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In Search of Self-Sufficiency -- the Field Experience of a Department of Community Medicine

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The Department of Community Medicine of St John's Medical College Bangalore, has been involved with the development of community health projects in many villages of Karnataka. The primary purpose of the department's involvement in health care delivery was the establishment of health centres for training intern doctors who have a compulsory three months rural posting during their rotating internship. This is a university and curriculum regulation.

From the very beginning it was decided that health projects would be planned and evolved in such a way that the community would be encouraged to participate in the financing and management of the centres. This decision arose from a pragmatic assessment of many other programmes that had been externally funded.

Whether the fund was governmental or voluntary, private or foreign, it was found that the process of external funding resulted in the super-imposition on the local community of a system planned, organised, budgeted and executed for the community through decisions taken outside the community. Such systems were often irrelevant, and consisted of structures that were too costly, too unwieldly and unrelated to local reality.

From 1973-1983, the department was involved with the development of three health care programmes in three different areas. While each project drew inspiration and caution from the previous experience, we tried NOT to get caught up/with the discovery of a 'model' approach. In each area we tried to build the best possible approach with the resources available following an informal process of analysing the local situation.

Case studies

Village M: The first venture was an attempt to tag on a health function to an existing successful milk cooperative. Village M had responded enthusiastically to the promotion of dairying by the government. Forty five per cent of the families owned milch animals and were members of a registered milk cooperative. The production of milk ranged from 2500-3000 litres per day. The milk cooperative committees agreed to a health cess of three paisa per litre of milk to be deducted at source when the payment to farmers was made. A sum of Rs 2500-2700 would thus be available every month for a basic health care system.

The health fund collected was used to employ a doctor and a nurse. Three villagers were selected for on the job training as dai, dispenser and records clerk. Apart from staff salaries the fund was also used for drugs, rentals, travelling allowance and other materials.

Resources like vaccines, vitamin and iron supplements, contraceptives, surveillance of communicable diseases and health education files and pamphlets were tapped from government health centres to avoid duplication. The college department provided supportive technical supervision and posted interns to assist the health team to various activities. It also supplied some equipment through courtesy of UNICEF.

The health cooperative was managed by a committee consisting of representatives of the milk cooperative, the department of community medicine and the government health department. This met every month to plan the activities of the centre.

Fifty five per cent of the families in the village were not members of the cooperative. These were families that were involved in sericulture (25 per cent) and landless labourers and harijans (30 per cent). In order to ensure an equitable and just availability of health services to the member and non-member sections of the village, the following policy was evolved.

Preventive and promotive services which included immunisation, vitamin and iron supplements, ante-natal and post-natal check up, chlorination of wells and so on was made available free to all members of the community. Curative services were free for members but non-members had to pay. A section of the village through this cooperative endeavour, were contributing the total costs of non-curative primary health care services available to all. This was an added and unusual benefit of the scheme.

The leaders of village M showed great foresight, entrepreneurship and ability to handle crisis. This was very much evident in some of

the decisions they took as the programme evolved.
Six months after starting the programme the village leadership boldly decided to sell milk to a private party rather than the government dairy because of the government's indecision to change procurement prices in spite of increasing costs. This was done in spite of the risk involved in the loss of certain subsidies promised by the government dairy. Even more remarkable was the decision to raise the health cess from three to five paise per litre in view of the 25 paise increase in returns per litre.
In later years there was a shift in the economy of village M from dairying to sericulture due to a massive World Bank supported programme in that district. Milk production decreased to 900 litres per day and the health cess had to be increased to 15 paise per litre to maintain committed costs. Sericulture boomed in that area but efforts to cooperatise it had failed.
The options available to the centre were to either close down or start charging for services irrespective of membership. Some money had been saved over the years for investment in a chilling plant. With decrease of milk production this had become unnecessary and the leaders with their usual foresight, unanimously decided to invest the money in a health endowment for the centre in fixed deposits in one of the local banks. The health cooperative thus became a health endowment.
Nine years later, the village leaders once again put aside some cooperative savings and tapped additional funds from a government scheme to invest in the construction of a permanent building for the health centre as well as a medical officer's quarter. Till then the centre had functioned in a a rented building. It is to the credit of the village committee that even ten years after involvement, the department of community medicine was not called upon to invest in a single brick in the village !
The relationship which evolved between the villagers and leaders of village M and the professional staff of the centre and department was one of respect and partnership. The professionals had to change their patronising and superior attitudes, often the result of 'professional education', and get used to discussing with the leaders and villagers as equals and co-workers. The health team's role changed from the traditional one of ordering, advising and prescribing to a new way of sharing and awareness building.
Since the community was paying for the whole scheme, another important learning experience which the team had was on the need for patience with representatives of the community. Every new investment, whether it was for polio vaccines, refrigerator or even health education materials, could be made only after the health committee was convinced of the need. This sometimes took weeks or months. In the years to come this patience resulted in a confident, active and sound local leadership which was neither subservient nor dependent.

