CHAPTER II

ESSAY

Community Financing of Drug Supply : A Strategy For Increasing Health Post Utilization through The Mobilization of Health Post Management Committees in Rural Nepal

2 .1 Introduction

His Majesty's Government of Nepal (HMG/N) has shown considerable enthusiasm for providing basic health services to the entire, largely rural population of Nepal. Health services in Nepal are based on the principle of Primary Health Care (PHC) approach. The present health policy of Nepal emphasizes an equitable and accessible extension of health activities throughout the country. Health services infrastructures have been developed in order to meet the increasing demand of population, and this has resulted in the establishment of 611 health posts as a mean of providing health services to those in rural settings. These health posts are financed by government and aimed to provide basic curative, preventive and promotional health services to the rural population without any costs from the consumers, in order to achieve better equality and access. However, it is not known that how this policy may impact in patterns of health service utilization among the rural population in Nepal.

Nationwide information on health service utilization is still lacking in Nepal. However, some studies conducted in small areas of Nepal have shown that these government health posts are not well utilized by the rural population (Sepehri Pettigrew; 1996; Fryatt, Rai, Crowley and Gurung, 1994). One of the study conducted in western rural district of Nepal, revealed that only 30 percent of the study population sought care from these public health posts, more importantly about 30 percent of the study population were found untreated (Sepheri and Pettigrew, 1996). The annual use rate of these health post is estimated at 0 .2 per population per year also indicates low utilization of these public health facilities by rural population in Nepal (DoHS, 1995).

Several studies on health service utilization have been conducted in developing countries (Sepehri and Pettigrew, 1996; Chalker, 1995; Fryatt et al., 1994; Litvack & Bodart, 1993 and Stone, 1986). These studies indicated that various factors influence the utilization of health services including age, sex, marital status, social class, education, health beliefs, income, price and payment mechanisms, availability, accessibility and acceptability of health services and level of illnesses.

The main issues are why these public health facility are underutilized by the rural population in Nepal, and how the utilization of these health facilities can be increased by using Primary Health Care approach. The reasons for low utilization of public health facilities in Nepal include: inaccessibility (all travel by foot), unavailability of essential drugs (Fryatt et al., 1994); failure of health system to appreciate villagers' values and their own perceived needs (stone, 1986). Absence of the staff from their

work place (INF 1995), Widespread use of traditional healers, and low quality of services (Chalker, 1995) also contribute to under-utilization of government health facilities at health post level in Nepal.

Increasing health service utilization at health post level is a primary health care approach PHC approach emphasizes that health services at primary level should be able to reflect the perceived need of the population and should be incorporated with traditional health systems of the community (Stone, 1986). Litvack and Bodart (1993) have suggested following strategies for increasing health service utilization at primary level:

a) Making health services accessible to most of the population. Making health services closer to the population and providing at affordable cost will increase the utilization.

b) Increasing availability of essential resources including staff, drugs and equipment for the operation of health facility.

c) Involving community people in health facility management.

d) Improving the quality of health services.

Implementation of different approaches for increasing health service utilization requires adequate financial resources and the financing of public health services is a worldwide problem. The problem is particularly acute in low- income countries such as Nepal. Since the declaration of Alma-Ata in 1978, primary health care has been regarded as the way forward to improve the health of people. World Bank oganization

recommended that government provides a minimum package of public health and essential clinical services for all sections of the population and that this will cost US $ 12 per capita per year (World Bank, 1993). Unfortunately, public spending on health in Nepal, is much less than this which results in a lack of adequate and accessible health services for much of the population. Provision of essential drugs in public health facilities is one of the components of primary health care (WHO/UNICEF, 1978). Lack of essential drugs due to lack of funds is a common problem, which seriously undermines the effectiveness of existing, public health services.

Methods of financing health services are relevant to health policy of a country. The World Bank in 1987 has recommended three main approaches to health care funding (World Bank, 1987). These are,

a) General system of taxation,

b) Health insurance and,

c) User charges or community financing.

Financing of health services through general taxation is the most commonly used approach throughout the world. Government collects revenue from different sources and put together then distribute to different public department. Developing countries like Nepal have been facing problems in raising adequate funds through general taxation. Sound administrative infrastructures are required for recognizing and collecting revenues from the entire economic activities. Nepal's revenue system rely heavily on indirect taxes which affects the poor people who spend a large share of their

income on taxable goods. Thus levying more taxes means to increase burden to the poor. Therefore, progressive tax system could do more harms than good as regards health (Abel & Mach, 1983).

Health insurance and risk sharing schemes have been emerging as a potential option for financing health services. The essence of insurance is the sharing of risks by the population. It is a mechanism designed so that those fortunate enough to be healthy pay for those who are sick, with a clear understanding that should those well now fall sick later on; their costs will in turn be covered. Though it is easier to collect premiums from the participants in comparison to taxation, it is not feasible for countries like Nepal where 90 percent of population rely on subsistence agriculture and very few people have regular sources of income.

