HEALTH FINANCING LANDSCAPE

in the

DEMOCRATIC REPUBLIC OF THE CONGO

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LOCAL HEALTH SYSTEMM SUSTAINABILITY PROJECT

Local Health System Sustainability Project

The Local Health System Sustainability Project (LHSS) under the USAID Integrated Health Systems IDIQ helps low- and middle-income countries transition to sustainable, self-financed health systems as a means to support access to universal health coverage. The project works with partner countries and local stakeholders to reduce financial barriers to care and treatment, ensure equitable access to essential health services for all people, and improve the quality of health services. Led by Abt Associates, the five-year, $209 million project will build local capacity to sustain strong health system performance, supporting countries on their journey to self-reliance and prosperity.

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CONTENTS

Acronyms iii
Executive Summary iv
Study Background – Rationale and Objectives 1
Study Objectives 2
Specific Objective 2
Study Methodology 3
Study Type 3
The PNDS Vision 4
Analysis of the Health Financing System for UHC in the DRC 5
Conceptual Framework for the Health Financing Strategy 5
Level of Health Financing 6
Main Sources of Financing 7
Areas of Health Financing 9
Main Findings Relating to the Health Financing Analysis in the DRC 27
Recommendations 30
Bibliographical References 33
Annex A: List of Institutions and Organizations for the Data Collection Phase 35
Annex B: Questions for Assessing the State of the Financial Landscape 37

LIST OF TABLES

Table 1. Evolution of The Main Health Accounts Aggregates from 2017 to 2021 in Million U.S. Dollars 6

Table 2. Evolution of CHE from 2017 to 2021 in Million U.S. Dollars 8

Table 3. Analysis of National Public Health Financing 10

Table 4. Analysis of Local Authorities' Financing 12

Table 5. External Financing Analysis 13

Table 6. Analysis of Household Financing 13

Table 7. Analysis of Private Financing 14

Table 8. Service Purchasing Methods 19

Table 9. Allocation of Government Expenditure by Provider Based on 2021 Activities (in U.S. dollars) 24

Table 10. Allocation of Rest of the World Expenditure by Provider Based on 2021 Activities (in U.S. dollars) 24

Table 11. Allocation of Household CHE by Provider by Function in 2021 (U.S. dollars) 25

Table 12. Analysis of Public Finance Management 27

LIST OF FIGURES

Figure 1. Conceptual Framework for the Health Financing Strategy 5

Figure 2. Analysis of Different Types of Care Purchaser in the DRC 22

ACRONYMS

CHE	Current Health Expenditure
DAF	Direction Administrative et Financière (Financial and Administrative Department)
DEP	Direction des Etudes et de la Planification (Research and Planning Directorate)
DPG	General Government Expenditure
DPS	Division Provinciale de la Santé (Provincial Health Division)
DRC	Democratic Republic of the Congo
GDP	Gross Domestic Product
HP	Classification of Health Care Providers
IHP	Integrated Health Program
MSPHP	Ministry of Public Health, Hygiene, and Prevention
NGO	Non-governmental Organization
NHA	National Health Accounts
PNDS	National Health Development Plan
PNPMS	National Program of Promotion of Health Mutuals
PSN CSU	National Strategic Plan for Universal Health Coverage
RBF	Results-Based Financing
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TFP	Technical and Financial Partner
UHC	Universal Health Coverage
USAID	United States Agency for International Development
WHO	World Health Organization
ZS	Zone de Santé (Health Zone)

EXECUTIVE SUMMARY

The Democratic Republic of the Congo (DRC) has rich natural resources, yet it is also one of the poorest countries in the world. The extreme and chronic challenges the DRC has faced over the past decades include armed conflict, political instability, and an Ebola epidemic that is the second most severe ever recorded in the world. This has hampered the development of a responsive health care system capable of delivering quality and equitable care to citizens.

Primary health care, maternal and child health, and family planning all suffer from a lack of resources. Performance on most of the key health indicators is low, such as the stunting rate of children under 5, which is 42 percent, one of the highest in sub-Saharan Africa (World Bank 2021). Public health financing is also low: total health expenditure expressed in percentage of gross domestic product (GDP) stood at 4 percent in 2021 (MSPHP 2021), with a high dependence on external financing—38 percent of Current Health Expenditure (CHE) in 2021 (MSPHP 2021).

e Local Health System Sustainability (LHSS) activity in the DRC conducted this study with the aim to describe the situation of health financing in the DRC, including aspects of governance, public finance, resource mobilization, pooling, and procurement of services. This is a retrospective and analytical descriptive study, focusing on the period from 2006 to 2023. It uses traditional methods: a literature review and key informant interviews. The aim is to explore the context and identify barriers and bottlenecks to adequate health sector financing, along with lessons learned and opportunities for solutions.

The analysis of the main indicators of the health financing system in the DRC and the data collected from key informants show that performance on these indicators varies strongly by province and region. Health care is paid for primarily by households (43 percent of the CHE in 2021), bilateral and multilateral donors (38 percent of the CHE), and the government (16 percent of CHE).

Several mechanisms of health care payments exist in the DRC:

- Public administration schemes
- Social insurance schemes
- Community insurance schemes
- Financing systems schemes for non-profit institutions serving households (including development agencies)
- Business financing schemes
- Direct payment by households

Direct household payments were 40 percent of CHE in 2021 and rank first, ahead of public administration schemes and mandatory contributory health financing schemes (37 percent) (MSPHP 2021) and voluntary private health care payment schemes (23 percent). This level of household contribution is very high, exceeding the threshold recommended by World Health Organization (WHO) of 20 to 25 percent (MSPHP 2021). The Congolese population is not protected against financial health risks and is exposed to catastrophic and impoverishing expenses.

In the DRC, the different procurement and payment methods for health services performed in the country are as follows: direct transfers, assigned funds, mandatory insurance, medical

support, payment for performance, major investments through targeted low-risk construction or rehabilitation, fee-for-service, flat-rate pricing, conditional cash transfers, and equity compensation payments. Strategic procurement is still in the testing phase, because of a lack of understanding of the National Health Development Plan (PNDS) and a failure to apply the rules of budgetary procedure internally. Similarly, the presence of inconsistent and sometimes non-transparent funding schemes creates distortions in the system and does not encourage the appropriate purchase of a predefined package of services at different levels.

The landscape analysis findings show that despite the increase in the state health budget (35.79 percent between 2017 and 2021), the resources mobilized are lower than the needs. This low budget allocation is compounded by a multiplicity of constraints:

- The significant fragmentation of funds
- The non-alignment of external funding with national policy and priorities for procuring and paying for services, exacerbated by inadequate leadership from the Ministry of Health
- The low rate of budget disbursement and execution because of insufficient technical and institutional capacity
- Heavy dependence on external financing
- Inequitable allocation of national budgetary resources between different levels of the health system and types of health facilities

The Strategic Purchasing Unit have developed and improved rules on budgetary management procedures for results-based financing (RBF) initiatives. However, the pooling institutions such as the Health Solidarity Fund and the Health Promotion Fund that have been created to support progress toward universal health coverage (UHC) are not in operation. Furthermore, governance problems persist, and the decentralization process is not effective. Dialogue between the Ministry of Health, the Ministry of Finance, other ministries, and stakeholders is insufficient. All of this creates enormous roadblocks to the Congolese government's ambitious project of achieving UHC by 2030.

At the end of this landscape analysis, LHSS will provide priority recommendations aimed at mobilizing all efforts to increase national and domestic financing for health care in line with international commitments; improving the use, accessibility, and quality of health services; and reducing the burden of household contributions.

Improving the health financing environment in the DRC requires strengthening leadership to facilitate alignment with national priorities and a true consensual sector approach around a single plan, synergistic financing, and a single monitoring and evaluation system. The strengthening of the legislative and regulatory framework must be a priority, along with adequate capacity strengthening (institutional and technical) at all levels to achieve the objectives of optimal public finance management, the full operation and scaling up of the program budget, and the effective implementation of efficient financial and budget systems to improve the level of planning, disbursement, and budget execution.

It is also necessary to move progressively toward a universal health insurance system adapted to the different target population groups by integrating the different procurement mechanisms, including free care. The promotion and development of health risk-sharing mechanisms must play an important role in this drive toward efficient programmatic implementation of UHC 2020–2030 National Strategic Plan, enabling the poorest and most marginalized people, families, and communities to access basic health care and services.

The effective implementation of these recommendations calls for more-ambitious, smart, and innovative coordinated actions to achieve convincing results in health financing, leading to a real improvement in the health and well-being of the population, which is fundamental to the country's social and economic development.

STUDY BACKGROUND – RATIONALE AND OBJECTIVES

The DRC has rich natural resources, but it is also one of the poorest countries in the world. Moreover, the country faces several socioeconomic challenges that severely limit its ability to improve its health system. In the DRC, primary health care services, including maternal and child health and family planning, suffer from a lack of resources. The under-5 stunting rate, 42 percent, is one of the highest in sub-Saharan Africa, and malnutrition is the underlying cause of nearly half of all under-5 deaths. The DRC, with a human capital index of 0.37, below the average for sub-Saharan Africa (0.40) in 2022, has made little progress in health. Mortality among children under 5 years old remains high, at 43 deaths per 1,000 live births (World Bank 2023). Public health financing is also low in relative and absolute terms: total health expenditure expressed in percentage of GDP stood at 4 percent in 2022 (MSPHP 2021). In 2021 the country had high levels of external financing (38 percent of the current health spending), and households' direct payments accounted for 40 percent of CHE (MSPHP 2021). Such an imbalanced health financing situation contributes to service delivery that is neither accessible nor equitable.

Like many other African countries, the DRC is also facing challenges in rationalizing available resources, which is hampering efficiency and effectiveness in health care. These challenges include:

- Multi-stakeholder presence with no effective coordination mechanisms
- Inappropriate institutional configurations
- Pervasive fragmentation of interventions
- A tangle of payment mechanisms with no consistent country-wide procurement strategy

Additionally, failures in governance, procurement, prioritization, and budget execution result in sub-optimal quality of care, characterized by high rates of stock-outs of essential medicines at the local level, with health workers whose salaries are not systematically paid and facilities that are either not equipped or poorly equipped (MSPHP 2018).

These health financing and governance issues have led the DRC government to embark on a series of health system reforms in recent decades, including the health function's decentralization from the central to the provincial level. Meanwhile, the central level of the Ministry of Public Health, Hygiene, and Prevention (MSPHP) is undergoing administrative reform, with the new "organic framework" reducing the number of directorates from 13 to 9. Under the new scheme, the new Direction Administrative et Financière (DAF, Administrative and Financial Department) has been created, and plays an important role in the implementation of UHC policy.

To provide an adequate financing system guaranteeing optimal and equitable allocation of resources, with financial protection for everyone using health services, a health financing strategy has also been developed covering the period 2018–2022 and aligned with the objectives of the 2016–2020 PNDS. Thanks to its directorates (DAF and Direction des Etudes et de la Planification (DEP, Research and Planning Directorate), the Ministry of Health is working in synergy with its various partners and other public and private actors to give concrete expression to the vision of the PNDS and to contribute to the development of a high-performance financing system with the aim of accelerating progress toward UHC in the country.

