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Public Financing of Health and Accessibility to Household Care in Kinshasa.

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ABSTRACT : This paper looks at public financinghealth and accessibility of health care for Kinshasa households in the Democratic Republic of Congo. Low funding for the health sector as well as household income levels hamper access to appropriate health care given the high costs. This results in an essential intervention by public authorities and their external technical and financial partners in the health sector in order to guarantee health coverage for vulnerable households against ruinous expenses.

He draws upat the same time an inventory of public finances in the health sector in the DRC using a theoretical approach. And yearanalysis by aLogit model the level of accessibility to health care. This analysis is carried out by postulating the constancy of the socio-economic environment “all other things being equal”.

It results from our analysis that public financing does not significantly impact household access to quality health care in Kinshasa, given that the majority of our respondents believe that the State must increase financial resources for health, the chi-square is 0.007. Thus we affirm our hypotheses

KEYWORDS: Public financing, health, Kinshasa households and logit model. JEL classification:H51, L12, I25

I. INTRODUCTION

Universal accessibility to health care remains an issue at the heart of all debates on progress towards universal health coverage.[1].The establishment of health systems that offer essential care, socially acceptable, equitable and made universally accessible to all individuals, to all families, to the entire community at all stages of their development and this, in a spirit self-responsibility was at the heart of the commitment made by several countries at ALMA ATA on the occasion of the first WHO summit on equitable care for all[2].

The health system has among its ultimate goals the protection of citizens against socio-health risks on the one hand and against impoverishment following catastrophic health expenditure on the other hand.[3].

The 2019 Global Monitoring Report indicates that people face enormous financial difficulties when having to pay for essential health services. This report indicates that financial protection is not improving and more than 930 million people worldwide spent more than 10% of their household budget on health care and more than 210 million spent more than 25%, and d Others were pushed into poverty because they sought health care.µ

In the DRC, access to care remains a problem for the population in need, according to the Enabel 2015 report on access to health care in the DRC, the commercialization of health care contributes to amplifying inequalities between rich and poor, the system is poorly regulated, fee-for-service payment initiates a vicious circle leading to a progressive deterioration of access to quality health care.

The health sector suffers from several ills, low budget allocation, excessively high household expenses, dependence on external financing[4]. It also faces enormous financial difficulties in meeting the growing needs of household health care demand. The

[1]*WHO “universal health coverage”, 2008. P58*

[2]*WHO “health for all in the 21st century”, 1997, p5*

[3]*WHO 2008, VAN Olmen2012 “universal health coverage and strengthening of the person-centered health system”, p, 4-58*

financing of the health sector in the DRC has traditionally, for several years, relied on actors made up of: households through direct and indirect payments (mutual health insurance), bilateral and multilateral external contributions, state budget, NGOs and international foundations . For the years 2018 and 2019 the shares allocated to the health function are respectively 8.5% in 2018 and 11% in 2019, while in 2020 the share of the budget allocated to health represents only 10% of the budget with a execution rate of 8.8%.

The 2021 budget, examined in the National Assembly in October 2020, the share of the budget allocated to health increases from 10% to 11.2% for 2021. This increase still remains insufficient compared to the Abuja recommendation. Health financing remains a barrier to the quality of care in health facilities, whether public or private; as public resources allocated to the health sector and their disbursement are low. Risk sharing mechanisms are almost non-existent, they are between 5% and 7% coverage[5].

Health spending in the DRC is mainly financed by households at 43% and external partners at 40%, the State has only intervened to the extent of 16% (in 2021)[6]. The rate of access to health care in the DRC fluctuates between 40 and 50% according to a demographic and health survey conducted by the World Health Organization in 2007 and updated in 2009. In fact, more than 30 million Congolese do not have access to quality health care according to this survey. Nearly 70% of households do not have access to formal health care and almost 80% of households are dissatisfied with health care.

