Country Assistance Framework, DRC
Proposal on Health Care Financing

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1. Current situation

The development of policy and implementation of a stable and sustainable health care financing mechanism has become an urgent need for DRC. The Draft Strategic Note for the Country Assistance Framework (CAF) has already noted the need for an increase in committed government funding, continued support from the development partners and review of the potential for expansion of social health insurance.

The PRSP (2005) for DRC notes the need to develop a financing mechanism to enable access to health care without financial barriers. The Health System Strengthening Strategy prepared by the Ministry of Health in 2006 sees that health funding is a key factor in the revitalization of the health zones and proposes that the following measures be adopted (Section 2.1.3.3):

(i) mobilization of both public- and private-sector resources for health,
(ii) reversal of the current trend in order to assign more resources to peripheral areas,
(iii) better use of community financing,
(iv) encouragement for mutual health insurance schemes, of scales of charges that fit with the principle of comprehensive care and which take into account the need to recover costs, and
(v) Health-care subsidies.

The Ministry of Health has already recognized the potential of social health insurance as a major health care financing method and established a National Programme for the Promotion of Mutuelles (PNPMS) in 2005, based on Ministerial Decree 1250. The team has drafted a three-year plan (2006-2008), with technical support from STEP, ILO. The Director PNPMS has formed a group of partners which holds monthly meetings.

The current scope of social protection for health is very limited. The National Social Security Institute (INSS) administers a compulsory social security scheme for salaried workers, now covering only old age pensions and work injuries and diseases. However, only 2% of the eligible salaried population is covered, compared with 27% in the past. The INSS is considered weak and its governance is no longer tripartite. Health care for workers is still covered by the Labour Code; last amended in 2001, obligating the employer to cover health costs of workers and their families. Only large enterprises still comply with this law, leaving most salaried workers without protection. In the past; civil servants were issued a card which entitled their family members to free of charge care in public facilities, but this is no longer practiced. So far, the government of DRC has not developed any policy on the expansion of the social security system to cover health care, or to reform the administrative structure. For this reason, the Federation of Employers and the Unions have shown interest in other health insurance arrangements.

Micro-insurance or community-based schemes or Mutuelles as they are termed in DRC have been in existence for several decades. Some of the existing Mutuelles provide health care and other benefits, such as coverage for expenditures for marriages, births and deaths. The funeral grant is considered an important benefit. Provider payment for health care is predominantly

by capitation and the schemes mainly contract with providers run by the churches (BDOM). While the concept has a positive connotation as a health care financing mechanism; there are currently several problems that have prevented their growth on a larger scale:

- Small membership of between 50 – 300 families
- Contributions are high, over 2 USD per person per month, and in most schemes are applied for individuals rather than families resulting in exclusion of some dependents, especially children in some families.
- The providers claim high utilization of between 2.7 – 3.7 contacts per insured person per year. There is concern that the rate is inflated due to abuse of the card by non-insured persons. (The current estimated use by the population of DRC is between 0.15 and 0.4 contacts per year.)
- As the schemes are listed as non-profit organizations they are obliged to pay state registration fees, based on an outdated law (1958). These fees are between 200 – 1,000 USD and deter the proper establishment of schemes.
- Concern that if health insurance is expanded, the enterprises which now operate their own health care facilities will try to stop providing services to their workers and the local population. These enterprise-owned hospitals and clinics are now considered of higher quality than other facilities in most parts of the country and so that their closure could have a negative impact on the quality of health care.

2. Proposal for the CAF Strategy paper
Big Idea 1 – All the population will have access to health care without financial barriers

Since financial barriers to seeking health care are a major reason for the lack of access to care, the area of health care financing should be given higher priority. In addition to proposing a substantial increase in government funding for health care to improve public health functions; the proposal calls for acceleration of the development of social health insurance, for all population groups.