The latest studies, such as the World Bank's 2019 analysis of the budget for the worldwide health sector, and UNICEF's 2021 budget briefing for a sustainable increase in funding for the health sector in the DRC, highlight the health financing deficits that stand in the way of UHC in the country. Furthermore, the 2018–2022 health sector financing strategy and the reframed 2019–2022 PNDS have ended. Hence, this is an opportune moment for this study to take stock of the situation of health financing in the DRC, to provide the various actors with information on the new guidelines and to facilitate the necessary updates. The aim is to help improve governance and leadership in resource mobilization, resource pooling, and procurement of services—the three functions of health financing—at all levels of the health pyramid.

STUDY OBJECTIVES

GENERAL OBJECTIVE

The current analysis aims to describe the health financing situation, including governance aspects and the three functions related to health financing.

Building on previous studies and existing policy documents, this analysis will provide additional information and document best practices and weaknesses in the process of resource mobilization, pooling, and purchasing of services. This will help strengthen dialogue between stakeholders on public finance issues as they review priorities in the field of health financing. The aim is to improve financial governance and adjust interventions already undertaken in the sector by the government and technical and financial partners (TFPs).

This analysis could also be used to update policy documents such as the health financing strategy and the manual of administrative and financial management procedures, among others. In this respect, the study provides a useful information base for political decision-making on strategic health financing issues in the coming years.

SPECIFIC OBJECTIVE

The situational analysis will enable an assessment of the current situation regarding:

- Health financing policies, processes, and governance
- Current resource mobilization strategies
- Mechanisms for pooling resources and risks
- Purchasing of services and provider payment methods

The analysis shows not only the current gaps between the available funding and the PNDS objectives, but also the deviations from the required financing and the arrangements needed to achieve the sector objectives described in the PNDS and the health financing strategy. The analysis also provides a better, more structured understanding of the gaps, opportunities, and institutional and technical capacity needs of the different public entities and departments working in the field of health financing and governance. In terms of public financing policies in the health sector, the findings of this analysis represent a resource with a view to the switch from resource-based budgeting to program-based budgeting. Additionally, options for bridging gaps will be identified and analyzed.

STUDY METHODOLOGY

STUDY TYPE

This situational analysis of health sector financing and governance is a retrospective and analytical descriptive study that uses traditional methods—literature review and key informant interviews—to explore the context and identify barriers and bottlenecks to adequate sector financing, along with lessons learned and opportunities for solutions.

ANALYSIS PERIOD

The primary data presented in this report were collected from August 2022 to January 2023. The documents examined (secondary data) cover the period from 2006 to 2023. The information collected from the documents refers to the health care financing schemes and programs in existence up to 2022, and implemented by the various organizations, institutions, and services covered by this study.

DATA COLLECTION METHOD AND TOOLS

Literature Review

The document review covered a wide range of documents, including the country's strategic and health plans, evaluation and survey reports on health financing and existing financing mechanisms, strategic documents on UHC and social protection, policy documents and development plans from national and international organizations with TFPs, other consultation reports, articles, and webography.

Key Informant Interviews

Information was collected during interviews involving all three levels of the health care system (national, intermediate, and operational) from a sample of provinces. Data were collected from key informants with a direct or indirect link to health governance and financing, through individual interviews.

The key informants were categorized into the following three groups: public administrative authorities in charge of health and other related sectors, TFPs, and national operational bodies responsible for implementing and supporting the various financing schemes. (See Annex A for details of the targeted facilities.)

Each level of the health care system and/or type of facility was interviewed using an interview guide (see Annex B). The interview guides were adapted to each interviewee according to their role and functions in the field of health financing and governance, and depending on their specific needs, certain questions were addressed in more detail.

DATA PROCESSING

Following data collection (literature review, key informant interviews), several levels of validation were conducted. These include:

- Interview quality: the team ensured that the right person to interview had been chosen, i.e., the head of the facility or the person empowered to give the right information delegated by the head of the facility.

- Comprehensiveness check: the team ensured that all the target groups of informants had been interviewed, and that the data had been entered based on the pre-approved data templates. Once the completeness of the database had been checked, a corrective plan for each level of data collection was implemented with the institutions and organizations concerned, enabling them to access and provide any missing data.

ANALYSIS OF THE FINDINGS

The literature review and initial investigations identified the main health financing schemes and programs investigated in the study, and highlighted the analyses and questions targeted for the interviews. This first step also contributed to a better and more structured understanding of opportunities for improving health governance and financing.

All the information from the key informant interviews was transcribed and entered into an Excel file. The data was manually analyzed by item and keyword, then compiled to highlight the structuring themes before proceeding with the thematic analysis of the data.

LIMITATIONS OF THE ANALYSIS

Two central administrative facilities did not respond even after several reminders; this represents around 10 percent of all targeted facilities at this level. LHSS had to use the literature review to fill the gap by collecting and analyzing the main documents relating to these facilities' respective functions in health financing.

THE NATIONAL HEALTH DEVELOPMENT PLAN (PNDS) VISION

The vision for the health sector in the PNDS 2019–2022 is formulated as follows: "By 2022, the Democratic Republic of the Congo will have moved towards universal access to quality services and the reduction of the incidence of unsustainable household expenditure, to enable them to contribute to the nation's economic development in an enabling environment for good health. This vision will be anchored in a strengthened national health care system focused on fair and supportive primary healthcare, aligned with the national context, legal framework, and priorities."

The priorities of the PNDS 2019–2022 are structured around three strategic pillars (goals), as follows:

- Pillar 1: Improve the delivery of health care services and continuity of quality care at different levels of the health system.
- Pillar 2: Support the health system pillars to improve the availability and accessibility of quality care.
- Pillar 3: Support the health system governance, leadership, and management.

The evaluation of the PNDS 2019–2022 in December 2022 showed some global progress but also persistent constraints in achieving its objectives. The evaluation's findings include the following:

- The proportion of health centers offering a basic health package rose from 5.1 percent in 2019 to 6.3 percent in 2021.
- The geographical distribution of human resources for health is unbalanced.

- For several years, civil servants have lacked motivation and loyalty; this is due among other things to the incomplete reform of the civil service at the national level.

Overall, according to the indicator analysis in the evaluation of the PNDS 2019–2022, the reframed PNDS 2019–2022 has been implemented with mixed impact at all levels of the health pyramid. A wide disparity in indicators was observed by province, and sometimes by *zone de santé* (ZS, health zone) within the same province. Isolated health zones generally recorded the lowest indicators.

The report highlights that in 2020 the allocation of resources mobilized at each level of the health pyramid did not fully meet the expectations of the PNDS. The central level received the expected allocations, and funding for the operational level exceeded expectations, at the expense of the provincial level, which was poorly financed.

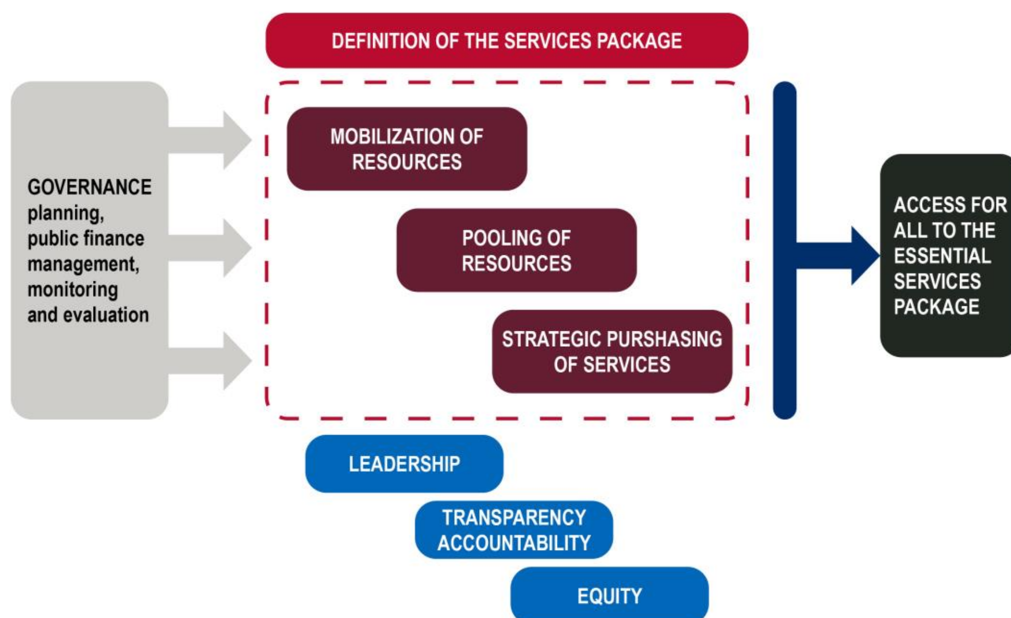
The mechanisms for implementing UHC are still limited and need to be strengthened in the upcoming PNDS. Total health expenditure fell short of the 2020 PNDS estimate by 4 percent, or 84 million, in 2020.

ANALYSIS OF THE HEALTH FINANCING SYSTEM FOR UHC IN THE DRC

CONCEPTUAL FRAMEWORK FOR THE HEALTH FINANCING STRATEGY

In the DRC, the PNDS represents the government's plan for the health sector. The PNDS is a response to the country's constitutional guarantee, in Article 47, of the indispensable right to health and food security for the entire population. It is the implementation tool for the revised health system strengthening approach adopted in 2010 by the Ministry of Public Health and its partners as a contribution to the country's development efforts. The strategies contained in these policy documents are broken down into key interventions as shown in Figure 1:

Figure 1. Conceptual Framework for the Health Financing Strategy



LEVEL OF HEALTH FINANCING

Based on the DRC's latest health accounts, total health expenditure has increased in recent years, rising from $1.6 to $2.2 billion U.S. dollars between 2017 and 2021, an increase of 35.79 percent. This increase is attributable to several sources, in particular the government's commitment in the co-financing system with partners such as the Global Fund. It is also attributable to:

- Resources mobilized in the context of COVID-19
- Initiatives implemented by the Government of DRC to be eligible to receive funds from the United States Millennium Challenge Corporation Account which accounted for a 1.14 percent increase in GDP for health (National Health Account)
- Commitments with the International Monetary Fund in the fight against diseases requiring more resources oriented toward HIV and reproductive maternal, newborn, child and adolescent health and nutrition, with defined targets

The proportion of CHE also increased by 96 percent while that of health investment expenditure fell by 4 percent over the period. Total expenditure per capita per year increased slightly over the period, from $21.27 in 2017 to $25.54 in 2021. Total health expenditure expressed as a percentage of GDP was 4 percent in 2021 (MSPHP 2021).

Table 1 below provides information on health macroeconomic indicators.

