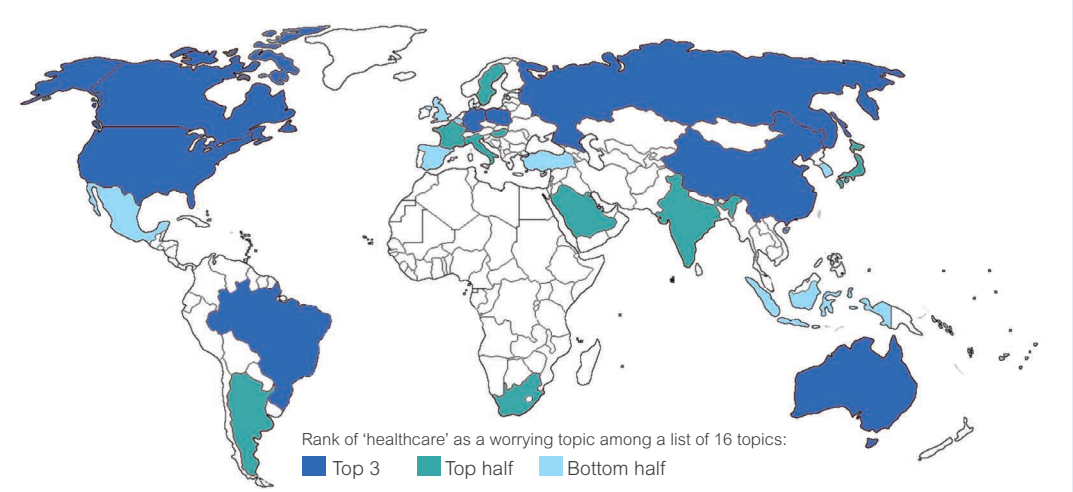
Source: Ipsos Global @dvisor Wave 6 (Fall 2009)

The results also show that the extent of concern about healthcare varies greatly by country. In Brazil and Canada, people worry more about healthcare than any other issue, with over half (55%) in Brazil perceiving it as one of the most worrying issues in their country (on a par with crime and violence) and 43% in Canada (four percentage points ahead of jobs and unemployment).

Concerns about healthcare are also high in Poland, the United States and Australia, where it is citizens' second greatest concern after unemployment. Those living in China, Germany and Russia see it as the third greatest cause of concern in their country.

On the other hand, in Belgium, Turkey, Mexico and South Korea, concern about healthcare is very low relative to other issues. Healthcare features further down the list, as the 10th or 11th most important issue out of a total of 16 topics in these countries.

Where is healthcare perceived to be an issue?



Source: Ipsos Global @dvisor Wave 6 (Fall 2009)

Is concern linked to objective ranking of health systems?

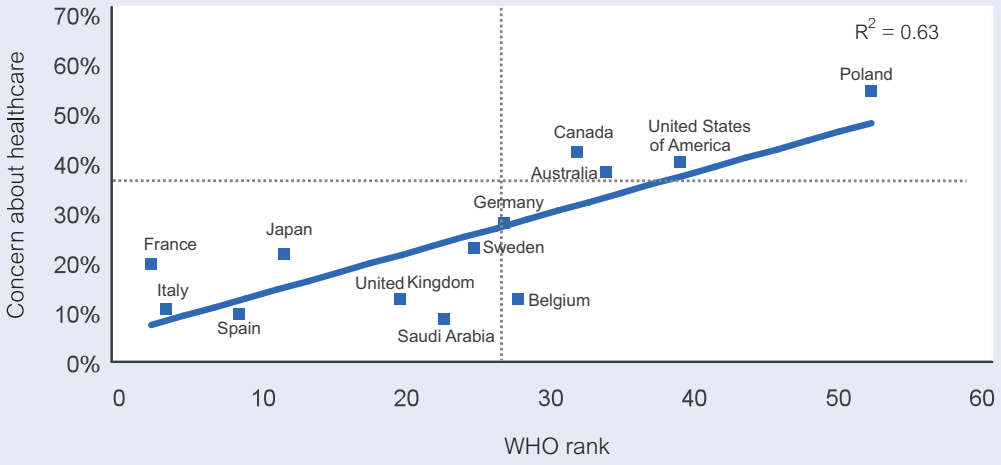
In the 2000 World Health report, the World Health Organisation (WHO) measured and ranked the overall performance of health systems for 191 countries.[10] Interestingly, our research shows that achieving a poor WHO rank does not necessarily correlate with strong public concern about healthcare. For example, healthcare is a great cause of concern in both Canada and Brazil, two countries that achieve very different WHO ranks (respectively 30 and 125 out of a total of 191).

However, clearer patterns emerge when we divide the countries into two groups: those with a better than average WHO rating (strong performers) and those with a worse than average rating (poor performers).[11]

In countries that achieve a good WHO rank, citizens worry more about healthcare relative to other issues, compared to those in the group of countries who achieve a poorer rank. This is likely to be as a result of differing expectations between countries about health service delivery and because those with a poor WHO rank tend to be facing a range of other problems, particularly economic ones, and these are taking priority over healthcare concerns. For example, our research shows that among these countries, poverty and corruption are perceived as a much greater problem.

However, if we look only at 'above average' performers, the level of public concern about healthcare varies according to WHO rank, as shown in the following chart. Countries that achieve the best rank, such as France or Italy, show lower levels of concern than those who achieve poorer ranks (e.g. United States and Poland).

Public concern about healthcare and WHO rank



Ipsos Global @dvisor, Wave 6 (Fall 2009)

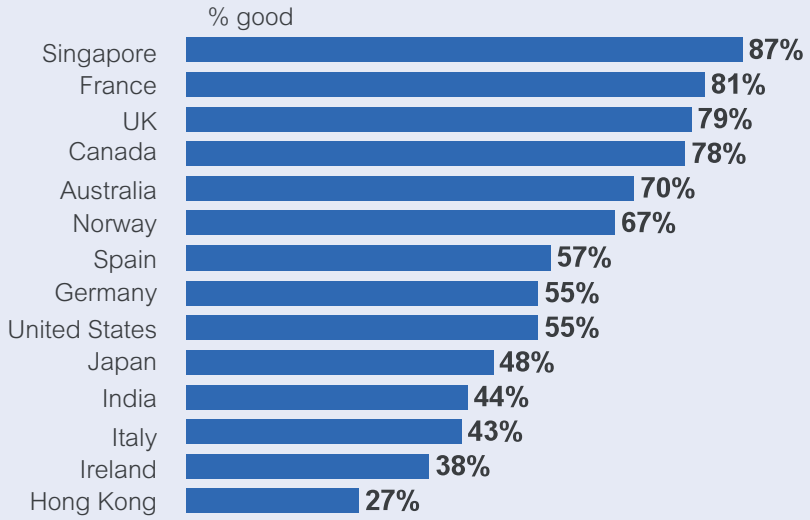
So it is only in more developed countries that perceptions of healthcare (defined here as concern) are in line with objective measures of quality. This reflects a range of other Ipsos Social Research Institute work, where there are 'perils' in perception measures when assessing performance – in particular, perceptions are often determined to a large degree by the nature of the population served by a public service, as much as the service itself[12]. As we regularly point out, any perception-based measure of services needs to bear this context in mind, particularly when making comparisons across countries or localities that are very different.

