contact

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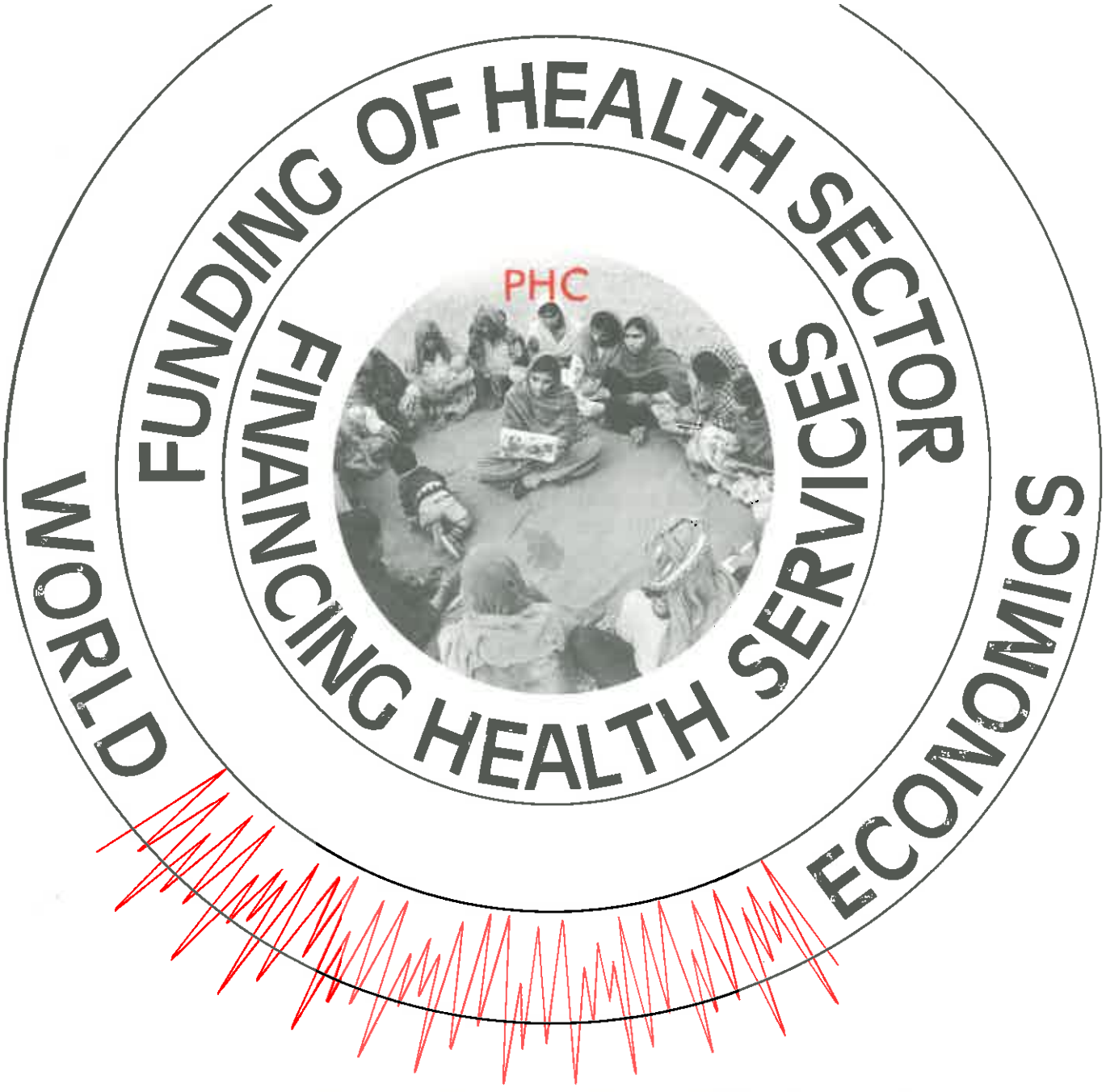
FINANCING PRIMARY HEALTH CARE PROGRAMMES



Can they be self-sufficient?

FOREWORD

I wish to express my deep gratitude to Mr. Victor H. Vaca, the principal author of this study, who has worked laboriously for several years, making field trips to Indonesia, the Philippines, Papua New Guinea, India, Brazil and Central America, interviewing PHC directors and other health workers, church people, and community organizers, in order to collect data, analyze the situation, and provide insights into their complexities. Many thanks are also due to Drs. Sidney and Mildred Kreider, who assisted in updating and collating additional information.

Eric R. Ram, Ph.D.
Director
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INTRODUCTION

Christian churches in developing countries have led the way in establishing development and health programmes in partnership with communities. By combining the resources of the community, the country and donors, often very imaginatively, primary health care (PHC) programmes have succeeded in improving the level of health while increasing the community's sense of self-confidence and self-reliance.

In 1977, the Christian Medical Commission undertook a study of the costs and financing of church-related community-based primary health care efforts, in an attempt to assist Christian churches to find ways of financing an equitable and continuing community health care system. The research was initiated due to frustration in implementing PHC programmes among the NGOs, particularly as they seldom seemed to attain self-sufficiency. After several years, many difficulties associated with the study became apparent. As such, it has taken much longer than anticipated to complete. And through the process of seeking answers, new questions have emerged. However, during this time more PHC projects were developed in which increased consideration was given to costs and financing.

Questions of community self-reliance remain as important now as ever. Indeed, the future existence of some church-sponsored programmes is dependant on finding a resolution between continued external funding and community self-reliance.

Christian churches are not alone in their concern for costs and financing. The World Health Organization has attempted to focus the attention of governments and other international organizations on the urgency of this matter. Information now being published helps provide an understanding of the context within which church programmes may be sponsored at the local level.

Cover: UNICEF Photo by T.S. Nagarajan, India.

Influences on costs and financing of Primary Health Care (PHC) seen as a ring of concentric circles by Hakan Hellberg, former Director of Health for All Strategy Coordination of the World Health Organization and former CMC staff member.

FINANCING CHURCH-RELATED COMMUNITY-BASED PRIMARY HEALTH CARE *

by Victor H. Vaca, M.A.
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PURPOSE OF STUDY

A. To identify the factors which influence financing and costs of community-based health care programmes – and to see how they operate in selected local programmes;

B. To exact those principles that would permit new initiatives to profit from the accumulated experience of already established PHC programmes.

There is little published information which gives a complete picture of the costs and methods of financing local PHC programmes. Financial information tends to leave many questions unanswered, although a recent extensive study on community financing, issued by the American Public Health Association, which reviewed over a hundred projects world-wide, may serve to encourage more systematic assessments of this important area.

