Self-financing and self-management of basic health services

In Zaïre's Kasongo health district an effort is being made by the community to reduce costs and increase income for the health centres. Decisions on improvements in the running of the centres are partly based on analyses of their utilization.

The Kasongo health district in the east of Zaïre comprises 15,000 square kilometres of savanna which, in 1980, had a population of 195,000 people, some 30,000 of whom were in the main town of the area. Cotton is produced for export, and rice, groundnuts and maize are also grown, any surpluses being sold to neighbouring areas. The health district is managed by a chief physician, who leads a team of four physicians, an administrator and a nursing supervisor. It has 16 health centres and one referral general hospital with 180 beds. Each health centre is staffed by a nurse, a nursing assistant, an administrator and a porter, and serves a population of about 10,000.

The health district receives state subsidies in the form of salaries and an allocation for running costs, including the purchase of drugs and expendable items from the central medical and pharmaceutical depot in Kinshasa. In 1985 the allocation to the district was 250,000 zaïres, equivalent to US$ 19,270. The budget is inadequate, not covering the running and maintenance costs of the general hospital.

Foreign aid is also received, most notably from Coopération Belge. In 1984 Belgian aid was of the order of US$ 0.75 per inhabitant. Some 15% of this aid goes towards running the general hospital, the remainder being spent in Belgium: 42% on the purchase of drugs and medical equipment, the rest on logistical equipment and office supplies.

The total funds available for running the whole health zone are equivalent to approximately US$ 1 per inhabitant per annum.

Basic options for self-funding

It is important to ensure that external funding does not create new needs. Only drugs on an approved list of approximately 150 generic products are ordered, and no new technique is introduced unless management agrees that it is likely to be of value in the district.

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In order to obtain additional funds, it was decided to introduce a scheme of self-funding for the health centres. The scheme was intended to encourage national solidarity, to cater for identifiable elements of the system, and to keep health care accessible and available.

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The notion of solidarity is important. There would have been no point in aiming to maintain the entire system by self-funding alone, while it had to be ensured that complete self-funding of one level did not lead to the establishment of two parallel and independent health systems.

Self-funding for identifiable elements of the system provides a link with development and participation. It is desirable to concentrate self-funding on the parts of the system that depend least on technology, where the people understand the choices made and where the results are clearly visible. In Kasongo the part of the health system that depends least on technology is the health centre; here the decision-making power of health professionals can be diminished without compromising the quality of care. Funding from outside the community, on the other hand, should go to the referral hospital and other parts of the system where technical arguments have a greater bearing on decision-making. Adjustments can be made in accordance with developments in self-funding or external funding. If self-funding develops well the population can be given increased responsibilities — e.g., for supervision or for part of the running costs of the second level.

Patients pay for treatment or preventive care at the health centres. However, with a view to encouraging community solidarity and keeping services available and accessible, payment is made for each course of treatment rather than for each consultation.

Management of the resources generated is entrusted to the health committee, with which discussions take place from the time the health centre is built.

Practical considerations

In order to extend coverage, new health centres had to be built, since the locations of most of the dispensaries already in place did not correspond to the distribution of the population. The people help to construct the centres and provide the non-medical furniture. Buildings erected by the community in the local style meet their purpose admirably and are easily maintained. They cost about US$ 8000 on rural sites and US$ 10 000 in the urban area. Twelve rural and four urban health centres have been built in this way. Money is thus saved and the community acquires a sense of responsibility for the project. The people regard the health centres as their own, a good basis for long-term community participation.

Each health committee reviews monthly reports prepared by the staff on the use of the centres. Income and expenditure are considered in detail. If the centre remains in deficit for three months the committee can take corrective measures.

Increasing consultation fees

One such measure is to increase the consultation fee. Clearly, prices have to be low enough to permit access and high enough for the health centre to function.
However, the conversion of the prices of imported items in United States dollars into local currency charges can be misleading. It is more accurate to relate fees to the market price of an everyday commodity, and that of eggs has been used for this purpose, since they are a common consumer product of fairly steady production and demand. Price indices are calculated by dividing the price observed on a given baseline date by that charged on 1 January 1980. Consultation fees have increased more rapidly than that of the selected product: at the baseline date the mother of a family could pay for a consultation by selling one egg, whereas in 1983 she had to sell two and in 1990 three eggs in order to obtain the same service. The US$ exchange rate between 1980 and 1990 increased from 1.5 to 700 zaïre.

An index of numbers of consultations was similarly established by dividing the number of consultations in a given month by the number in January 1980. If the chosen index is kept constant by dividing it by itself, the ratio of the price index for consultations to that for the chosen product reveals more clearly how much changes in the price of eggs differ from that of prices charged at health centres, and indicates the extent to which the numbers of people using health centres are affected. The rates for consultations always exceed the index values during the observation period (1980–83). Each price increase was accompanied by a drop in the numbers attending, followed by an increase to a level lower than previously.

An interesting achievement of the health committees was to persuade health workers that the demand for preventive care was relatively less affected by price increases than that for treatment. During the same three-year period the fees for pre-school consultations were actually lower than the standard price for over 12 months. They were then increased to twice the value of the index. In contrast to what happened in respect of treatment consultations, these rises did not affect attendance.

**Reduced free care**

Another corrective measure is to reduce the number of people who do not pay for services. The non-paying group comprises the indigent and people who, although in a good financial position, are entitled to free care because of their status as administrators or teachers. In rural communities it is difficult to know who is indigent and really in need of free care; people do not wish to be categorized as indigent, because if this happens they may be denied certain social rights, such as that of marrying. This problem has largely been solved by authorizing the health committees to pronounce on who should be exempted from paying. It is easier for health committees to withstand pressure from individuals of relatively high social rank than it would be for nurses. The proportion of non-paying patients in urban health centres fell from 70% in 1975 to 15% in 1981, while in rural areas the corresponding decrease was from about 50% to less than 5%, without affecting the rate of use. This was possible because the prices charged by health centres were not excessive and because the people appreciated that the health centres needed a usable surplus.

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Reducing costs

Finally, the health committees can try to cut health centre costs. Drugs account for between 50% and 70% of expenditure in the health centres, yet despite constant efforts by management teams to foster their rational use there is a marked tendency for consumption to increase. In order to encourage discussion on this subject between the people and the nurses it is clearly necessary to provide the community with relevant information. Every three months, therefore, the pharmacy that supplies the district gives nurses a table showing consumption of the principal drugs. The total quantities are indicated, as is the average amount used by each consultant in comparison with that of the other health centres in the district. Each nurse uses this table to compare his or her consumption with that of others, then makes any necessary changes. These procedures also enable the nurses to suggest to the committees where savings could be made by consuming less or using local rather than imported products.

Thus the programme is put to the people in a comprehensible way, encouraging their participation in decision-making. Consequently, the replacement of "wonder drugs" with less expensive, generic products and other measures of rationalization are rendered acceptable.

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If part of the system is financed by treatment fees, there is an interaction between price and usage as well as between usage and funding. A high number of patients leads to increased variable costs, whereas too low a number means that overheads are not covered. A balance has to be struck while adequate coverage of certain activities is maintained, without giving rise to excessive treatment. This requires discussion with the community, which is directly involved in managing the health centres' income. The health centres have little in the way of technological resources, and so the community can decide to reduce the contribution of health specialists to their work.

Self-financing and self-management offer a way of remaining solvent. Their main advantage, however, is probably that the power to make specific choices which they generate raises the level of community participation. Nevertheless, it should be realized that communities lacking experience or training in self-management take a long time to learn. Meanwhile, the health services have to relinquish some of their authority and confine themselves to an advisory role.