3. How do citizens rate the quality of healthcare?

Using data from the Accenture Citizen Experience Survey[13], we can see that, generally, the majority of citizens rate the quality of healthcare as good: more than 50% say it is good in ten of the 14 countries. There are again substantial differences between countries though. In Singapore, nearly nine in ten (87%) rate the quality of healthcare as good, falling to under three in ten in Hong Kong (27%). Objective measures of the quality of healthcare only partly explain these differences in perceptions. For example, although Italy and Singapore both figure among the best performing healthcare systems in the world according to the WHO (ranked second and sixth respectively), citizens in Singapore are twice as likely to rate the quality of their healthcare system as good than in Italy (87% compared to 43%). Other factors, such as a strong consensual support for the Government (and reluctance to criticise public authorities) in Singapore may help to account for these differences.[14]

Ratings of healthcare

Q Thinking generally about healthcare in your country, would you rate the quality of healthcare as... ?

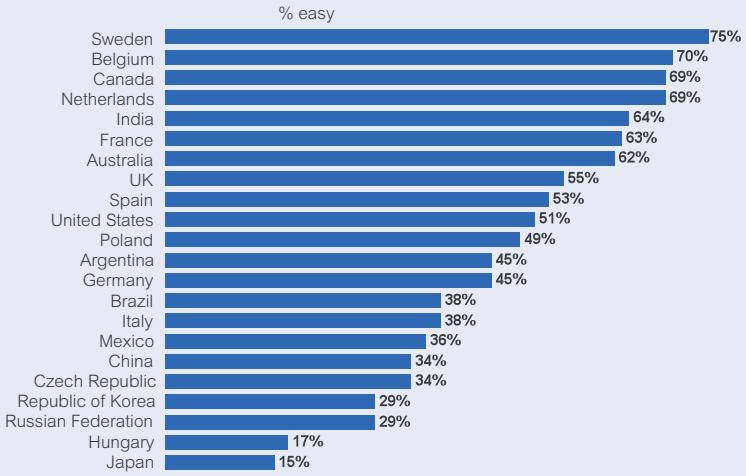


Source: Accenture Citizen Experience Survey 2009

But citizens are not just thinking about quality when judging their healthcare; access and affordability also play a part. In Ipsos' Global @dviser, we asked citizens how difficult they would find it to get quality, affordable healthcare services if a member of their family became very ill. As for ratings of quality, there is substantial variation across the countries, ranging from 15% saying "easy" in Japan to 75% in Sweden.

Ease of accessing quality, affordable health services

Q Imagine that a member of your family became very ill. How difficult would it be for them to get quality, affordable healthcare services?

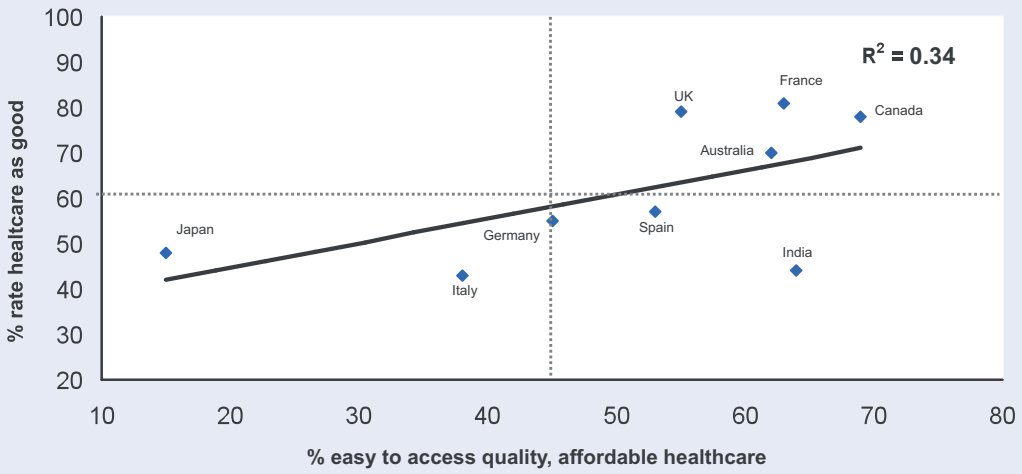


Ipsos Global @visor, Wave 6 (Fall 2009)

For all the countries included in both studies (Global @dviser and Accenture Citizen Experience Survey), citizens are more likely to rate the quality of healthcare in their country as good than they are to say it would be easy for them to get quality, affordable healthcare services for a seriously ill relative.[15] In particular, while 48% of Japanese citizens rate the quality of healthcare as good, only 15% say it would be easy to get quality, affordable healthcare services. This will be related to the additional dimensions of ease of access and affordability of healthcare; quality may be high, but this may be difficult to access or afford. This illustrates the importance of considering different dimensions of public perceptions in order to get a full picture of ratings of services.

India presents a very different picture though. While perceptions of ease of access to affordable care are comparable to developed countries such as France and Australia and higher than the UK, just 44% rate the quality of care as good. This will be explained by the fact that the online population in India is more affluent and therefore more able to afford healthcare, but that the standard of this care is less likely to meet their expectations.

Rating of quality of services and ease of access to quality, affordable healthcare



Sources: Ipsos Global @dvisor (Wave 6) and Accenture Citizen Experience Survey 2009

Case study – Ipsos Social Research Institute, Italy: The Italians and their healthcare

In 2009 Ipsos conducted a national survey to measure perceptions of the Italian healthcare system overall and in relation to the four national healthcare pillars: emergency, general practice doctors, hospital service and care for the elderly and seriously ill. The majority of Italians were satisfied with most aspects but there were particularly positive ratings for the quality of family doctors.

However, there were substantial differences on a regional level, with much higher satisfaction in Central and Northern Italy than in the South. This North/South divide is something that the federalist reform will need to address.