This article, while raising as many questions as it answers, will hopefully provide a useful basis for further study and research. With time, the unanswered questions may receive satisfactory answers as PHC programmes continue to share the benefit of their experiences.

Following Vaca's reports, the next phase of the study was initiated in September 1985, by group discussion of a series of focused questions with CMC staff. Then a review of related resources provided by the CMC and WHO libraries was conducted. Resources in the DIFäM archives and library in Tübingen were also made available. Current and former CMC staff members were interviewed, as were other selected resource persons. An outline was developed to analyze financing of primary health care programmes. Field posts were selected and individuals knowledgeable about the effort in each case were asked to supply more detailed information, either through personal interview or by mail. A total of 14 case studies from 11 countries were reviewed.

WHY IS THERE A LACK OF DATA?

Meetings with directors of community health projects in South America revealed that people did not usually follow up-to-date and accurate book-keeping methods. Almost all

UN Photo, Philippines.

Unless directors of PHC programmes attempt some financial analysis of their services, "affordable, accessible and appropriate" remain unproven slogans.

* *a study prepared for the Christian Medical Commission, April 1987.*

lacked statistical information on the results of their projects.

Among justifications for this lack were statements such as:

"We're not working to fill out forms and show statistics."
"Our job is to educate and promote people."

This seems to be a common attitude among project staff, and understandable when they tend to be working under great pressure against considerable odds. Health workers are not trained as economists or accountants and few projects have the money or inclination to employ such outside people. It is not surprising that questions of financing sometimes never go beyond the short-term problems of obtaining funds and supplying satisfactory accounts to donors.

Another reason may lie in an ideological objection to applying the hard questions of economics and cost-effectiveness in situations where the humanitarian motive is very high. Primary health care, with its emphasis on participation and practicality, has an inherent resistance to conventional economic analysis. Yet this resistance may only serve to cloud understanding of some very basic principles of PHC. It is commonly applauded as affordable, accessible and appropriate, but unless those who run PHC programmes attempt some financial analysis of their work, the 'affordable' aspect will remain an article of faith, unsupported by hard evidence.

SELF-RELIANCE BUILT INTO COMMUNITY-BASED HEALTH SERVICES?

We propose a "working definition" of self-reliance, indicating general principles and directions around which the discussion on financing of primary health care could be focused. Self-reliance is taken to mean development processes which include all or most of the *following objectives:*(*)

	INDICATORS of the degree to which self-reliance is being achieved:
1. Priority on producing for and meeting the basic needs of all members of the community by that community.	– A community or an organization with a strong degree of self-reliance would be quite AUTONOMOUS in its decision-making and its activities – as opposed to being dependent on the decisions or actions of others.
2. Maximum initiation of development by local people, and full participation of the people in all phases and aspects of the development process.	– A self-reliant community or organization would develop many SELF-SUSTAINING activities. It would be increasingly able to maintain itself and its development largely through its own efforts, capacities and resources – as opposed to activities being continually externally sustained.
3. Priority focus on the development and optimum use of local resources, structures and processes. Encouragement and care of local initiative, creativity, knowledge, skills and culture.	– A self-reliant unit would be substantially SELF-REGENERATING. It might receive and require some external inputs, but it would generate energy, direction, ideas and new resources internally too, and these would be the vital element.
4. Reduction in the need for relationships based on dominance or dependence between sectors and groups involved in development.	– A self-reliant group would relate to other groups as EQUALS. It would see itself as a PARTNER – as opposed to being 'receiver', or indeed, a 'giver'. It is likely to have a strong sense of PURPOSE and clear IDENTITY, which will be broadly based among all or most of its members.
5. Maximum sharing of both the benefits and costs of development at all stages and across all sectors and levels of society (global to individual).	
6. Promotion and support of local social institutions – especially strengthening of the family and cohesive communities.	

Self-reliance is a concept that is concerned with the inter-relationships between economic, political, cultural and geographic dimensions. We cannot measure degrees of self-reliance in financial terms alone. It is neither self-isolation, nor the narrow or competitive pursuit of self-interest. Self-reliance is the basis for interdependence and collaboration, which requires a framework of equitable partnership in order to be sustainable.

Self-reliance is not just 1 factor in development, nor even 1 goal. Self-reliance is a total approach – it is both the end and the means to social development, which seeks to create the widest opportunity for all people to realize their full potential.

(*) *"Self-Reliance in Social Development", International Council of Social Welfare, Austria, December 1986.*

A local community which consciously strengthens its self-reliant capacity will find that although it may sometimes lose donor support, it will generally have more security and be able to choose whether or not to accept offers from donors. It can accept or reject grants based on **its priorities,** not the priorities of the donors. On the other hand, a donor agency will find that more self-reliant local communities are likely to be more effective – they will achieve self-sustaining results. Results may be slower to appear but they will be more lasting because they have stronger and deeper organizational support. Properly approached, working for self-reliance will create much greater understanding and trust between agencies and communities. Possibilities for collaboration will increase, and working together will become easier and more fruitful. A support agency taking a self-reliant approach to working with communities will find its own support base strengthened and therefore its own capacities will increase. Relationship is stronger between equal partners and mutual learning becomes possible.

HOW WORLD ECONOMICS TOUCH THE VILLAGE

The funding of the health sector has been greatly affected by the world economic situation. (See cover illustration). In developed countries, influences on the spiralling costs of health services have been examined and measures to control costs implemented. Within the developing countries, real income available for the health sector has diminished at a time when these same countries are being encouraged to expand the health care of their citizens.

The resource gap to meet the goal of Health for All is now estimated at US$50 billion for the developing world as a whole – more than 14 times the current amount of external assistance for health.

Financing of health services has, in turn, been profoundly influenced by the funds available for the health sector. Developing countries have made commitments to primary health care, but are caught in a conflict between using scarce resources to continue existing services, or using them to expand into new primary health care services. While less expensive over time than hospital-based services, the costs of **establishing** and **continuing** primary health services **for a country** are substantial. Transferring large sums of money controlled by "professionals" (from services provided for the visible and vocal), to "non-professionals" (for services provided for distant "powerless people") is hampered at the national level by political difficulties.

SOURCES OF FINANCING

Within this context, primary health care is funded by government sources, by community effort and by charitable donations. The resources available in each of these areas is determined by the overall level of development within the country and the forces identified in the preceding paragraphs. The establishment of innovative programmes among the rural poor has been achieved largely through substantial support from churches and other donor agencies, sharing their economic resources from more developed countries.

