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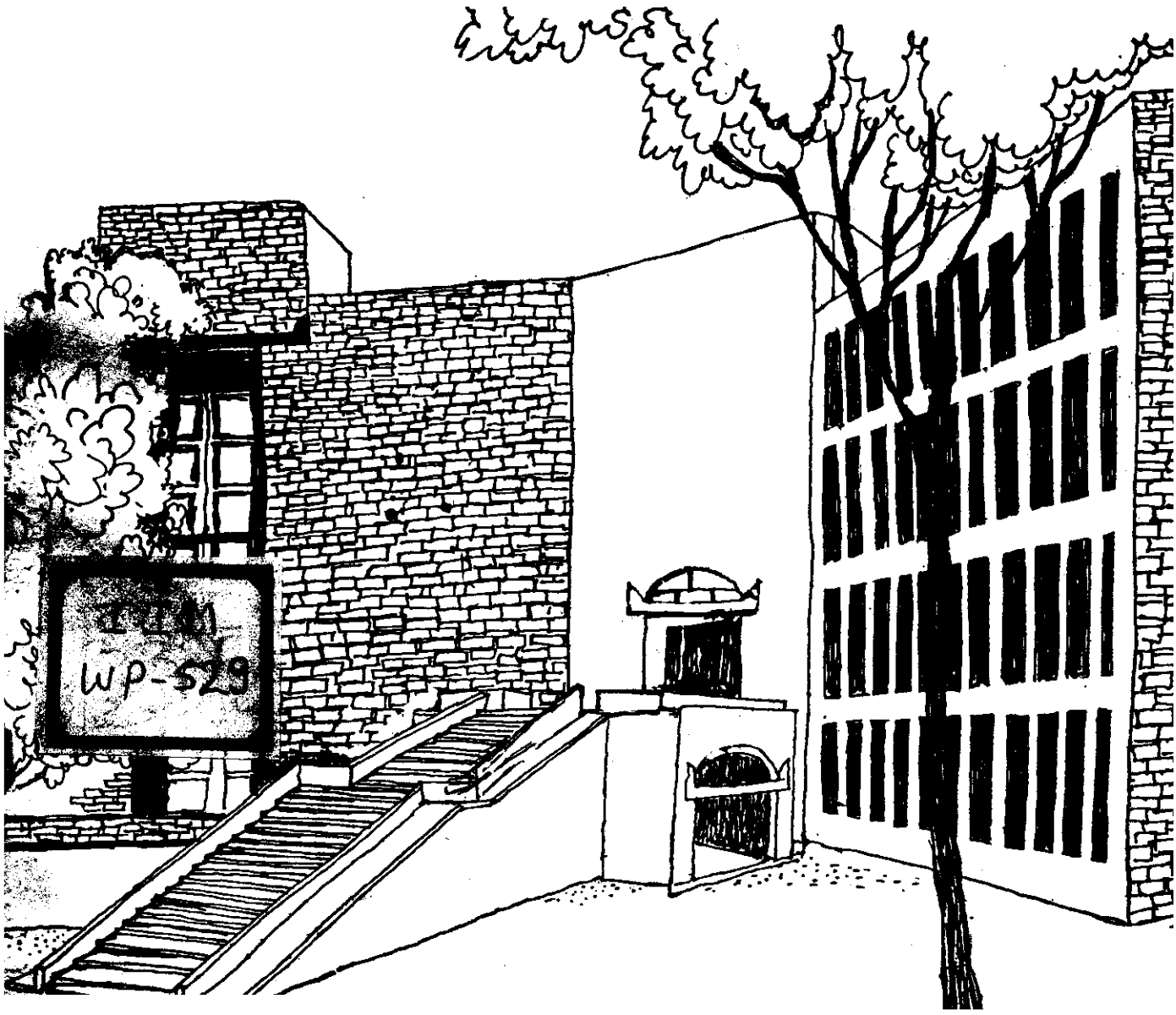

SELF SUFFICIENCY IN COMMUNITY HEALTH PROGRAMMES OF VOLUNTARY ORGANIZATIONS

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SELF SUFFICIENCY IN COMMUNITY HEALTH PROGRAMMES OF VOLUNTARY ORGANIZATIONS

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Self-sufficiency in development programmes and more specifically health programmes continues to be an issue of debate. Donor agencies are pressing their project holders to achieve self-sufficiency but meeting with failure. The projects on the other hand keep attempting, with increasing frustration, to become self-sufficient. This paper attempts to examine the issue of self-sufficiency and also help continue the debate with a little more understanding of the problems.

