

**Financing of the health service contribution
to primary health care**

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PRIMARY HEALTH CARE

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1. Primary health care and health services

Health service organisers whose work is governed by the philosophy of primary health care seek to strike a balance between equitable access to care, the effectiveness and efficiency of the care given, the self-reliance of the people served and the integration of health services into overall development (1).

The optimisation of the structures and activities of the health service must therefore be achieved with the participation of the population.

1.1. Adequate first level of care is the keystone of the system

To ensure that decisions in the health field are not based solely on professional criteria but also on value judgments by the community, the health care system must facilitate a continuous interaction between health professionals and the population.

The crucial element in the system, therefore, is the service's most decentralised structure, the first level of health care; for it is at the most decentralised level that the logic of the population concerned will come up against the logic of the health system.

It is at this level that the interaction between the two has the best chance of adjusting the service to a level of quality which is acceptable and affordable. If we want to have a service which does not put itself in place of people but is complementary to what people are capable of doing for themselves, and if we desire to increase the social competence of the population in the field of health, it is chiefly at this level that choices will have to be made. Similarly it is at the decentralised level that the population can make responsible choices as to the effort they are prepared to put into health taking into account the values they may desire to achieve.

In order to perform this function the first-level service must serve a defined and sufficiently small community. There will then be less difficulties of access, and the interaction between the population of the health service will remain on a human scale.

The ability of health service personnel to establish these human relationships is facilitated if health care is provided by a small polyvalent team (i.e. one providing a range of different professional skills), whose members so far as possible share the conditions of life of the population they serve.

However communication in itself and empathy alone are not enough. Communication is meaningful only if its content is complementary to the social competence of the population. In other words, the degree of decentralisation is limited by the possibility of assigning to the first-level service staff who have the technical competence necessary to respond in a rational manner to the demand for curative care and to

undertake the care of chronic illnesses and at-risk groups, and who have sufficiently mastered the logic of the health service to have a rewarding dialogue with the population concerned.

If this first-level service is to remain in harmony with overall development it must operate with equipment and resources which enable it to achieve an acceptable level of functioning at a cost which the community can bear, if need be with self-financing arrangements complementary to the budget allotted to it.

There is a growing consensus in favour of confining the name of health centre to a first-level health service which meets these criteria.

1.2. A first-level health service needs a level of referral

The rational decentralisation of first-level services implies that the technical resources at this level are not too advanced. For reasons of technical effectiveness and for economic reasons certain diagnostic and therapeutic procedures must be carried out at a second level, commonly called the district hospital.

In accordance with the principles of primary health care this hospital will be organised as a complement to the first level and not as a competing service. The health centre, the point of interaction between the population and the health service, is the gateway to a health care delivery system composed of the different levels. Health centres are responsible for dealing with the health problems of their

population and refer patients to the district hospital only if continuity of care calls for technical resources which are not available at the first level; and the patient will be referred back to the health centre as soon as possible, along with the relevant information.

The hospital will confine itself to activities which for technical or economic reasons (under-use) cannot be carried out at the first level. And it too has its own system of referral for procedures going beyond the technical resources of a general hospital.

1.3. The district health system needs an organ of management

If the services have fully qualified staff at all levels, a separate team can be made responsible for the monitoring and adjustment of the system. It is desirable, however, that such a team should have significant experience in the district provision of services and in working as a team.

In developing countries fully qualified staff (e.g. doctors, pharmacists and administrators) are in short supply. It is therefore advantageous to concentrate them at the district hospital levels. As a team, they might be engaged in work requiring their technical competence and as well be responsible for the organisation, monitoring and adjustment of the system, including the supply and supervision (continuous training) of the first-level staff. The advantages of the formula are a more efficient utilisation of qualified staff, an easier agreement on the allocation of resources to the different elements

of the health care system and a proper permanence of the medical staff in the hospital (2).

1.4. In conclusion, if the health service is to adapt to primary health care it must :

- re-orientate its work in two directions, the optimisation of its activities and the participation of the population;
- re-orientate its structures to become an integrated system; and
- have an organ of management at district level.

2. The financing of an integrated health service and the scope for self-financing

Particularly in poor countries, the central budget of the health service is, and until the year 2000 probably will remain, insufficient to allow the system to operate at a level acceptable to the population. It is necessary, therefore, to introduce an element of complementary self-financing (3) (4).

In rich countries on the other hand, in which the central budget is sufficient to finance an acceptable technical level of health care, autonomy and self-reliance have been sacrificed in favour of "safety". The users of the health service play little part in decision-making and are not confronted with the cost of their choices; all too often they are passive consumers or active demanders of sophisticated technical services, encouraged by the health professionals who create most of this demand. In these countries the decentralisation of financing and the participation of the population in the self-

management of the services would promote a sense of responsibility in the use of those services.