In the city of Kinshasa, the financing of health care significantly hinders access to quality care because despite the glaring poverty of the Kinshasa population, the latter is forced to take care of themselves to finance health care. The health sector displays several constraints including the low budget allocation, in the share of the budget allocated to health, the city province of Kinshasa represents only 14.5% in 2021 with a low execution rate of 33.7%[7].

This reflection questions: (i) the impact of public health financing on the population's access to health care and (ii) also to know whether the price of health care constitutes a constraint on 'Health care access?

Based on this questioning, we hypothesize that: (i) the level of public funding for health in Kinshasa would not significantly promote the population's access to quality care in the urban commune of Kinshasa, (ii) the high cost of health facilities would constitute a constraint on access to care, given the high level of costs and the low purchasing power of households.

The answer to these questions, as well as the acceptance or rejection of these hypotheses required the use of the analytical method based on descriptive analysis. The latter accompanied by the documentary technique with a view to a brief literature review and surveys of households affected by the problem of access to health care.

II. OVERVIEW OF THE FINANCING SITUATION AND ACCESS TO HOUSEHOLD HEALTH CARE AND DR CONGO

The good health of the population reflects its need for the State, which explains the involvement of the State through public finances and health expenditure, to maintain health balance.

A well-functioning health financing system ensures that people access the health services and care they need without incurring impoverishing expenses. Furthermore, this system must ensure that its resources are used equitably and efficiently.

Chart 1: Evolution of the State budget allocated to health from 2008 to 2021.

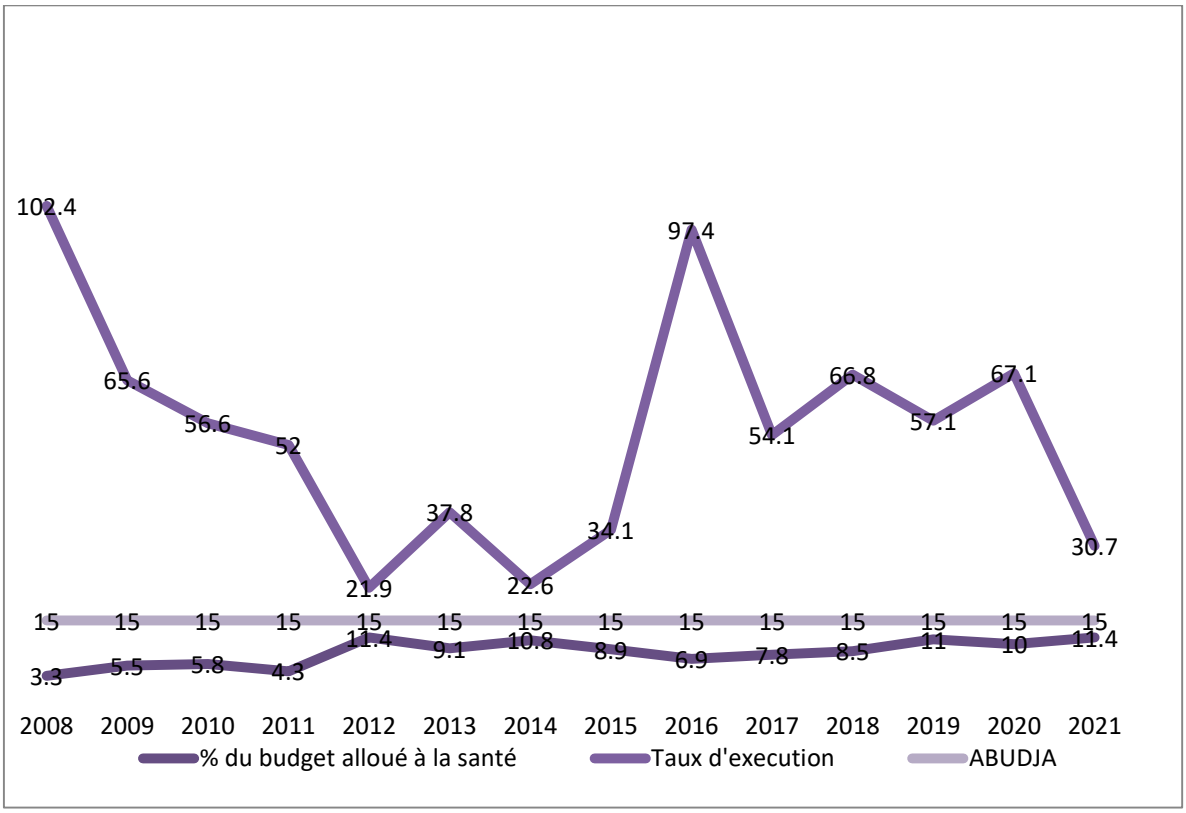
[4]*URL/http://www, Enabel Report, "access to health care in the DRC", 2015.*