Village S: At the request of a Women's League, the Department adopted village S to organise a health programme. Unlike village M, the economy of village S was very different. Most of the villagers were wage earners who had jobs in the city. They commuted to and fro through a government bus service. Very few families owned land and there was little dairy or sericulture. The church was an important feature of this village and had over the years responded to the needs of the people through sponsored charity and distribution programmes.
It was decided to start a health programme funded initially by grants from the Women's League and a foreign funding agency. A committee consisting of local leaders, the parish priest, the Medical Officer of the project and representatives of the Women's League and the Community Medicine Department was formed. This committee, in addition to managing the centre, was required to initiate development programmes in the village which would gradually contribute to the health fund and take over some of the costs of the programme.
Over the years the committee and more specially the medical officer and her husband, a social scientist (both resident in the village) initiated a poultry, a women's handicraft centre, a dairy and other programmes. They organised a youth club and a women's club to plan and run the development programmes. The health programme which was initiated concurrently concentrated on maternal and child health and two village girls were trained informally as health workers to assist the medical team.
However, all attempts at tapping local financial support for the health programme failed. It was neither possible to put a health cess on development activities nor convince the villagers to pay for the

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services. Years of church sponsored welfare had created a stubborn dependence. In the past, appeals to the Bishop routed through proper channels had provided most of their needs -- food, jobs, education and medicines. They failed to be convinced of any need for self-support.

Villagers from neighbouring hamlets were ready to make contributions, including fee for services but in the absence of any participation from the two primary villages attempts at self-sufficiency were given up. To this day, the centre continues to be funded from external sources.

Villages of A-Block: In 1978, the State Government affiliated a government primary health (situated in Community Development Block A) to the community medicine department. This centre catered to a population of 72,000 spread over 101 villages. For two years the Department had a programme of supportive participation in all the activities of the health centre especially its maternal and child health and family welfare programmes. Then it was decided that the department team would try and establish health care programmes in the sub-centre villages of the block using a strategy evolved from the experience in villages M and S. These programmes would tap village resources and enlist community participation in their organisation. They would also complement/supplement the extension work of the government health centre auxiliaries.

Villages were identified, which were keen to establish local health centres. In each of them, village health committees were formed to manage and supervise the centre, operate local bank accounts, supervise funds. The assumption made was that payment for service even on a no-profit, no-loss basis would run up a deficit if no patient was to be refused treatment. Since there was a sizable proportion of the community who could not afford even the minimal costs, supplementary collections were vital to ensure the viability of the centres.

A nationalised bank was tapped by the department for basic infrastructural costs for initiating such a programme. These included costs of a jeep, a social scientist's salary, internship stipends and seed grants per health programme for equipment and initiating a rolling drug bank of Rs. 3000 per centre.

In about a year's time villages B,G,Y and H were identified and four small programmes initiated. Village health committees were formed in all of them. These committees found accommodation for the doctors (interns from the medical college) and the clinic. The types of accommodation were a village cottage, a room of the village school, an unused parish priest's quarters and a village teacher's quarters. Rules for payment of services were drawn up and a committee member was put in charge of supervising collections and maintaining accounts. Follow up of defaulters was the responsibility of the committee.