Table 1. Evolution of The Main Health Accounts Aggregates from 2017 to 2021 in Million U.S. Dollars

Indicators (Million U.S. Dollars)	2017	2018	2019	2020	2021
Population (millions)	75.98	78.49	80.85	83.51	86.27
GDP	37,604.20	39,951.50	50,006.10	46,501.20	55,299.70
CHE (U.S. Dollars)	**1,580.60**	**1,556.20**	**1,785.70**	**1,973.50**	**2,119.20**
Total investment expenditure	42.05	29.78	52.21	66.10	84.26
Total health expenditure	1,622.60	1,586.00	1,837.90	2,039.60	2,203.40
Current government health expenditure	151.59	229.10	277.00	312.43	329.50
Current household health expenditure	692.24	705.92	749.00	852.34	913.91
CHE from the rest of the world (i.e., not the DRC)	671.32	548.03	693.32	739.67	802.83
CHE from other sources	65.42	73.11	66.35	69.04	72.92
Public Health Expenditure	**152.78**	**234.85**	**301.31**	**341.69**	**359.93**
Total health expenditure per capita per year	21.27	20.40	22.75	24.42	25.54
Total Health Expenditure as a Percentage of GDP	4.31%	3.97%	3.67%	4.38%	4.00%
Current government health expenditure as percentage of total CHE	10%	15%	16%	16%	16%
Household CHE as a percentage of total CHE	44%	45%	42%	43%	43%
C of the rest of the world as a percentage of total CHE	42%	35%	39%	37%	38%
CHE from other sources as a percentage of total CHE	4%	5%	4%	3%	3%
Public Health Expenditure as Percentage of GDP	**0.41%**	**0.59%**	**0.60%**	**0.73%**	**0.65%**

Analysis of this table shows that the level of mobilization of national resources does not allow the DRC to move toward UHC. The share allocated to the health sector is below international guidelines, and the DRC's GDP, by which the DRC is classified as low-income, does not

generate sufficient resources. The target threshold of 86 U.S. dollars per capita per year remains a benchmark used by the High-Level Group on Health System Financing in Low-Income Countries to promote universal access to primary care (MSPHP 2021). The DRC has not even reached a third of this threshold: its total health expenditure per capita was 25.54 U.S. dollars in 2021, the most recent year of reported data.

The share of the government budget allocated to the health sector is 11.5 percent, and public spending on health represented 0.65 percent of GDP in 2021(MSPHP 2021). The DRC will have to mobilize more efforts to reach the 1 percent additional annual increase required to reach UHC as defined by the United Nations.

Spending by households accounted for 43 percent of total health care expenditure in 2021, showing a real burden on populations, particularly the most vulnerable. A study recently undertaken at the highest decision-making level of the country aims to provide evidence for the provision of quality health care and services without financial difficulty to all residents of the country, through the creation of a Health Promotion Fund (Journal officiel DRC 2018).

MAIN SOURCES OF FINANCING

Analysis of health financing in the DRC shows that funds come from governments (central and provincial), donors (bilateral and multilateral), nongovernmental organizations (NGOs), international and national foundations, households, and public and private companies. Table 2 below shows the evolution of health care financing over four recent years.

This table shows that the main source of financing remains households (43 percent of CHE in 2021). Household financing rose from 692.2 million U.S. dollars to 913.9 million U.S. dollars between 2017 and 2021, representing an increase of 32.02 percent. Household spending increased 8.6 percent between 2017 and 2021, from 9.11 to 10.59 U.S. dollars per capita.

In 2021, household payments ranked first in terms of CHE, with direct household health payments accounting for 92 percent, voluntary prepayments by individuals for 7 percent, and social insurance by employees for 1 percent. This underscores how badly the Congolese population is exposed to financial risks and catastrophic expenses because of out-of-pocket payments for health care services. The most recent estimate available, for 2012, is that the percentages of people in the DRC who had incurred catastrophic health expenses at the 10 percent and 25 percent poverty thresholds were 4.8 and 0.6 percent respectively (World Health Organization 2020).

Table 2. Evolution of CHE from 2017 to 2021 in Million U.S. Dollars **(MSPHP 2021)**

Sources of Financing	2017	Percentage	2018	Percentage	2019	Percentage	2020	Percentage	2021	Percentage
Public administration	151.59	10%	229.10	15%	277.00	16%	312. 43	16%	329.50	16%
Private companies	63.87	4%	64.89	4%	66. 19	4%	67. 51	3%	68.86	3%
Households	692. 24	44%	705. 92	45%	749	42%	852. 34	43%	913. 91	43%
National NGOs and foundations	1.53	0.1%	8. 22	1%	0.18	0.01%	1.53	0.07%	4. 06	0.2%
Bilateral donors	202.81	13%	193.33	12%	212.84	12%	253. 59	13%	233.15	11%
Multilateral donors	390. 37	25%	331. 71	21%	466. 03	26%	483. 56	25%	562. 37	27%
International NGOs and foundations	78.159	5	22.99	1%%	14.46	1%%	2.52	0.12%	7.31	0.3%
Total CHE	**1,580.57**	**100%**	**1,556.17**	**100%**	**1,785.68**	**100%**	**1,973.49**	**100%**	**2,119.17**	**100%**

Donors are second behind households in paying for health care in the DRC; they funded 38 percent of CHE in 2021. Their funding rose from 671.317 million U.S. dollars to 802.832 million between 2017 and 2021, an increase of 20 percent. In 2020, funding for the Ebola virus disease reached 68.234 million U.S. dollars, of which 97 percent was funded by the rest of the world and 3 percent by the government. The country's COVID-19 response was also financed with a total of 68.627 million U.S. dollars, 55 percent of which came from donors and 45 percent from the government.

In third place was the DRC government, which funded 16 percent of CHE, increasing its funding from 151.592 million U.S. dollars to 329.499, an increase of 117 percent between 2017 and 2021.

In last place was spending from other funding sources (NGOs, foundations, and companies), which rose from 65.417 million to 72.920 million U.S. dollars, an increase of 11 percent, or 3 percent of CHE in 2021(MSPHP 2021).

AREAS OF HEALTH FINANCING

FINANCIAL RESOURCE MOBILIZATION

Resource mobilization involves advocating for sufficient and adequate allocation of public resources to the health sector, real alignment of external financing with national health sector priorities, and efficient allocation of resources from the population.

National Public Funding

In the DRC, the central government budget for 2022 was, Congolese Francs FC 22,253 billion (10.7 billion U.S. dollars) compared with, Congolese Francs FC 16,621.6 billion in 2021, representing a growth rate of 33.9 percent (Democratic Republic of Congo 2022). Table 3 shows the various components of a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis of national public health financing in the DRC.

Table 3. Analysis of National Public Health Financing

Strengths of National Public Financing	Weaknesses of National Public Financing
• Health is a fundamental right guaranteed by the Constitution of the DRC (Article 47). • The PNDS is the government's strategic plan for the health sector and the tool for implementing the health sector strengthening strategy. • Gradual increase in the health budget from 2017 to 2021 to meet the sector challenges: 7.8 percent to 11.5 percent of the total national budget • Evaluation of the performance of the health sector through periodic reviews • Creation of independent funding streams and offices to manage UHC (Social Solidarity Funds, Health Promotion Funds, and Institute for Public Health) (9th of the 20 pillars of the four strategic areas of the government's Program of Action) • Regular development of National Health Accounts (NHAs) for better evidence-based health policy decision-making and benchmarking of health financing performance in the DRC against other countries' performance	• Not considering the real needs the MSPHP expressed when defending budget forecasts at the budget conference • Low allocation of resources (10 percent), below the 15 percent Abuja Declaration • Setting assignment rates that do not consider the historical data on the basic services • Absence of a centralized health financing information management system, leading to disparities in information between different ministries • Inefficiency and inequity in the structuring of public health expenditure • Low disbursement of funds allocated for investment transfers to provinces and decentralized territorial entities • Poor use of strategic information for monitoring and evaluation • Low rate of disbursement and execution of the health budget • Delays in making funds available • Weak application of legal and regulatory texts for regulation and standardization in the sector • Slow implementation of structural reforms in the sector • Heavy dependence of the health sector on external aid • Low coverage of public administration employees • Absence of a centralized health financing information management system, leading to fragmentation of information management between different ministries • Inefficiency and inequity in the structuring of public health care expenditure • Significant disparities in the allocation of health transfers at the provincial level • Low health budget disbursement and execution rates • Delays in making funds available • Lack of effective regulation and standardization of the sector • Slow implementation of structural reforms in the sector • Lack of use of strategic information for monitoring and evaluation purposes • Heavy dependence of the health sector on external aid

Strengths of National Public Financing	Weaknesses of National Public Financing
National Public Financing Opportunities	**National Public Financing Threats**
• Ratification by the DRC of international legal instruments including the various conventions guiding the progress toward UHC such as: – Abuja Declaration on April 27, 2001 on commitments by African governments to devote 15 percent of national budgets to health – Adopted in 2017 by the Ministers of Health of the WHO African Region, the Framework of Actions for Strengthening Health Systems for the achievement of UHC and the other Sustainable Development Goals – Law No. 18/035 on December 13, 2018, laying down the fundamental principles relating to the organization of public health in the DRC, Article 41 of which provides for the establishment in the DRC of a UHC system – Laws and Decrees relating to the mutual insurance system, establishing, organizing and operating the National Social Security Fund for Public Civil Servants, and creating the National Support Program for Social Protection • Announced reform of the National Social Security Fund and promotion of the establishment of an adapted health coverage ecosystem covering all social categories (Felix- Antoine 2019); • Existing alternatives in the country for innovative financing for health, especially private sector financing	• Mixed GDP growth since 2017, with direct impact on the health budget; this explains why the health sector is largely under-financed • Heavy dependence of the health care sector on external aid, weakening the health care system and the sustainability of both interventions and financing

Financing for Local Authorities

Since 2011, transfers to the provinces have increased the health budget envelope during the planning phase, but with little effect on the volume of spending during execution. Public spending at provincial level fails to meet the health objectives due to the partial budget execution, between 20 percent and 30 percent of the budget, with a 40 percent reduction of budget at the provinces. Additionally, the public resources transferred for health in the provinces do not reflect a strategic allocation of resources according to needs or priority interventions, and the provinces do not use all these resources. Despite decentralization, the central level continues to execute a large proportion of public funds, including salaries, for the benefit of the provinces.

Table 4 sets out the various elements of a SWOT analysis of local authorities' health care financing in the DRC.

Table 4. Analysis of Local Authorities' Financing

Strengths of Local Authorities' Financing	Weaknesses of Local Authorities' Financing
• On average, provinces allocate 18 percent (MSPHP 2021) of their total central transfers to health. • Existence of multiple fundraising sources and opportunities; provincial government budget and central transfers, among others	• Low capacity to mobilize financial resources (outside the budget) by local authorities • Insufficient transfer of skills and resources to local authorities • Non-application of the 40 percent withholding tax • Failure to disseminate the Finance Act Volume III (decentralized services)/reduction to 40 percent • Transfers to health facilities do not include the operating budget, which comes from a central envelope. • Low implementation and absorption capacity for allocations received • Central government revenue centralization, limiting retrocession of funds to the provinces as planned
Local Authorities' Financing Opportunities	**Local Authorities' Financing Threats**
• The Constitution of the DRC on February 18, 2006, as amended by Law No. 11/002 on January 20, 2011, provided for the withholding tax (for the benefit of the provinces) of 40 percent of national revenues. • Proposal in the reframed PNDS 2019–2022 for a distribution key using indicators such as mortality rates and poverty levels to allocate health resources and transfers between the different provinces	• A system of centralization of revenues at the federal government level restricting the return of funds to the provinces as planned

External Financing

External resources represent an important source of health care funding, second only to households. They are directly or indirectly provided by TFPs (donors), who finance health care through investments, the purchase of health care services (i.e., through subsidizing payment for health care), health center operating expenses, and staff bonuses.