[5]*Ministry of Health-DRC, "Study on the budgetary space of the health sector in the DRC, it can if it wants to achieve universal health coverage, letter n°1, 2019, p.2.*

[6]*CNS, health financing policy, a guide for decision-makers*

[7]*Ministry of Public Health DRC, "Report on health accounts 2021"*

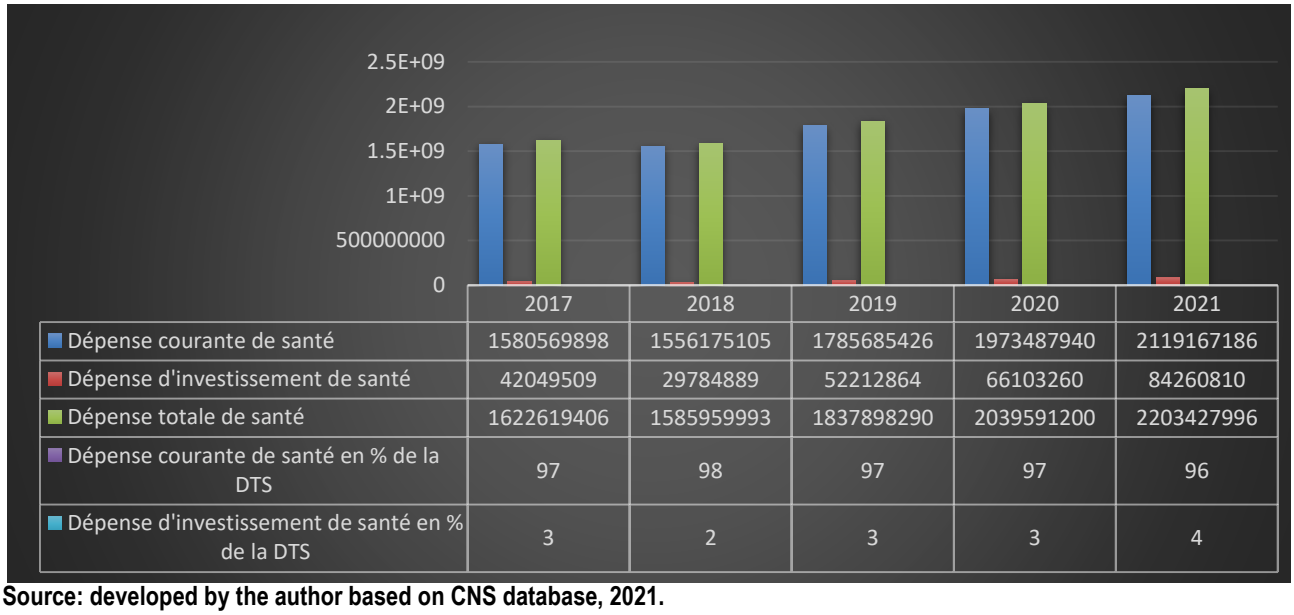
Public Financing of Health and Accessibility to Household Care in Kinshasa.



Source: Developed by the author based on CNS data, 2021.