Supplementary income was raised by each village committee in different ways. In one village donations were collected from the village families: others made collections during festival time, put a health cess on a milk cooperative collection, tapped, panchayat funds, got a water diviner to contribute his earnings during a season, or contributed the proceeds of a village drama to the fund, and so on.

In addition to financial resources, a host of other non-monetary resources were also contributed to the centres. These ranged from repair and maintenance of clinics and residences with materials obtained locally; hospitality for visiting staff and specialists during camps; assistance in the organisation of formal and informal health education programmes as well as village dramas and street theatre; prizes for baby shows; village volunteers for camps and clinics; participation of school teachers, dais and youth clubs and women's clubs in organising programmes and so on.

The village leaders participated in village committee meetings enthusiastically, offering advice providing frank feedback and criticism, registering protest, offering support and encouragement when necessary, sharing perspectives and ensuring execution of decisions. This active involvement in decision making and management of the centre turned out to be an important component of the dynamic totality of self-sufficiency. No doubt political wrangles, personality clashes and differences of opinion were part of the process but the overall experience was quite positive. Three village centres continue to function to date. Only one centre was closed down and this due to local politics which prevented the committee from functioning effectively.

These three case-studies (seven centres) represent a small attempt in the search for self-sufficiency of community health programmes. It is important to clarify that these

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were evolving processes with phases of smooth functioning and points of crisis. More important than the micro-level study and analysis of these projects, is the derivation of broad conclusions based on the reality of these field experiences which pertain to the relevance and rhetoric aspects of this whole quest for self-sufficiency.

Self-sufficiency: Relevance and rhetoric

We are convinced that given an open, informal, decentralised approach, it is possible to initiate and sustain processes of self-sufficiency in health care programmes. Such processes can help take over a substantial part of the recurring costs of a programme.

Wider definition of self-sufficiency

Self-sufficiency as a goal should not be visualised in its narrow definition of local finances or monetary resources but must include a host of non-monetary material resources and human resources in the community. In its broadest sense, active participation by representatives of the local community in decision making in the programmes should be a crucial component of the goal of 'self-sufficiency'.

Funding 'process' not 'structures'

In the present socio-political reality, funding from external sources, be they government or private, industrial house or foreign funding agency will continue to remain a starting point for health care intervention programmes, even those in quest of self-sufficiency. however, if such external funds were used cautiously to fund process rather than constructions' or 'structures', then self-sufficiency would make some headway. Large buildings not only raise expectations in villagers but convince them of the vested interest that project personnel will have in the continuity of an externally funded programme. Both these put a stamp on future dependence and stimulate local initiative to extract advantage and exploit the project rather than contribute to its future support or development. In the Indian experience, buildings are quite often available for use in the village. In our experience, investment in brick and mortar is not only unnecessary but also counter productive to the quest of self-sufficiency.

Tapping government sources

Even when non-governmental organisations are involved with health care programmes that aim at self-sufficiency, our experience has shown us the importance of tapping all the available government resources as part of the strategy. Apart from preventing overlap or duplication of efforts, tapping government resources, especially if it is done through generating pressure groups or some degree of social activism in the community, is almost always a good policy. It ensures that the NGO realises its catalyst role and does not get carried away with institutional or project development nor the pursuit of an unrealistic parallel services.

Maintaining status quo

Our experience evaluated from the perspective of social justice for the under-privileged and poorer sections of the community raises serious concern about the pursuit of self-sufficiency as an end by itself. If financial self-sufficiency becomes a primary goal of the programme then this will ensure that the main contact of the programme will be with the existing leadership of the village which in the Indian situation consists of land owners and rich farmers.