SELF SUFFICIENCY IN COMMUNITY HEALTH PROGRAMMES OF VOLUNTARY ORGANIZATIONS

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I

Introduction

Voluntary health organisations (VOs) have been increasingly concerned about financial self sufficiency in their community health programmes (CHP). There are two main reasons for this concern. Firstly, external donors do not want to support any developmental activity for an indefinite period. Secondly, as VOs begin to view development as a process of strengthening the community's socio-economic and political status, they question the value of continuing large doses of external funds. It is argued that dependence on such funds may lead to an erosion of the VOs' autonomy. On the other hand, use of local resources would eventually lead to lesser reliance on external funding. Consequently, many VOs search for ways and means of mobilizing resources from a variety of local sources, most importantly from within the community. It is quite common to come across discussions on this issue among the staff and managers of VOs, between VOs and between VOs and donors. This paper is a review of this issue. It is an attempt to clarify the meaning of self sufficiency and contribute to the discussion. This is not an academic exercise, but rather meant to serve as a self-explanatory document on the question of self sufficiency of VOs and their community health programmes, which VO leaders can read and reflect upon. The paper is divided into five

sections; introduction; aspects of self-sufficiency; the VOs' views; items for self review by VOs and conclusion.

II

Aspects of self sufficiency

Self sufficiency denotes a situation where the VO is not dependent on any other external agency such as a donor or government for funds to provide its services. That is, the income generated by the VO would be sufficient to meet the expenditures incurred on the services.

The VO normally incure two kinds of expenditure - recurring, operating expenditures and non recurring, capital expenditures. Recurring expenditures relate to salaries, supplies, utilities and other administration of the CHP. The latter expenditures relate to those of a capital nature such as on buildings, equipment etc. The question arises whether a self sufficient VO can finance its recurring and non recurring capital activities through income generated from its services. Even commercial organizations obtain funds for capital projects and expansion through a mix of loans, share capital and reserves. VOs too will have to seek external sources of funds for capital expenditures. In practical terms, self sufficiency signifies a situation in which the VO is able to meet the financial requirements of its annual recurring activities through income from its own services.

Raising income and reducing costs

The VO can meet its annual requirements for recurring funds in two ways : by raising income through provision of priced services or by reducing its expenditures so that available income can be utilized for ongoing activities. We shall now discuss strategies open to VOs to realize these goals.

Income raising efforts and their implications:

If the VO is to raise income through its programmes, it must price its services offered to the community. But not all sections of the community will be in a position to pay for services. A uniform price for services is likely to exclude the poor. The VO, with its concern for the economically weaker sections, will find this an unacceptable situation. It will then to have to resort to differential pricing for the same service, the price depending upon the user's capacity to pay. Concessions and free care are usually offered by VOs.

There are two main implications of this income raising strategy and they relate to the VO's services and to the beneficiary population. Firstly, the VO may be tempted and, in times of financial stringency, even compelled to concentrate on services which generate income rather than on those which produce deficits. Thus, services for which there is demand from the community will be given priority. In health, these are most likely to be curative services, because they are usually a greater felt need. The VO is, therefore, also likely to focus on curative care in its CHP instead of comprehensive care which includes

the more difficult, less demanded, deficit creating health education and other preventive measures. Consequently, curative services may become the unintended priority of the CHP.

Secondly, there may be a similar unintended shift in the type of beneficiary population served by the VO. The poor cannot pay for the VOs' services, but the VO needs the income. It is the middle and upper income groups that may be able to use the health services to the fullest extent because of their capacity to pay. Eventually, the VO may find that the dominant users of its services are not the weaker sections. Indeed, voluntary hospitals have the experience of being able to spend only 10% of their gross income as free care to subsidize the costs of treatment of those who cannot pay. While this is the usual "gross-subsidization" practice (extracting more from the better off to pay the bills of the poor), the danger is that over time, the dominant sections of the community, the better off, may become the VO's focus of activities and attention.

The VO can adopt an alternative strategy for raising income for its recurring activities. It can start an economic activity which will produce an income for the people and thus finance the CHP since the CHP on its own may not be able to generate the necessary funds from its operations. VOs usually start a cottage industry or handicraft activity and run it as a commercial venture. Some VOs rent out their land or premises in prime shopping areas and thereby raise funds for their social services. The main problem here is that the "economic" activity of the VO is very different from its social service programmes.