Case study – Ipsos Social Research Institute, Sweden: The Swedish Association of Local Authorities and Regions – Healthcare Gauge

The Ipsos Healthcare Gauge has been running in Sweden for nine years. In this study we have conducted 40,000 interviews per year on a national randomized sample. The Healthcare Gauge is national survey commissioned by The Swedish Association of Local Authorities and Regions (SALAR), the central body which represents the governmental, professional and employer-related interests of Sweden's 290 municipalities, 18 county councils and two regions. The study covers three main areas: How do people score different aspects of their last healthcare visit (primary and secondary)? What are their attitudes towards different sectors of the healthcare system? What is their knowledge of the healthcare system and patient rights?

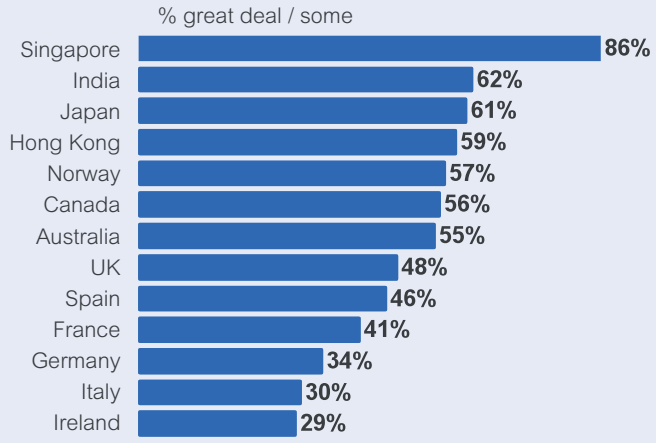
The Gauge is used as a tool to measure key health policies and initiatives. For example, it provides SALAR with data on the extent to which GPs are talking to patients about their smoking and drinking habits and physical activities – a new preventative intervention. It is also used to assess usage of the new medical-advice-over-the-phone system. Results are published in an open annual benchmark.

4. Increasing trust in government on healthcare

Models of healthcare provision, in terms of the role of government, the way in which it is paid for and provided, vary hugely across the world.[16] It is therefore not surprising that there is little relationship between assessments of the quality, affordability and access to care and a further question we asked on trust in governments to improve healthcare. With certain exceptions (Singapore, India, Japan and Hong Kong), citizens are far more likely to say that the quality of healthcare is good than they are to trust the government to improve services. For example, in Canada, over three quarters (78%) think the quality of healthcare is good, yet only slightly over half trust the government to improve the quality of services (56%). The UK shows a similar picture to Canada. Four in five (79%) rate the overall quality of healthcare as good, yet only half (48%) trust government to improve the quality of services.

Trust in the government to improve the quality of health services

Q Taking everything into consideration, how much or little trust do you have in government to improve the quality of health services that are available to you in your country?

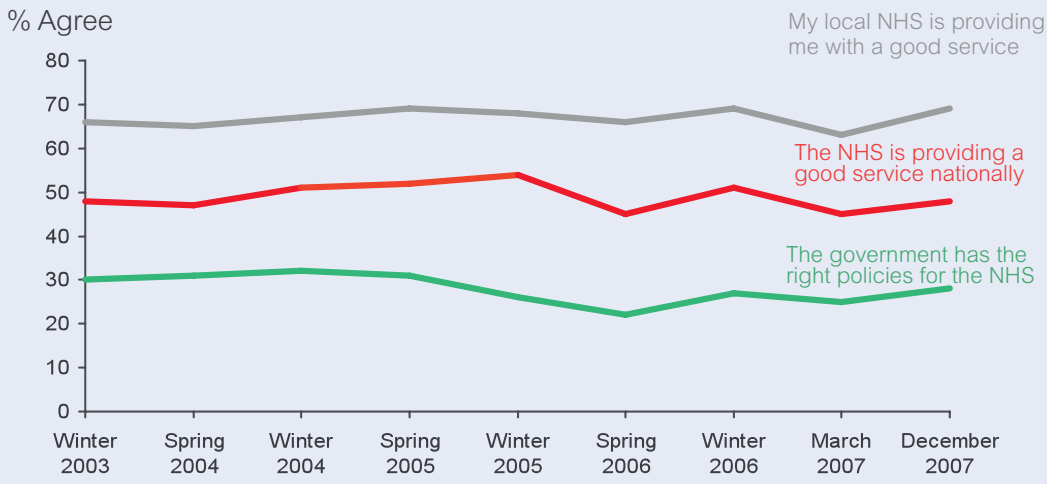


Source: Accenture Citizen Experience Survey 2009

These type of general trust in government questions also bring politics into peoples' minds in a much more direct way than when we ask them to consider particular services or experiences. For example, other Ipsos research shows that UK citizens have a clear hierarchy of satisfaction, where their direct, individual experience is much more positive than their general views of the service, and that in turn is more positive than their rating of government health policies.

The UK's National Health Service: a perception gap

Q To what extent, if at all, do you agree or disagree with the following statements?



Base: English adults aged 16+ (c.1,000 per wave)

Source: Ipsos MORI/DH Perceptions of the NHS Tracker

But this does not mean that there is nothing that governments can do to improve how healthcare services and their policies for them are viewed. There are a clear set of factors that citizens want them to do; where governments perform well on these individual aspects, they also tend to be rated more positively by their citizens overall and they are more likely to trust them to improve services. Establishing cause and effect from these types of relationship is not possible, as either could be influencing the other and both can be affected by something entirely different (for example, political views and support for the party in power).

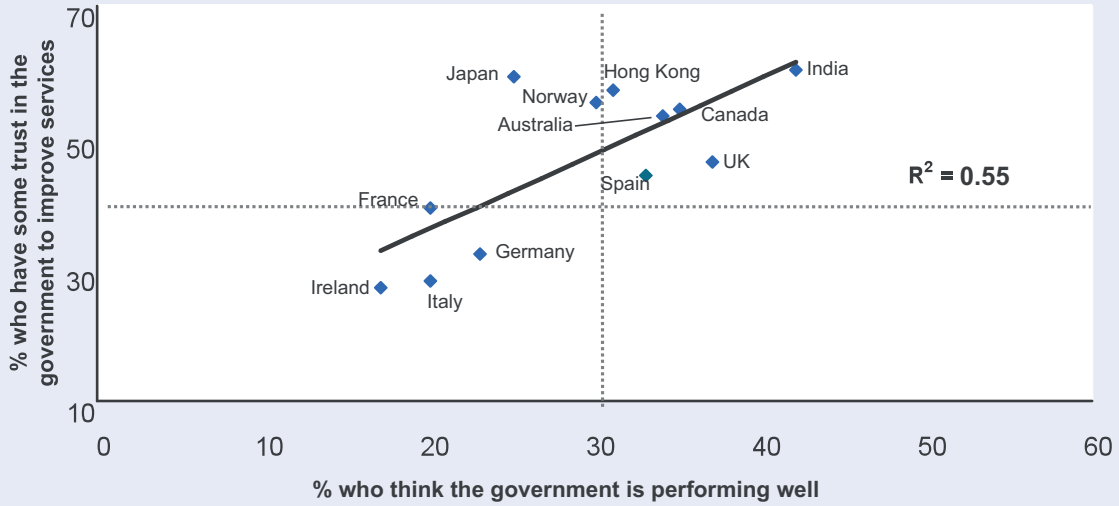
Nevertheless, examining which of the factors are most closely linked to trust to improve healthcare in the future will be useful if governments wish to consider how they might inspire confidence in the healthcare system as a whole.