User charges or community financing is another alternatives to health service financing within the health sector. User charges are fees levied to the patients or users of the health service for a service received. Such kind of user charges, are widespread in developing world and may contribute a better solution to raise funds at local level. Most private spending on health is through user charges, and private out of pocket expenditures account for a large fraction of total health expenditure-larger, often, than the developed countries (Ferranti, 1985). User charges are best suitable for curative services including drugs and can increase health facility utilization. The problem of inequality caused by user fees can be minimized with appropriate exemption policy (Gilson, Russel and Buse, 1995). Many studies have shown that user fees along with

adequate and regular supply of essential drugs and quality improvement resulted in increased health facility utilization (Bodart & Litvack, 1993; Holloway, 1997; Fryatt et al., 1994). Implementation of user fees is cost effective and does not require additional manpower. Community will feel more responsible when the revenue collected from the user fees is kept at local health facility for the improvement and expansion of health services.

Therefore the conclusion is that, increase access, availability of drugs and staff, improve quality of services and involvement of community in health facility management will be resulted in better utilization of public health facilities. Moreover, financing by the community is selected as a key component as it relates to the availability of drugs at health facility. Community financing with appropriate exemption policy adds fund to health facility by which essential drugs can be supplied adequately in a continuous basis. Orientation training for health post management committees and staff on community financing should result in better health facility management, and reinvestment of user charges at the discretion of local people will help to improve the services by which local people will gain more than the charges they paid.

2.2 Health Status and Needs of the Population

Health status of the population and need for medical care play a major role in determining health service utilization (Andersen, 1968). Many studies have supported the conceptual relationship between health service and self perceived illnesses or

injuries, the type of symptoms, and the ability to perform usual activities as measures of need. However, the need variable is an imprecise concept and divided into two broad categories, individually perceived health needs and professionally assessed health needs of the population (Hulka and Wheat, 1985).

The individual's need for seeking health care usually arise due to perceived symptoms of illnesses and it's severity. Thus, an individual's perception of poor health would influence his/her decision to use a health facility and that the physician's judgement of health status would also influence the remainder of individual's use of services, when illnesses do not exhibit symptoms.

Nepal's high Infant and Maternal Mortality Rates (IMR and MMR), high population growth rate and prevalence of particular diseases like malaria, tuberculosis, diarrhoea, acute respiratory infections and malnutrition among children suggest poor health status of the population and health planning is based on this epidemiological context (Stone, L.; 1986). The package of PHC program focus heavily on preventive health activities such as family planning, specific disease detection and control, maternal and child health and in general, health and nutrition education. However, curative health services are not lacking in Nepal's primary health care package. Rural people perceived most of these preventive services are unneed and irrelevant to the majority of people it is intended to serve.

2.3 Health service Utilization

An individual will use a service only when it is perceived that ones' need could be satisfied, that the health facility provides the desired and required services, and that is convenient and affordable (Hulka and Wheat 1985). Therefore, there is a crucial link between providing health services and improving health of the population. Health facilities should be able to create an incentive to serve the population for using services by the population. There will be negative impact on demand unless people accept these services.

Modern health services such as preventive and curative care activities may compete with traditional health practices (Stone, 1986). However, competition exist among public and private health services. Therefore, public health facilities must be able to aware of the people for the existing alternative services and that these are better in comparison to others.

Health services in comparison to other services and goods differ in many aspects. Lack of information is one of the most important factors in health services use (Hulka and Wheat, 1985). Users' of health services will only experience that there is something wrong with them but in most of the cases consumer don't know what has happened to them and how these could be avoided or treated. Therefore the consumer's level of knowledge plays an important role in health care utilization.

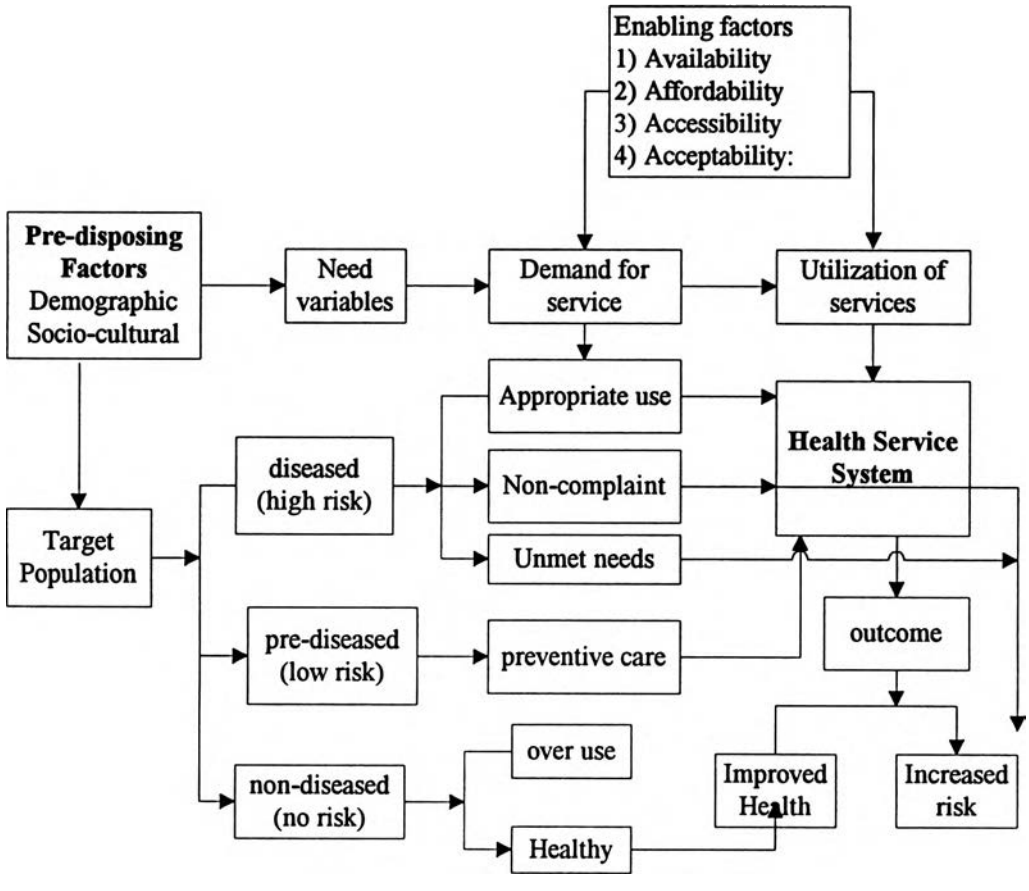
A community willingness for the utilization of health services depend greatly on the social and cultural context into which they are introduced. Modem health services should be able to address the need and interest of the local people and, health interventions should not be conflicting with traditional social beliefs systems of the community. A study carried out by Linda Stone in 1986, concluded that primary health care in Nepal primarily offers health education to the rural masses. But, equally understandably, when it comes to "modern health", these rural people decidedly oriented towards curative services (Stone, 1986). This is not only because curative services that are more impressive or more immediately gratifying, but also these people perceive that their own indigenous knowledge has already provided them with adequate preventive care whereas effective curative services are lacking. As a result, many rural people perceive PHC package of services as irrelevant.