It will require a commercial set up, business acumen and acute sensitivity to the market. The VO will usually find it difficult to obtain and retain expertise which can organize its commercial activities. The nature of the tasks and the nature of the organizations required for the commercial and developmental programmes are likely to create two somewhat incompatible wings within the GO. It will then be faced with the not-so-easy task of integrating these wings.

To the enterprising and dynamic VO, the picture presented here may appear to be too gloomy. We wish to encourage VOs to raise as much resources as possible; but we do want to point to certain possible consequences. The danger pointed out here is that the VO's programmes may turn out to be very different from the way they started out. A CHP is expected to provide a set of comprehensive curative, preventive and promotive services. In fact, the VO may find that only one kind of service, viz. curative, is rendered with the usual paraphernalia of injections, high cost drugs, tonics etc. Similarly, the VO may have set itself up as an alternative to the market which serves only those who can pay for services. The pricing mechanism and compulsions of self financing may instead push the VO towards a market model.

Cost reduction efforts and their implications:

If raising income presents possibilities and difficulties for the VO, another route to self sufficiency is that of cost reduction and containment. This will require a check on all expenditures of the VO's programme. Salaries, material supplies, transportation, utilities and office items account for almost all of the recurring expenditures. Of these, salaries and supplies are the major items. It is somewhat

difficult to reduce salary expenditures because a critical minimum number of personnel is needed for efficiency work. Often, the VO is short staffed with one person combining many tasks. Salary scales are also lower in comparison with the market rates. For instance, VOs find it difficult to retain nursing personnel because of the attraction of higher pay and greater security of tenure in government. The VO will therefore not have many means of reducing salary costs. It can certainly attempt a more efficient allocation of tasks. For instance, VOs have found that it is useful to conserve the time of the professionals for tasks they are better equipped to perform. The doctor and nurse can render referral services while the community health worker or health auxiliary can deal with first level treatment and care.

Material supplies is a promising item for cost reduction purposes. Thirty to forty per cent of all expenditures of a CHP could be on supplies. Of this, drugs can account for a substantial 80-90%. The VO can attempt means of reducing the cost of supplies through better purchasing, storing and dispensing. The generic drug vs. the brand name is an ongoing debate in this context. The branded drug has been known to cost a minimum of 100-200% more than the generic one. Syrup and injection based drugs can be more expensive than those available in tablet or capsule form. Of course, the patient rather than the VO is likely to benefit from reduced cost of care, but these measures can help the VO subsidize care of those who cannot pay for services.

Better scheduling can help reduce transportation costs which can be significant in a CHP with farflung outreach activities. Conservation of electricity and water can contribute to an attitude of austerity and some savings. Proper maintenance of available equipment - X-ray machine, laboratory equipment - will ensure adequate utilization of assets and avoid wasteful breakdowns.

Just as in the case of income-raising strategies, there are implications of cost reduction strategies.

Use of low cost drugs and non professional auxiliaries may convey the impression that the VO has sacrificed quality and professionalism. The impression providing socalled "cheap", "second-rate" services may result in several repercussions on the CHP. The number of beneficiaries may decrease, for example, if fever injections or tonics are prescribed. The use of grass roots auxiliaries may create a demand for referal curative services from the weaker sections of the community who will not able to pay for the services, thus creating a financial overload on the VO. Cost reduction measures may also face the wrath of the system at large, which frowns upon such innovations, as attempts to reduce quality and standards of care.

Design of the community health programme.

We have discussed various means of raising or releasing funds for the VO to finance its CHP. Changes in practices of the VO can produce some results as pointed out. Some VOs may wish to review the very design of the CHP. Five major elements of design can be considered for review : the CHP's goals; target population to be served; organisation of the programme; specific activities and the technology adopted.

The VO may start with any one of the elements and organize its CHP. For instance, the VO may decide that it wants to predominantly serve the poor; it may then search for the right type of organization and technology with this aim in mind. The VO may decide to rely considerably on auxiliaries and community health workers for first level care and on government centres and hospitals for referral services, without setting up such facilities in its own campus. The VO may also search intensively for low cost drugs and technology that reduce costs for the VO's programme as well as for the people served.

On the other hand, the VO may start with a choice of organization for its health services. It might want to provide all the tiers of health care necessary for any population. Consequently, it will set up local first level care as well as supportive hospital facilities. The organization of the programme will also depend on the relationship between the programme and the community. A provider-user relationship will place the entire burden of management of the CHP on the VO. In this approach, the VO gives and the community receives services. The beneficiary is a passive consumer, having no direct involvement in the supply of health care services. This approach may leave little scope for the VO to tap resources from the community or to educate the beneficiary on the cost of care.