First, citizens want governments to inform and educate them about the services available to them. Providing the public with the information they need to exercise choice about their healthcare and control over it appears to be strongly related to belief that the government will improve the quality of services. The following chart shows a strong correlation between those who say their government is performing well at providing reliable and trustworthy information / advice about health services and those who trust the government to improve the quality of health services.

There are similar relationships seen for encouraging and educating people to take more personal responsibility for their health and providing a clear way for people to access heath information quickly and easily.

Information and trust to improve services

Providing reliable and trustworthy information and advice about health services



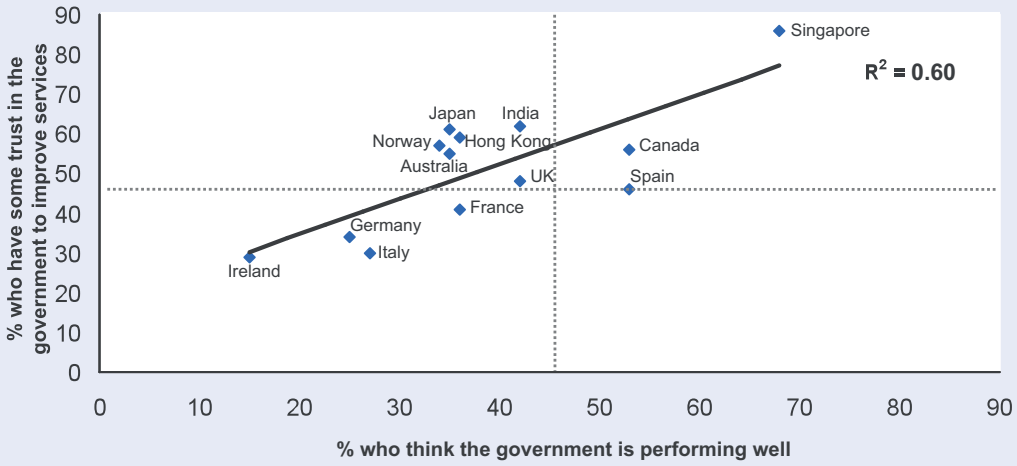
Source: Accenture Citizen Experience Survey 2009

Citizens also appear to place some importance on the extent to which health services are tailored to the needs of those who use them. There is a strong correlation between those who say their government is performing well at targeting services to help those with the greatest needs and those who trust the government to improve the quality of health services.

However, citizens also ask for fair and equal access to services for everyone – this is also strongly linked with trust in the government to improve services. This appears to be contradictory – is it possible to provide fair and equal access to services while also targeting them where they are most needed? This dilemma reveals the complexities in understanding the demands the public make of their services. Other Ipsos research shows that above all, members of the public want their services to be 'fair'. However, what is meant by 'fair' is not straightforward – and can relate both to uniformity in standards, uniformity of outcomes and/or helping those in particular need (especially where those people are seen to be deserving). The concept of fairness in health provision is also very specific to individual national contexts and cultures, but all governments should consider carefully how they are meeting this demand from their citizens.

Fair and equal access and trust to improve services

Providing fair and equal access to health services for everyone in the country



Source: Accenture Citizen Experience Survey 2009

CASE STUDY – Ipsos MORI Social Research Institute, UK: Do citizens want healthcare systems to be based on need or universal fairness?

An Ipsos study in the UK, on the future of healthcare, addressed one particularly difficult question – do the public think the NHS should be based on national standards or local need?

Survey research showed a clear preference for universal standards across the country, with almost three-quarters saying that they wanted NHS provision to be based on national standards. However, when participants were given the opportunity to engage with the subject in more detail through qualitative discussion groups, views changed significantly. Crucially, at this point all groups distributed treatment and services based on local need. Even those who said that they strongly agreed that treatments should only be available on the NHS if they were available to everyone now said that NHS budgets should be spent on the basis of local priorities. For example, they were happy to provide specialist services according to the needs of that local area, even if that meant that other areas were denied that service.

Balancing these competing demands will prove challenging. Perhaps the answer lies in public empowerment. If people are aware of how decisions on public health service provision are made, and have an opportunity to take part in those decisions should they wish to, this may have a positive impact on their confidence in the system itself. From our work across this diverse set of countries three aspects appear consistently important to citizens:

- providing clear explanations of how spending decisions are made;
- providing opportunities to take part in discussions about the quality of healthcare;
- seeking views when making decisions on priorities for health services.

5. How should governments meet the challenges ahead? A role for behaviour change?

So there are a number of areas where governments may want to focus their efforts if they are to build confidence in the quality of healthcare systems. However, as mentioned at the outset, delivering high quality care in the future will become increasingly difficult given rising costs and tougher economic times. Governments will undoubtedly be looking at a range of methods to meet the challenges ahead and they will want to consider how their populations might react to each option – what do the public think should be done?

When presented with a range of potential ways to reduce cost, greatest support is focused on lowering the demand placed on doctors' time by providing alternative methods of healthcare delivery. For example, the most popular options are seeing health professionals other than doctors and encouraging telephone and online consultation rather than seeing a doctor face-to-face. Citizens in ten of the 14 countries believe that these are two of the most acceptable ways of lowering the costs of healthcare.

Acceptable ways of lowering healthcare costs

Method of lowering costs of healthcare	Countries where citizens rate it as one of the most acceptable
Seeing health professionals other than doctors	Australia, Canada, France, Hong Kong, Ireland, Norway, Singapore, Spain, UK, United States
Encouraging telephone and online consultations	Australia, Canada, Germany, Hong Kong, India, Ireland, Norway, Singapore, Spain
Requiring patients to change their lifestyle before receiving treatment	Australia, France, Germany, Hong Kong, India, Japan, Spain, UK

Source: Accenture Citizen Experience Survey 2009

Next on the list though is something slightly different – placing responsibility on the citizen to remove some of the burden on the health system. Citizens in eight of the 14 countries thought that requiring patients to change their lifestyle before they can receive treatment was one of the most acceptable ways of reducing costs.

Of course, it isn't necessarily the case that the public is actively demanding any of these changes – only that these are the most acceptable means of lowering costs, should that be necessary. We have seen in other Ipsos research that while people are still quite uncomfortable with the notion of denying treatment until the patient has changed their behaviour, once other less attractive alternatives are proposed (e.g. longer waiting lists for treatment, top-up fees) then it becomes more acceptable.