A. Government

Government sources provide major funding for total health services within a country. Low income developing countries report government expenditure of US$1 – 7 per person per year (average $2.50). This is .006 to .025 of the GNP of these countries and from .015 to .110 of all government expenditures.

Governments hope to provide for all levels of health care with these funds, including primary health care. Many Latin American countries levy taxes on items such as alcohol and cigarettes for health revenues; but too much of the health spending goes to the military and police who represent only 5-11% of the population. Established hospital services get the lion's share of funds. (Of 4.5% of the GNP Brazil spent on health in 1979, 90% was on curative care). As noted earlier, forces within society discourage the development of new "unproven" services at the expense of established services of "proven" value.

Practically every Latin American health ministry has a slogan such as: "The health of the people is the supreme law", but evidence indicates that PHC has had little impact on the neediest communities.

In a number of countries, churches and governments work together to provide more equitable health care for all citizens. There are 3 popular ways this cooperative enterprise is taking place:

1. Major responsibility rests with the Ministry of Health, which provides major financing and direction. Churches and church-related organizations identify, recruit and support personnel, and mobilize community support.

2. Major responsibility rests with the church-related agency, which provides direction and obtains financing through community mobilization, fees for established services and donor support. The government provides limited funds for training community health workers, provision of equipment and pharmaceuticals, or grants for delivery of specific services.

3. Governments allocate funds for church health services. The financial burden of the service is then carried by the programme, the community and the government. In Papua New Guinea, (a) the church's medical health services were part of the national health plan, (b) a church/government liaison officer was appointed by the Church Medical Council and paid by the government and (c) the national government financed approximately 50% of the total health expenditures of the church health services.

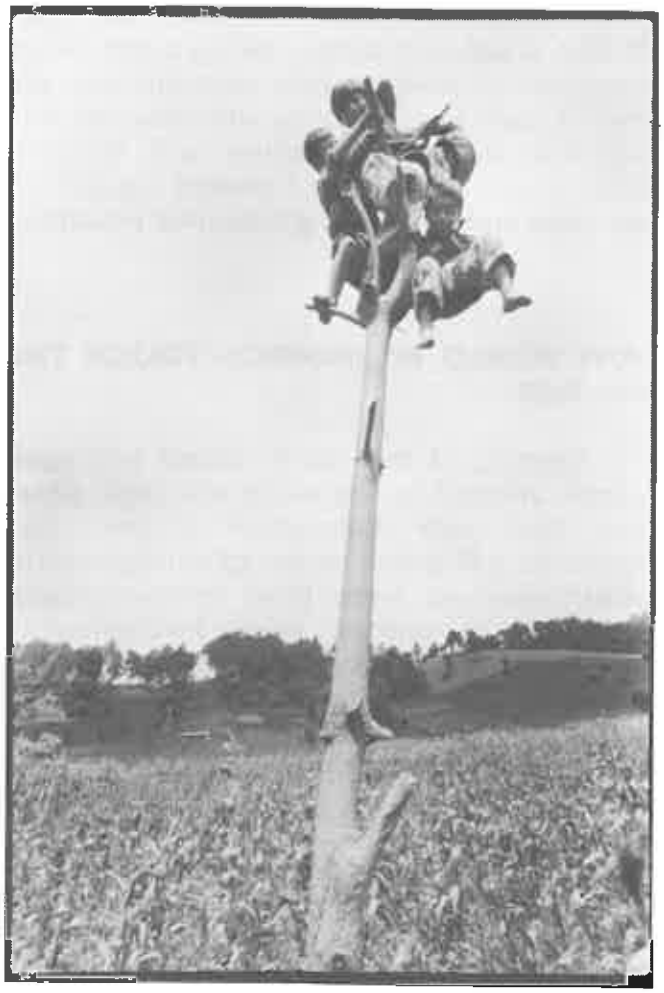
B. Community

An integral part of the definition of primary health care provided by the Alma Ata Declaration is "... at a cost the community and country can afford". That these services become self-supporting as soon as possible is a goal in their establishment. Arguments for and against community financing of primary health care abound.

ARGUMENTS

FOR:

"Advocates of community financing argue that it is a largely untapped resource and may be the only feasible way of overcoming the lack of funds for primary health care. Existing government financing is closely tied to secondary and tertiary care and would not be adequate for primary health care – even if it could be shifted – in face of the massive population growth now occurring. Community financing uses readily available non-monetary resources, such as labour and local produce. It increases community self-reliance and organizational ability for both health and other problems. It is the key to community participation and its advocates say that this is reason enough to encourage it – even if other funds are adequate. The impressive experience of China is often cited."



WCC Photo, Guatemala.

Does community financing mean that PHC becomes *independent of* or *cut off from* outside support?

AGAINST:

"Opponents of community financing argue that it places the burden of financing health care on the people least able to support it, namely the rural and urban poor and others

without access to existing facilities. Health care is a 'public good' and should, therefore, be nationally financed. It improves productivity, contributes to reduced birth rates, and has given people the sort of hope for the future that is essential for development. Community financing is particularly inequitable in countries that provide free services in political influential areas. Community financing is largely untested outside revolutionary China and a few small sponsored projects. Its development costs may be high because of initial failures and the need to mobilize thousands of individual communities. Community financing, its opponents argue, is not the solution its supporters think, but rather a diversion for governments lacking the political will to generate new national resources or to reallocate existing ones."

Stinson

Many programmes rely on the volunteer services of Village Health Workers (VHWs). Without this form of community involvement, the programmes would not exist. However, some question the use of volunteer workers. In one parish in the Diocese of Pernambuco, Brazil, the nurse running the post said, "... this is another way of exploiting the poor. It is true that sometimes the people give some vegetables, eggs, or a few cruzeiros, but the health agents should not live on public charity. These agents maintain their commitment to the work because of their great faith in God and love for their neighbour, and because they are convinced that they are raising the social conscience of the people."

How to pay for VHWs is the most common worry for programme planners. Using volunteers is an obvious solution, but seems to be adequate for only part-time, low-level health care. If workers receive small financial rewards from service fees and drug sales, more curative work will develop. Resolving the problem of appropriate incentives for community health workers appears to be a priority.

Programmes vary in their practices for remuneration of village health workers. In some programmes VHWs are paid directly by fees and donations collected from the community. This results in the VHW being dependent on the local power structure. In this setting, he/she may be reluctant to actively work towards changes within the community which are necessary to improve health, but which are not approved by the power structure. In addition, individuals paying the VHW may expect special services in return. For these reasons, some programmes advocate paying the VHW from a central PHC programme source.