In 2021, the central and operational levels benefited from more external resources than the threshold set in the programming of allocations planned for each level of the health pyramid in the PNDS. External funds also finance the provincial level, either directly or in the form of transfers (MSPHP 2020).

Table 5 sets out the various elements of a SWOT analysis of external health financing in the DRC.

Table 5. External Financing Analysis

Strengths of External Financing	Weaknesses of External Financing
• Significant financing: the sector's second-largest source of financing, after the population (households). The degree of dependence on this financing was on average 40 percent over the period from 2017 to 2021.	• Non-application of the single contract in certain provinces • Fragmentation of financing and overlapping field interventions because of the allocation of funds to vertical programs • Failure to align external funding with government priorities • Insufficient external funding to support research in the field of health economics and the training of future managers for more-effective health financing management
External Financing Opportunities	**External Financing Threats**
• Increased presence of TFPs and international NGOs • Existence of several planning and management documents and cooperation frameworks (Groupe Inter Bailleurs pour la Santé) for health financing • Increased coordination between the various stakeholders involved in health financing	• Widespread governance problems at all levels of the health pyramid and low government commitment to health sector external financing • Endemic/epidemic zone: malaria remains the leading cause of infant mortality, with over 17,000 deaths in 2019 and 20,000 in 2020 (MSPHP 2021) out of a total of over 21 million cases, of which more than 50 percent are children • Persistence and resurgence of increased epidemics of COVID-19, measles (8,000 deaths according to WHO from 2018 to 2020), cholera (691 from 2019 to 2020), and Ebola virus (2,154 deaths in 2019) • Armed conflict and insecurity in some health zones

Household Financing

Households (the population) account for the largest share of health financing in the DRC (43 percent in 2021), as indicated above. They finance their health by direct and voluntary payment, using health services, and this financing is often used for operations and to pay local staff bonuses at health facilities. In addition, 65 percent of households have lost income because of COVID-19 since the start of the pandemic, and 15 percent have lost all their income. Low-income households and people over 65 are the hardest hit (PERC 2021).

Table 6 shows the various components of a SWOT analysis of the households' financing of health care in the DRC.

Table 6. Analysis of Household Financing

Strengths of Household Financing	Weaknesses of Household Financing
• Contribution of households to the autonomous financing of health facilities and to the continuity of care in some facilities • Households' ability to choose between public and private facilities when they purchase health care services, and at different levels	• Highest household contribution to health financing of all sources, exposing households to catastrophic and impoverishing expenses • Virtually nonexistent financial protection against the risk of disease, with over 90 percent of health care expenditure paid for by households through out-of-pocket payments

Strengths of Household Financing	Weaknesses of Household Financing
	• Poor access to health care for the poor, and low mobility of resources
Household Financing Opportunities	**Household Finance Threats**
• Implementation of UHC for the protection of the population against financial risks with the creation of social protection mechanisms and bodies such as the Health Promotion Fund • Continuation of program budget reform and fiscal decentralization in the health care sector	• Difficulty in rationalizing and optimizing available system resources to reduce household contributions • Increase in current household expenditure per capita per year from 9.1 to 10.6 between 2017 and 2021, jeopardizing the country's commitment to UHC

Private Financing (NGOs, associations, communities, businesses)

The involvement of the private sector in resource mobilization is low, which is an obstacle to mobilizing significant resources. In the DRC, the private sector is not subject to corporate social responsibility, which could be a mechanism for mobilizing substantial resources.

Table 7 sets out the various elements of a SWOT analysis of private sector health care financing in the DRC.

Table 7. Analysis of Private Financing

Strengths of Private Financing	Weaknesses of Private Financing
• The labor code in force in the country mandates contribution to health sector financing through coverage of their employees and their families.	• Low employee coverage by companies
Private Financing Opportunities	**Private Financing Threats**
• Institutionalization of the National Support Program for Social Protection • Existence of the National Social Security Fund for Civil Servants	• Increasingly large households (large families) • Long-term sickness and inpatient care • Insufficient preventive and promotional health care services to prevent disease and accidents

In conclusion, households and donors pay for more than 80 percent of the DRC's health care system. The government's share (16 percent in 2021) is three times less than that of donors. The effective and rapid implementation of UHC could alleviate the hardships of the population, more than 60 percent of whom live in poverty.

POOLING OF MOBILIZED FINANCIAL RESOURCES

As defined in the DRC's 2018–2022 health financing strategy document, pooling aims to spread the financial risk associated with the need to use health services, and to better combine stakeholders' financing efforts. According to DRC legislation, pooling concerns all citizens, not just the sick. The funds to be pooled can come from direct taxes, indirect taxes, development aid, and/or contributions to an insurance system. Most systems that finance health care include a prepayment-financed pooling element, combined with direct payments to health care providers, sometimes referred to as cost sharing or cost recovery, or copayments.

Existence of Mechanisms for Pooling Funds

Several laws have been passed and adopted to facilitate the pooling of national public financing in the DRC. These include budget laws, finance laws, and the country's commitment to implementing UHC (PSN CSU 2020–2030) with the creation of two main instruments, the Health Solidarity Fund and more recently the Health Promotion Fund.

The Health Solidarity Fund was created by Law no. 18/035 on December 13, 2018, and its implementing decree no. 22/13 on April 9, 2022. The purpose of this fund is to mobilize financing for UHC and manage funds intended for the payment of health benefits. The Health Solidarity Fund will be represented in all provinces to ensure local services. At the local level, the fund will have the flexibility to contract with health service providers in the public and private for-profit and non-profit sectors. This contracting will respect the principle of segregation of duties (in this case, the fundraising duty and the use of these funds to purchase services). Facilitators and resource people have been appointed, but since its creation, the Health Solidarity Fund has had limited success in achieving its objectives as a common fund, in terms of its management, functionality, and level of coverage. In particular, the Fund suffers from lack of participation by TFPs.

The Health Promotion Fund was created on January 27, 2023, by a draft Ordinance-Law amending and supplementing Law N°18-035 of December 13, 2018 to support the national health system. This public institution, created with autonomous management, has as one of its missions to offer the public credit to ensure a UHC system based on the principles of equity, quality assurance of care, financial protection for all, and national solidarity. It is responsible for mobilizing and providing additional resources to develop the supply and quality of health services throughout the Republic for public actors (Ministry of Public Health, Ministry of Higher and University Education, Army and Police Health Services, etc.). The funds will be provided to these services on a contractual basis.

The National Health Sector Steering Committee has also been set up based on a legal text, which is in line with the principle of mutualization. In addition, the various strategic plans have been revised and reframed to better organize the pooling of health financing.

Despite all these legal and political measures adopted at the central level to ensure the success of pooling, difficulties exist in disseminating, applying, and exploiting them at intermediate and peripheral levels without a harmonized and coherent roadmap. Their adoption at the central level is not problematic, but there is a lack of ownership of programming texts and tools. Health care managers have little involvement in the process of implementing reforms, and the texts underpinning these reforms are not sufficiently disseminated. In fact, these texts are drawn up without any guarantee of funding for their dissemination and application. There is also a time gap between the planning and implementation of the various reforms. Technical and political dialogue between ministries to coordinate the reform process is not permanent, without a formal framework and clearly defined frequency. Additionally, coordination mechanisms in the pooling of funds are not harmonized, which does not facilitate the alignment of specific health programs with health financing strategies and policies.

***Mutuelles* (Community-Based Health Insurance)**

Organic Law no. 17/002 on February 8, 2017, determined the fundamental principles relating to the mutual health insurance scheme. The Law restates the obligations of employers to provide health care for their employees and their families, in terms of the provision of health care for workers and their families. It differentiates contributions based on the contributive capacity of the risks covered or benefits offered. It establishes different types of *mutuelles* for different categories (companies, public administration), and mandatory health insurance.

The ministry in charge of the organization, promotion, and approval of *mutuelles* (METPS) is responsible for overseeing *mutuelles* through the Directorate of Mutuelles and Insurance (MSPHP 2000) but it is the Programme National de Promotion des Mutuelles de Santé

(PNPMS), set up in 2001, that is currently operational and has experience in promoting and supporting the management of *mutuelles* (Journal officiel DRC 2015).

From an organizational point of view, the MSPHP, with its ZS offices, has a much denser territorial network than the METPS, the latter sometimes not being decentralized below the provincial level.

The health sector slightly anticipated the creation of the new provinces by organizing a national competition back in 2014, to set up the 26 new heads of the Division Provinciale de la Santé (DPS, Provincial Health Divisions). In the provinces, under the authority of the DPS, the Bureau de Coordination de la Zone de Santé (BCZ) directly supervises the health facilities. Although health has been a sector of exclusive provincial competence since the 2006 Constitution, the transfer of responsibilities and resources from the central government to the provincial governments has still not begun.

The social welfare sector also includes, in principle, a provincial division in each province, but its divisions often stop at district level, with distances of up to several hundred kilometers from the Decentralized Territorial Entities, creating a vacuum between state and population.

The assertion that the MSPHP should confine itself to providing a sufficient quantity and quality of care and leave the METPS to organize demand is likely to run up against questions of institutional, material, and human capacity.

The National Social Security Fund recommends health risk mutualization to reduce the financial risk for users, and, through the PNPMS, the PNDS planned to set up *mutuelles* in 1/10th of ZSes by 2020. Meanwhile, there are currently many local initiatives to set up *mutuelles* whose aim is to provide health care services for their members.

The platform of organizations promoting *mutuelles* adopted its statutes in early 2015. It brings together five organizations promoting mutual health insurance (CAMS, CENADEP, CGAT, MOCC, and PRODES). These organizations comprise a total of around 100 *mutuelles*, which include the vast majority of *mutuelle* members in the DRC, with around 317,000 beneficiaries. *Mutuelles* play all three roles in health financing: fundraising, pooling, and procurement of services.

Meanwhile, various partners in the field of health and social protection in the DRC are working to improve access to health care by promoting *mutuelles* initiatives (UNICEF, WHO, ANMC, BRS, GIZ, MEMISA, CORDAID, CTB, etc.).

Our assessment of the experience of *mutuelles* in the DRC is based on the literature review of various study reports and framework documents, as well as on the analysis of data from the survey of key informants. The METPS social protection policy and strategy documents state that "the number of *mutuelles* has increased significantly over the past twenty years," and position *mutuelles* as an "essential lever" that can "contribute to progress toward UHC," or "the foundations on which Social Protection in the DRC can take root (METPS 2015)." The following assets are cited:

- Low membership fees that enable mass membership
- Sustainability of the movement with good retention rates over a long period
- Current high level of interest and responsiveness among the general public

- The gradual professionalization of the *mutuelles* management and their greater ability to negotiate preferential rates
- Involvement of public authorities, which has a leveraging effect on the development of the *mutuelles*

However, the following shortcomings are also reported:

- Low membership and penetration rates
- The low membership fees limit the scope of the service package provided
- Difficulties in collecting contributions
- Low self-financing capacity of *mutuelles*
- Deficiencies in the supply and quality of services
- The (small) size of *mutuelles*, and hence the low level of risk pooling.