Case Study – Ipsos Reid Social Research Institute and the Canadian Medical Association

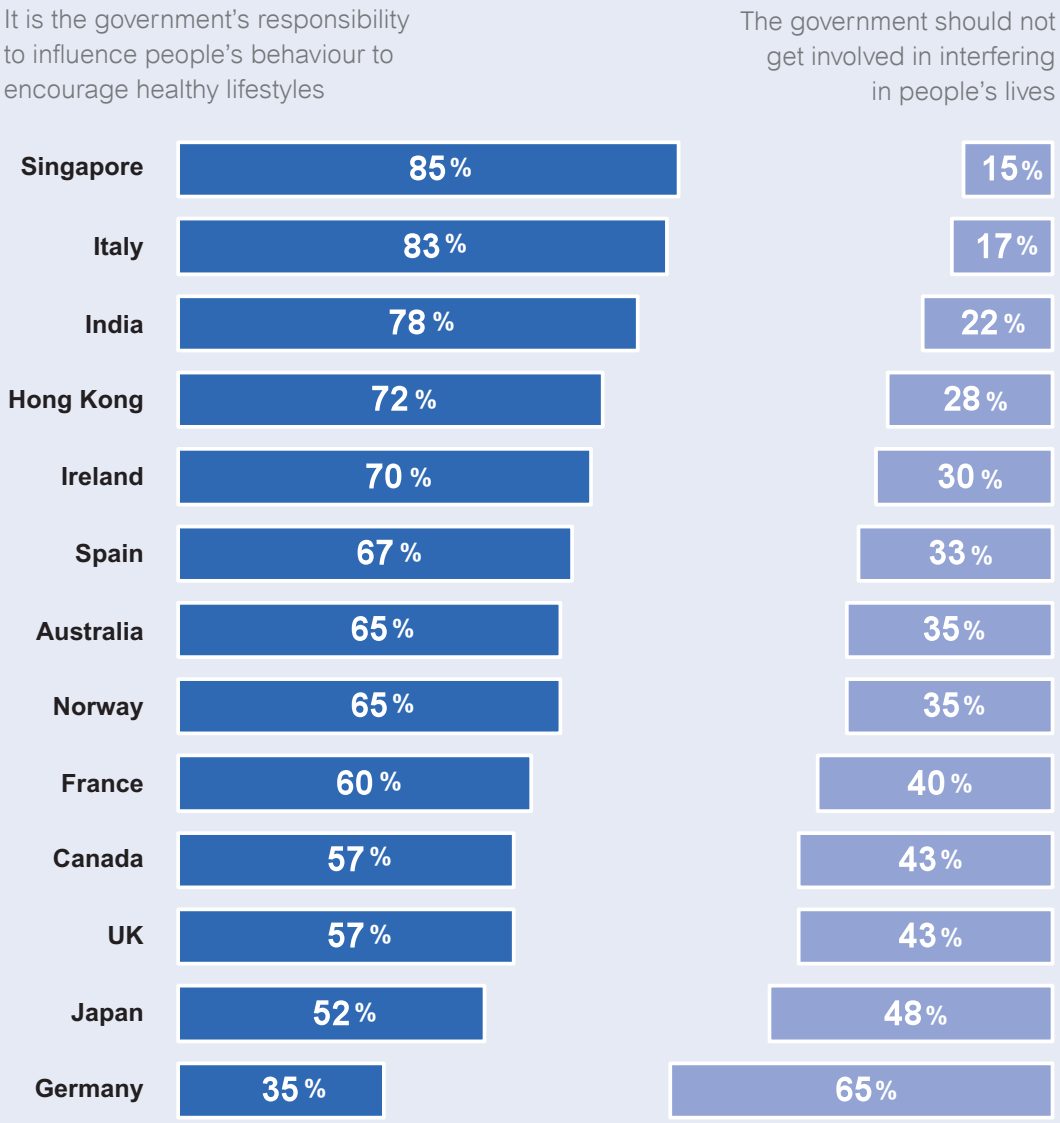
Over the past decade a number of indicators have shown Canadians becoming increasingly concerned about the sustainability of Canada's healthcare system. They are worried not only about the government's ability to deliver healthcare, but also that healthcare costs may jeopardize the ability to deliver other public services. Between 2000 and 2010 almost half of Canadians strongly agreed that healthcare costs will rise sharply. Over the same period those strongly agreeing that healthcare costs will be manageable due to economic growth declined from 19% to 7% and those who strongly agreed that Canada will be able to contain costs by operating the health system more efficiently also declined from 29% to 14%.

While there is growing public acceptance (as seen in the Global@dvisor data) for governments to get involved in improving the lifestyles of citizens as a means of reducing the cost of healthcare, Canadians still see improved efficiency as the best means of addressing the issue of rising costs. Nine in ten agree that the best way to slow down the growing costs of healthcare is to make the system more efficient and effective (but only 35% are confident governments will succeed at this). More Canadians (two thirds) agree that the best way to slow down the growing costs of healthcare is to introduce rewards and penalties that encourage people to be healthier and stay out of the health system. While fewer see this as an effective option for controlling costs they are more confident in governments' ability to do so with half saying they are confident.

While changing behaviours is increasingly being looked at as a means of reducing the demands on the health system it is very likely that governments will always need to take a two pronged approach and ensure that finding efficiencies is an on-going activity.

Nevertheless, the need for behaviour change is clearly something that citizens are starting to consider as part of the solution, as can be seen in the following chart. In fact, it is only Germany where a majority believe that government should not interfere in individual affairs.

Role of government



Source: Accenture Citizen Experience Survey 2009

However, efforts to influence behaviour can take many forms, as outlined in an extensive and growing literature on 'social marketing'[17]. Government actions can range from simple marketing campaigns to a more active influence, either on an individual level (such as restricting treatment until the patient has changed their behaviour) or at a population level (for example, the Danish government has become the first in the world to impose a tax on junk food). The next step for governments then is to understand the limits of their responsibility. What is it exactly that their populations think they should be doing? What is acceptable interference and what would be a step too far?

Case study – Ipsos-Eureka Social Research Institute, Australia: Australian Government Department of Health and Ageing – Indigenous Australians and Health Research

Indigenous Australians are disadvantaged in many ways when compared with the majority of the Australian population. In particular, they are more likely to suffer from serious illness and their life expectancy is over 10 years lower than the general population.

In order to address the challenge of improving the health of the indigenous population, the Australian government asked Ipsos-Eureka and their partner in Indigenous Affairs, Winangali Pty Ltd, to research Aboriginal and Torres Strait Islander people's views and attitudes towards healthcare and illness. The key aim was to develop health marketing campaigns targeting Indigenous Australians.