PHC requires financing from a variety of sources to ensure its viability, so we shall compare and assess the various methods of community financing, attempting to answer:

- To what extent has community financing occurred?
- What resources are communities providing?
- What are the factors which influence the community's ability to provide resources for its primary health care effort?

METHODS OF COMMUNITY FINANCING

1. Payment for Services Obtained

Individuals in communities are frequently able and willing to pay for curative services. Payment is usually based on the individual's ability to pay. Depending on the structure of the PHC programme, fees may be collected by the hospital, the dispensary or the village health worker.

- In the **Lardin Gabas Rural Health Programme, Nigeria,** the village health committee collects fees and pays the village health worker her salary from this money – a salary which is not guaranteed.

- The dispensary in the community health programme of the **Hôpital Albert Schweitzer, Haïti,** collects fees which cover 57% of its running costs. Village health workers are paid out of the hospital budget.

- At **Jamkhed, India,** fees are collected at the hospital from in- and out-patients, leprosy patients, x-rays and lab tests. This provided 71% of the income for 1983, covering 65% of the total operating costs for that year.

The income from curative services may be used for preventive work. Experience in industrial and developing countries has shown a reluctance on the part of consumers to pay directly for preventive care.

2. **Prepayment Plans (insurance schemes)**

– In the State of Pernambuco, Brazil, roughly half of the agricultural workers voluntarily affiliate with the Rural Workers' Trade Union. However, weekly dues are a hardship to many and equal the cost of 2 weeks of milk for the average family. With the dues money, the union finances educational, legal, health and social activities, including assistance in the development of a rural "mini-health post" though purchase of materials not available in the community, 1 physician to make a monthly visit, and training costs of health agents. The union assisted in financing the construction of a community centre, and paid 40% of the salary of a teacher of nutrition and sewing who was employed by the community.

– An early community-based health insurance plan which has endured was developed by Christian workers in Central Java. *Dana sehat,* begun by Dr. Gunawan Nugroho and colleagues in 1973 in a community in Solo, Indonesia, provided funds for health care and community development activities from its beginning. After being in operation for 18 months, 46% of the total health costs of the community were found to be financed through this health insurance plan. A small monthly fee was collected from each family, about 0.5% of their monthly income, considerably less than the amount people spent for herbal medicine and cigarettes.

In return for this contribution, a family with up to 3 or 4 children was eligible free of charge for: preventive activities of health workers, clinic visits, treatment of communicable diseases, medicines and in some cases, minor surgery. Maternity care and hospitalization were not included.

– The **United Mission to Nepal** has assisted the national primary health care programme there by promoting a local health insurance plan, designed to raise income to provide needed pharmaceuticals at health posts. In Nepal, free care for all is the policy in government health institutions. But the standardized drug supply, which is not modified to the size of the population served, or the specific needs of the geographic region, is inadequate and leads to interruption of services, frustration among the staff and public lack of confidence.

– Dr. Sigrun Møgedal described how district coordinating health committees in **Lalitpur District, Nepal,** initiated a family subscription scheme to raise funds which varied from Rs 12 to Rs 25 per family per year. Benefits included free medical services and drugs at the health post throughout the year and subsidized care at the base hospital when referred. This insurance scheme seeks only to provide funds to supplement curative services at the health post level and does not support comprehensive community health efforts. Some parallels in cultural traditions were found, such as sharing costs for temple rites. Dr. Møgedal reported that it was in keeping with Hindu philosophy: *if one got sick, one immediately got the benefit, whereas if one did not get sick, this was in itself a gift, and the contribution made to the insurance scheme would not be lost but go toward helping others.*

– Insurance plans designed to cover costs of curative care may be used as an incentive to increase community participation in the total

WCC Photo by John Taylor.

Haiti.

WCC Photo

Nicaragua.

health programme. In 1974, the **Raigarh-Ambikapur Health Association (RAHA)** in Madhya Pradesh, India was organized to coordinate the activities of all the health services run by different institutes of Catholic sisters in the Raigarh-Ambikapur Diocese.

The objectives of the scheme, in operation since 1980, are: (1) to facilitate essential medical care to the rural areas on a cooperative basis, so that the costs of treatment of illness or injury which could economically devastate the afflicted family are borne lightly by the community, (2) to act as an incentive to increased participation by the people in the total health programme, (3) to enable the base hospitals to more effectively provide care for all, including the poorest.

Initially RAHA, through donor funds, promised to match every rupee contributed by the people. In the first year several health centres decided on Rs 1 per person per year and had a fairly good response (about 10,000 members). The success stimulated other centres to try the same approach. The health centres felt a need for common directives and together fixed a minimum of Rs 2.50 per person per year, to begin to cover expenses. Membership grew to 37,000 in 1983. In 1986, the development director of this programme reported that the medical insurance scheme collected 2 kilogrammes of rice per person per year. It now gives near free treatment at the health centre level and hospital referral treatment at a nominal cost of Rs 100 (not including food and transport). He reports that when 2/3 of a community take part, and prevention is stressed in a spirit of solidarity, the programme can be fully self-supporting.

3. Payment in Labour and Kind

Community donations in labour and kind take many different forms:

- In Ghana, a local factory provided paint and manpower to paint the walls of the community health facility. Another company donated linen.

- In Piaxtla, Mexico, a system was developed in which patients or their families contributed either cash or 2 hours of field labour to the clinic in exchange for each consultation. Income from the agricultural effort was used to finance health activities.

- The Apayao Community Learning Centre Health Programme in the Philippines exists solely thanks to the community's donated labour in health care activities. Begun by 1 volunteer nurse, the programme now coordinates the activities of 25 VHWs. Local communities are planning some remuneration for health workers in cash or kind. At present, they receive assistance with farm work.

- The Saradidi Rural Health programme, Diocese of Maseno South, Kenya, began when a local physician gave part of his land and much of his time to starting the programme. A volunteer village health committee selects workers to serve the community on a voluntary basis.

It should also be noted that community participation where financing is concerned is often

induced – occurring because the participation of others has already facilitated change. For example, a supply of clean water may include participation by the community through unpaid labour and the gathering of stones and sand. Yet this is unlikely to occur without the piping system having come from outside the community.

4. **Payment from an Income-Generating Activity**

Many health programmes are part of a larger integrated development project, which provides opportunities for productive (income-generating) activities to finance those which are not self-supporting:

– Land held in common may generate health funds: In Paraguay in 1980 a former nurse donated her property to a very poor community of 35 families for the raising of pigs and chickens. Minimal programme costs were financed 60% by the community, 40% by the local church. The purchase of medicines proved the most difficult financial problem, as was payment in labour: Many people lacked time to devote to the programme, already having a heavy workload. In Jamkhed, leprosy patients are given a goat, together with training and assistance in its raising. The animal's first kid is given to another leprosy patient and family.

