Community financing for essential drugs in Nepal
Chet Nath Chaulagai

Local cost-sharing schemes have demonstrated that the revenues needed to supply essential drugs can be raised from the users and at the same time reduce wastage. A significant amount of resources have been made available in this way, but lack of clear operating principles and management support has prevented them from being put to good use.

The Government of Nepal is committed to providing basic health services for all its citizens through the primary health care approach. At present, this is done to the extent possible through 816 health posts, distributed at grass-roots level throughout the country. The goal is for the country to have at least 75 district hospitals, 205 primary health centres, 611 health posts and 3104 health sub-posts. This will ensure that each of the country’s 3995 village development committees has direct access to a health institution at one level or another. The health care system is financed from general government revenues, of which it receives about 4%, as well as contributions from voluntary agencies, and user fees. The running costs of the district hospitals and the health centres, posts and sub-posts are borne entirely by the government.

The annual quota of essential drugs supplied by the government to any of the health institutions is barely enough for four or five months, after which health posts often simply close until the next year’s supply arrives. When medicines cannot be obtained locally, people go to more distant health institutions, thereby often incurring heavy travel costs. To these are usually added the fees of a private practitioner or hospital. It is estimated that user payments for traditional and modern health care, including drugs, exceed the total paid by government. As government revenue available for health is expected to diminish rather than increase in the coming years, the situation cannot be expected to improve unless an alternative way of financing health services is found.

To meet this need, several nongovernmental organizations have worked with the government in experimenting with various schemes. The United Mission to Nepal has been running an insurance scheme in six health posts in the Lalitpur district since 1978. The British Nepal Medical Trust is running two schemes in eastern Nepal: the Cost Sharing Drug Scheme, in which all health post and hospital patients pay a prescription fee, and the Cost Recovery Drug Scheme, in which drugs are sold at cost price. There is also an Integrated Hill Development Project, with a prescription fee scheme in two districts, and a Health Development Project with a similar scheme in two other districts.

Mr Chaulagai is Senior Officer in the Policy Planning, Monitoring and Supervision Division at the Ministry of Health, Ram Shah Path, Kathmandu, Nepal.
The government initiative in Kaski district

In 1984 those in charge of the 14 health posts in the Kaski district decided that each health post should establish a committee to study the drug shortage problem and options for solving it. Each committee consisted of 9–15 people who were formal or informal leaders, social workers or women’s representatives, and one senior teacher. The solution favoured by all 14 committees was to levy a charge on the prescription ticket, starting in 1985. The amount to be paid and other regulations were to be established separately by each committee. These were gradually modified in response to the users’ reactions and other factors, and as the scheme became well established it spread to a large number of other health posts in the country.

With this large amount of experience to learn from, it was felt that a review of the scheme could yield valuable information. The two health posts of Batulechaur and Shishuwai in the Kaski district were selected for the study because of their good performance, easy access to regional and district headquarters, and their long experience with the scheme (both of them had been in it from the beginning). Also, it was felt that the problems arising at these two health posts would be fairly representative of those in other parts of the country.

There was a significant drop in patients attending these health posts when a fee was introduced. Thus it can be said that introducing even a nominal fee for the use of health services had the immediate effect of reducing the use made of them. One common phenomenon was expressed by a health post staff member as follows: “In the past, people used to drop into the health post whenever they were passing by, to pick up medicine for future use. This custom died out completely when charges were introduced, and now no one will pay for medicine until they are actually sick.”

The proportion of school-aged patients fell sharply. Before, they used to go to the clinic during the school break and demand drugs for which they had no immediate need, and the registration fee appears to have put a stop to this practice. Health post staff say essential services have never been denied to patients unable to pay, but no one normally asks for free services, and so the quota of 10% of the drugs available has never been fully used. The proportion of females over 15 years of age using the health post clinics increased, which is a positive trend as this is one of the targeted user groups.

The scheme has contributed significantly to the total budget for drugs at the health posts. From 1988 onwards, when the scheme was fully implemented, the money raised from user fees was equal to the money provided by the government. Each project has succeeded in raising a cash balance of over 150,000 Nepalese rupees (about US$ 3000), but too little of this money has been used to overcome drug shortages. This reflects a lack of understanding on the part of the health post staff and their supervisors about the purpose of the project. In the absence of clear guidelines and training on how to manage supplies and funds, the bias has been towards accumulating savings rather than providing drugs.

Seven main problem areas came to light in the course of analysing these projects, and they can be summarized as follows.

- Although the prescription charge was raised gradually during the first two years of the project, it has remained unchanged for the last five because the problem was no longer felt to be shortage of money but inability to use the resources that were already available.
The national list of essential drugs consists of 250 items, only 75 of which are designated for use at the health post level. Health posts are still buying drugs that are not designated as essential, as the government has been unable to enforce the use of the list, and is in fact itself supplying drugs that are either not on the list or even officially banned.

The government has set standard dosage and treatment schedules for use in the health posts, defining drugs of primary and secondary choice for designated diseases and conditions, but in general these guidelines have not been followed. Variations in treatment patterns and the use of antibiotics are still widespread.

The health post committees have conducted business quite erratically, with ill-defined responsibilities for supporting and managing the health posts. They often do not know how the drug scheme works or what authority they have beyond simply signing the minutes written by the person in charge of the health post.

Drugs purchased from local suppliers can cost up to three times their original price and are often of low quality or close to their expiry date. To protect users from being cheated in various ways of this kind, the Shishuwa health post committee decided to sell all the essential drugs on the list at a subsidized rate as of October 1992, using the drugs supplied by the government to pay for the subsidy. However, on this basis the health post is now spending more than it is earning.

Multiple drugs, often with the same properties, are prescribed in haphazard amounts, giving rise to serious problems of wastage and drug resistance.

The District Public Health Office has not taken the lead in making the scheme function properly by means of supervision and feedback. Both health posts studied were left without guidance on important issues related to the use of essential drugs.

**Outlook for the future**

The study makes it clear that although the government will never be able to supply the total amount of drugs needed at the health post level, this need can easily be met by community financing. Indeed, there is sufficient evidence of this now to move from local experiments to national programmes. The scheme that includes registration fee, prescription fee and drug sales could be effective, but in view of the current lack of management support and skills at the health post level, the use of registration fee alone might be more practicable; it is easy to operate and could to a large extent solve the problem of drug shortages on its own. However, as any scheme is subject to mismanagement, full guidelines should be drawn up and endorsed by the government, so that errors can be eliminated or reduced as much as possible. At the same time, the essential drug list and standard treatment schedules need to be strictly enforced.

Once cost-sharing has been fully established, it will be possible to move to a second level, in which cost recovery can be achieved. Then the third and final level, that of health insurance, could gradually be introduced throughout the country as the demand for it increases and the management skills of health post staff develop. Seed money to start this scheme is not needed, as every health institution receives an initial supply of drugs annually from the government. However, it would be practical to establish a fund for management support activities, so that good practices can be established as early on as possible.