Self-financing complementary to the central budget is thus not necessarily a mere expedient. It can be conceived as a means of promoting a sense of responsibility in the population and of improving the standard and the functioning of the service. It can contribute to the adaptation of the health service to the primary health care concept.

The analysis of the financing of the service must therefore go beyond the mere covering of costs. We must ask ourselves how the distribution of central finance and resources accruing from self-financing, the method of self-financing and the scales of charges adopted, can help to increase the scope of responsibility for self-help by families and local communities in health matters. We must also ask ourselves how these measures can help to promote participatory decision-making and co-management by the population, to provide services of better quality and more equitably accessible, to contribute to continuity of care. Moreover, by eliminating irrational financial barriers within the delivery system, the choice of charges can direct users of health care to the level which is best able to deal with their health problem and to meet the cost.

2.1. Self-reliance and complementary self-financing

Individuals, families and communities spend part of their income on self-treatment, traditional health care and "modern" care.

If health personnel sincerely desire to promote self-reliance, to strengthen personal independence and to increase people's scope for solving certain health problems themselves, they must seek to ensure that choices in the deployment of expenditure on health care are as carefully considered as possible.

These choices in the spending of money arise at three levels.

The first level is that of everyday care in the family. Various minor problems and inconveniences can be dealt with in this way at negligible cost. If we take people's independence seriously, we must recognise and protect such contributions to health care. In primary health care we opt for the improvement and if possible increase of people's scope for dealing with certain health problems themselves. The introduction of oral rehydration in the family is a good example of this. The organisation of household or village pharmacies is another.

The second level relates to the current level of expenditure (including travel expenses) for care received from the various available health care providers, private as well as public. Some services offered to patients, whether traditional or modern, are forms of exploitation rather than health care. Sometimes travel expenditure in order to reach the care providers is far above the cost of the care itself. The fact remains that the amount spent per family tells us how much people are prepared to pay for their health within the framework of the services, drug stores, private providers of care or drugs, at present available. A health service based on primary

health care seeks to achieve effectiveness and efficiency of care. It has probably little direct influence in profit-inspired forms of private health care, but it must seek to reduce the improper supply of care and can often reduce the cost of properly provided care or the cost of travel. Resources thus saved can then be redirected towards improving the quality of care. Thus by the introduction and regular supply of essential medicines the expenditure previously incurred on unnecessarily expensive medicines can be devoted to improvements in the service (e.g. better continuity of care, outreach clinics by the health centre staff).

The third level of choices in the expenditure of money on health concerns an increase of the household expenditure for health and tends to be speculative. The dialogue between the population and the staff of the health service may reveal, for example, that a more far-reaching improvement in the service is required for dealing with a problem that is felt to exist. It is possible that the population may be prepared to finance this service when it is offered, even if this involves expenditure which is higher than before. This will of course depend on the extent of the needs felt by them in other fields, on the importance they attach to values other than health.

It is evident that the development of self-reliance through self-financing will come about only if there is an effective interaction, a communication, a dialogue between the population and the health personnel.

It is evident also that self-financing will contribute to this self-reliance only if the resources which it produces are used by the local services on the basis of co-management with the population concerned, or at least with the approval of that population in the light of full information.

2.2. Distribution of central finance and resources from self-financing

Generally a community is not in a position to meet the cost of the district health service by self-financing alone. It follows, therefore, that a contribution to financing must also be made from national or international resources. The problem then arises of securing the most appropriate distribution of this finance from different sources. Which aspects and activities, which elements in the district health system, are best met from the central budget and which by money coming directly from the base ?

The basic principle seems to us to be that self-financing and the capacity for self-reliance which is conditioned by it will be strengthened if people understand the constituent elements and procedures which they have paid for from their own pocket.

A health centre is nearer the population, and more frequently used by them, than the district hospital. The technical elements and the decisions to be taken are less sophisticated in the health centre than in the district hospital, and it is easier for the users of the service to understand what happens in the health centre than what happens in the district hospital. The activities of the district

administrative office are probably still more of a mystery to the population. Accordingly if we want to use resources obtained by self-financing for the most readily understandable elements in the system it is logical to allocate them chiefly to the health centre, while money coming from the national budget will be used mainly for meeting the cost of the district hospital and administrative office.

It should be noted once again that all this is based on the logic of an integrated system at district level in which the first and second levels each have their specific and complementary roles.