– To combat malnutrition in Haïti, the Hôpital Albert Schweitzer has been running agricultural projects for 25 years. Income generated is cycled back into continuing projects.

5. **Other Activities**

Fund-raising for specific one-time costs and the sale of drugs (aimed at a profit to provide income for health workers or capital for new activities) are other methods of financing.

C. Outside Donations

Developing countries collectively spend an estimated 14 billion US dollars on the health sector annually, with official donor agencies and NGOs contributing an additional 3 to 4 billion dollars.

Denominational and ecumenical church agencies in industrialized countries have formed partnerships with planners in developing countries to support PHC efforts. Current estimates put the level of support at 100 million US dollars each year from Protestant Churches (1200 programmes) and 200 million dollars from Roman Catholic Churches (2000 programmes).

Although there have been few systematic reviews of donor policies and priorities regarding support of PHC, the following emerges from a *representative number of major donors* who have demonstrated their commitment to promoting PHC:

- *They provide assistance to national church organizations working in poor communities, in the form of funds, personnel, equipment, materials and pharmaceuticals.*
- *They include in their statement of objectives less dependence on outside help by the recipients, usually in a relatively short time.*
- *They wish to see joint planning with the national government to ensure long-term integration and coordination with national programmes.*
- *They provide capital starting costs and support volunteer activities. Comparatively few express willingness to continue support for training or running costs over a prolonged period.*
- *They recognize the risk of excessive and inappropriately timed outside support as being oppressive and serving to reduce the possibility of the community achieving self-reliance.*

Role of Supporting Institutions

PHC programmes sometimes evolve from "extension" work of an established health institution, such as a hospital. The case study of Bethesda GMIM Hospital (Dinas Kesehatan GMIM or GMIM Health Service), Indonesia shows that this can provide an important contribution to total financing if commitment and recognition of mutual interest are apparent.

This seems to be a largely untapped resource which merits further investigation. (Please see Programme Analysis, page 11.)

Components of a Primary Health Care Programme which Influence Costs and Financing

Costs of *local* or *regional* community-based *PHC programmes* are considered to be determined by the *services* offered, the *personnel* and the *equipment, pharmaceuticals, facilities and transportation* required to provide these services. Full determination of the costs of the programme involves considering both *initial* and *recurring* costs in each of these areas.

1) Services

As a matter of principle in a community-based programme, decisions cannot be based solely on immediate cost or cost-effectiveness criteria. In a community-based programme, the services offered reflect the priorities and emergent needs of the community. Determining the community's priorities and needs involves dialogue with and assessment of the community. Associated with these activities are expenses.

2) Research

Community needs may be identified in different ways, depending on the structure and resources of the community. The Pastoral of Health of the Goias Diocese in Brazil in 1979-80 initiated research because the community expressed an interest. The study group, composed of community members, a physician and a sociologist, set out to identify individuals from within the community who could serve as researchers and interviewers. The Pastoral asked CEDI (Ecumenical Centre of Documentation and Information) to help design the study and prepare the investigators.

The team of investigators was composed of 3 washer-women, 1 student, 1 sociologist, 7 peasant workers, 3 housewives, 3 health workers, 1 domestic worker, 1 physician and 1 anthropologist. A questionnaire was administered to families and community groups, rather than to individuals. The direct cost of the study was approximately US$1200 in 1979-80, and was estimated to be 16 times less than it would have been to pay a technical team. The diocese, the parishes and the communities financed the mobilization of the investigating teams. The communities visited paid for the team's meal.

> The information obtained from the study allowed the Pastoral of Health to build a successful programme of care because it was based on community **needs,** which were obtained through community **action.**

This principle of maximum involvement and partnership among project planners and the community is vital to lay the foundation for a programme which moves successfully towards self-reliance. There are direct and indirect costs associated with the implementation of this principle and it is essential for projects to include funds for these assessment activities in community-based programmes. The information needed from a community assessment is discussed in **Contact** No. 40 (August 1977), "Making the Community Diagnosis". The February 1978 issue, No. 43 on "The Planning Dialogue in the Community: Development of a Community Health Programme (Major Steps)" is also very helpful.

3) Personnel

The development and support of competent administrative leadership in PHC projects is critical, and related costs of local leadership should enter into a determination of total costs.

In the February 1973 issue of **Contact,** a letter to the editor emphasizes that the director of the programme need not be a physician – in fact, while the physician is extremely valuable as a consultant, he/she may be at the end of the "wanted list" for leaders. The letter goes on to note desirable qualities: "The man or woman should be familiar with the local situation, be politically aware and astute, have good economic sense, be evangelistic, be culturally sensitive, be sociologically sound, be experienced in personnel management, be flexible, be an educator, be a nutritionist, be a decision-maker, and be familiar with basic health principles".

Oral and written reports in many instances make reference to the importance of a particular person to the success of a project. Some claim that the accomplishments of a project are due solely to 1 individual.

Many Academically-Trained Workers?...

The ratio of *academically trained* members to total primary health team membership varies from project to project. Depending on the programme to be offered, access to a physician, nurse, nutritionist, educator or others may be essential. Decisions made about the quality of care, and scope and delegation of services, determine the number and function of academically trained personnel.

WCC Photo, India.

Many* academically trained workers... *or not?

For example, Sibley, in discussing the financing of the Kojedo Community Health Programme in rural Korea, emphasized the importance of quality care. Poor quality leads to loss of credibility and decreased utilization. He stated that the results of using needed PHC services less can be as disastrous to the health of a family as a serious mistake during highly complicated surgery in a major hospital. For this reason, members of this project felt it necessary to maintain a relatively expensive ratio of nurses to village health workers. The health team responsible for the 50 villages in the project's 2 townships (population 23,500) consisted of 1 specially trained community health nurse, 1 nurse midwife and 9 VHWs. *(Editorial note: This project is no longer in existence).*

... Or Not?

Others argue that high numbers of academically trained workers are *not necessary to maintain quality care.* Through continual training and delegation of responsibilities to the village level, Jamkhed personnel report they are able to maintain quality care at a cost the community can afford.

Generally, as the amount of care provided by academically trained members of the PHC team increases, costs rise. It is important to note, however, that as primary health care is successfully continued over time, priorities will change, the mix of personnel necessary to meet needs may change, and costs of services may change.

Members of the Comprehensive Rural Health Project, Jamkhed, stated their conviction that the *village health worker* is:

"the vital link between the health team and the people of the community, an essential member of the health team, and more effective in bringing about change than any other member of the health team".