2.4 Analytical framework

The model (Figures.2.1) is used here to analyse the factors associated with health service utilization by rural population has taken from the Hulka and Wheat's (1985) behavioral models of health services utilization. This model has explored patterns of health service utilization from the patient's perspective and had identified factors affecting an individual's decision to use the health care services. This model presented that use of health services is a function of three sets of factors, such as, 1) Need or illness related factors,2) Predisposing factors such as, age, sex, marital status, social and religious beliefs of the population, and 3) Enabling factors such as, income

level of the family, availability of services including drugs and staff, accessibility, acceptability of the health services.

Figure 2.1 Cconceptual framework of the relationship of factors affecting health service utilization



Source: Hulka and Wheat (1985), Patterns of Utilization: The patient perspective. Medical Care, Vol.23, No. 5, pp.438-460

2.4.1 Health need or illness-related factors

Need for health service is a basic component, which plays major role in determining utilization of health services by the population. Need, in this sense, refers to a condition characterized by the lack of an ingredient health care that is useful for maintaining a desired level of health (Hulka and Wheat, 1985). Need for health care generally arise due to an increased risk of diseases o conditions. Evidences have shown that individual's perception of increased risk contribute to utilization of health care.

The individual's need for seeking health care usually arise due to perceived symptoms of illness and its' severity. However, the need variable is an imprecise concept and divided into two broad categories as individually perceived need and professionally assessed health needs of the population. Individually perceived needs are based on symptoms of illnesses or conditions whereas professionally assessed needs are generally based on diagnosis.

2.4.2 The predisposing factors

Predisposing factors are mostly related to the clients of health services These include demographic variables such as age, sex, marital status, social variables such as religion, and belief variables such as values, attitude and knowledge. Among these factor, age, sex, religion and beliefs have potential influence on the utilization of health services.

A. Age and health service utilization

Age and sex are immutable variables related to use of health services through their biologic contributions to morbidity and mortality. The relationship between health service utilization and age is best described by a 'U' shaped curve (Hulka and Wheat, 1985). The very young and very old tends to use more services. This is because the younger have a higher prevalence of acute conditions and congenital malformation and the older have a higher prevalence of chronic diseases.

B. Sex and health service utilization

Sex influences the use of health services primarily due to factors related to female health, especially women's need for obstetrical care. Beginning with the child bearing years and continuing through old age, female utilize more health services than male (Nathanson, 1977).

C. Religion and health service utilization

Many socio-cultural factors such as religion and beliefs influence individual's decision in using health services. Religion may be described as a system of beliefs and practices of the society, which has functional roles in the life of individual. It provides both understanding of illness and mechanisms of coping with sickness and suffering, by which health service is being influenced/People's beliefs and practices affect health behavior and health care in different ways. There are some religious where beliefs are oppose to medical interventions, such as sterilization for family planning among Brahmin and Muslim population.

2.4.3 The Enabling Factors

The enabling component indicates that although an individual may be predisposed to use health services, he/she must have some means of obtaining these services. Enabling factors includes availability, accessibility, affordability, and acceptability of health care facilities.