This graph shows the evolution of the budget allocated to the health function as well as the execution rate. The average budget allocation share between 2008 and 2021 is 7.3%; which is far lower than the Abuja declaration of heads of state and government which recommended signatory states to allocate at least 15% of their budgets to the health sector. On the other hand, the execution rate of allocations in favor of the health function declined from 67.1% in 2020 to 53.9% in 2021. Public health expenditure as a percentage of GDP remained almost stationary below of 1% of GDP. It is therefore far from the target defined by the high-level working group on innovative financing of health systems, set at 5% of GDP on average to hope to achieve the sustainable development goals (in this case SDGs). Its financing is mainly focused on the remuneration of state agents, i.e. 83%.

Chart2: evolution of total health expenditure from 2017 to 2021 in USD



	2017	2018	2019	2020	2021
Dépense courante de santé	1580569898	1556175105	1785685426	1973487940	2119167186
Dépense d'investissement de santé	42049509	29784889	52212864	66103260	84260810
Dépense totale de santé	1622619406	1585959993	1837898290	2039591200	2203427996
Dépense courante de santé en % de la DTS	97	98	97	97	96
Dépense d'investissement de santé en % de la DTS	3	2	3	3	4

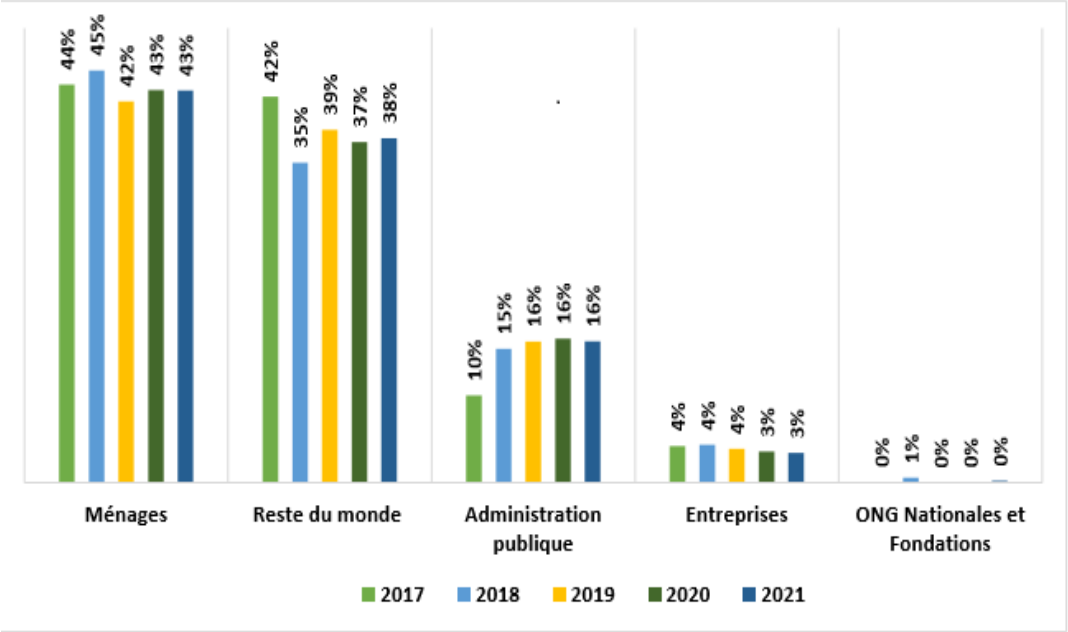
Source: developed by the author based on CNS database, 2021.

Over the last five years, total health expenditure has increased from 1622619406 to 2203427995 USD, an increase of 35.8%. The proportion 29 between DCS and DIS remained almost constant during the period (+95% for DCS and -5% for DIS).

- **Health spending by stakeholders**

The System of Health Accounts (HSA) is primarily concerned with health goods and services consumed by resident units only, regardless of where the consumption took place in the economic territory or in the rest of the world. Therefore, exports of health goods and services (supplied to resident units) are excluded, while imports of health goods and services for final use are included.