In 1982, within the Jamkhed project area, 78% of the patients were treated by VHWs and only 8% at the medical centre. Of the children under 5, 94% were treated by the VHWs and only 1% at the medical centre.

4) Pharmaceuticals

Pharmaceuticals have traditionally been viewed as consuming too large a share of resources in PHC, and agreement on a limited number of essential drugs has been a welcome development. The WHO has made progress in promoting this concept over the past decade, resulting in a reported reduction of pharmaceutical cost of as much as 70% in some areas.

Several examples exist of communities developing their own pharmaceutical product capacity in order to reduce cost. The June 1983 issue of **Contact** discusses programmes in Lesotho, Nigeria, Rwanda and Sierra Leone which are directed towards **"Strengthening and Regulating the Supply, Distribution and Production of Basic Pharmaceutical Products."**

5) **Facilities and Equipment**

Many primary health care projects have found themselves competing with established hospitals for scarce resources in developing countries where curative care has traditionally taken a large share of the resources. Costs may be moderated where the relationship between the 2 systems is mutually supportive. Such cooperation recognizes the hospital's dependence on community units for appropriate referral and information sharing, and the primary health team's dependence for back-up support and care of selected cases. In many instances, the PHC team assists in providing income for the hospital by appropriate referral of individuals, some of whom are able to pay for the costs of the curative care they receive. In turn, the hospital income provides financing for primary health care activities in many integrated programmes.

Equipment needs in PHC provide another opportunity for financial innovation and resultant increase in programme effectiveness. Numerous examples of such innovation are found in the WHO publication **Appropriate Technology.**

6) **Transport**

A cost frequently underestimated in planning for PHC has been the *transport* of both patients and health care staff. Even with careful distribution of village health centres, the cost for travel may be substantial. Concerns about increasing fuel costs are expressed in many programmes.

Studies of efforts to provide mobile health services have proved to be enormously expensive, although those persons unable to reach fixed posts have benefited. In addition, meaningful community input may be quite difficult to assess. Nevertheless, the limited use of mobile teams for specific services such as immunization has been successful.

Programme Analysis

All the case studies provided useful descriptions of their programmes, together with sources of financing and amounts and percentages spent on various activities. The GMIM Programme, Indonesia, however, provided a highly-detailed breakdown of their work and costs, together with an analysis of findings based on their experience. We have included this in detail, not only for its intrinsic interest, but as an example of how to set about looking at PHC programme's financing in a systematic way.

GMIM Health Services' Support in Primary Health Care Services, Indonesia (*)

The Bethesda GMIM Hospital is the centre of the GMIM Health Service and is located in Tomohon, at the northern tip of the island of Sulawesi, Indonesia. The area served covers about 5,000 square kilometres, and is inhabited by some 1.1 million people.

The hospital started its involvement in PHC in 1974 by surveying the needs of a nearby village. Small-scale activities began in 1 village quarter just a few steps away from the hospital. The programme developed slowly until 1979, and from 1980 onwards, saw rapid growth both in activities and in geographic area covered.

In addition to the survey's results, the availability of suitable staff also determined programme priorities. For example, in the first years an agriculturalist was available to help promote agriculture and livestock breeding. Later, the programme was able to offer a greater variety of services. After introducing

(*) *Taken from a detailed case study provided by Dr. B.A. Supit, Executive Director of Bethesda GMIM Hospital (Dinas Kesehatan GMIM) and CMC member, based on research done by Dr. H. Lems, Economist of the GMIM Health Service/Hospital staff. See CONTACT # 90 (April 1986) for futher information.*

Indonesia.

Posters used for family planning motivation as part of GMIM Health Services.

the philosophy and principles of PHC and training VHWs, it has been the village itself that decides on priorities for their programmes.

New VHWs, or cadres as they are called, with the technical assistance of the PHC staff, usually conduct a village survey on health nutrition, sanitation, etc. Findings are presented in village meetings, from which decisions on programme priorities stem. Planning is then a matter of formal village structure, with technical and motivational support of PHC staff to varying degrees.

The programme as a whole has been largely responsible for new services like tuberculosis control, training of traditional birth attendants, family planning, a credit union, and, in a later stage, safe water supply and treatment of simple illnesses.

Personnel

Twenty-four full-time staff are employed in this programme in 1 central team and 3 regional staff teams. All teams include 1 doctor and 1 or more nurses. In addition, depending on the function of the team, a sanitarian, nurse midwife, elder/cadre, motivator, social worker assistant or clerk may be members. The leaders are described as skilled in communication with the community, committed Christians and competent practitioners. The present PHC director is also a talented song writer who has composed numerous "health songs" which are already well-known in the area!

Initial costs for leadership training are difficult to determine. The current PHC director received his MPH through a governement-sponsored National Family Planning Programme. Continuing costs (mainly salaries) are covered by the hospital, the PHC programme and a government subsidy.

In discussing financing of training, a distinction should be made between "come-structure" courses, organized centrally and "go-structure" courses,

held in villages. In come-structure courses, donor funding is 75%, GMIM 20% and government funding 5%, with virtually no funding by the community in any direct way. Go-structure courses show more community financing, with donor funding about 67.5%, community funding 30% (mainly in board and lodging), and the remaining 2.5% by the government.

The activities of the general health cadres are supported by the community through the VHWs' volunteer work, labour and materials donated for construction of health posts, toilets, etc., monetary and in-kind contributions to the VHWs, and financial contributions to cover additional materials as needed.

Resources

GMIM programme personnel provided detailed information on costs and sources of financing. Where possible, actual figures from projects' and hospitals' accounts were taken to gain maximum insight from real figures. This information is unique in that it not only provides overall information on resources for financing but provides information by primary health care element.

Some Preliminary Findings on Financing Community Health in GMIM

PHC financing possibilities include: **government, community, institution and donor agencies.** Their level of financial involvement depends on the particular programme, as certain ways of financing are restricted to certain programmes and form of contribution.

In general, **community financing** is only possible for more **curative services on an individual basis,** the effect of which will be directly felt by the people. Large amounts of money or in-kind can be expected. For more preventive and promotive interventions,

GMIM Health Services, Indonesia.

If a community feels it benefits from a certain programme, it is usually willing and able to pay. Here, community participation helps to finance the construction of a simple and safe latrine.

sources from outside the community may need to be found.

The contributions of both the community and the institution are on the increase.