It is felt by some that changes in practices leading to higher income or lower costs can be useful but not significantly so. They argue that unless the entire design of the CHP stresses a low level of intrastructure, the VO is unlikely to move towards self sufficiency. That is, the VO should not undertake curative services (let alone commercial activities) or go in for sophisticated technology. Thus it

will not have the need to build a large campus and then worry about its maintenance.

While agreeing with the critique of CHP design, others hold that this is attractive in an ideological sense but is impracticable. Curative services are often a good entry point into any community and even for curative services, people these days expect more than a dispensary. Reliance on other facilities such as government hospitals is often counterproductive they feel, because of the overcrowding and alienating environment in these hospitals. In fact, the poor and the middle classes may lose in the bargain having access to neither the VO's nor the government's services. The rich will always find receptive nursing homes. According to this view, the so called community based model of health care should not be "overromanticized" and self sufficiency should not become the dominant goal displacing the more important one of serving vulnerable sections.

This discussion leads us to pose an important question : should the VO attempt self sufficiency for its services or should the VO try for self sufficiency of the community? This shifts the focus from the VO to the community. The VO need not be overly concerned about its own self sufficiency as long as it shows evidence of the local community gaining in self sufficiency.

III

VOs' views

The discussion so far suggests that there is no easy solution to the problem of self sufficiency. VOs and donor agencies desire it. Yet, they have nagging doubts about achieving the aim without distortion

in goals and practice. With the idea of presenting the contradictions and frustrations faced by the VOs in practice, we interviewed some of their managers. It is our hope that these views will throw some light on the intractable problem.

The VOs' views on the feasibility of self sufficiency were uniform. They thought, that it was infeasible especially when working with a poor community. The definition of the term may be many such as :

> "the ability of the VO to raise local resources for its expenditures",
>
> "the ability of the VO to make available government resources to meet the community's health needs" etc.

Irrespective of the definition, the VO can never hope to become self sufficient with regard to its CHP. In fact, the adoption of a more community based model makes it more demanding on the VO since it will not have the opportunity of charging for institutional services such as sophisticated hospital care and raising income.

Some of the VOs interviewed said that they have reached this viewpoint after trying out various measures for generating income.

One tried running a farm to generate a surplus while another attempted to develop and market handicrafts produced in slum areas. They found that the activities took up too much time; they failed as the VOs were not good at commercial activities and that finally they were forced to devote less time for health care. Most of them tried out various cost reduction methods, but felt that some cost

remained no matter what was tried and even this was too much for a poor community to raise. They felt that it was difficult to convey the state of impoverishment of the poor to outsiders and enthusiasts screaming for self sufficiency.

The practical failures have led some VOs to question the origin of self-sufficiency as a desirable and necessary factor in development. The origin of the concept of self sufficiency can be traced back to the 60's. Crores of rupees were then being poured into Third World countries by foreign donor agencies. When, after decades of such investment, commensurate effects were not seen, the methodology of aid was strongly questioned. The new concept of aid that emerged was based on the principles of "if you give a poor man a fish, he will eat a day but if you teach him to fish, he will eat all his life." From this reaction to doling out money and to charity also emerged the concept of self sufficiency. The pendulum had swung to the other extreme. Teaching a man to fish included the expectation of the project holders to eventually find and raise local resources. Anything leading to possible dependency was discouraged. Self sufficiency thus became a very desirable value. Sometimes it was a mere slogan.

The VOs who feel that financial self sufficiency was not possible were not opposed to efforts at raising local resources. They felt that self sufficiency could not be a criterion for evaluating CHPs. Moreover, acceptance of self sufficiency and measures to achieve this, assumed the existence of factors such as community participation; community's financial capabilities and perception of needs. These were the very aims of development and could not be taken as starting points in any CHP.

All of the VOs admitted to pressures from their respective funding agencies to attain self sufficiency. Some saw this positively as pressure to utilize resources efficiently; to raise as much local resources as possible and to maintain a lean infrastructure.

Others reacting to this pressure felt that it had dangerous effects on the VOs. The burden of attempting self sufficiency plus the guilt feelings when not succeeding made many VOs frustrated and ineffective. The VOs adopted measures like village health workers and auxiliaries and rational therapy as measures of cost reduction rather than through conviction as to their effectiveness or because of the value for deprofessionalised health care. This was dangerous as they were then fostering the idea of providing cheap care to the poor.