The DRC has 119 *mutuelles*—only 30 of which are approved by the Ministry of Employment, Labor and Social Security—including 117 community *mutuelles* and 2 mandatory *mutuelles* in 16 out of the 26 provinces. The number of beneficiaries of all *mutuelles* is estimated at 1,089,265, with a very low penetration rate of 1.6 percent. Sixty-one percent of provinces have at least one *mutuelle* (PNPMS 2021).

Private Insurances

Private insurers are profit-making organizations generally reserved for the wealthy minority. They cover a very small proportion of the Congolese population, with a very limited and non-diversified offer (Mundabi 2015). According to the list published by the DRC's Autorité régulation et de contrôle des assurances (Insurance Regulation and Control Authority) on June 29, 2022, the Congolese insurance market currently includes 41 insurers, only one of which includes health insurance in its products: Groupement de Gestion d'Assurance RDC Société Anonyme Their contribution to health financing, and more importantly to financial protection, will become even more significant as part of the structural reforms carried out by the state. The aim of those reforms is to provide a suitable environment for the promotion of *mutuelles*, by regulating the private insurance sector, including the effective application of regulatory texts obliging them to take on low-income people, and by defining the minimum coverage that these insurance companies must offer beneficiaries, such as emergency care. Moreover, the state will promote access to health care services for lower-income groups through subsidies. It is important to emphasize that the landscape of private insurance in financial risk-sharing in the DRC is poorly documented.

Distribution of Pooled Funds

The targeting of national public funding is based on all citizens, according to the fundamental texts in the DRC. However, there are systems for prioritizing allocations through funds earmarked for the poor, vulnerable people, and specific groups.

Given the multiplicity of small, generally voluntary funds offering limited financial protection, the targeting of national public funding suffers from a lack of qualified human resources at the level of decentralized state services (i.e., the DPS). Furthermore, this multiplicity of funds, with no real harmonization or pooling, entails the risk of service providers being charged twice, for

example by *mutuelles* and the government, for certain expenses already covered by subsidies and free-of-charge schemes for certain diseases.

Most external funding lacks flexibility, and the targeting is carried out by the partners themselves. There is a lack of coordination and pooling of these different sources of funding to align them with national priorities. However, the tools that should facilitate this coordination and alignment are hard to impose. Similarly, the signing of certain financing agreements does not comply with the health sector strategic choices. This is attributable to a lack of leadership and coordination of TFPs' funding arrangements by national officials.

PURCHASING OF SERVICES AND PAYING SERVICE PROVIDERS

Purchasing, in the health sector, is the allocation of funds to health care service providers for the benefit of the population, through pooled funds, or via direct payment. This is the process by which pooled funds are paid to providers to deliver health interventions by institutions such as the Ministry of Health and national health insurance agencies.

Health care providers receive money in exchange for carrying out a set of activities within the delimited scope of the health accounts. The functions are the types of goods and services provided, and the activities performed, according to the NHAs (System of Health Accounts 2011).

According to WHO guidelines, strategic purchasing involves aligning funding and incentives with entitlements to health care services and must therefore be based on detailed information about providers' performance and the health needs of the population served. It aims to best achieve health system objectives through an active, evidence-based process that defines which specific health services should be purchased from which providers, how these services should be paid for, and how they should be priced. Strategic procurement reforms typically involve improving the way the Ministry of Health, health insurers, and other purchasers make key decisions about the interventions they cover, the providers they contract with, and payment methods to improve access, equity, efficiency, quality of care, and financial protection.

Types of Service Purchases

An analysis of expenditure in the DRC shows the coexistence of several purchasing methods for health care services, with very different characteristics. The procedures for implementing the various service purchasing mechanisms are in place and are largely respected. There is a real segregation of duties, including between the facilities responsible for contracting and those responsible for ensuring payments. But for many purchasing methods, there is still a great challenge in ensuring regular and timely reimbursement of services provided by suppliers, coupled with long verification periods and cumbersome disbursement procedures. In addition, supplier payments are not consistent between buyers. Furthermore, there is a lack of measures or provisions to facilitate the alignment of the various actors with the National Health Service purchasing policy.

Through the state budget, the public sector, together with most subsidies from partners, provides funding for public or contracted health facilities in the form of "lump-sum" transfers, generally based on the number of beds. This is known as passive purchasing and is the most common form of financing in the DRC. Insurance mechanisms (community or compulsory) cover a very small proportion of the population. Several companies, mainly in Kinshasa and the major cities, pay for services on a fee-for-service basis, on behalf of their employees. Some partners also provide lump-sum support, although this is not precisely quantified. The public

sector and foreign aid partners systematically use input financing, mainly for medicines. With its TFP, the MSPHP implements several benefit purchasing schemes, such as the public administration scheme (strategic purchasing), subsidies, direct payments, the social health insurance scheme (mandatory health insurance), and the community insurance scheme (*mutuelles*)

Table 8. Service Purchasing Methods

Method	Buyer	Benefits	Disadvantages
Direct transfers (salaries)	Government	• Existence of a salary banking mechanism for civil servants at all levels • Greater predictability in the collection of funds, with deductions made at source • Reduced fraud in salary payments	• Lack of application of the financing transfer mechanism in the provinces, requiring 40 percent of national revenues to be transferred to the provinces)
Delegated credits	Government	• The DPS financing commission has set up a financing mechanism.	• Payments of delegated funds to suppliers are not harmonized, with no transparent, consistent allocation criteria • Allocation of delegated credits and subsidies to health care facilities is based on average historic performance vs results based, because of delays in implementing the reform. Recommendation: make the DAF operational to speed up implementation of the Program Budget. • Lack of prioritization in the allocation and disbursement of public resources • Inadequate accountability for and monitoring of execution of public resources
Mandatory insurance (civil servants)	Government	• Mandatory health scheme integrated into UHC and managed by the Mutuelle de Santé des Enseignants • Existence of a UHC framework and a steering committee consisting of the President of the Republic and the other ministries involved, which works with the technical coordinating committee of the national UHC council • Creation by the technical committee of six health commissions to help analyze the costs of care and services • Creation of five UHC facilitation bodies by government decree	• The resources pooled at the level of the National Social Security Fund cover only benefits related to occupational diseases and work-related accidents.
Medical assistance (free of charge) and Health Solidarity Fund (FSS)	Government	• Free health care and other forms of medical assistance are considered, in part, to be a strategic purchase—given their impact on access to services and care, improving the health of the most vulnerable, financial protection, and the existence of a well-defined care package.	The transition to strategic purchasing faces the following obstacles: • Insecure, inefficient selection of beneficiaries within the framework of a weak social register (targeting) • The pricing of services to be procured in terms of relevance and harmonization • Low quality of services offered • Optimal reimbursement of services based on invoices crosschecked

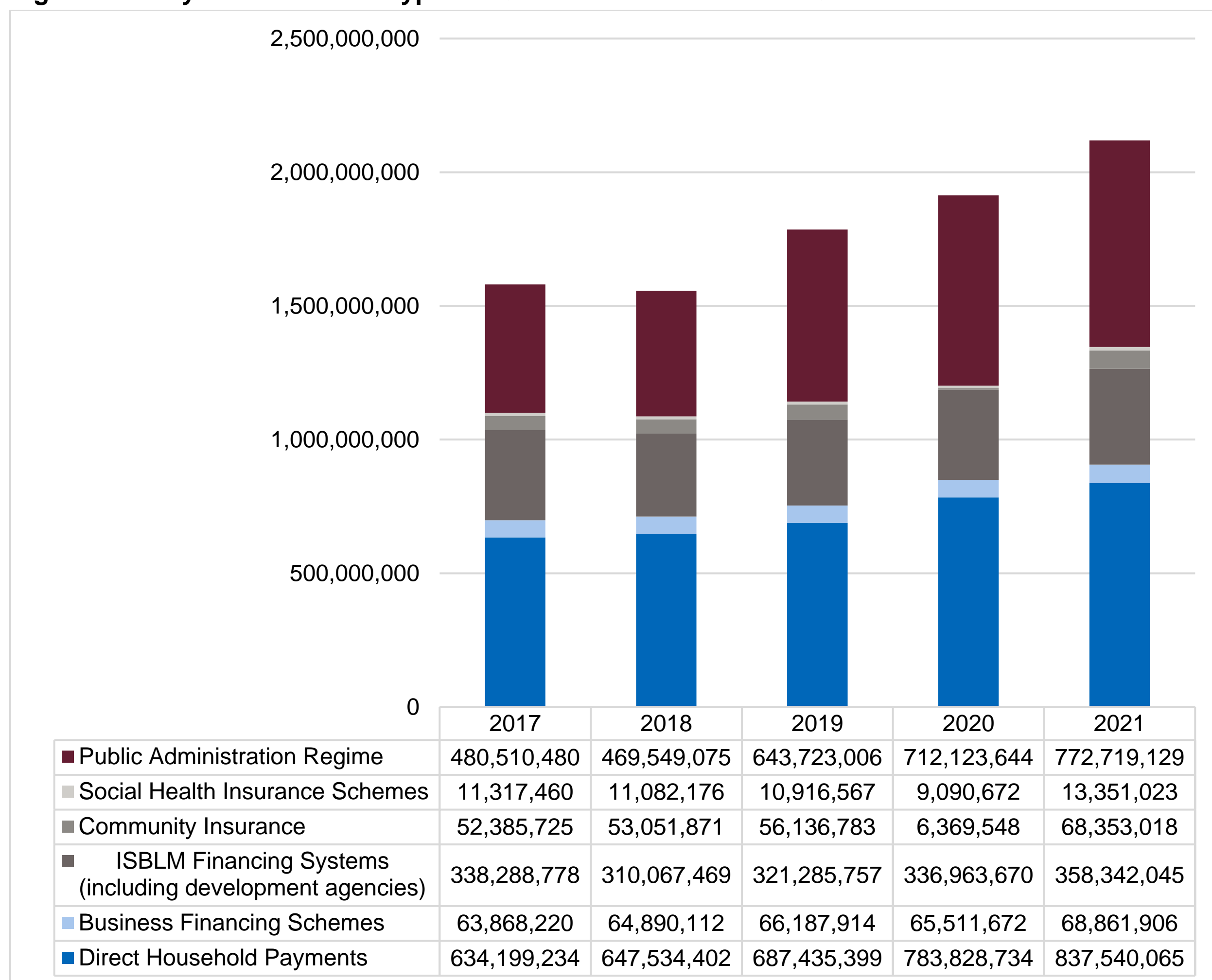
Method	Buyer	Benefits	Disadvantages
Pay-for-performance (earnings-based financing)	TFPs	• Provider payment is determined by information gathered during household satisfaction surveys: there is the score and a bonus based on the threshold. • Pilot tests of RBF, supported by some TFPs, are genuine strategic purchases that strengthen health care provision, establish a results-oriented culture, motivate health care staff. and involve the community in their health development.	• Existing earnings-based financing mechanisms face challenges in their implementation: lack of harmony between mechanisms and procedures, high management costs, the risk of data falsification, the risk of auditor complacency and complicity, and the heavy burden of documents and tools to be filled in periodically.
Improvement of major investments through targeted low-risk construction/ rehabilitation projects	Government	• Effective implementation thanks to the use of information from quality grids and management services • Competitive bidding by beneficiary communities to encourage their contribution	• Investment budgets face low execution rates. • Noncompliance with procedures and cumbersome processing of files and awarding of contracts
Fee-for-service	Direct payment by households	• Access to health care for people who can afford it	• Increasing household contributions, exposing households to unexpected expenses and impoverishment • Direct payments by households suffer from the lack of harmony and updating of services pricing, the high cost to the buyer given the power of the household, and providers overcharging. • Quality of care influences use of services. • High cost of medicines • Inadequate management of *mutuelles*, which need to be assessed to improve their functionality
	Insurance/ *mutuelles*	• Access to health care for beneficiaries • Early treatment of illnesses • Access to health care and social protection for the informal sector population	• The first constraint is the quality of care, which has an impact on the use of services, and is an important determining factor in the uptake of *mutuelles* by users. • High cost of medicines • Inadequate management of *mutuelles*, which requires an assessment of the existing situation to identify needs and gaps to be filled and improve their functionality
Flat-rate pricing	Government	• Improved affordability of care • Flat rates are negotiated between facilities and communities on the basis of prior cost surveys and performance subsidies, considering the specific context of each facility.	• Low coverage rate • Lack of harmonized pricing grids for all provinces
Conditional cash transfer	Government	• The condition of payment of the aid is subject to the beneficiary fulfilling certain obligations or criteria, such as sending their children for regular medical check-ups or vaccinations.	• Low population coverage nationwide • People who do not fulfil their obligations are denied coverage.

