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Editorial: **Community financing or cost recovery: Empowerment or social dumping?**

Paying for health care is not new in sub-Saharan Africa, or in the developing world in general. Traditional health workers have always been recompensed in cash or in kind. Already many years ago, Western services, run under the auspices of development projects, started collecting modest user fees to increase their operating budgets. The local payment schemes that eventually emerged were managed in a rather informal and unstructured way. They thrived in a context where free care—at the point of utilization—was a constitutional right and government funding the predominant source of health care financing. However, as a policy issue in the field of health systems planning and organization, paying for care is of relatively recent appearance and of a quite distinct nature. The contemporary call for the development of generalized and institutionalized user-payment mechanisms stems from the highjacking of the spontaneous and local financing dynamics of the past by two different movements: the Primary Health Care movement on the one hand, which identified the social and political potential of *community financing*, and neo-liberal economics on the other hand, that introduced *cost recovery* as part of an ideological agenda aimed at promoting privatization and limiting the initiative and control of the state in the health sector.

In the framework of the Primary Health Care concept community financing would comprise voluntary contributions that complement, but certainly do not replace, possibly insufficient government funding for the health sector. The modalities could range from fee-for-service charges at the utilization point to disbursement of lump sums towards local insurance-like schemes. The proceeds of these payments are managed by the community and its health workers and they are at least partially retained and reinvested in the services they were collected in. Such financing remains marginal when considering the expenditure for the entire health care system, but its relative contribution may be substantial at the less costly lower levels.

Community financing should, however, not be a mere instrument for generating additional resources but rather serve more political objectives, regardless of the level of government funding: making people responsible for more rational health care utilization and involving the population in the management of their health services. It is, though, neither a necessary nor a sufficient means for triggering or sustaining the dynamics of community emancipation, and other instruments might achieve these objectives more effectively. Introducing community financing implies, furthermore, drastic changes in a complex system whose structural, organizational and human environment will largely determine the outcome of the intervention. In this perspective it seems imperative that health service managers recognize that health is only a relative priority to people and that there are limits to their willingness to pay for care. Mechanisms for a continuous dialogue between health professionals and the community should then ensure that the health services' development be based on negotiations starting from the community's felt needs, and that people understand and endorse the use that is made of their financial contributions. Community financing schemes do not always function well, sometimes due to managerial and organizational flaws, sometimes as a consequence of the unfavourable political environment. But this does not detract from their potential as a powerful tool in the development of coherent and sustainable Primary Health Care systems.

Cost recovery, a conceptually different interpretation of 'paying for health care', fits nicely in the ideological agendas of policies aimed at privatization, limiting the role of the State and shifting responsibilities to the individual. Health is here viewed as a private responsibility and health care as a commodity that has to be purchased in a

competitive market. In line with this view, Ministries of Health in Africa increasingly focus on accommodating the health sector to the economic policy measures of structural adjustment programmes and the cuts in social expenditure they imply. This makes it even more difficult for them to meet the challenge of developing affordable, effective and equitable health care systems, certainly if these were to be based on publicly funded and operated health care delivery. Cost recovery is the easy way to offer the semblance of an alternative to the poor within a dismantled public sector. Such an approach to paying for health care is dangerous for three reasons. First, it is likely to be ineffective. In large strata of the African populations there is just not enough financial potential to pay for a minimum package of both first contact and referral level care and a substantial degree of subsidizing remains necessary for the foreseeable future. Basing health care delivery on cost recovery means that important components of care will stay or become inaccessible to large population groups, and particularly to women who have less control over disposable income. Second, the magic bullet of cost recovery fails to address the need for a reorganization of health care delivery structures, for finding efficient and effective ways of delivering quality care, and for generating new governmental sources of revenue or reallocating existing ones. Third, it reduces community financing to a dimension of mere accountancy: a major missed opportunity to reform the health sector. Calling cost recovery schemes 'community financing', and paying for health care 'health sector reform' is just looking for a way to legitimize, in the worst case, an ideological agenda, and in the best, a lack of imagination about how to tackle the problems of Africa's health sector.

The current epidemic of health sector reforms throughout the developing world indicates that there is a problem indeed. The health system is in crisis and reform is necessary to counteract developments whereby different levels of ability to pay lead to different levels of quality of care. State responsibilities could, possibly, be reviewed in a perspective where the main emphasis would shift from a prominent role of the state as health care *provider* to one of *planner* and *controller*. But to avoid the gloomy picture of a two-tier health care system, substantial government funding, allocated in an equitable way, will remain crucial. This is, at the same time, a necessary condition for community financing to achieve its political objective of genuine community participation.

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