As an example we may take the district of Kasongo in Zaire. In 1979 some 15 % of expenditure on the system for the delivery of health care in the district (a network of health centres and a district hospital) was met by self-financing. This self-financing applied only to the health centres, covering roughly half of the cost (medicines, pay supplements and some minor local purchases) (5). In 1985 the health centres are almost totally self-financed, with the central budget now meeting only the cost of certain specific medicines, vaccines and a small amount subsidising pay and supervision costs. Moreover the central budget is no longer sufficient to cover the cost of the activities of the hospital, even though these have been highly rationalised, and it has been necessary to look to the resources of the health centres to meet part of the hospital's expenditure. The contribution made by each health centre is proportionate to the use it makes (on a rational basis) of the hospital. The self-financing meets about 25 - 30 % of the expenditure on the health care

delivery system. This shows that the distribution must be sufficiently flexible to take account of local circumstances.

2.3. Methods of self-financing

To ensure the self-financing contributes to self-reliance, to the improvement in the quality of care and to the improvement in the functioning of the health system, four criteria seem to us important in the choice of the method of self-financing.

In the first place the method of financing must contribute to continuity of care. This means that financial barriers must be avoided during the handling of a health problem. It may thus be appropriate to ask the patient to pay a charge at the beginning of an episode of illness or of risk, but not to pay for technical procedures which become necessary during the episode or when continuity of care involves referral to the second level.

The second criterion, resulting from the principle of social justice which is one of the objectives of primary health care, is the promotion of solidarity. The payment must be independent of the cost of care (provided on a rational basis). It would be unfair to expect a chronically ill patient to meet the cost of all the diagnostic and therapeutic procedures required by this condition.

The third criterion relates to the fostering of a sense of responsibility in the users of the service. To enable people to make a responsible choice it is not enough that they should understand the effect of

the care to be given ; they must also be aware of its cost. Payment by item of service would solve this problem but would prejudice continuity and solidarity. It is important, therefore, that the population should know about the total cost of health care in the district as a whole and not merely the cost of the elements which are self-financed. The service can contribute to this awareness by the introduction of financial barriers against "unnecessary" demands for care. A modest financial contribution on entering the health care system has the advantage of encouraging people not to apply to the health service with a problem they can solve themselves. And similarly with any other unreasonable demand for service : if it cannot be turned down altogether it must be paid for in full, both to discourage this type of demand and to make clear the cost it involves. Thus a person who insists on a direct consultation with the hospital doctor without being referred by a health centre will be required to pay for the cost of the consultation and all care to which it gives rise.

In the fourth place the scale of charges must enable the health system to be financially viable. It is evident that to avoid bankrupting the whole system, self-financing must cover all costs which are not covered by the central budget. The community's capacity for self-financing (see paragraph 2.1.) will determine the degree of rationalisation of activities and structures which must be achieved to enable all costs to be covered.

The method of payment selected in the light of these four criteria will no doubt be a compromise or a hybrid solution lying somewhere between payment by

item of service and a flat-rate contribution to be paid periodically by each inhabitant or family.

As an illustration we may take the method of financing adopted in Kasongo (5). At the outset a decision was made in favour of a flat-rate payment per episode of illness or of risk (e.g. pregnancy or pre-school-age). This payment gives entitlement to all the care required for dealing with the particular problem, whatever the real cost may be. Following out the logic of the system, the payment also gives entitlement to hospital treatment if continuity of care during the particular episode requires this; for in that event transfer to hospital is the consequence of a more serious situation. The hospital is thus not financed as an isolated establishment : the whole network of health care services at the first level in the district and the district hospital services are financed as elements in a coherent system.

This method of financing, which achieves a certain level of solidarity, is applicable only to people who belong to the community served and therefore contribute to that solidarity. Persons not belonging to the community pay an item-of-service charge of an amount at least equal to the real cost of the service. By the same token, and in order to optimise a system which has very limited resources, the concept of solidarity does not extend to all the demands made by individuals even if they do belong to the community served. Thus, for example, direct access to the doctor and certain surgical interventions for the patient's convenience are treated as unreasonable and non-priority. In such cases an item-of-service charge is made, again of an

amount at least equal to the real cost. This illustrates the fact that solidarity is not an absolute either, but may vary in extent according to resources and objectives.

The amount of payment per episode is fixed and regularly altered by agreement and in a continuous dialogue between the health committees and the health centre.

It is sought to achieve a method of financing which goes beyond the mere solidarity of the users of the service and concerns the community as a whole by asking the population, through the health committees and the local authorities of the area served, to maintain the buildings and to meet, in part if not in full, the salaries of staff not paid for by the central budget.

3. Concluding remarks

Self-financing, as a complement of central financing, can carry much weight on the health care delivery system's possibilities to adjust to the primary health care concept.

The actual efficacy of various methods of self-financing will however greatly depend upon the quality of communication between the first line health manpower and the population they serve.

The staff in charge at the district level should consider the first line health services and their referral level as complementary elements of the same health system. If this is realised by a form of

coordination (the optimal form being teamwork) a rational distribution of the resources between the two levels of care will be easier.

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