Ipsos-Eureka conducted over 100 focus groups, involving more than 650 Indigenous people. The research also involved interviews with health professionals, to add context and insight to the findings. Indigenous communities can be both vulnerable and hard-to-reach; a lot of thought had to go into the most effective and ethical way of conducting the groups. Ipsos used peer recruitment and Indigenous moderators in order to gain high quality data in the most ethical way.

Ipsos analysed the data, uncovering common themes and differences from the groups and used this analysis to form the basis of three reports that set out to address the client's key objectives – namely, to inform the development of effective health marketing campaigns targeting Indigenous Australians. The results have been used to inform the development of social marketing campaigns in terms of their communication strategies, message style and delivery, communication channels segmentation needs and supporting strategies. These campaigns will focus on reducing smoking rates, encouraging healthy eating and active lifestyles, and further educating Indigenous Australians on the nature of the core chronic diseases and their modifiable risk factors.

Case study – Ipsos MORI Social Research Institute, UK: Waltham Forest Council – Sustainable Community Strategy

In 2008, Ipsos MORI designed a programme of community consultation that formed one part of a wider programme of engagement on the Sustainable Community Strategy for this local government body in the UK. One of the key findings from the research was that local residents were unhappy with number of fast food take-aways in the area and the impact that this had on the residents' health.

A year later, following recommendations from the research, Waltham Forest Council became the first local authority in the UK to ban fast food outlets from opening within 400 metres of schools, leisure centres and parks. The ban was supported by a drive to improve the quality of school meals to ensure all pupils receive at least one healthy meal a day.

Since the scheme was established the number of hot food takeaways in Waltham Forest has dropped from 253 to 241 (or five per cent). The Council received five applications to open new hot food takeaways between 24 March 2009 and 1 March 2010. They were all rejected. In the same period childhood obesity levels have dropped by ten per cent.

6. Conclusions

We have seen that citizens expect a lot of their healthcare services. They want to receive information that allows them to take control of their health and understand the services available to them. They want governments to target services where they are most needed but at the same time, ensure fair and equal access for everyone. They want to know how decisions are made and have the opportunity to give their views on those decisions. Above all, they want their own interactions with services to be good quality.

Citizens also recognise the role they as individuals can play in achieving the quality they desire at a lower cost - and crucially, many believe that governments have a role to play in encouraging this behaviour change. It is true that government activity to effect change will not be the only way of meeting the challenges ahead. Indeed, it is becomingly increasingly clear that governments need to design and target their behaviour change initiatives carefully, and to evaluate their impact, because not all such work, however well-intentioned, is cost-effective.[18] However, promoting individual behaviour change does appear to be an approach that citizens around the world are willing to accept from their governments.

The research therefore confirms that two key themes current to many public policy debates around the world – citizen engagement and behaviour change – are indeed central to the successful future provision of health services. However, as so often, the devil is in the detail of implementation. Taking account of local structural and cultural contexts is vital – and it is here that research among citizens can play a vital role.

Notes

1. An online survey carried out in the 19 countries making up the G-20 plus Belgium, Hungary, Poland, Spain and Sweden.
2. An online survey carried out in 14 countries.
3. Both of these are online surveys – in more developed countries we can be confident that our sample provides a good picture of the population. In some developing countries, where a minority of the population has access to the internet, the sample should be seen as representing a more affluent and connected segment of citizens. In our private sector work we analyse these groups as 'brand influencers' and we believe their value for studies on perceptions of public services is similar.
4. World Health Organization's ranking of the world's health systems, World Health Report 2000
5. The average WHO rank for the 22 countries included in the Ipsos Global @dvisor survey was 58. The countries were then split into two groups according to whether they were in the top or bottom half (countries achieving a better rank, lower than 58, and those achieving a poorer ranking, of 58 and above).
6. Tsan-Kuo Chang, Reporting Public Opinion in Singapore, Journalistic Practices and Policy Implications in The International Journal of Press/Politics January 1999 vol. 4 no. 1 11-28
7. UN Department of Economic and Social Affairs, World Population Ageing 1950-2050, (2002), http://www.un.org/esa/population/publications/worldageing19502050/
8. Congressional Budget Office, The Long-Term Outlook for Healthcare Spending, (2007), http://www.cbo.gov/ftpdocs/87xx/doc8758/Frontmatter.2.3.shtml
9. Ipsos Global @dvisor is a monthly international survey carried out online in 24 countries and involving 500 to 1,000 interviews in each country: Argentina, Australia, Belgium, Brazil, Canada, China, France, Germany, Great Britain, Hungary, India, Indonesia, Italy, Japan, Mexico, Poland, Russia, Saudi Arabia, South Africa, South Korea, Spain, Sweden, Turkey and United States.
10. This study is now relatively old, but is the last fully comprehensive and consistent information available.
11. The average WHO rank for the 24 Global @dvisor countries was 58. The countries were then divided into two groups: those achieving a better rank (lower than 58), and those achieving a poorer ranking (58 and above).
12. Ipsos MORI (2008) Frontiers of performance in the NHS II
13. An online survey carried out in 16 countries – the data used in this report excludes results from Brazil and Mexico due to differing methodologies and questions.
14. Tsan-Kuo Chang, Reporting Public Opinion in Singapore, Journalistic Practices and Policy Implications in The International Journal of Press/Politics January 1999 vol. 4 no. 1 11-28
15. Please note that the chart shows results only for those countries included in both studies.
16. See Appendix for a very summary outline of the healthcare provision models in different countries covered in this study.
17. The last few years have seen growing attention being paid to ways that citizens can be encouraged to change their behaviour. The tools that social marketing offers have been widely used across a range of areas. The thinking behind many of these approaches is to understand current behaviour, the reasons behind it and the barriers to change, with a view to developing ways and means to change it. Thaler and Sunstein argue in Nudge that "we can design choice environments that make it easier for people to choose what is best for themselves, their families, and their society."
18. Cohen, J. et al (2008) Does Preventive Care Save Money? Health Economics and the Presidential Candidates. N Eng J Med 358;7

Appendix – Summary outline of healthcare systems[1]

Argentina

The healthcare system is composed of three main subsectors: the public subsector (i.e., government-provided financing and services), the obras sociales (employee-benefit plans formerly run by unions and now organized by professional category), and the private subsector (prepaid voluntary insurance plans based on actuarial risk). There is a strong bias toward curative care, with emphasis on hospital services. The Ministry of Health and Social Action (MSAS), oversees all three subsectors of the healthcare system and is responsible for setting of regulation, evaluation and collecting statistics.