Method	Buyer	Benefits	Disadvantages
Equity compensation payment	Government	• Contributes to various anti-poverty strategies • Complements the strategy of abolishing direct payment for care by users • Helps disadvantaged patients overcome nonmedical barriers to accessing health care services	• Inconsistency of information collected during household satisfaction surveys with the data available at the health facility level to determine the score and a bonus based on the defined threshold

Different Types of Buyers

Figure 2 shows the evolution of the different types of health care purchases by buyer.

Figure 2. Analysis of Different Types of Care Purchaser in the DRC



	2017	2018	2019	2020	2021
Public Administration Regime	480,510,480	469,549,075	643,723,006	712,123,644	772,719,129
Social Health Insurance Schemes	11,317,460	11,082,176	10,916,567	9,090,672	13,351,023
Community Insurance	52,385,725	53,051,871	56,136,783	6,369,548	68,353,018
ISBLM Financing Systems (including development agencies)	338,288,778	310,067,469	321,285,757	336,963,670	358,342,045
Business Financing Schemes	63,868,220	64,890,112	66,187,914	65,511,672	68,861,906
Direct Household Payments	634,199,234	647,534,402	687,435,399	783,828,734	837,540,065

As mentioned above, the Congolese population is not protected against the financial consequences of direct payment for health care services. At 40 percent in 2021, the direct purchase of services by households was in first place, ahead of public administration schemes, compulsory contributory health financing schemes, and voluntary private health care payment schemes. This level of direct payment for household health care services is very high, exceeding the threshold recommended by the WHO (20 to 25 percent). These figures confirm the results of the financial risk protection study carried out in the DRC with WHO support in 2018 showing that the incidence of poverty increases among households after they make direct health expenditures at all thresholds. This study also showed that the poverty gap widens after households have made direct payments for health care services (Matangelo et al 2018).

Package of Services to Purchase

- The lack of consistency between different health care payment plans and sometimes a lack of transparency

- The lack of objective criteria for internal resource allocation and the ineffectiveness of program-based budgeting leads to shortcomings in the resource allocation system.
- The shortcomings of the allocation system can be seen in the inequity in the allocation of national budgetary resources between different levels of the health care system and between different types of health care facilities.
- The funds are not transferred in a stable manner.
- Program managers do not effectively implement the directives defined for them, resulting in lack of transparency and lack of involvement of sector managers in decision-making on internal resource allocation.

The lack of consistency between the different care payment schemes, and sometimes the absence of transparency, creates distortions in the system, and prevents the appropriate purchase of a harmonized, predefined package of services by level. The combination of several payment mechanisms—direct payment, marginal lump-sum support, purchase of services, performance-based bonuses, inputs and multiform external support—with no coordinated country-wide purchasing strategy is a source of major disparities and inefficiencies in health care financing.

It will be necessary to identify those health care expenses, to develop the strategy, and to initiate a real scaling up of strategic purchasing for such services, with a real involvement of the state in light of the increasing cost of the care package. According to the PSN CSU 2020–2030, the total cost of the care package will reach over 2.7 billion dollars in 2030, compared with half a billion in 2015. In 2015, health center services accounted for 72 percent of total costs and hospital services for 28 percent. The proportion of services provided by health centers is set to rise between 2015 and 2030, from 72 percent to 77 percent, with the majority of care package services concentrated at the primary level. Moreover, the bulk of costs are for curative care, which accounted for 86 percent of total costs in 2015 and will rise to 90 percent by 2030. Currently, curative services account for 93 percent of total costs, while preventive services account for the remaining 7 percent. The per capita cost, which was $6.89 in 2015, would rise to $22.25 in 2030. With the addition of treatment of malnutrition, the per capita cost would rise from to $24.81 in 2030 (MSPHP 2020).

According to government resource planning for 2023, a basic package will be put in place, consisting of equity mechanisms and strategic purchasing (a results-based management approach). Financing is also planned to improve supply to boost demand.

Service Providers

More than half of the government's health care expenditure was allocated to curative care in hospitals (52 percent), compared with 28 percent for ambulatory health care providers (22 percent for ambulatory curative care and 6 percent for preventive care). This allocation does not meet the expected standards for primary health care. (Table 9)

Table 9. Allocation of Government Expenditure by Provider Based on 2021 Activities (in U.S. dollars)

Service Provider (*Classification of Health Care Providers* (HP))	Functions (HC)	Amount (U.S. dollars)	Percentage *Classification of Health Care Functions*	Percentage of HP
Hospitals	Curative care	172,495,752	52%	52%
	Preventive care	143,175	0.04%	
Ambulatory health care providers	Curative care	71,571,519	22%	28%
	Preventive care	18,278,284	6%	
Auxiliary service providers	Auxiliary services (not specified by function)	30,874	0.01%	0.01%
Preventive care providers	Preventive care	246,869	0.07%	0.07%
Providers of administrative and financial services to the health care system	Health system governance, administration and financing	60,578,614	18%	18%
Everyone else	Curative care	6,154,240	2%	2%
Total		**329,499,331**	**100%**	**100%**

Source: NHAs 2021 Report.

Providers of administrative and financial services for the health care system received 18 percent of the government's health care expenditure. The rest of the world accounted for 2 percent for curative inpatient care outside the country (evacuations, etc.).

Funding from the rest of the world went mainly to providers of administrative and financial services for the health care system (50 percent), followed by health facilities (43 percent), including 23 percent for curative care and 21 percent for preventive care. Preventive care providers (excluding health facilities) accounted for 4 percent and auxiliary services (1 percent). (Table 10)

Table 10. Allocation of Rest of the World Expenditure by Provider Based on 2021 Activities (in U.S. dollars)

Service Provider (HP)	Functions (HC)	Amount (U.S. dollars)	HC Percent	HP Percent
Hospitals	Curative care	90,756,065	11%	12%
	Preventive care	5,206,413	1%	
Ambulatory health care providers	Curative care	94,060,147	12%	31%
	Preventive care	158,641,659	20%	
Auxiliary service providers	Auxiliary services (not specified by function)	7,271,824	1%	1%
Preventive care providers	Preventive care	32,412,332	4%	4%
Providers of administrative and financial services for the health care system	Governance, health system administration and financing	400,698,300	50%	50%
Rest of economy	Preventive care	13,785,570	2%	2%
Total		**802,832,314**	**100%**	**100%**

Source: National Health Accounts report, 2021.

Table 11. Allocation of Household CHE by Provider by Function in 2021 (U.S. dollars)

Service Providers	Functions	Amount (U.S. dollars)	HC%	HP%
Hospitals	Curative care	533,384,753	58%	58%
Ambulatory health care providers	Curative care	145,874,579	16%	18%
	Preventive care	18,533,987	2%	
Auxiliary service providers	Auxiliary services (not specified by function)	21,696,495	2%	2%
Retailers and other providers of medical goods	Medical commodities (not specified by function)	194,425,293	21%	21%
Total		**913,915,109**	**100%**	**100%**

Source: Health Accounts Report, 2021.

Of total recurrent household health care expenditure, 58 percent went to hospitals, 21 percent to retailers and other providers of medical goods (mainly prescription drugs), and 18 percent to outpatient care providers, including 16 percent for curative care and 2 percent for preventive care, and 2 percent to auxiliary providers.

Facilitating Results-based Management

The DRC has adopted RBF to achieve its objectives of improving health system performance, in line with the PNDS and the objectives of some donors such as USAID, with the Integrated Health Program (IHP) aimed at improving the quality, access and availability of a basic health package and Complementary Activity Package, plus services in targeted areas. One of the strong points of results-based management in public health financing is the payment of services by administrative facilities based on performance, and the existence of quality grids associated with the evaluation of quality scores.

Provider payment is generally determined by information gathered from household satisfaction surveys. There is a score and a bonus based on a threshold. At the end of the satisfaction survey, a report is provided to the health facilities. The DPS financing commission also has established payment mechanisms. Providers are autonomous. They receive and manage their own funds but are subject to controls and audits.

The use of national public resources for the RBF suffers from a lack of efficiency and the absence of an active internal control and accountability mechanism in the health sector. The rigidity of the procedures of most TFPs leads to delays in the disbursement of external funds. Performance evaluation is lacking.

Efficient Resource Allocation

Budget mechanisms and procedures for resource allocation are clearly defined in the DRC. The principles of equity in resource allocation for administrative bodies are based on volume of activity and performance contract score. Performance frameworks contain the contractual benefits or indicators, their targets, sources of verification, validation criteria, and weighting. The evaluation criteria for these performance contracts provide clarification of the roles and responsibilities of each actor, the transparency of verification procedures, and payment terms and conditions. Based on these criteria, control and verification missions measure the level of performance for each contracting entity, which determines the level of equity in the allocation of resources.

One of the strengths of this allocation approach lies in the fact that, with decentralization, the government has refocused resources as recommended by administrative management. However, the absence of objective criteria that must be respected when allocating resources internally, and the non-effectiveness of program-based budgeting, have led to certain shortcomings in the resource allocation system. These shortcomings include inequitable allocation of national budgetary resources between different levels of the health care system, and between different types of health care facility. These shortcomings have led to a high level of centralization of health care expenditure, with resources being misused at the central level. Consequently, funds are not transferred in a stable manner. In fact, program managers do not actually have the directives that have been reported as delivered, which means that sector managers are not sufficiently transparent or involved in decision-making on the internal distribution of resources.