2.1 Objectives

The proposal recognizes the multiple objectives of developing social health insurance for DRC as:

- achieving a stable and adequate financing mechanism
- a source of predictable additional revenue for health care providers which can be allocated to the improvement of the income of health workers
- equity in access to health care through the sharing of risks and pooling of resources,
- facilitating rational household expenditure on health and health seeking behaviour through regular prepayment rather than at the time of use,
- as a mechanism to generate confidence and trust through the commitment between the insured population, fund holders and health care providers,
- As a means of promoting improvement in the health care system
- As a means of promoting achievement of the MDGs in DRC.

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2.2 Approach for different populations

A parallel approach for the development of social health insurance for the different population groups is recommended:

- **Compulsory social health insurance** through a social security framework for the public and private salaried sector workers and their dependents, through the development of legislation and an appropriate tripartite administrative structure. The monthly contributions should be set as a percentage of salary, to be shared by employer and salaried employee (with employer contributing at least 50%).

- **Voluntary insurance** through the development of Mutuelles or community based health insurance (CBHI) schemes sponsored by different development partners, national non-government organizations, and health care providers for families that can contribute on a regular basis. The monthly contribution should be a flat rate amount, equal to 2 – 3% of household income and with levels for households with different family size, as long as large families are not deterred from membership. A single contribution should cover all family members, as defined by the scheme.

- **Social assistance** through the use of government and donor funds to purchase health insurance for the indigent, non-economically active and other vulnerable populations. The amount of monthly contribution should not be less than the average per individual covered by voluntary insurance. Social assistance funds could also be used to subsidize all households, without prior identification of the poorest, through a uniform subsidy, which will be reduced and replaced by household contributions over a period of five years. Decisions on the subsidies could involve community organizations, as part of the Community Recovery approach.

2.3 The major characteristics of all the schemes:

Health insurance benefits: should be comprehensive and cover including primary health care in the community and hospital based outpatient and inpatient care, available within the Health Zone and provincial levels, and including health promotion and prevention. Family planning and the treatment of STI´s and mental health services should be included as benefits. To assist in reducing maternal mortality, a Safe Motherhood programme should be included, with a protocol to guide appropriate ante-natal, delivery and post-natal care. Testing for HIV/AIDS and prevention of mother-to-child transmission should be included in the protocol.

In addition to health care benefits, specific cash benefits could be included, according to local conditions:

- Payment for transport to referral hospital, preferably to be paid directly to the provider of transport, at set tariffs arranged by contract in specific locations.
- Cash maternity benefit on completion of a Safe Motherhood Protocol.
- Cash funeral grant in the event of death of an insured person.

The benefits should not be limited according to the volume or cost of health care required or used by an individual insured person or household. Time limitations may be imposed, such as a maximum of 45 days of inpatient hospital care in one year.

Provision of health care benefits: The health care benefits should be provided by accredited health care providers in both the public and private sectors, and on the basis of annual contracts defining the insured, benefits, payment conditions and quality assurance requirements. The collaboration between the social health insurance and the vertical disease programmes funded by other sources is essential to ensure that social health insurance does not replace government funding but supplements it.
Provider payment: Capitation should be the main method with an allocation of a fixed percentage of the contribution revenues for services outside the capitation contract.

Co-payments or ticket moderateur: It is strongly recommended that the compulsory and voluntary schemes do not allow co-payments to the provider at the time of use. Every effort should be made to demonstrate that prepayment does indeed cover the costs of care at the time of use and provider and patient education should be used to counter misuse and abuse.

Allocation of health insurance contribution revenues: The revenues should be allocated to allow the maximum expenditure on health care benefits including health promotion and prevention; a reasonable level of reserves, with administrative costs kept to a minimum but should cover the costs of a basic information system to support the management and quality assurance functions. The table below illustrates how the revenues could be allocated.