Australia

Australia's healthcare system is complex, with delivery provided by both the public and private sectors. The aim of the Australian health system is to give universal access to healthcare under what is known as 'Medicare', while allowing choice for individuals through substantial private sector involvement in delivery and financing. The public system is a partnership between the national, state and territory governments. The Australian Government also funds a system of private health insurance rebates that subsidize the cost of premiums to private health insurance. Every Australian can elect to be treated as a private patient in a public hospital in order to have a choice of doctor. In addition, private hospitals provide an alternative to the public hospital system for many procedures. Medicare is a compulsory insurance system financed by general taxation revenue, some of which is raised by an income-related levy collected by the Australian Government.

1 Source: WHO website, Western Pacific region website and Healthcare Systems in Transition report series (1999-2009) updated by Ipsos

Belgium

Belgium has a compulsory healthcare system based on the social health insurance model. Healthcare is publicly funded and mainly privately provided. The National Institute for Sickness and Disability Insurance oversees the general organisation of the healthcare system, transferring funds to the not-for-profit and privately managed sickness funds. Patients have free choice of provider, hospital and sickness fund. The federal government regulates and supervises all sectors of the social security system, including health insurance. Responsibility for most preventive care and health promotion has been transferred to the communities and regions.

Brazil

Brazil's healthcare system is made up of a complex network of public and private institutions. Primary healthcare remains the responsibility of the federal government, elements of which (such as the operation of hospitals) are overseen by individual states. The country's Unified Health System is exclusively responsible for providing health coverage to 78.8% of the Brazilian population, and is the primary network of public health institutions that provide, finance, and manage health services. The remaining 21.2% of the population, which are covered by the Supplementary System, is also entitled to access the health services provided by the UHS. The Family Health Strategy is the country's primary instrument for providing basic care to the population. Facilitating access to essential pharmaceutical drugs is part of basic care, and is provided through special financing mechanisms and government-owned "people's pharmacies" (farmácias populares).

Canada

Canada's publicly funded healthcare system is best described as a set of ten provincial and three territorial health insurance plans, plus the federal government, which has responsibility for First Nations and Inuit peoples, the Royal Canadian mounted police, the military and inmates of federal penitentiaries. Known to Canadians as 'Medicare', the system provides universal access to first dollar coverage for hospital and physician services that is funded out of general taxation revenues. Provincial and territorial governments are responsible for the management, organization and delivery of health services for their residents. Funding of healthcare is shared by the Federal and Provincial Governments. The Canada Health Act is federal legislation that puts in place five conditions that provinces and territories must satisfy in order to receive federal funding for healthcare services. They are: Public Administration, Comprehensiveness, Universality, Portability and Accessibility.

China

Health insurance coverage at the end of 2005 was approximately 40% - including the urban basic health insurance scheme, new rural cooperative medical scheme and other health insurances. Out-of-pocket payments constitute the majority of growing health expenditures (54%). China has a complex health financing system decentralized to the lowest administrative level with a strong reliance on service fees. More than 12 ministries or agencies administer health in China, including the Ministry of Health, Ministry of Labour and Social Security and the National Development and Reform Commission.

France

Jurisdiction in terms of health policy and regulation of the healthcare system is divided between the state, the statutory health insurance funds and, to a lesser extent, local communities. Financial responsibility for healthcare in France is mainly borne by the statutory health insurance system as a branch of the wider system of social security. Since 1 January 2000, statutory health insurance covers the whole population.

Germany

In healthcare, governments traditionally delegate competencies to membership-based, self-regulated organisations of payers and providers. Healthcare financing in Germany is characterized by a pluralistic funding system. Statutory health insurance is the major source of financing healthcare, with a small proportion of citizens opting for private health insurance.

Hong Kong

Primary healthcare services, which include a range of health-promotion, preventive and curative services, are provided by the Department of Health, the Hospital Authority and the private sector. The public sector is the dominant provider of secondary and tertiary services, with a complementary role for the private sector. The health services provided by the public sector are heavily subsidized. Health-promotion and disease-prevention activities, such as treatment of tuberculosis and childhood immunization, are provided free of charge. The private healthcare sector is financed largely by household out-of-pocket payments and, to some extent, private insurance and employer-provided group medical benefits.

Hungary

Social health insurance is the main source of public funding for the health sector. Participation in the social health insurance scheme is mandatory for everyone who works in Hungary, including the self-employed.

India

India's health sector is diverse and includes what is known as the modern system of medicine as well as multiple traditional systems. Under the Constitution, health is largely the responsibility of the states, but the Union Government finances national public health programmes which have high social returns, or which are characterized as public goods. The private sector is large and unregulated. Out of pocket expenditures at the point of service account for more than 70% of health expenditures.

Indonesia

The 2001 general decentralization process has had implications on health financing, health information systems, human resources for health and service provision. Under decentralization, the responsibility for healthcare provision is largely in the hands of regional governments. The overall health financing situation in Indonesia is complex and incompletely documented. Around 36% of total expenditure is undertaken by public sector agencies, while 64% is private. By far the largest single source of private expenditure is direct out-of-pocket payments by households, accounting for nearly half of the total expenditure. Services provided privately are largely financed by out-of-pocket payments, with some insurance and employer-financed expenditure benefiting a minority of formal sector employees. Publicly provided services are financed by a mix of public budgets and user fees, in turn financed by a combination of households, employers and insurers.

Ireland

Overall responsibility for the healthcare system lies with the Government, exercised through the Department of Health and Children (DoHC). More than 50% of the population have voluntary private health insurance. The Irish healthcare system remains predominantly tax funded, including pay-related social insurance (PRSI) and other sources of government income, such as excise duties. The remaining components of total health expenditure are from private sources, in particular out-of-pocket household expenditure on general practitioner (GP) visits, pharmaceuticals and public/ private hospital stays, as well as payments to voluntary health insurance providers.

Italy

Italy's healthcare system is a regionally based national health service (Servizio Sanitario Nazionale (SSN)) that provides universal coverage, free of charge at the point of service. Regional governments, through the regional health departments, are responsible for ensuring the delivery of a benefits package through a network of population-based health management organizations (azienda sanitaria locale, 'local health enterprises' (ASLs)) and public and private accredited hospitals. Healthcare is mainly financed by earmarked central and regional taxes. Inpatient care and primary care are free at the point of use. There are two main types of out-of-pocket payment. The first is cost-sharing: patients pay a co-payment for diagnostic procedures, specialist visits and some pharmaceuticals (in some regions). Since 2007, a fixed co-payment has been levied for unwarranted access to hospital emergency departments. The second type of out-of-pocket payment is direct payment by users to purchase private healthcare services and over-the-counter (OTC) drugs.

Japan

The basic principle governing the delivery of healthcare services is that all citizens should be able, at any time and place, to receive the care they require, with an affordable personal contribution. It combines a mainly private provision of services with mandatory health insurance.