Two things must be noted:

Potential financing from the community may be expected as long as the community feels it benefits from a certain programme and is motivated to contribute. **The *willingness to pay* for PHC will be matched by the *ability to pay.***

At the same time the input from donor agencies has been increasing as well, which indicates that *some of the increased community/institution contributions* happened because they *were induced by donor contributions.*

Donor agencies' inputs are still considerable, and community and institution inputs increased more than average. But self-sufficiency still seems far away.

We face a dilemma here. Thanks to the increases from all sources, a far greater volume of activities could be realized; the project could enter into new fields of service, and reach many, many new locations. However, whenever a donor agency and provider (PHC director) discuss assistance programmes, not only the period of years of assistance will have to be indicated, but also the planned scale of operations, both in fields of service and in number of locations.

After reaching the agreed level of operation, the assistance can be gradually decreased, as the provider searches for local resources to cover the next level of financing: maintenance costs. In this way, the continuity of PHC programmes may be guaranteed, freeing donor agencies from eternal involvement.

Programme maintenance costs, including planning, monitoring, transport, technical guidance, motivation and evaluation, have a **tendency to increase at a rate faster than overall programme services.**

Causes: increased isolation of locations served, due to efforts to situate programmes as close as possible to the community / demands for more professional services which need to be met by more skilled PHC staff. Understanding this is an important key to successful operating of VHWs and yet a cost item the community is not ready to pay for.

"Small is beautiful" is often enthusiastically advocated in PHC programmes. However, it has its economic restrictions. For instance in the TB control programme, from 1980-1982, some 200 patients were treated at an average overall cost of about $345 per person; from 1983-1985, some 900 patients were served at average overall cost of about $90 per person. Better use of resources, better prices with greater quantities ordered, and more combined costs contribute to this reduction.

Note:

A. Economics of scale apply not only to the size, but also to the efficiency of a programme.

B. The costs to initiate a new programme are often underestimated, and donors may impose unrealistic expectations on a programme struggling to achieve self-reliance. A programme should be allowed to mature in order to reach levels of more efficient performance. Donors should remember this as it will require extended financial involvement.

HOW FEASIBLE IS SELF-SUFFICIENCY?

Not very. PHC programmes would have difficulty being self-sufficient, because their beneficiaries are so poor. They live in a state of economic, social and political dependency making it nearly impossible for them to sustain their own programmes. In Brazil, where church contributions to mini-health posts range from 2% to 95%, a nurse asserted: "If the community had to pay for its services, the health post would disappear".

On the other hand, the Lardin Gabas programme in Nigeria, being operated by the EYN church, is self-supporting and continues to train health workers for 20 new villages annually. Fees from treatment at a group of 10 dispensaries staffed by health assistants with 2 years' training are used to fund administration, training and supervision of 80 health posts.

While village health *programmes* may well be self-sufficient, *training* for new ones may require open-ended outside funding. This kind of funding has been shown to be far more cost effective than funding of hospital operating costs.

The Editors.

Community financing should be 1 element in a balanced financing approach. No single source is ideal for every purpose. **The Kojedo project in Korea** concluded that *partial* long-term financial assistance is a requirement if the effectiveness of out-reach efforts is to be maintained.

Well-run programmes which tend to expand both in services and number of locations served, may be heading for a degree of self-reliance. But, their very "success" means that they will need additional funding, which disturbs the goal of eliminating outside support.

Hospitals operating as private enterprises (in the capitalistic sense) serve the wealthier parts of the population, which enables them to generate money surpluses to spend on community health programmes. They function as donor institutions by accepting payments from the rich to redistribute to the poor. The acceptability of this system depends on how far hospital services are denied to the poor for the purpose of exercising a principle.

Value for Money?

How to spend the limited resources available for PHC in the most effective way should be the number 1 priority in every programme plan-

WCC Photo by David Hilton.

Lardin Gabas, Nigeria.

ner's mind. Because a service is cheap (offered by a volunteer), does not mean that quality can be ignored:

– In Latin America, local parishes could run programmes at less cost than regional organizations, because of less bureaucracy, fewer technical personnel and their rural locality. This may be obvious, but we need to remember that low cost alone is not an indication of what a community actually gets from a programme's efforts. Depending on who pays for services, there is cost to the community, its individual members, the programme organizers and the donors. **THE COST OF TRAINING A HEALTH PROMOTER IN LATIN AMERICA MAY BE ONLY 1 DOLLAR FOR EVERY 200 DOLLARS IT TAKES TO TRAIN A DOCTOR OR A NURSE. IT DOES NOT FOLLOW THAT THE DOCTOR OFFERS 200 TIMES THE VALUE.**

– The emphasis on participatory, "bottom-up" development offers, on the surface, ways of utilizing local resources at little or no cost (such as volunteer labour, donated buildings). Yet there is a cost to the volunteer – in time that could be spent earning wages. We need to find ways to measure this kind of financial participation and evaluate the contribution of the ultimate users of the service.

– Small-scale projects have attractions in that they are manageable and can run on low financial inputs. Yet certain services may be more efficiently delivered if organized on a larger scale: in the case of GMIM, immunizations and TB treatment.

CONCLUSIONS

1. It seems unikely that a PHC programme will ever be 100% self-reliant. It may be more useful to accept that certain income-producing components of PHC programmes have the potential to become self-sufficient, and even to generate surpluses to pay for educational and preventive work.
2. Church-related hospital services often become self-sufficient, as they are well-placed to re-invest money from richer people to services for the more deprived.
3. No single source of financing is adequate for any 1 purpose. Programmes need to find the right combination for their requirements.
4. The heart of PHC, community participation, is difficult to measure in financial terms. The spiritual component of PHC, where the greatest resource is the people, cannot be denied, but financing has to be considered, as in the practical question of if and how to pay health workers.
5. Donors often underestimate the time a programme needs to establish roots before assessing the quality of its work. An unrealistic demand to achieve "self-reliance" within a short time-span can severely restrict a programme's effectiveness.
6. The questions of who pays for what services and how equitable health care can work in communities subject to injustice and poverty remain unresolved.
7. PHC systems and existing hospitals could enter into partnership and increase each other's effectiveness.
8. It is advisable and sometimes necessary for support agencies and churches to maintain "open funding" for certain programme aspects, such as the training of primary health care workers, in order to achieve the goal of making health care available to all a reality.

Note: The original report, published in a small 55-page brochure, contains more detailed information, graphs and charts. It is available from the CMC.

WORTHY MENTION

The editors of CONTACT find the following effort most heartening, as it is in keeping with the publication's goal of reporting on "topical, innovative and courageous approaches to the promotion of health and integrated development."