This situation may be exacerbated by a lack of evidence and appropriate studies at all levels to better guide resource allocation. The NHAs and other studies have found low capacity and lack of skills for data collection, entry, and analysis at the provincial level.

Although external resources play an important role in financing health care in the DRC, their allocation lacks equity—for reasons including the absence of binding national tools for TFPs to use in multi-year sectoral programming with thematic, geographic, and population-based prioritizing, combined with the absence of an exhaustive mapping of TFP interventions.

Currently, the state budget allocation from the public treasury is transferred to the governor's provincial authorizing officers and does not always reach the health facilities. For greater equity, it needs to be operationalized to ensure that funds are transferred directly to the facilities.

At the same time, there is a delay in the release of funds, and even the order in which they are released, which fails to address the sector's real priorities. The fragmented release of delegated funds, and inadequate control over public procurement and health expenditure procedures, account for the partial execution of investment financing allocated to the health sector in the state budget.

Besides, external financing also faces access difficulties, including:

- The clear willingness of some TFPs to keep their specific programming methods, implementation procedures, and monitoring and evaluation tools
- TFPs' lack of confidence in national procedures to guarantee the expected efficiency, transparency, and accountability: the "imposed" single treasury account without prior consultation and the delays that TFP fund disbursing fund disbursement confirm these concerns

In summary, strategic purchasing and efficient allocation are still at an experimental stage in the DRC, because of insufficient understanding of the PNDS and the lack of internalization of the rules of budgetary procedure. TFPs are currently carrying out sustained strategic purchasing initiatives, but with limited coverage. MSPHP entities and bodies at the central, provincial, and operational level, which manage strategic purchasing, operate on an a posteriori rather than a priori basis. This means it is time to capitalize on the first experiences and scale up strategic purchasing. Strategic purchasing could contribute to improving the quality of services and the governance of mechanisms. However, the success of strategic purchasing in the DRC also requires a higher level of governance.

PUBLIC FINANCE MANAGEMENT

"**Public finance management** is a set of rules and institutions, policies, and procedures that govern the use of **public funds** in all sectors, from revenue collection to **public expenditure** management" (USAID n.d.). Public funds include health care expenditure by the central government, provincial governments, and Decentralized Territorial Entities. Delivery factors represent the total value of resources, in cash or in kind, used in the provision of health commodities and services. Public finance management covers all the different areas of health financing: resource mobilization, resource pooling, and purchasing of services. It is crucial to achieve the objectives of providing quality, affordable health care to the Congolese population. The table below presents a SWOT analysis of public finance management in the DRC.

Table 12. Analysis of Public Finance Management

Strengths of Public Finance Management	Weaknesses of Public Finance Management
• Existence and knowledge of procedures for implementing the various budget planning and allocation mechanisms • Authorization for public administrative entities to have bank accounts to deviate from the instructions relating to the Single Treasury Account • Autonomous management by service providers of the funds allocated to them, backed up by controls and audits • Clear segregation of duties of the authorizing officer and budget executor • Regularly updated texts and implementing bodies within the framework of public management and the budget circuit	• Weak involvement of program managers (under the program budget reform) in public finance management decisions • Inadequate monitoring and evaluation of public finance execution: – Poor alignment of budget execution with public resource allocation planning – Low motivation of health care managers to use resources more efficiently – Delays in releasing funds and cumbersome procedures for disbursing government funds – Lack of capacity in the technical and administrative departments directly involved in public procurement • Public resources transferred to provincial health care are not aligned with priority strategic and programmatic actions, nor with population distribution. • Despite decentralization, a large proportion of public funds, including salaries, continue to be executed by the central government, with consequences for performance monitoring and accountability.
Public Finance Management Opportunities	**Public Finance Management Threats**
• Existence of the Public Finance Act, the Multi-Year Expenditure Planning Document (five years, with a minimum budgetary period of three years), payment authorizations and payment credits, and the Budgetary Management Act to improve the organization of public finance management • Existence of the budgetary principle of retrocession of 40 percent of national revenues to the provinces by the federal government to reinforce their management autonomy • Since 2011, the health budget has been increased each year during the planning phase. • Institutionalization of NHAs to ensure availability of information for decision-making	• Inefficient use of health care resources at national and provincial levels (PNDS 2019–2022) • Weak DPS growth because of uncertain economic forecasts

MAIN FINDINGS RELATING TO THE HEALTH FINANCING ANALYSIS IN THE DRC

This situational analysis of health financing in the DRC highlights the following key findings:

- Despite the efforts made, the resources mobilized remain well below the country's needs in relation to the estimates and guidelines developed at the international level. This lack of funding is related to insufficient prioritizing of health in the state budget—11.5 percent in

2021 and 8.08 percent on average since 2014, and government public spending on health as a percentage of GDP is virtually unchanged at less than 1 percent—combined with an unfavorable macroeconomic environment, weak capacity to mobilize local resources, and inadequate monitoring of the performance of resources allocated under the program budget reform. The state will have to reinforce the budget priority given to health to reach the Abuja objective of investing at least 15 percent of the general government budget in health.

- The financial gap for health care is substantial and could represent an average of between $60.46 and $86.46 per capita per year. The gap is estimated by comparing the international advised $86 (or the more ambitious $112 for primary care) with the $25.54 available in the DRC. The DRC health system's path toward UHC requires its government to consider investing more in health and using the funds more effectively.
- The high degree of health care expenditure centralization is related to a shortage of qualified human resources in decentralized government departments and inadequate application of the texts establishing the decentralization of public services.
- The allocation of investment funding in the state budget is partial and piecemeal because of fragmented release of delegated credits, inadequate control of the public procurement procedure, and political and security instability.
- Household expenditure on health care remains high. To finance its needs—considering the major challenges it faces—the health care system has turned to households, which bear half of health care expenditure, with major risks of catastrophic expenditure among the poorest, who moreover live in rural areas less covered by health care services. All this has harmful consequences for financial protection and equity. This situation is linked to the weakness of health risk coverage systems compared with the objectives set by the 2019–2022 PNDS. Those objectives included to increase the population's financial access to quality health care and services by 30 percent, and to reduce household expenditure from 90 percent to 60 percent by implementing risk-sharing mechanisms across the country. The problem also stems from the inadequacy of the budgets of health care facilities, leading them increasingly to collect resources while providing care under a pricing system that is poorly harmonized and not based on an objective assessment of the costs involved in producing care.
- Insufficient appropriation by sector managers of the new budget management tools (*Document de Programmation Pluriannuelle des Dépenses, Rapport Annuel de Performance, Plan Annuel de Performance*) is linked to insufficient political dialogue between the Ministry of Health on the one hand and the Ministries of Finance and Planning on the other. This dialogue should extend to the principles of mutual accountability between the three ministries with regard to commitments, to improve the quantity and quality of the state budget.
- By committing to an increase in the share of DPS in general public expenditure to reach, by 2030, the Abuja commitment level (15 percent), the country could free up substantial fiscal resources (mobilizing revenues from a strategy of taxing certain products) for health care, which would complement the efforts of the sector itself in improving the efficiency of its spending, and those of the TFPs in providing effective support toward this goal.
- The DRC has made significant progress with legislation to facilitate the pooling of national public funding. Several budget and finance laws have been passed and adopted, and the country committed to implementing UHC (PSN CSU 2020–2030) with the creation of two main instruments, the Health Solidarity Fund and, more recently, the Health Promotion Fund. Despite its various limitations, the Health Solidarity Fund is a real example of pooling

resources for a jointly financed health initiative. It will be necessary to improve the monitoring of its performance and the transparency of its management at the operational level to convince more PTFs to become involved.

- The allocation of national budget resources lacks equity between different levels of the health care system and between different types of health care facilities. This is because of the absence of objective criteria that must be respected when allocating resources internally, the lack of effective program-based budgeting, and the lack of engagement (and, to the extent that they are engaged, of transparency) of sector managers in decision-making on the internal distribution of resources.
- Also lacking in equity is the distribution of external funding by geographic area and target groups, because of the absence of binding national tools for multi-year sectoral programming with thematic, geographic, and population-based prioritization; the absence of an exhaustive mapping of TFP interventions; insufficient coordination between the Ministry of Health and the Ministry of Finance and other relevant ministries; and insufficient assertion of leadership and governance by the Ministry of Health.
- The volume of subsidies for health care facilities remains marginal, both for the state budget and for that of local authorities. Health facilities are mainly remunerated by direct payments from users, disbursed at the time services are used.
- The procedures for implementing the various service purchasing mechanisms are in place and almost fully respected. There is a real segregation of duties, including of the structures responsible for contracting and paying. However, the purchasing system allocates resources based on standards that often do not consider the real needs of each type of facility, and it does not consider quality monitoring based on performance.

RECOMMENDATIONS

1. Mobilizing Financial Resources

- Switch to Program Budget mode to improve financial management in the sector.
- Intra-governmental advocacy to increase the share of the budget allocated to health in line with the Abuja commitments (15 percent).
- Accelerate the digitization of tax and non-tax procedures to improve revenue collection.
- Effective application of international declarations—in particular, the Paris Declaration on Partner Alignment.
- Sensitize local authorities to capture information on resources allocated to health.
- Increase community participation in the supply of and access to essential health services, and toward the use and quality of services.
- Strengthen the capacities of health personnel by providing them with the expertise required to enable them to advocate effectively for the mobilization of resources, and also to equip them to make rational use of the sector's resources.
- Integrate corporate social responsibility approaches by encouraging the private sector to increase resources.
- Increase the share of financing for health investments and operating subsidies for health services, to make up for the deficit in the health system, for greater portability and sustainability of interventions.

2. Pooling Financial Resources

- The MSPHP must play its leadership role within the framework of a genuine, consensual sectoral approach based on a single, achievable Strategic Plan, synergistic financing, and a joint monitoring and evaluation system.
- Encourage the *Groupe Inter Bailleur du Secteur de la Santé* to align itself with the country's 2024–2030 strategic plan, which is firmly in line with the health sector-wide approach based on a single plan, complementary and synergistic financing, and a single monitoring and evaluation system.
- Clarify the roles of each stakeholder and the entities involved in health financing, to better support the state in pooling the program budget.
- Involve health managers at all levels of the health pyramid in the process of implementing resource pooling reforms.
- Mobilize upstream the financial resources needed to implement strategic plans (PNDS, PPDS, and PDZS).
- Draw up the text and laws on the pooling of financial resources for health.
- Establish a permanent dialogue between the various ministries to operationalize the coordination mechanism.
- Update the decree creating the National Steering Committee and the framework for consultation and coordination of health financing organizations, to ensure effective coordination of the resource pooling reform process.

- Scale up and professionalize existing *mutuelles*.
- Promote *mutuelles* unions and federations.
- Draw up a comprehensive map of *mutuelles*.
- Support the creation of inter-ministerial provincial commissions.
- Use risk pooling initially at the *zone de santé* level, then at network level (partially, or totally when conditions are favorable).
- Support professional management skills at provincial level.
  - Technical and financial management skills
  - Marketing skills
  - Governance support capacity
  - Personnel
  - Adapted data management software (IMIS)
  - Operating resources
- Use *mutuelles* as a mechanism for financing health care for the needy, where they exist.
- Include *mutuelles* as an integral part of the health system.
- Develop and implement a *mutuelles* expansion project.