Mexico

Mexico's health system has three principal providers: the Secretariat of Health (SSA), Social Security (Mexican Social Security Institute (IMSS) and the Social Security Institute for State Workers (ISSSTE)), and the private sector.

Norway

The Norwegian healthcare system is organized on three levels, i.e. national, regional and local levels. It is primarily funded through taxes. The municipalities have the right to levy proportional income taxes on their respective populations, while the regional health authorities must rely on transfers from the central government. Block grants provide the primary source of funding, but the financing of healthcare services is also supplemented by state grants, earmarked means and some user charges.

Poland

As a result of recent reforms, the Polish healthcare system is now decentralized and universal and compulsory health insurance have been introduced. A National Health Fund centrally pools and distributes funds within the social insurance system. The Fund with regional branches is also responsible for contracting out health services. The system is oriented towards primary care services, which strengthen the function of family doctors as gatekeepers. Outpatient services in specialist healthcare centers and hospital treatment are provided on the basis of a referral from a family doctor, with the exception of services provided by selected clinics. Patients are entitled to a choice of any service provider, private or public, registered as approved providers by the Fund.

Russia

The healthcare system follows the administrative structure of the country and is divided into federal, regional (oblast-level) and municipal (rayon-level) administrative levels. According to the Constitution of the Russian Federation, the state is to be responsible for the regulation and protection of human and citizen rights and freedoms, and the federal and regional levels are to be jointly responsible for the coordination of healthcare issues. There is a compulsory health insurance system, funded by obligatory medical insurance payments made by companies and government subsidies.

Saudi Arabia

The Saudi state provides primary healthcare services and referral secondary care all residents. Currently, hospitals consume c60% of the Ministry of Health budget, but there are moves to give hospitals independence and guide the role of the Ministry of Health towards policy setting, purchasing equipments, monitoring and evaluation.

Singapore

There is a dual system of healthcare delivery. The public system is managed by the Government, while the private system is provided by private hospitals and general practitioners. The Government heavily subsidizes public healthcare for Singaporeans. At the same time, patients are expected to co-pay their medical expenses. To help Singaporeans to pay for their medical expenses, the Government has put in place a financing framework, which includes a national savings scheme, compulsory for workers.

South Africa

The Constitution outlines a cooperative system for the health sector constituted as national, provincial and local spheres of governance which are distinctive, interdependent and interrelated. South Africa's health system consists of a large public sector and a smaller private sector. Healthcare expenditure through the Department of Health was less than 50% of total expenditure in 2006-2007, despite providing care for more than 80% of the country's population relative to the private healthcare sector.

South Korea

South Korean citizens are entitled to healthcare benefits through either National Health Insurance (NHI; 96% of the total population) or the Medical Aid programme. The NHI is operated by the Ministry for Health, Welfare and Family Affairs, the National Health Insurance Corporation (NHIC), and the Health Insurance Review Agency (HIRA). The Ministry for Health, Welfare and Family Affairs is in charge of supervision and management of the overall operation of the NHI, while the NHIC oversees everyday tasks. The HIRA reviews healthcare benefits and evaluates healthcare performance, independent of insurers, providers and other involved parties. The finances of the NHI mainly comprise contributions from the insured and their employers, along with government subsidies, including the National Health Promotion Fund. For the self-employed, contributions are calculated per household unit, and the amount is determined by considering the insured person's assets and income, as well as other factors. The Government subsidizes healthcare benefits and the operation of the insurance programmes for the self-employed.

Spain

Central government has the responsibility for promoting coordination and cooperation in the health sector. From 1986, the transition to a National Health System involved a reform of financing, which has transformed the former insurance-oriented system into a system financed by taxes, with almost universal coverage. The decentralization reform was completed in 2002 which resulted in governance of the system being decentralized to all 17 autonomous communities.

Sweden

Sweden's healthcare system is decentralized, with county councils responsible for supplying healthcare and ensuring access to adequate care for all citizens. The system is financed through county council taxes, patient charges and the sale of services. In addition, there is state support in the form of general central government grants and targeted grants to increase access to care and to pharmaceutical benefits.

Turkey

Health services disbursement agencies have been merged within the framework of the "Health Transformation Programme". Healthcare is provided by public, semi-public, private and philanthropic organizations, including the Ministry of Health (MOH), universities, the Ministry of Defence and private health professionals. Provincial Health Directorates (81 provinces) are responsible for service planning and provision at provincial level. In 2007, legal measures mandated that all citizens of Turkey would have access to free primary care, even if they are not covered under the social security system.

UK

The National Health Service (NHS) is the world's largest publicly funded health service. It is financed mainly through central government general taxation together with an element of national insurance (NI) contributions. The remainder of NHS finance is raised through user charges – mainly charges for pharmaceutical prescriptions and dental charges; and from other miscellaneous sources. All persons normally resident in the United Kingdom are eligible for services through the NHS.

United States

The United States does not currently have a universal system of healthcare coverage. There are federally funded programs, the two biggest being Medicaid (covering those on low incomes) and Medicare (covering the elderly and disabled with a historical work record). However, private, employer-sponsored insurance is the primary source of insurance in the United States, covering more than 60% of Americans. According to the US Census Bureau, around 15% of Americans had no health insurance in 2007.

For more information on the issues raised in this report or the Ipsos Social Research Institute's municipal research, please get in touch with the authors of this report, or any of the contacts listed below.

Bobby Duffy
bobby.duffy@ipsos.com

Anna Quigley
anna.quigley@ipsos.com

Kate Duxbury
kate.duxbury@ipsos.com

REGIONAL CONTACTS

Global Chief Executive Officer
Darrell Bricker
+1 416 324 2001
darrell.bricker@ipsos.com

Global Director and Europe
Bobby Duffy
+44 20 7347 3267
bobby.duffy@ipsos.com

North America
Clifford Young
+1 312 777 3911
clifford.young@ipsos.com

Mike Colledge
+1 613 688 8971
mike.colledge@ipsos.com

South America
Alfredo Torres
+511 610 0100
alfredo.torres@ipsos.com

Asia-Pacific
Ben Barnes
+61 2 9900 5100
ben.barnes@ipsos.com

Middle East and Africa
Rahif Kayal
+961.1.494136
rahif.kayal@ipsos.com

Mari Harris
+27 11 686 8458
mari.harris@ipsos.com

Ipsos Social Research Institute

The Ipsos Social Research Institute works closely with international organisations, national governments, local public services and the not-for-profit sector. Research staff focus on issues of fundamental importance to the world's policy-makers and citizens. This, combined with our methodological and communications expertise, ensures that our research makes a difference for decision makers and communities worldwide.