Table 1: Allocation of health insurance revenues

Health insurance benefits		**82.0 %**
Primary health care (including health centre and home care)	45.0%	
Secondary level hospital care (including outreach to health centres)	20.0%	
Provincial level hospital care	12.0%	
Transport	2.5%	
Cash benefits (funeral grant, maternity grant)	2.5%	
Management Functions		**18.0%**
Administration (including information system)	7.0 %	
Training	1.0%	
Scheme Promotion	1.0 %	
Public benefits fund	2.0 %	
Contingency fund	3.0 %	
Non compliance allowance	4.0 %	
Total:		**100.0 %**

Allocation of health insurance revenues at provider level: Guidelines should be put in place to assure that providers allocate a fixed minimum percentage of their revenues from capitation to provide incentive payments to all health workers and a fixed percentage to improvement in patient conditions.

Administration of the compulsory scheme: it is recommended that the National Social Insurance Institute serve as the administrative structure, through legislation to extend benefits to health care, and following reform of the organizational structure and representation.

Administration of the voluntary schemes: The scheme may be set up and managed by a defined community organization, health care provider, NGO, cooperative or association. Whatever management structure is chosen, it must have the following components:

- Registration as a legal entity according to national legislative requirements regarding such non-profit entities,
- Accreditation and registration following regulations of the Ministry of Health.
- Scheme Management Committee, with representatives of the insured members and contracted providers.

3. Risks to the development of social health insurance in DRC

The major risks are obviously related to political stability and steady economic growth in DRC in the recovery and transition stage. However, there are certain factors that pose specific threats to the sustainable implementation of social health insurance. These include health care worker conditions in the public sector, the poor condition of health care facilities and equipment in most parts of the country and weak knowledge on the appropriate management of common diseases, the lack of understanding about prepayment among the majority of the population and the lack of trust in authorities and the high proportion of the population with very low incomes. A major threat is the uncontrolled development of schemes without any uniformity, coordination and supervision. The table below has proposals to deal with these risks.

Table 2: Summary of proposals to deal with risks and special problems

Risk/Problem	Proposed intervention/arrangement/condition
Major health problems	Facilitate use of updated protocols and treatment guidelines at health facility level. Use "public benefit" health insurance budget allocation for training on selected health problems and health education and improve infrastructure and maintenance of equipment. Include outreach in provider contracts to assure higher trained levels of health workers to provide consultations and training in health centres.
Cultural and credibility factors	Carry out repeated campaigns to inform community leaders and all community members of the potential benefits of membership and compliance with contribution payment. Demonstrate the "safety" of the members money by transparent management of money Use seed money to assure initial supplies of drugs, other items, and demonstrate availability of services for patients who have prepaid. Use public benefit allocation to improve patient comfort
Public Health workers	Allocate revenues to health worker incomes and stress the regularity of the increment Include outreach programmes to bring hospital doctors to health centres, and encourage follow-up of hospitalized patient by health centre staff. Plan continued education for health professionals at later stage Include health workers in Management Committee.
Uniformity in Schemes	Coordination of Schemes through a network developed by the PNPMS of the Ministry of Health, following regulations and guidelines The uniformity should facilitate comparison among schemes and constructive competition in reaching coverage targets.

4. Linkage with other pillars of the CAF

The proposal follows the general approach of the CAF, with achievements of the MDGs as basic goals. Moreover, the proposal follows the main emerging Big Ideas – **"Security, Jobs and Services for All" and represents a Rights Based approach.** It is stressed here that social health insurance covering each family member in all population sectors enables access to health care for each individual in his/her own right and thereby diminishes the possibilities of gender or other discrimination.

Several components of the proposal are included in the recommendations of other pillars outside the health sub-pillar. These include:

Pillar One: Good Governance

The proposal contains several legislative and regulatory mechanisms that should contribute to good governance:

- Policy development, legislation on compulsory social security and reform of the National Institute of Social Security to achieve appropriate tripartite representation
- Regulations on voluntary social insurance schemes to achieve uniformity, coordination and monitoring

Pillar Two – Pro-Poor Growth

The proposal calls for coverage of the very low income/indigent population as well as other vulnerable groups through social assistance, with committed financing to cover membership in social insurance schemes, without discrimination and stigma.