A. Availability of services and utilization

The availability of resources, including staff, drug and equipment are major component which contribute to effective delivery of health services. Studies have indicated that greater the availability of health workers, medicines and equipment the greater will be their use (Bodart and Litvack, 1993; Holloway and Gautam, 1997). Furthermore, irregularity of staff and inadequate supply of essential drugs have resulted in low utilization of public health facilities in rural Nepal (Chalker, 1990; Stone, 1986)

B. Accessibility and utilization

The presence of health facilities and physicians in a community does not guarantee that the population will use them. Along with the availability of these services, reasonable access to these services is necessary. Accessibility not only refers to distance but also indicates ability to pay in economic term. Therefore, basic health service package must be within the access of population and affordable in relation to their income. Countries like Nepal, where other means of transportation is lacking, health facilities should be closer to the population. Studies have shown that cost of

health facilities should be closer to the population. Studies have shown that cost of health services has direct impact on supply and demand of health services. Higher costs have relatively greater negative effects on health service utilization, especially for poor people (McPake, 1993). Use of health services drops sharply beyond two hours of walking distance in rural areas where transportation is on foot.

Normal working hours and administrative procedures in public health facilities cause inconveniences to rural people (INF 1995), which discourage people to use health services. Such inconveniences resulted in consumer's dissatisfaction toward health services. In urban areas, people have many choices to choose health care provider in order to satisfy their health needs. But in rural areas where health care providers are limited, consumers, either should rely on those whatever available or travel long distance to get alternatives which increases burden to them due to the travelling cost and absence from their work.

2.5 Strategies for increasing health post utilization

Increasing health service utilization at health post level is a primary health care approach. Approach of primary health care emphasizes that health services at primary level should be able to reflect the perceived needs of the population and should be available within the reasonable distance. Health messages and interventions should be incorporated with traditional health beliefs of the community (Stone, 1986). Involvement of community members in decision process of health service system and

quality of services as perceived by the population contribute to better utilization of health facilities. Thus increasing access, quality of services as perceived by the population, availability of resources such as drugs at health facility and involvement of community representatives in health facility management contribute better utilization of public health services.

2.5.1 Making health services accessible

Accessibility to health services refers to distance in physical sense. Increasing access brings people more closer to the health facilities and thus reduces the travel and time cost for seeking health care. Study has shown that reducing the distance to health facilities increase demand for health service utilization (Mwabu, Ainswortha and Nyamete, 1995). Accessibility in economic terms refers to ability to pay for the services. Chalker's study in health service utilization have shown relationship between cost and demand of health services and indicated that increase in service fee decreases the utilization of health services (Chalker, 1995). Therefore, health services should be within reasonable distance and be available at affordable price to increase better utilization.

Increasing access of health services in physical terms is not an easy task in country like Nepal, where huge number of people lives in the rural settings. Villages are not only scattered; many rivers and forests make travel more difficult to reach. In such a situation making health services closer to the population requires a lot of resources, which may not be cost effective in comparison to urban setting. In such a

situation, exemption policy targeting to geographical location will be more effective by which people living out of reach of health facility may get compensation for travel and time cost incur for seeking health services.

2.5.2 Increasing availability of essential drugs

Provision of essential drugs has been considered as one of the components of primary health care (WHO/UNICEF, 1978). The World Health Organization's definition states that "*essential drugs are those that satisfy the health care needs of the population, they should therefore be available at all times in adequate amounts and in the appropriate dosage forms*"(WHO, 1990). This definition of essential drugs emphasizes mainly in selecting appropriate drugs based on morbidity patterns of the local health area, adequate quantity and regularity in availability, and appropriate dosage forms. Public health facilities intend to provide services to the massage of people, therefore essential drugs should be in the cheapest dosage forms and of good quality. Drug dosage in the form of syrup and capsules cost more in comparison to tablets. Thus essential drug policy contributes to adequate supply of safe and effective drugs of good quality at a reasonable price to ensure that they are properly prescribed and used.

People use health facilities in order to satisfy their perceived need generally arise due to illnesses or injuries. Drugs are considered most potential agents in satisfying the need of patients. Thus drugs play an important role in inducing demand

for health service utilization. Study has revealed that scarcities of essential drugs at public health facilities decrease health service utilization (Mwabu, et al. 1995).

Drugs are related to curative services and frequently offer an immediate solution to a visible problem. Some study indicated that availability of drugs in a health facility makes health workers job more comfortable. Health workers in Uganda experienced that lack of chloroquine made them difficult in providing other services (Goodman & Wellington, 1993).

Modern health care is to a large extent synonymous with modem drugs (Stone, 1986). In developing countries, in the absence of the basic prerequisites of good health like adequate nutrition, safe drinking water, and sanitation measures, drugs play an even more decisive role as the first line of defense against communicable diseases.

Curative services are perceived most important and people often willing to pay charges for drugs in comparison to other health services in rural settings. Thus, drugs are regarded as potential source for generating revenues at local level. Regular supply of drugs in adequate amount and at an affordable cost in a health facility contributes better use of health services (Muwabu et al., 1995; Holloway, 1997, Bodart & Litvack, 1993). Bodart and Litvack's study in Cameroon showed than availability of essential drugs at local health facility in a reasonable price resulted in better use of health services by the lower socio-economic group of people. At is because of the availability

of drugs at nearby facility reduces transportation and time cost, thus the effective price of care is actually decreasing not increasing.

Therefore, availability of essential drugs at public health facility is a perceived need of both health providers and community people. Drugs are potential in generating the revenues and demand. Designing the financing mechanism for drugs is not difficult and administratively more feasible than other forms of health care financing. In spite of these realities, the problem of drugs goes beyond the question of shortage in many developing countries including Nepal.