3. Procurement of Financial Resources

- The MSHPH must set up a basket fund to harmonize payments, avoid duplication of funds, and ensure consistency in purchasing and payments.
- Make the DAF operational to accelerate implementation of the Program Budget.
- Strengthen the accountability mechanism for budget execution.
- Risk-based verification of procurement.
- Strengthen control mechanisms and the application of sanctions.
- Simplify and harmonize standard tools for RBF implementation.
- Streamline procedures for files processing and executing contract awards.
- Strengthen mechanisms for monitoring the execution of contracts.
- Wait for the current study to harmonize procedures for implementing flat-rate pricing.
- Strengthen the legal and regulatory framework to ensure greater devolution of responsibility and accountability for the resources provided to the provinces.
- Determine the package of care to be covered by level of the pyramid and by type of provider, which will initially include high-impact preventive, curative, and promotional interventions for maternal, newborn, and child health.
- Determine the real costs of producing essential care and service packages by level of the health pyramid and by type of care provider, for harmonized updating of tariffs to contribute to good strategic purchasing, better coverage, and efficient allocation of resources.

- Harmonize PBF models on the basis of independent joint evaluations to remove obstacles to scaling up.
- Gradually move toward a universal health insurance system adapted to the various target population groups by integrating the different free-of-charge schemes.
- Motivate households and make it compulsory for them to join risk-sharing institutions, with a subsidy for vulnerable and low-income groups to participate.
- Promote community-based structures enabling the implementation of health risk-sharing mechanisms, to give the poorest and most marginalized access to basic health care and services through efficient programmatic implementation of the CSU 2020–2030 NSP.

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ANNEX A: LIST OF INSTITUTIONS AND ORGANIZATIONS FOR THE DATA COLLECTION PHASE

	Institution Name
Public Administrative Authorities in Charge of Health and Other Relevant Sectors	
1	General Health Secretary (Secrétaire Général à la Santé)
2	Department of Studies and Planning (Direction des études et de la planification) from the MSPHP
3	Administrative and Financial Department (Direction administrative et financière) from the MSPHP
4	NHAs Program (Programme National des Comptes Nationaux de la Santé)
5	National Program for the Promotion of *Mutuelles* (Programme National de Promotion des Mutuelles de la Santé)
6	Coordination of Financial and Administrative Management (Coordination de la Gestion Financière et Administrative)
7	Department of Human Resources for Health (Direction des Ressources Humaines pour la Santé)
8	Strategic Purchasing Technical Unit (Cellule Technique d'Achat Stratégique)
9	General Directorate for Organization and Management of Health Services and Care (Direction Générale d'Organization et de Gestion des Services et Soins de Santé)
10	General Health Inspectorate (Inspection Générale de la Santé)
11	Public Finance Reform Commission (Commission des reformes des finances publiques)
12	Kinshasa School of Public Health (École de Santé Publique de Kinshasa)
13	Health System Development Project (Projet de Développement de Système de Santé)
Members of the Groupe Inter bailleur du Secteur de la Santé (Health Inter-Donor Group) and Other TFPs	
14	United States Agency for International Development
15	French Development Agency
16	World Bank Group
17	World Health Organization
18	Belgian Development Cooperation Directorate General
19	Foreign, Commonwealth & Development Office of the United Kingdom
20	Abt Associates Integrated Health Program
21	Catholic Organization for Relief and Development Aid
National Operational Implementation Bodies	
22	National Council of Health NGOs (Conseil National des NGO en Santé)
23	Platform of Organizations Promoting *Mutuelles* (Plateforme des Organizations Promotrices des Mutuelles de Santé)
24	Kinshasa Provincial Health District (Division Provinciale de la Santé)
25	*Zone de santé* of Gombe Central Office
26	Kinshasa General Hospital (Hôpital Général de Kinshasa)
27	Bumbu Mother and Child Center
28	Sud-Kivu Provincial Health District (Division Provinciale de la Santé)
29	*Zone de santé* of Kadutu Central Office
30	Ibanda General Hospital
31	Nguba Health Center
32	Haut-Lomami Provincial Health District (Division Provinciale de la Santé)
33	*Zone de santé* of Kamina Central Office
34	Kamina General Referral Hospital
35	Kamina Health Center

	Institution Name
36[1]	Tanganyika Provincial Health District (Division Provinciale de la Santé)
37	*Zone de santé* of Kalemie Central Office
38	Kalemie General Referral Hospital
39	Kalemie Health Center
40	Kasaï-Central Provincial Health District (Division Provinciale de la Santé)
41	*Zone de santé* of Kananga Central Office
42	Kananga General Referral Hospital
43	Katoka Health Center
44	Kongo Central Provincial Health District (Division Provinciale de la Santé)
45	*Zone de santé* of Nzanza Central Office

[1] This questionnaire is adapted from the list of questions in the WHO's "The health financing progress matrix: country assessment guide": https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix

ANNEX B: QUESTIONS FOR ASSESSING THE STATE OF THE FINANCIAL LANDSCAPE

This annex includes all the questions analyzed in this study, by key function. And each level of the health care system and/or each type of institution will be interviewed on the basis of a specific interview guide.

For each of the financing mechanisms explored for this study, and depending on the source of information (literature review or key informant interview), the following questions will be investigated. It must be emphasized that this interview guide will be adapted to each interlocutor according to their role and functions in the field of health financing and governance, and depending on specificities certain questions may be the subject of more-detailed analysis.

Evaluation Field	Questions
General information	Who is financing health care and how (name two or three main sources)?
	Does your organization receive financial support for its operations (not including staff salaries and bonuses) from the Congolese government (central and/or provincial)?
	If so, how many years has this support been in place? (Less than three years? Three to five years? More than five years?)
	When was the last time you received money from the government (national or provincial)?
	If your institution has received financial support from the government (national or provincial), what is the amount (in U.S. dollars or CDF)?
	What are the relevant schemes to be included in the analysis that you can you tell us briefly about?
	Which are the existing social protection mechanisms?
	In which areas do you intervene (mobilization, pooling and purchasing, governance)?
	Which is your role in health financing and governance in the DRC?
	Which texts, policy documents, and strategies on health financing are you familiar with?
	In your opinion, what is their level of adoption, dissemination, and understanding?
	What is the level of implementation of strategic and policy documents (e.g., on strategic purchasing, institutionalization of National Health Accounts (NHA), program budgets, etc.)? What are the gaps and challenges?
	Which departments, organizations and other actors do you interact with in your field?
	What are the levels of implementation of your intervention in the field of health financing?
	How do you rate the coordination between your institution and stakeholders (DAF, DEP, PNCNS, etc.)?
	How do the various actors perceive the financing system (outlook)?
	What are the opportunities for developing your actions/interventions in health financing?
	What constraints and challenges have you encountered in playing your role in health financing?
	What are your capacity-building needs (technical, organizational, institutional, etc.) to fully play your role in health financing?
	Are there any recommendations you would like to make?
Policy, processes and governance	Is there a health financing policy statement? If so, which one? Is it up-to-date, target-driven, and evidence-based?

Evaluation Field	Questions
Health financing	Are health financing organizations structured according to appropriate governance arrangements and processes (consultation and coordination framework)?
	Is health financing information systematically used to monitor, evaluate and improve policy development and implementation?
	Are specific health programs aligned with or integrated into overall health financing strategies and policies (disease-specific health programs)?
Resource mobilization	Does the country's strategy for mobilizing national resources reflect international experience and evidence?
	To what extent is public funding for health care in the DRC predictable over several years?
	How are budget transfers carried out in a decentralized system? How stable is the flow of public funds to health care providers?
	Apart from those listed below, what are the existing financing schemes or programs?
	Strategic purchasing, subsidies, direct payment, flat-rate pricing, voluntary prepayment, and mandatory health insurance.
	To what extent are the various sources of revenue raised in a progressive manner?
	What are the sources and capacities for mobilizing resources at intermediate and decentralized levels?
	What are the capacities of decentralized levels to manage and execute the financing mobilized?
	How do you rate the involvement of the private sector in resource mobilization? What role does the private sector play in this function? What steps can be taken to promote private sector involvement in health care financing at all levels?
Pooling resources	Does the DRC's revenue pooling strategy reflect international experience and evidence?
	How do you rate the health system's ability to redistribute prepaid funds (available funds)?
	What measures are in place to address the problems resulting from several fragmented pools?
	Are the multiple sources of revenue and funding streams organized in a complementary way, supporting a common set of benefits?
	What is the role and scope of voluntary health insurance in health financing? What are the challenges and gaps?
	Do pooling arrangements promote coordination and integration between health programs and with the wider health system?
	Is there a national purchasing policy for health care services in the Democratic Republic of Congo?

Evaluation Field	Questions
Purchasing and payment for services	What are the different purchasing mechanisms for health care services developed in the country?
	Determine which mechanism we can discuss with the informant (choose one or two, depending on his or her knowledge)
	a. Direct payment
	i. Fee-for-service
	ii. Lump-sum payment
	b. Mandatory health insurance (AMO)
	c. Subsidies and gratuities
	d. Strategic purchasing (PBF, etc.) (CTAS)
	e. *Mutuelles* (PNPMS)
	Are there any procedures for implementing these various purchasing mechanisms?
	Does the DRC have any experience of purchasing health services with other countries?
	How many stakeholders/suppliers are involved in purchasing services in the country? What is the level of alignment of stakeholders/suppliers with this national health services purchasing policy?
	How are the services of administrative institutions subsidized in the purchase of services?
	How does the government purchase health care services? How do other funders purchase health care services?
	What are the criteria used to allocate resources?
	To what extent is provider payment determined by information on the health needs of the population they serve?
	Are provider payments harmonized within and between buyers to ensure consistency?
	Are purchasing mechanisms efficient? To which extent?
	Is the information on providers' activities gathered by purchasers, including the government, adequate to guide purchasing decisions? Is there a mechanism in place to analyze data on the procurement of health services in the country?
	What measures have been taken by the health authorities to ensure that the various stakeholders are aligned with the DRC's national health services purchasing policy?
	Do purchasing methods promote quality of care?
	How does the purchase of services contribute to good governance of resources in the health sector in the Democratic Republic of Congo?
	Do provider payment methods and complementary administrative mechanisms address any over- or under-provision of services?
	How does the procurement of services ensure the accountability of implementing partners?
	What lessons have been learned and what steps need to be taken to ensure the effectiveness of the mechanisms and policy for purchasing health services in the DRC?
Public finance management	Is there an up-to-date assessment of the main bottlenecks in public finance management?
	Do health budget formulation and implementation promote alignment with sector priorities and flexible use of resources?
	To what extent do providers have financial autonomy?
	What are the mechanisms for channeling public funds to health care facilities at each level?
	Does your facility have an annual operating budget?
	If so, who is involved in its preparation? (Please indicate the status of the people involved in preparing this budget? Members of the steering committee, members of the management committee...)?
	Are processes in place for health authorities to engage in comprehensive budget planning and multi-year budgeting?
	Are measures in place to address problems arising from both under- and over-budgeting in the health sector?
	Are reports on health expenditure complete, timely and accessible to the public?