Pillar Three – Sub-Pillar on Social Protection

While this proposal focuses on health care, it conforms with the approach in four of the five recommendations in the paper for the Social Protection pillar: Advance and protect the rights of vulnerable groups, Build the capacity of structures providing social protection/ assistance, guarantee universal access to social services and reform the existing system of social security and extend its coverage to workers in the informal economy.

Pillar Four – HIV/AIDS

As noted in the proposal, the health insurance benefits include the diagnosis and treatment of sexually transmitted infections. This is important to encourage early detection and prevent spread. With regard to HIV/AIDS, the services funded by national programmes including ARV treatment, should be covered by the programmes, through referral by the providers of health care that contract with the schemes. Voluntary testing and prevention of mother-to-child transmission are part of the recommended Safe Motherhood Programme.

Pillar Five –Community Recovery

The proposal stressed at the outset the building of confidence and trust are at the basis of the approach. This conforms to Big Ideas 1, which is to help communities take control over their own future and mobilize their own skills and resources, by a) establishing and strengthening local organizations that set priorities, plan and manages community recovery and b) funding community groups that deliver collective benefits.

4. Next Steps

In addition to inclusion in the CAF Strategy paper, it is recommended that the contents be discussed within the Ministry of Health as well as Ministries of Finance and Labour as well as INSS and the Civil Service Administration. The creation of PNPMS already signifies to a large extent the commitment of government to extending social health insurance. A detailed Plan of Action can be developed, defining the role of each partner based on a declaration of willingness to provide technical and/or financial support. At this point in time, it is not recommended that additional studies be undertaken except those already being carried out by STEP/ILO to obtain better information on costs and use of health care.

WHO and STEP/ILO can assist in preparation of the Plan of Action for the initial phase and collaborate with the development partners to reach an estimate for funds needed for defined stages over a period of 5 years. This Plan should be an integral part of the CAF resource mobilization effort and could then become a fully funded project with major technical support from STEP/ILO in collaboration with WHO.

The plan should also consider assistance in criteria and selection of new target populations for new schemes and training and orientation of stakeholders as well the agencies involved in new schemes. The plan should furthermore determine criteria for start-up funds and possible needs for investment in infrastructure where these are lacking. Important components will be capacity building at central, provincial activities and health zone levels.

It is considered extremely important to assure uniformity in the voluntary social health insurance scheme design in DRC and all schemes should be part of a network receiving support from the Ministry of Health. To ensure and coordinate this uniformity in scheme design, the National Programme for the Promotion of Health Mutuelles (PNPMS) should have primary responsibility for development, oversight and eventual amendments to the uniform design principles.

To carry out its role, it is proposed that in a very short time, the PNPMS undertakes the following, with the technical assistance of STEP/ILO and WHO.

- Confirmation of the commitment of the Ministry of Health to include social health insurance in its Health System Strengthening Strategy
- Sensitizing of high-level decision makers, development partners and other stakeholders in health and related agencies, as well as health care provider groups on the plans for acceleration of social health insurance as a major health financing strategy for DR Congo.
- Training of the core staff in PNPMS (ILO Turin Training Centre) and continued sensitization of all the stakeholders/decision-makers following the training.
- Drafting of interim Ministerial Regulations and Guidelines for establishment and operations as well as registration procedures for agencies interested in establishing schemes. The guidelines will include the process of launching schemes, principle design components, guidelines on the allocation of the health insurance revenues, updating of protocols for the management of common diseases (also as quality assurance benchmarks), standard information system tools, standard contracts with local public health care facilities, including health centres and referral hospitals and guidelines for Management Committees with composition adapted to local options.