Nepal has been spending 20.15 % of its health care budget, for the supply of drugs and equipment (DoHS, 1995/96). Most of this amount goes for the supply of essential drugs at rural health posts. There are 611 health posts and 3199 sub health posts throughout the country. These health facilities receive a bulk of drugs from ministry of health once in a year. Studies have shown that these drugs met only 50 % of need of these health posts (Chalker, 1995; BNMT, 1995). For rest of the time, patients of these health posts rely on private drug stores for essential drugs. More importantly, in most of the rural area, drug are not available and people have to travel many days to get to the drug stores. This problem of essential drug has resulted in low utilization of public health facilities in rural Nepal.

This situation of drug shortage at rural health facilities indicates that there is a greatest need for providing fund in order to supply adequate amount of essential drugs

and there is less possibility that government will increase budget for these health facilities. Therefore, community financing or user charges levied against curative services and supply of essential drug along with quality improvement could be the best alternatives in increasing health post utilization in Nepal.

2.5.3 Involving community people in health facility management

Community participation is one of the basic themes of primary health care and involvement of community is considered as a determinant of a program's acceptability in the community. Thus the extent to which the community is involved with planning and management can significantly affect the operation of the health program/community participation can mean very different things, depending on the process by which decisions are made and the community representatives who are involved (Goodman & Wellington, 1993). The success and failure of community participation will depend on the quality of commitment given to participation as a process whether it is real, or it is a token gesture.

Involving community people or their representatives in planning and management of health facility in a fully consultative way increases acceptability of services and contribute to better use of health services (Shaw, 1995). Participation of community people play an important role in information process within health system and provide better opportunity for health managers to understand people's perceptions regarding health services, thus it contributes to necessary alteration of the program in a more acceptable form.

The involvement of individuals and the community has been increasingly seen as an important means decentralizing decision making in health matters. The emphasis of community support in most developing countries has been on providing resources, either financial or material and human for the establishment of health facilities. Community involvement sustains health programs, indicates people's willingness and ability to pay for better services. People likely to involve in health activities only if they recognize needs that are not covered or only partially covered by government program and the necessary resources.

The need for community involvement in every stage of the health programs has given priority but in reality communities are only seen but not heard (INF, 1995). They are only seen as receiver of services whatever available and most often ignored during decision process. Health development, is the responsibility of community, health care providers and other people outside health sector. Therefore, there is a need for developing partnership between these potential partners when developing health related strategies especially in developing health care financing mechanisms (WHO, 1988).

Experiences from many community financing schemes have shown that involvement of community people in planning and management of these schemes has not given priority and where communities are considered as a partners of health development programs, communities were found successful to manage and finance health services at local level (Manic, 1989).

development programs, communities were found successful to manage and finance health services at local level (Manic, 1989).

Implementation of community financing schemes requires effective management. Only making a committee of community representatives does not necessarily bring improvements in health system management. It requires strong commitment of all potential partners involved and even more orientation and refresher training in planning, management, supervision, monitoring and evaluation is needed for health staffs and community representatives and study tours to existing schemes are found effective means of orientation training, and sharing experiences (Kanji, 1989).

2.5.4 Improving quality of health services

Quality of health services refers different meaning to different people. The health professional's viewpoint regarding quality of health service, represents technical standards of the care to be provided which is related to better facilities, equipment and other technological aspects of health services. Butfrom the public viewpoint quality of care refers to the ability of services to satisfy the individual's health need. Therefore, availability of services including drugs, time taken for receiving the service, attitude and behavior of health care provider are more important factors regarding quality of health services.

Studies have shown direct relationship between quality of health services and utilization.Improvement in quality of health services from the perspective of consumers

has shown greater positive effects on health service utilization (Mwabu et al., 1993), but improvement in quality of health services from the perspective of health professional has shown very little effect on health care utilization (Levy and Germain, 1995). Lavy's study in Ghana showed that improvement in availability of drugs and services and reducing distance to health facility appears to have a larger positive effect on use of public health facilities than does the negative effects of raising user fees. Therefore, Experiences have shown that when user fees are accompanied by a notable improvement in quality of health care, over all utilization does not decrease, but in fact increases.

Interventions for improving quality of care as perceived by the people require less resources compared to professionally perceived quality and people can contribute for this. Thus improvement in quality of health services make people more tolerable to pay for services. Notable improvement in quality of services contribute to compensate welfare losses from the introduction of user fees when revenues are reinvested for the benefit of community at local level (McPake, 1993).

2.6 Role of health post committees

Community-level health or development committees are found in many countries. Health committee is defined as a group of selected people representing different socio-economic and political classes who then act as an agent on behalf of the community for specific health activities. Health committees, in the context of primary

health care are simply means for involving a community in management and financing of a health facility. Such involvement implies that the committee participates in the planning, organization, operation and control of local, public and other available resources (Agudelo, 1983).

Health promoters, health committees, user groups, co-operatives and the community as a collective whole are agents of community participation (Agudelo, 1983). The presence or absence of such agents, tend to reflect the community's level of development and experiences with participation in health work reveal key aspects of the community involved, at least with respect to its organization, ability to act and autonomy.

The role of health committees as an agent of participation in primary health care is to manage the agents, resources and activities available to the health facility. The idea of working through health committees is most suitable where social, economic, cultural and political diversities exist (Madam, 1987; Usalde, 1985). This approach of participation through health committees wore with the principle of co-management when a community shares management of the services with a health facility, and decisions regarding the health services to be carried out will also be shared.