VOs also felt that the burden of self sufficiency was all too easily placed on the poor. Many services for the rich such as electricity for irrigation were subsidized by government, while the poor were expected to raise their own resources. Donor agencies and policy makers situated in urban areas did not realise the problems or the reality in the rural areas. They did not see the difficulty of people surviving without employment or food for days.

IV

Some items for self review:

Despite the many if's and buts regarding the issue of self sufficiency, VOs and donors alike agree that efficient use of available resources is important. They also agree that building a health care organisation which is infrastructure heavy makes it absolutely necessary to seek funds from the government or private donors on a permanent basis. In order to make efficient use of resources and ensure a lean infrastructure, certain questions should be kept in mind. Some indicators may also be useful for a periodic review by the VOs. These are listed below:

The VO has to decide on the type of service and the target population in terms of its microeconomic status. The VO can offer only curative services through its hospital, but this will not then fulfil the needs of a CHP. It can provide primary health care suited to local needs and leave secondary and teritary care to other agencies. Similarly, the VO's decision on the beneficiary is critical ; should be dominant section served be the poor, middle classes, women and children or urban slums? This point has already been discussed in an earlier section but is reiterated in order to stress the importance of raising this question.

The VO desirous of a lean infrastructure can keep in mind the following items for review :

Category	Item of expenditure
Land	- Capital cost
	- Maintenance
	- Costs due to location
Buildings & Equipment	- Construction costs or price
	- Maintenance
	- Utilization of space
Vehicles	- Price of vehicle
	- Maintenance
	- Utilization
	- Number of vehicles

Project Organization: (Figures given in bracket are ranges based on an analysis of data from CHPs of 4 VOs).

Personnel	- Ratio of personnel to population served (1:700 to 1:1300)
	- Ratio of supervisory to non supervisory staff (1:1 to 1:3)
	- Ratio of administrative to field workers (1:5 to 1:25)
	- Proportion of salaries to total expenditures (30 to 40%).
Transportation	- Proportion of transportation to total expenditures (15 to 20%)
	- Utilization (number of trips per month; population covered).

Supplies	- Proportion of supplies to total expenditures (20 to 30%)
	- Material cost per patient (Re.0.30 to Re. 0.70)
	- No. of low cost innovations in the year.
Total Expenditure	- Expenditure per unit population served (Rs. 7 to Rs.15 per capita)
Local Resources	- Funds raised from beneficiaries as a proportion of total funds (15 to 60%).

This is not an exhaustive list of items which the VO can use for self review. But the VO can put down items of income or expenditure it wants to monitor if it aims for greater self sufficiency or even self reliance. A special mention must be made of gifts. Equipment received as gifts are free of initial cost but maintenance expenditures and cost of spare parts will have to be met by the VO. The VO can also unwillingly "get hooked" into a system of health care which it cannot easily reject later. For example, the VO may go in for heavy prescriptions due to the availability of gift drugs and thus avoid the more difficult option of searching for low cost alternatives.

Conclusion

This paper is a quick review of perceptions and points of view on the issue of financial self sufficiency in community health programmes of voluntary organisations. The push for self sufficiency does impose a financial discipline on the VO. Yet the ultimate

realization of complete self sufficiency may be infeasible and even undesirable in the sense that it can distract the VO from its primary purpose of serving vulnerable sections with a range of services.

Since self sufficiency connotes a "closed" concept of an agency generating all the resources that it needs, some suggest an alternative concept of self reliance. Self sufficiency, they say, is not desirable in view of the fact that interdependence rather than independence was necessary. One need not generate all the required resources oneself. What is needed is the capacity to raise resources irrespective of the source. The source can be private donors, government or the beneficiary. The critical tasks are identification of sources, presenting the programme well and finding resources. It is also important to manage the relations with these sources so that no one dominates or interferes in the affairs of the VO and its programme. The VO should therefore not worry so much about self sufficiency as about self reliance or the capacity to deal with the environment so that adequate resources can be raised and utilized effectively. Taking this point further, it can be aruged that the VO must be concerned about raising the capacity of the vulnerable sections it serves to cope with their environment. So the beneficiary population, in particular, the weaker sections must be educated so that they gain the strength to identify needs, design services, locate funds and manage their own community health programmes. This view is presented here as a concluding note so that debate centred the entire question of financial requirements can be related to the goals of a voluntary organization.