ONE MILLION deaths are now being prevented annually, thanks to the efforts of the Expanded Programme on Immunization (EPI) and the resultant increase in world-wide immunization of children, as reported by the "WHO PRESS" in Press Release WHO/24 of 10 August 1987. Ten years ago, less than 5% of the world's children were being immunized against BCG, diphtheria, pertussis and tetanus, poliomyelitis and measles. Today 50% are protected.

There is, however, "no room for complacency", as vaccine coverage remains lowest in the developing countries for the 2 EPI diseases which cause the most deaths: measles and neonatal tetanus. "Programmes must continue to be accelerated during the coming 3 years if the 1990 goal of universal childhood immunization is to be attained", said Dr. Ralph Henderson, the Programme's Director.

Additional information, tables and graphs are available from: World Health Organization, EPI, 1211 Geneva 27, SWITZERLAND. Ask for WHO "Weekly Epidemiological Record", Number 33, 14 August 1987.

USEFUL PUBLICATIONS

CONSOLIDATED LIST OF PRODUCTS WHOSE CONSUMPTION AND/OR SALE HAVE BEEN BANNED, WITHDRAWN, SEVERELY RESTRICTED OR NOT APPROVED BY GOVERNMENTS (second issue, 1986), copyright United Nations, 1987, 655 pages. This edition, prepared in accordance with General Assembly resolutions 37/137, 38/149 and 39/229, is intended to be a useful tool in monitoring the use of products harmful to health and environment. It includes alphabetical and classified lists of products, codes for countries, territories and areas, regulatory and commercial data.

Available from: Sales Office, DC 2-0858, 2 UN Plaza, New York, New York 10017, USA.

BANNED & BANNABLE DRUGS, prepared by Voluntary Health Association of India (VHAI), 1986, 67 pages. VHAI has been deeply concerned about the increasing misuse of drugs, non-availability of essential drugs, flooding of the markets with hazardous, irrational, and sub-standard drugs, non-availability of unbiased drug information and poor drug controls and legislation. This association continues the fight for rational drug use, and is issuing a very portable book towards the efforts of the All India Drug Action Network (AIDAN).

Available from: VHAI, 40 Institutional Area, South of IIT, New Delhi-110 016, INDIA

Price: Rs 15.

Measurement in health promotion and protection, edited by T. Abelin, Z.J. Brzeziński, Vera D.L. Carstairs. WHO Regional Publications, European Series No. 22, 1987, 658 pages. Departing from the traditional approach of measuring health by concentrating on sickness, this book shows not only people's current state of health, but also how to measure the changes in their overall well-being. This knowledge can then be used to assess the effectiveness of public health policies and programmes. The book clarifies central concepts of health promotion and encourages all concerned to put them into action. It aims particularly at people in health departments who are responsible for health management, policy development and health promotion – of enormous importance in the movement towards health for all.

Available from: World Health Organization, Distribution and Sales Service, 1211 Geneva 27, Switzerland. Will also be available in French soon.

Price: Sw.fr. 80. "Special terms for developing countries are obtainable..."

Know Your Body (1986, 118 pages)

Family Care (1981, 121 pages)

FIRST AID for Community Health Workers in Developing Countries (1984, 101 pages)

by Muriel Skeet

The author is an international consultant in health manpower development, former Chairman, Nursing Advisory Committee of the League of Red Cross Societies, and former President and Chairman, Commonwealth Nurses' Federation. Her overall aim in writing these 3 companion volumes is to help primary health care workers in developing countries acquire the elementary knowledge needed to be of timely and appropriate assistance. She also hopes they will contribute to responsible self-care and, where appropriate, competent and safe community self-help. The books' easy and well-organized format helps them serve as both reference and teaching aid.

Available from: TALC (Teaching Aids at Low Cost), P.O. Box 49, St. Albans, Herts. AL1 4AX, U.K.

SPECIAL OFFER: As part of the Churches' Ecumenical Decade in Solidarity with Women (1988-1998), the WCC's Sub-Unit "Women in Church and Society" is pleased to provide documentation containing news, stories, information and tips on constructive ways to celebrate these 10 years. Cassette tapes are also available to blind or sight-disabled people. A special braille edition highlighting events for Easter 1988 is currently being prepared.

Available from: Women in Church and Society, WCC, P.O. Box 66, CH-1211 Geneva 20, SWITZERLAND.

Price: Free of charge. Quantities limited.

From "Images of Life" by David Walker for WCC.

CONTACT SPECIAL SERIES

Special Series Number 2 – June 1979 is devoted to the Study/Enquiry programme of the CMC and is titled "In Search of Wholeness... Caring and Healing". It brings together papers on such topics as:

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Special Series Number 3 – June 1980 entitled "Health: The Human Factor. Readings in Health, Development and Community participation" focuses on the subject of community participation – a factor long recognized as crucial in the process of development and in primary health care. This series of articles gathered together by guest editor Susan B. Rifkin offers many illuminating insights into the several levels and dimensions of community participation and its relationship to justice and self-reliance in, and sustained commitment and support for, health care and development.

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CMC NOTES

THE HUNGER PROJECT's "Africa Prize for Leadership" has been awarded to Abdou Diouf and Thomas Odhiambo. H.E. Abdou Diouf, President of the Republic of Senegal and Dr. Thomas R. Odhiambo, founder and director of the International Centre for Insect Physiology and Ecology (ICIPE) were named as joint winners of this 1st annual award. A cash prize of US$ 100,000 will support their continued work on behalf of the people of Africa.

The announcement was broadcast live by satellite from Washington D.C. to the international media in Nairobi, Kenya.

For more information, contact: The Hunger Project, 1 Madison Avenue, New York, New York 10010 USA.

CONTACT is the periodical bulletin of the Christian Medical Commission (CMC), a sub-unit of the World Council of Churches (WCC). It is published 6 times a year in 4 languages: English, French, Spanish and Portuguese. Present circulation is in excess of 26,000.

Papers presented in CONTACT deal with varied aspects of the Christian community's involvement in health and seek to report topical, innovative and courageous approaches to the promotion of health and integrated development. A complete list of back issues is published in the 1st issue of each year in each language version.

Editor: Eric Ram (Director). Editorial Assistant: Sanda Freeman. Editorial Committee: Eric Ram, Reginald Amonoo-Lartson, David Hilton, Sanda Freeman, Birgitta Rubenson, Christel Albert. The rest of the CMC staff also participate actively in choosing topics and the development of materials. Mailing List: Fernande Chandrasekharan. Printer: Imprimerie Arduino. Correspondence: CMC/WCC, PO Box 66, CH-1211 Geneva 20, Switzerland.

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