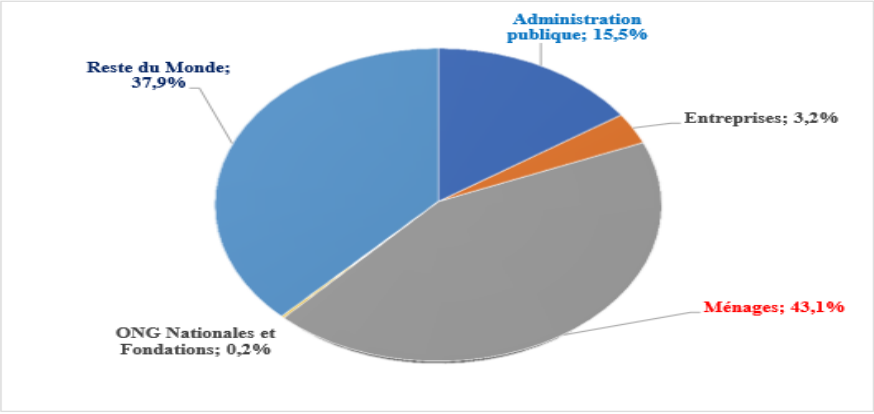
Chart 3: evolution of current health expendit ure by source from 2017 to 2021



Source: developed by the author based on CNS data, 2021.

The figure above shows the evolution of current health expenditure from 2017 to 2021. It appears that households remain the first source of financing followed by the rest of the world, the government is in third position followed by businesses. National NGOs and foundations have a negligible share

Chart 4: Analyzes of current health expenditure from 2017 to 2021 by source of financing



Source: developed by the author based on CNS data, 2021.

The financing of the DRC health system in 2021 was mainly provided by Households 43%, the Rest of the World, in other words Bi and Multilateral Cooperation and international NGOs 37%, public funds 16%, businesses 3% and National NGOs 0.99.
Government funding comes from Central, Provincial and ETD Governments. Its financing which was 329,499,332 USD, represents 0.6% as a percentage of GDP. The share allocated to the health function remains lower compared to the Abuja Declaration of Heads of State and Government which recommended signatory States to allocate at least 15% of their budgets to the health sector.

- **Capital expenditure**

Gross capital formation in the health system is measured by the total value of assets that providers acquired during the fiscal year (less the transfer value of assets of the same nature) and which are used frequently or for more than 'a year in the provision of health services.

Capital expenditure increased from USD 42,049,509 to USD 84,260,810. The construction of health infrastructure remains the first item of investment expenditure (46% in 2021) in health, followed by purchases of machines and equipment (30%) and medical equipment (23%).

- **Household intervention**

Households constitute the primary source of financing health expenditure. With an estimated contribution of 43% of the DCS in 2021. In relation to its own expenditure, direct household health payment amounts to 92%, voluntary prepayment from individuals represents 7% and social insurance coming from 1% employees.

The insufficiency of risk-sharing mechanisms accentuates the preponderance of direct payments for household health. These direct payments punish the poor and have the following consequences: the exclusion of 20 to 39% of the population from health services and care due to lack of money, renunciation or delay in seeking health services and care, impoverishment of households (debt and pawning or sale of property), Sequestration of sick people and corpses, high use of the informal sector[8](self-medication and traditional medicine).

Households allocated 58% of their spending to hospitals, 21% to retailers and other providers of medical goods (mainly prescription drugs), 18% to outpatient care providers including 16% for outpatient curative care and 2% for preventive care, and 2% for auxiliary providers (laboratory examinations and imaging). The majority of their spending is focused on the purchase of pharmaceutical products. In relation to the current expenditure for each disease, they spent 80% on reproductive health, 65% on nutritional deficiencies, 36% on infectious and parasitic diseases, 15% on non-communicable diseases[9].

Although the right to health is a fundamental right of the citizen and a duty of the State, however, access to health services and care poses enormous problems given the low purchasing power of the populations and also close ¾ of populations are excluded from formal health services and care due to poverty[10].