Agents of community participation posses different level of expertise which may contribute to better health facility management, if their roles are defined clearly

and make known to each other. Caries A. Agudelo in 1983 (Table 2. 1) suggested that making an inventory of various activities that may be performed at each stage of the managerial process of the health facility helps in assigning specific roles to each possible agents in a health facility. Further more, it provides guidelines for evaluating the level of community participation. The assignment of roles to different agents depends upon the policy, level of education or ability to perform the task and the nature of activities to be carried out.

Table 2.1 an inventory of basic participatory activities that can be performed at each stage of the managerial process in a health facility.

Stages of managerial process	Activities to be carried out	Examples of indicated activities	Assignment of role
a) Planning	1) Diagnosis 2) Establishment of Goals and priorities 3) Programming	Performance of surveys and community studies, Problem identification Discussion of goals and priorities Development of proposals, discussion of activities and collective actions	Health committee
b)Implementation	1)Administration of services 2) Performance of technical activities 3) Provision of education 4) Use of services	Management of health facilities including collection of fees, drug purchase, etc Consultation, Dispensing of drugs, vaccination, home visits etc. Disseminate information to the community. Use of service	Health committee Health workers Health committee Community
c) Control	1) Supervision	Analysis of quantity, quality of health services provided	Health committee
d) Evaluation	1)Discussion and assessment of results	Holding of seminars, and meetings of the committee	Health committee

Source: Caries A. Agudelo C., (1983). Community participation in health activities: some concepts and appraisal criteria, *Bull. Pan. Am. Health Organization.* 17(4), pp. 375-386.

Local health committees could be effective means to resolve some immediate health problems, to improve the utilization of services, monitoring/control the performances of health facilities and articulate communities' interests and demands (Ugalde, 1985). Therefore, health post committees, if formed carefully with better representation of each socio-economic stratum and given a specific role can be an effective means for improving health facility management. It creates a forum for different agents of community participation and promotes better collaboration of efforts made for health development and community collectively accepts a program, decides to promote it and use its services.

2.7 Approaches to health care financing

Health care financing is a general term, which refers to the resources used to provide health care to the population (Goodman & Wellington, 1993). While it most often refers to money, it also includes other resources that are used, such as voluntary Tabor or gifts in kind by the communities or people outside the health system.

Methods of financing health services are relevant to health policy of a country and vary from one another. Abet- Smith in 1984 has suggested four main approaches to health care financing (Abel-Smith, B., 1984) such as general taxation, insurance, foreign aid or grants, and user charges or community financing. The World Health Organization in 1986 has set seven criteria for choosing financing strategies such as

equity, adequacy, reliability, impact on supply and demand, and administrative feasibility (WHO, 1988).

2.7.1 Indirect financing through general taxation

Financing of health services by the government through public revenues is perhaps the most widespread approach in the wold. Governments collect revenues from different sources in order to provide funding for different public activities. All revenues go to central government account and then allocated to public departments as agreed policies. Public health department receives a portion of such revenues usually very less than the amount allocated to defense in many countries. Sound administrative infrastructures are required for recognizing and collecting revenues from entire economic activities, thus collecting taxes itself is an expensive task in many developing countries.

Countries like Nepal where such infrastructures are lacking rely heavily on indirect taxes as a source of revenues. This approach of financing health care is reliable but less equitable in developing countries like Nepal. Because tax system affects mostly to the poor who spend a large share of their income on taxable ,Goods, and there is no guarantee that these people who pay taxes receive health services (WHO, 1988). Although, government finance contribute to free health services, it does not necessarily result in services being available to the rural people, where health services are concentrated in urban areas, the rural poor may not be able to get them even they are free (Able-Smith & Leiserson, 1980).

2.7.2 Health Insurance or Risk Sharing Schemes

Insurance or risk-sharing schemes operate to provide health care for those who are the members of the scheme. It is necessary to make a regular payments of a ore determined sum of amount (premium) for getting services, which means that people how to pay whether they are healthy or sick. This payment enables a person to receive health care with or without additional cost depending on the insurance policies. Thus, it is an insurance mechanism against the risk of falling ill and suddenly having to pay high treatment cost. Sharing of cost between sick and healthy people is the most important advantage of health insurance schemer. Collecting premium is easier than collecting other government revenues and the payer receives services directly under such provisions. Although, health insurance and other social security schemes have many advantages than other forms of health financing, feasibility of such schemes is less likely in least developing countries, where people rely heavily on non cash economic activities (Abel-Smith, 1986).

2.7.3 Financing through external aid, direct transfer and grants

This type of financing mechanism refers to the provision of a quantity of resources, whether money or supplies, which does not have to be repaid. The quantity or amount and utilization of such grants have been decided in advance between donor and receiver.

Many developing countries such as Nepal still heavily rely on external aid for funding health services. Although government has been trying to generate revenues from various internal sources in order to provide fund for different public activities, Nepal still rely on external aid for funding public health services. It is estimated that 56.4 % of Nepal's health budget has been born by external aid agencies (DoHS, 1995/96).