Two experiences clearly taught us the subtle but definite way in which this aspect of village reality operates:

* When harijans and landless labourers began to invest in milch cattle, because jobs in sericulture provided alternative green fodder, the village leadership intervened by closing cooperative membership and forcing prospective members to sell milk to the cooperative rather than participate in it -- thus effectively keeping out the lower sections and affecting the availability of health services to them.
* Another case in point was that village leaders had agreed that Rs. 200 would be set aside every month from the cooperative fund for concessional or free treatment of poorer sections in village M. When there was an economic crisis due to shift in economy from dairy to sericulture this subsidy was slashed making health services once again inaccessible to the poorer sections.

Unethical Medical Practices

With the escalating cost of drugs, health teams committed to quests of self-sufficiency are often pressurised to balance the budget by resorting to practices such as administering of unnecessary injections and tonics, selling of physicians' samples, prescribing unnecessary drugs. These practices help to increase the returns. However even though these practices may be directed towards the affluent sections of the community, they are in principle unethical in both a professional and a social sense and not compatible with the principles of community health.

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What next? A plan of action

At the end of four days, out of the floating, colliding, and exploding of issues, a plan of action somewhat miraculously emerged. It addressed the workshop's many recurring themes. First, a committee was formed to pursue the acquisition of management skills and the documentation of health financing experience.
Second, a commitment was made and a committee formed to increase the sector's advocacy role in policy making; particular priority was placed on regulation of the private health sector.
Finally, the importance of of continuing the debate over the sector's future directions was asserted.
To this end, a second annual health financing meeting was scheduled.

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(This report is based on the workshop papers listed below, presentations, and give and take during animated and often fast-paced discussion. As the presenters alone are explicitly referred to in the text, we would like to acknowledge and thank all the workshop participants, many of whose ideas are included above, for their contributions to this evolving assessment of health finance in the voluntary sector.)

Berman, Peter, "Information Needs for Programme Financing"

Berman, Peter and Priti Dave, " Experiences in paying for Health Care -- India's Voluntary Sector"

Bhagatt, A.K., "Management Information and Supervision"

Dave, Priti, " Community and Self-financing of Health Programmes: Experiences from India's Voluntary Sector"

Duggal, Ravi, "State Health Financing and Health Care Services in India"

Ghosh, Sanjoy, "The Case of Urmul Rural Health and Development Trust"

Jajoo, UN, "Financing of Health Projects: Mahatma Gandhi Institute of Medical Sciences: The Sevagram Experience"

Mahapatra, Prasanta, "The Need for Developing a System of Sub-Allocation of Resources for Health Institutions in Developing Countries"

Menon, Raja, "Income Generating Projects for Health Financing"

Menon, Raja, "Health Financing - The CINI Experience"

Mukherjee, A.K., "Government Funding of Health Care"

Kumar, Paresh and Ravi Narayan, "In Search of Self-sufficiency: The Field Experience of a Department of Community Medicine"

Poddar, D.P., "Financing of Health Projects: WBVHA CDMU Experience"

Prabha, Sr., "Financing of Health Care - The Experience of RAHA

Rao, K. Venkateshwara, "Financing of Health Care - The Experience of Voluntary Health Services"

Sharma, S.C., "Government Funding of Healthcare Programmes"

Talwar, Prem P., "Strategies for Development of Technical Skills Among Voluntary Organisations: Some Experiences"

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The goal of arriving at some sort of a model project in one village which can then be replicated in every other village has plagued the organisers of community health programmes all over the world. Our experience has clearly shown that this pursuit of model approaches is nonsense in reality. In the final analysis, self-sufficiency in terms of generating local community resources, be they monetary or material, should be an important but not exclusive objective of a community health programme. When it is exclusive it will ultimately keep out the poorer and under-privileged groups in society. For self-sufficiency to mean much to people and particularly the poor, the good should be reappraised and strengthened in its human sense of participation in planning and active decision making. Community health programmes would then strengthen the people's own ability to plan and organise programmes for maintaining their own health. These would mean an increasing commitment to demystifying medicine, health education, skill transfer, promoting autonomy and improving group relationships. Only such a process would make the pursuit of self-sufficiency 'relevant' rather than 'rhetoric.

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