CONCLUSION

The study analyzes the impact of health financing by public authorities on access to household health care. It is observed in our societies that the demand for health care, which translates into access to care (primary, secondary and tertiary) is low compared to needs; this is justified by the lack of financial means and the high costs of care, self-medication, the non-seriousness of the illness, etc.

After analyzing the results, we affirm our two hypotheses. Public funding does not significantly impact household access to quality health care in the urban commune of Kinshasa, given that the majority of our respondents(56) believe that the State must increase financial resources for health, the chi-square is 0.007.

The majority of our respondents with a low income level, 85% affirmed that the prices that health facilities impose in fact constitute a blockage to access to care for households with a low income level. (85% of our respondents say the prices are high). Chi-square = 0.001

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ANNEX

Appendix 1: Model summary

Stage	-2log-likelihood	R-two of Cox & Snell	R-two of Nagelkerke
1	55.568a	0.516	0.715
2	46,200a	0.560	0.774
3	35.384a	0.605	0.837

Source: our surveys, 2023

Appendix 2: Result of the logit model

Dependent variable: Health care access				
Variables	Terms	Coef(A)	Exp(A)	P value
Socio-Professional Category	unemployed			0.178
	official	-4,141	0.016	0.038
	Agent in the private sector	-1.346	0.260	0.294
	independent	-3,744	0.024	0.027
	Other (s) to be specified	-21,152	0.000	1,000
Monthly income level	Less than 100,000 FC			0.002
	100,000-290,000 FC	3,756	42,756	0.004
	300,000-490,000 FC	9,094	8901,403	0.000
	500,000-690,000 FC	8,120	3359,960	0.000
	700,000 and more	30,115	1199474348 6271,895	0.997
The prices that health facilities offer	Accessible			0.039
	Good	7,257	1418.675	0.005
	Students	3,919	50,342	0.041
	Too high	2,776	16,061	0.149
		-6,583	0.001	0.002

Source: our surveys, 2023

Appendix 3: Survey questionnaire

Q1. Gender	1. Masculine 2. Feminine	|_ _|
Q2. Age	1. Under 25 years old 2. 25-34 years old 3. 35-44 years old 4. 45-54 years old 5. 55-64 years old 6. 65 years old and over	|_ _|
Q3. . Educational level	1. None 2. Primary 3.Secondary 4. Higher 5. University. 6. Others to be specified……	|_ _|
Q4. Socio-Professional Category.	1. Unemployed 2. Civil servant or State agent. 3. Agent in the private sector 4..Independent 5. Other to specify	|_ _|
Q5. Income level	**1.**Less than 100,000Fc 2. 100,000Fc-290,000Fc 3. 300,000-490,000Fc **4.**500,000-690,000Fc 5. 700,000Fc and more	|_ _|
Q6. This income allows you to access health care, upon request?	1. Yes 2. No	|_ _|
Q7Marital status	**1**. Single 2. Married 3. Common-law union **4.**Divorced 6. Widowed	|_ _|
Q8. Household size	**1.**0 to 4 2. 5 to 9 3. 10 to 14 4. 15 and more	|_ _|
Question regarding access to care		
Q9. How do you assess access to health care?	Difficult Easy impossible	|_ _|
Q10. If you are sick, what do you usually do?	Self-medication 2. Going to a hospital 3. prayer 4. Others to be specified.	|_ _|
Q11. The prices that the health facilities offer you are:	1. Accessible 2. Good 3. High 4. Too high	|_ _|
Q12. In your opinion, what should be done to improve access to health services and care?	The State must increase financial resources for health; Resources that are already allocated must be well managed, 3. 1 and 2	|_ _|
Q13.. If you need care and your income is insufficient, what do you do to access health services and care?	1. prayer, 2. Self-medication, 3. Loan and assistance, 4. Salary advance, 5. sale of goods 6. 1 and 2 7. Others to be specified	|_ _|