External aid and grants are such sources of health care financing, which do not put on additional burden to the population. But most of these grants and aid will be provided under ore determined criteria usually set by donors. More importantly, such aid and grants provider always ask the government for allocating some amount of their national income for the proposed program. Most of these programs follow the donor interest rather than the needs of the populations.

2.7.4 Community financing or user charges

The problem of lack of adequate funding for public health service in developing countries has becoming a global issue. Due to the increasing demand of population for basic health care facilities, many developing countries like Nepal have been facing problem in providing fund for public health services through government sources. Therefore the need to search an alternative other than general public funds is no longer a question in most of the developing countries. Since the declaration of Alma-Ata in 1978, many developing countries have shown their commitment for providing basic health care facilities to the population with or without imposing cost to the users of

health services. As a result of this, primary health care networks have been expanded in order to increase the accessibility of such basic health services. Most of these services require funds in a regular basis for providing salaries to the health workers, medicines and for maintenance of equipment. Because of high operational cost of these public health facilities, many governments in developing countries have been facing problem for funding such public health facilities.

The idea of community financing has developed from the traditional health care system of the community, where people have been paying something against the services. The only difference is that the form of payment was mainly in kind and health care providers are not the part of public health facility. Such types of health services are still popular in many countries and providing both traditional and modem health services to the population. De Ferranti in 1985, noted that the most private spending on health is through user charges, and private out of pocket expenditure accounts for a large fraction of total health expenditure, larger, often, than public expenditure in developing world (be Ferranti, 1985).

Community financing refers to fees or charges levied to the patients or users of the health service for a treatment or service received. The fee might be for the consultation, drugs, diagnosis tests or all or any of these things depending on the policy set by the health care system or community or both. Thus community financing is a direct form of financing health services, where people pay set charges for service in order to receive them.

Countries like Nepal, where health care financing through general taxation is inadequate and possibility of introducing insurance schemes are less likely to happen due to large agriculture based rural population, user charge may be the potential option for Financing some of the health activities provisional at rural health posts. User charges are best suitable for curative services and drugs as these are perceived most important by the rural population and provide immediate satisfaction (Ferranti, 1985; Stone, 1986). Though user charges may not generate adequate amount of funds required for the health facility, it can provide some fund for health facility such as for purchasing essential drugs. Management of user fees including collection and allocation takes place at local health facilities for which extra manpower and cost is not required.

2.8 Implications of user charges

Introduction of user charge inside the public health network has been viewed with disfavor because of its possible impact on equity, and utilization of health service. These people argue that a free health service should be a basic right for all citizens. This type of reluctance to consider alternatives to free health services became a barrier to the exploration of other means of health financing. However, the reality of the situation often is such that an insistence that health services should be free of charge meant there would be virtually no health services at all (Goodman and Weddington, 1993)

2.8.1. The issue of equity and user charges

Many studies have claimed that user charges generate revenue only at the cost of equity. But this is not always true and inequity is always existed with in the health system. Such type of inequity is not only because of the financing mechanism. When drug stock run out in a very remote health facility the people have to travel even many days in country like Nepal in order to get a simple medicine. In such a situation, travel cost and time cost will be many times greater than the user charge of health services levied at health facility. Most of the user charges based on cost sharing principle can easily compete with private health providers in urban areas due to less coverage charge in comparison to private providers. Therefore introduction of user charge in public health facilities, based on cost sharing principle does not necessarily cause inequity. The possibility of inequity can be minimized by appropriate exemption policy at health facility level (Gilson et al., 1995)

Gilson has suggested three ways of targeting for exemption while making decisions regarding users fee policy. These are:

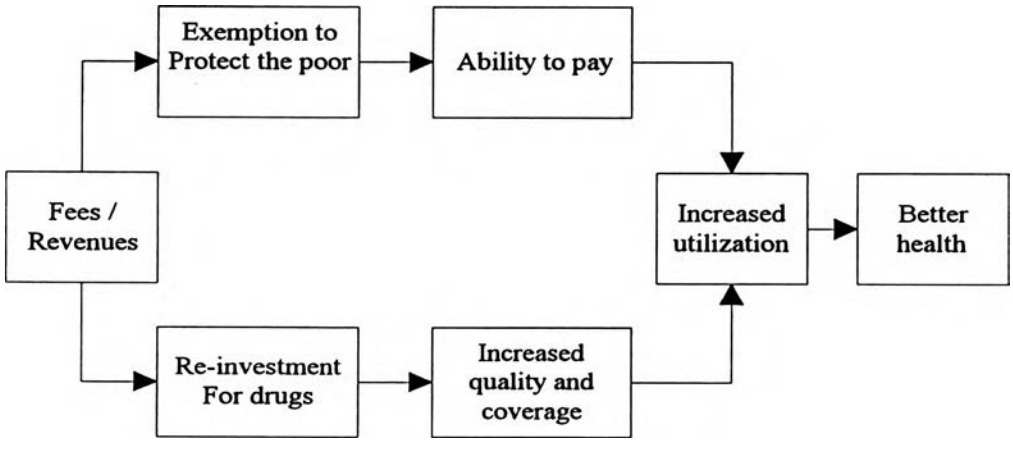
a) Exemption targeting to different health activities: Policy can be made to charge only for specific services such as curative services and drugs and other preventive services can be made free of cost.

b) Exemption targeting to different economic status: Different level of fees can be set for the people with different economic status such as less fee for poor and more for rich or even complete exemption for very poor who are not able to pay the services.

c) Exemption targeting to different age group: While making fee policies, people of certain age group can be completely exempted from the user fee such as under five years of children and adult over the age of 65 years.

These are the ways, which contribute better equity while introducing users fee in an ideal situation Implementing of exemption policies are really difficult in real situation. Exemption policy targeted to economic status is the most difficult one to implement. The difficulty in identification is the most problem. Exemption targeted to age group seems to be workable but people may not say their right age and there is possibility of misuse of this provision. Exemption targeted to the services is the most appropriate policy among these.

Figure 2.2 An ideal model of promoting equity through user fees and targeting



Source: Gilson et al., (1995), "The political economy of user fees with targeting: developing equitable health financing policy". *Journal of International Development.* Vol. 7, No. 3, pp. 369-401

This model (fig. 2.2) indicates how user charges introduced by government health facility promote equity in health service utilization. Appropriate exemption policy will protect poor and vulnerable group like children under five and people who need especial care such as tuberculosis; leprosy and other preventive health services will increase their ability to pay for services. From the user charges, levied for selective curative services and drugs will provide fund for health facilities for the supply of essential drugs in a regular basis, which will improve the quality of services. Thus, better equity and utilization of health services can be achieved through the introduction of user fees if there is provision of appropriate exemption policy, and quality improvement in health services.

2.8.2. Impact of user fees on health service utilization

Studies have shown direct link between financing mechanisms and health service utilization. Some studies (Chalker, 1995) have shown decrease in utilization, where as some studies (Dave, 1991; Bodart & Litvack, 1993; Holloway and Gautam, 1997) have shown increase in utilization after the implementation of user charges at government health facilities. Therefore, experiences with different financing methods and health service utilization are mixed. Introduction of user charges without any provision of quality improvement in existing health services have shown greater

negative impact on health service utilization whereas, implementation of user charges with appropriate exemption policy and quality improvement have resulted in better use of health facilities by the population. Such type of increase in health service utilization have found in India where immunization coverage rate was increased from 50 % to 90 % after the introduction of user fees (Dave, 1991). Thus introduction of user fees are not necessarily reduce health service utilization if this will be accompanied with exemption policies and quality improvements. More importantly, user fees should be set with some references to service cost and some basis of household income.

2.8.3. Potential of community financing,

Community financing contributes to better utilization of health services in many ways and promote effectiveness of health care system (Abet & Mach, 1983). User fees create incentives for both users and providers of health services such as,

a) Fees add to the finance of services and thus improve them.
b) People value more highly services for which they pay and thus a more cost conscious atmosphere is created.
c) Exemption policy with targeting, decrease problem of inequity.
d) Even small fees will reduce the overuse of services and particularly the consumption of drugs.
e) Fees if used at local level contribute to availability of drugs and health staffs may feel comfortable in providing quality services.

2.9 Sustainability of community financing

Sustainability refers to the capacity of a system to survive in relation to a (river level of external support. Sustainability does not necessarily imply self-sufficiency; it does however, imply self- reliance, which describes a communities' initiative in assuming responsibility for their own health development (Goodman and Weddington, 1993). Thus a program can be said sustainable when the participants of the program understand their own limitations and know when and for what purpose to turn to others for support and co-operation. Sustainability is a process of making people critically aware about the factors that influence the long- term success of a program.

Many factors influence the long-term sustainability of a health program. Availability of finance and its stability or security does not guarantee the sustainability of a program. technical and managerial capacity of the organization is equally important, as is the external environment in which it operates. Motivation of the staffs and people always contribute to sustainability of the program.

Health planners should always consider income level of households, their willingness to pay for a service and appropriate exemption policy for a sustainable health care financing scheme. More importantly, policy should allow representatives of the community to have an active role in making decisions regarding collection of fees, making exemption criteria and reinvestment of the revenues. Training activities, supervision and monitoring in a regular basis contribute to better facility management,

and make program more sustainable. Health programs managed and financed by villagers in Senegal are found most successful and sustainable among the P programs in the world (Manic, 1989).

2.10 Conclusion

Under use of public health, services is a problem characterized by various socio-economic, cultural, and health system related factors. The present rate of health service utilization in rural Nepal is estimated at 0. 2 per population per year indicate that the population has not properly used these health facilities.

The need and demand for health services are influenced by various factors. These factors vary from person to person, place and time. The individual's need for health services is determined by age, sex, marital status and perceived symptoms of illness. Health professionals also play some role in producing health need and demand for health care but these are mainly to follow up services. Ability to pay for services, availability, acceptability and accessibility of health services play important role in producing demand for the use of health services by the population.

Unavailability of essential drugs due to lack of fund, lack of proper balance between curative and preventive health services and poor quality of services are the main reasons for low utilization of public health services at primary level in rural Nepal. Therefore, it can be concluded that introduction of user fees with considering

Families' level of income, can generate adequate revenue for the supply of essential drugs at local level. The issue of inequity and welfare loss due to implementation of user charges can be better addressed by appropriate exemption policy, re-investment of revenues for the supply of drugs and improvement in quality of services. Thus community financing of health services contribute better utilization of health services by the rural population, if this approach is incorporated with community participation, availability of essential drugs and quality improvement.

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